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April 1, 2024

The Honorable Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Becerra:

On behalf of the State of Michigan, I am pleased to submit the State's §1115 Behavioral Health Demonstration Extension Application (Project No. 11-W-00305/5). Michigan's §1115 Demonstration was approved in April 2019 and permitted the Michigan Department of Health and Human Services to provide a broader substance use disorders (SUD) continuum of care service, including the crucial component of residential SUD services for withdrawal management services in treatment facilities that meet the definition of an institution for mental disease.

While preliminary findings of the impact of the demonstration are encouraging in several key areas, the COVID-19 public health emergency (PHE) had a substantial impact on implementation. The PHE made it difficult to detect some trends in administrative measures and implementation of some demonstration activities was delayed due to the PHE, such that the available data does not represent post-implementation outcomes. Michigan seeks to extend the demonstration period to further advance and study progress toward meeting demonstration goals and proposes to implement a new initiative, Contingency Management, to further efforts in addressing SUD.
The State looks forward to its ongoing work with federal partners at the Centers for Medicare & Medicaid Services (CMS) to ensure people living with SUD's continue to have access to a full continuum of SUD treatment and recovery supports that improves health outcomes and sustained recovery.

[redacted]

Governor

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# Section 1115 Demonstration Extension Application Request

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

Submission Date:
4/1/2024

State of Michigan
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# I. PROGRAM DESCRIPTION

## Summary

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

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

## Background

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

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

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

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

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

### Contingency Management

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

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

### Growing SUD Crisis and Disparities in Outcomes

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

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

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

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

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

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

### Need for Contingency Management

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

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

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[6] SUDORS Dashboard: Fatal Overdose Data | Drug Overdose | CDC Injury Center
[7] Ibid.
[8] MDHHS Data (2018-2022)
[9] Dutra, L., Stathopoulou, G., Basden, S. L., Leyro, T. M., Powers, M. B., & Otto, M. W. C. I. N. (2008). A meta-analytic review of psychosocial interventions for substance use disorders. Am J Psychiatry, 165(2), 179–187. doi:10.1176/appi.ajp.2007.06111851
[10] Peirce, J. M., Petry, N. M., Stitzer, M. L., et al. (2006). Effects of lower-cost incentives on stimulant abstinence in methadone maintenance treatment: A National Drug Abuse Treatment Clinical Trials Network study. Arch Gen Psychiatry, 63(2), 201–208.
[11] Petry, N. M., Peirce, J. M., Stitzer, M. L., et al. (2005). Effect of prize-based incentives on outcomes in stimulant abusers in outpatient psychosocial treatment programs: A National Drug Abuse Treatment Clinical Trials Network study. Arch Gen Psychiatry, 62(10), 1148–1156.
[12] Roll, J. M. (2007). Contingency management: An evidence-based component of methamphetamine use disorder treatments. Addiction, 102(Suppl 1), 114–120.
[13] Bolívar, H. A., Klemperer, E. M., Coleman, S. R. M., DeSarno, M., Skelly, J. M., & Higgins, S. T. (2021). Contingency management for patients receiving medication for opioid use disorder: A systematic review and meta-analysis. JAMA Psychiatry. Published online 2021. doi:10.1001/jamapsychiatry.2021.1969
[14] Ronsley, C, Nolan S, Knight R, Hayashi K, Klimas J, Walley A, et al., 2020. Treatment of stimulant use disorder: A systematic review of reviews. PLoS ONE 15(6): https://doi.org/10.1371/journal.pone.0234809.
[15] Bolívar, H. A., Klemperer, E. M., Coleman, S. R. M., DeSarno, M., Skelly, J. M., & Higgins, S. T. (2021). Contingency management for patients receiving medication for opioid use disorder: A systematic review and meta-analysis. JAMA Psychiatry. Published online 2021. doi:10.1001/jamapsychiatry.2021.1969.

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

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

## Demonstration Goals and Objectives

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

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

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

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

## Contingency Management

Through the RI Pilot, MDHHS seeks to offer CM services to improve treatment and outcomes for people living with SUDs, including StimUD and/or OUD. By deploying CM, MDHHS believes it can improve outcomes by supporting beneficiaries in meeting treatment goals and making the behavior changes that drive recovery. Further, the RI Pilot aims to address health disparities by increasing access to evidence-based SUD treatment for certain SUDs – StimUD and OUD – that disproportionately impact people of color.[18]

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

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

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

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

Like other states that have pursued CM, a key goal of the state's is to fill the gap in treatment services that otherwise exists for beneficiaries living with StimUD.[19,20,21] In addition, MDHHS intends to provide CM services to beneficiaries living with OUD, reflecting the need for more tools in addition to MAT. Under no circumstances will CM services be used to replace, diminish, limit, or otherwise restrict access to and support for MAT. To the contrary, MDHHS intends to deploy CM in such a way that it will encourage greater use of MAT.

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

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

## Progress Toward Demonstration Goals and Milestones

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

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

Prior to implementation of the demonstration, Michigan provided coverage for all ASAM LOC. During the initial demonstration term, the state focused efforts on ensuring a strong SUD provider network to ensure sufficient access and service delivery consistent with ASAM criteria and evidence-based practices. MDHHS established PIHP network adequacy standards for SUD/OUD provider types and PIHPs were required to submit plans on how standards would be effectuated by region. Additionally, telehealth was expanded during the PHE. MDHHS also enacted a new policy in August 2021 to update and expand reimbursement for office-based treatment for alcohol use disorder and OUD.

As illustrated in Table 1, the overall number of qualified SUD providers increased slightly from FY2020 to FY2022, but the rate per beneficiaries overall and among those with an SUD

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

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

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

diagnosis has decreased. This trend is likely related to the expanded Medicaid enrollment during the COVID-19 PHE. Additionally, the number of SUD providers contracting with at least one PIHP increased from FY2020 to FY2022 at every LOC except withdrawal management.

*Table 1. Qualified SUD Providers by Fiscal Year*

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

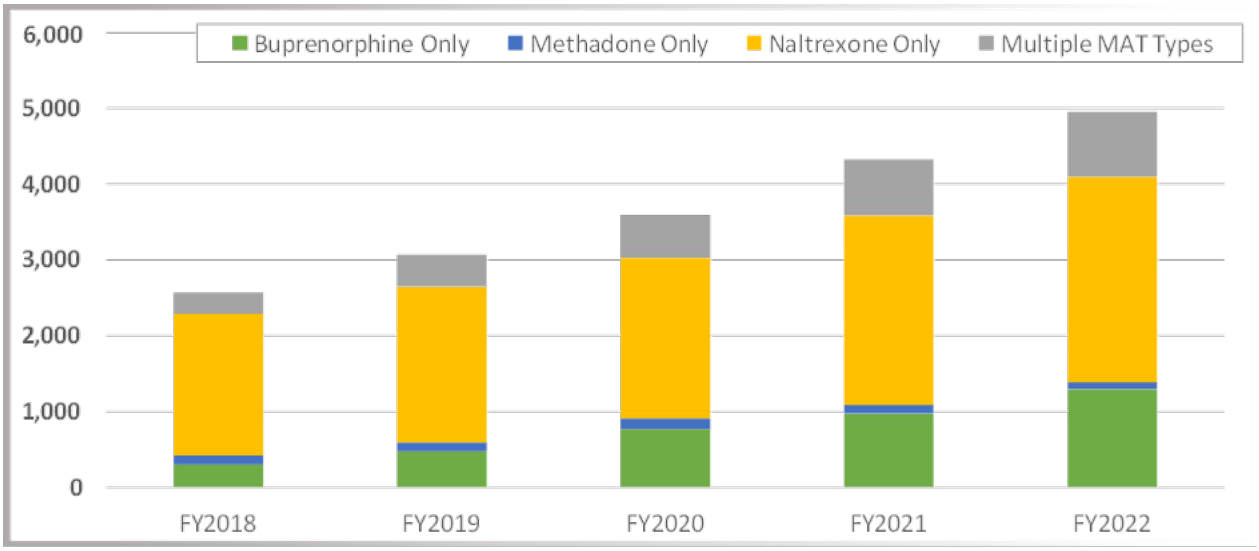
Regulatory changes were implemented in June 2023 to reduce provider burdens and as a strategy to increase access. For example, the requirement to obtain an SUD Service Program MAT License for the provision of buprenorphine or naltrexone for the treatment of OUD was removed. The number of MAT providers,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

*Table 2. MAT Providers by Fiscal Year*

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

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

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




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

### *Milestone 2. Use of ASAM Placement Criteria*

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

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

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

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

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

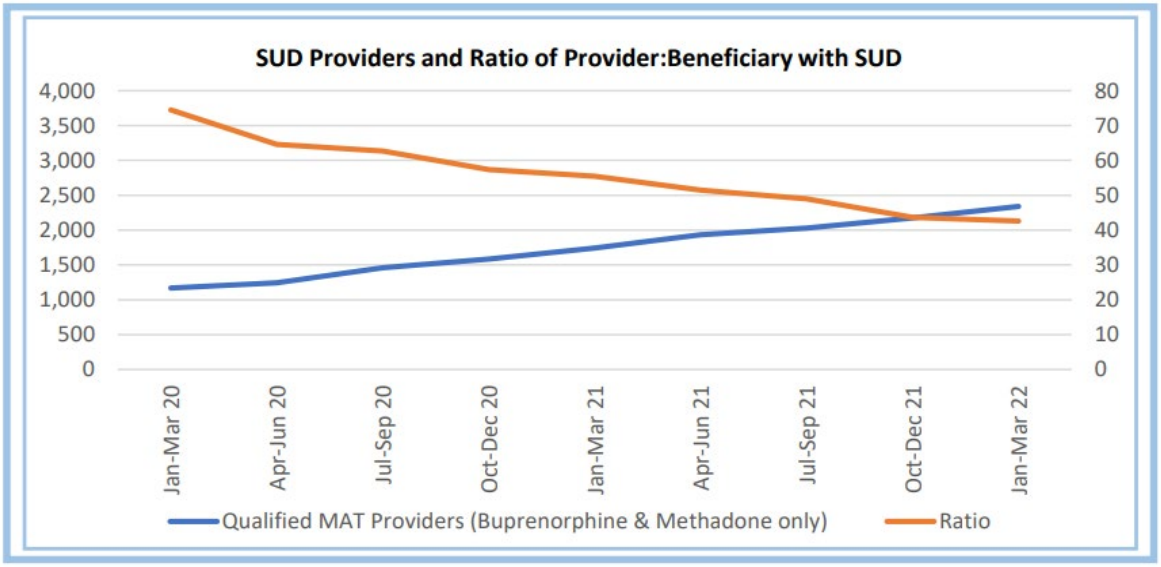
level clinicians will not be required to also receive the Certified Advanced Alcohol and Drug Counselor (CAADC) credential. Additionally, during the extension term, MDHHS will be evaluating what changes may be required to align with implementation of the fourth edition of the ASAM Criteria.

