Assessment of Network Adequacy

2015

Mid-State Health Network

Assessment of Network Adequacy

Contents

Definitions

The following are definitions for key terms used throughout the Mid-State Health Network Assessment of Provider Network Adequacy:

1. CMHSP Participant: One of the twelve member Community Mental Health Services Program (CMHSP) participants in the MSHN Regional Entity.

2. CMHSP Participant and/or Substance Use Disorder Sub-Regional Entity (SUDSRE) Subcontractors: An individual or organization that is directly under contract with a CMHSP and/or SUDSRE to provide behavioral health services and/or supports.

3. Provider Network: MSHN CMHSP Participants and SUDSRE's directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements.

4. Substance Use Disorder Sub-Regional Entities (SUDSRE's): Former Substance Abuse Coordinating Agencies under contract with MSHN to perform managed care functions for substance use disorder treatment programs and services, including management of contracted service providers.

Background

As a Pre-Paid Inpatient Health Plan (PIHP), Mid-State Health Network (MSHN) must assure the adequacy of its network in order to provide access to a defined array of services for specified populations over its targeted geographical area. This document outlines the assessment of such adequacy as performed by Mid-State Health Network.

This assessment of the adequacy of its provider network demonstrates MSHN has the required capacity to serve the expected enrollment in its 21 county service area in accordance with Michigan Department of Health and Human Services (MDHHS) standards for access to care, with exceptions only for still evolving service areas for specialty behavioral health services in Michigan, such as the new Autism Benefit services implemented statewide in 2014.

The counties in the MSHN service area include:

Arenac	Eaton	Huron	Jackson	Newaygo	Tuscola
Bay	Gladwin	Ingham	Mecosta	Osceola	
Clare	Gratiot	Ionia	Midland	Saginaw	
Clinton	Hillsdale	Isabella	Montcalm	Shiawassee	

Mid-State Health Network is a free-standing entity, but it was formed on a collaborative basis by twelve Community Mental Health Service Programs (CMHSP Participants). MSHN entered into agreements with the CMHSP Participants to deliver Medicaid funded specialty behavioral health services in their local areas, so the twelve CMHSP Participants also comprise MSHN's Provider Network. Each CMHSP Participant in turn directly operates or enters into subcontracts for the delivery of services, or some combination thereof. There are twelve CMHSP Participants for the 21 counties, as follows:

- Bay-Arenac Behavioral Health (BABH)
- CMH Authority of Clinton-Eaton-Ingham Counties (CEI)
- CMH for Central Michigan (CMHCM)
- Gratiot County CMH Services (GCCMHA)
- Huron Behavioral Health (HBH)
- Ionia County CMH (ICCMHA)
- LifeWays CMH (LCMHA)
- Montcalm Center for Behavioral Health (MCBH)
- Newaygo County Mental Health Center (NCMHC)
- Saginaw County CMH Authority (SCCMHA)
- Shiawassee County CMH Authority (SHIACMH)
- Tuscola Behavioral Health Systems (TBHS)

As of 10/1/14 the Coordinating Agency designation for substance use disorder (SUD) services was eliminated by the MDHHS and full responsibility for managing and delivering SUD treatment and prevention services funded under Medicaid, Public Act 2, MI-Child and related Block Grants was transferred to the PIHP's in Michigan. MSHN has assumed responsibility for these additional managed care obligations, and has contracted with three sub-regional entities, for purposes of delegating selected managed care functions. These entities are:

- Bay-Arenac Behavioral Health (dba Riverhaven)
- Saginaw County Health Department
- CMH Authority of Clinton Eaton Ingham Counties

During FY15 MSHN received a communication from MDHHS directing the region to reduce the number of sub-regional entities to ensure continuity of service access and delivery across the region. MSHN is in the process of planning for a change to the multi-SUDSRE strategy for the 2016 Fiscal Year, which will result in a single SRE or direct performance of SUD managed care functions by MSHN personnel.

Scope

The primary responsibility for assessing local need and establishing the scope of subcontracted and direct operated service providers and programs remains with the CMHSP's and the Substance Use Disorder Sub-Regional Entities. The MSHN Assessment of Provider Network Adequacy is intended to support CMHSP, SUDSRE and MSHN efforts by generating regional consumer demand and provider network profiles that may precipitate adjustments to local provider arrangements. MSHN and the CMHSP's and the SUDSRE(s) would then act upon these ideas as warranted.

