

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



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

SEP 27 2019

Dear Mr. Gordon:

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

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

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

Objectives of the Medicaid Program

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

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

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

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

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

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

Background on Medicaid Coverage in Michigan

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

Extent and Scope of Demonstration

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

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

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

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

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

Consideration of Public Comments

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

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

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

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

Other Information

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

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

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

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

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

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

Sincerely,


Calder Lynch
Acting Deputy Administrator and Director

Enclosures

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

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00305/5

TITLE: Michigan 1115 Behavioral Health Demonstration

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

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

1. Residential Treatment for Individuals with Substance Use Disorder (SUD).

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

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

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

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

NUMBER: 11-W-00305/5

TITLE: Michigan 1115 Behavioral Health Demonstration

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

I. PREFACE

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

The STCs have been arranged into the following subject areas:

- I. [Preface](#)
- II. [Program Description and Objectives](#)
- III. [General Program Requirements](#)
- IV. [Eligibility and Enrollment](#)
- V. [Substance Use Disorder \(SUD\) Program](#)
- VI. [Cost Sharing](#)
- VII. [Delivery System](#)
- VIII. Eligibility Transition for HCBS State Plan Benefit
- IX. [General Reporting Requirements](#)
- X. [Monitoring](#)
- XI. [Evaluation of the Demonstration](#)
- XII. [General Financial Requirements Under Title XIX](#)
- XIII. [Monitoring Budget Neutrality for the Demonstration](#)
- XIV. [Schedule of Deliverables for the Demonstration](#)

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

- [Attachment A: Developing the Evaluation Design](#)
[Attachment B: Preparing the Interim and Summative Evaluation Reports](#)
[Attachment C: Reserved for Evaluation Design](#)
[Attachment D: OUD/SUD Implementation Plan](#)
[Attachment E: Reserved for OUD/SUD Monitoring Protocol](#)

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

This demonstration sought to accomplish these efforts by:

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

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

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

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

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Laws.** The state must comply with applicable federal civil rights laws relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 in eligibility and documentation requirements, to ensure they understand program rules and notices, in establishing eligibility for an exemption from community engagement requirements on the basis of disability, and to enable them to meet and document community engagement requirements, as well as meeting other program requirements necessary to obtain and maintain benefits.
- 2. Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in federal law, regulation, and written policy, not expressly waived or identified as not applicable in the expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3. Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state

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

4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

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

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

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

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

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

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

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

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

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

- c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
- d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
- e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
- f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
- g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

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

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

- demonstration authority for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities.
- b. Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
 - c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration authority expiration plan. CMS will consider comments received during the 30-day period during its review of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) calendar days after CMS approval of the demonstration authority expiration plan.
 - d. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

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

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

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

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

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

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

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

IV. ELIGIBILITY AND ENROLLMENT

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

V. SUBSTANCE USE DISORDER (SUD) PROGRAM

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

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

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

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

ODU/SUD Benefit	Medicaid Authority	Expenditure Authority
Early Intervention Services	State plan (Individual services covered)	
Ambulatory Withdrawal Management	State plan	
Outpatient Services	State plan (<i>Individual services covered</i>)	
Intensive Outpatient Services	State plan (<i>Individual services covered</i>)	
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 (<i>Individual services covered</i>)	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	State plan	Services provided to individuals in IMDs
Inpatient Services	State plan (<i>Individual Services covered</i>)	Services provided to individuals in IMDs
SUD Support Services	State plan (<i>Individual services covered</i>)	Services provided to individuals in IMDs

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

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

- a. **Access to Critical Levels of Care for OUD and other SUDs:** Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;
- b. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other patient placement assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;
- c. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care

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

- d. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in the *State Administrative Rules for the Licensure of Substance Use Disorder Programs*. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;
- e. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;
- f. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;
- g. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for OUD:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;
- h. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;
- i. **Improved Care Coordination and Transitions between levels of care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

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

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

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

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

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

- a. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.
- b. Evaluation Questions and Hypotheses Specific to the OUD/SUD Program. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component must have at least one evaluation question and hypothesis. The hypothesis testing must include, where possible, assessment of both process and outcome measures. Proposed measures must be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

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

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

¹ Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the “opioid” epidemic and facilitate a nimble and targeted response.

² *Ibid.*

³ Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

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

- k. The state must include in its SUD Monitoring Protocol (STC 19) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.
- l. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (STC 31).
- m. As applicable, the state must advance the standards identified in the ‘Interoperability Standards Advisory—Best Available Standards and Implementation Specifications’ (ISA) in developing and implementing the state’s SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
 - i. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state must use the federally-recognized standards, barring another compelling state interest.
 - ii. Where there are opportunities at the state and provider level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state must use the federally-recognized ISA standards, barring no other compelling state interest.

VI. COST SHARING

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

VII. DELIVERY SYSTEM

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

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

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

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

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

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

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

VIII. TRANSITIONAL ELIGIBILITY FOR HCBS REQUIREMENTS

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

- 31.** By November 1, 2019, the State will phase in the proposed tool to assess and evaluate beneficiaries against the 1915(i) HCBS State plan benefit needs-based eligibility criteria.
- 32.** From June 1, 2020 through September 30, 2020, the State will provide technical assistance to all PIHPs on the 1915(i) HCBS State plan benefit needs-based eligibility packets and tools developed to assure individuals meet all the eligibility requirements.

33. From October 1, 2020 through January 1, 2021, the State will do the joint Application and Design (JAD) Sessions for requirements/design.
34. From January 1, 2021 through March 1, 2021, the State will phase in enrolled beneficiaries information packets to the online system with the state testing the eligibility capabilities and notifications.
35. From June 1, 2021 through July 1, 2021, the State will analyze the adequacy of administration needed to process information and to make eligibility determinations.
36. From September 1, 2021 through September 30, 2021, the State will finalize the process and requirements via manual revisions and training to all PIHP users.
37. From October 1, 2021 forward, the State will demonstrate full compliance in executing eligibility determinations for all individuals currently enrolled in or seeking 1915(i) HCBS State plan benefits to ensure all individuals receiving services will be determined eligible by the state on or before October 1, 2022. NOTE: PIHPs will no longer be responsible for determining needs-based criteria and eligibility for initial or re-evaluations.
38. The state will adhere to all of the requirements, including quality monitoring and reporting, in accordance with the information specified in the approved 1915(i) HCBS State plan benefit which will become effective as of October 1, 2022.

IX. GENERAL REPORTING REQUIREMENTS

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

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

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

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

42. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
- b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

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

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

X. MONITORING

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

- a. Operational Updates - Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b. Performance Metrics – Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the

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

- c. Budget Neutrality and Financial Reporting Requirements - Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.
- d. Evaluation Activities and Interim Findings - Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.
- e. SUD Health IT - The state will include a summary of progress made in regards to SUD Health IT requirements outlined in STC 23.