### *Milestone 4. Provider Capacity of SUD Treatment Including MAT*

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

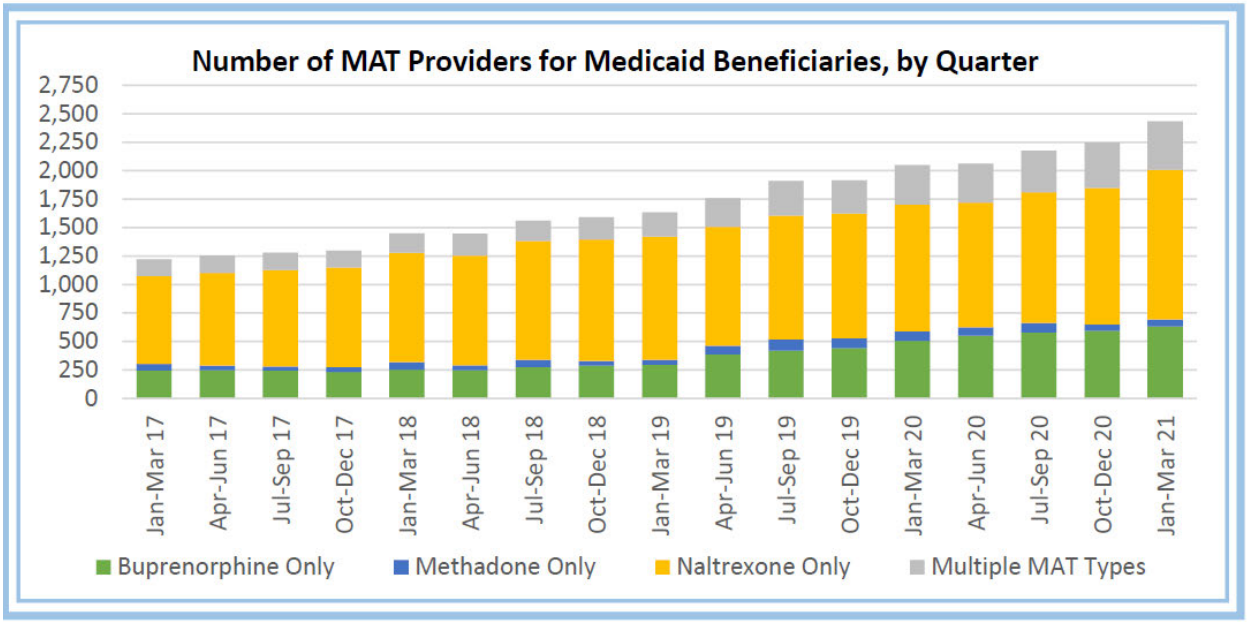
The state also saw a steady increase in the number of providers enrolled in Medicaid and qualified to provide buprenorphine or methadone during the demonstration period. This increased number of MAT providers was associated with a sizable decrease in the ratio of MAT providers to Medicaid beneficiaries,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

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




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

*Figure 3. Number of MAT Providers By Type By Quarter*




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

### *Milestone 5. Implementation of OUD Comprehensive Treatment and Prevention Strategies*

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

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

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

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

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

### Milestone 6. Improved Care Coordination and Transition Between LOCs

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

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

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

## Quality Assurance Monitoring

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

## External Quality Review

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

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

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

*Table 3. SFY 2021 and 2022 Statewide Performance Measure Rates*

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

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

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

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

## Non-EQR Reporting and Initiatives

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

### Timely Follow-Up Care After Substance Use Detox Discharge

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

### PIHP Performance Bonus Incentive Program

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

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

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

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

## Evaluation

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

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

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

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

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

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

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

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

### Coordination of care across settings

Administrative data demonstrated a slight increase in follow-up after ED visits for SUD. Key informants suggested that state health IT initiatives to facilitate care coordination have had limited impact, while beneficiaries indicated room for improvement in facilitating transitions in

care. Additional years of data are needed to determine whether the demonstration improved care coordination.

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

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

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

### Overall impact on health and health services utilization

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

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

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

### Cost

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

## Evaluation During the Extension Period

MDHHS does not propose any changes to the currently approved evaluation design for the IMD portion of the demonstration. Continuation of the current plan will permit additional study of outcomes over an extended period. Table 4 outlines the hypotheses, research questions and analytic approach that will continue to be studied during the extension.

*Table 4: IMD Waiver Evaluation Components*

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

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

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

### Contingency Management

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

*Table 5. Contingency Management Evaluation Hypotheses Under Consideration*

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

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

## II. DEMONSTRATION ELIGIBILITY

### Eligibility

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

### Contingency Management

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

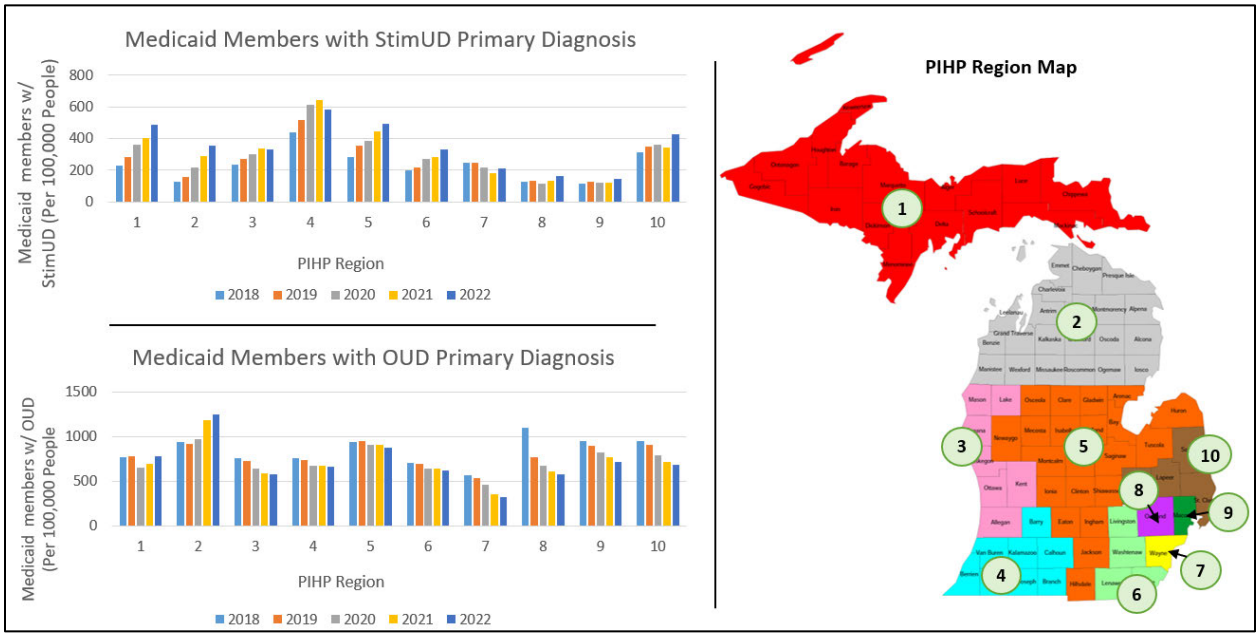
- Diagnosed with a StimUD and/or OUD for which the CM benefit is medically appropriate. The presence of additional SUD and/or diagnoses will not disqualify an individual from receiving the CM benefit.

- Enrolled in a PIHP that elects and is approved by MDHHS to provide the CM benefit.
- Receive services from a non-residential provider that offers the CM benefit in accordance with MDHHS policies and procedures.

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

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

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




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

### Enrollment

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

## III. DEMONSTRATION BENEFITS AND COST SHARING REQUIREMENTS

### Benefits

Michigan Medicaid enrollees will continue to have access to a comprehensive package of evidence-based OUD/SUD treatment and withdrawal management services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in

cost-effective community-based settings. The state will continue to provide the benefits outlined in Table 6 over the course of the demonstration extension term.

*Table 6: Demonstration Benefits*

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

### Contingency Management

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

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

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

- A “recovery” of the pre-reset value will occur after two consecutive stimulant/opioid-negative UDTs.

### Cost Sharing

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

## IV. DELIVERY SYSTEM

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

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

### Contingency Management

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

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

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

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

## V. IMPLEMENTATION OF THE DEMONSTRATION

### Contingency Management

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

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

## VI. DEMONSTRATION FINANCING AND BUDGET NEUTRALITY

Michigan has estimated projected spending for the five-year Demonstration renewal period. The state's budget neutrality model is included in Attachment 2 of this application.

## VII. WAIVER AND EXPENDITURE AUTHORITIES

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

### Waiver Authorities

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

*Table 7. Waiver Requests*

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

### Expenditure Authorities

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

*Table 8. Expenditure Authority Requests*

| Expenditure Authority | Use for Expenditure Authority | Currently Approved Expenditure Authority? |
|---|---|---|
| **Expenditures related to CM pilot** | Expenditure authority to provide CM through small incentives via gift cards to beneficiaries living with qualifying StimUD and/or OUD. Authority is requested through September 30, 2026. | No |
| **Residential Treatment for Individuals with SUD** | Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD. | Yes |
| **PIHP Services** | Expenditures for all PIHP services, including case management and health education services that are not available to other Medicaid beneficiaries to the extent that not all services for categorically needy individuals will be equal in amount, duration, and scope. The state will ensure that all beneficiaries use a specific regional PIHP and will restrict disenrollment from them. The state is also granted the authority to restrict freedom of choice of provider for the demonstration eligible population. | Yes |

## VIII. PUBLIC NOTICE AND TRIBAL CONSULTATION

The state conducted public notice in accordance with 42 CFR § 431.408. The public had an opportunity to comment on the demonstration extension through the public notice and comment process which ran from February 20, 2024, through March 20, 2024. A summary notice was published in newspapers of widest circulation in cities with a population of 100k or more. A link to the full public notice is available in Attachment 3 – Public Notice. The public notice and all waiver documents were posted on the state's website and available in paper form at the Bureau of Specialty Behavioral Health Services. Outreach was also conducted via the state's

listservs to ensure appropriate stakeholder awareness. All notices provided the option for individuals to submit written feedback to the state by email or US postal service mail.

Finally, the state held two public hearings on February 28, 2024 (Medical Care Advisory Council that operates in accordance with 42 CFR § 431.12), and March 1, 2024 (open forum for interested parties to learn about the contents of the extension application, and to comment on its contents). Both provided telephonic and virtual access to ensure statewide accessibility.

### Summary of Public Comments

The state received two written comments during the course of the public comment period. Additionally, two individuals commented during the first public hearing; no comments were received during the second public hearing.

One comment during the first public hearing requested clarification on the proposed CM pilot, seeking understanding that the benefit would be dependent on the PIHP. The state confirmed that the benefit would be dependent upon enrollment in a PIHP participating in the pilot, of which eight PIHPs have expressed interest. The other commenter also sought clarification on the CM pilot. Specifically, they questioned whether the state would consider other substance use at some point, what providers are eligible, and whether engagement in treatment is also incentivized. The state clarified other types of substance use may be considered in a future phase of the pilot and clarified the scope of the incentives and eligible providers.

The first written comment was received by a provider that expressed support for the extension. The second comment was received by a PIHP, that expressed overall support, and made four recommendations. The first recommendation was for PIHPs versus the counties to provide non-emergency medical transportation (NEMT) for behavioral health and SUD, citing current inconsistencies and barriers. The second recommendation was to create a targeted case management program for individuals with SUD-only. The third recommendation was to expand the 1915(i) state plan to provide housing supports for individuals with SUD. The state appreciates these comments but has determined these expansions will not be made at this time. Finally, this commenter urged the state to apply for a Reentry Section 1115 Demonstration. The state plans to pursue this opportunity set forth in SMD# 23-003 via a separate application.

### Post-Award Forum

The most recent post-award forum, as required under the Special Terms and Conditions and 42 CFR § 431.420, was held on February 29, 2024, to allow the public an opportunity to comment on the progress of the demonstration. No comments were received.

### Tribal Notice

The state conducted tribal notice in accordance with the Michigan Medicaid State Plan and 42 CFR § 431.408(b). On February 5, 2024, notice was issued to tribal chairs and health directors for federally recognized tribes within the state. Please see the link in Attachment 5 – Tribal Notice for the full list of entities consulted. Additionally, the state offered to hold either group or individual consultation meetings to discuss this application, according to the tribes' preferences. The state did not receive any comments or requests for consultation meetings in response to the tribal notice.

