Section 1115 Demonstration Extension Application Request

Michigan 1115 Behavioral Health Demonstration
Project Number 11-W-00305/5

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I. PROGRAM DESCRIPTION

Summary

The Michigan Department of Health and Human Services (MDHHS) is requesting a five-year extension of the Michigan § 1115 Behavioral Health Demonstration, which is currently authorized through September 30, 2024. This renewal application requests continued authority to provide residential treatment services for individuals who are receiving treatment and withdrawal management for substance use disorders (SUD) and are short-term residents in facilities that meet the definition of an institution for mental disease (IMD). Through this extension, the state also intends to continue operation of its prepaid inpatient health plan (PIHP) delivery system to manage specialty mental health and SUD treatment benefits.

Additionally, MDHHS is seeking new authority to provide contingency management (CM) as part of a comprehensive treatment model for Medicaid beneficiaries living with SUD. The state initially intends to provide CM on a pilot basis to individuals living with a stimulant use disorder (StimUD) and/or an opioid use disorder (OUD), but may consider extending the service on a mandatory, statewide basis after gaining experience with the intervention. MDHHS is seeking a two-year approval of this component of the demonstration, from October 1, 2024, through September 30, 2026.

Background

On April 5, 2019, the Centers for Medicare and Medicaid Services (CMS) approved Michigan's § 1115 Demonstration to allow the state to broaden the crucial component of residential SUD services. This approval permitted MDHHS to provide a broader continuum of care, including withdrawal management services in residential treatment facilities that meet the definition of an IMD. While Michigan has historically maintained a robust network of SUD providers and services, the prohibition against Medicaid reimbursement for services provided to adults aged 21-64 in an IMD setting resulted in a disjointed benefit package and the inability to ensure access to needed services. The state sought to improve health outcomes and sustained recovery by offering a full continuum of SUD treatment and recovery supports based on American Society of Addiction Medicine (ASAM) criteria or other nationally recognized, SUD-specific program standards.

Since 1998, Michigan has operated a behavioral health carve-out for the Specialty Service Populations[1] using county-sponsored PIHPs. Physical health care, including a benefit for persons with mild and/or moderate behavioral health disorders, is operated through Medicaid Health Plans (MHPs). Funding for SUD services was traditionally managed by regional Coordinating Agencies (CAs), which contracted for the delivery of SUD services. In 2013, to better integrate behavioral health and SUD services, CAs were dissolved and incorporated into the PIHP management and governance structures. The PIHPs are now responsible for all SUD service and supports (except for certain medically monitored supports) regardless of severity of condition. Authority to operate PIHPs is granted through this demonstration.

While preliminary findings of the impact of the demonstration are encouraging in several key areas, the COVID-19 public health emergency (PHE) had a substantial impact on implementation. The disruption in services and inflated Medicaid enrollment related to the PHE

[1] Includes adults with severe and persistent mental illness, children with severe and emotional disturbance, individuals with intellectual/developmental disabilities, and individuals with SUD.

make it difficult to detect trends in administrative measures. Additionally, implementation of some demonstration activities was delayed due to the PHE, such that the available data does not represent post-implementation outcomes. Michigan intends to utilize the extension period to further advance and study progress toward meeting demonstration goals. Additionally, MDHHS proposes to implement a new initiative, Contingency Management (CM), to further its efforts in addressing SUD.

Contingency Management

CM is an evidence-based behavioral health treatment in which individuals living with a SUD can earn motivational incentives in the form of small, non-cash rewards when they avoid the use of specified substances or otherwise take steps to engage in recovery. CM delivers vouchers, gift cards or other rewards for the desired behaviors as evidenced by specific activities such as negative drug screens. The rewards are an inherent and central element of the CM treatment. CM works because illicit drugs can take over the natural reward pathway in the brain. CM helps revert the reward pathway into balance by offering people non-drug rewards in exchange for not using certain substances. The immediate reward helps tip decision-making away from use and helps individuals get through difficult periods when cravings are overwhelming, and the long-term benefits of recovery seem remote.

MDHHS is proposing to offer CM services to Medicaid beneficiaries living with a StimUD and/or OUD. Under the Recovery Incentives (RI) pilot, eligible beneficiaries will be able to earn motivational incentives for non-use of stimulants and/or opioids as evidenced by negative urine drug tests. To address treatment retention with beneficiaries who struggle with non-use early in treatment, MDHHS also proposes to offer a partial incentive for continued CM engagement over a limited period for beneficiaries with positive urine drug tests. Under the proposed design, a participating beneficiary would be eligible to earn a maximum of $599 in the form of low-denomination gift cards annually.

Growing SUD Crisis and Disparities in Outcomes

Like other states, Michigan is grappling with a persistent and shifting SUD crisis. Since 2000, opioid overdose deaths have grown tenfold in Michigan.[2] This epidemic impacts thousands of Michiganders and their families, friends and communities. While the state had been making progress in addressing the opioid overdose crisis, data shows Michigan experienced increases in overdose fatalities in 2020 and 2021 after two years of improvement.[3] Now, as the pandemic recedes, there are again some encouraging signs that Michigan's investments in prevention, treatment and recovery are having an effect, but it is clear that more tools are needed.[4]

The complexity of addressing Michigan's SUD epidemic has increased as it changes to include more fentanyl, stimulant and polysubstance use. In 2021, 84.3% of overdose deaths involved at least one opioid, and almost half (49.1%) involved at least one stimulant. Illicitly manufactured fentanyl is the most common cause of opioid-related deaths while cocaine is the most identified drug in stimulant-related deaths.[5] Of the states reporting to the CDC State Unintentional Drug

[2] About the Epidemic (michigan.gov)
[3] Data (michigan.gov)
[4] Ibid.
[5] KFF. 2021. Opioid Overdose Deaths and Opioid Overdose Deaths as a Percent of All Drug Overdose Deaths.

Overdose Reporting System (SUDORS) dashboard, Michigan has the 13th highest rate of cocaine-involved overdose.[6]

In Michigan in 2021, 68.4% of people who died of a drug overdose identified as male and 31.6% identified as female, with the majority for both genders falling between the ages of 35-44 years old. Further, the data suggests that while most overdoses occur among people who identify as White (65.6% of total overdose deaths), when adjusted for population, people who identify as Black are overrepresented in overdose deaths.[7] This disparity highlights a need for creative and innovative solutions to increase access to evidence-based substance use treatment and to address disparities in outcomes.

Data on other outcomes – beyond overdose deaths – also attest to the changing nature of the state's SUD crisis. For example, in 2022, the rate of Medicaid beneficiaries in Michigan living with a primary diagnosis of StimUD reached a four-year peak among members in seven of the 10 PIHPs in the state.[8]

Need for Contingency Management

Multiple studies conducted over the past 30 plus years demonstrate that CM is an effective intervention for SUD, including for stimulant use disorders linked to methamphetamine, amphetamine and cocaine. Given the relative dearth of other treatment options for stimulant drugs (there are currently no FDA-approved medications for StimUD), CM is an especially important clinical tool in the treatment of StimUD.[9,10,11,12,13] A 2020 systematic review of five reviews found that CM programs were associated with consistently positive results, demonstrating their effectiveness compared to treatment as usual, as well as other interventions, including community reinforcement, pharmacotherapy and cognitive behavioral therapy (CBT).[14]

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[6] SUDORS Dashboard: Fatal Overdose Data | Drug Overdose | CDC Injury Center

[7] Ibid.

[8] MDHHS Data (2018-2022)

[9] Dutra, L., Stathopoulou, G., Basden, S. L., Leyro, T. M., Powers, M. B., & Otto, M. W. C. I. N. (2008). A meta-analytic review of psychosocial interventions for substance use disorders. Am J Psychiatry, 165(2), 179–187. doi:10.1176/appi.ajp.2007.06111851

[10] Peirce, J. M., Petry, N. M., Stitzer, M. L., et al. (2006). Effects of lower-cost incentives on stimulant abstinence in methadone maintenance treatment: A National Drug Abuse Treatment Clinical Trials Network study. Arch Gen Psychiatry, 63(2), 201–208.

[11] Petry, N. M., Peirce, J. M., Stitzer, M. L., et al. (2005). Effect of prize-based incentives on outcomes in stimulant abusers in outpatient psychosocial treatment programs: A National Drug Abuse Treatment Clinical Trials Network study. Arch Gen Psychiatry, 62(10), 1148–1156.

[12] Roll, J. M. (2007). Contingency management: An evidence-based component of methamphetamine use disorder treatments. Addiction, 102(Suppl 1), 114–120.

[13] Bolívar, H. A., Klemperer, E. M., Coleman, S. R. M., DeSarno, M., Skelly, J. M., & Higgins, S. T. (2021). Contingency management for patients receiving medication for opioid use disorder: A systematic review and meta-analysis. JAMA Psychiatry. Published online 2021. doi:10.1001/jamapsychiatry.2021.1969

[14] Ronsley, C, Nolan S, Knight R, Hayashi K, Klimas J, Walley A, et al., 2020. Treatment of stimulant use disorder: A systematic review of reviews. PLoS ONE 15(6): https://doi.org/10.1371/journal.pone.0234809.

CM also works well for treating OUD and other substance use disorders. A 2021 meta-analysis found that the use of CM for individuals receiving medication treatment for OUD was associated with increased abstinence from illicit opioid use at end-of-treatment.[15]

The most common focus of CM interventions is on supporting abstinence from substance use. A 2016 systematic review reported that 74% of studies focused exclusively on increasing abstinence from drug use while the remainder focused on another therapeutic goal or a combination. The review found that CM was efficacious for all these purposes.[16]

In a survey among SUD treatment providers in Michigan, many noted how extraordinarily difficult it can be to engage beneficiaries living with StimUD or OUD and help them to remain in treatment. Challenges in engaging and retaining clients were cited as a source of "burnout" by practitioners, making the ability to deploy CM to support retention key to supporting Michigan's SUD workforce, as well as to improving outcomes for individual beneficiaries.[17]

Demonstration Goals and Objectives

Through the demonstration, Michigan seeks to improve health outcomes and sustained recovery for beneficiaries with SUD/OUD by:

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

The state has the following milestones to measure progress toward these goals:

- Access to critical levels of care (LOC) for OUD and other SUDs.
- Use of evidence-based, SUD-specific patient placement criteria.
- Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities.
- Sufficient provider capacity at critical LOC including for medication assisted treatment (MAT) for OUD.

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[15] Bolívar, H. A., Klemperer, E. M., Coleman, S. R. M., DeSarno, M., Skelly, J. M., & Higgins, S. T. (2021). Contingency management for patients receiving medication for opioid use disorder: A systematic review and meta-analysis. JAMA Psychiatry. Published online 2021. doi:10.1001/jamapsychiatry.2021.1969.

[16] Davis DR, Kurti AN, Skelly JM, Redner R, White TJ, & Higgins ST (2016). A review of the literature on contingency management in the treatment of substance use disorders, 2009–2014. Preventive Medicine, 92, 36–46. 10.1016/j.ypmed.2016.08.008 [PubMed: 27514250]

[17] MDHHS, Support Act Section 1003: Exploring Michigan's SUD Treatment Capacity and Access, Final Project Report, October 2022.

Contingency Management

Through the RI Pilot, MDHHS seeks to offer CM services to improve treatment and outcomes for people living with SUDs, including StimUD and/or OUD. By deploying CM, MDHHS believes it can improve outcomes by supporting beneficiaries in meeting treatment goals and making the behavior changes that drive recovery.

While a handful of Michigan providers have some experience with CM through grant-funded activities, the RI pilot offers the opportunity to roll out CM in a systemized way to more beneficiaries. Through the RI Pilot, Michigan can evaluate and test how best to integrate CM services into a comprehensive community-based approach to providing care to Medicaid beneficiaries living with SUD.

Like other states that have pursued CM, a key goal of the state's is to fill the gap in treatment services that otherwise exists for beneficiaries living with StimUD. [18,19,20] In addition, MDHHS intends to provide CM services to beneficiaries living with OUD, reflecting the need for more tools in addition to MAT. Under no circumstances will CM services be used to replace, diminish, limit or otherwise restrict access to and support for MAT. To the contrary, MDHHS intends to deploy CM in such a way that it will encourage greater use of MAT.

The goals of the RI Pilot are to improve health outcomes for beneficiaries living with StimUD and/or OUD. This includes:

- Reducing the number of emergency department (ED) visits.
- Reducing the rate of repeated ED visits.
- Reducing adverse health outcomes (e.g., death, overdoses).
- Increasing engagement and retention in treatment.

Progress Toward Demonstration Goals and Milestones

Michigan established a strategic approach, as documented in the CMS-approved Implementation Plan, to advance the demonstration goals. The following sections outline the state's progress toward meeting these goals during the first approval period of the demonstration.

Milestone 1. Access to Critical LOCs for Opioid Use Disorder (OUD) and Other SUDs

Prior to implementation of the demonstration, Michigan provided coverage for all ASAM LOC. During the initial demonstration term, the state focused efforts on ensuring a strong SUD provider network to ensure sufficient access and service delivery consistent with ASAM criteria and evidence-based practices. MDHHS established PIHP network adequacy standards for SUD/OUD provider types and PIHPs were required to submit plans on how standards would be

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[18] De Crescenzo, F., Ciabattini, M., D'Alò, G. L., De Giorgi, R., Del Giovane, C., Cipriani, A. "Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: A systematic review and network meta- analysis." 2018. PLoS Medicine. 15(12), e1002715. PMCID: PMC6306153. Available at: https://pubmed.ncbi.nlm.nih.gov/30586362/.

[19] Farrell, M., Martin, N. K., Stockings, E., Baez, A., Cepeda, J. A., Degenhardt, L., Ali, R., Tran, L. T., Rehm, J., Torrens, M., Shoptaw, S., "Responding to global stimulant use: challenges and opportunities." Lancet. 394, 1652-1667. 2019. doi: 10.1016/S01406736(19)32230-5. Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32230- 5/fulltext.

[20] AshaRani, P. V., Hombali, A., Seow, E., Jie, W. O., Tan, J. H., Subramaniam, M. "Non-pharmacological interventions for methamphetamine use disorder: a systematic review, Drug and Alcohol Dependence." 2020. doi:https://doi.org/10.1016/j.drugalcdep.2020.108060. Available at: https://pubmed.ncbi.nlm.nih.gov/32445927/.

effectuated by region. Additionally, telehealth was expanded during the PHE. MDHHS also enacted a new policy in August 2021 to update and expand reimbursement for office-based treatment for alcohol use disorder and OUD.