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

- a. The draft close-out report must comply with the most current Guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the close-out report.
- c. The state must take into consideration CMS' comments for incorporation into the final close-out report.
- d. The final close-out report is due to CMS no later than 30 calendar days after receipt of CMS' comments.
- e. A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 21.

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

- a. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on the evaluation.
- b. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The state and CMS will jointly develop the agenda for the calls.

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

XI. EVALUATION OF THE DEMONSTRATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

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

- 59. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding. CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the limits described in Section XII:
- a. Administrative costs, including those associated with the administration of the demonstration;
 - b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
 - c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

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

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

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

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

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

- d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
- e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

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

Table 2: Master MEG Chart					
MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description

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

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

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

- a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
- b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures

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

- c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.
- d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

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

Table 3: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
DAB	See Brief Description above	N/A	Standard lines by type of service	Date of service	MAP	Yes ⁴	Oct. 1, 2019	Sep. 30, 2024

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

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

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

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

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

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

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

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

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

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

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

- a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
- b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.
- c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

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

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

ATTACHMENT A

Developing the Evaluation Design

Introduction

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

Expectations for Evaluation Designs

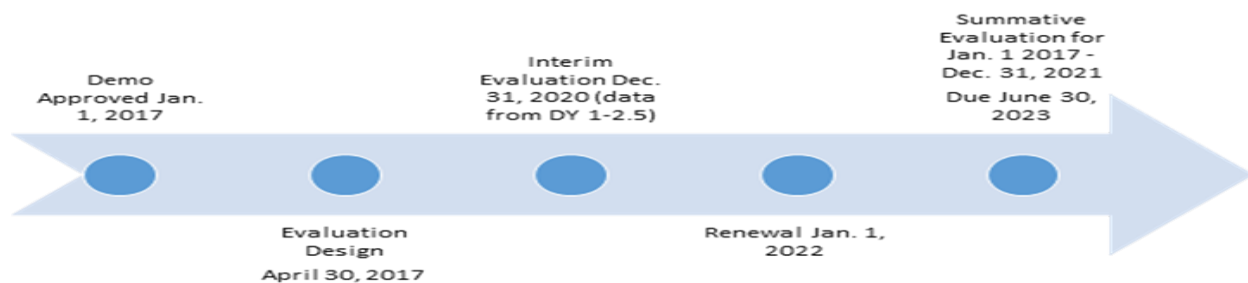
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses,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

The format for the Evaluation Design is as follows:

General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

Submission Timelines

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



Required Core Components of All Evaluation Designs

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

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

- 1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

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

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

- 2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams:
<https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>
- 3) Identify the state’s hypotheses about the outcomes of the demonstration:
- 4) Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
- 5) Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

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

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

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

- 1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
- 2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
- 3) *Evaluation Period* – Describe the time periods for which data will be included.

- 4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
- a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used, and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
 - d. Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
 - f. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
 - g. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
- 5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

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

- 6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
- a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

- b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
 - c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
 - d. The application of sensitivity analyses, as appropriate, should be considered.
- 7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

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

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

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

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

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

E. Attachments

- 1) **Independent Evaluator.** This includes a discussion of the state’s process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include “No Conflict of Interest” signed by the independent evaluator.
- 2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.
- 3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B

Preparing the Interim and Summative Evaluation Reports

Introduction

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

Expectations for Evaluation Reports

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

Intent of this Guidance

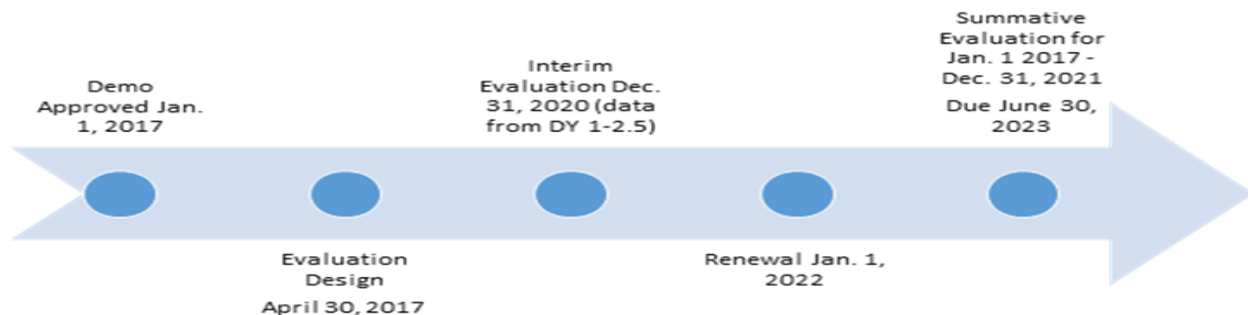
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved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

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

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

Submission Timelines

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



Required Core Components of Interim and Summative Evaluation Reports

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

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
 - 1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
 - 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
 - 3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
 - 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
 - 5) Describe the population groups impacted by the demonstration.
- C. Evaluation Questions and Hypotheses** – In this section, the state should:
 - 1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

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

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

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

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

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

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

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

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

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

- 1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
- 2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

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

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

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

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

**ATTACHMENT C:
Reserved for Evaluation Design**

STATE OF MICHIGAN
1115 DEMONSTRATION WAIVER
OPIOID USE DISORDER/SUBSTANCE USE
DISORDER IMPLEMENTATION PLAN

MAY 2018

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

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

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

1. Ensure a Comprehensive Evidence-Based Benefit SUD Benefit
 - To guarantee a full continuum of evidence-based practices
 - To ensure use of evidence-based practices including Screening, Brief Intervention, and Referral to Treatment (SBIRT), withdrawal management, medication assisted treatment, care coordination, long-term recovery supports and services
 - To confirm service availability and use of services (e.g., short-term inpatient and short-term residential), including in IMDs
2. Ensure that SUD providers meet ASAM Program and Service Requirements
 - By establishing standards of care using ASAM criteria
 - By using ASAM standards to develop residential, withdrawal management, outpatient, early intervention and opioid treatment programs
 - By requiring all providers to meet ASAM level of care standards prior to participating in Medicaid
3. Ensure the Presence and Maintenance of a Strong SUD Provider Network
 - By developing and implementing a plan and strategy to ensure a sufficient network of providers across all ASAM levels
 - By ensuring that providers have the ability to deliver services consistent with ASAM criteria and provide evidence-based SUD practices
 - By ensuring that the provider network is robust in the event providers stop participating in Medicaid, are suspended or terminated

Michigan provides coverage for an extensive array of SUD treatment and recovery support services. Below we list all of the SUD services available under the waiver, including those newly covered under the 1115 waiver. SUD treatment services are arrayed by the ASAM Level of Care.

Recovery Support Services are available to individuals regardless of ASAM care level. Unless otherwise noted, all services are available to adults and children/adolescents. For each service we also provide definitions and components for each service.