Therefore, this assessment is a global document for provider network capacity determinations, and is intended to generate dialogue between the PIHP and the CMHSP participant or SUDSRE regarding the composition and scope of local networks, and ensure that the region is meeting its obligations as a specialty Medicaid Health Plan. In some instances the response to an identified gap in services could result in the implementation of new and creative service delivery models that may not be possible for a single CMHSP or SUDSRE, such as a collaborative initiative to provide a regional level crisis response program, similar to the MDHHS statewide model for positive living supports or a regional effort to build therapeutic and non-therapeutic recovery oriented housing.

The focus of this assessment of provider network adequacy is both MSHN's mental health and substance use disorder provider networks. The scope of services is Medicaid funded specialty behavioral health services, including 1915(b) State Plan and Autism services, the 1915(b)(3) services, services for adults with developmental disabilities enrolled in the Habilitation Support Waiver program, and specialty behavioral health (mental health and substance use disorder) services under the Healthy Michigan program. The scope also includes Block Grant, MI-Child and PA2 funded substance use disorder treatment programs. Excluded are those services which are exclusively the focus of the CMHSP system through direct contract with MDHHS, such as services financed with General Funds and the waiver programs for Children with Developmental Disabilities and Serious Emotional Disturbance.

MSHN assumes the process of assessing the adequacy of its provided network is a relatively resource independent process. In other words, an objective assessment of enrollee needs is performed that is not tempered by the availability or lack of resources to fulfill that need. Acting upon the results of the assessment to establish and fund a provider network is a separate and distinct process, and of course, is directly tied to the availability of resources.

Assessment Updates

MSHN performed an initial or prospective assessment of network adequacy in 2014 and is updating the assessment for 2015; MSHN will continue to do so on an annual basis. Through the assessment process the PIHP must prospectively determine:

- How many individuals are expected to be in the target population in its geographic area for the upcoming year
- Of those individuals, how many are likely to meet criteria for the service benefit
- Of those individuals, what are their service needs
- The type and number of service providers necessary to meet the need
- How the above can reasonably be anticipated to change over time

Once services have been delivered, the PIHP must retrospectively determine:

- Whether or not the service provider network was adequate to meet the assessed need
- If the network was not adequate, what changes to the provider network are required

Appropriateness of the range of services

MSHN must offer an appropriate range of specialty behavioral health services that is adequate for the anticipated number of enrollees in the service area.[1] MSHN assesses the "appropriateness" of the range of services by comparing the service array available within the region, to the array determined to be appropriate by MDHHS for the target population(s).

The service array is articulated by MDHHS in the Medicaid Managed Specialty Support and Services Concurrent 1915(b)/(c) Waiver Program contract. MSHN is contractually obligated by MDHHS to provide the services described in the aforementioned contract boilerplate and its attachment, for which additional specifications and provider qualifications are articulated for Medicaid funded services in the Michigan Medicaid Provider Manual, Mental Health-Substance Abuse section:

- Michigan 1915(b) Waiver State Plan services
- Michigan State Plan SUD services
- Michigan 1915(c) Waiver Habilitation and Support Waiver (HSW) services
- Michigan 1915(b)3 Waiver alternative community based services
- Michigan 1915(i) Waiver Autism Benefit services
- SUD services funded by MI-Child, Public Act 2 and Block Grants
- Michigan 1115 Demonstration Project Healthy Michigan Plan (HMP) mental health and substance use disorder services authorized through the Affordable Care Act provisions for Medicaid expansion programs.

MSHN believes its service array to be appropriate and adequate for the needs of Medicaid enrollees, with limited exceptions. These exceptions are noted after the tables below which depict the services available for each fund source, and are addressed as recommendations at the end of this assessment.

The array of State Plan mental health services covered under the 1915(b) waiver are to be provided based upon the particular needs of the seriously emotionally disturbed children, adults with mental illness and individuals with intellectual/ developmental disability populations in a given community but MSHN must assure equity and appropriateness in service availability across the region. The following table lists the service array and which services are

[1] 42CFR438.207(b)(1) "Offers an appropriate range of preventative, primary care and specialty services that is adequate for the anticipated number of enrollees in the service area."

either directly provided or contracted by each CMHSP participant in the MSHN region, based on local needs.