As illustrated in Table 1, the overall number of qualified SUD providers increased slightly from FY2020 to FY2022, but the rate per beneficiaries overall and among those with an SUD diagnosis has decreased. This trend is likely related to the expanded Medicaid enrollment during the COVID-19 PHE. Additionally, the number of SUD providers contracting with at least one PIHP increased from FY2020 to FY2022 at every LOC except withdrawal management.

Table 1. Qualified SUD Providers by Fiscal Year

Qualified SUD Providers (all types)	FY2020	FY2021	FY2022
Number	19,128	19,576	19,468
Number per 1000 beneficiaries	10.19	9.89	9.13
Number per 1000 beneficiaries with an SUD diagnosis	114.87	110.19	106.75

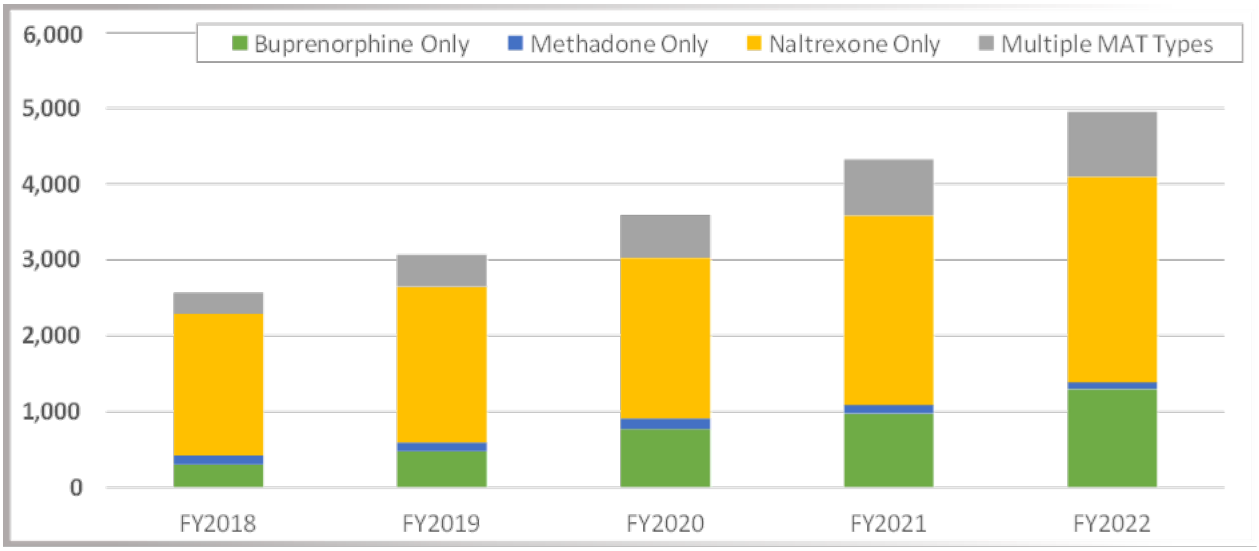
Regulatory changes were implemented in June 2023 to reduce provider burdens and as a strategy to increase access. For example, the requirement to obtain an SUD Service Program MAT License for the provision of buprenorphine or naltrexone for the treatment of OUD was removed. The number of MAT providers, as well as the rate per Medicaid beneficiary, has increased consistently over the past five years.

Table 2. MAT Providers by Fiscal Year

	FY2018	FY2019	FY2020	FY2021	FY2022
Buprenorphine/Methadone Providers					
Number with at least one claim	693	1,014	1,475	1,821	2,242
Rate per 1,000 Medicaid beneficiaries	0.37	0.54	0.79	0.92	1.05
Rate per 1,000 Medicaid beneficiaries with an SUD diagnosis	3.98	5.83	8.86	10.25	12.29
All MAT Providers (includes naltrexone)					
Number with at least one claim	2,563	3,068	3,590	4,319	4,951
Rate per 1,000 Medicaid beneficiaries	1.36	1.64	1.91	2.18	2.32
Rate per 1,000 Medicaid beneficiaries with an SUD diagnosis	14.73	17.65	21.56	24.31	27.15

Figure 1 presents the combination of MAT types provided to at least one Medicaid beneficiary. While the most pronounced increase was in the number of providers administering or prescribing naltrexone only, there were noticeable increases across years in the number of providers prescribing buprenorphine alone or in combination with another MAT type.

Figure 1. Types of MAT Prescribed/Administered, Among all MAT Providers



MDHHS remains committed to maintaining coverage of all ASAM LOCs during the demonstration extension period. Additionally, the state intends to continue exploring opportunities to enhance access across all LOC.

Milestone 2. Use of ASAM Placement Criteria

During the initial demonstration term, the state has made substantial progress in the use of evidence-based SUD-specific patient placement criteria. In consultation with PIHP leadership, the state selected the ASAM Continuum as the standard assessment tool for adults and the GAIN-I for youth. The ASAM Continuum software was successfully embedded in the electronic medical record (EMR) of each PIHP. Additionally, the state facilitated ASAM Continuum training for SUD providers and developed an online module for training all newly enrolled SUD providers. PIHPs also conducted audits of their contracted providers and confirmed usage of the ASAM Continuum.

During the extension term, MDHHS intends to conduct a formal assessment of SUD provider fidelity to the tool. Additionally, the state will focus on implementing the fourth edition of the ASAM Criteria.

Milestone 3. Use of ASAM Program Standards for Residential Provider Qualifications

At the onset of the initial demonstration period, the state's laws and regulations that applied to organizations and practitioners rendering SUD services aligned with some of the ASAM program expectations. The state has since fully aligned required qualifications for residential treatment facilities with ASAM and outlines these requirements in regulations promulgated by Licensing and Regulatory Affairs (LARA). Provider compliance with these requirements is reviewed through several strategies. For example, PIHP officials are responsible for verifying that their contracted SUD providers have completed the appropriate licensure and certification. Additionally, MDHHS conducts site visits of PIHPs that includes structured review of their compliance with credentialing, licensure and accreditation requirements.

The state is also in the process of modifying SUD provider credentialing requirements with the goal of reducing administrative barriers and expanding access. Specifically, licensed master's

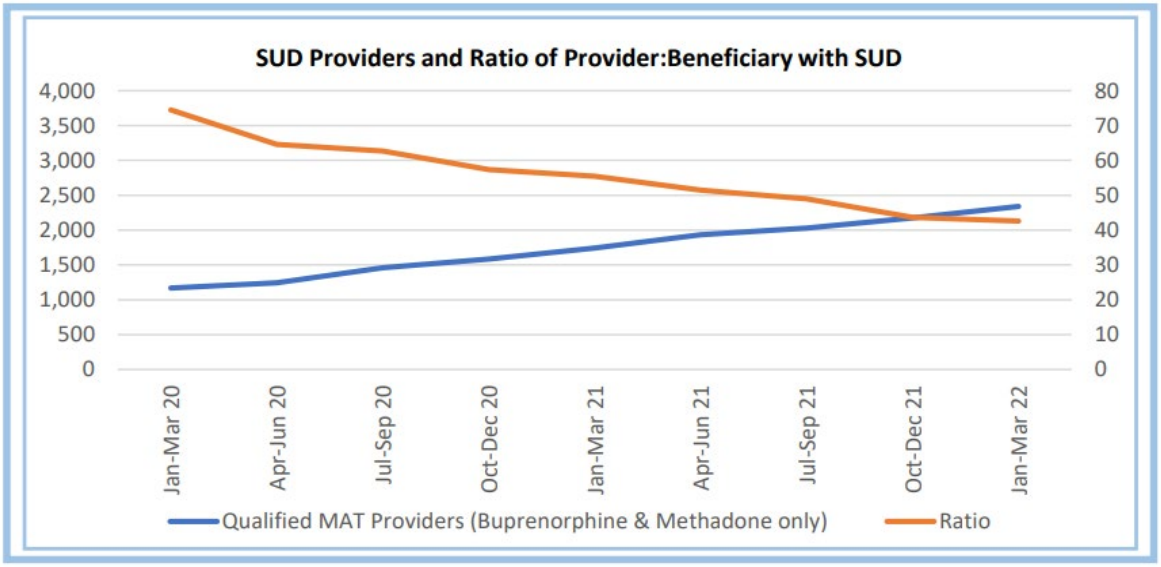
level clinicians will not be required to also receive the Certified Advanced Alcohol and Drug Counselor (CAADC) credential. Additionally, during the extension term, MDHHS will be evaluating what changes may be required to align with implementation of the fourth edition of the ASAM Criteria.

Milestone 4. Provider Capacity of SUD Treatment Including MAT

The state made substantial progress in furthering SUD provider capacity, including MAT, during the course of the initial demonstration term. Notably, despite complications caused as a result of the COVID-19 PHE, the number of SUD providers contracted with at least one PIHP increased for every LOC during the term of the demonstration with the exception of Level 1 and Level 2 Withdrawal Services, which has remained steady throughout the demonstration period.

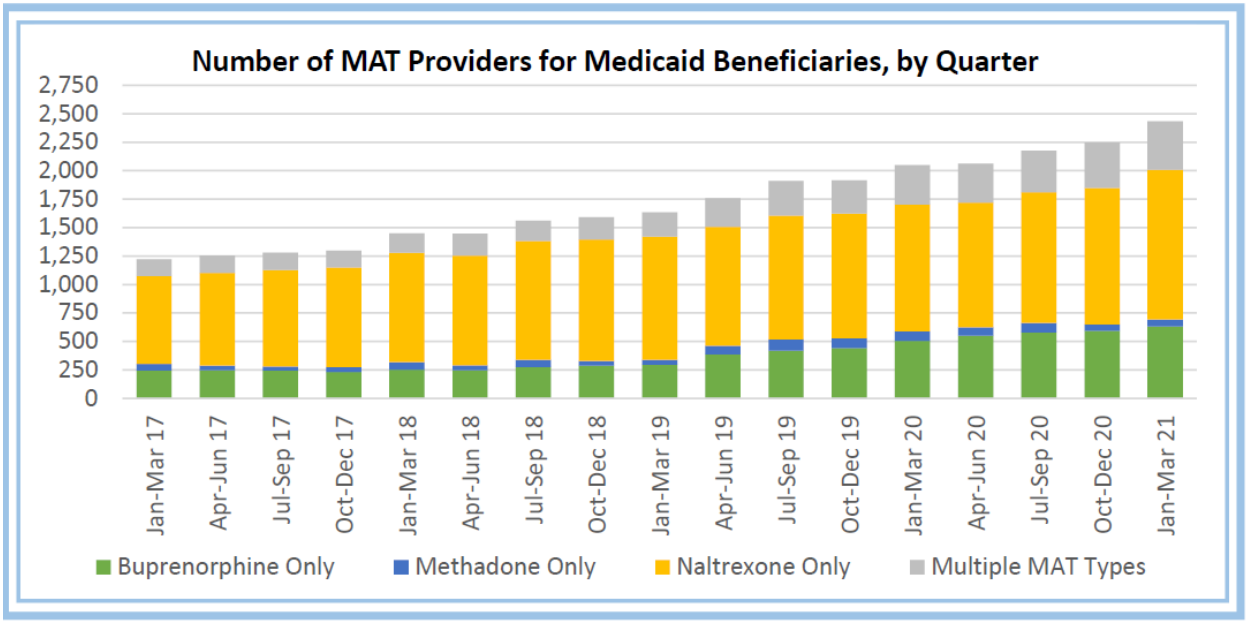
The state also saw a steady increase in the number of providers enrolled in Medicaid and qualified to provide buprenorphine or methadone during the demonstration period. This increased number of MAT providers was associated with a sizable decrease in the ratio of MAT providers to Medicaid beneficiaries, as shown in Figure 2, indicating increased access to MAT.

Figure 2. Ratio of MAT Providers (Buprenorphine & Methadone only) to Beneficiaries with SUD



Corresponding with the steady increase in MAT providers reflected in Figure 2, above, quarterly data also shows a small but noticeable increase, reflected in Figure 3, in the number of providers offering multiple types of MAT.

Figure 3. Number of MAT Providers By Type By Quarter



During the current demonstration period, as part of its efforts toward progress on this milestone, MDHHS distributed guidance to PIHPs that their network providers should support all avenues to an individual's recovery by providing clinically appropriate access to MAT either within the provider organization or through arrangements with another provider. This requirement was incorporated into the state's PIHP SUD site visit protocol, and the state intends to continue monitoring this requirement during the term of the extension.

Milestone 5. Implementation of OUD Comprehensive Treatment and Prevention Strategies

The state's Opioid Taskforce has continued to serve as a driving force in furtherance of the state's goal for comprehensive OUD treatment and prevention strategies during the course of the demonstration. While the Opioid Taskforce, consisting of stakeholders from local and state government, as well as representatives from health care, public health, justice and social service sectors, was developed prior to the outset of the demonstration, it has continued to meet regularly during the demonstration period. It continues to offer a unique forum to identify the barriers and facilitators to comprehensive provision of services and to discuss priorities for future state activities.

The state has also engaged in numerous actions to address OUD and facilitate access to other services for individuals released from jail or prison during the course of the demonstration, including automating the process of restoring Medicaid eligibility upon release, providing additional education to law enforcement officials on SUD and OUD, and supporting the expansion of drug treatment courts.

MDHHS' contracted PIHPs play an integral role in OUD treatment and prevention throughout the state. As such, MDHHS required PIHPs to develop strategic plans for the period FY2021-FY2023 describing the needs of their respective region and outlining specific actions to support

prevention, treatment and recovery. These state-approved strategic plans were utilized to guide implementation of an array of actions in each region addressing treatment and prevention.

As part of the state's ongoing efforts in this area, MDHHS issued a Request for Proposals for a Peer Navigator Pilot Project in January 2024 seeking to increase support for pregnant and postpartum people impacted by SUD by placing Peer Navigators in health care and behavioral health settings. The goal under this Peer Navigator Pilot Project is to support individuals and families with recovery while also helping to connect them to resources within the community. The initial award will be for a five-month period from May 2024 – September 2024. The state intends to allow annual renewals for the entities chosen to implement this Peer Navigator Pilot Project; however, this will be based on acceptable program performance and state availability of funds.