Table: 1

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
SUD TREATMENT					
0.5 - Early Intervention					
	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Assessment and education for at-risk individuals. A face-to-face service for the purpose of identifying functional, treatment, and recovery needs and a basis for formulating the Individualized Treatment Plan.	Primary care providers payable under the state's managed care/ fee for service physical health care system.	NA.	Currently Available

	Early intervention services	Includes stage-based interventions for individuals with substance use disorders and individuals who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use.	<p>Provider agency licensed and accredited as substance abuse treatment program. State approval for ASAM level of care.</p> <p>Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.</p>	Services are not subdivided by the number of hours received during a week. The amount and type of services provided are based on individual needs based on the beneficiary's motivation to change and other risk factors that may be present.	Currently Available
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ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
Level 1 - Opioid Treatment Program (OTP)					
	Approved pharmacological support services	Oral medication administration, direct observation, physician evaluations, individual and person centered assessments, nursing assessments, counseling and laboratory testing and access to primary care (approved for use of Methadone and/or Buprenorphine).	Services must be provided under the supervision of a physician licensed to practice medicine in Michigan. Programs must meet applicable state licensure, CSAT certification, DEA licensure and accreditation requirements. State approval for ASAM level of care.	Service limitations as indicated by state and federal requirements (e.g., physical examination, laboratory tests, etc.).	Currently Available
Level 1 - Outpatient Services					
	Psychiatric evaluation	Physician evaluation/exam	Psychiatrist or psychiatric mental health nurse practitioner.	Services provided as medically necessary.	Currently Available
	Assessment	A face-to-face service for the purpose of identifying functional, treatment, and recovery needs and a basis for formulating the Individualized Treatment Plan.	Provider agency licensed and accredited as substance abuse treatment program. State approval for ASAM level of care. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.	ASAM level 1 Services from one to eight hours during a week. Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.	Currently Available
	Treatment planning	Activities associated with the development and periodic review of the plan of service, including all aspects of the person-centered	Provider agency licensed and accredited as substance abuse treatment program. State approval for ASAM level of care.	Services provided as medically necessary.	Currently Available

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

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

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
	Crisis Intervention	A service for the purpose of addressing problems/issues that may arise during treatment and could result in the beneficiary requiring a higher level of care if intervention is not provided.	Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP. A recovery coach or SUD peer specialist must be certified through an MDHHS-approved training program.	Services provided as medically necessary.	Currently Available
	Medication review	Evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.	A physician, physician assistant, nurse practitioner, registered nurse, licensed pharmacist, or a licensed practical nurse assisting the physician may perform medication reviews. Only an MD or DO, or a licensed physician's assistant or nurse practitioner under the supervision of a physician may prescribe medications.	Services provided as medically necessary.	Currently Available
	Laboratory Tests	Laboratory analysis of specimens to detect presence of alcohol or drugs.	Medicaid eligible and enrolled laboratory services providers.	Services provided as medically necessary.	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
Level 2.1 – Intensive Outpatient Services					
	Intensive Outpatient Services (IOP)	<p>Includes assessment, counseling, crisis intervention, and activity therapies or education.</p> <p>Outpatient services can include any variety of the covered services and are dependent on the individual needs of the beneficiary. The assessment, treatment plan and recovery support preparations are the only components that are consistent throughout the outpatient levels of care as each beneficiary must have these as part of the authorized treatment services.</p>	<p>Provider agency licensed and accredited as substance abuse treatment program. State approval for ASAM level of care.</p> <p>Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.</p>	<p>Provided as 9 to 19 hours of structured programming per week based on an individualized treatment plan. As a beneficiary's needs increase, more services and/or frequency/duration of services may be utilized if these are medically necessary.</p>	Currently Available
Level 2.5 – Partial Hospitalization Services					
	Partial hospitalization (Expanded Intensive Outpatient)	20 or more hours of service/week for multidimensional instability not requiring 24-hour care.	<p>Provider agency licensed and accredited as substance abuse treatment program. State approval for ASAM level of care.</p> <p>Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.</p>	<p>Authorization for the partial hospitalization admission and continued stay includes authorization for all services related to that admission/stay, including laboratory, pharmacy, and radiology services.</p>	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
Level 3.1 – Clinically Managed Low-intensity Residential Services					
	Clinically Managed Low-Intensity Residential Services	<p>The services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in work, education, and family life. Treatment services are similar to low intensity outpatient services focused on improving the individual’s functioning and coping skills in Dimension 5 and 6.</p> <p>Functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. The setting allows clients opportunity to develop and practice skills while reintegrating into the community.</p> <p>Services are inclusive of structured supervision within the 24-hour program, provided by available trained personnel; at least 5 hours of clinical service/week in which services are preparing individual for outpatient treatment.</p>	<p>Provider agency licensed and accredited as substance abuse treatment program.</p> <p>Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.</p> <p>Providers assessed by the state or its designee and confirmed to meet ASAM program level requirements for this level of care.</p>	<p>At least 5 hours per week of clinical services (Assessment; Episode of Care Plan-addressing treatment, recovery, discharge and transition across episode; interaction/teaching to process skills and information adapted to the individual needs; includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention); coordination and referral; medical evaluation and linkage to services; connection to next provider and medical services; preparation for next step.</p>	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
				At least 5 hours of life skills and self-care per week.	
Level 3.3 – Clinically Managed Population-specific High-Intensity Residential Services					
	Clinically Managed Population-specific High-Intensity Residential Services (Adult only)	<p>The program provides a structured recovery environment in combination with medium-intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning. Treatment services are directed to provision of simple interventions to increase awareness and understanding of dangerous consequences of behavior and improving functioning and coping in Dimensions 4 and 5.</p> <p>The deficits for clients at this level are primarily cognitive, either temporary or permanent. Clients in this LOC have needs that are more intensive and to benefit effectively from services, they must be provided at a slower pace and over a longer period</p>	<p>Provider agency licensed and accredited as substance abuse treatment program.</p> <p>Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.</p> <p>Providers assessed by the state or its designee and confirmed to meet ASAM program level requirements for this level of care.</p>	<p>Not less than 13 hours per week of core services (Assessment; Episode of Care Plan-addressing treatment, recovery, discharge and transition across episode; interaction/teaching to process skills and information adapted to the individual needs; includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention); coordination and referral; medical evaluation and linkage to services; connection to next</p>	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
		<p>of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.</p> <p>Services are inclusive of structured supervision 24/7, provided by trained counselors to stabilize the multidimensional aspects of imminent danger. Services are offered within the less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or the therapeutic community as they prepare for outpatient treatment.</p>		<p>provider and medical services; preparation for next step.</p> <p>Not less than 13 hours per week of life skills and self-care services.</p>	