State Plan Services (1915(b) Waiver) Available in MSHN Provider Network

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Applied Behavioral Analysis	X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	X	X	X		X	X	X	X	X	X	X	X
Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Behavior Treatment Review	X	X	X	X	X	X	X	X	X	X	X	X
Child Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Clubhouse Psychosocial Rehabilitation	X	X	X				X	X		X		
Crisis Interventions	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Residential Services	X	X	X	X	X	X	X	X	X	X	X	X
Family Therapy		X	X	X	X	X	X	X	X	X	X	X
Health Services	X	X	X	X	X	X	X	X	X	X	X	X
Home-Based Services	X	X	X	X	X	X	X	X	X	X	X	X
Individual and Group Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Inpatient Psychiatric Hospital Admission	X	X	X	X	X	X	X	X	X	X	X	X
Intensive Crisis Stabilization Services										X		
ICF Facility for Ind. w/ Mental Retardation												
Medication Administration	X	X	X	X	X	X	X	X	X	X	X	X
Medication Review	X	X	X	X	X	X	X	X	X	X	X	X
Nursing Facility Mental Health Monitoring	X	X	X	X	X	X	X	X	X	X	X	X
Occupational Therapy	X	X	X	X	X	X	X		X	X	X	X
Outpatient Partial Hospitalization Services				X			X	X				
Personal Care in Licensed Spec. Residential	X	X	X	X	X	X	X	X	X	X	X	X
Physical Therapy	X		X	X	X	X		X	X	X		X
Speech, Hearing and Language Therapy	X	X	X	X	X	X	X	X	X	X		X
Substance Abuse Services		X		X		X	X			X		
Targeted Case Management	X	X	X	X	X	X	X	X	X	X	X	X
Telemedicine	X	X		X	X	X	X	X	X	X		X
Transportation		X		X	X					X	X	
Treatment Planning	X	X	X	X	X	X	X	X	X	X	X	X

The State Plan services for treatment of substance use disorders for which MSHN receives Medicaid funding are shown in the following table, with indication of the services contracted by each SUDSRE, based on local needs:

Medicaid Funded Substance Use Disorder Services for the MSHN Provider Network

Service	Bay-Arenac Behavioral Health dba Riverhaven	CMH Authority of Clinton Eaton Ingham Counties	Saginaw County Public Health Department
Individual Assessment	X	X	X
Individual Treatment Planning	----	----	----
Individual Therapy	X	X	X
Group Therapy	X	X	X

Service	Bay-Arenac Behavioral Health dba Riverhaven	CMH Authority of Clinton Eaton Ingham Counties	Saginaw County Public Health Department
Family Therapy	X	X	----
Crisis Intervention	X	----	----
Referral/Linking/Coordinating/Management of Services	X	X	X
Peer Recovery and Recovery Support	X	X	X
Compliance Monitoring	----	----	----
Early Intervention	X	----	----
Detoxification/Withdrawal Monitoring	X	X	X
Pharmacological Supports	X	X	X
SA Treatment Services	X	X	X

In 2014 the region addressed a gap in coverage for SUD services in Gratiot County by the local CMHSP Participant, Gratiot County Community Mental Health, which is successfully pursuing licensure as a substance use disorder treatment provider.

Michigan's 1915(c) Habilitation Support Waiver (or HSW) offers community support (mental health) services for those beneficiaries in the MSHN service area who experience intellectual and developmental disabilities and meet program criteria. Services are offered to consumers based upon need once they are approved by MDHHS for enrollment. The MSHN region in aggregate has been assigned 1,637 HSW slots.

The following table shows which CMHSP Participant either directly provides or contracts for a particular service.

1915c Habilitation and Support Waiver Services Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Community Living Supports	X	X	X	X	X	X	X	X	X	X	X	X
Enhanced Medical Equip & Supplies	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request
Enhanced Pharmacy		X		X	X		X		X	X	X	X
Environmental Modifications	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request
Family Training	X	X	X	X		X	X	X	X	X	X	X
Goods & Services	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request
Out-of-Home Non-Voc. Habilitation			X			X	X			X	X	X
Personal Emerg. Response Systems			per request	per request	per request					per request		per request
Pre-Vocational Services	X	X	X	X	X	X	X			X		X
Private Duty Nursing	X	X					X			X	X	X
Respite Care	X	X	X	X	X	X	X	X	X	X	X	X
Supports Coordination	X	X	X	X	X	X	X	X	X	X	X	X

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Supported Employment	X	X	X	X	X	X	X	X	X	X	X	X

Mid-State Health Network must also assure Medicaid-funded mental health services and supports are available, in addition to Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act. These "B-3"services support community inclusion and participation, independence and productivity and include some of the services listed in the tables above, as well as the following:

