Mid-Point Assessment of Michigan's Section 1115 Substance Use Disorder Waiver

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Abbreviations

ADT	Admission, Discharge, and Transfer
AUD	Alcohol use disorder
ASAM	American Society of Addiction Medicine
BHDDA	Behavioral Health and Developmental Disabilities Administration
CA	Coordinating Agency
CC360	CareConnect 360
CMHSP	Community Mental Health Services Provider
CMS	Centers for Medicare & Medicaid Services
CRM	Customer Relationship Management
e-consent	Electronic consent
ED	Emergency department
EMR	Electronic medical record
FFCRA	Families First Coronavirus Response Act
GAIN-I	Global Appraisal of Individual Needs assessment tool
Health IT	Health Information Technology
HIE	Health Information Exchange
IDD	Intellectual and Developmental Disability
IHPI	Institute for Healthcare Policy & Innovation
IMD	Institution for Mental Disease
IOP	Intensive Outpatient Program
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LARA	Department of Licensing and Regulatory Affairs
LOC	Level of care
LOS	Length of stay
MAT	Medication Assisted Treatment
MDHHS	Michigan Department of Health and Human Services
MHP	Medicaid Health Plan
MiCAL	Michigan Crisis and Access Line
MiCARE	Michigan Care Access Referral Exchange
MiHIN	Michigan Health Information Network Shared Services
MYTIE	Michigan Youth Treatment Improvement and Enhancement
OBOT	Office Based Opioid Treatment
OHH	Opioid Health Homes
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PDMP	Prescription Drug Monitoring Program
PHE	[COVID] Public Health Emergency
PIHP	Prepaid Inpatient Health Plans
RFP	Request for Proposal
SAMHSA	Substance Abuse and Mental Health Services Administration
STC	Special Terms and Conditions
SUD	Substance Use Disorder
UM	University of Michigan

Executive Summary

Michigan's 1115 Behavioral Health Demonstration Waiver seeks to improve health outcomes and sustained recovery for beneficiaries with SUD/OUD by:

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

The Michigan Department of Health and Human Services (MDHHS) identified specific strategies to accomplish these goals, organized by the following milestones:

1. Access to Critical Levels of Care for OUD and other SUDs
2. Use of Evidence-based, SUD-specific Patient Placement Criteria
3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities
4. Sufficient Provider Capacity at Critical Levels of Care including MAT for OUD
5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD
6. Improved Care Coordination and Transitions between Levels of Care

The state's SUD Health IT plan calls for enhancing two existing IT structures (the Michigan Health Information Network and CareConnect 360) to leverage real-time data to support care coordination. The plan outlined five strategies related to these health IT structures.

The University of Michigan Institute for Healthcare Policy & Innovation (UM IHPI) was awarded a contract to serve as the Independent Evaluator of Michigan's SUD waiver. The evaluation team used several data sources to assess the state's progress toward meeting each of the six milestones outlined in the Implementation Plan and the SUD Health IT plan. These data sources included:

- review of documents and other evidence of progress;
- review of trends on Monitoring Metrics and other quantitative measures; and
- stakeholder feedback from PIHP officials, SUD providers, and beneficiaries.

The evaluation team considered these data sources in assessing the state's progress toward meeting each of the six milestones outlined in the Implementation Plan. The evaluation team assigned each milestone a risk level of "low", "medium" or "high" that the state would not achieve success in reaching that milestone by the end of the waiver period. For each milestone, the evaluation team developed recommendations to the state for potential modifications to its Implementation Plan to better equip the state to achieve each milestone.

A summary of this information appears in the table on the next four pages.

Table of Mid-Point Assessment Findings				
Milestone	**% of fully completed action Items**	**% of Monitoring Metrics going in target direction by Monthly and Annually reported metrics (# metrics/total)**	**Key themes from stakeholder feedback**	**Risk level**
Milestone 1. Access to Critical Levels of Care for OUD and other SUDs	N/A	57% Monthly (4/7) 100% Annually (1/1)	1. Transportation is a common barrier to accessing SUD services. 2. Provider capacity and process barriers contribute to extended wait times for assessment and treatment initiation. 3. Expansion of telehealth facilitated access to SUD services during the COVID PHE.	Medium
Recommendations for Potential Modifications to Implementation Plan or Monitoring Protocol	1. MDHHS is encouraged to develop specific Action Items with target dates to achieve this milestone outlining key steps to achieve access to critical levels of OUD/SUD care. 2. MDHHS is encouraged to articulate their process to assess beneficiary access to SUD services from a state-level perspective, to identify a threshold for inadequate access that would prompt state-level action, and potential strategies to be deployed to address inadequate access. 3. MDHHS is encouraged to enact policy changes to ensure beneficiaries have equitable transportation assistance for SUD treatment services and to minimize the transportation burden for SUD treatment and recovery (e.g., policies related mobile MAT units, MAT telehealth, take-home doses, and drug testing requirements). 4. MDHHS is encouraged to outline a plan for interagency cooperation related to the residential bed registry.			
Milestone 2. Use of Evidence-based, SUD-specific Patient Placement Criteria	N/A	50% Annually (1/2)	1. Implementation of ASAM Continuum has occurred in all PIHP regions. 2. The ASAM Continuum does not include all assessment components required by some PIHPs and accrediting organizations 3. The ASAM Continuum tool is not fully integrated with practice EMRs and other systems, creating a burden of duplicate recordkeeping	Low
Recommendations for Potential Modifications to Implementation Plan	1. MDHHS is encouraged to develop specific Action Items with target dates to achieve this milestone, including specific plans for audits to assess fidelity to the ASAM Continuum in assessments and placement decisions. 2. MDHHS is encouraged to facilitate the identification and/or development of a comprehensive tool that incorporates the ASAM Continuum assessment as well as other required assessment components.			

	3. MDHHS is encouraged to address health IT barriers to systems integration of the ASAM Continuum through targeted funding, technical assistance, or other mechanisms.			
Milestone 3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	N/A	N/A	1. Certain state requirements appear to exceed nationally recognized standards, which creates unnecessary staffing challenges and increased costs.	Low
Recommendations for Potential Modifications to Implementation Plan	1. MDHHS is encouraged to develop specific Action Items with target dates to sustain this milestone.			
	2. MDHHS is encouraged to maintain a log to track actions toward achieving potential and/or proposed regulatory changes to better align regulations with national standards.			
Milestone 4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD	N/A	100% Annually (2/2)	1. PIHPs report difficulty maintaining sufficient provider capacity.	Medium
			2. Some SUD providers report some capacity to expand to additional regions and/or levels of care.	
			3. There is a question of whether all providers allow beneficiaries to use MAT while in their care.	
			4. Primary care providers offering SUD services through the physical health benefit may need SUD clinical expertise and technical support.	
Recommendations for Potential Modifications to Implementation Plan	1. MDHHS is encouraged to develop specific Action Items with target dates to achieve this milestone.			
	2. MDHHS is encouraged to articulate a process to assess SUD provider capacity from the state-level perspective, to identify a threshold of insufficient SUD provider capacity that would prompt state-level action, and to describe potential strategies to address insufficient capacity.			
	3. MDHHS is encouraged to develop a process to assess whether all provider sites are allowing patients to use MAT while in their care.			
	4. MDHHS is encouraged to expand cooperation between MHPs and PIHPs to ensure that primary care providers have options for training and technical support.			
	5. MDHHS is encouraged to develop joint information systems to ensure that frontline staff at both MHPs and PIHPs are able to direct beneficiaries to providers who offer SUD services.			

Milestone 5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	N/A	100% Monthly (1/1) 100% Annually (3/3)	1. Beneficiaries and providers report broader treatment availability for OUD compared to other SUDs.	Low
Recommendations for Potential Modifications to Implementation Plan	1. MDHHS is encouraged to develop specific Action Items with target dates to ensure continued progress related to this milestone.			
	2. MDHHS is encouraged to consider how to leverage OUD funding and policies to facilitate access to comprehensive treatment for all beneficiaries with SUD.			
Milestone 6. Improved Care Coordination and Transitions between Levels of Care	N/A	54% Annually (7/13)	1. Opioid Health Homes providers have developed relationships with providers in other settings and have expanded their deployment of peer recovery coaches.	Medium
			2. Policies limit the options to hire, deploy and fund peer recovery coaches.	
			3. Inadequate progress on health IT initiatives impedes care coordination.	
Recommendations for Potential Modifications to Implementation Plan	1. MDHHS is encouraged to develop specific Action Items with target dates to ensure continued progress related to this milestone, particularly for delayed health IT initiatives.			
	2. MDHHS is encouraged to consider additional strategies to support beneficiary engagement with treatment across levels of care.			
	3. MDHHS is encouraged to continue to implement strategies to address barriers to hiring and funding peer recovery coaches.			
	4. MDHHS is encouraged to expand cooperation between MHPs and PIHPs to facilitate systems to coordinate and transition care across systems.			

Section I: Background

Introduction

Since 1998, Michigan has operated a behavioral health carve-out for the Specialty Service Populations using county-sponsored Prepaid Inpatient Health Plans (PIHPs). Physical healthcare, including a benefit for persons with mild and/or moderate behavioral health disorders, is operated through profit and not-for-profit Medicaid Health Plans (MHPs). Funding for substance use disorder (SUD) services was initially managed by regional Coordinating Agencies (CAs), which contracted for the delivery of SUD services. In 2013, to better integrate behavioral health and SUD services, CAs were incorporated into the management and governance structures of ten regional PIHPs. The PIHPs are responsible for all SUD services and supports (except for certain medically monitored supports) regardless of the severity of condition.

Building upon the strong foundation of covered benefits, evidence-based practices, and service delivery infrastructure, the state believes that offering a full continuum of SUD treatment and recovery supports based on American Society of Addiction Medicine (ASAM) criteria will result in improved outcomes and sustained recovery for this Specialty Services population.

The Centers for Medicare & Medicaid Services (CMS) approved Michigan's 1115 Demonstration Waiver amendment entitled Michigan's 1115 Behavioral Health Demonstration Waiver (Project No. 11-W-00305/5) on April 5, 2019, for the period of October 1, 2019, through September 30, 2024, for beneficiaries with SUD, including opioid use disorder (OUD). Due to the COVID pandemic which caused a delay in the implementation of the demonstration, the demonstration approval period was extended a year to September 30, 2025.

This Mid-Point Assessment reviews the state's progress toward achieving the demonstration project goals for the period October 1, 2019, through September 30, 2022.

Primary Goals of Michigan's Section 1115 SUD Demonstration Waiver

As noted in the Special Terms and Conditions (STCs), the demonstration will allow Michigan to broaden the crucial component of residential SUD 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). The benefits will continue to be provided through a managed care delivery system for SUD services. The state and CMS expect that offering a full continuum of SUD treatment and recovery support based on ASAM criteria or other nationally recognized, SUD-specific program standards, will result in improved health outcomes and sustained recovery for this population.

The demonstration seeks to improve health outcomes and sustained recovery for beneficiaries with SUD/OUD by:

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

- Expanding the use of recovery coach-delivered support services; and
- Establishing coordination of care models between SUD providers, primary care, and other behavioral health providers.

Michigan's revised Implementation Plan, approved on September 17, 2019, proposes specific strategies to accomplish the goals of the demonstration waiver, organized by the following milestones:

7. Access to Critical Levels of Care for OUD and other SUDs
8. Use of Evidence-based, SUD-specific Patient Placement Criteria
9. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities
10. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD
11. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD
12. Improved Care Coordination and Transitions between Levels of Care

For Milestone 1 (Access to Critical Levels of Care), the Implementation Plan notes that benefit management for SUD services is the responsibility of the ten regional PIHPs. PIHPs employ utilization management for prior authorization and continued stay reviews which include applying the ASAM criteria to identify individual treatment and support needs. The Implementation Plan notes that under the current system, beneficiaries have access to services at all ASAM levels, though beneficiaries in rural areas may have a longer distance to services.

For Milestone 2 (Use of Evidence-based, SUD-specific Patient Placement Criteria), the Implementation Plan notes the need for additional efforts to ensure that beneficiaries are assessed and recommended for treatment services according to evidence-based criteria. To this end, the Implementation Plan establishes the expectation that all SUD providers contracting with a PIHP will use a standard assessment tool that utilizes ASAM criteria.

In addition, the Implementation Plan establishes the expectation that PIHPs will utilize information from ASAM-based assessments and ASAM criteria to make authorization decisions for treatment services regarding length of stay, change in level of care, and discharge. For residential and withdrawal management services, SUD providers are expected to use the six ASAM dimensions to guide decision-making for needed level of care, transitions in care, and discharge planning.

The Implementation Plan notes that each PIHP region is responsible for ensuring that their contracted SUD providers are appropriately trained/educated in the application and use of ASAM criteria and that their treatment recommendations are guided by ASAM criteria and individual need. PIHPs are tasked with conducting quality monitoring to ensure SUD providers meet these requirements.

For Milestone 3 (Use of National Standards to Set Provider Qualifications for Residential Treatment Facilities), the Implementation Plan calls for the state to maintain its robust process for ensuring SUD providers meet standards at the time of initial licensure and on an ongoing basis. This process includes state licensure, along with credentialing and certification of individual clinical providers. The state's existing 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.

The Implementation Plan notes that the state's existing structure includes additional steps to ensure that SUD providers meet 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 criteria, must be submitted for review. Based on the information submitted, the state will assign the appropriate ASAM level of care or reject the application. The Implementation Plan outlines the goal of converting this manual (paper) process to an online system during the demonstration period.

For Milestone 4 (Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment), the Implementation Plan notes that the ASAM enrollment work already completed by the state establishes the initial provider capacity in the publicly funded system. The plan states that regional PIHPs can provide access to each ASAM level of care and support services, and that OUD treatment is available through both Opioid Treatment Programs (OTPs) and Office Based Opioid Treatment (OBOT) providers. The plan notes that the state promulgated policy, activated in FY2019, requiring PIHPs to comply with network adequacy standards, including OTPs.

The Implementation Plan notes that PIHPs are required to ensure that their network providers facilitate access to medication assisted treatment (MAT) when it is clinically appropriate, either directly by a program or through an arrangement with another provider. In addition, network providers must have appropriate arrangements for continuing treatment as part of the discharge and recovery planning.

Finally, the Implementation Plan notes the unique circumstances surrounding provider capacity for youth, and describes the Michigan Youth Treatment Improvement and Enhancement (MYTIE) initiative.[1] The ongoing MYTIE activity is separate from this demonstration project and thus not included in this Mid-Point Assessment.

For Milestone 5 (Implementation of Comprehensive Treatment and Prevention Strategies), the Implementation Plan outlines a lengthy list of programmatic and policy activities to promote comprehensive treatment and prevention.

For Milestone 6 (Improved Care Coordination and Transitions between Levels of Care), the Implementation Plan notes that the state has begun implementing strategies to improve care coordination and care transitions. This includes implementation of Michigan's Opioid Health Homes (OHH) under Section 1945 of the US Social Security Act; OHH was piloted in one PIHP region beginning in FY2019, with plans for expansion during the demonstration period.

The Implementation Plan points to coordination agreements between the Medicaid Health Plans (MHPs) and PIHPs as another key strategy to improving care coordination and transitions. These agreements call for collaboration to identify and provide joint care management to beneficiaries with significant behavioral health issues and complex physical co-morbidities. The state will develop and implement shared metrics and incentives for performance around these elements.

[1] Information regarding the MYTIE program can be found at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_4877_77211---,00.html.

SUD Health IT Plan

The state's SUD Health Information Technology (Health IT) plan focuses on enhancements to two existing IT structures. These enhancements are intended to leverage real-time data to support care coordination.

The ***Michigan Health Information Network (MiHIN)*** is a not-for-profit statewide electronic health information exchange. MiHIN is currently 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 eligible to participate as data sharing organizations in the MiHIN.

CareConnect 360 (CC360) is a web portal created and launched as a care coordination tool. CC360 can provide a comprehensive view of both individual and population health, based on information pulled from the Enterprise Data Warehouse. Claims and encounters are the main data available, including from behavioral and physical health providers. MHPs, PIHPs, and Community Mental Health Services Providers (CMHSPs) use CC360 for alerts on admissions, discharges, and transfers (ADTs), joint care plans, and self-review on performance measure rates.

The Health IT plan outlines five specific strategies:

1. Expand the cross-program use of the Master Person Index to enable greater precision in identifying high-need beneficiaries.
2. Modify the CC360 to allow expanded access to SUD claim and encounter information, including ADT messaging.
3. Implement an electronic consent management system for data sharing.
4. Implement an SUD residential bed registry within the context of a broader integrated crisis and access system.
5. Develop a customer relationship management database to facilitate and track access to needed SUD treatment across providers and designated contractors.

Independent Evaluator

The University of Michigan Institute for Healthcare Policy & Innovation (UM IHPI) was awarded a contract to serve as the Independent Evaluator of Michigan's SUD waiver. UM IHPI's scope of work includes the following:

- Developing the evaluation design (approved June 9, 2020)
- Conducting tasks related to the development and drafting of the Mid-Point Assessment
- Conducting tasks related to the development of and drafting the Summative Evaluation
- Providing technical assistance to MDHHS, as needed

The UM IHPI evaluation team has met regularly with MDHHS officials to hear updates of progress on key waiver activities. On request, MDHHS provided the evaluation team with documents and materials to support the Mid-Point Assessment review of progress.

MDHHS did not direct the UM IHPI evaluation team during preparation of the Mid-Point Assessment. An attestation from the evaluation team appears in Appendix A of this report.

Section II: Methodology

This Mid-Point Assessment examines the state's progress toward achieving the demonstration project goals and the activities outlined in the Implementation Plan and SUD Health IT plan for the period October 1, 2019, through September 30, 2022.