## IX. DEMONSTRATION ADMINISTRATION

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Telephone Number: (517) 284-1190
Email Address: colemanj@michigan.gov

## ATTACHMENT 1 – INTERIM EVALUATION REPORT

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

# ATTACHMENT 2 – BUDGET NEUTRALITY

MILLIMAN CLIENT REPORT

# Michigan Behavioral Health 1115 Waiver Extension – Budget Neutrality

## State of Michigan, Department of Health and Human Services

## Project Number 11-W-00305/5

March 29, 2024


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Milliman


Milliman

# Contents

# I. Background

Milliman, Inc. (Milliman) was retained by the State of Michigan, Department of Health and Human Services (MDHHS) to complete the budget neutrality template (Template) that will accompany the Michigan 1115 Behavioral Health Demonstration Project Number 11-W-00305/5 renewal application (1115 Waiver application) for demonstration year (DY) 6 through DY 10, defined as October 1, 2024 through September 30, 2029. The Centers for Medicare and Medicaid Services (CMS) requires all 1115 Waivers to demonstrate budget neutrality.

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

**FIGURE 1: MEDICAID ELIGILITY GROUP DESCRIPTIONS**

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

This report documents the narrative for the *"Section 1115 Demonstration BN Template.xlsx"* Excel workbook, which illustrates budget neutrality in the form of financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the Demonstration as stipulated by 42 CFR 431.412 of the CMS Final Rule. Appendix 1 of this document also includes the results summarized in the Excel workbook.

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

# II. Budget Neutrality Narrative

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

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

Budget neutrality for this behavioral health 1115 waiver, which was developed using CMS budget neutrality requirements, will be demonstrated using the per capita method. Appendix 1 provides the completed 1115 Waiver Budget Neutrality Template worksheets (Template) for this extension.

Historical data and projected expenditures have been stratified as follows:

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

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

## A. Historical Data

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

## B. Without Waiver Projections for Historical Medicaid Populations

### i. DY 5 (SFY 2024)

#### a. DAB, TANF, HMP, HSW, SED, and CWP

The SFY 2024 (October 2023 through September 2024) capitation rates from the *State Fiscal Year 2024 Behavioral Health Capitation Rate Certification Amendment* (Amendment) dated March 28, 2024 have been used as the 1115 waiver application DY 5 PMPM costs. Please note that PMPM costs exclude the Hospital Reimbursement Adjustment (HRA) program, which is paid outside of the capitation rates based on actual hospital utilization that occurs during the year. Correspondingly, SFY 2024 eligible member months are equal to the member month projections in the Amendment.

#### b. SUD-IMD-DAB, SUD-IMP-HMP, and SUD-IMP-TANF

DY 5 PMPMs for the SUD-IMD-DAB, SUD-IMP-HMP, and SUD-IMP-TANF MEGs have been projected from SFY 2023 (DY 4) experience using simplified adjustments of 5% PMPM cost trend and no enrollment trend.

## ii. DY 6 (SFY 2025)

Figure 2 illustrates the projected SFY 2024 and SFY 2025 enrollment for each of the non-SUD MEGs as well as the estimated impact of known program changes and trend assumptions underlying the development of DY 6 (SFY 2025) PMPMs. Each of the program changes is described below.

**FIGURE 2: DY 6 (SFY 2025) DEVELOPMENT**

| MEDICAID POPULATIONS | DAB | TANF | HMP | HSW | CWP | SED |
|---|---|---|---|---|---|---|
| **SFY 2024** | | | | | | |
| Eligible Member Months | 6,104,134 | 15,747,129 | 9,659,262 | 88,068 | 6,467 | 6,264 |
| PMPM Cost | $ 382.89 | $ 36.02 | $ 44.55 | $ 7,128.12 | $ 3,316.80 | $ 1,964.28 |
| **SFY 2025** | | | | | | |
| Eligible Member Months | 5,908,946 | 14,645,524 | 8,281,280 | 90,938 | 7,029 | 6,264 |
| Enrollment Acuity | 1.5% | 2.9% | 5.4% | 0.0% | 0.0% | 0.0% |
| Annual Trend | 5.0% | 5.0% | 5.0% | 5.0% | 5.0% | 5.0% |
| Contingency Management | 0.0% | 0.1% | 0.3% | 0.0% | 0.0% | 0.0% |
| Waskul Cost per Unit | 0.0% | 0.0% | 0.0% | 2.1% | 0.0% | 0.0% |
| IP Psych Tiered Rates | 0.6% | 1.5% | 3.5% | 0.0% | 0.0% | 0.0% |
| PMPM Cost | $ 410.41 | $ 39.52 | $ 51.20 | $ 7,645.29 | $ 3,482.64 | $ 2,062.49 |
| **Composite PMPM Adjustment** | **7.2%** | **9.7%** | **14.9%** | **7.3%** | **5.0%** | **5.0%** |

### a. Eligible Member Months

SFY 2025 eligible member months assume that enrollment for DAB, TANF, and HMP will remain flat following the end of the PHE unwinding. Eligible member months for HSW and CWP have been adjusted to reflect projected enrollment consistent with the expected 1915(c) waiver renewal application for SFY 2025 through SFY 2029.

### b. Enrollment Acuity related to COVID-19 public health emergency (PHE)

Although enrollment for DAB, TANF, and HMP is expected to remain flat following the end of the PHE unwinding, a further acuity adjustment is necessary for these three MEGs to annualize the impact of the PHE unwinding on the acuity assumptions underlying the DY 6 (SFY 2025) expenditures given SFY 2025 is the first full year after the unwinding has ended.

### c. SFY 2025 Annual PMPM Trend

Unless otherwise specified, all expenditures in the Template assume an annual PMPM trend of 5%, which reflects the unit cost trend assumed in the SFY 2024 capitation rate certification.

### d. Contingency Management

MDHHS is seeking new authority to provide contingency management (CM) as part of a comprehensive treatment model for Medicaid beneficiaries living with SUD. The State initially intends to provide CM on a pilot basis to individuals living with a stimulant use disorder (StimUD) and/or an opioid use disorder (OUD), but may consider extending the service on a mandatory, statewide basis after gaining experience with the intervention. MDHHS is seeking a two-year approval for this component of the 1115 Waiver, from October 1, 2024, through September 30, 2026 (i.e., DY 6 (SFY 2025) and DY 7(SFY 2026)).

We have assumed 3,000 participants in the pilot over the two year time period with one-third of related services and corresponding incentive payments made during DY 6 (SFY 2025) and two-thirds made during DY 7 (SFY 2026). The effective fiscal impact included in the 1115 waiver renewal is $2.2M for DY 6, $4.4M for DY 7, and no expenditures for DY 8 through DY 10. The multiplicative nature of the adjustment factors in Figure 2 have been taken into account in the development of the percentage adjustments for CM.

#### e. Waskul Cost per Unit

Pending court approval, MDHHS anticipates that expenditures related to Self-Determination Community Living Supports provided through the Habilitation Supports Waiver (HSW SD CLS) will equal the CLS Self-Determination Minimum Fee Schedule outlined in the pending settlement agreement for Case No. 16-cv-10936 (Waskul Lawsuit). A similar minimum fee schedule is prescribed for HSW Self-Determination Overnight Health and Safety Supports (HSW SD OHSS).

It is important to note that the adjustment factor listed in Figure 2 only accounts for the impact of the minimum fee schedule and does not include any assumptions for utilization changes that may occur following implementation. While both the CLS and OHSS HSW services may be delivered through Agency Delivered Care or Self-Directed Care (SD Care), the minimum fee schedule related to the lawsuit does not apply to Agency Delivered Care resulting in the potential for a shift in demand for services from Agency Delivered Care to SD Care. No utilization adjustments have been assumed for the CLS or OHHS services. The 2.1% adjustment factor in Figure 2 along with the intended 5% annual trend results in estimated DY6 (SFY 2025) expenditures of approximately $14.6M.

#### f. Inpatient Psychiatric Tiered Rates

MDHHS has been engaging a workgroup for the past two years and anticipates implementing a state directed minimum fee schedule for inpatient psychiatric tiered rates beginning October 1, 2024. This program change includes an estimated increase of $34.6M in state and federal inpatient psychiatric hospital expenditures for SFY 2025 (inclusive of the intended multiplicative impact of the SFY 2025 trend and acuity adjustments as illustrated in Figure 2).

### iii. Member Months, PMPM Trend, and Other Adjustments

#### a. Eligible Member Months DY 7 (SFY 2026) – DY 10 (SFY 2029)

Enrollment estimates for all MEGs except HSW and CWP have been projected to be flat following the end of the PHE reenrollment period. Thus, neither eligible member months nor acuity adjustments are needed for DY 7 through DY 10. As illustrated in Appendix 1, eligible member months for HSW and CWP have been adjusted to reflect projected enrollment consistent with the expected 1915(c) waiver renewal application resulting in eligible member months growing between DY 6 and DY 7 at 2.0% for HSW and 4.8% for CWP but remaining flat thereafter.

#### b. PMPM Trend and Contingency Management pilot

Expenditures in the Template assume an annual PMPM trend of 5% consistent with the unit cost trend assumed in the SFY 2024 capitation rate certification. The PMPM trends for DAB, TANF, and HMP in DY 7 have been slightly increased to recognize the additional $2.2M increase for Contingency Management over the $2.2 million added in DY 6 for a total of $4.4 million in assumed Contingency Management expenditures during DY 7. The PMPM trends for DY 8 have been correspondingly decreased to recognize the end of the Contingency Management pilot resulting in the removal of a combined $4.4 million in expenditures across the DAB, TANF, and HMP MEGs.

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

The With-Waiver PMPM cost and member month projections are fully consistent with the Without-Waiver projections. Figure 3 presents the 1115 Budget Neutrality expenditure projections by MEG for each of the five demonstration years corresponding to the renewal application. The values in Figure 3 are consistent with the budget projections in Appendix 1.

**FIGURE 3: 1115 BUDGET NEUTRALITY EXPENDITURE PROJECTIONS BY GROUPING**

| MEG | DY 06 | DY 07 | DY 08 | DY 09 | DY 10 |
|---|---|---|---|---|---|
| DAB | $ 2,425.1 | $ 2,547.3 | $ 2,674.0 | $ 2,807.8 | $ 2,948.2 |
| TANF | $ 578.8 | $ 609.0 | $ 638.5 | $ 670.5 | $ 704.0 |
| HMP | $ 424.0 | $ 449.6 | $ 469.0 | $ 492.4 | $ 517.0 |
| HSW | $ 695.2 | $ 744.3 | $ 781.6 | $ 820.6 | $ 861.7 |
| CWP | $ 24.5 | $ 26.9 | $ 28.3 | $ 29.7 | $ 31.2 |
| SED | $ 12.9 | $ 13.6 | $ 14.2 | $ 15.0 | $ 15.7 |
| SUD IMD DAB | $ 12.3 | $ 12.9 | $ 13.6 | $ 14.3 | $ 15.0 |
| SUD IMD TANF | $ 5.7 | $ 5.9 | $ 6.2 | $ 6.6 | $ 6.9 |
| SUD IMD HMP | $ 32.5 | $ 34.1 | $ 35.8 | $ 37.6 | $ 39.5 |

**Notes**:

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

## D. Disproportionate Share Hospital (DSH)

Not applicable.