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

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

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

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
Level 2-WM – Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)					
	Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)	<p>Ambulatory sub-acute detoxification with extended on-site monitoring for patients expected to demonstrate moderate withdrawal with all day withdrawal management and support and supervision.</p> <p>Services must have arrangements for access to licensed medical personnel as needed.</p> <p>Patient has a supportive family or living situation at night.</p>	<p>Provider agency licensed and accredited as substance abuse treatment program.</p> <p>Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.</p> <p>Ambulatory detoxification services must be monitored by appropriately credentialed and licensed nurses.</p> <p>Providers assessed by the state or its designee and confirmed to meet ASAM program level requirements for this level of care.</p>	Initial length-of-stay authorizations may be for up to three days, with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization requirements continue to be met.	Currently Available
Level 3.2-WM – Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)					
	Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)	<p>Detoxification management and monitoring of services to client determined to need moderate withdrawal, and 24-hour support to complete withdrawal supervision and increase likelihood of continuing treatment or recovery. This residential setting for detoxification emphasizes peer and social support for persons who warrant 24-hour support.</p>	<p>Provider agency licensed and accredited as substance abuse treatment program. Licensure as a sub-acute detoxification program is required.</p> <p>Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.</p> <p>Providers assessed by the state or its designee and confirmed to meet ASAM</p>	Initial length-of-stay authorizations may be for up to three days, with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization	Currently Available

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

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
		The service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting.			
Level 4 WM – Medically Managed Intensive Inpatient					
	Medically Monitored Inpatient Withdrawal Management	<p>Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits.</p> <p>Inpatient medical acute detoxification services provided in a hospital setting must meet one of the following criteria as documented in the physician's orders and patient care plan: Vital signs, extreme and unstable; uncontrolled hypertension, extreme and unstable; delirium tremens, e.g., confusion, hallucinations, seizures or a documented history of delirium tremens requiring treatment; convulsions or multiple convulsions within the last 72 hours; unconsciousness; occurrence of SUD; with pregnancy, monitoring the fetus is vital to the continued health of the fetus; severe/complex medical conditions including insulin-dependent diabetes complicated by diabetic ketoacidosis; suspected</p>	<p>A hospital providing medically managed intensive inpatient services is accredited and licensed and staffed 24/7 to provide licensed nursing and physician services to patients requiring access to a range of services including ancillary such as laboratory, x-ray, nutrition services) and specialty physician services.</p> <p>The staff are licensed and credentialed by the hospital and meet the accreditation standards related to practice within their licensures.</p> <p>The inpatient unit must be staffed by a physician and nursing personnel.</p>	Service provided as medically indicated and through established medical protocols.	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
		diagnosis of closed head injury based on trauma injury; congestive heart disease, ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease; suicidal ideation and gestures necessitating suicidal precautions as part of treatment; blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse; blood alcohol level 400 mg/dl with diagnosis of alcohol dependence; active presentation of psychotic symptoms reflecting an urgent/emergent condition.			
SUD SUPPORT SERVICES					
	Recovery Supports	To support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Recovery programs are designed and delivered to and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery.	Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP. A recovery coach or SUD peer specialist must be certified through an MDHHS-approved training program.	Available as medically necessary and appropriate (i.e., one to eight hours during a week; 9 to 19 hours in a week; 20 or more hours in a week.	Currently Available
	Peer Supports	To support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an	Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP. A recovery coach or SUD peer specialist must be	Available as medically necessary and appropriate (i.e., one to eight hours during	Currently Available

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

I. Use of Evidence-Based SUD Specific Patient Placement Criteria

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

To support the use of the ASAM criteria and aid in matching individuals with the appropriate level of care, Michigan is requiring the use of a standardized assessment tool that utilizes the ASAM criteria. Michigan is adopting the use of the Global Appraisal of Individual Needs Initial (GAIN-I) Core assessment that will be used statewide. The GAIN-I Core is a comprehensive assessment that supports clinical diagnosis, level of care placement and treatment planning. It collects necessary information to provide a Diagnostic and Statistical Manual based diagnosis and the recommended ASAM placement needs.

Michigan began statewide training with the Pre-paid Inpatient Health Plans (PIHP) SUD provider network on the GAIN-I Core in October 2017. The state has contracted with the GAIN Coordinating Center, through Chestnut Health Systems to train state providers and establish the necessary licensing agreements with the state to ensure full access to this instrument. Michigan is planning to require full use of the GAIN assessment by the provider system by October 1, 2020 to allow adequate time for training and system changes.

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

For residential and withdrawal management services, PIHPs, with the support of the GAIN-I Core assessment recommendations, will use the six ASAM dimensions as a component of decision making for needed level of care as follows:

Table 2:

Level of Care	Level 3.1	Level 3.3	Level 3.5	Level 3.7
Dimension 1 Withdrawal Potential	No withdrawal risk, or minimal/stable withdrawal; concurrently receiving Level 1-WM or Level 2-WM	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2-WM	At minimal risk of severe withdrawal. If withdrawal is present, manageable at Level 3.2-WM	At high risk of withdrawal, but manageable at level 3.7 WM and does not require the full resources of a licensed hospital

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

Dimension 6 Recovery/living environment	Environment is dangerous, but recovery achievable if Level 3.1 24-hour structure is available	Environment is dangerous and client needs 24-hour structure to cope	Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting	Environment is dangerous and the patient lacks skills to cope outside of a highly
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Level of Care	Level 3.1	Level 3.3	Level 3.5	Level 3.7
				structured 24-hour setting

The use of the GAIN-I Core will allow the appropriate review and application of the ASAM dimensions and assist in matching the individual with a residential program that has been approved to provide the identified level of care. The PIHPs will also use the ASAM dimensions and the GAIN-I Core for establishing the appropriate level of care for withdrawal management, outpatient and opioid treatment programs.

This approach will solidify ASAM as the foundation of the entire SUD service system in Michigan.

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

An expectation for this waiver is that the state implement a process to assess and demonstrate that residential providers meet ASAM criteria prior to participating in the Medicaid program. The State of Michigan ensures that providers meet key program requirements set forth by ASAM for each of the residential levels of care. Approximately 75 organizations provide the residential level of SUD treatment services in Michigan.

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

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

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

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

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

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

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

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

The ASAM designation application process is always open which allows new programs to apply so they may join a PIHP network. An online application process is being developed by the state to manage the assignment procedure. It is targeted to be available for use by the end of demonstration year two and moving forward. Until then, it will continue to be a manual, paper process.

Michigan is working directly with national experts, to provide training on the use of ASAM criteria. The training is targeted to providers to assist in overall education and program development. These trainings began in fiscal year 17 and will continue through fiscal year 19 and then as needed.

III. Standards of Care

The PIHPs are required to ensure that their providers and/or the intake agencies within their networks are all appropriately trained/educated in the application and use of ASAM. The frequency and duration of treatment services are expected to be guided by the ASAM criteria and individual need, not the designation of the provider program that may be conducting an assessment. PIHPs will provide evidence of initial training and ongoing training of providers during site reviews conducted by the state.