Milestone 6. Improved Care Coordination and Transition Between LOCs

During the course of the demonstration to date, the state has sought to improve care coordination and transition between LOCs via multiple strategies. While efforts to expand cooperation between MHPs and PIHPs to facilitate and coordinate care across systems were ongoing at the outset of the demonstration, such efforts were relatively new, and they were significantly expanded during the initial term of the demonstration. The goal of this ongoing initiative is to encourage collaboration between PIHPs and MHPs in identifying high-risk beneficiaries and implementing joint care coordination. The state has made significant progress toward this goal, including working closely with MHPs and PIHPs to gain consensus around shared metrics representing PIHP and MHP coordination efforts. These metrics have been refined over the demonstration period and made available in the state's web portal, CareConnect 360 (CC360), launched as a care coordination tool. Information in the portal is now updated quarterly, allowing both PIHPs and MHPs to focus their quality improvement efforts.

Additionally, the state has expanded its Opioid Health Home (OHH) initiative, which had begun as a unique pilot program in one region at the outset of the demonstration. Under this program, which provides enhanced reimbursement for comprehensive care to beneficiaries with OUD, the OHH serves as the central point of contact for directing patient-centered care across the broader health care system. This model has allowed participating beneficiaries to work with an interdisciplinary team of providers to develop an individualized recovery care plan to best manage their care. Through the model, the state has also elevated the roles of peer recovery coaches and community health workers to foster a connection to improve overall health and wellness, attending to the beneficiary's complete health and social needs. Throughout the demonstration period, MDHHS has expanded the OHH initiative to eight additional regions, with OHHs now in operation in nine of the 10 PIHP regions.

The state has also made progress with information technology (IT) efforts in furtherance of this milestone. As previously noted, the state's web portal, CC360, was launched as a care coordination tool. This portal was then expanded to include an "SUD User" module to allow PIHPs to have access to a broader array of information to support care coordination and manage transitions and house an SUD monitoring dashboard incorporating data on homelessness, chronic conditions and risk scoring to allow identification of high-risk beneficiaries.

Quality Assurance Monitoring

MDHHS has a robust oversight plan for continually monitoring quality of and access to care provided under the demonstration. This includes strategies such as an annual external quality review (EQR) of PIHPs, conducted in accordance with 42 CFR § 438.358, and oversight through regular monitoring and reporting requirements.

External Quality Review

The State Fiscal Year (SFY) 2022 External Quality Review (EQR) for the PIHPs demonstrates areas of high performance in managing and adhering to expectations established for the Medicaid program through state and federal requirements. Of the 13 performance measures included under the Michigan Mission-Based PIHP Performance Indicator System (MMBPIS), four measures have an MDHHS-established Minimum Performance Standard (MPS), and three of the four measures are further stratified by populations for a total of seven indicators having an established MPS. Programwide, the MPS of 95% was met for three performance indicators where benchmarks were established, including the percentage of:

- Persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.
- Discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within seven days.
- Readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.

These findings indicate that most members receiving services through the PIHPs received timely pre-admission screening dispositions for psychiatric inpatient care, and that members discharged from a substance abuse detox unit were seen by an SUD provider in a timely manner after discharge. Overall, there was also a low prevalence of members being readmitted to an inpatient psychiatric unit within 30 days of hospital discharge. Low readmission rates imply that the PIHPs implemented effective care coordination processes, such as ensuring members had effective transition plans prior to discharge, including appointments for follow-up services, crisis or relapse prevention plans, discharge medications and referrals to other services as necessary to prevent readmission. A summary of statewide performance on all reviewed measures is provided in Table 3.

Table 3. SFY 2021 and 2022 Statewide Performance Measure Rates

Performance Indicator	2021 Rate	2022 Rate
The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *MPS = 95%*		
Children	99.22%	98.40%
Adults	97.75%	97.90%

Performance Indicator	2021 Rate	2022 Rate
The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.		
MI–Children	64.31%	60.48%
MI–Adults	61.57%	59.27%
I/DD–Children	69.19%	62.06%
I/DD–Adults	72.51%	56.33%
Total	64.60%	59.78%
The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs.		
Consumers	74.88%	70.34%
The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.		
MI–Children	78.59%	72.27%
MI–Adults	81.17%	73.90%
I/DD–Children	80.50%	80.39%
I/DD–Adults	82.85%	76.05%
Total	80.38%	73.95%
The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within seven days. *MPS = 95%*		
Children	96.01%	92.07%

Performance Indicator	2021 Rate	2022 Rate
Adults	95.32%	89.91%
The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within seven days. *MPS = 95%*		
Consumers	97.59%	98.43%
The percent of Medicaid recipients having received PIHP managed services.		
The percentage of Medicaid recipients having received PIHP managed services.	6.48%	6.07%
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percentage of HSW enrollees during the reporting period with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	94.51%	88.22%
The percent of (a) adults with mental illness, the percentage of (b) adults with intellectual or developmental disabilities, and the percentage of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.		
MI–Adults	98.81%	99.66%
I/DD–Adults	55.03%	79.93%
MI and I/DD–Adults	55.19%	82.77%
The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. *MPS = 15%*		
MI and I/DD–Children	8.57%	6.53%
MI and I/DD–Adults	14.40%	12.34%
The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
I/DD–Adults	19.48%	19.39%

Performance Indicator	2021 Rate	2022 Rate
MI and I/DD–Adults	26.14%	26.24%
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
MI–Adults	43.31%	44.11%

Non-EQR Reporting and Initiatives

Beyond EQR, MDHHS employs a robust plan for continually monitoring the performance of the PIHPs delivering services under the demonstration. This includes CAHPS® Member Surveys, performance improvement plans (PIPs), specific monitoring standards, performance bonuses and site reviews. The state employs ongoing data collection and performance analysis and implementation of pay for performance measures intended to incentivize continued improvement in quality and access to services. Following are some specific activities and data related to services provided to individuals with SUD.

Timely Follow-Up Care After Substance Use Detox Discharge

For the most recent quarter for which reporting is available SFY 2023, Q3 (reported December 2023), more than 90% of all individuals discharged from a substance use detox unit received follow-up services within seven days of discharge for all PIHPS, with the percentage receiving such services exceeding 95% for eight of the ten PIHPs. Additionally, two PIHPs were at 100% for this measure.

PIHP Performance Bonus Incentive Program

As part of its ongoing efforts to address alcohol or other drug (AOD) abuse or dependence, MDHHS has included two AOD performance measures in the PIHP Performance Bonus Incentive Program for SFY 2024:

- Initiation and engagement of alcohol and other drug abuse or dependence treatment: The percentage of adolescents and adults with a new episode of AOD abuse or dependence who received initiation of AOD treatment within 14 days of diagnosis and engagement of AOD treatment will be measured. For purposes of measuring engagement of AOD treatment, MDHHS will review the percentage of beneficiaries who initiated treatment and those who had two or more additional AOD services or MAT within 34 calendar days of the initiation visit. Data will be stratified by race/ethnicity and provided to PIHPS who may then receive points based on reduction in the disparity between the index population and at least one minority group in receiving AOD initiation and treatment to potentially earn back a portion of withheld payment.

- Follow-up after emergency department (ED) visit for alcohol and other drug dependence: For purposes of this measure, MDHHS will review the percentage of beneficiaries 13 years and older with an ED visit for AOD within each PIHP that had a follow-up visit within 30 days. Similar to the prior measure, data will be stratified by race/ethnicity and provided to PIHPS who may then receive points based on reduction in the disparity

between the index population and at least one minority group to potentially earn back a portion of withheld payment.

Evaluation

The University of Michigan Institute for Healthcare Policy and Innovation, the state's independent evaluator, completed the interim evaluation in accordance with the demonstration special terms and conditions (STCs) and the evaluation design approved by CMS on June 9, 2020. Overall, data available for the Interim Evaluation Report demonstrate that in several key areas the demonstration was effective in achieving its goals and objectives. These include:

- Increasing the proportion of beneficiaries assessed using evidence-based standards.
- Expanding the availability of MAT.
- Decreasing the number of opioid prescriptions.

Several of these goals were accomplished through strategies outlined in the state's implementation plan, such as consistent use of ASAM-based tools for SUD assessments and expanded use of the prescription drug monitoring program (PDMP). Other factors contributed to improvements, including the broad array of state programs to address the opioid crisis, the expansion of SUD treatment under the Medicaid physical health benefit, and regulatory changes that reduced administrative burden for SUD providers.

However, the COVID-19 PHE and other factors delayed the implementation of several activities in the demonstration plan, including implementation of ASAM-consistent assessment tools and health IT strategies to improve care coordination. At the time the Interim Evaluation Report was prepared, data sources were available only through FY2022, reflecting the period before full implementation occurred. Additional years of post-implementation are needed to draw reliable conclusions about most evaluation measures. Key findings are highlighted below, and a link to the full Interim Evaluation Report is included as Attachment 1.

Use of evidence-based standards to support SUD/OUD assessment and placement for care

Findings from key informant interviews indicated that the demonstration has been successful in increasing the proportion of beneficiaries assessed using evidence-based standards, due in large part to the required use of the ASAM Continuum for all contracted SUD providers. There are opportunities to refine health IT structures to reduce administrative barriers and to offer consistent guidance to providers on repeat assessments.

Availability of and access to critical levels of SUD/OUD care

The overall number of SUD providers has increased since the start of the demonstration project. Challenges remain with uneven access to all levels of SUD care across the 10 PIHP regions, particularly for residential and withdrawal management. For MAT, both the number of providers and the type of MAT offered has increased since the start of the demonstration period. Overall, the demonstration has been successful in expanding the availability of MAT. Additional years of data are needed to evaluate trends for other levels of SUD care.

Coordination of care across settings

Administrative data demonstrated a slight increase in follow-up after ED visits for SUD. Key informants suggested that state health IT initiatives to facilitate care coordination have had

limited impact, while beneficiaries indicated room for improvement in facilitating transitions in care. Additional years of data are needed to determine whether the demonstration improved care coordination.

Administrative data indicated a decline in continuity of MAT and counseling after residential treatment since the start of the demonstration period. In Cohort 1's beneficiary surveys, transportation and issues with prescription medication refills were common barriers to sticking with treatment. PIHP officials confirmed longstanding challenges with transportation and described recent initiatives to expand options for transportation assistance. Additional years of data are needed to determine whether the demonstration results in increased duration of SUD/OUD treatment.

Receipt of primary care services among beneficiaries with SUD/OUD declined throughout the demonstration period, according to administrative data. Most Cohort 1 beneficiaries reported having a primary care provider (PCP), but many reported difficulties getting appointments. People with no PCP reported difficulty finding a local provider who will accept Medicaid. Additional years of data, including Cohort 2 beneficiary surveys, are needed to determine whether the demonstration improves the health and well-being of beneficiaries with SUD/OUD.

Data demonstrates that the state's high-risk management strategies have resulted in fewer opioid fills. Participation in the state's PDMP is high among prescribers and pharmacists. Opportunities exist to expand PDMP use to include other health professionals involved in providing SUD treatment services.

Overall impact on health and health services utilization

Overdose death rates have not improved since the start of the demonstration period. In Cohort 1's beneficiary surveys, some beneficiaries reported improved health status and material well-being from baseline to follow-up interviews. Additional years of data, including Cohort 2 beneficiary surveys, are needed to determine whether the demonstration improves the health and well-being of beneficiaries with SUD/OUD.

Rates of ED visits and inpatient stays for SUD appeared to be on a downward trend starting in FY2022, while SUD readmissions remained relatively unchanged. In the Cohort 1 beneficiary surveys, three-quarters of beneficiaries were very confident they could connect with a provider if they were having a crisis.

While this data appears promising, additional years of data is needed to determine if the demonstration decreases utilization of crisis care among beneficiaries with SUD/OUD.

Cost

Through FY2022, average spending per member-month increased for MAT; but, it remained relatively flat for ED and inpatient services related to SUD, with some variation by PIHP region. These trends appear promising, but additional years of data are needed to confirm that implementation of the demonstration will be sustainable for the Medicaid program regarding costs.

Evaluation During the Extension Period

MDHHS does not propose any changes to the currently-approved evaluation design for the IMD portion of the demonstration. Continuation of the current plan will permit additional study of

outcomes over an extended period. Table 4 outlines the hypotheses, research questions and analytic approach that will continue to be studied during the extension.

Table 4: IMD Waiver Evaluation Components

Hypotheses	Primary Research Question	Analytic Approach
Implementation of Michigan's Behavioral Health Demonstration Waiver will increase utilization of evidence-based standards for patient assessment and treatment placement.	Does the proportion of beneficiaries assessed and recommended for placement using evidence-based standards increase over the demonstration period?	• Descriptive comparison over time. • Qualitative analysis.
Implementation of Michigan's Behavioral Health Demonstration will expand availability of critical levels of SUD/OUD treatment, including residential treatment, withdrawal management and MAT.	Does the number of qualified SUD providers increase over the demonstration period?	• Descriptive comparison over time. • Qualitative analysis.
Implementation of Michigan's Behavioral Health Demonstration will increase utilization of SUD treatment.	Does utilization of SUD treatment increase over the demonstration period?	• Interrupted time series; multivariable logistic regression models. • Descriptive comparison over time. • Qualitative analysis. • Comparison of Cohort 1 vs. Cohort 2 (chi-square tests; multivariable logistic regression).
Implementation of Michigan's Behavioral Health Demonstration will improve care coordination and transitions in care for beneficiaries with SUD/OUD.	Does care coordination for beneficiaries with SUD increase over the demonstration period?	• Interrupted time series; multivariable logistic regression models. • Comparison of Cohort 1 vs. Cohort 2 (chi-square tests; multivariable logistic regression). • Descriptive comparison over time. • Qualitative analysis.
Implementation of strategies to improve care coordination and transitions in care will result in	Does the duration of SUD/OUD treatment	• Interrupted time series; multivariable logistic regression models.