1915(b)(3) Services Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Assistive Technology	----	----	----	----	----	----	----	----	----	----	----	----
Crisis Observation Care		X										
Housing Assistance	----	----	----	----	----	----	----	----	----	----	----	----
Peer Specialist Services	X	X	X	X	X	X	X	X	X	X	X	X
Drop-In Centers (Peer Operated)	X	X	X	X	X	X	X		X	X	X	X
Prevention Direct Service Models			X			X	X			X		
• Child Care Expulsion Prevention												
• School Success Program												
• Children of Adults w/ MI/ Integ. Serv.										X		
• Infant Mental Health	X	X	X	X	X	X	X		X	X	X	
• Parent Education		X	X	X			X			X	X	
Skill Building Assistance	X	X	X	X	X	X	X	X	X	X	X	X
Wraparound Services	X	X	X	X	X	X	X	X	X	X	X	X
Fiscal Intermediary Services	X	X	X	X	X	X	X	X	X	X	X	X

The Michigan Medicaid and MI-Child Autism Benefit went into effect on April 1, 2013 to provide children ages 18 months through 5 years old who have a medical diagnosis of Autism Spectrum Disorder (ASD) with Applied Behavioral Analysis services. Services are contracted or directly delivered by the CMHSP Participants as follows:

1915(i) Autism Benefit Services Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Screening Referral	Performed by pediatrician or family physician as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Service											
Diagnosis	X	X	X	X	X	X	X	X	X	X	X	X
Determination of Eligibility	Performed by MDHHS											
Independent Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Early Intensive Behavioral Intervention	X	X	X	X	X	X	X	X	X	X	X	X
Applied Behavioral Intervention	X	X	X	X	X	X	X	X	X	X	X	X

The (non-Medicaid) Public Act 2 of 1986, Block Grant and MI-Child services contracted by each SUDSRE for FY15 are defined in the MSHN-SRE Contract and the MSHN SUD Service Provider

Manual and shown in the table below. Priority for access to Block Grant funded services are determined at the federal level and include consumers who are pregnant injecting drug users, pregnant users, injecting drug users or parents of children who have been or are at risk of being removed from their home, in that order. MI-Child is a health care coverage program using state and federal health care funds for uninsured individuals under age 19 who are not eligible for Medicaid but with limited incomes.

Other Substance Use Disorder Services for the MSHN Provider Network

Service	BABH (dba Riverhaven)	CEI	SCCMHA (Sag Co. Public Health Dep't)
MI-Child			
Outpatient Treatment*	X	X	X
Residential Treatment	X	X	X
Block Grant			
Outpatient Treatment*	X	X	X
Residential Treatment	X	X	X
Detox Treatment	X	X	X
PA 2 of 1986			
Treatment and Prevention Programs	X	X	X

*Outpatient programming includes individual, group, family therapy, medication assisted treatment, recovery support, case management, early intervention, medication reviews, lab fees and medication dosing.

Recovery housing for consumers with SUD was added as a covered service fairly recently by MDHHS. The CEI SUDSRE added a program in 2014; in 2015 a similar need was identified in Bay and Saginaw counties and is being addressed by the BABH SUDSRE.

PA 2 funding are subject to a sunset provision and as a consequence are being reduced by 50% for FY16. MSHN and the SUDSRE's believe the reduction will largely be offset by the SUD services available through the Healthy Michigan Program, for which many individuals with SUD treatment and prevention needs have become eligible.

It would be the intention of MSHN to continue the same provider network capacity and service array into FY16 regardless of any transitions from multiple SRE's to one or direct performance of SUD managed care functions by MSHN personnel.

In 2014 the state of Michigan established a new program, the Healthy Michigan Plan (HMP), for purposes of expansion of Medicaid eligibility to the medically uninsured and underinsured. Mental health services offered through the HMP are similar to those previously offered via the Adult Benefit Waiver program, but the substance use disorder treatment options are expanded from the services previously available through Medicaid. The resulting service array is a comprehensive mix of mental health and substance use disorder services.

MSHN and the CMHSP Participants, as well as the SUDSRE's have made relatively minor capacity adjustments to existing provider networks as needed in order to provide HMP services. Limited change has been required because many HMP enrollees were previously served by CMHSP Participants through general funds. The CMHSP Participants and SUDSRE's are still determining optimal access pathways for HMP enrollees needing concurrent mental health and SUD services.