The evaluation team compiled the results of its review of documents and other evidence of progress, the review of trends on Monitoring Metrics and other quantitative measures, and stakeholder feedback from PIHP officials, SUD providers and beneficiaries to assess state progress toward meeting each of the six milestones outlined in the Implementation Plan. The evaluation team assigned each milestone a risk level of "low", "medium" or "high" that the state would not achieve success in reaching that milestone by the end of the waiver period. For each milestone, the evaluation team offers recommendations to the state for potential modifications to its Implementation Plan to better equip the state to achieve each milestone.

Data Sources

Multiple data sources were used to help examine the state's progress to date. These sources are described below.

Implementation Plan and SUD Health IT Plan – Evidence of Progress

The state's Implementation Plan did not include a listing of specific Action Items to guide them in achieving the demonstration project goals. In the absence of specific Action Items, the evaluation team sought evidence of state progress toward achieving new strategies outlined in the Implementation Plan, as well as evidence of how the state maintained or enhanced existing strategies.

The state's SUD Health IT plan includes specific milestones, actions needed, and target dates. The evaluation team sought evidence of state progress toward meeting these milestones and target dates.

In response to the evaluation team's request, the state provided a wide array of documents related to new and existing activities. These documents include the following.

- *PIHP Site Visit Materials*: State plans call for site review of each PIHP every two years to assess compliance with the 1115 waiver demonstration requirements. The state provided its newly developed PIHP SUD Site Visit Protocol that outlines PIHP responsibilities across each milestone. PIHPs prepare an extensive array of information to document their compliance with these responsibilities; state officials review this information and request additional information on areas that are unclear or not fully supported. The PIHP has the opportunity to clarify and/or provide additional documentation. The state then assigns a compliance rating in each requirement domain. After each site visit, the state sends the PIHP a Site Visit Findings Letter that outlines their compliance determinations. At the time of this Mid-Point Assessment, the state had completed three PIHP Site Visits, and shared with the evaluation team the PIHP-submitted documentation and Site Visit Findings Letters for those PIHPs.
- *PIHP Planning Documents*: The state provided planning documents requested of and received from each PIHP. These included Network Adequacy and Provider Stability Plans submitted in June 2020, outlining each PIHP's response to unexpected challenges brought on by the COVID pandemic; and Three-Year Strategic Plans for SUD Prevention, Treatment & Recovery Services, submitted in September 2020, outlining proposed activities for FY2021-FY2023.

- *SUD Provider Guidance Documents*: The state provided User Manuals, Program Handbooks, and other documents developed to guide SUD providers through technical and policy information. Examples of guidance documents include initial and revised provider handbooks for Opioid Health Homes; user guides for CC360 and the online customer relationship management (CRM) tool; and Medicaid Provider Letters related to the new residential bed registry.
- *Working Documents*: The state provided a variety of working documents to demonstrate progress. These include project management tools showing tasks, completion dates, and problem lists; formal and informal meeting summaries; and slide decks from presentations.
- *Direct Email Responses*: In several cases, the state provided information and explanation via email in response to questions from the evaluation team.

Monitoring Metrics

For each demonstration milestone, CMS has identified a subset of Monitoring Metrics that the state must include in its Monitoring Plan. These metrics reflect key outcomes such as assessment of need and qualification for SUD treatment services, access to critical levels of SUD/OUD care, provider capacity at critical levels of care, implementation of comprehensive treatment and prevention strategies, improved care coordination and transitions between levels of care, health outcomes, and spending. Collectively, the CMS-required demonstration Monitoring Metrics have clear directionality and direct alignment with demonstration milestones. The state has also selected state specific metrics. Appendix B defines the Monitoring Metrics and state specific metrics associated with each milestone.

The state's contracted vendor generates the Monitoring Metrics. For this Mid-Point Assessment, data on monitoring metrics are available for different timeframes, depending on periodicity:

- **Monthly metrics** are available from October 2019 to March 2022
- **Annual metrics** are available for only two time periods: October 2019 to September 2020 (demonstration year 1) and October 2020 to September 2021 (demonstration year 2)

With only two timepoints available as of this Mid-Point Assessment, the annual metrics provide limited value in assessing the state's progress on outcomes. In contrast, the monthly metrics offer a more nuanced reflection of trends during the first half of the demonstration period.

Additional Measures

To supplement the Monitoring Metrics, the evaluation team generated additional measures in key areas. These include quarterly numbers of beneficiaries with newly initiated SUD diagnosis and their types of services at initiation; timing and type of follow-up SUD services after discharge from residential treatment; and type of MAT (buprenorphine, methadone, or naltrexone) prescribed or administered by providers.

Data to construct these additional measures were extracted from the State of Michigan's Enterprise Data Warehouse by an authorized member of the evaluation team under the authority of a Business Associates Agreement executed between MDHHS and the University of Michigan. Data processing, encryption and storage were conducted in accordance with established data security protocols at the University of Michigan and approved by the MDHHS Compliance Office.

Provider Availability Assessment Data

The state maintains a customer relationship management (CRM) system that includes information about the level of care (LOC) services for each SUD provider that contracts with one or more PIHP regions.

PIHPs are responsible for ensuring that each contracted provider submits specific information including application for designated ASAM level of care at each provider location. Providers submit information through the CRM to support their designation to provide specific LOC; that information is reviewed by the PIHPs, with a final review by the state.

At the outset of the waiver demonstration period, the state had compiled ASAM level of Care Information from contracted providers into a single Excel file, which served as a central repository of SUD provider capability through the SUD system of care. In FY2022, the state began transitioning to its new online CRM system. Data for this Mid-Point Assessment encompass both the Excel document and information extracted from the online system.

Stakeholder Feedback - Key Informant Interviews with Professionals

The evaluation plan calls for conducting key informant interviews with a range of professional stakeholders, including state officials from the [then] Behavioral Health and Developmental Disabilities Administration (BHDDA), PIHP leadership, and SUD treatment providers across a variety of settings. The goal is to describe the experiences of stakeholders in implementing the strategies outlined in the state's Implementation Plan.

To date, the evaluation team has conducted key informant interviews with each stakeholder group, as shown below.

Key Informant Category	**Interview Count**
BHDDA/Medicaid officials	4 participants
PIHP leadership	10 group interviews (46 participants)
Opioid Health Homes participants	10 group interviews (21 participants)
SUD treatment providers	16 participants

The evaluation team developed structured interview protocols for each group of key informants. Interviews with state officials explored administrative barriers to implementation of key elements of the demonstration. Interviews with PIHP leadership (Chief Executive Officers, SUD directors, and other leaders responsible for clinical operations, finances and quality improvement) encompassed provider recruitment and retention, as well as implementation of new policies and programs, introduction of the standardized ASAM-based assessment tool, and new health IT features. Interviews with SUD treatment providers (physicians, clinicians, and administrators) included more extensive discussion of the day-to-day barriers and facilitators to implementation and adoption of key elements of the demonstration, as well as challenges with recruiting and retaining staff. Interview guides can be found in Appendix C.

The evaluation team scheduled and conducted interviews in groupings that promoted confidentiality (e.g., separate interviews with each PIHP leadership team and with each OHH participating clinic). Generally, interviews lasted 45-60 minutes; in some cases, the evaluation team followed up by email to pursue additional information mentioned during interviews. Interviews were conducted via teleconference and recorded with the approval of all participants.

Stakeholder Feedback - Beneficiary Surveys

The evaluation plan calls for conducting surveys of adult Medicaid beneficiaries with SUD/OUD to collect key patient-reported measures. The target population is beneficiaries who initiated SUD treatment 2-3 months prior to the baseline survey, with a follow-up survey approximately 6 months later. The beneficiary surveys are being conducted in two cohorts: Cohort 1 surveys were collected prior to full

implementation of the demonstration strategies, including ASAM-based assessment and treatment recommendations, and health IT improvements to support care coordination; Cohort 2 surveys will be collected in FY2023-FY2024.

Data to conduct survey sampling and recruitment are drawn from the State of Michigan's Enterprise Data Warehouse, which includes Medicaid enrollment files and administrative claims. Data were extracted by an authorized member of the evaluation team under the authority of a Business Associates Agreement executed between MDHHS and the University of Michigan. Data processing, encryption and storage were conducted in accordance with established data security protocols at the University of Michigan and approved by the MDHHS Compliance Office.

The evaluation team developed baseline and follow-up survey instruments to explore beneficiary experiences related to key aspects of the demonstration. The baseline survey included questions to allow beneficiaries to disclose current or prior SUD-related services and/or diagnoses. Both baseline and follow-up surveys asked fixed-choice and open-ended questions about use of primary care, behavioral health and SUD treatment and support services; interactions with providers around choice of treatment; barriers to care and receipt of assistance to access care. Other questions documented health status, employment, recent homelessness and food insecurity. The beneficiary survey instruments are found in Appendix D.

Cohort 1 baseline surveys were conducted March 2021 to September 2021, with 2,210 completed surveys (response rate 37%). Cohort 1 follow-up surveys were conducted November 2021 to March 2022, with 1,608 completed surveys (response rate 79%).

State Cost Reports

Cost reports are filed each year per legislative requirement. These reports reflect expenditures by funding source and by service category, statewide and for each PIHP. The evaluation team pulled reports for FY19-22 from the state website[2].

Analytic Methods

The evaluation team incorporated qualitative and quantitative methods to examine the state's demonstration progress.

Implementation Plan and SUD Health IT Plan – Evidence of Progress

The state's Implementation Plan did not include specific Action Items. This precludes any quantitative assessment (e.g., % of Action Items completed) of the state's progress toward achieving full implementation of the milestones.

Instead, the evaluation team reviewed documents to:

- confirm the presence of policies and structures described in the Implementation Plan as being in place at the outset of the demonstration period;
- identify evidence of progress toward implementing new or expanded strategies; and
- consider progress relative to target implementation dates outlined in the Implementation Plan and/or SUD Health IT plan.

[2] Information regarding state cost reports can be found at: https://www.michigan.gov/mdhhs/inside-mdhhs/budgetfinance/boilerplate.

Monitoring Metrics

Michigan's SUD Monitoring Protocol specifies 27 SUD performance metrics to be tracked as part of the demonstration. Whereas some metrics correspond to specific milestones, others have more general relevance to assessing the performance of the state's SUD delivery system. The SUD metrics and their directional targets per the SUD Monitoring Protocol are summarized in the Table of Monitoring Metrics (see page 38).

The state's vendor has generated monthly Monitoring Metrics from the start of the demonstration period through March 2022. For these monthly metrics, the evaluation team calculated both absolute and percent change. However, to limit the potential for data skewing from a single atypical month, the evaluation team compared the average of the first three months of the demonstration period (first quarter) to the last three months of available data (mid-point quarter). For Monitoring Metrics with an annual periodicity, the state's vendor has generated results for only two periods. The evaluation team calculated the absolute and percent change from the first to second annual result; however, these calculations have limited usefulness in assessing the state's progress since the most recent data point is more than a year past.

	Measurement Timepoint	
Monitoring Metric Type	**Baseline**	**Mid-point**
Monthly Metrics	10/1/2019-12/31/2019	1/1/2022-3/31/2022
Annual Metrics reported by the demonstration year	10/1/2019 - 9/30/2020 (DY1)	10/1/2020 - 9/30/ 2021 (DY2)

CMS guidance calls for analyzing change in Monitoring Metrics over time, using two methods:

- Absolute Change = Value of metric at mid-point - Value of metric at baseline
- Percent Change = (Value of metric at mid-point - Value of metric at baseline)/Value of metric at baseline

To inform the assessment of progress and risk at mid-point, the evaluation team used the absolute change in metrics from baseline to mid-point, comparing the direction of change with the targeted direction specified in the state's waiver application.

In addition, to appreciate trends over time, particularly with respect to the COVID public health emergency, the evaluation team produced graphs showing monthly trends for a number of highly relevant Monitoring Metrics.

Provider availability assessment data

The evaluation team reviewed the state's customer relationship management information to quantify SUD provider availability within the public SUD system. Data reflect two types of calculations:

- *SUD Provider Availability by Geographic Region* – defined as the number of PIHPs with at least one provider at each ASAM level of care at the start and at the mid-point of the demonstration period, as well as the number who added at least one provider at that level of care during the demonstration period.
- *SUD Provider Availability Statewide* – defined as the total number of SUD providers at each level of care at the start and at the mid-point of the demonstration period, as well as the number added at each level of care during the demonstration period.

To supplement the CRM information, the evaluation team reviewed monitoring metrics related to number of SUD providers, and generated other measures demonstrated the number of SUD providers by quarter.

Provider availability assessment data is presented as part of the assessment of Milestones 1 and 4.

Other data sources

Stakeholder Feedback - Key Informant Interviews with Professionals

The evaluation team transcribed interview recordings, and then conducted qualitative analysis of transcripts to identify common themes and experiences related to implementation of the ASAM Continuum, SUD provider capacity and its impact on treatment initiation and engagement; experiences with Opioid Health Homes; and implementation of health IT initiatives.

Stakeholder Feedback - Beneficiary Surveys

The evaluation plan calls for comparison of survey findings from Cohort 1 vs Cohort 2 to assess the overall impact of the demonstration project. For purposes of this Mid-Point Assessment, the evaluation team generated frequency distributions from Cohort 1 surveys for a limited number of fixed-choice questions (e.g., frequency of reported access barriers) and reviewed transcribed comments from open-ended questions (e.g., experiences initiating SUD treatment).

State Cost Reports

Analysis of state cost reports is descriptive in nature, documenting changes from FY2019 to FY2021 in SUD expenditures by service category.

Assessment of overall risk of not meeting milestones

In assessing the overall risk of not meeting each milestone, the evaluation team considered three areas of information.

Evidence of progress was based on review of documents related to each milestone to confirm the ongoing use of policies/strategies described in the Implementation Plan as in place at the outset of the demonstration period, and to identify evidence of progress toward implementation of new strategies. In addition, the evaluation team looked for evidence of specific plans (e.g., action steps, target dates) to fully achieve that milestone by the end of the demonstration period.

Monitoring Metrics were considered primarily in the context of the direction of movement from start of the demonstration project (i.e., combined average for the first three months) to the mid-point (i.e., combined average for the most recent three months). The direction of change was considered in the context of the state's target direction for the overall demonstration period.

Stakeholder feedback was obtained through key informant interviews with state officials, PIHP leadership, SUD providers, and Medicaid beneficiaries. Stakeholder feedback was considered for each milestone, with feedback from each group labelled as generally positive, generally negative, or mixed.

		Overall risk of not meeting milestone		
Data Source	*Considerations*	***Low***	***Medium***	***High***
Evidence of Progress Documents	*Do documents confirm the use of existing strategies and/or provide evidence of progress to date? Where needed, is there evidence of plans to fully achieve the milestone?*	Confirmation or evidence of progress; evidence of future plans	Evidence of some delay; future plans unclear	Evidence of substantial delay; little evidence of future plans
Monitoring Metrics	*For each metric associated with the milestone, is the state moving in the direction of the demonstration target?*	≥75% of metrics moved in the targeted direction	25-74% of metrics moved in the targeted direction	<25% of metrics moved in the targeted direction
Stakeholder Feedback	*For each stakeholder group, is feedback related to that milestone positive, negative, or mixed?*	The majority of stakeholder feedback was positive	Stakeholder feedback was mixed	The majority of stakeholder feedback was negative

Budget Neutrality

At the time this Mid-Point Assessment was prepared, the state is still updating logic to meet budget neutrality requirements. The state expects to submit reports to CMS in FY23. The evaluation team cannot provide any statements regarding the status of budget neutrality requirements.

Limitations and Contextual Factors

There are several limitations and contextual factors likely to affect this Mid-Point Assessment.

Data limitations. Data sources available for this Mid-Point Assessment have known limitations. As noted above, for Monitoring Metrics with an annual periodicity, results are available only two periods, which limits their usefulness in assessing the state's progress since the most recent data point is more than a year past.

The state directs each PIHP to maintain detailed information about SUD provider availability within its contracted network. There is no single source that compiles this detailed information on a statewide level. Some information is found in the state's customer relationship management system, which shows each contracted provider's approved level of care designation and the PIHPs with which they contract. However, the CRM system is neither designed nor intended to track real-time capacity (i.e., number of beds available, wait time) or detailed information about site closure, license suspensions, or other factors that would impact provider availability. While site closure, licensure suspensions, and other changes can be found on the LARA website, the information is not limited to the public SUD system. Without background information from state or PIHP officials, the CRM data and LARA website offer an incomplete description of SUD provider availability.

The state's Implementation Plan did not contain a specified set of Action Items for each milestone. This precludes the evaluation team from quantifying progress (e.g., proportion of Action Items completed) for most milestones. Additionally, many elements of the Implementation Plan were in place at the outset of the demonstration period. In response to this situation, the evaluation team sought to confirm elements described as in place, and to review an array of documents to find evidence of progress and future plans for each milestone.

Key informant interviews were conducted with leadership from all PIHP regions and with a broad set of SUD providers. Structured phone interviews were conducted with more than 2,000 beneficiaries. Still, it is likely that some perspectives are not represented.

Since the outset of the demonstration period, the state has conducted site visits with only three PIHP regions due to COVID-related delays. Site visit information is not available for the other seven regions. Also, the state has not yet initiated audits of SUD providers to assess fidelity to ASAM Continuum treatment and placement recommendations, so this data is not available for the Mid-Point Assessment.

Contextual factors. The primary contextual factor that is likely to affect the state's implementation of demonstration project milestones is the COVID public health emergency (PHE). The COVID pandemic has had a dramatic effect on virtually all aspects of health and health care delivery. Particularly in the first 12 months of the pandemic, in-person health services delivery was constrained. Some constraints were implemented to comply with recommended distancing of patients; others were related to staffing shortages when personnel were sick with or exposed to COVID or when they were off to care for family members. In addition, some individuals declined to seek health care services to avoid exposure to COVID. This situation created financial pressures for some SUD providers.