Hypotheses	Primary Research Question	Analytic Approach
increased duration of SUD/OUD treatment.	increase over the demonstration period?	• Comparison of Cohort 1 vs. Cohort 2 (chi-square tests; multivariable regression).
Implementation of care coordination strategies will increase the receipt of primary care services during or after SUD/OUD treatment.	Does the proportion of beneficiaries with SUD/OUD who receive primary care services increase over the demonstration period?	• Descriptive comparison over time. • Comparison of Cohort 1 vs. Cohort 2 (chi-square tests; multivariable logistic regression).
Implementation of high-risk management strategies will result in decreased number of opioid fills among beneficiaries with OUD.	Does the average number of opioid fills among enrollees with OUD decreased over the demonstration period?	• Descriptive comparison over time. • Qualitative analysis.
Implementation of the demonstration will improve the health and well-being of beneficiaries with SUD/OUD.	Do beneficiaries with SUD/OUD report improved health and well-being over the demonstration period?	• Comparison of Cohort 1 vs. Cohort 2 (chi-square tests; multivariable regression). • Descriptive comparison over time.

As described further below, the state will develop an evaluation plan to study the impact of the CM program.

Contingency Management

The impact of the RI pilot will be measured through an independent evaluation conducted over the course of the pilot. The study team will work with participating PIHPs and SUD providers to ensure that all entities are informed regarding the purpose of the evaluation, protocols and reporting requirements to be used for the pilot, and any follow-up needed that is specific to the evaluation during the pilot. All analyses will be conducted at both the state and regional levels. The hypotheses under consideration for the new authorities requested for this demonstration are outlined in Table 5.

Table 5. Contingency Management Evaluation Hypotheses Under Consideration

Hypotheses	Evaluation Approach	Data Sources
The number of ED visits with StimUD and OUD as the primary reason will decrease.	Examine the number of ED visits with StimUD and OUD as the primary cause compared to	• Claims data.

Hypotheses	Evaluation Approach	Data Sources
	number prior to launch of the Recovery Incentives Pilot.	
The number of repeat ED visits will decrease among beneficiaries living with StimUD and OUD if participating in the Recovery Incentives Pilot.	Examine rates of ED visits for beneficiaries participating in the Recovery Incentives Piot compared with rates prior to the Pilot.	• Claims data.
The number of adverse outcomes (e.g., deaths, overdoses) among beneficiaries living with StimUD and OUD will be lower relative to what they would have been in the absence of the Recovery Incentives Pilot.	Examine the number of deaths and rates of overdoses among beneficiaries living with StimUD and OUD who have participated in the Recovery Incentives Pilot and those who have not.	• Claims data. • Death data from the MDHHS.
SUD treatment retention rates will increase among beneficiaries living with StimUD and OUD who receive incentives.	Examine usage of SUD treatment services among beneficiaries participating in the Recovery Incentives Pilot.	• Claims data. • Patient-reported outcomes survey.
The percentage of beneficiaries living with StimUD and OUD who participate in the Recovery Incentives Pilot will increase during the Demonstration period.	Examine participation in the Recovery Incentives Pilot for beneficiaries living with StimUD and OUD (contingent on benefit implementation and establishment of billing codes).	• Claims data.
The rate of negative drug screens (stimulant-free biological tests) will increase among beneficiaries living with StimUD and OUD who participate in the Recovery Incentives Pilot.	Examine rates of positive and negative drug screens among beneficiaries living with StimUD and OUD, and who are participating in the pilot.	• Data from CM vendor.

II. DEMONSTRATION ELIGIBILITY

Eligibility

Under the demonstration extension there is no change to Medicaid eligibility requirements. Standards and methodologies for eligibility remain set forth under the state plan.

Contingency Management

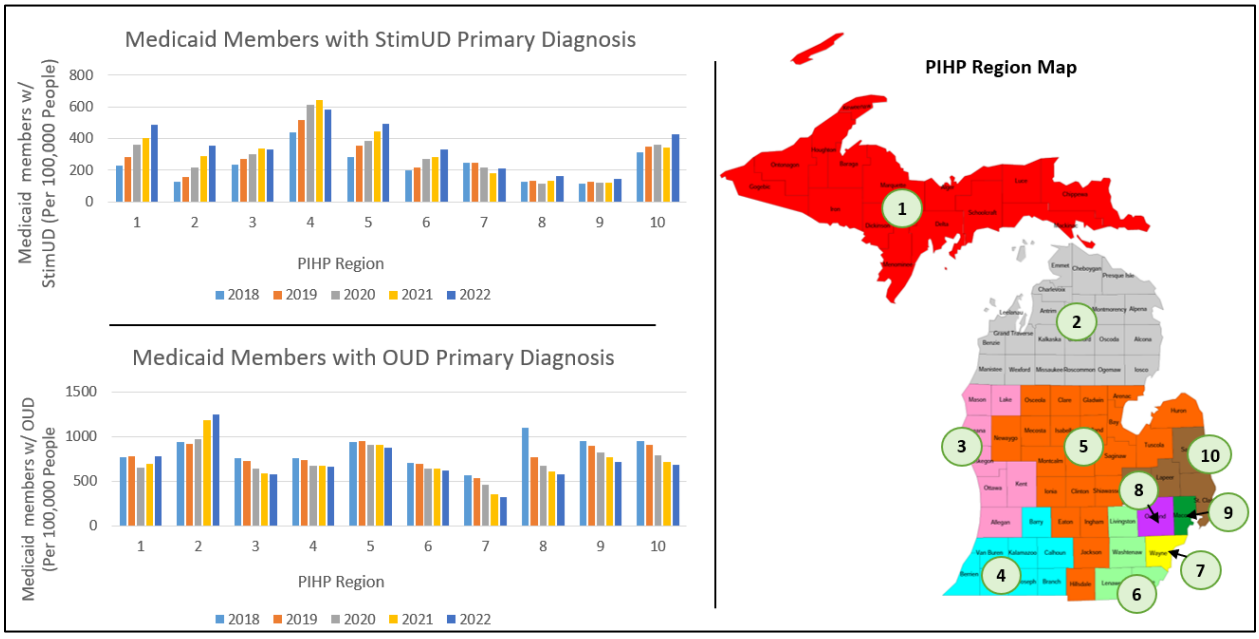
Michigan Medicaid beneficiaries are eligible for CM services if they meet the service-specific criteria listed below.

- Diagnosed with a StimUD and/or OUD for which the CM benefit is medically appropriate. The presence of additional SUD and/or diagnoses will not disqualify an individual from receiving the CM benefit.
- Enrolled in a PIHP that elects and is approved by MDHHS to provide the CM benefit.
- Receive services from a non-residential provider that offers the CM benefit in accordance with MDHHS policies and procedures.

Medicaid beneficiaries are eligible for CM without regard to the basis for their Medicaid eligibility if they meet service-specific criteria.

If all PIHPs participate in the pilot, Michigan projects approximately 31,000 Medicaid beneficiaries will meet the service-specific criteria for CM. This estimate is based on an analysis of PIHP encounter data on stimulant and opioid use rates in each region of the state. Below is an analysis of Medicaid beneficiaries living with StimUD or OUD as a primary diagnosis by PIHP region.

Figure 4. Medicaid Members with StimUD or OUD as a Primary Diagnosis



Native American/American Indian beneficiaries not enrolled in a PIHP are also eligible to receive CM services through participating Tribal Health Centers (THCs) and tribal providers.

Enrollment

The state is not proposing any changes to Medicaid eligibility rules. As such, the demonstration is not expected to affect enrollment trends, which will continue to be determined largely by demographic changes and economic conditions.

III. DEMONSTRATION BENEFITS AND COST SHARING REQUIREMENTS

Benefits

Michigan Medicaid enrollees will continue to have access to a comprehensive package of evidence-based OUD/SUD treatment and withdrawal management services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective community-based settings. The state will continue to provide the benefits outlined in Table 6 over the course of the demonstration extension term.

Table 6: Demonstration Benefits

Benefit	Medicaid Authority	Expenditure Authority
Early Intervention Services	State Plan (Individual services covered)	N/A
Ambulatory Withdrawal Management	State Plan	N/A
Outpatient services	State plan (Individual services covered)	N/A
Intensive outpatient services	State plan (Individual services covered)	N/A
Opioid Treatment Program Services	State Plan	Services provided to individuals in IMDs.
Office Based Opioid Treatment Services	State Plan	Services provided to individuals in IMDs.
Residential Treatment	State plan (Individual services covered)	Services provided to individuals in IMDs.
Medically Supervised Withdrawal Management	State plan	Services provided to individuals in IMDs.
Inpatient services	State plan (Individual services covered)	Services provided to individuals in IMDs.
SUD Support Services	State plan (Individual services covered)	Services provided to individuals in IMDs.

Contingency Management

Additionally, this demonstration will add CM as a benefit to Michigan's current array of treatment services for people living with a SUD. The benefit will be available only in outpatient settings to Medicaid members who meet the service-specific benefit criteria for CM. As noted above, CM consists of small motivational incentives for meeting treatment goals, such as negative urine drug tests (UDTs) or participating in clinical interventions when a UDT is positive. Under the demonstration, incentives will be disbursed to eligible beneficiaries at the point of testing and in the form of low-denomination gift cards; beneficiaries will be able to earn up to $599 annually. An incentive manager vendor will track beneficiary UDT results and calculate and disburse incentives. The benefit will be available only in outpatient settings to Medicaid beneficiaries who meet the service-specific benefit criteria for CM.

Under the demonstration, CM will be provided over a 24-week outpatient treatment period followed by a six month or longer period of aftercare and recovery support services. Incentives will follow an Escalation, Reset and Recovery (ERR) model as follows:

- The value of incentives will "escalate" or increase for each week a beneficiary demonstrates non-use of stimulants/opioids.
- A "reset" to the baseline incentive value will occur when a beneficiary submits a positive UDT or has an unexcused absence. The beneficiary will receive an incentive for a limited number of positive UDT submissions to support continued engagement in treatment but will not receive an incentive for unexcused absences.
- A "recovery" of the pre-reset value will occur after two consecutive stimulant/opioid-negative UDTs.

Cost Sharing

This demonstration extension will not modify current cost sharing arrangements. Cost sharing requirements under the demonstration will not differ from the approved State Plan requirements. Similar to other outpatient SUD treatments in Michigan, CM will be exempt from cost sharing.

IV. DELIVERY SYSTEM

This demonstration extension will not modify current fee-for-service (FFS) and managed care delivery system arrangements. All Medicaid populations except Native American/American Indian beneficiaries will continue to be mandatorily and passively enrolled into a PIHP.

Native American/American Indian beneficiaries may continue to elect to obtain Medicaid mental health and SUD services directly from Medicaid enrolled Indian Health Services (IHS) facilities and tribal health centers (THC). For mental health and SUD services provided to Native American/American Indian beneficiaries, the IHS facilities and THCs will be reimbursed directly for those services by MDHHS under the memorandum of agreement as specified in the Michigan Medicaid Provider Manual. Any Native American/American Indian beneficiary who needs specialty mental health, developmental disability or SUD services may also elect to receive such care under the demonstration through the PIHP.

Contingency Management

The CM benefit will be delivered through PIHPs and their provider networks. Participation in the RI Pilot Program will be optional for PIHPs. All PIHPs that MDHHS determines can meet the criteria for participation in the RI pilot program in accordance with a timeline established by MDHHS will be approved to participate in the RI pilot.

THCs and tribal providers who participate in the CM pilot will provide CM services to Medicaid beneficiaries. THCs and tribal providers may bill their contracted PIHP for CM services or they may bill MDHHS directly on a FFS basis.

SUD providers offering outpatient, intensive outpatient and/or partial hospitalization services and/or narcotic treatment programs will be eligible to participate in the RI pilot. This includes OHHs and certified community-based behavioral health clinics (CCBHC). Participating providers will be required to:

- Offer complementary services and evidence-based practices for StimUD and OUD in addition to CM (e.g., individual and group counseling, MAT, peer supports).
- Develop a treatment approach that includes other behavioral interventions to support beneficiaries to reduce stimulant and opioid use.
- Verify beneficiaries' Medicaid eligibility before permitting them to enroll in the RI pilot.
- Obtain beneficiary consent to receive CM.
- Hire and/or designate a RI coordinator who will lead the delivery of CM, including UDTs and incentive distribution.

V. IMPLEMENTATION OF THE DEMONSTRATION

Contingency Management

MDHHS will contract with its existing PIHPs to administer the demonstration through their provider network. In January 2024, MDHHS released a request for applications (RFA) to solicit PIHP interest and willingness to participate and identify providers who will participate in the RI Pilot. All PIHPs who express interest can participate if they apply and demonstrate they can administer CM in a manner consistent with all federal and MDHHS requirements.

The CM component of the demonstration is anticipated to launch in October 2024. MDHHS has awarded a contract to a vendor to help prepare PIHPs and providers of SUD treatment to participate in the pilot through training and technical assistance. PIHPs who opt to participate in providing CM under the demonstration will work with MDHHS and providers to develop outreach and communication materials to engage participants. Individual members who are served by a participating CM provider in a participating PIHP region and who meet the service-specific criteria for CM may enroll at their option.

VI. DEMONSTRATION FINANCING AND BUDGET NEUTRALITY

Budget neutrality is a comparison of without-waiver expenditures (WOW) to with-waiver expenditures (WW). CMS recommends two potential methodologies of demonstrating budget neutrality:

1. Per capita method: Assessment of the per member per month (PMPM) cost of the Demonstration
2. Aggregate method: Assessment of both the number of members and PMPM cost of the Demonstration

Budget neutrality for this behavioral health 1115 waiver, which was developed using CMS budget neutrality requirements, will be demonstrated using the per capita method. Attachment 2 provides the completed 1115 Waiver Budget Neutrality Template worksheets (Template) for this extension.

It should be noted that the budget neutrality section of this report is intended for public comment only. The accuracy and completeness of this budget neutrality illustration is limited because of, but not limited to, the considerations below. It is certain that values within the document and accompanying budget neutrality template will change prior to its final filing with CMS, and it is possible that those changes may be material.