Additionally, as part of quality monitoring during site reviews, clinical records will be reviewed to determine appropriate application and fidelity to the GAIN-I Core assessment and ASAM processes. This quality monitoring will address the expectations that the assessment for all SUD services, level of care and length of stay recommendations has an independent third party reviewing and determining if the provider has the necessary competencies on the use of ASAM in the assessment process and determining

an appropriate level of care. If the PIHP, or the state, determines during this monitoring that the provider is not using ASAM to make the appropriate level of care and length of stay decisions and recommendations, the state and PIHP will take the necessary corrective action.

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

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

At the time of provider enrollment or re-enrollment in the PIHP's provider network, the PIHP is required to search the Office of Inspector General's (OIG) exclusions database to ensure that the provider entity, and any individuals with ownership or control interests in the provider entity (direct or indirect ownership of five percent or more or a managing employee), have not been excluded from participating in federal health care programs. Because these search activities must include determining whether any individuals with ownership or control interests in the provider entity appear on the OIG's exclusions database, the PIHP mandates provider entity disclosure of ownership and control information at the time of provider enrollment, re-enrollment, or whenever a change in provider entity ownership or control takes place.

The PIHP must notify the Division of Program Development, Consultation and Contracts, Behavioral Health and Developmental Disabilities Administration in MDHHS immediately if search results indicate that any of their network's provider entities, or individuals or entities with ownership or control interests in a provider entity are on the OIG exclusions database.

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

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

The ASAM enrollment work already completed by the state has established the initial provider capacity in the publicly funded system. The regional PIHPs are able to provide access to each ASAM Level of Care and the support services identified in Table 1. Residential treatment is available in all areas of the state. However, even with the use of IMD's, access to the more intensive level (3.7) has some limitations due to the geographic location of the program which may result in having to travel several hours to access this service from the rural areas of the state. Likewise, level 3.7-WM for withdrawal management, is in the same situation. There is access to this service however, getting to the program from a rural area may result in a significant amount of travel. The medically managed residential (4.0) and withdrawal management (4-WM) levels of care, which are not a component of this 1115 Waiver, are more readily available due to these services being provided in a medical hospital setting. These services are being identified to demonstrate that the full ASAM Level of Care continuum is available in the state.

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

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

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

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

Adolescents will also have access to the various Withdrawal Management Services set forth in the Continuum of Care Sections. When appropriate, older adolescents will also have access to SUD medications as part of the State's Medication Assisted Treatment approach.

While the current continuum reflects services that can be effective for treating adolescents with SUD, the state is aware that the current system of care reflects poor penetration rates for the treatment of adolescents and transitional youth age. Only approximately 8% of those with an identified need are receiving SUD treatment services.

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

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

Information regarding the MYTIE program and a description of current activities regarding the needs assessment and workforce development can be found at:

http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_4877_77211---,00.html.

Information from the gaps analysis in the MYTIE program will assist the State and PIHPs in their network development strategies, including age- appropriate recovery support services for adolescents

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

Former Governor Rick Snyder created a Prescription Drug and Opioid Task Force in 2015 to address the growing prescription drug and opioid problem in Michigan. The task force reported the following information on the escalation of Michigan's problem.

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

1. Tennessee and Washington.
 - a. MDHHS employs a Benefits Monitoring System that flags Medicaid Beneficiaries that are pharmacy shopping and doctor shopping to acquire additional opioid prescriptions than legally prescribed. Beneficiaries that are flagged are contacted and limited to one pharmacy and one prescriber for opioid prescriptions.

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

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

Prevention

2. Require additional training for all professionals who will be prescribing controlled substances, including training on the new CDC prescribing guidelines.
 - a. STR grant funds a project through the University of Michigan that has been offering training on the CDC prescribing guidelines.
 - b. Medicaid is also tracking prescribing outliers and offering technical assistance and guidance to reducing the prescribing appropriately. (State Opioid Response {SOR} grant funded)
3. Development and maintenance of relationships among state and local agencies to provide necessary information regarding prescription drug abuse, prevention and treatment.
 - a. Partnership for Success (PFS) funding provides resources to establish State and Community level infrastructure for Prevention Prepared Communities that includes the capacity to develop and implement data guided programming. PFS funds State and Community level Epidemiological Outcomes Workgroups charged with collecting, analyzing and reporting on morbidity, mortality, prevalence, incidence, trend and social indicator data need to identify the extent of prescription drug abuse and the need for prevention and treatment services at the State and Community levels.
4. Collaboration among local coalitions, pharmacies, health profession boards, state agencies and the DEA to increase the availability of prescription drop off bins.

- a. Collaboration among coalitions, pharmacies, DEA State and local law enforcement continues to occur in various Prepaid Inpatient Health Plan target communities funded by the PFS and other federal, state and local resources.

Review programs and parameters established within the Medicaid system as well as actions taken by other states to determine the best route forward to eliminate doctor and pharmacy shopping. Recommend looking at programs already in use in

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

Treatment

1. Pursue increased public awareness regarding the laws that limit civil and criminal liabilities for administering Naloxone.
 - a. While Michigan has laws that limit civil and criminal liabilities for administering Naloxone, there has not been any major public campaigns to publicize the laws. Children's Services Agency staff are not allowed to carry it or be trained because of potential liability issues.
2. Explore the possibility of limited statutory immunity for low-level offenses involved in reporting an overdose and seeking medical assistance.
 - a. Michigan has a Good Samaritan Law which prevents drug possession charges against those that seek medical assistance in certain circumstances.
3. Explore ways for the State to increase access to care, including wraparound services and MAT, as indicated by national and state guidelines for treatment. In addition, the Task Force recommends that insurance companies consider providing health plans that cover the costs of MAT with reasonable quantity limits on medication used.
 - a. The State Targeted Response (STR) and SOR grant both increase access to care, increase access to case management and peer services, and increase access to MAT through DATA 2000 waiver training and development of a SUD specific curriculum for medical schools.
 - b. Initiation of an Opioid Health Home in a PIHP region to make treatment more assessible for Medicaid beneficiaries with an OUD. Look alike model being developed for Michigan's Upper Peninsula using SOR funding.
4. Explore ways to increase the number of addiction specialists practicing in Michigan.
 - a. SOR project promoting the development of a curriculum specific to substance use disorders to be used in medical schools to prepare physicians entering the field.
5. Additional training for law enforcement in the area of recognizing and dealing with addiction for those officers who do not deal directly with narcotics regularly. The Task Force also recommends expansion of treatment courts as called for by former Governor Rick Snyder in his 2015 Criminal Justice Message, as well as expanding the courts' ability to create pilot programs for the use of MAT.
 - a. There has been a significant increase in the number of Drug Courts implementing MAT programming. MDHHS has provided several trainings

on the efficacy of MAT to Michigan Drug Court Professionals including judges.