Michigan Medicaid used the flexibility of the PHE to enact policies to address constraints on the health care system. For example, officials expanded the list of services that could be delivered via telehealth, including initiation of medication assisted treatment for SUD. Michigan also allowed telephone-only (i.e.,

no video component) visits for most of the expanded services and allowed telehealth visits to be done from the beneficiary's home. These policy change altered the provision of SUD treatment services, yet also created a burden on providers to adopt new technology and new billing and recordkeeping procedures. The need to rapidly disseminate new policies, combined with the limited availability of providers to attend to other initiatives, was a likely factor in delaying implementation of demonstration project milestones.

After declaration of the COVID PHE, the US Congress provided increased Medicaid funding to states through the Section 6008 of the Families First Coronavirus Response Act (FFCRA). To receive FFCRA funds, states must meet a maintenance of effort requirement that prohibits termination of Medicaid coverage. This led to a dramatic increase in Medicaid enrollment, from approximately 2,387,133 individuals in March 2020 to over 2,919,492 individuals as of March 2022, a 22.3% increase. With limited information on the number or proportion of enrollees who have moved out of state, obtained other health insurance coverage or would be otherwise ineligible, it is difficult to interpret Monitoring Metrics calculated "per Medicaid member" for the PHE period.

FFCRA funding also may affect SUD expenditure patterns, as Michigan Medicaid used the additional funding to offer flexibility to PIHPs in order to maintain provider capacity. Broadly, the overwhelming impact of the COVID PHE clouds any assessment of spending trends during this period.

Beyond the COVID PHE, other policy changes may affect the state's implementation of demonstration project milestones. In March 2022 state officials announced a restructuring of MDHHS units; BHDDA, which had oversight of the PIHPs, was shifted to different divisions within MDHHS to improve coordination of services. Several BHDDA officials were reassigned to other areas not directly related to SUD administration. It is unclear whether or how this organizational change will affect the state's ability to sustain progress toward demonstration project milestones.

In August 2021 Michigan Medicaid enacted a new policy to update and expand reimbursement for office-based treatment for alcohol use disorder and opioid use disorder in primary care and other office-based settings under the beneficiary's physical health benefit, without a requirement for contracting with the PIHP. This policy likely expands access to SUD services but in a way that PIHPs may be unable to monitor; it also raises questions of how PIHPs and Medicaid Health Plans share information and coordinate care to ensure that beneficiaries have access to the full array of SUD treatment and recovery services.

Section III: Findings

Progress Towards Demonstration Milestones

Milestone 1. Access to Critical Levels of Care for OUD and other SUDs

Key Findings of Milestone Progress

The state invests its ten regional PIHPs with the responsibility to ensure access to critical levels of care for OUD and other SUD. Review of documents confirms that the state uses this existing structure to convey expectations to PIHPs and to periodically review compliance with those expectations. The state charges each PIHP with establishing and maintaining a network of contracted providers that span all levels of care. The state informed PIHPs via written communication that effective FY2019, specific network adequacy standards would be in effect:

Medicaid Enrollee-to-Provider Ratio Standards for Select Services

Adult Services	**Standard**
Assertive Community Treatment	30,000:1 (Medicaid Enrollee to Provider Ratio)
Psychosocial Rehabilitation (Clubhouses)	45,000:1 (Medicaid Enrollee to Provider Ratio)
Opioid Treatment Programs	35,000:1 (Medicaid Enrollee to Provider Ratio)
Crisis Residential	16 beds per 500,000 Total Population
Children's Services	**Standard**
Home-Based	2,000:1 (Medicaid Enrollee to Provider Ratio)
Wraparound	5,000:1 (Medicaid Enrollee to Provider Ratio)
Crisis Residential	8-12 beds per 500,000 Total Population

The state communicated the expectation that each PIHP will submit plans on how the standards will be effectuated by region, including consideration of access issues such as time and distance, availability of timely appointments, and language, cultural competence and physical accessibility.

The state reviews PIHP compliance with the SUD network requirements, including network adequacy standards, during routine site reviews. The state's Implementation Plan called for site reviews every two years. PIHP site reviews were suspended during FY2020 and FY2021 due to the COVID PHE. The state resumed site reviews in FY2022; at the time of this Mid-Point Assessment, the state has completed the site visit process with three PIHPs; others are scheduled to be completed by October 1, 2023.

Site visit components related to Milestone 1 include:

- Ensure a comprehensive evidence-based SUD benefit
- Ensure that SUD providers meet ASAM program and service requirement
- Ensure the presence and maintenance of a strong SUD provider network

For the three PIHPs with completed site visits, the state found all to be in full or substantial compliance for all Milestone 1 requirements.

Expanded Use of Telehealth. The COVID pandemic created unprecedented challenges with access to SUD services. The state implemented and promulgated policy changes to allow expanded use of telehealth to promote engagement with SUD services during the PHE. Notable among these changes: (1) telehealth

could originate from the beneficiary's home; (2) audio-only telehealth was allowed due to widespread difficulties with internet access; and (3) providers were allowed to initiate medication assisted treatment by telehealth.

The state took actions to disseminate the telehealth policy changes to PIHPs and their network of SUD providers, and to other Medicaid providers seeing beneficiaries with SUD challenges. As the end of the PHE draws near, state officials have worked to craft policies for continued telehealth options for SUD services, informed by feedback from providers, beneficiaries, and advocates.

Residential Bed Registry. To expand access to critical SUD services, the state's SUD Health IT plan called for development of an SUD residential bed registry in the contest of the state's broader integrated crisis and access system. The target date for implementation was October 1, 2021.

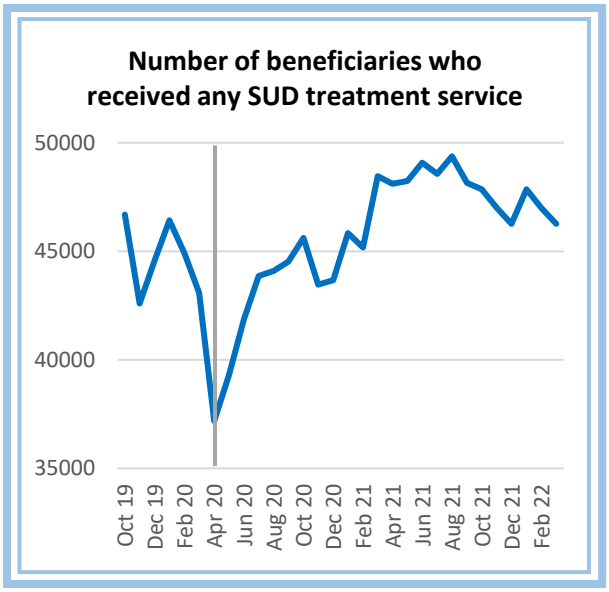
Although the state did not achieve its target implementation date for the new SUD registry, documents provide evidence of progress. In FY2021, the Open Bed registry system was named the Michigan Care Access Referral Exchange (MiCARE). The Department of Licensing and Regulatory Affairs (LARA) drafted system standards and guidelines, and worked with MDHHS on the scope and requirements for integrating MiCARE with the legislatively required Michigan Crisis and Access Line (MiCAL). In response to new legislative requirement for MDHHS to develop a psychiatric bed registry, LARA and MDHHS worked on an agreement to include inpatient psychiatric beds in MiCARE. LARA also continued their efforts to onboard individual facilities to MiCARE, including region-specific orientations with facilities in four PIHP regions. They demonstrated the system to PIHP directors and met with two individual PIHPs to understand their workflow and authorization processes

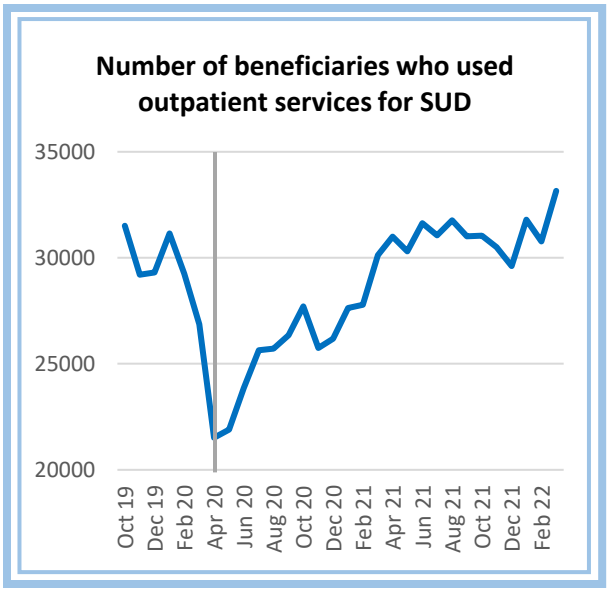
In FY2022, LARA met with three additional individual PIHPs to understand their workflow and authorization processes, held region-specific orientations with facilities in one PIHP region, and continued onboarding of individual facilities in the five active PIHP regions. They also met with the five PIHPs that had not yet started the onboarding process, held orientations for facilities in two of these regions, and began onboarding facilities in those two regions..

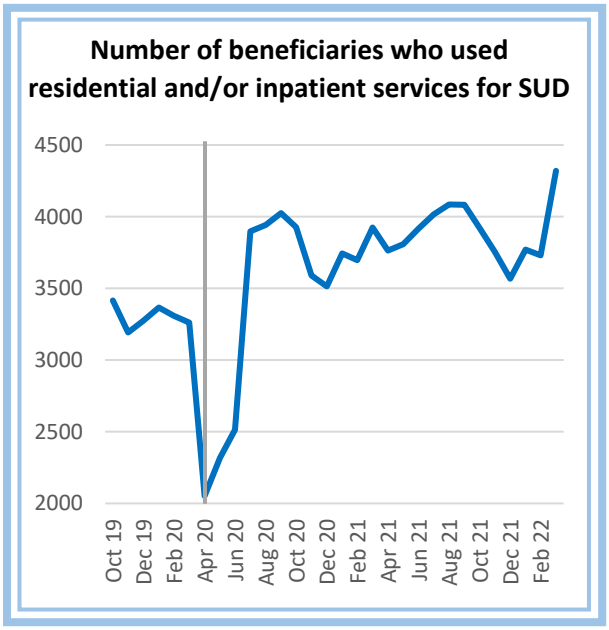
The state aims to implement the residential bed registry statewide by the end of the demonstration period. LARA has outlined several steps and target dates to achieve this implementation. However, it is unclear whether there is sufficient coordination between LARA and MDHHS to facilitate effective integration within the state SUD system of care, including opportunity to assess the impact of the new system.

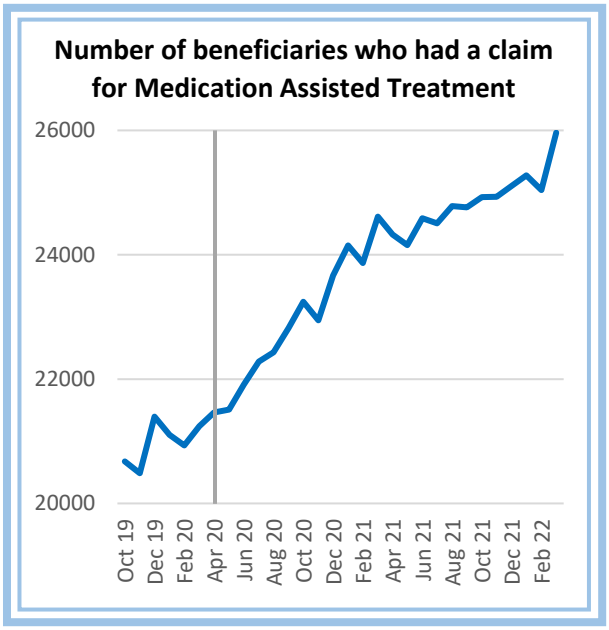
Monitoring Metrics

Review of month-to-month data points for key metrics clearly demonstrate a drop in use of SUD treatment services at the outset of the COVID PHE, with a steady increase thereafter. The trajectory of change differed by service type. Numbers of beneficiaries receiving any SUD treatment, outpatient services, residential/inpatient services, and MAT increased beyond pre-COVID levels, consistent with the state's demonstration target for these metrics. Also increased from baseline to mid-point is the percentage of beneficiaries receiving greater than 180 days of continuous pharmacotherapy for OUD.

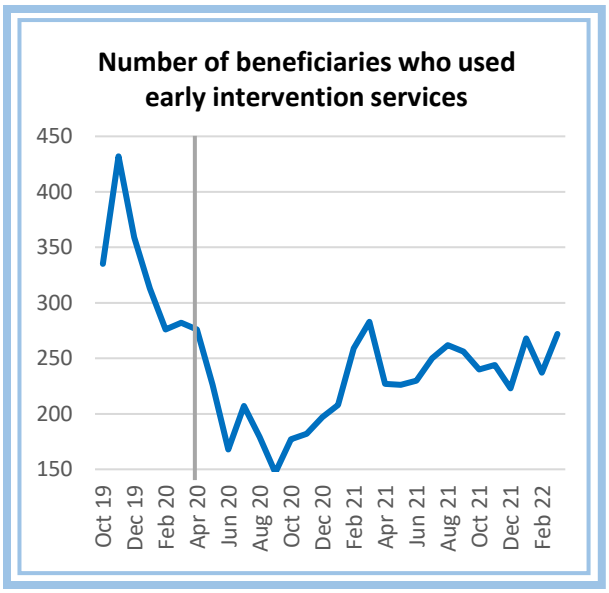


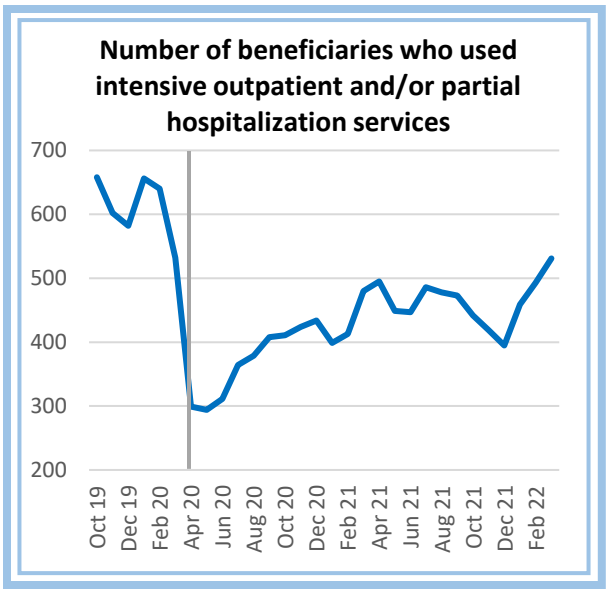


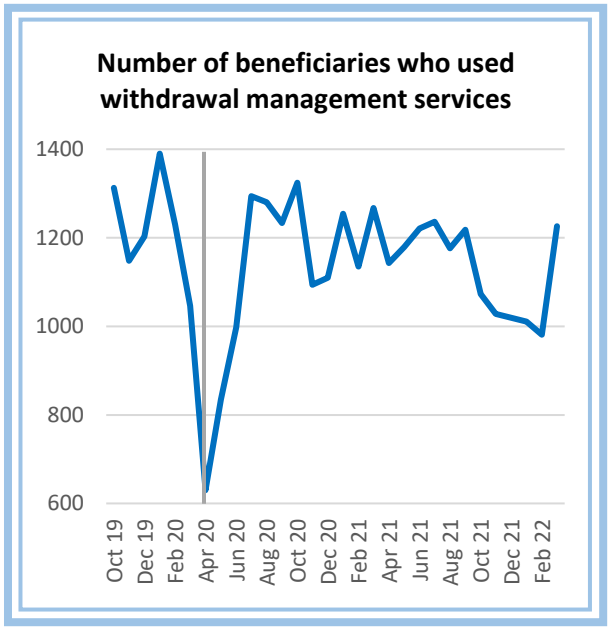




In contrast, the numbers of beneficiaries receiving early intervention, intensive outpatient/partial hospitalization services, and withdrawal management did not rebound to pre-COVID levels; this is not consistent with the state's demonstration target for these metrics.