- ***Several policy decisions related to key programmatic considerations for SFY 2024, SFY 2025, and future years remain outstanding.***
- ***Recent historical experience from SFY 2023, which will be used in the development of SFY 2025 capitation rates and valuation of program changes, is not fully complete nor reconciled to financial reports.***
- ***The data stratification and analysis that is required to value policy decisions which have been more recently decided cannot be effectively completed within the timeframe for release of the document for public comment.***
- ***The impact of eligibility redetermination following the COVID-19 PHE is still emerging and is expected to have a material impact on the average acuity for members who retain eligibility.***

Figure 1 describes each of the Medicaid Eligibility Groups (MEGs) which are covered under MDHHS' Behavioral Health 1115 Waiver:

FIGURE 1: MEDICAID ELIGILITY GROUP DESCRIPTIONS

MEG NAME	MEG DESCRIPTION
DAB	Includes non-dual and dual eligible members who are enrolled in the disabled, aged, or blind (DAB) eligibility categories.
TANF	Includes non-dual and dual eligible members who are enrolled in the Temporary Assistance for Needy Families (TANF) eligibility categories.
HMP	Includes non-dual and dual eligible members who are enrolled in the Healthy Michigan Plan (HMP) eligibility categories.
HSW	Includes members who are enrolled in the 1915(c) Habilitation Supports Waiver (HSW) program.
SED	Includes members who are enrolled in the 1915(c) Serious Emotional Disturbances (SED) Waiver program.
CWP	Includes members who are enrolled in the 1915(c) Children's Waiver Program (CWP).
SUD-IMD-DAB	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to individuals in the DAB eligibility category during a month in which the individual is a short-term resident in an IMD.
SUD-IMD-HMP	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to individuals in the HMP eligibility category during a month in which the individual is a short-term resident in an IMD.
SUD-IMD-TANF	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, 1115 Behavioral Health Demonstration Approval Period: April 5, 2019 through September 30, 2024 Page 28 of 132. Amended on September 27, 2019 provided to individuals in the TANF eligibility category during a month in which the individual is a short-term resident in an IMD.

Historical data and projected expenditures have been stratified as follows:

- Actual historical data: demonstration year (DY) 1 through DY 4 (October 1, 2019 through September 30, 2023)

- Base year: Capitation rates for DY 5 (October 1, 2023 through September 30, 2024)
- Projected expenditures: DY 6 through DY 10 (October 1, 2024 through September 30, 2029)

In addition to requesting continued authority corresponding to the existing 1115 Waiver approval, MDHHS is seeking new authority to provide contingency management (CM) as part of a comprehensive treatment model for Medicaid beneficiaries living with SUD. The state initially intends to provide CM on a pilot basis to individuals living with a stimulant use disorder (StimUD) and/or an opioid use disorder (OUD), but may consider extending the service on a mandatory, statewide basis after gaining experience with the intervention. MDHHS is seeking a two-year approval of this component of the demonstration, from October 1, 2024, through September 30, 2026. This service has been reflected as hypothetical expenditures under the DAB, TANF, and HMP MEGs with identical costs included in both the WOW and WW projections.

B. Without Waiver Projections for Historical Medicaid Populations

i. Base year (DY 5) for DAB, TANF, HMP, HSW, SED, and CWP

The SFY 2024 (October 2023 through September 2024) capitation rates from the *State Fiscal Year 2024 Behavioral Health Capitation Rate Certification* dated September 19, 2023 (current SFY 2024 PMPMs) are the starting point for development of DY 5 PMPM costs. Those capitation rates are expected to be amended during quarter 3 (Q3) of SFY 2024 in consideration of known program changes retroactively effective to October 1, 2023 resulting in amended SFY 2024 PMPMs. The amended SFY 2024 PMPMs and corresponding estimated enrollment are illustrated in figure 2 below and represent the base year (DY5) values documented in the WOW sheet of the template. The applicable program changes are described below.

FIGURE 2: DY 5 BASE PMPM

	SFY 2024 CAPITATION RATES		SFY 2024 WITH AMENDMENT PROGRAM CHANGES			
MEDICAID POPULATIONS	ELIGIBLE MEMBER MONTHS	PMPM COST	ELIGIBLE MEMBER MONTHS	ENROLLMENT ACUITY	DCW OVERTIME	PMPM COST
DAB	6,292,038	$ 378.32	6,013,780	4.6%	0.4%	$397.59
TANF	16,421,393	34.58	15,606,942	5.2%	0.1%	36.43
HMP	10,284,690	42.46	9,458,519	8.7%	0.1%	46.22
HSW	89,482	7,102.89	89,482	0.0%	0.8%	7,157.05
CWP	5,852	3,304.46	5,852	0.0%	0.8%	3,330.25
SED	5,411	1,962.26	5,411	0.0%	0.2%	1,966.34

a. *Enrollment/acuity adjustments related to COVID-19 public health emergency (PHE)*

This adjustment recognizes the impact of unwinding COVID-19 PHE-related enrollment growth and the resumption of redeterminations and discontinuation of Medicaid coverage associated with the continuous eligibility expiration during SFY

2024. Additional funding was included in the September 19, 2023 rate certification for acuity changes due to the anticipation that lower acuity members will be disenrolled from the program, leaving a higher level of average acuity for remaining members than reflected in the base period for capitation rate development. Development of the current SFY 2024 PMPMs assumed that 70% of the enrollment increase from pre-COVID levels would be disenrolled over the course of 12 months following the end of the PHE using the distribution of member redetermination dates. Emerging enrollment data indicates that approximately 90% of additional enrollment growth during the PHE will not meet redetermination requirements. Thus, additional acuity adjustments have been reflected in the development of the base year (DY 5) PMPM costs.

b. Direct Care Worker (DCW) overtime adjustment

Effective October 1, 2024, MDHHS increased DCW services by $3.60 per hour ($3.20, including an additional 12% for employer related expenses) over hourly pay effective prior to the COVID-19 Pandemic. The planned SFY 2024 amendment reflects a further increase in DCW reimbursement to $4.80 per hour for overtime hours, which were assumed to comprise 10% of overall DCW hours.

ii. Base year (DY 5) for SUD-IMD-DAB, SUD-IMP-HMP, and SUD-IMP-TANF

SFY 2024 (DY 5) PMPMs for the SUD-IMD-DAB, SUD-IMP-HMP, and SUD-IMP-TANF MEGs have been projected from SFY 2023 (DY 4) experience using simplified adjustments of 5% PMPM cost trend and no enrollment trend. Determination of estimated impacts related to the separate program changes between SFY 2023 and SFY 2024 will be addressed in the final 1115 Behavioral Health Demonstration extension filing.

iii. SFY 2025 Program Changes and Trend

Figure 3 illustrates the estimated combined impact of known program changes and trend assumptions underlying the development of SFY 2025 (DY 6) PMPMs and enrollment for each of the MEGs except SUD-IMD-DAB, SUD-IMP-HMP, and SUD-IMP-TANF. Similar to the projection of SFY 2024 (DY 5) expenditures for those MEGS, adjustments between SFY 2024 (DY 5) and SFY 2025 (DY 6) are limited to a 5% PMPM cost trend and no enrollment trend. Determination of the impact of separate program changes will be addressed in the final 1115 Behavioral Health Demonstration extension filing.

FIGURE 3: SFY (2025) DY 6 DEVELOPMENT

MEDICAID POPULATIONS	DAB	TANF	HMP	HSW	CWP	SED
SFY 2024						
Eligible Member Months	6,013,780	15,606,942	9,458,519	89,482	5,852	5,411
PMPM Cost	$ 397.59	$ 36.43	$ 46.22	$ 7,157.05	$ 3,330.25	$ 1,966.34
SFY 2025						
Eligible Member Months	5,786,068	14,763,272	8,159,031	89,482	5,852	5,411
Enrollment Acuity	3.9%	5.7%	15.9%	0.0%	0.0%	0.0%
Annual Trend	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

Contingency Management - Incentive	0.0%	0.1%	0.4%	0.0%	0.0%	0.0%
Contingency Management - Utilization	0.0%	0.1%	0.3%	0.0%	0.0%	0.0%
Other Program Changes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PMPM Cost	$ 434.02	$ 40.50	$ 56.62	$ 7,514.90	$ 3,496.76	$ 2,064.65
Composite PMPM Adjustment	**9.2%**	**11.2%**	**22.5%**	**5.0%**	**5.0%**	**5.0%**

a. Enrollment/acuity adjustments related to COVID-19 public health emergency (PHE)

Enrollment is expected to remain flat following the end of the PHE unwinding. However, as illustrated in Appendix C a further acuity adjustment is necessary to annualize the impact of the PHE unwinding on the acuity assumptions underlying the SFY 2025 (DY 6) expenditures.

b. Contingency management

MDHHS is seeking new authority to provide contingency management (CM) as part of a comprehensive treatment model for Medicaid beneficiaries living with SUD. The state initially intends to provide CM on a pilot basis to individuals living with a stimulant use disorder (StimUD) and/or an opioid use disorder (OUD), but may consider extending the service on a mandatory, statewide basis after gaining experience with the intervention. MDHHS is seeking a two-year approval for this component of the 1115 Waiver, from October 1, 2024, through September 30, 2026 (i.e., DY 6 and DY 7).

As illustrated in Appendix C, the estimated cost impact for addition of CM has been separated into two categories: (1) cost of the member incentives, and (2) projected costs associated with increased service utilization associated with increased testing because of the program. Since these services are included as hypothetical expenditures, identical costs have been included in the WOW and WW projections. The enclosed estimates should generally be considered placeholders given the broad array of outstanding policy decisions related to the service. We have preliminarily assumed 3,000 participants in DY 6 and 12,000 participants in DY 7, with fiscal impact estimates of $4.3M and $19.4M respectively based on data provided by MDHHS. The cost assumptions for CM will be further refined and detailed in the final budget neutrality documentation for the 1115 Behavioral Health Demonstration extension filing.

c. SFY 2025 program changes

A list of programmatic changes that may become effective with the SFY 2025 behavioral health capitation rates is listed below. However, due to the limitations highlighted in Section I. Background, the financial impact of those changes cannot be calculated for this distribution of the budget neutrality documentation. Each of these items will be addressed in the final 1115 Behavioral Health Demonstration extension filing.

- DCW wage increases.
- Inpatient psych tiered rates.

- MICAS service array.
- Waskul lawsuit.
- Others.

d. SFY 2025 Trend Assumptions

Expenditures in the template assume an annual PMPM trend of 5%, which reflects the unit cost trend assumed in the SFY 2024 capitation rate certification.

iv. Projections, PMPM costs, and Member Months

Expenditures in the template assume an annual PMPM trend of 5% consistent with the unit cost trend assumed in the SFY 2024 capitation rate certification. Enrollment has been projected to be flat following the end of the PHE reenrollment period.

C. With-Waiver Projections, PMPM Cost, and Member Months

The With-Waiver PMPM cost and member month projections are fully consistent with the Without-Waiver projections.

FIGURE 4: 1115 BUDGET NEUTRALITY EXPENDITURE PROJECTIONS BY GROUPING

MEG	DY 06	DY 07	DY 08	DY 09	DY 10
DAB	$ 2,511.3	$ 2,639.8	$ 2,771.8	$ 2,910.4	$ 3,055.9
TANF	$ 597.9	$ 631.4	$ 663.0	$ 696.2	$ 731.1
HMP	$ 462.0	$ 497.9	$ 522.7	$ 548.9	$ 576.3
HSW	$ 672.4	$ 706.1	$ 741.4	$ 778.4	$ 817.4
CWP	$ 20.5	$ 21.5	$ 22.6	$ 23.7	$ 24.9
SED	$ 11.2	$ 11.7	$ 12.3	$ 12.9	$ 13.6
SUD IMD DAB	$ 12.9	$ 13.5	$ 14.2	$ 14.9	$ 15.7
SUD IMD TANF	$ 5.7	$ 6.0	$ 6.3	$ 6.7	$ 7.0
SUD IMD HMP	$ 32.7	$ 34.4	$ 36.1	$ 37.9	$ 39.8

Notes:

1. Values reflect state and federal expenditures, illustrated in millions of dollars.
2. DY 06 - DY 10 represent the waiver demonstration period of October 1, 2024 through September 30, 2029.

D. Disproportionate Share Hospital (DSH)

Not applicable.

E. Summary of Budget Neutrality

Appendix A illustrates the 1115 Waiver Budget Neutrality worksheets, which include the following applicable tabs:

i. Historic Data.
ii. WOW (Without-Waiver).
iii. WW (With-Waiver).
iv. Summary (of Budget Neutrality).

VII. WAIVER AND EXPENDITURE AUTHORITIES

MDHHS requests continued waiver and expenditure authority as approved in the current demonstration. Additionally, new waiver and expenditure authorities are requested to operate the CM pilot through September 30, 2026.

Waiver Authorities

Under the authority of Section 1115(a)(1) of the Act, the state is requesting the following new waiver authorities, on a time-limited basis, to enable Michigan to implement CM through September 30, 2026.

Table 7. Waiver Requests

Waiver Authority	Use for Waiver	Currently Approved Waiver?
§ 1902(a)(1) Statewideness	To enable the state to provide contingency management as a pilot and on a geographically limited basis.	No
§ 1902(a)(10)(B) and § 1902(a)(17) Amount, Duration, and Scope and Comparability	To enable the state to provide contingency management services that are otherwise not available to all members in the same eligibility group.	No

Expenditure Authorities

Under the authority of Section 1115(a)(2) of the Act, Michigan is requesting expenditure authorities so that the items identified below, which are not otherwise included as expenditures under Section 1903 of the Act, shall be regarded as expenditures under Medicaid Section 1115.

Table 8. Expenditure Authority Requests

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
Expenditures related to CM pilot	Expenditure authority to provide CM through small incentives via gift cards to beneficiaries living with qualifying StimUD and/or OUD. Authority is requested through September 30, 2026.	No
Residential Treatment for Individuals with SUD	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD.	Yes

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
PIHP Services	Expenditures for all PIHP services, including case management and health education services that are not available to other Medicaid beneficiaries to the extent that not all services for categorically needy individuals will be equal in amount, duration, and scope. The state will ensure that all beneficiaries use a specific regional PIHP and will restrict disenrollment from them. The state is also granted the authority to restrict freedom of choice of provider for the demonstration eligible population.	Yes

VIII. PUBLIC NOTICE AND TRIBAL CONSULTATION

The state is conducting public notice in accordance with 42 CFR § 431.408. A summary of comments received and any applicable waiver updates in response to comments will be completed pending completion of the public and tribal notice periods.