6. Require a bona-fide physician-patient relationship as defined in Michigan law prior to prescribing controlled substances.
7. The State should review current best practice guidelines for reducing the development of neonatal abstinence syndrome (NAS) and consider pilot programs for the development of testing of pregnant women to reduce the risk of NAS caused by prescription drug and opioid abuse.
 - a. The state and other entities are piloting several initiatives to identify pregnant women who are using opioids and connect them to any services needed including treatment and other supports.

Regulation

1. Consider legislation to better define and identify pain management practice for the purposes of licensing.
2. Update regulations to delineate licensing for clinics (methadone) based on the population being treated. The State should consider a tiered system of licensing that regulates the functions and prescription capabilities of the clinics and their staff.
3. Recommend the establishment of an exemption from civil liability when a pharmacist is acting in good faith and has reasonable doubt regarding the authenticity of the prescription or believes the prescription is being filled for non-medical purposes.
4. Review the Michigan College of Emergency Physicians policy and then endorse a best practices policy that hospitals and doctors could use as a model.
5. Review the limitation of the sale of pseudoephedrine by pharmacies only.

Policy and Outcomes

1. Create an ongoing Prescription Drug and Opioid Task Force or Commission to evaluate the efficacy of current proposals and continually develop new solutions to address societal changes.
2. Add outcomes to the State Dashboard to track the success of efforts.
3. The State should consider mechanisms to ensure patient continuity of care during an abrupt closure of a medical practice to ensure that necessary treatments can continue without interruption.
4. Document law enforcement efforts with local coalitions and focus groups that have resulted in a reduction of prescription overdose deaths to determine if replication and expansion are possible and warranted.

Enforcement

1. Review the budgetary requirements for updating or replacing the Michigan Automated Prescription System (MAPS.) There should be mandatory registration in MAPS by all licensed prescribers to ensure all are registered when the updated or new system is brought online.

- a. The MAPS upgrades were completed with the new Appriss software. STR grant funds were used to help support the additional NarxCare portion of the Appriss program.
2. Allow broader access to MAPS for law enforcement purposes when investigating questionable business practices by prescribers.
 - a. Requires legislation with is being reviewed.
3. Require enhanced licensing sanctions for health professionals that violate proper prescribing and dispensing practices.

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

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

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

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

- Increase multi-system collaboration at state and community levels
 - Assure and monitor PIHPs to develop and implement action plans for the prevention of prescription and over-the-counter drugs to prevent unintentional deaths from drug overdoses.
 - Provide training to strengthen infrastructure to enhance substance use

disorder prevention and mental health promotion at the community/coalition level.

- Promote to develop leadership structure combining MDHHS, Licensing and Regulatory Affairs, Law Enforcement and other stakeholders to oversee surveillance, intervention, education and enforcement to prevent illegal distribution and use of controlled substances.

- Secure federal discretionary funding to implement the activity listed above.
- Broaden statewide media messages
 - Promote the use of statewide media campaigns entitled: Stop Overdoses (www.michigan.gov/stopverdoses) and Do Your Part: Be the Solution to Prevent Prescription Drug Abuse (www.michigan.gov/doyourpart), that include information portals for parents, physicians, youth, educators and the general public interested in learning about prescription drug and opioid abuse.
- Broaden Rx/OTC drug abuse education and use of brief screenings in behavioral and primary health care settings
 - Ensure that public health approached to the delivery of early intervention such as SBIRT are implemented in behavioral and primary health care settings by providing funding and training
 - Ensure on-going surveillance to monitor data relevant to drug overdoses and deaths from drug overdoses

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

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

VI. SUD Health IT Plan

The state of Michigan assures CMS that it has sufficient health IT infrastructure at every appropriate level (i.e. state, delivery system, PIHP and individual provider) to achieve the goals of this demonstration.

The primary tool available at the state level is the MDHHS data warehouse. The warehouse supports the use of data sets related to SUD services for utilization monitoring, quality measurement, treatment outcome and other purposes. Data sets can be used independently or linked and include: capitation payments, claims/encounters, eligibility and benefit plan enrollment, demographics, vital records, level of need assessments, treatment outcome, MMIS provider enrollment, etc. MDHHS uses a quality measurement tool to generate rates on a

quarterly basis, for all Medicaid beneficiaries. Rates are available state-wide and by PIHP on HEDIS measures, including:

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)
- Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET) within 14 days and 30 days.

Michigan makes two important resources available to enable PIHPs and behavioral health providers to improve care coordination through use of health information: (1) The Michigan Health Information Network (MiHIN) is the state authority for electronic health information exchange. MiHIN is currently being used by providers of mental health, SUD and intellectual and developmental disability (IDD) services to facilitate and initiate electronic exchange with physical health providers. PIHPs are also eligible to participate as data sharing organizations in the MiHIN network; (2) Data analytics and population health management have been aided by the state's creation of a web portal, CareConnect 360 (CC360), which was created and launched as a care coordination tool. CC360 provides a comprehensive view of a beneficiary's health, or the overall health of a population, based on information pulled from the MDHHS data warehouse. Claims and encounters are the main data set available, including from behavioral and physical health providers. Medicaid Health Plans, PIHPs and CMHSPs use CC360 for a) alerts on admissions, discharges, deaths, b) joint care plans, c) self-review on performance measure rates,

etc. These resources assist PIHPs and providers to identify a range of health conditions in individual beneficiaries and support both PIHP and provider-level care coordination activities.

VII. Improved Care Coordination and Transitions Between Levels of Care

Benefit management for SUD services has been the responsibility of the PIHPs since 2014. The PIHP will employ its established utilization management system for prior authorization and continued stay reviews which will include applying the ASAM criteria to identify the more appropriate individual treatment and support needs. Eligibility to receive services is based on medical necessity criteria that are outlined through currently established guidelines. These criteria were created for both behavioral health and developmental disabilities services and read as follows:

Medical Necessity Criteria

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

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

recovery, or productivity.

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

Determination Criteria

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

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

Consistent with federal statutes and regulations that apply parity to the Medicaid program, the benefits available in this demonstration will not have preset limits placed on them. There will be individual determination of medical and clinical necessity by qualified providers for each beneficiary for initial and ongoing care needs. The frequency and duration of treatment services are expected to be guided by the ASAM criteria, which is a standardized process based on significant research evidence and application. As set forth in the Standards of Care discussion, PIHPs make authorization decisions (initial and continuing stay) regarding residential length of stay, change in LOC and discharge based on the ASAM criteria. PIHPs will continue to apply the ASAM criteria to both outpatient and residential services for adolescents and adults. In addition, PIHPs will make information regarding medical necessity and information regarding denials or changes in lengths of stay for residential services available to the client or the provider. The PIHP must disseminate all practice guidelines it uses to all affected providers and upon request to beneficiaries.

MDHHS is committed to integrating physical and behavioral health care services for beneficiaries with behavioral health conditions and has been implementing several solutions to improve care coordination and care transitions to ensure warm hand-offs and successful engagement in treatment and transitions across levels of care, particularly for high-risk cohorts with complex care needs. Michigan will work with stakeholders to develop a framework to evaluate successful care transitions to outpatient care, including hand-offs between levels of care within the SUD care continuum as well as linkages with primary care upon discharge.