## E. Summary of Budget Neutrality

Appendix 1 of this document as well as the accompanying Excel file "*Section 1115 Demonstration BN Template.xlsx*" contain the 1115 Waiver Budget Neutrality worksheets, which include the following applicable tabs:

i. Historic Data

ii. WOW (Without-Waiver)

iii. WW (With-Waiver)

iv. Summary (of Budget Neutrality)

# III. Limitations and Qualifications

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

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

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

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

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

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

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

# Appendix 1: Budget Neutrality Template

| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 1 | **4 YEARS OF HISTORIC DATA** | | | | | | |
| 2 | | | | | | | |
| 3 | **SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:** | | | | | | |
| 4 | | | | | | | |
| 5 | **DAB** | **FY 19 (DY 00)** | **FY 20 (DY 01)** | **FY 21 (DY 02)** | **FY 22 (DY 03)** | **FY 23 (DY 04)** | **4-YEARS** |
| 6 | **TOTAL EXPENDITURES** | | $ 1,956,715,404 | $ 2,167,184,551 | $ 2,210,892,328 | $ 2,214,719,508 | $ 8,549,511,791 |
| 7 | **ELIGIBLE MEMBER MONTHS** | | 5,979,951 | 6,182,467 | 6,364,767 | 6,526,172 | |
| 8 | **PMPM COST** | $ - | $ 327.21 | $ 350.54 | $ 347.36 | $ 339.36 | |
| 9 | **TREND RATES** | | | | | | **4-YEAR** |
| 10 | | | | **ANNUAL CHANGE** | | | **AVERAGE** |
| 11 | TOTAL EXPENDITURE | | | 10.76% | 2.02% | 0.17% | 4.22% |
| 12 | ELIGIBLE MEMBER MONTHS | | | 3.39% | 2.95% | 2.54% | 2.96% |
| 13 | PMPM COST | | | 7.13% | -0.91% | -2.30% | 1.22% |
| 14 | | | | | | | |
| 15 | **TANF** | **FY 19 (DY 00)** | **FY 20 (DY 01)** | **FY 21 (DY 02)** | **FY 22 (DY 03)** | **FY 23 (DY 04)** | **4-YEARS** |
| 16 | **TOTAL EXPENDITURES** | | $ 424,553,810 | $ 492,779,489 | $ 498,444,483 | $ 578,973,639 | $ 1,994,751,421 |
| 17 | **ELIGIBLE MEMBER MONTHS** | | 14,806,951 | 16,098,937 | 17,215,735 | 18,051,721 | |
| 18 | **PMPM COST** | $ - | $ 28.67 | $ 30.61 | $ 28.95 | $ 32.07 | |
| 19 | **TREND RATES** | | | | | | **4-YEAR** |
| 20 | | | | **ANNUAL CHANGE** | | | **AVERAGE** |
| 21 | TOTAL EXPENDITURE | | | 16.07% | 1.15% | 16.16% | 10.89% |
| 22 | ELIGIBLE MEMBER MONTHS | | | 8.73% | 6.94% | 4.86% | 6.83% |
| 23 | PMPM COST | | | 6.76% | -5.41% | 10.78% | 3.81% |
| 24 | | | | | | | |
| 25 | **HMP** | **FY 19 (DY 00)** | **FY 20 (DY 01)** | **FY 21 (DY 02)** | **FY 22 (DY 03)** | **FY 23 (DY 04)** | **4-YEARS** |
| 26 | **TOTAL EXPENDITURES** | | $ 430,063,209 | $ 547,922,871 | $ 579,376,791 | $ 615,785,841 | $ 2,173,148,712 |
| 27 | **ELIGIBLE MEMBER MONTHS** | | 8,330,272 | 10,281,936 | 11,317,439 | 12,043,911 | |
| 28 | **PMPM COST** | $ - | $ 51.63 | $ 53.29 | $ 51.19 | $ 51.13 | |
| 29 | **TREND RATES** | | | | | | **4-YEAR** |
| 30 | | | | **ANNUAL CHANGE** | | | **AVERAGE** |
| 31 | TOTAL EXPENDITURE | | | 27.41% | 5.74% | 6.28% | 12.71% |
| 32 | ELIGIBLE MEMBER MONTHS | | | 23.43% | 10.07% | 6.42% | 13.08% |
| 33 | PMPM COST | | | 3.22% | -3.93% | -0.13% | -0.32% |
| 34 | | | | | | | |
| 35 | **Habilitative Supports Waiver (HSW)** | **FY 19 (DY 00)** | **FY 20 (DY 01)** | **FY 21 (DY 02)** | **FY 22 (DY 03)** | **FY 23 (DY 04)** | **4-YEARS** |
| 36 | **TOTAL EXPENDITURES** | | $ 481,950,866 | $ 535,374,337 | $ 526,437,341 | $ 531,997,911 | $ 2,075,760,456 |
| 37 | **ELIGIBLE MEMBER MONTHS** | | 90,950 | 91,275 | 89,461 | 88,346 | |
| 38 | **PMPM COST** | $ - | $ 5,299.07 | $ 5,865.51 | $ 5,884.55 | $ 6,021.75 | |
| 39 | **TREND RATES** | | | | | | **4-YEAR** |
| 40 | | | | **ANNUAL CHANGE** | | | **AVERAGE** |
| 41 | TOTAL EXPENDITURE | | | 11.08% | -1.67% | 1.06% | 3.35% |
| 42 | ELIGIBLE MEMBER MONTHS | | | 0.36% | -1.99% | -1.25% | -0.96% |
| 43 | PMPM COST | | | 10.69% | 0.32% | 2.33% | 4.35% |
| 44 | | | | | | | |
| 45 | **Children's Waiver Program (CWP)** | **FY 19 (DY 00)** | **FY 20 (DY 01)** | **FY 21 (DY 02)** | **FY 22 (DY 03)** | **FY 23 (DY 04)** | **4-YEARS** |
| 46 | **TOTAL EXPENDITURES** | | $ 17,630,853 | $ 19,866,038 | $ 23,229,653 | $ 18,112,242 | $ 78,838,786 |
| 47 | **ELIGIBLE MEMBER MONTHS** | | 4,601 | 5,076 | 5,849 | 6,335 | |
| 48 | **PMPM COST** | $ - | $ 3,831.96 | $ 3,913.72 | $ 3,971.56 | $ 2,859.08 | |
| 49 | **TREND RATES** | | | | | | **4-YEAR** |
| 50 | | | | **ANNUAL CHANGE** | | | **AVERAGE** |
| 51 | TOTAL EXPENDITURE | | | 12.68% | 16.93% | -22.03% | 0.90% |
| 52 | ELIGIBLE MEMBER MONTHS | | | 10.32% | 15.23% | 8.31% | 11.25% |
| 53 | PMPM COST | | | 2.13% | 1.48% | -28.01% | -9.30% |
| 54 | | | | | | | |
| 55 | **Serious Emotional Disturbance Waiver (SEDW)** | **FY 19 (DY 00)** | **FY 20 (DY 01)** | **FY 21 (DY 02)** | **FY 22 (DY 03)** | **FY 23 (DY 04)** | **4-YEARS** |
| 56 | **TOTAL EXPENDITURES** | | $ 11,227,994 | $ 11,230,689 | $ 11,307,436 | $ 9,384,293 | $ 43,150,412 |
| 57 | **ELIGIBLE MEMBER MONTHS** | | 4,996 | 5,364 | 5,411 | 5,685 | |
| 58 | **PMPM COST** | $ - | $ 2,247.40 | $ 2,093.72 | $ 2,089.71 | $ 1,650.71 | |
| 59 | **TREND RATES** | | | | | | **4-YEAR** |
| 60 | | | | **ANNUAL CHANGE** | | | **AVERAGE** |
| 61 | TOTAL EXPENDITURE | | | 0.02% | 0.68% | -17.01% | -5.80% |
| 62 | ELIGIBLE MEMBER MONTHS | | | 7.37% | 0.88% | 5.06% | 4.40% |
| 63 | PMPM COST | | | -6.84% | -0.19% | -21.01% | -9.77% |
| 64 | | | | | | | |
| 65 | **SUD IMD DAB** | **FY 19 (DY 00)** | **FY 20 (DY 01)** | **FY 21 (DY 02)** | **FY 22 (DY 03)** | **FY 23 (DY 04)** | **4-YEARS** |
| 66 | **TOTAL EXPENDITURES** | | $ 7,946,501 | $ 8,493,679 | $ 11,316,582 | $ 11,179,120 | |
| 67 | **ELIGIBLE MEMBER MONTHS** | | 5,570 | 5,606 | 7,287 | 6,975 | |
| 68 | **PMPM COST** | $ - | $ 1,426.66 | $ 1,515.11 | $ 1,552.98 | $ 1,602.74 | |
| 69 | **TREND RATES** | | | | | | **4-YEAR** |
| 70 | | | | **ANNUAL CHANGE** | | | **AVERAGE** |
| 71 | TOTAL EXPENDITURE | | | 6.89% | 33.24% | -1.21% | 12.05% |
| 72 | ELIGIBLE MEMBER MONTHS | | | 0.65% | 29.99% | -4.28% | 7.79% |
| 73 | PMPM COST | | | 6.20% | 2.50% | 3.20% | 3.96% |
| 74 | | | | | | | |
| 75 | **SUD IMD TANF** | **FY 19 (DY 00)** | **FY 20 (DY 01)** | **FY 21 (DY 02)** | **FY 22 (DY 03)** | **FY 23 (DY 04)** | **4-YEARS** |
| 76 | **TOTAL EXPENDITURES** | | $ 2,972,115 | $ 3,252,641 | $ 4,820,720 | $ 5,134,202 | |
| 77 | **ELIGIBLE MEMBER MONTHS** | | 4,195 | 4,237 | 5,792 | 5,247 | |
| 78 | **PMPM COST** | $ - | $ 708.49 | $ 767.68 | $ 832.31 | $ 978.50 | |
| 79 | **TREND RATES** | | | | | | **4-YEAR** |
| 80 | | | | **ANNUAL CHANGE** | | | **AVERAGE** |
| 81 | TOTAL EXPENDITURE | | | 9.44% | 48.21% | 6.50% | 19.99% |
| 82 | ELIGIBLE MEMBER MONTHS | | | 1.00% | 36.70% | -9.41% | 7.74% |
| 83 | PMPM COST | | | 8.35% | 8.42% | 17.57% | 11.36% |
| 84 | | | | | | | |
| 85 | **SUD IMD HMP** | **FY 19 (DY 00)** | **FY 20 (DY 01)** | **FY 21 (DY 02)** | **FY 22 (DY 03)** | **FY 23 (DY 04)** | **4-YEARS** |
| 86 | **TOTAL EXPENDITURES** | | $ 19,601,741 | $ 22,280,664 | $ 30,982,497 | $ 29,448,987 | |
| 87 | **ELIGIBLE MEMBER MONTHS** | | 24,397 | 24,096 | 31,486 | 26,222 | |
| 88 | **PMPM COST** | $ - | $ 803.45 | $ 924.66 | $ 984.01 | $ 1,123.06 | |
| 89 | **TREND RATES** | | | | | | **4-YEAR** |
| 90 | | | | **ANNUAL CHANGE** | | | **AVERAGE** |
| 91 | TOTAL EXPENDITURE | | | 13.67% | 39.06% | -4.95% | 14.53% |
| 92 | ELIGIBLE MEMBER MONTHS | | | -1.23% | 30.67% | -16.72% | 2.43% |
| 93 | PMPM COST | | | 15.09% | 6.42% | 14.13% | 11.81% |