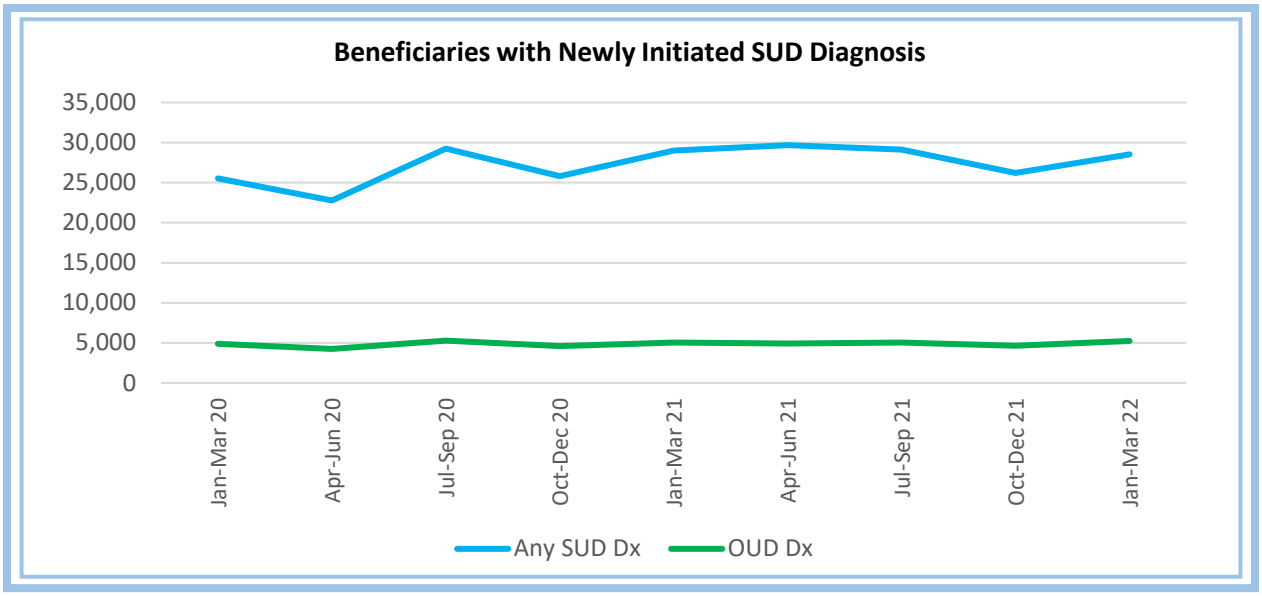




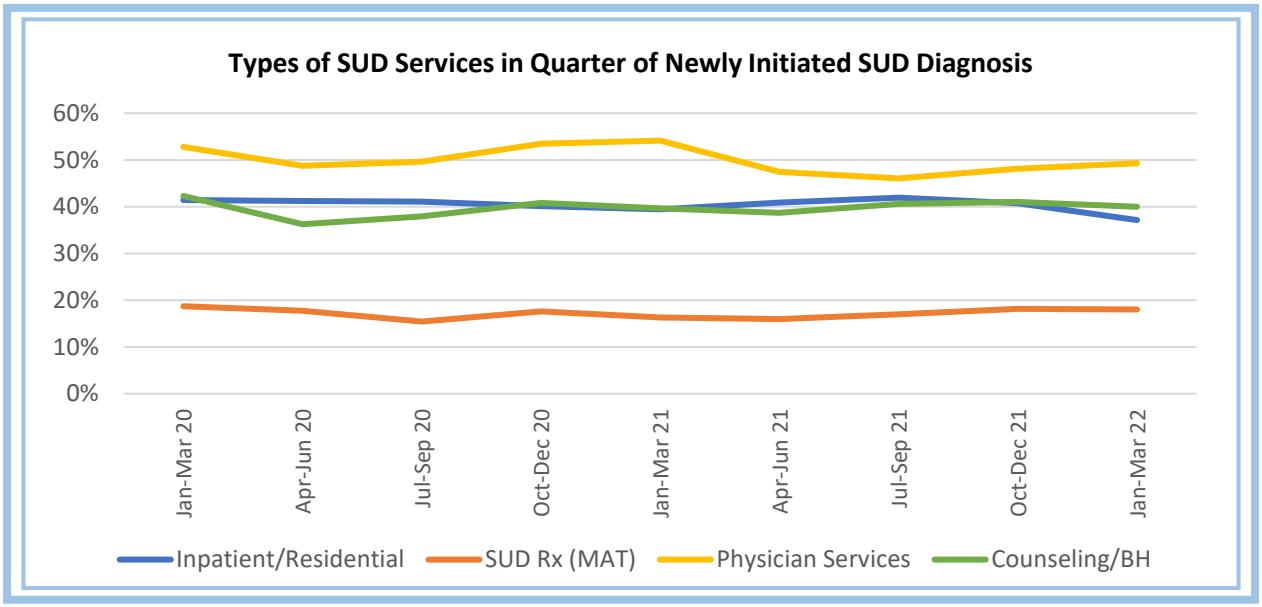


Other Measures

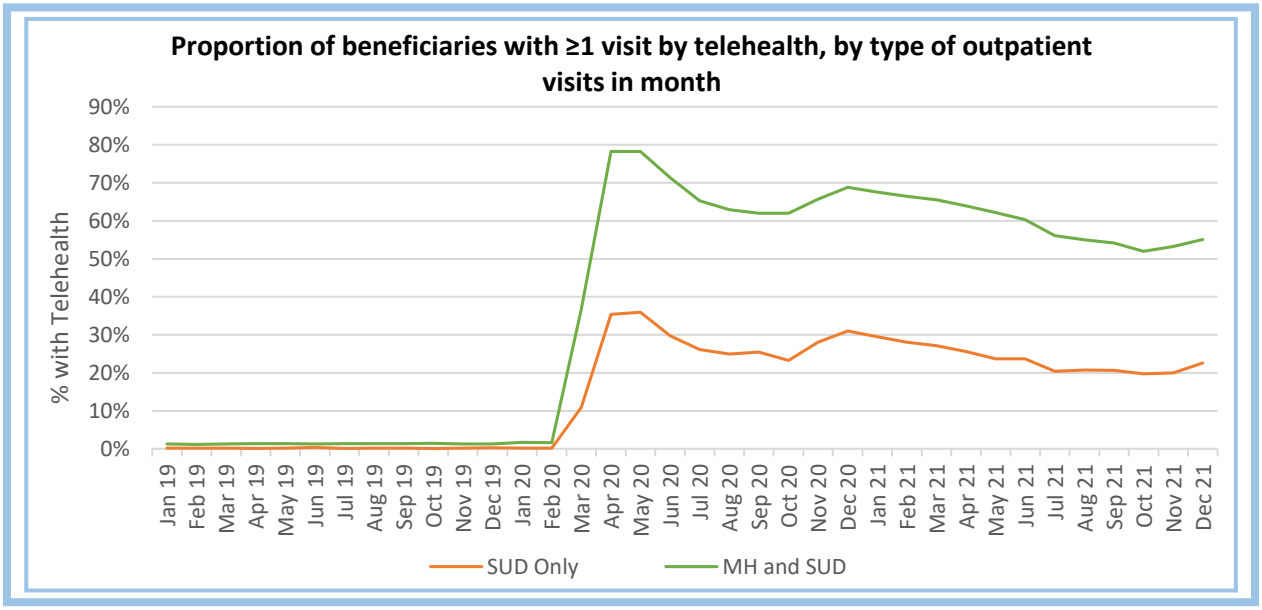
Companion measures demonstrate trends for beneficiaries with newly initiated SUD diagnosis, which may reflect an individual's first SUD diagnosis, or a re-engagement after multiple months without SUD services, or a continuation of SUD diagnosis and treatment in the context of new Medicaid enrollment. Quarterly data demonstrate a slight drop in the number of beneficiaries with newly initiated SUD diagnosis near the start of the COVID pandemic, followed by a consistently elevated number (compared to the baseline month) thereafter.



Consistently, physician services are the most common type of SUD services received in the quarter of newly initiated SUD diagnosis; however, the proportion receiving physician services dropped in the second part of FY2021, falling below 50%. In contrast, the proportion receiving inpatient/residential services continues to hover around 40%, along with the proportion receiving counseling.



Monthly data demonstrate the dramatic increase in SUD services provided through telehealth, consistent with the state's policy changes related to the COVID pandemic. Use of telehealth is higher among beneficiaries who have both SUD and other mental health diagnoses, compared to those with SUD diagnosis only.



Provider Availability Assessment Data

The state's CRM database documents each SUD provider approved to deliver services through the SUD system of care, along with their designated ASAM LOC and the specific PIHP regions with which they contract. Because beneficiaries receive SUD services through the PIHP region of their home address, this PIHP-level description reflects a minimum threshold of geographic access.

Outpatient SUD Services. As shown in the table below, all PIHP regions were contracting with at least one outpatient SUD provider at the start of the demonstration period. CRM data indicate that most PIHPs added providers at each outpatient level during the demonstration period; this could reflect expansion of LOC services at contracted provider sites, additional provider sites, or new providers.

	# of PIHPs with ≥1 contracted provider		
Outpatient Levels of Care	Existing at the start of the demonstration period	*Newly contracted since the start of the demonstration period*	At the mid-point of the demonstration period
0.5 - Early Intervention	10 of 10	*9 of 10*	10 of 10
Level 1 - Outpatient Services	10 of 10	*10 of 10*	10 of 10
Level 2.1 - Intensive Outpatient Services	10 of 10	*8 of 10*	10 of 10
Level 2.5 - Partial Hospitalization Services	10 of 10	*6 of 10*	10 of 10

Residential Services. The availability of residential SUD services in the public SUD system was uneven at the outset of the demonstration period, with two PIHPs having no contracted providers documented in the CRM at Level 3.3 and one PIHP having no provider at Level 3.7. CRM data indicate that many PIHPs added residential providers during the demonstration period; this could reflect expansion of LOC services at contracted provider sites, additional provider sites, or new providers. One PIHP appears to have achieved new availability at Level 3.3.

	# of PIHPs with ≥1 contracted provider		
Residential Levels of Care	Existing at the start of the demonstration period	*Newly Contracted since the start of the demonstration period*	At the mid-point of the demonstration period
Residential services			
Level 3.1 - Clinically Managed Low-Intensity Residential Services	10 of 10	*8 of 10*	10 of 10
Level 3.3 - Clinically Managed Population Specific High Intensity Residential Services	8 of 10	*5 of 10*	9 of 10
Level 3.5 - Clinically Managed High Intensity Residential Services	10 of 10	*9 of 10*	10 of 10
Level 3.7 - Medically Monitored High-Intensity Inpatient Services	9 of 10	*5 of 10*	9 of 10

Withdrawal Services. The availability of withdrawal services in the public SUD system was uneven at the outset of the demonstration period. Five PIHPs had no evidence of contracted providers offering ambulatory withdrawal management without extended onsite monitoring (Level 1), and no additional providers were contracted at this level during the demonstration period. Nine PIHPs had contracts with providers for ambulatory withdrawal management with extended onsite monitoring (Level 2), but these contracts were with the same two providers; no additional providers were contracted during the demonstration period. In contrast, withdrawal with clinical or medical monitoring was available in most regions at the start of the demonstration period, and many PIHPs have expanded contracting at these levels.

	# of PIHPs with ≥1 contracted provider		
Withdrawal Levels of Care	Existing at the start of the demonstration period	*Newly Contracted since the start of the demonstration period*	At the mid-point of the demonstration period
Level 1-WM - Ambulatory Withdrawal Management without Extended On-Site Monitoring	5 of 10	*0 of 10*	5 of 10
Level 2-WM - Ambulatory Withdrawal Management with Extended On-Site Monitoring	9 of 10	*0 of 10*	9 of 10
Level 3.2-WM - Clinically Managed Residential Withdrawal Management	10 of 10	*6 of 10*	10 of 10
Level 3.7- WM - Medically Monitored Inpatient Withdrawal Management	9 of 10	*9 of 10*	9 of 10

Overall, most PIHPs regions continue to contract with at least one SUD provider at each ASAM level of care. However, several PIHPs continue to have no documented provider contracts at higher ASAM levels.

Stakeholder Feedback

Stakeholder feedback revealed several key themes related to access to critical levels of SUD services.

Transportation. Although Medicaid has a broad policy to assist beneficiaries with non-emergency transportation, Michigan's Medicaid program designates that NEMT for SUD services is administered differently than for physical health services. Beneficiaries would need to call their county DHHS office to arrange for SUD-related transportation; this process is not well known to beneficiaries and providers. Moreover, county DHHS offices often do not have adequate transportation services available.

- Nearly half of beneficiary survey respondents (41%) rated transportation as a barrier to initiating SUD treatment – greater than other barriers. Transportation barriers are highest among beneficiaries who receive methadone, consistent with requirements for onsite dosing and drug testing.
- Among beneficiaries receiving MAT, 1 in 6 reported missing at least one MAT dose in the prior six months because they couldn't get to the clinic or pharmacy. Missing doses creates a no-win set of options: go without and experience withdrawal symptoms, try to obtain MAT doses diverted from another person in treatment, or obtain a substitute drug through other means.
- SUD providers express frustration that transportation options for SUD treatment are unclear, inconsistent, and inequitable. Providers have trouble understanding the different systems for accessing transportation assistance.
- PIHPs use block grants or other flexible funds to cover transportation, but indicate these funds are insufficient relative to the overall need for assistance. Some PIHPs limit the use of transportation assistance while they assess their spending levels; thus, transportation assistance may not be consistently available throughout the year. This creates a problem for clients, who experience changes in whether and how they can receive transportation assistance

Provider Capacity vs Access to Services. Generally, PIHPs believe they have adequate SUD provider capacity to meet the needs of adults. However, provider capacity is not synonymous with availability. Timely access to SUD treatment relies on availability of appointments, beds, and other services.

- SUD providers note that since the start of the COVID PHE they are often operating below capacity; thus network adequacy assessments may not reflect the actual level of access.
- Beneficiaries describe frustration with calling multiple SUD providers and finding no availability; 1 in 3 respondents were *somewhat* or *not confident* they would be able to see or talk with a provider if they were having a crisis.

Process Barriers to Timely Access. The path to accessing SUD services starts with intake and initial eligibility screening, which includes verifying Medicaid enrollment and residency within the region. The next step is a more comprehensive assessment and determination of the appropriate level of care.

- Frontline staff note that lack of clinician availability can delay scheduling of comprehensive assessments up to two weeks.
- Frontline staff also note that delays in receiving clinical data from other providers and the inability to share information collected during screenings and assessments with external providers add to the administrative burden and delay the initiation of SUD treatment.
- Beneficiaries express confusion about PIHP eligibility screening, especially when told they are "out of region" for SUD services, which has no parallel within their medical benefit. The resulting confusion and delay can impact their resolve to follow through with treatment.

Milestone 2. Use of Evidence-based, SUD-specific Patient Placement Criteria

Key Findings of Milestone Progress

The state has made substantial progress in the use of evidence-based SUD-specific patient placement criteria. In consultation with PIHP leadership, state SUD officials selected the ASAM Continuum as the standard assessment tool for adults, with the GAIN-I identified as the standard tool for youth. State officials facilitated efforts to embed ASAM Continuum software within the electronic medical record (EMR) of each PIHP. The state met the October 1, 2021, target date for adoption by all ten PIHP regions.

The state communicated to PIHPs the expectation that all contracted SUD providers are required to be trained in and use the ASAM Continuum as of October 2021. The state facilitated ASAM Continuum training for all existing SUD providers, with an online module for training of all new SUD providers.

Assessment of the use of the ASAM Continuum to guide assessment and placement actions is occurring at two levels. First, as part of their routine operations, PIHP officials review a sample of medical records for each contracted SUD provider to ensure they are using appropriate criteria for assessment and placement, with targeted education to address deficiencies. PIHPs have begun incorporating the ASAM Continuum in these record reviews. As confirmation, medical record review information was included in site visit documentation for the three PIHPs with completed site visits

Second, the more formal assessment of SUD provider fidelity to the ASAM Continuum tool will be conducted by the state. Direct communication from state officials indicates that these audits will begin in FY2023. However, the evaluation team did not find documentation outlining a detailed plan for these audits, including processes, timelines, and thresholds for remediation.

Monitoring Metrics

The Monitoring Metrics associated with this milestone are annual measures. The number of beneficiaries treated for SUD in an IMD showed a 3% decrease from the demonstration year 1 to demonstration year 2. This is counter to the state's targeted direction of *increase*. However, both measures are likely to be affected by constraints to inpatient care related to the COVID PHE. It is likely that data from demonstration year 3 will better reflect any progress the state has made.

The second metric, average length of stay for residential/inpatient SUD care, was 4.55 days in demonstration year 1 and 4.44 days in demonstration year 1. While technically a decrease, it equates to a difference of 2.64 hours, which is not a clinically meaningful change in length of stay. The evaluation team felt this was consistent with the state's target direction of *staying the same*.

Stakeholder Feedback

Pre-implementation Feedback about the ASAM Continuum. In training evaluations, the 840 providers trained by September 2021 rated the ASAM Continuum as *very useful* (70%) or *somewhat useful* (27%) to their SUD assessment and treatment recommendations.

- SUD providers' top concerns about implementation of the ASAM Continuum were time required to administer the tool (67%), individual's acceptance of LOC recommendations (22%), provider capacity at each LOC (19%), compatibility with EMR and other practice recordkeeping systems (17%), and accuracy of the LOC recommendations (10%).

Post-implementation Feedback about the ASAM Continuum. Interviews with SUD providers 6-12 months after implementation offered a description of the real-world experience with the tool.

- Some initial concerns proved to be overblown. SUD providers reported that time to administer the tool has improved with experience. They are generally satisfied that the ASAM Continuum provides accurate assessment and treatment recommendations.
- Some initial concerns were borne out in practice. SUD providers across settings described having to record ASAM Continuum information in the PIHP EMR and in their practice systems. This a burden of duplicate recordkeeping was widespread but particularly problematic for providers serving both Medicaid and privately insured patients.
- Some challenges were unexpected. Numerous providers noted that the ASAM Continuum assessment doesn't include all components (e.g., trauma assessment) required by some PIHPs and certain accrediting organizations (e.g., JCAHO). Several provider organizations had developed internal workarounds. Providers expressed a desire for the state and/or PIHPs to designate a comprehensive tool that would meet all requirements.

Milestone 3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Key Findings of Milestone Progress

Document review confirms that the state has implemented and is using nationally recognized SUD-specific program standards to set qualifications for residential treatment facilities. LARA requirements spell out the specific criteria for residential facilities. PIHP officials are responsible for verifying that their contracted SUD providers have completed the appropriate licensure and certification.

To facilitate this process, the state worked with a vendor to develop an online CRM system that will more readily capture information about residential provider credentialing. The state met the target date of October 1, 2021, for system development. As of this Mid-Point Assessment, eight of ten PIHPs are using the online CRM system. The state reviews information submitted through the system and makes the final designation of approved levels of care for that provider.

The state's revised PIHP site visit protocol includes several requirements related to Milestone 3 including compliance with credentialing, licensing, and accreditation requirements. The state has used the revised protocol in three PIHP site visits; all three PIHPs were able to provide documentation of compliance.

Stakeholder Feedback

Overall, PIHP officials and SUD providers had positive feedback about this milestone, with one area of concern.

- PIHP officials and SUD providers both noted that certain LARA requirements are unnecessarily restrictive and do not reflect ASAM guidance. An example is the requirement to have a registered nurse on site for withdrawal management/detox services; this requirement does not distinguish between withdrawal management conducted at ASAM levels 3.7 vs 3.2. The state requirement creates additional staffing challenges which impede availability of services; moreover, the requirement create additional costs that are not reflected in reimbursement levels. Proposed changes in LARA regulations may address this issue.