A description of selected activities intended to ensure improved coordination of care among individuals with SUD are below. Michigan continues to explore and plan for an increasing number of care coordination and care integration strategies as part of the state's ongoing Medicaid system transformation:

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

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

In carrying out this requirement, MHPs and PIHPs have collaborated to work with MDHHS to establish a uniform process for identifying high-risk individuals and stratify populations as required under the MHP [contract](#), which state in part that MHPs must work collaboratively with PIHPs to:

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

VIII. Quality measures

Reporting of Quality Measures

Michigan intends to develop a rigorous evaluation design that will utilize valid and reliable data, standardized measures and specifications, and robust methodology.

Measures

Michigan will use the following measures to assess quality and access to care throughout the demonstration. Where nationally-recognized specifications for these measures exist, they will be utilized.

Measure	Steward	Data Source	Notes
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NQF #0004	Data Warehouse (encounter data)	Admin data only (have baseline data)
SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	NQF # 1664	To be determined	Admin and medical records
Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	NQF # 2605	Data warehouse (encounter data)	Admin data only (have baseline data)
Readmission rates (Plan All Cause Readmission)	NQF # 1768	Data Warehouse (encounter data)	May currently be available in Symmetry
Emergency Department Utilization	Need to determine a specific measure	Data Warehouse (encounter data)	Admin data only
Inpatient Utilization (IPU)	NCQA	Data Warehouse (encounter data)	May currently be available in Symmetry
Number of People Engaged in Recovery Support	State-specific	Data Warehouse (encounter data)	Need to determine exactly what they're asking
Length of Time in Formal Treatment	State-specific	Data Warehouse (encounter data)	Need to determine exactly what they're asking
Improvement in Overall Health	State-specific	Survey	Need to determine exactly what they're asking
Adult Access to Preventive/Ambulatory Services	NCQA	Data Warehouse (encounter data)	May currently be available in Symmetry
Rate of completed follow up appointments with Specialty Service System providers	State-specific	Data Warehouse (encounter data)	Need to determine the best way to measure

Methodology

Baselines for two of the measures (Initiation and Engagement of Alcohol and Other Drug Dependence Treatment and Follow-up after Discharge from the Emergency Department for Mental

Health or Alcohol or Other Drug Dependence) have already been established and the state will continue to report on these data at least annually. For the remaining measures, we expect to establish baselines by the end of demonstration year 1. Data will be extracted for these measures for each PIHP and Michigan will allow the opportunity for stakeholder review and feedback on the methodology and results. Performance standards will be set using baseline data. Payment of bonus dollars will be contingent upon meeting quality thresholds. Reports will be published at

intervals to be determined. Michigan's complete pay-for-performance strategy is outlined in Section 8.4.2 (Contract Withholds) and Section 8.4.2.1 (2016 2016 Performance Bonus Integration of Behavioral Health and Physical Health Services) of the Medicaid

Managed Specialty Supports and Services FY 16 Contract, Amendment #1, available at <http://www.midstatehealthnetwork.org/docs/AmendmentNo-1ToFY16MSHN-MDHHSContract.pdf>.

Improving partnerships

Building on work already done in Michigan, the demonstration will enhance the ability of Specialty Service System payers and providers to work with Medicaid Health Plans to improve service delivery by jointly developing processes, procedures, and methods for population identification and intervention.

Addressing Social Determinants of Health

The demonstration will afford Michigan the opportunity to develop meaningful linkages to community-based resources that can assist providers in address social determinants (including housing) to their patients.

Evaluation

The goal of the evaluation is to determine whether the waiver program impacts services utilization, cost, and health outcomes of SUD treatment. Michigan will work with an independent evaluator to ensure the highest rigor and adherence to evaluation methodology.

Because the demonstration is statewide, encompassing all patients who are eligible for the program Michigan will employ a time trend analysis evaluation design to validate the following hypotheses:

1. The demonstration increases access to services for patients in the intervention group.
2. The demonstration increases quality of care and enhances health outcomes for patients in the intervention versus the control group.
 - a. There are no differences in quality or outcomes by region, race/ethnicity, or other demographic factors.
3. The demonstration reduces overall utilization of emergency department visits, inpatient stays, and inpatient readmissions for patients in the intervention versus control group.
4. The demonstration reduces costs associated with utilization of emergency department visits, inpatient stays, and inpatient readmissions for patients in the intervention vs. control group.

Michigan will implement a formative evaluation design. In addition to the required mid-point evaluation report, the evaluator will develop interim reports on demonstration progress at intervals to be determined. The reports may be used to drive discussion, stakeholder engagement, and program/policy change at the state or provider level. A final evaluation report will be submitted as required.

IX. Single State Agency

The Single State Agency for SUD is the Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration.

Attachment A

Document #1: MDHHS ASAM Residential Level of Care Designation

Questionnaire Document #2: MDHHS ASAM Outpatient Level of Care
Designation Application

Document #3: MDHHS ASAM Withdrawal Management Level of Care
Designation Application

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

Program/Facility Name:

Facility Address:

City/State/Zip:

License Number:

Treatment Capacity:

Please indicate the ASAM Level being applied for:

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

Please indicate the population served by the program:

- Adolescent
- Adult

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

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

SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided.

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

SUPPORT SYSTEMS

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

- 1) Telephone or in-person consultation with physician and emergency services available 24/7? Yes No
- 2) Direct affiliations with other levels of care and/or close coordination for referrals to other services? Yes No
- 3) Ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures. Yes No
- 4) Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications. Yes No
- 5) Psychiatric/psychological consultation available as needed. Yes No

STAFF

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

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

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

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

- 4) Please indicate program staff conducting each service.

Check all that apply on the following table:

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

THERAPIES

Please describe the therapy services that are available:

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

2) Focus of counseling and clinical program activities:

- 3) Recovery support services available:
- 4) Involvement of family members and significant others?

Yes No

5) Medication assisted treatment available?

Yes No

6) Monitoring of medication adherence (for behavioral health and physical health)?

Yes No

7) Use of random drug screens to monitor compliance?

Yes No

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

ASSESSMENT/ TREATMENT PLAN REVIEW

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

1) Individualized, comprehensive bio-psychosocial assessment utilized?

Yes No

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

Yes No

3) Daily assessment of progress and treatment changes?

Yes No

4) Physical examination by (MD/DO, PA, NP) performed as part of initial assessment/admission process?

Yes No

5) Ongoing transition/continuing care planning?

Yes No

I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE

IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE
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ENTER THE CONTACT INFORMATION OF THE PERSON THAT CAN BE REACHED FOR FOLLOW-UP IF NEEDED.