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | |
| 4 | ELIGIBILITY | TREND | MONTHS | BASE YEAR | TREND | DEMONSTRATION YEARS (DY) | TREND | DEMONSTRATION | TREND | FY 27 (DY 08) | TREND | FY 28 (DY 09) | TREND | FY 29 (DY 10) | TOTAL |
| 5 | GROUP | RATE 1 | OF AGING | FY 24 (DY 05) | RATE 2 | FY 25 (DY 06) | RATE 3 | FY 26 (DY 07) | RATE 4 | | RATE 5 | | RATE 6 | | WOW |
| 6 | | | | | | | | | | | | | | | |
| 7 | DAB | | | | | | | | | | | | | | |
| 8 | Pop Type: | Medicaid | | | | | | | | | | | | | |
| 9 | Eligible Member Months | -6.6% | 12.0 | 6,104,134 | -3.2% | 5,908,946 | 0.0% | 5,908,946 | 0.0% | 5,908,946 | 0.0% | 5,908,946 | 0.0% | 5,908,946 | |
| 10 | PMPM Cost | 12.8% | 12.0 | $ 382.89 | 7.2% | $ 410.41 | 5.0% | $ 431.10 | 5.0% | $ 452.54 | 5.0% | $ 475.17 | 5.0% | $ 498.93 | |
| 11 | Total Expenditure | | | $ 2,337,195,642 | | $ 2,425,078,206 | | $ 2,547,346,743 | | $ 2,674,034,551 | | $ 2,807,754,005 | | $ 2,948,150,569 | $ 13,402,364,073 |
| 12 | | | | | | | | | | | | | | | |
| 13 | TANF | | | | | | | | | | | | | | |
| 14 | Pop Type: | Medicaid | | | | | | | | | | | | | |
| 15 | Eligible Member Months | -12.8% | 12.0 | 15,747,129 | -7.0% | 14,645,524 | 0.0% | 14,645,524 | 0.0% | 14,645,524 | 0.0% | 14,645,524 | 0.0% | 14,645,524 | |
| 16 | PMPM Cost | 12.3% | 12.0 | $ 36.02 | 9.7% | $ 39.52 | 5.1% | $ 41.58 | 4.9% | $ 43.60 | 5.0% | $ 45.78 | 5.0% | $ 48.07 | |
| 17 | Total Expenditure | | | $ 567,227,727 | | $ 578,769,709 | | $ 608,960,896 | | $ 638,544,854 | | $ 670,472,097 | | $ 704,010,348 | $ 3,200,757,904 |
| 18 | | | | | | | | | | | | | | | |
| 19 | HMP | | | | | | | | | | | | | | |
| 20 | Pop Type: | Medicaid | | | | | | | | | | | | | |
| 21 | Eligible Member Months | -20.0% | 12.0 | 9,659,262 | -14.3% | 8,281,280 | 0.0% | 8,281,280 | 0.0% | 8,281,280 | 0.0% | 8,281,280 | 0.0% | 8,281,280 | |
| 22 | PMPM Cost | -12.9% | 12.0 | $ 44.55 | 14.9% | $ 51.20 | 5.3% | $ 54.29 | 4.3% | $ 56.63 | 5.0% | $ 59.46 | 5.0% | $ 62.43 | |
| 23 | Total Expenditure | | | $ 430,275,471 | | $ 424,019,216 | | $ 449,590,682 | | $ 468,968,877 | | $ 492,404,899 | | $ 517,000,300 | $ 2,351,983,973 |
| 24 | | | | | | | | | | | | | | | |
| 25 | Habilitative Supports Waiver (HSW) | | | | | | | | | | | | | | |
| 26 | Pop Type: | Medicaid | | | | | | | | | | | | | |
| 27 | Eligible Member Months | -0.3% | 12.0 | 88,068 | 3.3% | 90,938 | 2.0% | 92,724 | 0.0% | 92,724 | 0.0% | 92,724 | 0.0% | 92,724 | |
| 28 | PMPM Cost | 18.4% | 12.0 | $ 7,128.12 | 7.3% | $ 7,645.29 | 5.0% | $ 8,027.56 | 5.0% | $ 8,428.94 | 5.0% | $ 8,850.39 | 5.0% | $ 9,292.91 | |
| 29 | Total Expenditure | | | $ 627,758,535 | | $ 695,248,910 | | $ 744,345,630 | | $ 781,563,097 | | $ 820,641,530 | | $ 861,673,653 | $ 3,903,472,821 |
| 30 | | | | | | | | | | | | | | | |
| 31 | Children's Waiver Program (CWP) | | | | | | | | | | | | | | |
| 32 | Pop Type: | Medicaid | | | | | | | | | | | | | |
| 33 | Eligible Member Months | 2.1% | 12.0 | 6,467 | 8.7% | 7,029 | 4.8% | 7,369 | 0.0% | 7,369 | 0.0% | 7,369 | 0.0% | 7,369 | |
| 34 | PMPM Cost | 16.0% | 12.0 | $ 3,316.80 | 5.0% | $ 3,482.64 | 5.0% | $ 3,656.77 | 5.0% | $ 3,839.61 | 5.0% | $ 4,031.59 | 5.0% | $ 4,233.17 | |
| 35 | Total Expenditure | | | $ 21,448,995 | | $ 24,480,921 | | $ 26,946,193 | | $ 28,293,514 | | $ 29,708,186 | | $ 31,193,599 | $ 140,622,413 |
| 36 | | | | | | | | | | | | | | | |
| 37 | Serious Emotional Disturbance Waiver (SEDW) | | | | | | | | | | | | | | |
| 38 | Pop Type: | Medicaid | | | | | | | | | | | | | |
| 39 | Eligible Member Months | 10.2% | 12.0 | 6,264 | 0.0% | 6,264 | 0.0% | 6,264 | 0.0% | 6,264 | 0.0% | 6,264 | 0.0% | 6,264 | |
| 40 | PMPM Cost | 19.0% | 12.0 | $ 1,964.28 | 5.0% | $ 2,062.49 | 5.0% | $ 2,165.62 | 5.0% | $ 2,273.90 | 5.0% | $ 2,387.60 | 5.0% | $ 2,506.98 | |
| 41 | Total Expenditure | | | $ 12,305,213 | | $ 12,920,473 | | $ 13,566,505 | | $ 14,244,824 | | $ 14,957,097 | | $ 15,704,951 | $ 71,393,850 |
| 42 | | | | | | | | | | | | | | | |
| 43 | SUD IMD DAB | | | | | | | | | | | | | | |
| 44 | Pop Type: | Medicaid | | | | | | | | | | | | | |
| 45 | Eligible Member Months | 0.0% | 12.0 | 6,975 | 0.0% | 6,975 | 0.0% | 6,975 | 0.0% | 6,975 | 0.0% | 6,975 | 0.0% | 6,975 | |
| 46 | PMPM Cost | 5.0% | 12.0 | $ 1,682.88 | 5.0% | $ 1,767.02 | 5.0% | $ 1,855.37 | 5.0% | $ 1,948.14 | 5.0% | $ 2,045.55 | 5.0% | $ 2,147.83 | |
| 47 | Total Expenditure | | | | | $ 12,324,980 | | $ 12,941,206 | | $ 13,588,277 | | $ 14,267,711 | | $ 14,981,114 | $ 68,103,288 |
| 48 | | | | | | | | | | | | | | | |
| 49 | SUD IMD TANF | | | | | | | | | | | | | | |
| 50 | Pop Type: | Medicaid | | | | | | | | | | | | | |
| 51 | Eligible Member Months | 0.0% | 12.0 | 5,247 | 0.0% | 5,247 | 0.0% | 5,247 | 0.0% | 5,247 | 0.0% | 5,247 | 0.0% | 5,247 | |
| 52 | PMPM Cost | 5.0% | 12.0 | $ 1,027.43 | 5.0% | $ 1,078.80 | 5.0% | $ 1,132.74 | 5.0% | $ 1,189.38 | 5.0% | $ 1,248.85 | 5.0% | $ 1,311.29 | |
| 53 | Total Expenditure | | | | | $ 5,660,458 | | $ 5,943,487 | | $ 6,240,677 | | $ 6,552,716 | | $ 6,880,339 | $ 31,277,676 |
| 54 | | | | | | | | | | | | | | | |
| 55 | SUD IMD HMP | | | | | | | | | | | | | | |
| 56 | Pop Type: | Medicaid | | | | | | | | | | | | | |
| 57 | Eligible Member Months | 0.0% | 12.0 | 26,222 | 0.0% | 26,222 | 0.0% | 26,222 | 0.0% | 26,222 | 0.0% | 26,222 | 0.0% | 26,222 | |
| 58 | PMPM Cost | 5.0% | 12.0 | $ 1,179.22 | 5.0% | $ 1,238.18 | 5.0% | $ 1,300.09 | 5.0% | $ 1,365.09 | 5.0% | $ 1,433.34 | 5.0% | $ 1,505.01 | |
| 59 | Total Expenditure | | | | | $ 32,467,509 | | $ 34,090,960 | | $ 35,795,390 | | $ 37,585,041 | | $ 39,464,372 | $ 179,403,272 |