Milestone 4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Key Findings of Milestone Progress

The state invests its ten regional PIHPs with the responsibility to maintain sufficient SUD provider capacity at critical levels of care. Review of documents confirms that the state uses existing structures to convey expectations to PIHPs and to periodically review compliance with those expectations. As described in Milestone 1, this includes specific network adequacy standards for certain services.

During the demonstration period, the state disseminated guidance to PIHPs that their network providers should support all avenues to an individual's recovery by providing access to medication assisted treatment when it is clinically appropriate. Access to MAT can be achieved either within the provider organization or through arrangements with another provider. The state's revised PIHP SUD site visit protocol includes this requirement. As noted above, PIHP site visits were delayed due to COVID; as of this Mid-Point Assessment, the state has completed three site visits and deemed all three PIHPs as in compliance for this milestone.

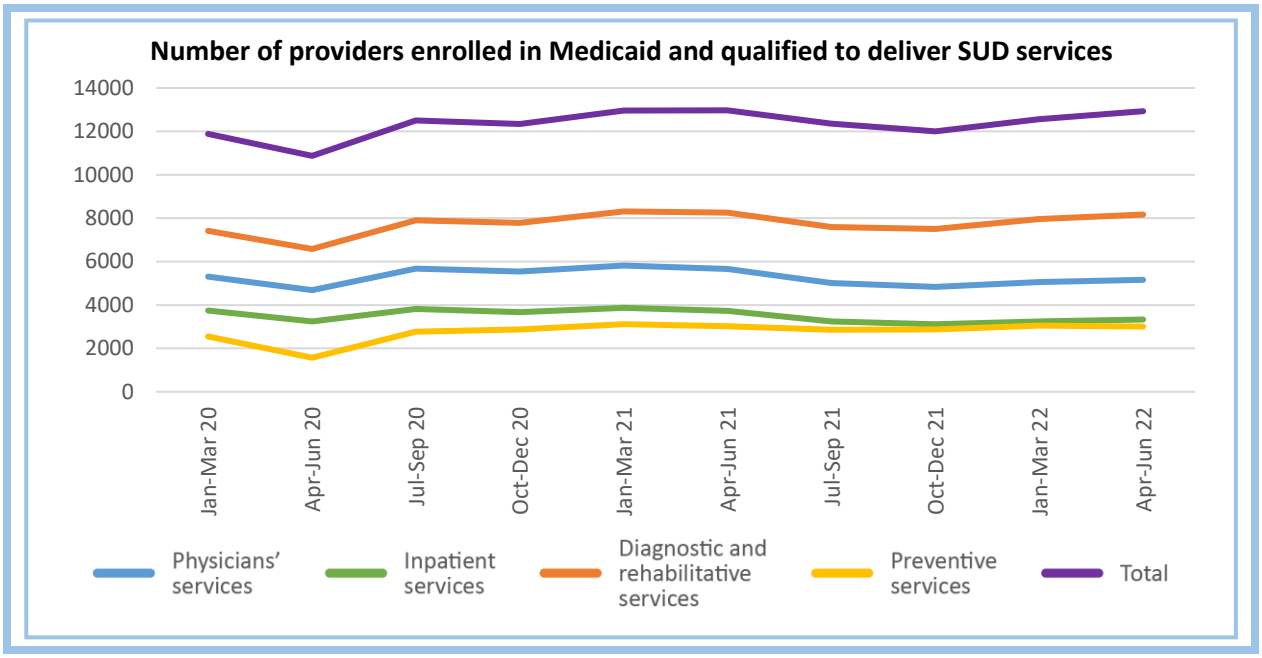
Network stability during the COVID PHE. In response to challenges created by the COVID pandemic, the state requested PIHPs to submit network financial stability plans in June 2020. The stability plans outlined each PIHP's policy and/or contractual actions to sustain and support its provider network, including descriptions of the funding mechanism(s) employed, expected length of time the mechanism would be used, criteria to determine when the plan would be discontinued, and internal audit processes to monitor for effectiveness and compliance with established rules and regulations. MDHHS reviewed each plan and provided approval within one week of receipt.

Monitoring Metrics

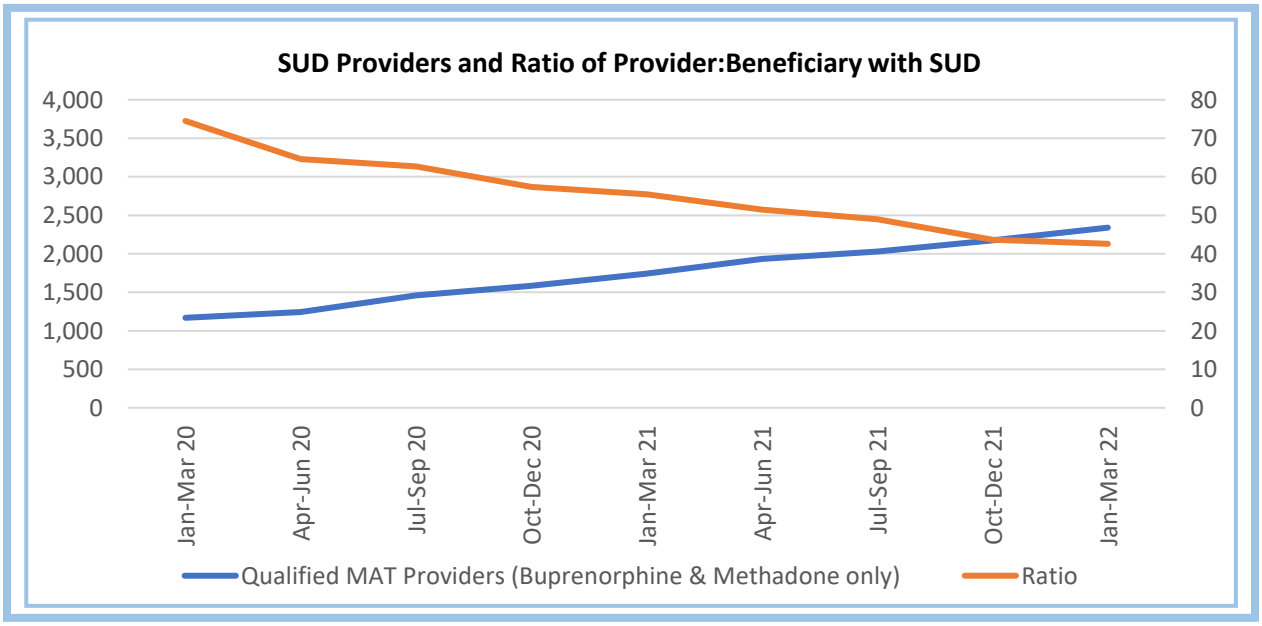
Two annual Monitoring Metrics are associated with Milestone 4. Consistent with the state's demonstration target, there was an increase in the number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period, and the number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who met the standards to provide buprenorphine or methadone as part of MAT.

Other Measures

Two companion measures offer additional insight into provider capacity patterns during the demonstration period. Quarterly data on the number of Medicaid-enrolled providers qualified to deliver different categories of SUD services demonstrate a COVID-related drop early in the PHE across all provider categories, followed by a rapid rebound to similar or higher levels as pre-COVID. The exception was inpatient SUD providers, which remain slightly below pre-COVID levels.

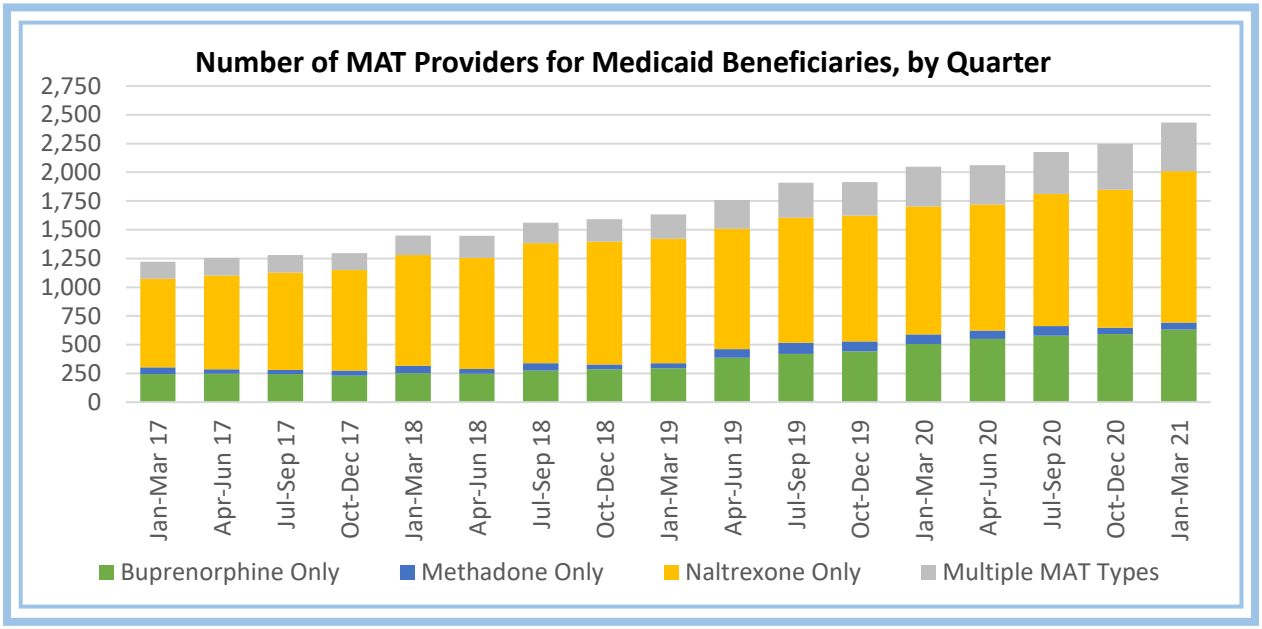


Quarterly data also demonstrates a steady increase throughout the demonstration period in the number of providers enrolled in Medicaid and qualified to provide buprenorphine or methadone. Importantly, the increased number of MAT providers was associated with a substantial decrease in the ratio of MAT providers to Medicaid beneficiaries – a strong indicator of increased access to MAT.



Guidelines recommend that MAT type should be chosen based on the needs and preferences of the individual. However, all MAT products are not available across all providers in all treatment settings. The figure below presents quarterly data of provider-level MAT services from 2017 to 2021. This extended view confirms the overall increase in MAT providers during the demonstration period. Importantly, this

view also demonstrates a small but continued increase in the number of providers offering multiple types of MAT.



Provider Availability Assessment Data

Data from the state's CRM database represent the total number of providers approved at each LOC through the CRM system. Review of CRM data demonstrated an increase in the number of contracted providers at nearly all levels of care; this could reflect expansion of LOC services at contracted provider sites, additional provider sites, or new providers.

The exceptions to this pattern were Level 1 and Level 2 ambulatory withdrawal management, where no additional providers were contracted since the start of the demonstration period.

	# of SUD providers contracting with ≥1 PIHP		
	Existing at the start of the demonstration period	*Contracted since the start of the demonstration period*	At the mid-point of the demonstration period
Outpatient Services			
0.5 - Early Intervention	93	*23*	116
Level 1 - Outpatient Services	266	*49*	315
Level 2.1 - Intensive Outpatient Services	99	*22*	121
Level 2.5 - Partial Hospitalization Services	16	*6*	22
Residential services			
Level 3.1 - Clinically Managed Low-Intensity Residential Services	20	*12*	32
Level 3.3 - Clinically Managed Population Specific High Intensity Residential Services	9	*4*	13

Level 3.5 - Clinically Managed High Intensity Residential Services	46	*18*	64
Level 3.7 - Medically Monitored High-Intensity Inpatient Services	8	*2*	10
Withdrawal services			
Level 1-WM - Ambulatory Withdrawal Management without Extended On-Site Monitoring	6	*0*	6
Level 2-WM - Ambulatory Withdrawal Management with Extended On-Site Monitoring	2	*0*	2
Level 3.2-WM - Clinically Managed Residential Withdrawal Management	17	*2*	19
Level 3.7- WM - Medically Monitored Inpatient Withdrawal Management	14	*5*	19

Stakeholder Feedback

Key informant interviews and beneficiary surveys provided numerous insights into the challenges of maintaining sufficient provider capacity at all levels of care.

Financial Barriers. PIHPs are funded through state-established capitation rates for Medicaid and funding algorithms for other funding sources (e.g., block grant). PIHPs typically reimburse network SUD providers on a fee-for-service basis.

- PIHP officials recognize that their provider reimbursement rates are low compared to other sectors, but say they are limited by state funding formulas. PIHP officials describe SUD services as being chronically underfunded relative to other behavioral health services; moreover, the low rates are incorporated into the rate-setting process which perpetuates the low funding.
- Some PIHP leaders feel they have adequate funding and flexibility to develop and deploy strategies to provide targeted financial support to critical providers that are experiencing financial difficulty, including low-volume providers. However, they do not have sufficient funds for a broad correction of low reimbursement rates across their SUD provider network.

PIHP Network Decisions. The state's Implementation Plan states that once providers are approved for a designated level of care, they are eligible to join a PIHP network. However, PIHPs do not accept all eligible SUD providers in their networks. Nine of ten PIHPs either have a closed network or utilize periodic Request for Proposals (RFPs) for specific needs (e.g., certain provider types, geographic areas).

- PIHPs say that in addition to network adequacy ratios and geographic accessibility, they also consider the financial viability of current network providers in determining whether, when, and where to seek additional providers.
- SUD providers question this rationale, expressing frustration with their inability to expand their range or location of services in regions that have not opened their network in some time. Some providers indicate they untapped capacity in geographic regions and at levels of care where there appear to be long wait times or other indicators of insufficient provider availability.

Recruitment and Retention of Staff. Clinicians (e.g., licensed clinical social workers, addiction counselors) are the backbone of the SUD workforce, providing individual and group counseling to individuals working to overcome addiction. Both PIHP officials and SUD providers described significant challenges

hiring and retaining SUD clinicians, which impacts beneficiary access to services. These challenges were exacerbated by the COVID PHE and have not subsided.

- Beneficiaries view engagement with clinicians as a key element of their SUD treatment; 15% rated delays in getting counseling as a major problem.
- PIHP officials and SUD providers point to the low salary levels in the public SUD system compared to salaries offered by health systems or other behavioral health organizations.
- Some SUD providers described the availability of funds for recruitment and retention of staff. However, these funds are not available in all regions, and are limited where they do exist.

Administrative Barriers. LARA administers licensing and certification for SUD providers; PIHPs are responsible for ensuring that all contracted providers have met LARA criteria for their level of care.

- PIHP officials indicate that the regulatory and administrative requirements for SUD provider organizations in the public system are substantial and represent a major deterrent to recruitment of new provider organizations.
- SUD providers confirm that the administrative burden is substantial. Providers who contract with multiple PIHP regions describe separate parallel processes for each region. PIHPs indicate interest in streamlining this burden, but also express some reluctance around accepting administrative audits conducted by another PIHP.

Availability of MAT Through the SUD Provider Network. The state has established the expectation that all contracted SUD providers offer MAT, either directly from a network provider or through an arrangement with another provider. Some question whether this is sufficient.

- Some SUD providers note that certain residential and intensive outpatient program (IOP) providers are known to not allow MAT. These providers questioned whether their patients are offered and allowed to have access to MAT through the secondary arrangement option.
- Some SUD clinicians expressed frustration at the slow pace of MAT availability through the secondary arrangement option. They described situations their clients waited several days to get an appointment with a MAT provider.
- Some beneficiaries receiving other SUD services through the PIHP system reported challenges with finding a MAT provider that was accepting new patients and within a reasonable vicinity.

MAT Provision Outside the SUD Provider Network. In August 2021 Michigan Medicaid enacted a new policy to update and expand reimbursement for OUD/SUD treatment in primary care setting and other office-based settings under the beneficiary's physical health benefit, without contracting with a PIHP or going through SUD provider certification.

- PIHP leaders acknowledge they have limited interactions with primary care providers who are not in their contracted network. Other than primary care sites that participate in integrated care initiatives, PIHPs are generally unaware of which providers are offering MAT for beneficiaries with OUD and other SUD.
- PIHP officials are uncertain if primary care providers have adequate knowledge about SUD treatment and recovery, or if primary care practices understand how to connect patients to SUD services in the PIHP system. Several PIHPs have tried to include primary care providers in their education activities, with limited success.
- Many beneficiaries express frustration over their health plan's lack of helpfulness in finding a primary care provider who offers MAT.

- Some beneficiaries describe punitive practices, such as being suspended or expelled by their provider site due to positive drug test or multiple missed appointments. This disrupts their engagement with SUD treatment.

Milestone 5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Key Findings of Milestone Progress

The evaluation team found ample evidence of the state's ongoing efforts to promote SUD treatment and prevention.

Per the state's request, PIHPs drafted three-year strategic plans for the period FY2021-FY2023. Strategic plans were submitted in September 2020; they described the needs of their region and outlined specific actions to support SUD prevention, treatment, and recovery. These strategic plans will guide the implementation of an array of actions.

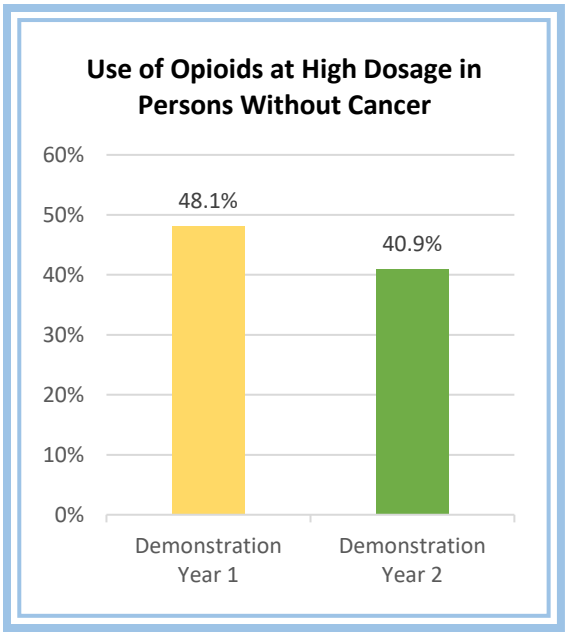
The state's Opioid Taskforce has continued to meet regularly during the demonstration period, bringing together stakeholders from local and state government, as well as representatives from health care, public health, justice, and social service sectors. The Taskforce offers a unique forum to identify the barriers and facilitators to effective provision of services, and to discuss priorities for future activities.