NAME	TITLE	EMAIL	TELEPHONE

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

Program/Facility Name:

Facility Address:

City/State/Zip:

License Number:

Treatment Capacity:
(If Applicable)

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

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

Please indicate the population served by the program:

- Adolescent
- Adult

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

- Community Mental Health Partnership of Southeast Michigan
- Detroit Wayne Mental Health Authority
- Lakeshore Regional Entity
- Macomb County Community Mental Health Services
- Mid-State Health Network
- Northcare Network

- Northern Michigan Regional Entity
- Oakland County Community Mental Health Authority
- Region 10 Pre-paid Inpatient Health Plan
- Southwest Michigan Behavioral Health

SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided.

- Behavioral health clinic/office based program
- Primary care office/clinic
- Integrated care clinic (combined physical and behavioral health)
- Work sites
- School
- Community based
- Individuals home

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

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

e. Combined with a co-occurring mental health disorder – %

SUPPORT SYSTEMS

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

6) Does your program provide referral and linking to ongoing treatment?
 Yes No

7) Does your program provide referral for community social services?

Yes

No

8) Are emergency services available 24/7 outside normal program hours?

Yes

No

- 9) Does your program have direct affiliations with other levels of care and/or close coordination for referrals to other services?
Yes No
- 10) Does your program have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures?
Yes No
- 11) Does your program have the ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications?
Yes No
- 12) Are psychiatric and medical consultation available within 24 hours by phone and in person based on severity of condition (Level 1)?
Yes No
- 13) Are psychiatric and medical consultation available within 24 hours by phone and 72 hours in person (Level 2.1)?
Yes No
- 14) Are psychiatric and medical consultation available within 8 hours by phone and 48 hours in person (Level 2.5)?
Yes No

STAFF

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

- 4) Do you employ trained personnel who are knowledgeable about substance use and addiction?
Yes No
- 5) Is counseling/therapy provided by appropriately licensed and credentialed professionals?
Yes No
- 6) Is there a generalist physician(s) and/or physician assistant(s) available?
Yes No

7) Are nursing staff available?

Yes

No

8) Is the physician(s) or physician assistant specially trained in addiction medicine?

Yes

No

9) Are staff cross-trained in mental health, psychotropic medications and interactions with addictive substances?

Yes No

7) Please indicate program staff conducting each service.

Check all that apply on the following table:

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

Specifically trained staff explanation:

THERAPIES

Please describe the following in reference to the program:

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

10) Recovery support services:

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

11) Individual therapy/counseling/psychotherapy provided?

Yes No

12) Group therapy provided?

Yes No

13) Family therapy provided?

Yes No

a. If provided is there involvement of family members, guardians and significant others in the assessment, treatment and continuing care of the client?

Yes No

14) Educational/didactic services provided?

Yes No

15) Occupational therapy?

Yes No

16) Recreational therapy available?

Yes No

17) Medication management (SUD) available?

Yes No

18) Medication management (mental health) available?

Yes No

19)Monitoring of medication adherence (for behavioral health and physical health)?

Yes No

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

Yes No

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

ASSESSMENT/ TREATMENT PLAN REVIEW

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

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

Yes No

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

Yes No

8) Individualized, comprehensive bio-psychosocial assessment utilized?

Yes No

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

Yes No

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

Yes No

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

Yes No

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

Yes No

13) Documentation of progress and treatment changes?

Yes No

14) Ongoing recovery/continuing care planning?

Yes

No

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

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE

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

NAME	TITLE	EMAIL	TELEPHONE

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

Program/Facility Name:

Facility Address:

City/State/Zip:

License Number:

Treatment Capacity:

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

- Level 1-WM – Ambulatory Withdrawal Management without Extended On-site Monitoring (Outpatient Withdrawal Management)
- Level 2-WM – Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)
- Level 3.2-WM – Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)
- Level 3.7-WM – Medically Monitored Inpatient Withdrawal Management (Residential Withdrawal Management)

Please indicate the population served by the program:

- Adolescent
- Adult

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

- Community Mental Health Partnership of Southeast Michigan
- Detroit Wayne Mental Health Authority
- Lakeshore Regional Entity
- Macomb County Community Mental Health Services
- Mid-State Health Network
- Northcare Network

- Northern Michigan Regional Entity
- Oakland County Community Mental Health Authority
- Region 10 Pre-paid Inpatient Health Plan

Southwest Michigan Behavioral Health

SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided:

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

Please indicate how services are provided in the program:

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

SUPPORT SYSTEMS

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

- 1) Available specialized psychological and psychiatric/clinical consultation and supervision. Yes No
- 2) Comprehensive medical history and physical examination completed as part of admission. Yes No
- 3) Affiliation with other levels of care, including other specialty substance use disorder treatment. Yes No
- 4) Ability to conduct and or arrange for laboratory/toxicology tests.
Yes No
- 5) 24 hour access to emergency medical consultation services.
Yes No

6) Ability to provide/assist with access to safe transportation services.

Yes No

STAFF

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

- 1) Physicians and/or nurses present as needed. Yes No
- 2) Physicians and/or nurses readily available. Yes No
- 3) Physicians and/or nurses present at all times. Yes No
- 4) Counseling staff available or accessed through affiliation relationships.
Yes No
- 5) Recovery coach/peer support staff available or accessed through affiliation relationships. Yes No
- 6) Please indicate program staff conducting each service. Check all that apply:

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

THERAPIES

Please describe the therapy services that are available:

- 1) Medication supported withdrawal management.
Yes No
- 2) Self-administered withdrawal management medications.
Yes No
- 3) Supervised self-administered withdrawal management medications.
Yes No
- 4) Non-medication supported withdrawal management.
Yes No
- 5) Education/didactics.
Yes No
- 6) Involvement of family members and significant others.
Yes No
- 7) Discharge/transfer planning.
Yes No
- 8) Physician/nurse monitoring/management of intoxication and/or withdrawal.
Yes No
- 9) Range of therapies available in group and/or individual format (cognitive, behavioral, medical).
Yes No
- 10) Please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify what is reported above and attach other programmatic documentation that will support the ASAM Level being sought.

ASSESSMENT/TREATMENT PLAN REVIEW

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

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

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

3) Biopsychosocial screening assessments used to determine level of care and to

address treatment priorities in ASAM dimensions 2-6.

Yes No

4) Interdisciplinary team available to participate in treatment and to obtain and interpret information regarding client needs.

Yes No

5) Individual treatment plan, with problem identification for ASAM dimensions 2-6, with treatment goals and measurable objectives.

Yes No

6) Daily assessment of progress and treatment

changes. Yes No

7) Transfer/discharge planning beginning at point of

admission. Yes No

8) Referral and linking arrangements for

continuing care. Yes No

9) Medical assessments, using appropriate measures of

withdrawal. Yes No

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

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE

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

NAME	TITLE	EMAIL	TELEPHONE

**ATTACHMENT E:
Reserved for OUD/SUD Monitoring Protocol**