| | A | B | C | D | E | F | G | H | I | J | K | L | M |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | |
| 4 | | | | DEMONSTRATION YEARS (DY) | TREND | DEMONSTRATIO | TREND | | TREND | | TREND | | TOTAL WW |
| 5 | ELIGIBILITY GROUP | FY 24 (DY 05) | DEMO TREND RATE | FY 25 (DY 06) | RATE 3 | FY 26 (DY 07) | RATE 4 | FY 27 (DY 08) | RATE 5 | FY 28 (DY 09) | RATE 6 | FY 29 (DY 10) | |
| 6 | | | | | | | | | | | | | |
| 7 | DAB | | | | | | | | | | | | |
| 8 | Pop Type: | Medicaid | | | | | | | | | | | |
| 9 | Eligible Member Months | 6,104,134 | -3.2% | 5,908,946 | 0.0% | 5,908,946 | 0.0% | 5,908,946 | 0.0% | 5,908,946 | 0.0% | 5,908,946 | |
| 10 | PMPM Cost | $ 382.89 | 7.2% | $ 410.41 | 5.0% | $ 431.10 | 5.0% | $ 452.54 | 5.0% | $ 475.17 | 5.0% | $ 498.93 | |
| 11 | Total Expenditure | | | $ 2,425,078,206 | | $ 2,547,346,743 | | $ 2,674,034,551 | | $ 2,807,754,005 | | $ 2,948,150,569 | $ 13,402,364,073 |
| 12 | | | | | | | | | | | | | |
| 13 | TANF | | | | | | | | | | | | |
| 14 | Pop Type: | Medicaid | | | | | | | | | | | |
| 15 | Eligible Member Months | 15,747,129 | -7.0% | 14,645,524 | 0.0% | 14,645,524 | 0.0% | 14,645,524 | 0.0% | 14,645,524 | 0.0% | 14,645,524 | |
| 16 | PMPM Cost | $ 36.02 | 9.7% | $ 39.52 | 5.1% | $ 41.58 | 4.9% | $ 43.60 | 5.0% | $ 45.78 | 5.0% | $ 48.07 | |
| 17 | Total Expenditure | | | $ 578,769,709 | | $ 608,960,896 | | $ 638,544,854 | | $ 670,472,097 | | $ 704,010,348 | $ 3,200,757,904 |
| 18 | | | | | | | | | | | | | |
| 19 | HMP | | | | | | | | | | | | |
| 20 | Pop Type: | Medicaid | | | | | | | | | | | |
| 21 | Eligible Member Months | 9,659,262 | -14.3% | 8,281,280 | 0.0% | 8,281,280 | 0.0% | 8,281,280 | 0.0% | 8,281,280 | 0.0% | 8,281,280 | |
| 22 | PMPM Cost | $ 44.55 | 14.9% | $ 51.20 | 5.3% | $ 54.29 | 4.3% | $ 56.63 | 5.0% | $ 59.46 | 5.0% | $ 62.43 | |
| 23 | Total Expenditure | | | $ 424,019,216 | | $ 449,590,682 | | $ 468,968,877 | | $ 492,404,899 | | $ 517,000,300 | $ 2,351,983,973 |
| 24 | | | | | | | | | | | | | |
| 25 | Habilitative Supports Waiver (HSW) | | | | | | | | | | | | |
| 26 | Pop Type: | Medicaid | | | | | | | | | | | |
| 27 | Eligible Member Months | 88,068 | 3.3% | 90,938 | 2.0% | 92,724 | 0.0% | 92,724 | 0.0% | 92,724 | 0.0% | 92,724 | |
| 28 | PMPM Cost | $ 7,128.12 | 7.3% | $ 7,645.29 | 5.0% | $ 8,027.56 | 5.0% | $ 8,428.94 | 5.0% | $ 8,850.39 | 5.0% | $ 9,292.91 | |
| 29 | Total Expenditure | | | $ 695,248,910 | | $ 744,345,630 | | $ 781,563,097 | | $ 820,641,530 | | $ 861,673,653 | $ 3,903,472,821 |
| 30 | | | | | | | | | | | | | |
| 31 | Children's Waiver Program (CWP) | | | | | | | | | | | | |
| 32 | Pop Type: | Medicaid | | | | | | | | | | | |
| 33 | Eligible Member Months | 6,467 | 8.7% | 7,029 | 4.8% | 7,369 | 0.0% | 7,369 | 0.0% | 7,369 | 0.0% | 7,369 | |
| 34 | PMPM Cost | $ 3,316.80 | 5.0% | $ 3,482.64 | 5.0% | $ 3,656.77 | 5.0% | $ 3,839.61 | 5.0% | $ 4,031.59 | 5.0% | $ 4,233.17 | |
| 35 | Total Expenditure | | | $ 24,480,921 | | $ 26,946,193 | | $ 28,293,514 | | $ 29,708,186 | | $ 31,193,599 | $ 140,622,413 |
| 36 | | | | | | | | | | | | | |
| 37 | Serious Emotional Disturbance Waiver (SEDW) | | | | | | | | | | | | |
| 38 | Pop Type: | Medicaid | | | | | | | | | | | |
| 39 | Eligible Member Months | 6,264 | 0.0% | 6,264 | 0.0% | 6,264 | 0.0% | 6,264 | 0.0% | 6,264 | 0.0% | 6,264 | |
| 40 | PMPM Cost | $ 1,964.28 | 5.0% | $ 2,062.49 | 5.0% | $ 2,165.62 | 5.0% | $ 2,273.90 | 5.0% | $ 2,387.60 | 5.0% | $ 2,506.98 | |
| 41 | Total Expenditure | | | $ 12,920,473 | | $ 13,566,505 | | $ 14,244,824 | | $ 14,957,097 | | $ 15,704,951 | $ 71,393,850 |
| 42 | | | | | | | | | | | | | |
| 43 | SUD IMD DAB | | | | | | | | | | | | |
| 44 | Pop Type: | Medicaid | | | | | | | | | | | |
| 45 | Eligible Member Months | 6,975 | 0.0% | 6,975 | 0.0% | 6,975 | 0.0% | 6,975 | 0.0% | 6,975 | 0.0% | 6,975 | |
| 46 | PMPM Cost | $ 1,682.88 | 5.0% | $ 1,767.02 | 5.0% | $ 1,855.37 | 5.0% | $ 1,948.14 | 5.0% | $ 2,045.55 | 5.0% | $ 2,147.83 | |
| 47 | Total Expenditure | | | $ 12,324,980 | | $ 12,941,206 | | $ 13,588,277 | | $ 14,267,711 | | $ 14,981,114 | $ 68,103,288 |
| 48 | | | | | | | | | | | | | |
| 49 | SUD IMD TANF | | | | | | | | | | | | |
| 50 | Pop Type: | Medicaid | | | | | | | | | | | |
| 51 | Eligible Member Months | 5,247 | 0.0% | 5,247 | 0.0% | 5,247 | 0.0% | 5,247 | 0.0% | 5,247 | 0.0% | 5,247 | |
| 52 | PMPM Cost | $ 1,027.43 | 5.0% | $ 1,078.80 | 5.0% | $ 1,132.74 | 5.0% | $ 1,189.38 | 5.0% | $ 1,248.85 | 5.0% | $ 1,311.29 | |
| 53 | Total Expenditure | | | $ 5,660,458 | | $ 5,943,487 | | $ 6,240,677 | | $ 6,552,716 | | $ 6,880,339 | $ 31,277,676 |
| 54 | | | | | | | | | | | | | |
| 55 | SUD IMD HMP | | | | | | | | | | | | |
| 56 | Pop Type: | Medicaid | | | | | | | | | | | |
| 57 | Eligible Member Months | 26,222 | 0.0% | 26,222 | 0.0% | 26,222 | 0.0% | 26,222 | 0.0% | 26,222 | 0.0% | 26,222 | |
| 58 | PMPM Cost | $ 1,179.22 | 5.0% | $ 1,238.18 | 5.0% | $ 1,300.09 | 5.0% | $ 1,365.09 | 5.0% | $ 1,433.34 | 5.0% | $ 1,505.01 | |
| 59 | Total Expenditure | | | $ 32,467,509 | | $ 34,090,960 | | $ 35,795,390 | | $ 37,585,041 | | $ 39,464,372 | $ 179,403,272 |
| 60 | | | | | | | | | | | | | |

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

| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 1 | **Budget Neutrality Summary** | | | | | | |
| 2 | | | | | | | |
| 3 | **Without-Waiver Total Expenditures** | | | | | | |
| 4 | | **DEMONSTRATION YEARS (DY)** | | | | | **TOTAL** |
| 5 | | **FY 25 (DY 06)** | **FY 26 (DY 07)** | **FY 27 (DY 08)** | **FY 28 (DY 09)** | **FY 29 (DY 10)** | |
| 6 | **Medicaid Populations** | | | | | | |
| 7 | **DAB** | $ 2,425,078,206 | $ 2,547,346,743 | $ 2,674,034,551 | $ 2,807,754,005 | $ 2,948,150,569 | $ 13,402,364,073 |
| 8 | **TANF** | $ 578,769,709 | $ 608,960,896 | $ 638,544,854 | $ 670,472,097 | $ 704,010,348 | $ 3,200,757,904 |
| 9 | **HMP** | $ 424,019,216 | $ 449,590,682 | $ 468,968,877 | $ 492,404,899 | $ 517,000,300 | $ 2,351,983,973 |
| 10 | **Habilitative Supports Waiver (HSW)** | $ 695,248,910 | $ 744,345,630 | $ 781,563,097 | $ 820,641,530 | $ 861,673,653 | $ 3,903,472,821 |
| 11 | **Children's Waiver Program (CWP)** | $ 24,480,921 | $ 26,946,193 | $ 28,293,514 | $ 29,708,186 | $ 31,193,599 | $ 140,622,413 |
| 12 | **Serious Emotional Disturbance Waiver (SEDW)** | $ 12,920,473 | $ 13,566,505 | $ 14,244,824 | $ 14,957,097 | $ 15,704,951 | $ 71,393,850 |
| 13 | **SUD IMD DAB** | $ 12,324,980 | $ 12,941,206 | $ 13,588,277 | $ 14,267,711 | $ 14,981,114 | $ 68,103,288 |
| 14 | **SUD IMD TANF** | $ 5,660,458 | $ 5,943,487 | $ 6,240,677 | $ 6,552,716 | $ 6,880,339 | $ 31,277,676 |
| 15 | **SUD IMD HMP** | $ 32,467,509 | $ 34,090,960 | $ 35,795,390 | $ 37,585,041 | $ 39,464,372 | $ 179,403,272 |
| 16 | | | | | | | |
| 17 | **DSH Allotment Diverted** | $ - | $ - | $ - | $ - | $ - | $ - |
| 18 | | | | | | | |
| 19 | **Other WOW Categories** | | | | | | |
| 20 | **Category 1** | | | | | | $ - |
| 21 | **Category 2** | | | | | | $ - |
| 22 | | | | | | | |
| 23 | | | | | | | |
| 24 | **TOTAL** | $ 4,210,970,382 | $ 4,443,732,301 | $ 4,661,274,060 | $ 4,894,343,282 | $ 5,139,059,245 | $ 23,349,379,270 |
| 25 | | | | | | | |
| 26 | **With-Waiver Total Expenditures** | | | | | | |
| 27 | | **DEMONSTRATION YEARS (DY)** | | | | | **TOTAL** |
| 28 | | **FY 25 (DY 06)** | **FY 26 (DY 07)** | **FY 27 (DY 08)** | **FY 28 (DY 09)** | **FY 29 (DY 10)** | |
| 29 | **Medicaid Populations** | | | | | | |
| 30 | **DAB** | $ 2,425,078,206 | $ 2,547,346,743 | $ 2,674,034,551 | $ 2,807,754,005 | $ 2,948,150,569 | $ 13,402,364,073 |
| 31 | **TANF** | $ 578,769,709 | $ 608,960,896 | $ 638,544,854 | $ 670,472,097 | $ 704,010,348 | $ 3,200,757,904 |
| 32 | **HMP** | $ 424,019,216 | $ 449,590,682 | $ 468,968,877 | $ 492,404,899 | $ 517,000,300 | $ 2,351,983,973 |
| 33 | **Habilitative Supports Waiver (HSW)** | $ 695,248,910 | $ 744,345,630 | $ 781,563,097 | $ 820,641,530 | $ 861,673,653 | $ 3,903,472,821 |
| 34 | **Children's Waiver Program (CWP)** | $ 24,480,921 | $ 26,946,193 | $ 28,293,514 | $ 29,708,186 | $ 31,193,599 | $ 140,622,413 |
| 35 | **Serious Emotional Disturbance Waiver (SEDW)** | $ 12,920,473 | $ 13,566,505 | $ 14,244,824 | $ 14,957,097 | $ 15,704,951 | $ 71,393,850 |
| 36 | **SUD IMD DAB** | $ 12,324,980 | $ 12,941,206 | $ 13,588,277 | $ 14,267,711 | $ 14,981,114 | $ 68,103,288 |
| 37 | **SUD IMD TANF** | $ 5,660,458 | $ 5,943,487 | $ 6,240,677 | $ 6,552,716 | $ 6,880,339 | $ 31,277,676 |
| 38 | **SUD IMD HMP** | $ 32,467,509 | $ 34,090,960 | $ 35,795,390 | $ 37,585,041 | $ 39,464,372 | $ 179,403,272 |
| 39 | | | | | | | |
| 40 | **Expansion Populations** | | | | | | |
| 41 | | | | | | | |
| 42 | | | | | | | |
| 43 | | | | | | | |
| 44 | **Excess Spending From Hypotheticals** | | | | | | $ - |
| 45 | | | | | | | |
| 46 | **Other WW Categories** | | | | | | |
| 47 | **Category 3** | | | | | | $ - |
| 48 | **Category 4** | | | | | | $ - |
| 49 | | | | | | | |
| 50 | **TOTAL** | $ 4,210,970,382 | $ 4,443,732,301 | $ 4,661,274,060 | $ 4,894,343,282 | $ 5,139,059,245 | $ 23,349,379,270 |
| 51 | | | | | | | |
| 52 | **VARIANCE** | $ - | $ - | $ - | $ - | $ - | $ - |

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## ATTACHMENT 3 – PUBLIC NOTICE

A copy of the Public Notice is available here.