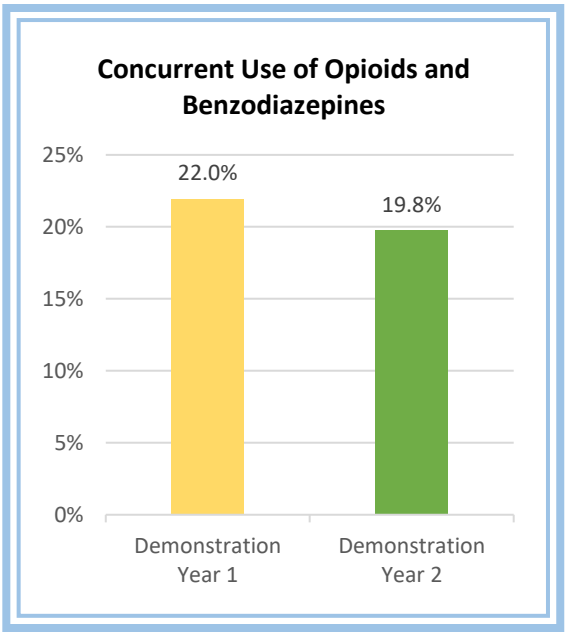
The state has engaged in numerous actions to facilitate SUD and other services for individuals released from jail or prison. These efforts include automating the process of restoring Medicaid eligibility upon release, educating law enforcement officials about SUD, and supporting the expansion of treatment courts and other justice system initiatives.

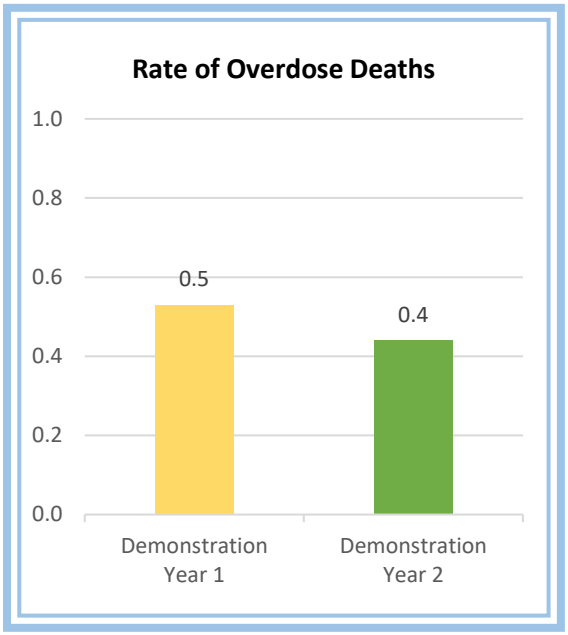
The state sought to enhance the "ease of use" of its prescription drug monitoring program (PDMP) to encourage greater utilization of the PDMP for clinical monitoring purposes. This includes use of NarxCare, a comprehensive SUD analytics platform that sits on top of provider EHRs to provide quick access to the PDMP, including dashboarding and decision support tools to aid in clinical decision making and maximize appropriateness of controlled substance prescription. The state's internal data confirms that PDMP use has nearly doubled since the start of the demonstration period, from 19,128 registered providers in FY2020 to 37,070 registered providers in FY2021.

Monitoring Metrics

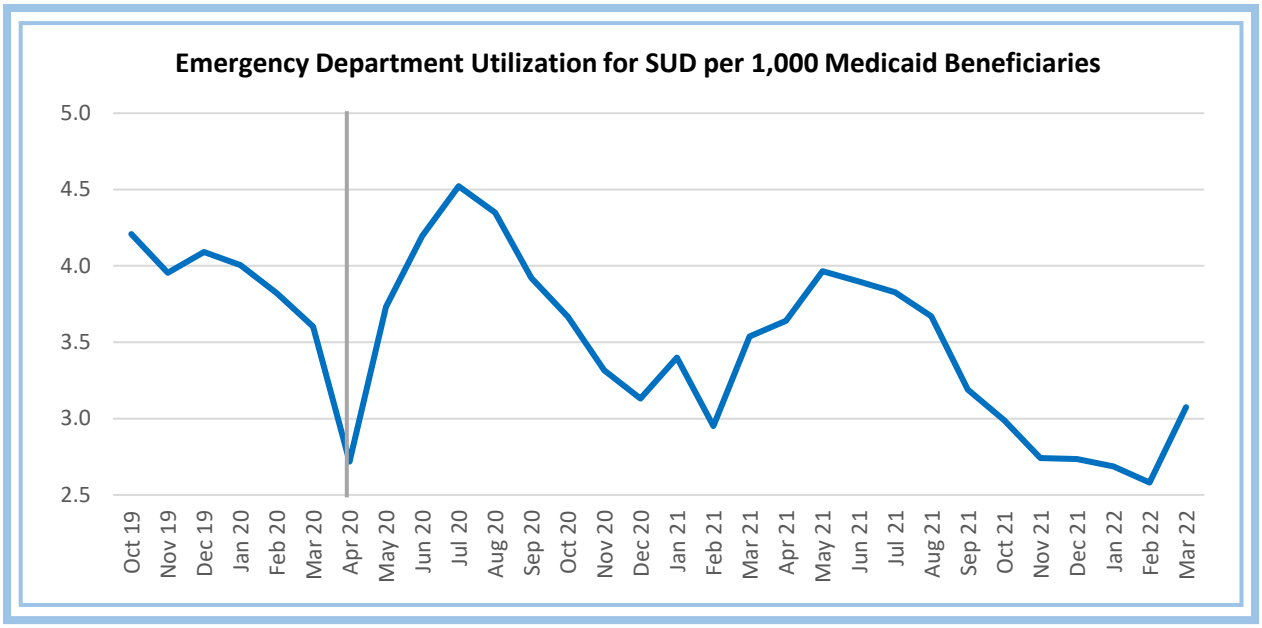
The three annual Monitoring Metrics associated with Milestone 5 demonstrate change consistent with the state's demonstration target. From demonstration year 1 (October 2019 to September 30) to year 2 (October 2020 to September 2021), there was a decrease in the percentage of beneficiaries prescribed high-dose opioids and the percentage with concurrent use of prescription opioids and benzodiazepines, as well as the rate of overdose deaths.







The one monthly metric related to Milestone 5 is the total number of emergency department (ED) visits for SUD per 1,000 beneficiaries. Monthly data demonstrate a sharp drop in ED visits near the beginning of COVID, followed by a dramatic increase, with inconsistent patterns thereafter.



Stakeholder Feedback

Some beneficiaries and SUD providers report that while OUD treatment options have increased, services for other SUDs, particularly methamphetamine, are lacking.

Milestone 6. Improved Care Coordination and Transitions between Levels of Care

Key Findings of Milestone Progress

The evaluation team identified progress related to two key programmatic initiatives to support care coordination.

Opioid Health Homes. The state initiated Opioid Health Homes (OHH), a unique program that provides enhanced reimbursement for comprehensive care to beneficiaries with OUD.. At the outset of the demonstration period, the state had begun initial implementation in one pilot region by October 1, 2019. During FY2021, OHH expanded to two additional regions, and two counties within a PIHP. The PIHP serving as the lead agency to support participating primary care practices, SUD provider organizations, and behavioral health agencies. The state provided technical assistance to OHH sites, developing, and updating the OHH handbook for participating sites, setting up IT systems, establishing payment rates and processes, and coordinating regular calls for guidance and networking.

In FY2022, the state expanded OHH to an additional three regions, drawing on the same successful processes to assist and support PIHP leads and OHH provider sites in those regions.

MHP/PIHP Coordination Agreements. At the outset of the demonstration period, the state had in place a relatively new effort to encourage coordination between Medicaid Health Plans and PIHPs. This effort focused on patients with co-occurring physical health and behavioral health conditions, including SUD.

The goal of the initiative was to encourage collaboration between the two entities around identification of high-risk beneficiaries and implementation of systems for joint care coordination.

The state has made progress toward MHP/PIHP coordination. Representatives from MHPs and PIHPs continue to meet to develop systems and strategies to support joint coordination. The state worked closely with MHPs and PIHPs to gain consensus around shared metrics that would represent their efforts. Importantly, the coordination efforts and the shared metrics include a component around reducing racial disparities.

The state has refined the shared metrics over the demonstration period in collaboration with MHPs and PIHPs. The shared metrics (Initiation and Engagement with Treatment; Follow-up after Hospitalization for Mental Illness; Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence) are calculated at the state level, plan level, and MHP/PIHP combination level. The state generates rates by race/ethnicity to support health equity initiatives. Shared metrics are available in CC360 and updated quarterly, allowing both PIHPs and MHPs to focus their quality improvement efforts. Due to LARA determinations around data sharing policies, some event-level data cannot be incorporated into CC360; instead, PIHPs can log in directly to the PDMP system and view a beneficiary's information. Finally, the state has incorporated MHP/PIHP coordination efforts into its performance bonus incentive pool.

Health IT Initiatives. The state also has made some progress on health IT activities to support care coordination and transitions.

E-Consent Management System. The state's Health IT plan called for development of a new system to obtain electronic consents (e-consents) from beneficiaries and to share those e-consents across providers and settings. This new system should facilitate the ability of providers in different settings to coordinate care and share patient-specific information to support transitions in care.

The state achieved its target date of developing the e-consent system by October 2021, and documents provide evidence of progress. In FY2021, the state and its contractor worked on updated use case documentation, including drafting a use case summary and presentation, conducting extensive legal review of use cases, and drafting an implementation guide. They also began pre-production pilot testing of the system, including onboarding of three PIHP regions to serve as pilot sites, and establishing and validating connectivity to the production data hub. In FY2022, the state and its contractor finalized the use case summary, presentation, and implementation guide. They also finished pre-production pilot testing and began preparing for the production pilot testing with the three PIHPs. Efforts to identify and communicate with Medicaid providers and payers for onboarding to the e-consent portal got underway. In addition, the vendor initiated work on the technical design and development of several related tools (e.g., a behavioral consent awareness/alerting service, an interoperable multi-vendor supported use case).

The state aims to implement the e-consent management tool statewide by the end of the demonstration period. The evaluation team received some documentation of planned steps and target dates to meet this goal.

Expansion of CareConnect 360. The state sought to modify the CC360 platform to afford designated access to SUD claim/encounter information including ADT messaging. The intention was to establish an

"SUD User" module that would allow PIHPs to have access to a broader array of information to support care coordination and manage transitions.

The state contracted with the vendor and established action items for developing and testing the new SUD module to enact this expansion. Though implementation was slightly delayed, the SUD User Interface is place, with 74 current users across the ten PIHPs.

The restriction of the SUD User interface to PIHP staff only affects the ease and timeliness of how SUD providers are able to use CC360 for care coordination. The evaluation team did not find evidence of state plans to continue to work with PIHPs and SUD providers to ensure that the SUD User interface adequately supports care coordination at the SUD provider level.

Inclusion of SUD information in MiHIN. The state also sought to integrate information from the PDMP into MiHIN and other health information exchanges (HIEs) throughout the state. LARA determined that this activity is consistent with SUD data sharing policies. Working through the technical specifications with the vendor, the state met its target date of October 1, 2022, for this activity; PDMP information currently is integrated in several HIEs.

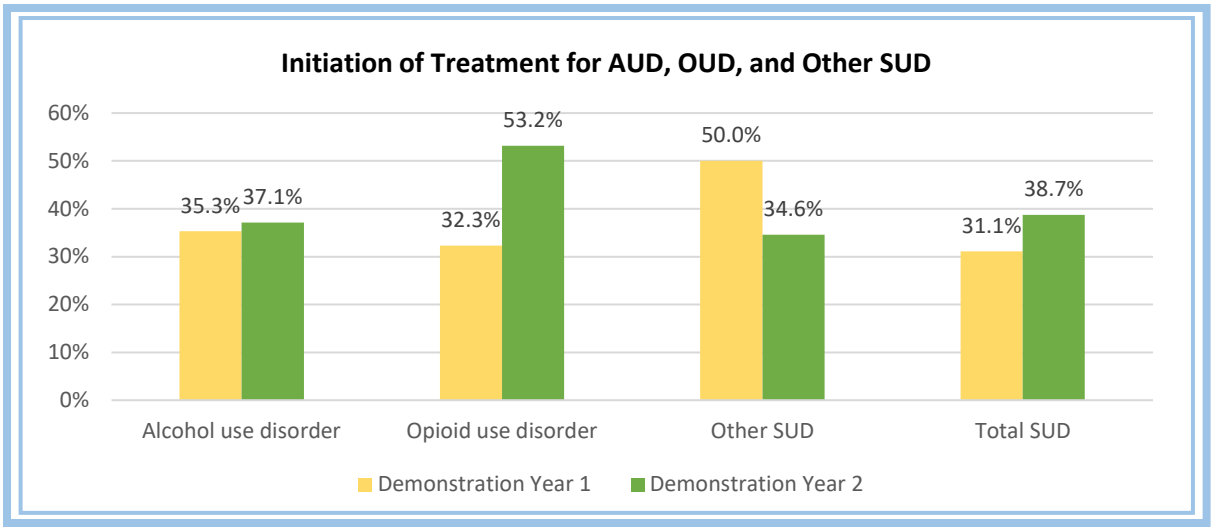
SUD Dashboard. The state sought to develop an SUD monitoring dashboard for PIHPs that would incorporate metrics required for federal reporting. In addition, this dashboard would incorporate data from other sources to allow identification of high-risk beneficiaries.

The state has accomplished the development of this dashboard, meeting its target date of October 1, 2021. The dashboard is housed within CC360 and incorporates data on homelessness, chronic conditions, and risk scoring. As noted above, LARA determinations have placed some limited on the inclusion of PDMP data. However, the progress to date allows PIHPs to identify high-risk populations and generate stratified data to measure their utilization rates.

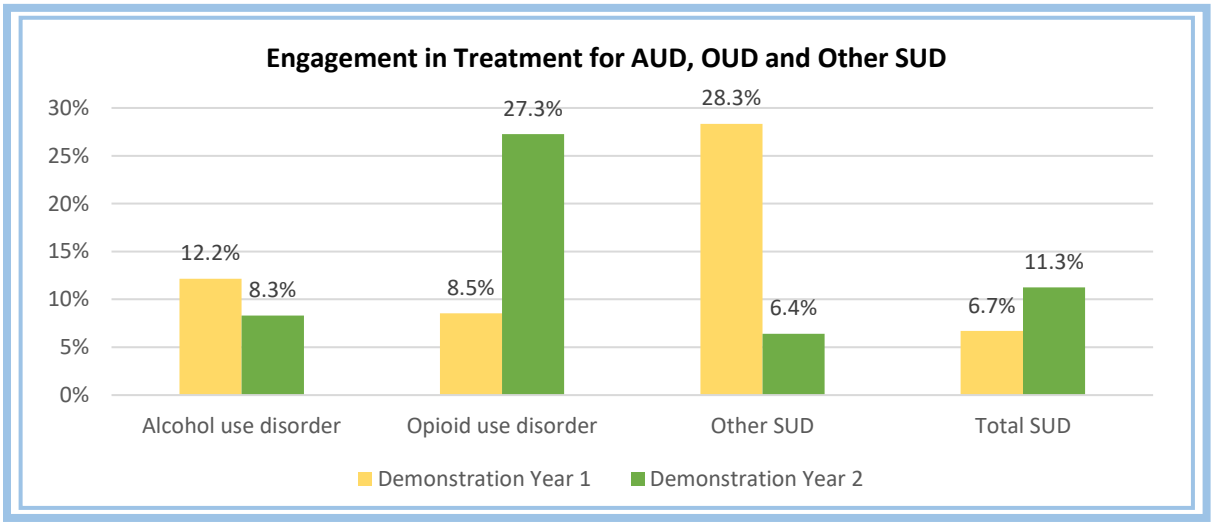
Monitoring Metrics

There are 4 annual Monitoring Metrics associated with Milestone 6.

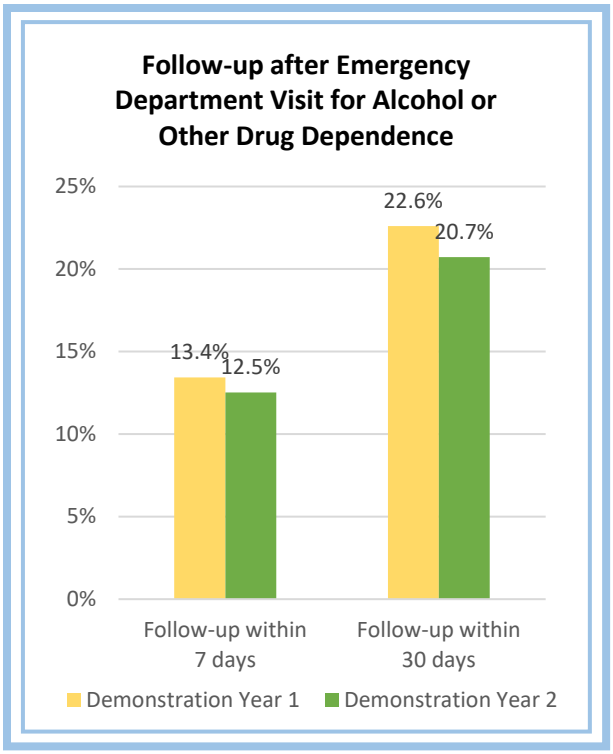
Initiation of treatment for alcohol use disorder (AUD) and for OUD increased from demonstration year 1 to year 2; initiation of treatment for other SUD decreased. However, the overall trend was an increase, consistent with the state's demonstration target.