TRIBAL NOTICE

The state is conducting tribal notice in accordance with the Michigan Medicaid State Plan and 42 CFR § 431.408(b). On February 5, 2024, notice was issued to tribal chairs and health directors for federally recognized tribes within the state. Additionally, the state offered to hold either group or individual consultation meetings to discuss this application, according to the tribes' preferences. Issues raised during the tribal comment period and any applicable waiver updates in response will be completed pending completion of the tribal comment period.

ATTACHMENT 1 – INTERIM EVALUATION REPORT

A copy of the Interim Evaluation Report completed by the University of Michigan, Institute for Healthcare Policy and Innovation is available at www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Adult Behavioral Health & Developmental Disability >> BH Recovery & Substance Use.

ATTACHMENT 2 – BUDGET NEUTRALITY

MILLIMAN CLIENT REPORT

Michigan Behavioral Health 1115 Waiver Extension – Budget Neutrality

State of Michigan, Department of Health and Human Services

Project Number 11-W-00305/5

DRAFT FOR PUBLIC COMMENT

February 20, 2024

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Contents

I. Background

Milliman, Inc. (Milliman) was retained by the State of Michigan, Department of Health and Human Services (MDHHS) to complete the budget neutrality template that will accompany the Section 1115 Medicaid Demonstration Waiver extension application (1115 Waiver) for MDHHS' Behavioral Health Program for demonstration year (DY) 6 through DY 10, defined as October 1, 2024 through September 30, 2029. The Centers for Medicare and Medicaid Services (CMS) requires all 1115 Waivers to demonstrate budget neutrality.

It should be noted that while this document may accompany a distribution of the 1115 waiver extension application for public comment, the accuracy and completeness of this budget neutrality illustration is limited because of, but not limited to, the considerations below. It is certain that values within the document and accompanying budget neutrality template will change prior to its final filing with CMS, and it is possible that those changes may be material.

- ***Several policy decisions related to key programmatic considerations for SFY 2024, SFY 2025, and future years remain outstanding.***
- ***Recent historical experience from SFY 2023, which will be used in the development of SFY 2025 capitation rates and valuation of program changes, is not fully complete nor reconciled to financial reports.***
- ***The data stratification and analysis that is required to value policy decisions which have been more recently decided cannot be effectively completed within the timeframe for release of the document for public comment.***
- ***The impact of eligibility redetermination following the COVID-19 PHE is still emerging and is expected to have a material impact on the average acuity for members who retain eligibility.***

Figure 1 describes each of the Medicaid Eligibility Groups (MEGs) which are covered under MDHHS' Behavioral Health 1115 Waiver:

FIGURE 1: MEDICAID ELIGILITY GROUP DESCRIPTIONS

MEG NAME	MEG DESCRIPTION
DAB	Includes non-dual and dual eligible members who are enrolled in the disabled, aged, or blind (DAB) eligibility categories.
TANF	Includes non-dual and dual eligible members who are enrolled in the Temporary Assistance for Needy Families (TANF) eligibility categories.
HMP	Includes non-dual and dual eligible members who are enrolled in the Healthy Michigan Plan (HMP) eligibility categories.
HSW	Includes members who are enrolled in the 1915(c) Habilitation Supports Waiver (HSW) program.
SED	Includes members who are enrolled in the 1915(c) Serious Emotional Disturbances (SED) Waiver program.
CWP	Includes members who are enrolled in the 1915(c) Children's Waiver Program (CWP)
SUD-IMD-DAB	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to individuals in the DAB eligibility category during a month in which the individual is a short-term resident in an IMD.
SUD-IMD-HMP	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to individuals in the HMP eligibility category during a month in which the individual is a short-term resident in an IMD.
SUD-IMD-TANF	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, 1115 Behavioral Health Demonstration Approval Period: April 5, 2019 through September 30, 2024 Page 28 of 132 Amended on September 27, 2019 provided to individuals in the TANF eligibility category during a month in which the individual is a short-term resident in an IMD.

This letter documents the narrative for the *"Preliminary Section 1115 Demonstration BN Template.xlsx"* Excel workbook, which illustrates budget neutrality in the form of financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the Demonstration as stipulated by 42 CFR 431.412 of the CMS Final Rule.

It is our understanding that the final version of this letter will be incorporated into an overall response to CMS regarding the 1115 Waiver extension application.

II. Budget Neutrality Narrative

Budget neutrality is a comparison of without-waiver expenditures (WOW) to with-waiver expenditures (WW). CMS recommends two potential methodologies of demonstrating budget neutrality:

1. Per capita method: Assessment of the per member per month (PMPM) cost of the Demonstration
2. Aggregate method: Assessment of both the number of members and PMPM cost of the Demonstration

Budget neutrality for this behavioral health 1115 waiver, which was developed using CMS budget neutrality requirements, will be demonstrated using the per capita method. Appendix A provides the completed 1115 Waiver Budget Neutrality Template worksheets (Template) for this extension.

Historical data and projected expenditures have been stratified as follows:

- Actual historical data: DY 1 through DY 4 (October 1, 2019 through September 30, 2023)
- Base year: Capitation rates for DY 5 (October 1, 2023 through September 30, 2024)
- Projected expenditures: DY 6 through DY 10 (October 1, 2024 through September 30, 2029)

In addition to requesting continued authority corresponding to the existing 1115 Waiver approval, MDHHS is seeking new authority to provide contingency management (CM) as part of a comprehensive treatment model for Medicaid beneficiaries living with SUD. The State initially intends to provide CM on a pilot basis to individuals living with a stimulant use disorder (StimUD) and/or an opioid use disorder (OUD), but may consider extending the service on a mandatory, statewide basis after gaining experience with the intervention. MDHHS is seeking a two-year approval of this component of the Demonstration, from October 1, 2024, through September 30, 2026. This service has been reflected as hypothetical expenditures under the DAB, TANF, and HMP MEGs with identical costs included in both the WOW and WW projections.

A. Historical Data

We have provided four years of actual historical capitation payment data by MEG for MDHHS' Behavioral Health Program representing DY 1 through DY 4 of the previous Demonstration. DY 1 through DY 4 correspond to state fiscal year (SFY) 2020 through SFY 2023.

B. Without Waiver Projections for Historical Medicaid Populations

i. Base year (DY 5) for DAB, TANF, HMP, HSW, SED, and CWP

The SFY 2024 (October 2023 through September 2024) capitation rates from the *State Fiscal Year 2024 Behavioral Health Capitation Rate Certification* dated September 19, 2023 (current SFY 2024 PMPMs) are the starting point for development of DY 5 PMPM costs. Those capitation rates are expected to be amended during quarter 3 (Q3) of SFY 2024 in consideration of known program changes retroactively effective to October 1, 2023 resulting in amended SFY 2024 PMPMs. The amended SFY 2024 PMPMs and corresponding estimated enrollment are illustrated in figure 2 below and represent the base year (DY5) values documented in the WOW sheet of the Template. The applicable program changes are described below.

FIGURE 2: DY 5 BASE PMPM

	SFY 2024 CAPITATION RATES		SFY 2024 WITH AMENDMENT PROGRAM CHANGES			
MEDICAID POPULATIONS	ELIGIBLE MEMBER MONTHS	PMPM COST	ELIGIBLE MEMBER MONTHS	ENROLLMENT ACUITY	DCW OVERTIME	PMPM COST
DAB	6,292,038	$ 378.32	6,013,780	4.6%	0.4%	$397.59
TANF	16,421,393	34.58	15,606,942	5.2%	0.1%	36.43
HMP	10,284,690	42.46	9,458,519	8.7%	0.1%	46.22
HSW	89,482	7,102.89	89,482	0.0%	0.8%	7,157.05
CWP	5,852	3,304.46	5,852	0.0%	0.8%	3,330.25
SED	5,411	1,962.26	5,411	0.0%	0.2%	1,966.34

a. Enrollment/acuity adjustments related to COVID-19 public health emergency (PHE)

This adjustment recognizes the impact of unwinding COVID-19 PHE-related enrollment growth and the resumption of redeterminations and terminations of Medicaid coverage associated with the continuous eligibility expiration during SFY 2024. Additional funding was included in the September 19, 2023 rate certification for acuity changes due to the anticipation that lower acuity members will be disenrolled from the program, leaving a higher level of average acuity for remaining members than reflected in the base period for capitation rate development. Development of the current SFY 2024 PMPMs assumed that 70% of the enrollment increase from pre-COVID levels would be disenrolled over the course of 12 months following the end of the PHE using the distribution of member redetermination dates. Emerging enrollment data indicates that approximately 90% of additional enrollment growth during the PHE will not meet redetermination requirements. Thus, additional acuity adjustments have been reflected in the development of the base year (DY 5) PMPM costs.

b. Direct Care Worker (DCW) overtime adjustment

Effective October 1, 2024, MDHHS increased DCW services by $3.60 per hour ($3.20, including an additional 12% for employer related expenses) over hourly pay effective prior to the COVID-19 Pandemic. The planned SFY 2024 amendment reflects a further increase in DCW reimbursement to $4.80 per hour for overtime hours, which were assumed to comprise 10% of overall DCW hours.

ii. Base year (DY 5) for SUD-IMD-DAB, SUD-IMP-HMP, and SUD-IMP-TANF

SFY 2024 (DY 5) PMPMs for the SUD-IMD-DAB, SUD-IMP-HMP, and SUD-IMP-TANF MEGs have been projected from SFY 2023 (DY 4) experience using simplified adjustments of 5% PMPM cost trend and no enrollment trend. Determination of estimated impacts related to the separate program changes between SFY 2023 and SFY 2024 will be addressed in the final 1115 Behavioral Health Demonstration extension filing.

iii. SFY 2025 Program Changes and Trend

Figure 3 illustrates the estimated combined impact of known program changes and trend assumptions underlying the development of SFY 2025 (DY 6) PMPMs and enrollment for each of the MEGs except SUD-IMD-DAB, SUD-IMP-HMP, and SUD-IMP-TANF. Similar to the projection of SFY 2024 (DY 5) expenditures for those MEGS, adjustments between SFY 2024 (DY 5) and SFY 2025 (DY 6) are limited to a 5% PMPM cost trend and no enrollment trend. Determination of the impact of separate program changes will be addressed in the final 1115 Behavioral Health Demonstration extension filing.

FIGURE 3: SFY (2025) DY 6 DEVELOPMENT

MEDICAID POPULATIONS	DAB	TANF	HMP	HSW	CWP	SED
SFY 2024						
Eligible Member Months	6,013,780	15,606,942	9,458,519	89,482	5,852	5,411
PMPM Cost	$ 397.59	$ 36.43	$ 46.22	$ 7,157.05	$ 3,330.25	$ 1,966.34
SFY 2025						
Eligible Member Months	5,786,068	14,763,272	8,159,031	89,482	5,852	5,411
Enrollment Acuity	3.9%	5.7%	15.9%	0.0%	0.0%	0.0%
Annual Trend	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Contingency Management - Incentive	0.0%	0.1%	0.4%	0.0%	0.0%	0.0%
Contingency Management - Utilization	0.0%	0.1%	0.3%	0.0%	0.0%	0.0%
Other Program Changes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PMPM Cost	$ 434.02	$ 40.50	$ 56.62	$ 7,514.90	$ 3,496.76	$ 2,064.65
Composite PMPM Adjustment	**9.2%**	**11.2%**	**22.5%**	**5.0%**	**5.0%**	**5.0%**

a. Enrollment/acuity adjustments related to COVID-19 public health emergency (PHE)

Enrollment is expected to remain flat following the end of the PHE unwinding. However, as illustrated in Appendix C a further acuity adjustment is necessary to annualize the impact of the PHE unwinding on the acuity assumptions underlying the SFY 2025 (DY 6) expenditures.

b. Contingency management

MDHHS is seeking new authority to provide contingency management (CM) as part of a comprehensive treatment model for Medicaid beneficiaries living with SUD. The State initially intends to provide CM on a pilot basis to individuals living with a stimulant use disorder (StimUD) and/or an opioid use disorder (OUD), but may consider extending the service on a mandatory, statewide basis after gaining experience with the intervention. MDHHS is seeking a two-year approval for this component of the 1115 Waiver, from October 1, 2024, through September 30, 2026 (i.e., DY 6 and DY 7).

As illustrated in Appendix C, the estimated cost impact for addition of CM has been separated into two categories: (1) cost of the member incentives, and (2) projected costs associated with increased service utilization associated with increased testing because of the program. Since these services are included as hypothetical expenditures, identical costs have been included in the WOW and WW projections. The enclosed estimates should generally be considered placeholders given the broad array of outstanding policy decisions related to the service. We have preliminarily assumed 3,000 participants in DY 6 and 12,000 participants in DY 7, with fiscal impact estimates of $4.3M and $19.4M respectively based on data provided by MDHHS. The cost assumptions for CM will be further refined and detailed in the final budget neutrality documentation for the 1115 Behavioral Health Demonstration extension filing.

c. SFY 2025 program changes

A list of programmatic changes that may become effective with the SFY 2025 behavioral health capitation rates is listed below. However, due to the limitations highlighted in Section I. Background, the financial impact of those changes cannot be calculated for this distribution of the budget neutrality documentation. Each of these items will be addressed in the final 1115 Behavioral Health Demonstration extension filing.

- DCW wage increases
- Inpatient psych tiered rates
- MICAS service array
- Waskul lawsuit
- Others

d. SFY 2025 Trend Assumptions

Expenditures in the Template assume an annual PMPM trend of 5%, which reflects the unit cost trend assumed in the SFY 2024 capitation rate certification.

iv. Projections, PMPM costs, and Member Months

Expenditures in the Template assume an annual PMPM trend of 5% consistent with the unit cost trend assumed in the SFY 2024 capitation rate certification. Enrollment has been projected to be flat following the end of the PHE reenrollment period.

C. With-Waiver Projections, PMPM Cost, and Member Months

The With-Waiver PMPM cost and member month projections are fully consistent with the Without-Waiver projections.

D. Disproportionate Share Hospital (DSH)

Not applicable.