## ATTACHMENT 4 – ABBREVIATED PUBLIC NOTICE

A copy of the Abbreviated Public Notice is available here.

# Classified





## ANNOUNCEMENTS

### Public Notices

Wolverine Building Group is seeking Section 3 subcontractors to bid on the upcoming multi-family project "The Seymour." This project will adapt the former Seymour Christian School into a 27-unit condominium for ICCF Community Homes. Bids are due February 28, 2024 at midnight. For bid documents, contact Brian Steinberg bsteinberg@wolvgroup.com or call 616-281-6467.

STATE OF MICHIGAN
PROBATE COURT
KENT COUNTY

NOTICE TO CREDITORS
Decedent's Estate

CASE NO. and JUDGE
18-202694-DE

Court address:
180 Ottawa Ave. NW
Suite 2500
Grand Rapids, MI 49503

Court telephone no.:
(616) 632-5440

Estate of Patricia Lynn Reynolds. Date of birth: 05/19/1957.

TO ALL CREDITORS:
NOTICE TO CREDITORS: The decedent, Patricia Lynn Reynolds, died 12/03/2017.
Creditors of the decedent are notified that all claims against the estate will be forever barred unless presented to Nicole Belden, personal representative, or to both the probate court at 180 Ottawa Ave. NW, Suite 2500, Grand Rapids and the personal representative within 4 months after the date of publication of this notice.
Date: February 25, 2024.

Meaghan J. Miracle P80338
1850 44th St. SW
Wyoming, MI 49519
(616) 227-0870

Nicole Belden
3797 Omaha St. SW
Grandville, MI 49418
(616) 204-0437

STATE OF MICHIGAN
PROBATE COURT
KENT COUNTY

NOTICE TO CREDITORS
Decedent's Estate

CASE NO. and JUDGE
23-214350-DE

Court address:
180 Ottawa Ave. NW
Suite 2500
Grand Rapids, MI 49503

Court telephone no.:
(616) 632-5440

Estate of Marion Grace Rodenburg. Date of birth: 04/15/1922.

TO ALL CREDITORS:
NOTICE TO CREDITORS: The decedent, Marion Grace Rodenburg, died 11/17/2023.
Creditors of the decedent are notified that all claims against the estate will be forever barred unless presented to Donna Shirilla, personal representative, or to both the probate court at 180 Ottawa Ave. NW, Suite 2500, Grand Rapids and the personal representative within 4 months after the date of publication of this notice.
Date: February 25, 2024.

Meaghan J. Miracle P80338
1850 44th St. SW
Wyoming, MI 49519
(616) 227-0870

Donna Shirilla
1126 Warrington Dr.
Ann Arbor, MI 48103
(734) 474-3769

STATE OF MICHIGAN
PROBATE COURT
KENT COUNTY

NOTICE TO CREDITORS
Decedent's Estate

CASE NO. and JUDGE
24-214608-DE

Court address:
180 Ottawa Ave. NW
Suite 2500
Grand Rapids, MI 49503

Court telephone no.:
(616) 632-5440

Estate of Louise Mary Ignasiak. Date of birth: 06/17/1924.

TO ALL CREDITORS:
NOTICE TO CREDITORS: The decedent, Louise Mary Ignasiak, died 12/23/2023.
Creditors of the decedent are notified that all claims against the estate will be forever barred unless presented to Kathleen Alice Gole, personal representative, or to both the probate court at 12426 Aleigha Dr. NW, Grand Rapids, MI 49534 and the personal representative within 4 months after the date of publication of this notice.
Date: February 25, 2024.

Kathleen Alice Gole
12426 Aleigha Dr. NW
Grand Rapids, MI 49534
(616) 540-8119

NOTICE
February 25, 2024
The Ottawa County Board of Commissioners Special Hearing regarding Adeline Hambley will resume on Monday, February 26, 2024, at 9:00 a.m. in the Board Room of the Board of Commissioners, 12220 Fillmore Street, West Olive, Michigan.
Justin F. Roebuck Ottawa County Clerk/Register

Abbreviated Public Notice
Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration

Michigan § 1115 Behavioral Health Demonstration
Waiver Renewal Application

In accordance with 42 CFR §431.408, the Michigan Department of Health and Human Services (MDHHS) is providing public notice of its intent to submit an application to the Centers for Medicare and Medicaid Services (CMS) under § 1115 of the Social Security Act seeking a five-year extension of the Michigan § 1115 Behavioral Health Demonstration. The current Demonstration is authorized through September 30, 2024. Additionally, MDHHS is seeking new authority to provide contingency management (CM) as part of a comprehensive treatment model for Medicaid beneficiaries living with substance use disorder (SUD). The complete application and applicable attachments are available at www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Adult Behavioral Health & Developmental Disability >> BH Recovery & Substance Use. Additionally, paper copies are available at the Bureau of Specialty Behavioral Health Services located in the Capitol Commons Center, 400 S.Pine St., Lansing, MI 48913.

Public Hearings
MDHHS will host two hearings at which the public may provide comments.

Public Hearing #1
Wednesday,
February 28, 2024
1 p.m. – 3:30 p.m.
Virtual/Teleconference:
Phone only option:
(248) 509-0316
ID: 822 584 861#
https://www.microsoft.com/en-us/microsoft-teams/join-a-meeting?rtc=1

Meeting ID: 287 623 829 036
Passcode: AXgGGs

Public Hearing #2
Friday, March 1, 2024
12 p.m. – 1:30 p.m.
Library of Michigan & Historical Center
1st Floor Forum
702 W. Kalamazoo St.
Lansing, MI 48915
Link to online access available upon registration.
https://us06web.zoom.us/meeting/register/tZ0ufuqrDMpHtWX5dhM3n1-V-zt0T0Az98V
Meeting ID: 893 9636 8341

Written Public Comments
MDHHS will also accept written public comments until 5:00 p.m. EST on March 20, 2024. Written comments may be sent via email to: mdhhs-bhdda@michigan.gov. Please include "Behavioral Health 1115 Demonstration Extension" in the subject line. Additionally, comments may be mailed to MDHHS/Behavioral and Physical Health and Aging Services Administration, Program Policy Division, PO Box 30479, Lansing, MI 48909-7979.

Kent County Road Commission

The Kent County Road Commission, 1900 4 Mile Road NW, Walker, MI 49544 will receive bids until Tuesday, March 5, 2024 @ 8:30 A.M deadline via BidNet Direct for the following:

- Bid #24-MNT-08: Summer Bituminous Patching Materials
- Bid #24-MNT-09: Chip Seal Emulsion Materials
- Bid #24-MNT-10: Fog Seal Emulsion Materials
- Bid #24-MNT-11: Spray Patch Mix Emulsion Materials

Specifications are available at www.bidnetdirect.com/mitn/kentcountyroads

The Kent County Road Commission, in accordance with Title VI of the Civil Rights Act of 1964, 78 Stat. 252, 42 USC 2000d to 2000d-4 and Title 49, Code of Federal Regulations, Department of Federally-assisted programs of the Department of Transportation issued pursuant to such Act, hereby notifies all bidders that it will affirmatively insure that in any contract entered into pursuant to this advertisement, minority business enterprises will be afforded full opportunity to submit bids in response to this invitation and will not be discriminated against on the grounds of gender, disability, race, color, or national origin in consideration for an award.

Andrew Nordstrom, Purchasing Manager, (616) 242-6928 anordstrom@kentcountyroads.net

Kent Intermediate School District
Request for Proposal
2024 Kent ISD Lincoln School Roof Project

Kent ISD is seeking proposals for Kent ISD Lincoln School Roof Project per specifications. Proposals will be due in printed format prior to 10:00 am on Wednesday, March 13, 2024. Specifications are available at SIGMA VSS (sigma.michigan.gov) - Bid # 240000001370. Faxed proposals will not be considered. Proposals received after the deadline will not be accepted. All proposals shall be accompanied by a sworn and notarized statement disclosing any familial relationship that exists between the owner(s) or any employee of the bidder and any member of the Kent ISD School Board or the Superintendent of Kent ISD. Kent ISD shall not accept a proposal that does not include this statement.

STATE OF MICHIGAN
COUNTY OF KENT
17TH JUDICIAL CIRCUIT
FAMILY DIVISION
ORDER FOR PUBLICATION
ON HEARING

TO: MARTA ALICIA GOMEZ HERNANDEZ
Child's Name: JUAN GILDARDO CHOC GOMEZ
Case No.: 24-50425-NA-106012101
Hearing: APRIL 9, 2024 AT 10:30 A.M.
Referee WINTHER For Judge GOTTLIEB, 4TH FLOOR, COURTROOM 4-A
Due to the Covid 19 pandemic, this hearing may be conducted via Zoom. Please contact marie.bolen@kentcountymi.gov to participate remotely.

An initial and/or supplemental child protective petition has been filed in the above matter. A hearing on the petition, including a permanency planning hearing, will be conducted by the Court on the date and time stated above in the 17th Judicial Circuit Court, Family Division, Kent County Courthouse, 180 Ottawa NW, Grand Rapids, Michigan. The permanency planning hearing will result in the child(ren) being returned home, continued in foster care, or the court may order proceedings to terminate parental rights. IT IS THEREFORE ORDERED that you personally appear before the court at the time and place stated above and exercise your right to participate in the proceedings.

This hearing may result in a temporary or permanent loss of your right to the child(ren).

Dated: February 23, 2024

DEBORAH L. MCNABB
CHIEF CIRCUIT COURT JUDGE

STATE OF MICHIGAN
COUNTY OF KENT
17TH JUDICIAL CIRCUIT
FAMILY DIVISION
ORDER FOR PUBLICATION
ON HEARING

TO: PUTATIVE/UNKNOWN FATHER
Child's Name: JUAN GILDARDO CHOC GOMEZ
Child's Date and Place of Birth: 06/24/07, ALTA VERAPAZ, GUATEMALA
Mother's Name: MARTA ALICIA GOMEZ HERNANDEZ
Case No.: 24-50425-NA-106012101
Hearing: APRIL 9, 2024 AT 10:30 A.M.
Referee WINTHER For Judge GOTTLIEB, 4TH FLOOR, COURTROOM 4-A
Due to the Covid 19 pandemic, this hearing may be conducted via Zoom. Please contact marie.bolen@kentcountymi.gov to participate remotely.

A petition has been filed with this court regarding the above-named child(ren). If you are, or may be, the natural father you should personally appear before the court at the time and place stated above to express your interest, if any, in the child(ren).

Failure to appear at this hearing will constitute a denial of interest in the child(ren), waiver of notice for all subsequent hearings, and a waiver of a right to appointment of an attorney. Failure to appear at this hearing COULD RESULT IN PERMANENT TERMINATION OF ANY PARENTAL RIGHTS.

Dated: February 23, 2024

DEBORAH L. MCNABB
CHIEF CIRCUIT COURT JUDGE

TOWNSHIP
ADA TOWNSHIP
BUDGET PUBLIC HEARING NOTICE

The Ada Township Board will hold a public hearing on the proposed township budget for the fiscal year April 1, 2024 through March 31, 2025 and the 2024-2030 capital improvement plan during its regular Township Board meeting held on Monday March 11, 2024 at 7:00 PM at 7330 Thornapple River Drive Ada, MI 49301.

***The property tax millage rate proposed to be levied to support the proposed budget will be a subject of this hearing.**

There is no proposed increase to the millage rates levied in last years approved budget. A copy of the draft budget is available for public inspection at Ada Township, 7330 Thornapple River Drive, S.E., Ada, Michigan or at www.adatownshipmi.com.