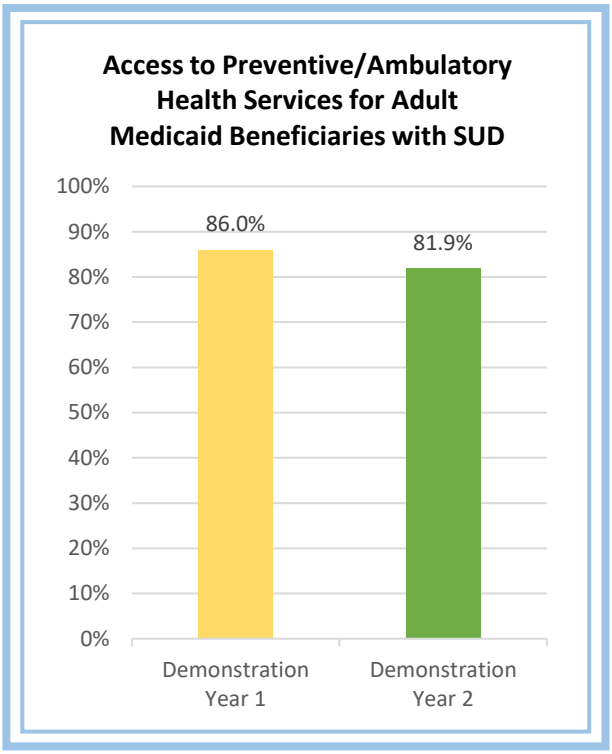


For engagement with treatment, results were more mixed. While engagement with OUD treatment increased dramatically from demonstration year 1 to year 2, engagement decreased for AOD and for other SUD. Although overall SUD treatments engagement increased, consistent with the state's targeted direction, the negative trends for non-OUD populations is concerning.



Two measures reflect beneficiaries' ability to get care in the primary care setting. Follow-up within 7 and within 30 days after an ED visit for SUD decreased from demonstration year 1 to year 2, as did the proportion of beneficiaries with SUD who had an ambulatory care visit. Both measures moved in a direction contrary to the state's targeted direction and likely were affected by COVID-related healthcare constraints; data from demonstration year 3 will provide a better signal of directionality.

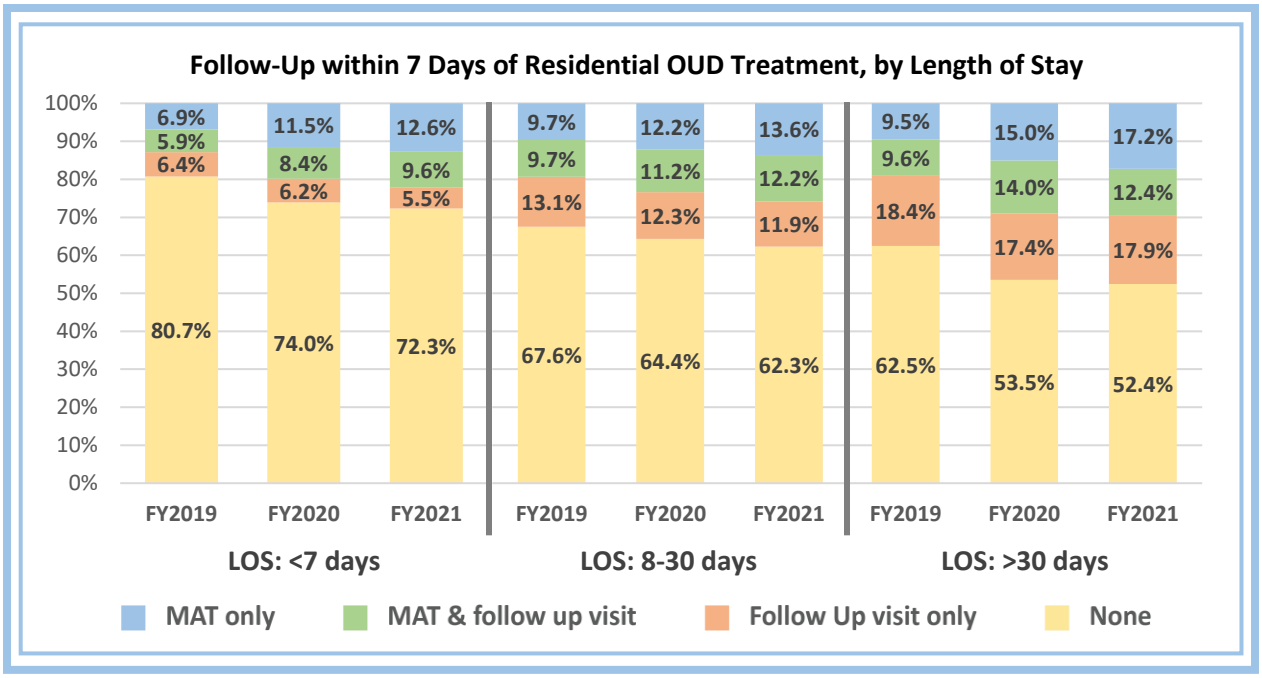




Other Metrics

Engagement with treatment often requires coordination across levels of care within the SUD system. An important area to examine is receipt of follow-up within 7 days of discharge from residential OUD treatment. Timely follow-up supports treatment continuity and protects against overdose risk for individuals who have decreased their drug use during a residential stay.

As shown below, follow-up rates are consistently better with longer residential stays. Second, follow-up rates improved from 2019 to 2021 across all length-of-stay (LOS) groups. Third, the proportion of follow-up that included MAT increased from 2019 to 2021 across all length-of-stay groups. Finally, even in the group with the best performance, less than half of beneficiaries receiving residential OUD treatment had evidence of follow-up services within 7 days.



Stakeholder Feedback

Stakeholders had positive feedback about the initiatives related to Milestone 6, along with suggestions for continued progress.

Opioid Health Homes. OHH providers were enthusiastic about the program, noting that it fosters increased engagement with clients across an array of providers.

- SUD/behavioral health providers noted that OHH prompted them to strengthen relationships and increase collaboration with primary care practices in their area. This benefits patients by creating a more efficient pathway to all aspects of care, but also benefits the primary care providers by facilitating their access to behavioral health expertise when needed.
- Primary care, SUD and behavioral health providers indicated that without OHH, they would be unlikely to develop relationships across settings that allow them to facilitate transitions in care and other care coordination activities.
- Beneficiaries enrolled in OHH consistently reported access to needed services and willingness of providers to support them.
- OHH providers emphasized the value of peer recovery coaches and appreciate this new mechanism to be reimbursed for these services. They described challenges identifying peer coaches, state requirements that have impeded their ability to hire qualified coaches, and a need for technical assistance to optimize their deployment. [Note that one state requirement was recently modified, which should eliminate one type of impediment.]
- More broadly, SUD providers urged expansion of reimbursement for peer recovery coaches beyond the OHH program so it is financially viable for primary care practices and CMHSPs to utilize this resource.
- Some OHH providers felt the health IT support was inadequate. They noted a lack of data sharing due to few area practices participating in MiHIN, as well as delays in getting data. In addition, they were dissatisfied with the length of time it took to get PIHP approval for a patient to move to a higher LOC.

MHP/PIHP Coordination. Stakeholders recognized the need for coordination between MHPs and PIHPs. They did not perceive that coordination is occurring.

- PIHP officials and SUD providers desire administrative changes to allow reimbursement for the care coordination they provide for beneficiaries with co-occurring physical and behavioral health conditions.
- Beneficiaries report lack of knowledge on the part of MHP customer service related to finding a provider who offers services and processes to initiate SUD treatment.
- Some PIHPs have expanded partnerships to provide SUD-focused technical assistance to primary care practices that offer SUD-related services. They feel this is essential to ensuring that primary care providers are equipped to deliver appropriate care, but question whether their relatively small efforts are sufficient.

Budget Neutrality

As noted in the CMS guidance, the ongoing coordination and collaboration between the state and CMS will serve to fulfill this aspect of the Mid-Point Assessment.

State Cost Reports

Required reporting of SUD expenditures shows slight decrease in overall SUD expenditures from demonstration year 1 (FY2020) to year 2 (FY2021), and a decrease from pre-demonstration FY2019. State officials believe the slight decrease is related to COVID PHE constraints in provider capacity and service delivery.

SUD Statewide Expenditures by Service Category

Service Category	**FY2019** (pre-demonstration)	**FY2020** (demonstration year 1)	**FY2021** (demonstration year 1)
Access Management System	$5,480,817	$3,227,033	$2,628,133
Case Management	$4,646,204	$5,252,899	$3,810,511
Detox	$13,667,143	$16,979,153	$14,684,165
Early Intervention	$2,824,235	$3,858,398	$3,345,788
General Administration	$10,999,031	$13,092,784	$12,316,785
Intensive Outpatient	$481,525	$856,006	$422,706
Methadone	$31,699,289	$35,843,357	$28,869,057
Outpatient	$55,992,275	$56,715,442	$57,668,433
Other Services	$8,691,850	$0	$1,465,882
Prevention	$30,662,399	$14,488,752	$12,922,588
Recovery & Support	$20,185,676	$20,516,216	$17,872,352
Residential	$45,306,527	$60,475,051	$52,023,464
Total	$230,636,970	$231,305,093	$208,029,864

Table of Monitoring Metrics							
		Monitoring metric rate or count					
Metric # (reported Monthly or Annually)	Metric Name (Unit of measurement)	At baseline[1]	At mid-point[2]	Absolute change	Percent change	State's demonstration target	Directionality at mid-point
Milestone 1. Access to Critical Levels of Care for OUD and other SUDs							
6 (Monthly)	Any SUD Treatment (Number of beneficiaries)	44625	47040	2415	5.41%	Increase	Increase
7 (Monthly)	Early Intervention (Number of Beneficiaries)	375	259	-116	-30.99%	Increase	Decrease
8 (Monthly)	Outpatient Services (Number of beneficiaries)	30010	31910	1900	6.33%	Increase	Increase
9 (Monthly)	Intensive Outpatient and Partial Hospitalization Services (Number of beneficiaries)	614	494	-120	-19.49%	Increase	Decrease
10 (Monthly)	Residential and Inpatient Services (Number of beneficiaries)	3295	3940	645	19.59%	Increase	Increase
11 (Monthly)	Withdrawal Management (Number of beneficiaries)	1221	1073	-149	-12.17%	Increase	Decrease
12 (Monthly)	Medication Assisted Treatment (Number of beneficiaries)	20853	25426	4574	21.93%	Increase	Increase
22 (Annually)	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175] (%)	62.36	63.37	1.01	1.62%	Increase	Increase
Milestone 2. Use of Evidence-based, SUD-specific Patient Placement Criteria							
5 (Annually)	Medicaid Beneficiaries Treated in an IMD for SUD (Number of beneficiaries)	18148	17608	-540	-3.0%	Increase	Decrease
36 (Annually)	Average Length of Stay in IMDs (Days)	14.55	14.14	-0.41	-2.8%	Stay Consistent	Stay Consistent
Milestone 4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD							
13 (Annually)	SUD Provider Availability (Number of providers)	19128	19576	448	2.34%	Increase	Increase
14	SUD Provider Availability - MAT	1651	2265	614	37.19%	Increase	Increase

(Annually)	(Number of providers)						
Milestone 5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD							
18 (Annually)	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set] (%)	48.11	40.90	-7.20	-14.98%	Decrease	Decrease
21 (Annually)	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA] (%)	21.95	19.76	-2.19	-9.95%	Decrease	Decrease
23 (Monthly)	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries (Rate)	4.09	2.78	-1.30	-31.92%	Decrease	Decrease
27 (Annually)	Overdose Deaths (Rate)	0.53	0.44	-0.09	-17.76%	Decrease	Decrease
Milestone 6. Improved Care Coordination and Transitions between Levels of Care							
15 (Annually)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure] (%)						
	•Initiation of AOD Treatment - Alcohol abuse or dependence	35.34	37.13	1.78	5.05%	Increase	Increase
	• Initiation of AOD Treatment - Opioid abuse or dependence	32.30	53.17	20.86	64.59%	Increase	Increase
	• Initiation of AOD Treatment - Other drug abuse or dependence	50.04	34.61	-15.44	-30.85%	Increase	Decrease
	• Initiation of AOD Treatment - Total AOD abuse of dependence	31.13	38.71	7.58	24.36%	Increase	Increase
	• Engagement of AOD Treatment - Alcohol abuse or dependence	12.16	8.30	-3.85	-31.69%	Increase	Decrease
	• Engagement of AOD Treatment - Opioid abuse or dependence	8.53	27.26	18.74	219.81%	Increase	Increase
	•Engagement of AOD Treatment - Other drug abuse or dependence	28.34	6.42	-21.92	-77.36%	Increase	Decrease

	• Engagement of AOD Treatment - Total AOD abuse of dependence	6.70	11.25	4.54	67.81%	Increase	Increase
17(1) (Annually)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure] (%)						
	• Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).	22.60	20.73	-1.87	-8.29%	Increase	Decrease
	• Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	13.43	12.53	-0.90	-6.72%	Increase	Decrease
17(2) (Annually)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]						
	• Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	51.96	52.47	0.51	0.99%	Increase	Increase
	• Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	36.32	37.94	1.62	4.47%	Increase	Increase
25 (Annually)	Readmissions Among Beneficiaries with SUD (Rate)	0.20	0.21	0.00	0.85%	Decrease	Stay Consistent
Assessment of need and qualification for SUD treatment services							
3 (Monthly)	Medicaid Beneficiaries with SUD Diagnosis (Number of beneficiaries)	128622	141821	13200	10.26%	Increase	Increase
4 (Annually)	Medicaid Beneficiaries with SUD Diagnosis (Number of beneficiaries)	199573	205012	5439	2.73%	Increase	Increase
Other SUD-related metrics							

24 (Monthly)	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries (Rate)	1.54	1.12	-0.42	-27.45%	Decrease	Decrease
26 (Annually)	Overdose Deaths (Count)	1520	1291	-229	-15.07%	Decrease	Decrease
32 (Annually)	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP) [Adjusted HEDIS measure] (%)	86.01	81.98	-4.03	-4.68%	Increase	Decrease

1. Baseline from 10/1/2019 through 9/30/2020 for annual metrics and 10/1/2019-12/31/2019 for monthly metrics
2. Mid-point from 10/1/2020 through 9/30/2021 for annual metrics and 01/1/2022-3/31/2022 for monthly metrics

Assessment of overall risk of not meeting milestones

Summary of Progress, Potential Risks, and Recommendations for the Future

In this final section, the UM IHPI evaluation team presents a high-level summary of the state's progress to date, potential risks and corresponding risk level for not achieving the demonstration project goals, and recommendations for MDHHS as it continues for the remainder of the waiver demonstration period. The presentation of this information is organized around the six milestones.

Milestone 1. Access to Critical Levels of Care for OUD and other SUDs

Summary of Progress:

- The state maintains a structure for establishing expectations of the ten PIHPs around access to critical levels of SUD care and a structure for verifying compliance.
- The state's expansion of telehealth alleviated some access barriers during the COVID-19 public health emergency.
- The number of beneficiaries receiving outpatient, residential/inpatient, and MAT services has rebounded to pre-COVID levels or greater.
- Most PIHPs report at least one contracted provider at each level of care.

Potential Risks:

- The development of the SUD residential bed registry is significantly delayed, and it is unclear whether there is adequate interaction and cooperation between MDHHS and LARA to develop and fully implement a registry that meets the needs of PIHPs and SUD providers.
- The number of beneficiaries receiving IOP, partial hospitalization and withdrawal management has not fully rebounded since the start of the COVID PHE.
- Transportation is a substantial barrier to accessing SUD services, exacerbated by uneven availability of higher levels of care across PIHPs and by Medicaid policies that limit beneficiaries from receiving non-emergency transportation assistance for most SUD services.
- Providers and beneficiaries cited delays in appointments for services as a substantial problem, but state plans do not articulate strategies to monitor this issue nor a threshold for action.

Risk Level for Not Achieving the Demonstration Project Goals: Medium

Recommendations to MDHHS:

- MDHHS is encouraged to develop specific Action Items with target dates to achieve this milestone outlining key steps to achieve access to critical levels of OUD/SUD care.
- MDHHS is encouraged to articulate their process to assess beneficiary access to SUD services from a state-level perspective, to identify a threshold for inadequate access that would prompt state-level action, and potential strategies to be deployed to address inadequate access.
- MDHHS is encouraged to enact policy changes to ensure beneficiaries have equitable transportation assistance for SUD treatment services and to minimize the transportation burden for SUD treatment and recovery (e.g., policies related mobile MAT units, MAT telehealth, take-home doses, and drug testing requirements).
- MDHHS is encouraged to outline a plan for interagency cooperation related to the residential bed registry.

Milestone 2. Use of Evidence-based, SUD-specific Patient Placement Criteria

Summary of Progress:

- The state adopted and fully implemented the ASAM Continuum as the standard assessment tool for adults, with the GAIN-I identified as the standard tool for youth.
- The state facilitated training of SUD providers on the ASAM Continuum assessment tool.

Potential Risks:

- The state's plan for formal audits to assess ASAM Continuum compliance is unclear.
- The ASAM Continuum does not include all assessment components required by some PIHPs and certain accrediting organizations, forcing providers to develop workarounds.
- The ASAM Continuum tool is not fully integrated with practice EMRs and other systems, creating a burden of duplicate recordkeeping.