E. Summary of Budget Neutrality

Appendix A illustrates the 1115 Waiver Budget Neutrality worksheets, which include the following applicable tabs:

i. Historic Data

ii. WOW (Without-Waiver)

iii. WW (With-Waiver)

iv. Summary (of Budget Neutrality)

III. Limitations and Qualifications

The information contained in this letter, including the appendices, has been prepared for the State of Michigan, Department of Health and Human Services and their consultants and advisors. It is our understanding that this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

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

We have developed certain models to estimate the information included in this correspondence. The intent of the models is to support the documentation of budget neutrality for Michigan's 1115 waiver. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models, including all input, calculations, and output may not be appropriate for any other purpose.

In performing this analysis, we relied on data and other information provided by MDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Appendix A: Budget Neutrality Template

	A	B	C	D	E	F	G
1	**4 YEARS OF HISTORIC DATA**						
2							
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**						
4							
5	**DAB**	**FY 19 (DY 00)**	**FY 20 (DY 01)**	**FY 21 (DY 02)**	**FY 22 (DY 03)**	**FY 23 (DY 04)**	**4-YEARS**
6	**TOTAL EXPENDITURES**		$ 1,956,717,321	$ 2,167,187,947	$ 2,210,900,487	$ 2,214,584,034	$ 8,549,389,788
7	**ELIGIBLE MEMBER MONTHS**		5,979,963	6,182,487	6,364,805	6,525,787	
8	**PMPM COST**	$ -	$ 327.21	$ 350.54	$ 347.36	$ 339.36	
9	**TREND RATES**						**4-YEAR**
10				**ANNUAL CHANGE**			**AVERAGE**
11	TOTAL EXPENDITURE			10.76%	2.02%	0.17%	4.21%
12	ELIGIBLE MEMBER MONTHS			3.39%	2.95%	2.53%	2.95%
13	PMPM COST			7.13%	-0.91%	-2.30%	1.22%
14							
15	**TANF**	**FY 19 (DY 00)**	**FY 20 (DY 01)**	**FY 21 (DY 02)**	**FY 22 (DY 03)**	**FY 23 (DY 04)**	**4-YEARS**
16	**TOTAL EXPENDITURES**		$ 424,553,810	$ 492,779,731	$ 498,445,434	$ 578,936,074	$ 1,994,715,049
17	**ELIGIBLE MEMBER MONTHS**		14,806,951	16,098,947	17,215,765	18,049,949	
18	**PMPM COST**	$ -	$ 28.67	$ 30.61	$ 28.95	$ 32.07	
19	**TREND RATES**						**4-YEAR**
20				**ANNUAL CHANGE**			**AVERAGE**
21	TOTAL EXPENDITURE			16.07%	1.15%	16.15%	10.89%
22	ELIGIBLE MEMBER MONTHS			8.73%	6.94%	4.85%	6.82%
23	PMPM COST			6.76%	-5.41%	10.78%	3.81%
24							
25	**HMP**	**FY 19 (DY 00)**	**FY 20 (DY 01)**	**FY 21 (DY 02)**	**FY 22 (DY 03)**	**FY 23 (DY 04)**	**4-YEARS**
26	**TOTAL EXPENDITURES**		$ 430,063,929	$ 547,924,149	$ 579,378,600	$ 615,735,905	$ 2,173,102,582
27	**ELIGIBLE MEMBER MONTHS**		8,330,289	10,281,960	11,317,474	12,042,817	
28	**PMPM COST**	$ -	$ 51.63	$ 53.29	$ 51.19	$ 51.13	
29	**TREND RATES**						**4-YEAR**
30				**ANNUAL CHANGE**			**AVERAGE**
31	TOTAL EXPENDITURE			27.41%	5.74%	6.28%	12.71%
32	ELIGIBLE MEMBER MONTHS			23.43%	10.07%	6.41%	13.07%
33	PMPM COST			3.22%	-3.93%	-0.13%	-0.32%
34							
35	**Habilitative Supports Waiver (HSW)**	**FY 19 (DY 00)**	**FY 20 (DY 01)**	**FY 21 (DY 02)**	**FY 22 (DY 03)**	**FY 23 (DY 04)**	**4-YEARS**
36	**TOTAL EXPENDITURES**		$ 481,950,866	$ 535,374,337	$ 526,437,341	$ 531,909,553	$ 2,075,672,097
37	**ELIGIBLE MEMBER MONTHS**		90,950	91,275	89,461	88,329	
38	**PMPM COST**	$ -	$ 5,299.07	$ 5,865.51	$ 5,884.55	$ 6,021.91	
39	**TREND RATES**						**4-YEAR**
40				**ANNUAL CHANGE**			**AVERAGE**
41	TOTAL EXPENDITURE			11.08%	-1.67%	1.04%	3.34%
42	ELIGIBLE MEMBER MONTHS			0.36%	-1.99%	-1.27%	-0.97%
43	PMPM COST			10.69%	0.32%	2.33%	4.35%
44							
45	**Children's Waiver Program (CWP)**	**FY 19 (DY 00)**	**FY 20 (DY 01)**	**FY 21 (DY 02)**	**FY 22 (DY 03)**	**FY 23 (DY 04)**	**4-YEARS**
46	**TOTAL EXPENDITURES**		$ 17,630,853	$ 19,866,038	$ 23,229,653	$ 18,100,309	$ 78,826,853
47	**ELIGIBLE MEMBER MONTHS**		4,601	5,076	5,849	6,331	
48	**PMPM COST**	$ -	$ 3,831.96	$ 3,913.72	$ 3,971.56	$ 2,859.00	
49	**TREND RATES**						**4-YEAR**
50				**ANNUAL CHANGE**			**AVERAGE**
51	TOTAL EXPENDITURE			12.68%	16.93%	-22.08%	0.88%
52	ELIGIBLE MEMBER MONTHS			10.32%	15.23%	8.24%	11.23%
53	PMPM COST			2.13%	1.48%	-28.01%	-9.30%
54							
55	**Serious Emotional Disturbance Waiver (SEDW)**	**FY 19 (DY 00)**	**FY 20 (DY 01)**	**FY 21 (DY 02)**	**FY 22 (DY 03)**	**FY 23 (DY 04)**	**4-YEARS**
56	**TOTAL EXPENDITURES**		$ 11,227,994	$ 11,230,689	$ 11,307,436	$ 9,361,000	$ 43,127,119
57	**ELIGIBLE MEMBER MONTHS**		4,996	5,364	5,411	5,671	
58	**PMPM COST**	$ -	$ 2,247.40	$ 2,093.72	$ 2,089.71	$ 1,650.68	
59	**TREND RATES**						**4-YEAR**
60				**ANNUAL CHANGE**			**AVERAGE**
61	TOTAL EXPENDITURE			0.02%	0.68%	-17.21%	-5.88%
62	ELIGIBLE MEMBER MONTHS			7.37%	0.88%	4.81%	4.31%
63	PMPM COST			-6.84%	-0.19%	-21.01%	-9.77%
64							
65	**SUD IMD DAB**	**FY 19 (DY 00)**	**FY 20 (DY 01)**	**FY 21 (DY 02)**	**FY 22 (DY 03)**	**FY 23 (DY 04)**	**4-YEARS**
66	**TOTAL EXPENDITURES**		$ 8,766,320	$ 8,896,072	$ 12,026,556	$ 11,679,482	
67	**ELIGIBLE MEMBER MONTHS**		5,570	5,606	7,286	6,973	
68	**PMPM COST**	$ -	$ 1,573.85	$ 1,586.88	$ 1,650.64	$ 1,674.96	
69	**TREND RATES**						**4-YEAR**
70				**ANNUAL CHANGE**			**AVERAGE**
71	TOTAL EXPENDITURE			1.48%	35.19%	-2.89%	10.04%
72	ELIGIBLE MEMBER MONTHS			0.65%	29.97%	-4.30%	7.78%
73	PMPM COST			0.83%	4.02%	1.47%	2.10%
74							
75	**SUD IMD TANF**	**FY 19 (DY 00)**	**FY 20 (DY 01)**	**FY 21 (DY 02)**	**FY 22 (DY 03)**	**FY 23 (DY 04)**	**4-YEARS**
76	**TOTAL EXPENDITURES**		$ 3,103,665	$ 3,358,531	$ 5,107,411	$ 5,213,122	
77	**ELIGIBLE MEMBER MONTHS**		4,195	4,237	5,792	5,246	
78	**PMPM COST**	$ -	$ 739.85	$ 792.67	$ 881.80	$ 993.73	
79	**TREND RATES**						**4-YEAR**
80				**ANNUAL CHANGE**			**AVERAGE**
81	TOTAL EXPENDITURE			8.21%	52.07%	2.07%	18.87%
82	ELIGIBLE MEMBER MONTHS			1.00%	36.70%	-9.43%	7.74%
83	PMPM COST			7.14%	11.25%	12.69%	10.33%
84							
85	**SUD IMD HMP**	**FY 19 (DY 00)**	**FY 20 (DY 01)**	**FY 21 (DY 02)**	**FY 22 (DY 03)**	**FY 23 (DY 04)**	**4-YEARS**
86	**TOTAL EXPENDITURES**		$ 22,280,891	$ 22,465,064	$ 32,421,320	$ 29,678,042	
87	**ELIGIBLE MEMBER MONTHS**		24,397	24,096	31,486	26,221	
88	**PMPM COST**	$ -	$ 913.26	$ 932.32	$ 1,029.71	$ 1,131.84	
89	**TREND RATES**						**4-YEAR**
90				**ANNUAL CHANGE**			**AVERAGE**
91	TOTAL EXPENDITURE			0.83%	44.32%	-8.46%	10.03%
92	ELIGIBLE MEMBER MONTHS			-1.23%	30.67%	-16.72%	2.43%
93	PMPM COST			2.09%	10.45%	9.92%	7.41%

	A	B	C	D	E	F	G	H	I	J	K	L
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**											
2												
3												
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**BASE YEAR**	**TREND**	**DEMONSTRATION YEARS (DY)**	**TREND**	**DEMONSTRATION YEARS (DY)**				**TOTAL**
5	**GROUP**	**RATE 1**	**OF AGING**	**FY 24 (DY 05)**	**RATE 2**	**FY 25 (DY 06)**	**RATE 3**	**FY 26 (DY 07)**	**FY 27 (DY 08)**	**FY 28 (DY 09)**	**FY 29 (DY 10)**	**WOW**
6												
7	**DAB**											
8	**Pop Type:**	**Medicaid**										
9	Eligible Member Months	-7.9%	12.0	6,013,780	-3.8%	5,786,068	0.0%	5,786,068	5,786,068	5,786,068	5,786,068	
10	PMPM Cost	17.2%	12.0	$ 397.59	9.2%	$ 434.02	5.0%	$ 456.24	$ 479.05	$ 503.00	$ 528.15	
11	Total Expenditure					$ 2,511,287,543		$ 2,639,835,530	$ 2,771,815,735	$ 2,910,392,056	$ 3,055,911,659	$ 13,889,242,523
12												
13	**TANF**											
14	**Pop Type:**	**Medicaid**										
15	Eligible Member Months	-13.6%	12.0	15,606,942	-5.4%	14,763,272	0.0%	14,763,272	14,763,272	14,763,272	14,763,272	
16	PMPM Cost	13.6%	12.0	$ 36.43	11.2%	$ 40.50	5.0%	$ 42.77	$ 44.91	$ 47.16	$ 49.52	
17	Total Expenditure					$ 597,851,407		$ 631,425,143	$ 663,018,545	$ 696,235,907	$ 731,077,229	$ 3,319,608,232
18												
19	**HMP**											
20	**Pop Type:**	**Medicaid**										
21	Eligible Member Months	-21.6%	12.0	9,458,519	-13.7%	8,159,031	0.0%	8,159,031	8,159,031	8,159,031	8,159,031	
22	PMPM Cost	-9.6%	12.0	$ 46.22	22.5%	$ 56.62	5.0%	$ 61.02	$ 64.07	$ 67.27	$ 70.63	
23	Total Expenditure					$ 461,972,852		$ 497,864,101	$ 522,749,147	$ 548,858,047	$ 576,272,393	$ 2,607,716,539
24												
25	**Habilitative Supports Waiver (HSW)**											
26	**Pop Type:**	**Medicaid**										
27	Eligible Member Months	1.3%	12.0	89,482	0.0%	89,482	0.0%	89,482	89,482	89,482	89,482	
28	PMPM Cost	18.9%	12.0	$ 7,157.05	5.0%	$ 7,514.90	5.0%	$ 7,890.65	$ 8,285.18	$ 8,699.44	$ 9,134.41	
29	Total Expenditure					$ 672,448,351		$ 706,071,143	$ 741,374,477	$ 778,443,290	$ 817,365,276	$ 3,715,702,537
30												
31	**Children's Waiver Program (CWP)**											
32	**Pop Type:**	**Medicaid**										
33	Eligible Member Months	-7.6%	12.0	5,852	0.0%	5,852	0.0%	5,852	5,852	5,852	5,852	
34	PMPM Cost	16.5%	12.0	$ 3,330.25	5.0%	$ 3,496.76	5.0%	$ 3,671.60	$ 3,855.18	$ 4,047.94	$ 4,250.34	
35	Total Expenditure					$ 20,463,053		$ 21,486,203	$ 22,560,513	$ 23,688,545	$ 24,872,990	$ 113,071,304
36												
37	**Serious Emotional Disturbance Waiver (SEDW)**											
38	**Pop Type:**	**Medicaid**										
39	Eligible Member Months	-4.6%	12.0	5,411	0.0%	5,411	0.0%	5,411	5,411	5,411	5,411	
40	PMPM Cost	19.1%	12.0	$ 1,966.34	5.0%	$ 2,064.65	5.0%	$ 2,167.89	$ 2,276.28	$ 2,390.09	$ 2,509.59	
41	Total Expenditure					$ 11,171,834		$ 11,730,453	$ 12,316,951	$ 12,932,777	$ 13,579,391	$ 61,731,407
42												
43	**SUD IMD DAB**											
44	**Pop Type:**	**Medicaid**										
45	Eligible Member Months	0.0%	12.0	6,973	0.0%	6,973	0.0%	6,973	6,973	6,973	6,973	
46	PMPM Cost	5.0%	12.0	$ 1,758.71	5.0%	$ 1,846.64	5.0%	$ 1,938.97	$ 2,035.92	$ 2,137.72	$ 2,244.61	
47	Total Expenditure					$ 12,876,629		$ 13,520,438	$ 14,196,470	$ 14,906,322	$ 15,651,666	$ 71,151,524
48												
49	**SUD IMD TANF**											
50	**Pop Type:**	**Medicaid**										
51	Eligible Member Months	0.0%	12.0	5,246	0.0%	5,246	0.0%	5,246	5,246	5,246	5,246	
52	PMPM Cost	5.0%	12.0	$ 1,043.42	5.0%	$ 1,095.59	5.0%	$ 1,150.37	$ 1,207.89	$ 1,268.28	$ 1,331.69	
53	Total Expenditure					$ 5,747,466		$ 6,034,841	$ 6,336,591	$ 6,653,397	$ 6,986,046	$ 31,758,341
54												
55	**SUD IMD HMP**											
56	**Pop Type:**	**Medicaid**										
57	Eligible Member Months	0.0%	12.0	26,221	0.0%	26,221	0.0%	26,221	26,221	26,221	26,221	
58	PMPM Cost	5.0%	12.0	$ 1,188.43	5.0%	$ 1,247.86	5.0%	$ 1,310.25	$ 1,375.76	$ 1,444.55	$ 1,516.78	
59	Total Expenditure					$ 32,720,042		$ 34,356,065	$ 36,073,803	$ 37,877,546	$ 39,771,488	$ 180,798,944