Those with disabilities may utilize the Michigan Relay System (7-1-1) to participate in the meeting. If other aids or services are needed for individuals with disabilities please contact the Township Clerk, Jackie Smith, at jsmith@adatownshipmi.com or 616-676-9191 at least 24 hours prior to the meeting.

Jacqueline Smith
Ada Township Clerk
7330 Thornapple River Dr. SE
Ada, Michigan
616-676-9191

## MERCHANDISE

### Antiques, Art & Collectibles

COMIC BOOKS
Buying large or small collections.
Paying Cash!!
(616) 638-2105

Vintage & Estate Clothing Wanted - Men's/ women's vintage clothing, shoes & access. 1920-90's. Hoarder calls welcome; we make house calls. Don't give it away. Fair prices paid. We're local! 30 years in business. 616-446-7048

### Auctions & Auctioneers

Gun & Ammo Online Auction. 200+ new, used & collector firearms, ammo & accessories. Shipping Available. Now 2 Locations Charlotte & Gladwin. To Bid Johnpeckauctions.com. Selling Guns? Call John Peck 989-345-4866

Lansing area downsizing online auction - ends March 6 - variety of electronics, furniture, household goods, tools, small appliances, vintage cameras, books, vinyl albums, great usale items. View catalog and bid at EpicAuctions.com.

Online Only
AUCTION
Tuesday February 27th - first lot ends at 6pm
Join us for our February 2024 Online Only Auction. Many great items including furnishings, nautical items, tools, antiques, appliances, pallet lots and more!
Vander Kolk Auctions
www.VKauctions.com
(616) 437-1047

### Auctions & Auctioneers

Live Public
AUCTION
Saturday March 2nd - 10am
930 110th Ave Plainwell, Michigan
Danny Sturman having sold his home will sell the following at public auction: New Holland TC30 tractor with loader, 2009 Quality dump trailer, Snowmobiles, Firearms, Husqvarna zero turn mower, Tools, Horse tack, Sporting goods, Furniture, Farm Equipment & attachments, Garage and Yard items, Household
See our website for photos and info
Vander Kolk Auctions
www.VKauctions.com
(616) 437-1047

St. Michael School inventory reduction online auction. Coca-Cola beverage machine, 54" snowplow, Case rotary mower, fryers, desks, tables, more. Ends March 31. Go to Bid.SherwoodAuctionService LLC.com to view catalogue, other auctions. 1-800-835-0495.

### Miscellaneous Items

Adjustable Bed Brand New with mattress. Made is U.S.A., in plastic, with warranty. Retail cost $3,995.00, sacrifice for $875.00. Call for showing or delivery: DanDanTheMattressMan.com 989-832-1866

Alaska, Europe, Hawaii plus dozens of other popular trips! Starting at $1649 per person (double occupancy req'd.) YMT Vacations plans everything, leaving you to relax and enjoy. Call 1-855-958-4689 for more details. Use promo code YMT2024 for $250 off. Limited time only.

AMISH BUILT storage sheds and mini cabins delivered to your site anywhere in Michigan! Starting at $2,500.00 mynextbarn.com 989-832-1866

ATTENTION OXYGEN THERAPY USERS! Discover Oxygen Therapy That Moves with You with Inogen Portable Oxygen Concentrators. FREE information kit. Call 866-348-1952

BEAUTIFUL BATH UPDATES in as little as ONE DAY! Superior quality bath and shower systems at AFFORDABLE PRICES! Lifetime warranty & professional installs. Call Now! 877-401-2404

DIRECTV Sports Pack - 3 Months on Us! Watch pro and college sports LIVE. Plus over 40 regional and specialty networks included. NFL, College Football, MLB, NBA, NHL, Golf and more. Some restrictions apply. Call DIRECTV 1-888-351-0154

Donate your car, truck, boat, RV and more to support our veterans! Schedule a FAST, FREE vehicle pickup and receive a top tax deduction! Call Veteran Car Donations at 1-877-691-4117 today!

Eliminate gutter cleaning forever! LeafFilter, the most advanced debris-blocking gutter protection. Schedule a FREE LeafFilter estimate today. 20% off Entire Purchase. Plus 10% Senior & Military Discounts. Call 1-844-369-2501

Get Boost Infinite! Unlimited Talk, Text and Data For Just $25/mo! The Power Of 3 5G Networks, One Low Price! Call Today and Get The Latest iPhone Every Year On Us! 855-796-1382

Is 2024 your year? Were here for it and here for you. Reach your goals this year with WeightWatchers. Get started with THREE months FREE, visit www.weightwatchersoffer.com/51

Jacuzzi Bath Remodel can install a new, custom bath or shower in as little as one day. For a limited time, we're waiving all installation costs! (Additional terms apply.) Subject to change and vary by dealer. Offer ends 12/31/23. Call 1-888-510-0901

METAL ROOFING regular and shingle style, HALF OFF SPECIAL COLORS! Lifetime asphalt shingles. Steel and vinyl siding. Hail damage. Licensed and insured builders. Pole Buildings. Quality work for 40 years! AMISH CREW. 517-575-3695.

Prepare for power outages today with a Generac Home Standby Generator. Act now to receive a FREE 7-Year warranty with qualifying purchase* Call 1-855-922-0420 today to schedule a free quote. It's not just a generator. It's a power move.

PROFESSIONAL LAWN SERVICE: Fertilization, weed control, seeding, aeration and mosquito control. Call now for a free quote. Ask about our first application special! 1-877-411-0998

Replace your roof with the best looking and longest lasting material - steel from Erie Metal Roofs! Three styles and multiple colors available. Guaranteed to last a lifetime! Limited Time Offer - 50% off installation + Additional 10% off install (for military, health workers & 1st responders.) Call Erie Metal Roofs: 1-888-718-1856

Safe Step. North America's #1 Walk-In Tub. Comprehensive lifetime warranty. Top-of-the-line installation and service. Now featuring our FREE shower package and $1600 Off for a limited time! Call today! Financing available. Call Safe Step 1-866-319-1374

Switch to DISH and get up to a $300 gift card! Plus get the Multisport pack included for a limited time! Hurry, call for details: 1-866-950-6757

VIAGRA and CIALIS USERS! 50 Generic Pills SPECIAL $99.00! 100% guaranteed. 24/7 CALL NOW! 888-835-7273 Hablamos Espano

### Miscellaneous Items

YOU MAY QUALIFY for disability benefits if you are between 52-63 years old and under a doctor's care for a health condition that prevents you from working for a year or more. Call now! 1-866-891-5858

## EMPLOYMENT

### General Help Wanted

Digital Strategist (Grand Rapids, MI). Consult with clients and prospective clients on digital marketing PPC (pay-per-click) strategies; scope, quote and kick off PPC projects; review PPC deliverables for compliance with client requirements; train and mentor junior PPC team members on use of Google Ads, Google Workspace, Hubspot, CallRail, Google Analytics, Facebook advertising and SEMRush. Teach/guide interns and apprentices on updating PPC campaigns (using budget allocation, bid management, keyword and demographic targeting, and ad creative development), monitoring and updating SEO (search engine optimization) strategies for websites based on algorithmic changes and ranking factors, writing/editing blogs on topics like SEO Best Practices, Digital Marketing Trends, and Social Media Integration. Analyze digital marketing reporting metrics using Google Ads, Sprout Social and Whatagraph. Requires bachelor's degree in Marketing, Organizational Communication, Communications or a closely related field, and at least two years of experience as a search marketing strategist, digital marketing specialist, or closely related occupation, performing the following duties: analyzing digital marketing data for trends in design and language that may be affecting performance using Google Analytics, Google Data Studio/Looker Studio, Google Sheets, SuperMetrics and CallRail; building and launching digital marketing campaigns using Meta Ads, Google Ads, LinkedIn Ads, Google Tag Manager, Wordpress and Shopify; identifying issues with marketing campaigns and proposing solutions; and use of tracking pixels, tracking events, and conversion tracking. Mail resumes to: Deksia LLC, Attn: Aaron VanderGalien, 49 Coldbrook St NE, Grand Rapids, MI 49503. Ref 10191.

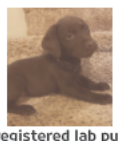


### General Help Wanted

Field Service Manager (WaterJet). CMS North America, Inc. Caledonia, MI. 2 yrs exp. Oversee maintenance & repair of WaterJet machines. Salary: $75,400/yr. Resumes: HR (Atn: CMS-1) CMS North America, Inc. 4095 Karona Ct., Caledonia, MI, 49316

## PETS & FARMS

AKC Lab Puppies born 11/17/2023 & 11/28/2024. Yellow, Black, Chocolate available. Breeding for over 30 years! Health Guarantee, All Puppies go to their forever homes with AKC Registration, Vet Certified, Shots dewormed, dew claws removed and a 30lb bag of puppy food currently eating. $800 269-998-5873



Akc registered lab puppies Redu ed price must sell asap Akc registered lab puppies for sale. Born Dec 23rd. Ready to go now. Chocolate and black 500 Championship bloodlines. 1st shots and vet checked.call John at 2316291158 for more details. 2316291158

AKC Registered Rottweiller Puppies- Ready For Their New Homes. One Year Health Guarantee. ONe Month Free Insurance. With Papers $1000 Without Papers $800. 231-429-0188

Cocker Spaniel Puppies- Good Colors, Shots, Dewormed Vet Checked. 989-426-3866 or 989-965-4278 Text Karen

French Bulldog/Pug (Frug) Puppies Born 1-3-24 Beautiful home raised Frug puppies. Great family dogs. 3 boys and 2 girls available. Mostly brindle. 1 black and white girl. Vet checked with 1st shots. $1,100 for boys and $1,300 for girls. No breeding restrictions. $1,100 for boys and $1,300 for girls. (269)929-7807

Shih Tzu Puppies 8 weeks with 1st shots and wormed beautiful playful pups. Parents on site. 5 males, and 1 female. Ready now. $700-$750 616-204-8616

Standard Goldendoodle Puppies- Will Have First Shots & Dewormed. Parents On Site. Will Be Ready For Forever Home Feb. 23rd. 269-908-6836

## REAL ESTATE FOR SALE

## REAL ESTATE FOR RENT

### Apartment Furnished

Partially Furnished Basement Apartment- $800/mo Utilities Included. Very Clean. Own Bathroom & Shower. Access To Laundry Room. 616-328-1685

### Apartment Unfurnished

MARYLAND PARK
1-BDRM $840-$1000
2-BDRM $950-$1200
3-BDRM $1060-$1300

Mon-Fri 9-5
616-454-4275 EHO
www.marylandparkapts.com

### Senior

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## TRANSPORTATION

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Tom Monette 231-855-3107,
Tracy Hilty 616-690-3854,
231-830-3000

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10831407-01


**Assistant Catering Manager** - Ferris State University. Assist in the management of catering. Assists in coordinating and supervising the catering activities and/or other assigned units in the planning, purchasing, production, and presentation of food. Required: Associate's degree or five years of direct experience in a food service environment. Current ServSafe Manager and Allergen or equivalent certifications or ability to obtained certifications within 90 days of employment Two years of food service experience, including recent supervisory responsibilities.

To apply and view full job description, visit https://jobs.ferris.edu. Ferris State University is an Equal Opportunity employer committed to inclusion and equity. Learn more about the Ferris mission, commitment to diversity and to equal opportunity, and dynamic, student-focused community at ferris.edu. Applicants requiring accommodation or assistance completing an application/participating in the hiring process should contact Human Resources at (231) 591-2150 or fsujobs@ferris.edu.

10827461-02

## ATTACHMENT 5 – TRIBAL NOTICE

A copy of the Tribal Notice is available here.