Risk Level for Not Achieving the Demonstration Project Goals: Low

Recommendations to MDHHS:

- MDHHS is encouraged to develop specific Action Items with target dates to achieve this milestone, including specific plans for audits to assess fidelity to the ASAM Continuum in assessments and placement decisions.
- MDHHS is encouraged to facilitate the identification and/or development of a comprehensive tool that incorporates the ASAM Continuum assessment as well as other required assessment components.
- MDHHS is encouraged to address health IT barriers to systems integration of the ASAM Continuum through targeted funding, technical assistance, or other mechanisms.

Milestone 3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Summary of Progress:

- The state maintains a structure for documenting SUD provider qualifications, with both PIHP and state-level review and designation of appropriate levels of care.
- The new online CRM system is operational and in use by eight of ten PIHPs.

Potential Risks:

- Certain state requirements appear to exceed nationally recognized standards, which creates unnecessary staffing challenges and increased costs.

Risk Level for Not Achieving the Demonstration Project Goals: Low

Recommendations to MDHHS:

- MDHHS is encouraged to develop specific Action Items with target dates to sustain this milestone.
- MDHHS is encouraged to maintain a log to track actions toward achieving potential and/or proposed regulatory changes to better align regulations with national standards.

Milestone 4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Summary of Progress:

- The state established the expectation that all SUD providers will offer MAT as clinically appropriate, either directly or through an arrangement with another provider.
- The number of MAT providers, and the number offering multiple types of MAT, has increased substantially since the start of the demonstration period.
- For most levels of care, PIHPs have increased the number of contracted SUD providers since the start of the demonstration period.
- The state expanded reimbursement for OUD/SUD treatment in primary care and other office-based settings through the physical health benefit; this offers additional provider capacity outside of the PIHP system.

Potential Risks:

- Some PIHPs have difficulty maintaining sufficient provider capacity due to low reimbursement levels, challenges hiring and retaining clinicians, and administrative barriers that deter participation in the public SUD system. Still, most PIHPs do not contract with all eligible and willing SUD providers.
- The state's process to identify, track, and address insufficient provider capacity is unclear.
- Few details are known about the process and timing of MAT availability for SUD providers that facilitate MAT though an arrangement with an outside provider, or if all provider sites allow beneficiaries to use MAT while in their care.
- Primary care providers may not have sufficient clinical expertise, technical support, and other resources to be equipped to offer MAT and other SUD services using best practices.

Risk Level for Not Achieving the Demonstration Project Goals: Medium

Recommendations to MDHHS:

- MDHHS is encouraged to develop specific Action Items with target dates to achieve this milestone.
- MDHHS is encouraged to articulate a process to assess SUD provider capacity from the state-level perspective, to identify a threshold of insufficient SUD provider capacity that would prompt state-level action, and to describe potential strategies to address insufficient capacity (e.g., directives for PIHPs to open provider networks). This should include both the SUD system of care and the expansion of SUD services through the physical health benefit.
- MDHHS is encouraged to develop a process to assess whether all provider sites are allowing patients to use MAT while in their care. This should include providers offering SUD services through the physical health benefit.
- MDHHS is encouraged to expand cooperation between MHPs and PIHPs to ensure that primary care providers have options for training and technical support.
- MDHHS is encouraged to develop joint information systems to ensure that frontline staff at both MHPs and PIHPs are able to direct beneficiaries to providers who offer SUD services.

Milestone 5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Summary of Progress:

- The number of providers using the PDMP has increased substantially.
- The rate of problem opioid use among Medicaid beneficiaries is decreasing.

- All PIHPs have extensive plans to provide comprehensive prevention, treatment and recovery services.

Potential Risks:

- Trends in initiation and engagement suggest that beneficiaries with non-opioid SUD may have less treatment access or options.

Risk Level for Not Achieving the Demonstration Project Goals: Low

Recommendations to MDHHS:

- MDHHS is encouraged to develop specific Action Items with target dates to ensure continued progress related to this milestone.
- MDHHS is encouraged to consider how to leverage OUD funding and policies to facilitate access to comprehensive treatment for all beneficiaries with SUD.

Milestone 6. Improved Care Coordination and Transitions between Levels of Care

Summary of Progress:

- Opioid Health Homes are well received by primary care, SUD, and behavioral health providers, as well as beneficiaries, warranting their continued expansion into additional regions.
- The number of providers using the PDMP has increased substantially.
- Expanded health IT options are supporting new care coordination initiatives for PIHPs and for joint MHP/PIHP efforts.
- Rates of treatment initiation and engagement for beneficiaries with OUD have increased.

Potential Risks:

- The planned e-consent management system is substantially delayed.
- State policies limit the hiring and funding of peer recovery coaches.
- Transitions between SUD providers may be overlooked; less than half of beneficiaries receive follow-up SUD services after discharge from residential SUD treatment.

Risk Level for Not Achieving the Demonstration Project Goals: Medium

Recommendations to MDHHS:

- MDHHS is encouraged to develop specific Action Items with target dates to ensure continued progress related to this milestone, particularly for delayed health IT initiatives.
- MDHHS is encouraged to consider additional strategies to support beneficiary engagement with treatment across levels of care.
- MDHHS is encouraged to continue to implement strategies to address barriers to hiring and funding peer recovery coaches.
- MDHHS is encouraged to expand cooperation between MHPs and PIHPs to facilitate systems to coordinate and transition care across systems.

Table of Mid-Point Assessment Findings				
Milestone	**% of fully completed action Items**	**% of Monitoring Metrics going in target direction by Monthly and Annually reported metrics (# metrics/total)**	**Key themes from stakeholder feedback**	**Risk level**
Milestone 1. Access to Critical Levels of Care for OUD and other SUDs	N/A	57% Monthly (4/7) 100% Annually (1/1)	1. Transportation is a common barrier to accessing SUD services. 2. Provider capacity and process barriers contribute to extended wait times for assessment and treatment initiation. 3. Expansion of telehealth facilitated access to SUD services during the COVID PHE.	Medium
Recommendations for Potential Modifications to Implementation Plan or Monitoring Protocol	1. MDHHS is encouraged to develop specific Action Items with target dates to achieve this milestone outlining key steps to achieve access to critical levels of OUD/SUD care. 2. MDHHS is encouraged to articulate their process to assess beneficiary access to SUD services from a state-level perspective, to identify a threshold for inadequate access that would prompt state-level action, and potential strategies to be deployed to address inadequate access. 3. MDHHS is encouraged to enact policy changes to ensure beneficiaries have equitable transportation assistance for SUD treatment services and to minimize the transportation burden for SUD treatment and recovery (e.g., policies- related mobile MAT units, MAT telehealth, take-home doses, and drug testing requirements). 4. MDHHS is encouraged to outline a plan for interagency cooperation related to the residential bed registry.			
Milestone 2. Use of Evidence-based, SUD-specific Patient Placement Criteria	N/A	50% Annually (1/2)	1. Implementation of ASAM Continuum has occurred in all PIHP regions. 2. The ASAM Continuum does not include all assessment components required by some PIHPs and accrediting organizations 3. The ASAM Continuum tool is not fully integrated with practice EMRs and other systems, creating a burden of duplicate recordkeeping	Low

Recommendations for Potential Modifications to Implementation Plan	1. MDHHS is encouraged to develop specific Action Items with target dates to achieve this milestone, including specific plans for audits to assess fidelity to the ASAM Continuum in assessments and placement decisions.			
	2. MDHHS is encouraged to facilitate the identification and/or development of a comprehensive tool that incorporates the ASAM Continuum assessment as well as other required assessment components.			
	3. MDHHS is encouraged to address health IT barriers to systems integration of the ASAM Continuum through targeted funding, technical assistance, or other mechanisms.			
Milestone 3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	N/A	N/A	1. Certain state requirements appear to exceed nationally recognized standards, which creates unnecessary staffing challenges and increased costs.	Low
Recommendations for Potential Modifications to Implementation Plan	1. MDHHS is encouraged to develop specific Action Items with target dates to sustain this milestone.			
	2. MDHHS is encouraged to maintain a log to track actions toward achieving potential and/or proposed regulatory changes to better align regulations with national standards.			
Milestone 4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD	N/A	100% Annually (2/2)	1. PIHPs report difficulty maintaining sufficient provider capacity.	Medium
			2. Some SUD providers report some capacity to expand to additional regions and/or levels of care.	
			3. There is a question of whether all providers allow beneficiaries to use MAT while in their care.	
			4. Primary care providers offering SUD services through the physical health benefit may need SUD clinical expertise and technical support.	
Recommendations for Potential Modifications to Implementation Plan	1. MDHHS is encouraged to develop specific Action Items with target dates to achieve this milestone.			
	2. MDHHS is encouraged to articulate a process to assess SUD provider capacity from the state-level perspective, to identify a threshold of insufficient SUD provider capacity that would prompt state-level action, and to describe potential strategies to address insufficient capacity.			
	3. MDHHS is encouraged to develop a process to assess whether all provider sites are allowing patients to use MAT while in their care.			

	4. MDHHS is encouraged to expand cooperation between MHPs and PIHPs to ensure that primary care providers have options for training and technical support.			
	5. MDHHS is encouraged to develop joint information systems to ensure that frontline staff at both MHPs and PIHPs are able to direct beneficiaries to providers who offer SUD services.			
Milestone 5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	N/A	100% Monthly (1/1) 100% Annually (3/3)	1. Beneficiaries and providers report broader treatment availability for OUD compared to other SUDs.	Low
Recommendations for Potential Modifications to Implementation Plan	1. MDHHS is encouraged to develop specific Action Items with target dates to ensure continued progress related to this milestone.			
	2. MDHHS is encouraged to consider how to leverage OUD funding and policies to facilitate access to comprehensive treatment for all beneficiaries with SUD.			
Milestone 6. Improved Care Coordination and Transitions between Levels of Care	N/A	54% Annually (7/13)	1. Opioid Health Homes providers have developed relationships with providers in other settings and have expanded their deployment of peer recovery coaches.	Medium
			2. Policies limit the options to hire, deploy and fund peer recovery coaches.	
			3. Inadequate progress on health IT initiatives impedes care coordination.	
Recommendations for Potential Modifications to Implementation Plan	1. MDHHS is encouraged to develop specific Action Items with target dates to ensure continued progress related to this milestone, particularly for delayed health IT initiatives.			
	2. MDHHS is encouraged to consider additional strategies to support beneficiary engagement with treatment across levels of care.			
	3. MDHHS is encouraged to continue to implement strategies to address barriers to hiring and funding peer recovery coaches.			
	4. MDHHS is encouraged to expand cooperation between MHPs and PIHPs to facilitate systems to coordinate and transition care across systems			

Assessment of state's capacity to provide SUD services

Overall, SUD provider capacity appears to be adequate in most parts of the state at most levels of care, but there are important caveats that limit the evaluation team's ability to determine the overall adequacy.

Some aspects of inadequate SUD provider capacity are well documented. PIHPs maintain details of changes that affect their provider networks (e.g., expanded locations, site closures, license suspensions). Specific PIHPs acknowledge challenges with lack of providers for residential care and for withdrawal management services; to some extent this is borne out in utilization patterns. Some PIHPs, particularly those with substantial rural areas, note that contracted providers are not accessible throughout the region; this is echoed in beneficiary feedback around transportation challenges.

Several key elements of state oversight of provider capacity are unclear. The CRM database is helpful in documenting approval for providers to offer services at designated levels of care. It is less useful in describing current provider capacity at any given time. Questions related to state-level assessment of provider capacity include:

- Whether and how state officials assess provider capacity relative to beneficiary access to services
- Whether and how state officials have a threshold and process to intervene in situations with inadequate capacity and/or access
- Whether and how state officials plan to incorporate into their capacity assessment any information about providers offering services under the physical health benefit

These questions should be clarified in the final years of the demonstration project.

Next Steps

Medium Risk Activities identified

Milestone 1. Access to Critical Levels of Care for OUD and SUDs

MDHHS moving forward will identify action items and target dates that provide details related to Milestone 1 to achieve access to critical levels of OUD/SUD care.

MDHHS has contracts and policies that PIHPs must follow to be in compliance with state requirements, and these contractual requirements are passed down to provider agencies that contract with the PIHPs. MDHHS plans to produce a comprehensive plan that will address the need to identify a threshold to ensure adequate access for all SUD beneficiaries.

MDHHS understands the challenges around transportation in our rural areas. Transportation is a benefit that can be utilized by all Medicaid beneficiaries. MDHHS has continued to give guidance to providers and beneficiaries on how to access transportation resources. MDHHS will continue to provide guidance moving forward. MDHHS has also encouraged PIHPs to use grant funds to assist with transportation burdens on the SUD population and has convened a workgroup to address the process for getting transportation arranged through a beneficiaries Medicaid benefit.

MDHHS has an agreement with the Licensing and Regulatory Affairs (LARA) department, with the intention that the bed registry will be integrated into the Michigan Crisis and Access Line (MiCAL) that MDHHS has developed. LARA retains sole contractual responsibility for the residential bed registry with oversight of project timelines and workplans. MDHHS continues to work on the partnership around the residential bed registry as appropriate.

Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

MDHHS moving forward will identify action items and target dates that provide detail related to Milestone 2 to achieve fidelity across the ASAM Continuum assessment and placement decisions. MDHHS has worked with PIHP Electronic Health Records (EHR) to incorporate the ASAM Continuum tool into EHRs for provider accessibility. Providers have been using the ASAM Continuum tool for over a year and the state has seen positive feedback from providers. The state continues to receive reports identifying the number of assessments completed by provider site and level of care determination. The state has been sharing this information within the 1115 Narrative report.

Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

MDHHS continues to review applications from all contracted treatment providers every other year to ensure they are offering services appropriate to the ASAM Level of Care they have been offering. MDHHS offers training on the ASAM Criteria regularly to the provider agencies and PIHPs to ensure an understanding of the Levels of Care, what it means to offer services specific to a level of care and how services would differ from level to level. MDHHS moving forward will identify action items and target dates that provide detail related to Milestone 3 to ensure MI continues to affirm provider qualifications for residential treatment facilities.

MDHHS ensures all PIHPs are aware of any policy changes or updates, and information is posted on the state website. The state also maintains a website pertaining to any specific Medicaid policy changes or updates. All policy updates or changes are announced in the monthly PIHP meeting and SUD Directors meetings facilitated by the state. The state maintains open communication to PIHPs, and providers pertaining to any changes and offers PIHP and provider feedback per state law.

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD

MDHHS moving forward will identify action items and target dates that provide detail related to Milestone 4 to ensure MI continues to have sufficient provider capacity at critical levels of Care. MDHHS has contracts and policies that PIHPs must follow to be in compliance with federal and state guidance. MDHHS continues to review required Priority Population Reports and 90 Percent Capacity Reports related to persons who inject drugs and reaches out to PIHPs as needed to offer technical assistance and support if a region indicates they are out of compliance with federal requirements. MDHHS plans to produce a comprehensive plan that will address the need to identify a threshold to ensure adequate access for all SUD beneficiaries.

MDHHS has reviewed the states network adequacy and created a report. This report FY22 Network Adequacy Supplemental Data Request will be shared in the state's final evaluation.

MDHHS holds site visits with PIHPs and ensures the PIHPs and providers are following all requirements ensuring beneficiaries can receive MAT in the providers care or the provider must ensure care coordination is in place that allows the beneficiary to continue to receive treatment.

MDHHS has put in place many avenues for MHPs and PIHPs to have access to trainings and technical support. The SOR grants allowed for MHPs and PIHPs to go through provider and care coordination trainings, ensuring the best care for the state's beneficiaries. MHPs and PIHPs have access to the states CC360 database that houses beneficiaries' behavioral health information. MHPs and PIHPs have access to shared care plans and are able to review shared beneficiaries' information. Each PIHP has a 24-hour access line that is able to direct beneficiaries and administration to care in their area. The state has also implemented MiCAL that has been an integral piece in assisted in patient care and placement.

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

MDHHS moving forward will identify action items and target dates that provide detail related to Milestone 5 to continue MI comprehensive treatment and prevention strategies addressing Opioid Abuse and OUD. MDHHS has developed a strategic plan to address the Opioid Epidemic and this work happens through multiple divisions across the department and other state departments.

MDHHS continues to ensure all funding is appropriate to its funding stream based on the guidelines given. MDHHS has been reviewing statewide metrics and ensuring the state is aware of new and developing SUD increases. Through other funding from the CDC a dashboard (Data (michigan.gov)) has been created to monitor metrics across the state and the State Epidemiological Outcomes Workgroup also reviews metrics and reports on outcomes across the state. MDHHS stratifies information based on a multitude of metrics including but not limited to diagnoses, race, age, gender, geographic location, and has recently developed a Substance Use Vulnerability Index allowing counties to assess their vulnerabilities related to SUD issues that will be available on the website soon. MDHHS has implemented Opioid Health Homes throughout the state that focus on OUD beneficiaries but look at the whole person by assessing a beneficiary's complete health and social needs.

Milestone 6: Improved Care Coordination and Transitions between Levels of Care

MDHHS moving forward will identify action items and target dates that provide detail related to Milestone 6 to continue to improve care coordination and transition levels of Care.

MDHHS has emphasized the importance of Care Coordination and transitions within the behavioral health system. The state has implemented Health Homes and CCBHCs. The state has implemented trainings assisting providers in how to coordinate with not only behavioral health but physical health as well to ensure the beneficiary receives appropriate care and support in their recovery. MDHHS has required each PIHP to hire a Priority Population Care Coordinator this fiscal year, and that position will work with vulnerable populations to ensure their connections to appropriate services within established time requirements.

MDHHS has updated new policies that allow for Peer Recovery Coaches to be reimbursed through Medicaid funding. This has allowed more options for facilities to reimburse Peer Recovery Coaches and has allowed peers to work in a multitude of settings. MDHHS grants help support Peer Recovery Coach training. For individuals in recovery who have not been certified through MDHHS, grant funds are able to support their services through provider agencies.