	A	B	C	D	E	F	G	H	I	J
1	**DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**									
2										
3										
4				**DEMONSTRATION YEARS (DY)**	**TREND**	**DEMONSTRATION YEARS (DY)**				**TOTAL WW**
5	**ELIGIBILITY GROUP**	**FY 24 (DY 05)**	**DEMO TREND RATE**	**FY 25 (DY 06)**	**RATE 3**	**FY 26 (DY 07)**	**FY 27 (DY 08)**	**FY 28 (DY 09)**	**FY 29 (DY 10)**	
6										
7	**DAB**									
8	**Pop Type:**	**Medicaid**								
9	Eligible Member Months	6,013,780	-3.8%	5,786,068	0.0%	5,786,068	5,786,068	5,786,068	5,786,068	
10	PMPM Cost	$ 397.59	9.2%	$ 434.02	5.0%	$ 456.24	$ 479.05	$ 503.00	$ 528.15	
11	Total Expenditure			$ 2,511,287,543		$ 2,639,835,530	$ 2,771,815,735	$ 2,910,392,056	$ 3,055,911,659	$ 13,889,242,523
12										
13	**TANF**									
14	**Pop Type:**	**Medicaid**								
15	Eligible Member Months	15,606,942	-5.4%	14,763,272	0.0%	14,763,272	14,763,272	14,763,272	14,763,272	
16	PMPM Cost	$ 36.43	11.2%	$ 40.50	5.0%	$ 42.77	$ 44.91	$ 47.16	$ 49.52	
17	Total Expenditure			$ 597,851,407		$ 631,425,143	$ 663,018,545	$ 696,235,907	$ 731,077,229	$ 3,319,608,232
18										
19	**HMP**									
20	**Pop Type:**	**Medicaid**								
21	Eligible Member Months	9,458,519	-13.7%	8,159,031	0.0%	8,159,031	8,159,031	8,159,031	8,159,031	
22	PMPM Cost	$ 46.22	22.5%	$ 56.62	5.0%	$ 61.02	$ 64.07	$ 67.27	$ 70.63	
23	Total Expenditure			$ 461,972,852		$ 497,864,101	$ 522,749,147	$ 548,858,047	$ 576,272,393	$ 2,607,716,539
24										
25	**Habilitative Supports Waiver (HSW)**									
26	**Pop Type:**	**Medicaid**								
27	Eligible Member Months	89,482	0.0%	89,482	0.0%	89,482	89,482	89,482	89,482	
28	PMPM Cost	$ 7,157.05	5.0%	$ 7,514.90	5.0%	$ 7,890.65	$ 8,285.18	$ 8,699.44	$ 9,134.41	
29	Total Expenditure			$ 672,448,351		$ 706,071,143	$ 741,374,477	$ 778,443,290	$ 817,365,276	$ 3,715,702,537
30										
31	**Children's Waiver Program (CWP)**									
32	**Pop Type:**	**Medicaid**								
33	Eligible Member Months	5,852	0.0%	5,852	0.0%	5,852	5,852	5,852	5,852	
34	PMPM Cost	$ 3,330.25	5.0%	$ 3,496.76	5.0%	$ 3,671.60	$ 3,855.18	$ 4,047.94	$ 4,250.34	
35	Total Expenditure			$ 20,463,053		$ 21,486,203	$ 22,560,513	$ 23,688,545	$ 24,872,990	$ 113,071,304
36										
37	**Serious Emotional Disturbance Waiver (SEDW)**									
38	**Pop Type:**	**Medicaid**								
39	Eligible Member Months	5,411	0.0%	5,411	0.0%	5,411	5,411	5,411	5,411	
40	PMPM Cost	$ 1,966.34	5.0%	$ 2,064.65	5.0%	$ 2,167.89	$ 2,276.28	$ 2,390.09	$ 2,509.59	
41	Total Expenditure			$ 11,171,834		$ 11,730,453	$ 12,316,951	$ 12,932,777	$ 13,579,391	$ 61,731,407
42										
43	**SUD IMD DAB**									
44	**Pop Type:**	**Medicaid**								
45	Eligible Member Months	6,973	0.0%	6,973	0.0%	6,973	6,973	6,973	6,973	
46	PMPM Cost	$ 1,758.71	5.0%	$ 1,846.64	5.0%	$ 1,938.97	$ 2,035.92	$ 2,137.72	$ 2,244.61	
47	Total Expenditure			$ 12,876,629		$ 13,520,438	$ 14,196,470	$ 14,906,322	$ 15,651,666	$ 71,151,524
48										
49	**SUD IMD TANF**									
50	**Pop Type:**	**Medicaid**								
51	Eligible Member Months	5,246	0.0%	5,246	0.0%	5,246	5,246	5,246	5,246	
52	PMPM Cost	$ 1,043.42	5.0%	$ 1,095.59	5.0%	$ 1,150.37	$ 1,207.89	$ 1,268.28	$ 1,331.69	
53	Total Expenditure			$ 5,747,466		$ 6,034,841	$ 6,336,591	$ 6,653,397	$ 6,986,046	$ 31,758,341
54										
55	**SUD IMD HMP**									
56	**Pop Type:**	**Medicaid**								
57	Eligible Member Months	26,221	0.0%	26,221	0.0%	26,221	26,221	26,221	26,221	
58	PMPM Cost	$ 1,188.43	5.0%	$ 1,247.86	5.0%	$ 1,310.25	$ 1,375.76	$ 1,444.55	$ 1,516.78	
59	Total Expenditure			$ 32,720,042		$ 34,356,065	$ 36,073,803	$ 37,877,546	$ 39,771,488	$ 180,798,944

	A	B	C	D	E	F	G
1	**Panel 1: Historic DSH Claims for the Last Five Fiscal Years:**						
2	**RECENT PAST FEDERAL FISCAL YEARS**						
3		**20__**	**20__**	**20__**	**20__**	**20__**	
4	State DSH Allotment (Federal share)						
5	State DSH Claim Amount (Federal share)						
6	DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -	
7							
8	**Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period**						
9	**FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS**						
10		**FFY 00 (20__)**	**FFY 01 (20__)**	**FFY 02 (20__)**	**FFY 03 (20__)**	**FFY 04 (20__)**	**FFY 05 (20__)**
11	State DSH Allotment (Federal share)						
12	State DSH Claim Amount (Federal share)						
13	DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
14							
15	**Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period**						
16	**FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS**						
17		**FFY 00 (20__)**	**FFY 01 (20__)**	**FFY 02 (20__)**	**FFY 03 (20__)**	**FFY 04 (20__)**	**FFY 05 (20__)**
18	State DSH Allotment (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
19	State DSH Claim Amount (Federal share)						
20	Maximum DSH Allotment Available for Diversion (Federal share)						
21	Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
22	DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
23	DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
24							
25	**Panel 4: Projected DSH Diversion Allocated to DYs**						
26	**DEMONSTRATION YEARS**						
27			**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**
28	DSH Diversion to Leading FFY (total computable)						
29	FMAP for Leading FFY						
30							
31	DSH Diversion to Trailing FFY (total computable)						
32	FMAP for Trailing FFY						
33							
34	Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -

	A	B	C	D	E	F	G
1	**Budget Neutrality Summary**						
2							
3	**Without-Waiver Total Expenditures**	SFY 2025	SFY 2026	SFY 2027	SFY 2028	SFY 2029	
4		**DEMONSTRATION YEARS (DY)**					**TOTAL**
5		**FY 25 (DY 06)**	**FY 26 (DY 07)**	**FY 27 (DY 08)**	**FY 28 (DY 09)**	**FY 29 (DY 10)**	
6	**Medicaid Populations**						
7	**DAB**	$2,511,287,543	$2,639,835,530	$2,771,815,735	$ 2,910,392,056	$ 3,055,911,659	$ 13,889,242,523
8	**TANF**	$ 597,851,407	$ 631,425,143	$ 663,018,545	$ 696,235,907	$ 731,077,229	$ 3,319,608,232
9	**HMP**	$ 461,972,852	$ 497,864,101	$ 522,749,147	$ 548,858,047	$ 576,272,393	$ 2,607,716,539
10	**Habilitative Supports Waiver (HSW)**	$ 672,448,351	$ 706,071,143	$ 741,374,477	$ 778,443,290	$ 817,365,276	$ 3,715,702,537
11	**Children's Waiver Program (CWP)**	$ 20,463,053	$ 21,486,203	$ 22,560,513	$ 23,688,545	$ 24,872,990	$ 113,071,304
12	**Serious Emotional Disturbance Waiver (SEDW)**	$ 11,171,834	$ 11,730,453	$ 12,316,951	$ 12,932,777	$ 13,579,391	$ 61,731,407
13	**SUD IMD DAB**	$ 12,876,629	$ 13,520,438	$ 14,196,470	$ 14,906,322	$ 15,651,666	$ 71,151,524
14	**SUD IMD TANF**	$ 5,747,466	$ 6,034,841	$ 6,336,591	$ 6,653,397	$ 6,986,046	$ 31,758,341
15	**SUD IMD HMP**	$ 32,720,042	$ 34,356,065	$ 36,073,803	$ 37,877,546	$ 39,771,488	$ 180,798,944
16							
17	**DSH Allotment Diverted**	$ -	$ -	$ -	$ -	$ -	$ -
18							
19	**Other WOW Categories**						
20	**Category 1**						$ -
21	**Category 2**						$ -
22							
23							
24	**TOTAL**	$ 4,326,539,178	$ 4,562,323,917	$ 4,790,442,232	$ 5,029,987,887	$ 5,281,488,138	$ 23,990,781,351
25							
26	**With-Waiver Total Expenditures**						
27		**DEMONSTRATION YEARS (DY)**					**TOTAL**
28		**FY 25 (DY 06)**	**FY 26 (DY 07)**	**FY 27 (DY 08)**	**FY 28 (DY 09)**	**FY 29 (DY 10)**	
29	**Medicaid Populations**						
30	**DAB**	$2,511,287,543	$2,639,835,530	$2,771,815,735	$ 2,910,392,056	$ 3,055,911,659	$ 13,889,242,523
31	**TANF**	$ 597,851,407	$ 631,425,143	$ 663,018,545	$ 696,235,907	$ 731,077,229	$ 3,319,608,232
32	**HMP**	$ 461,972,852	$ 497,864,101	$ 522,749,147	$ 548,858,047	$ 576,272,393	$ 2,607,716,539
33	**Habilitative Supports Waiver (HSW)**	$ 672,448,351	$ 706,071,143	$ 741,374,477	$ 778,443,290	$ 817,365,276	$ 3,715,702,537
34	**Children's Waiver Program (CWP)**	$ 20,463,053	$ 21,486,203	$ 22,560,513	$ 23,688,545	$ 24,872,990	$ 113,071,304
35	**Serious Emotional Disturbance Waiver (SEDW)**	$ 11,171,834	$ 11,730,453	$ 12,316,951	$ 12,932,777	$ 13,579,391	$ 61,731,407
36	**SUD IMD DAB**	$ 12,876,629	$ 13,520,438	$ 14,196,470	$ 14,906,322	$ 15,651,666	$ 71,151,524
37	**SUD IMD TANF**	$ 5,747,466	$ 6,034,841	$ 6,336,591	$ 6,653,397	$ 6,986,046	$ 31,758,341
38	**SUD IMD HMP**	$ 32,720,042	$ 34,356,065	$ 36,073,803	$ 37,877,546	$ 39,771,488	$ 180,798,944
39							
40	**Expansion Populations**						
41							
42							
43							
44	**Excess Spending From Hypotheticals**						$ -
45							
46	**Other WW Categories**						
47	**Category 3**						$ -
48	**Category 4**						$ -
49							
50	**TOTAL**	$ 4,326,539,178	$ 4,562,323,917	$ 4,790,442,232	$ 5,029,987,887	$ 5,281,488,138	$ 23,990,781,351
51							
52	**VARIANCE**	$ -	$ -	$ -	$ -	$ -	$ -
53							
54							
55							
56							
57	**HYPOTHETICALS ANALYSIS**						
58							
59	**Without-Waiver Total Expenditures**						
60		**DEMONSTRATION YEARS (DY)**					**TOTAL**
61		**FY 25 (DY 06)**	**FY 26 (DY 07)**	**FY 27 (DY 08)**	**FY 28 (DY 09)**	**FY 29 (DY 10)**	
62							
63							
64							
65							
66							
67							
68	**TOTAL**	$ -	$ -	$ -	$ -	$ -	$ -
69							
70	**With-Waiver Total Expenditures**						
71		**DEMONSTRATION YEARS (DY)**					**TOTAL**
72		**FY 25 (DY 06)**	**FY 26 (DY 07)**	**FY 27 (DY 08)**	**FY 28 (DY 09)**	**FY 29 (DY 10)**	
73							
74							
75							
76							
77							
78							
79	**TOTAL**	$ -	$ -	$ -	$ -	$ -	$ -
80							
81	**HYPOTHETICALS VARIANCE**	$ -	$ -	$ -	$ -	$ -	$ -