During FY14 the following behavioral health services were provided for HMP enrollees in the region; since the SUDSRE's were not contracted during FY14, the responsible Coordinating Agencies are shown (BABH d.b.a. Riverhaven Coordinating Agency (RCA), CEI, Northern Michigan Substance Abuse Services (NMSAS) and Saginaw County Public Health Department (SCPHD):

1115 Demonstration Project Healthy Michigan Plan Services Available in the MSHN Provider Network in FY14

	BABH (inc. RCA)	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	NMSAS	SCCMHA (inc. SCPHD)	SHIACMH	TBHS
Assertive Community Treatment	X	X	X		X		X	X	X			X	X
Assessments	X	X	X	X	X	X	X	X	X	X	X	X	X
Assistive Technology													
Behavior Treatment Review				X	X							X	
Clubhouse Psychosocial Rehabilitation	X	X					X	X			X		
Community Living Supports	X	X	X	X			X	X			X	X	X
Crisis Services	X	X	X	X	X		X	X			X	X	X
Enhanced Pharmacy				X			X						
Environmental Modifications													
Family Support and Training			X	X	X			X	X			X	
Fiscal Intermediary Services			X		X		X					X	X
Hospital Based Psychiatric Services												X	
Housing Assistance			X				X				X		
ICF for Individuals w/DD													
Medication Administration	X	X	X	X	X	X	X	X	X		X	X	X
Medication Review	X	X	X	X	X		X				X	X	
Occupational Therapy		X									X		X
Outpatient Counseling and Therapy	X	X	X	X	X	X	X	X	X	X	X	X	X
Peer Delivered/Operated Support Services	X	X	X	X	X	X	X		X		X	X	X
Peer Specialist Services (Recovery Coach)												X	
Personal Care in Licensed Spec. Residential		X	X	X	X		X	X			X	X	X
Physical Therapy													
Prevention – Direct Service Model			X				X				X		
Residential SUD Treatment	X	X					X			X	X		
Respite Care		X	X		X						X	X	X
Skill Building Assistance	X	X	X	X	X	X	X	X			X	X	X
Speech, Hearing and Language Therapy													
Sub-Acute Detoxification	X	X								X	X		
Support and Service Coordination	X		X	X	X	X	X	X			X	X	X
Supported/Integrated Employment Services	X	X	X	X	X		X		X		X	X	X
Targeted Case Management	X		X	X	X	X	X	X	X		X	X	X
Transportation	X		X		X		X				X		X

	BABH (inc. RCA)	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	NMSAS	SCCMHA (inc. SCPHD)	SHIACMH	TBHS
Treatment (DPT/CSAT) Approved Pharmacological Supports	X	X								X	X		
Treatment Planning	X	X	X	X	X	X	X	X	X		X	X	X
Additional Services													
Community Psychiatric Inpatient	X		X	X	X	X	X	X	X		X	X	X
Crisis Residential	X	X	X		X		X		X		X	X	X
Home Based	X		X	X	X	X		X	X			X	
Health Services	X	X	X	X	X	X	X	X	X			X	X
Outpatient Partial Hospitalization				X									

Numbers and types of providers (training, experience, and specialization)

The adequacy of the numbers and types of providers (in terms of training, experience and specialization) required to furnish the contracted Medicaid services [2] in the MSHN region can be assessed through review of the direct operated and contracted service provider networks established by the CMHSP Participants.

Training and experience

Each of the CMHSP participant agencies in the region have been in operation in the behavioral health care industry for decades, as have many of their contracted service providers. Practitioners and staff employed or contracted by the CMHSP's are properly licensed (by the Michigan Department of Licensing and Regulatory Affairs (LARA)) and credentialed in accord with MDHHS requirements for provider qualifications as defined in the Michigan Medicaid Manual. Disciplines include licensed/board certified Psychiatrists, licensed Nurse Practitioners, Registered Nurses, Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Full and Limited License Psychologists, and Licensed Professional Counselors, among others.

Credentialing and re-credentialing procedures, as well as privileging procedures for psychiatrists, are utilized by each CMHSP with their provider networks. Agencies under contract are overseen by CMHSP staff and residential settings are licensed in accordance with MDHHS requirements.

In Michigan, staff providing certain Medicaid mental health services to specific clinical populations must meet education and work experience criteria for designation as a Child Mental Health Professional (CMHP), a Qualified Intellectual Disability Professional (QIDP), or a Qualified Mental Health Professional (QMHP).

The SUDSRE's have similar credentialing procedures for their sub-contracted service providers. Provider agencies must be licensed as Substance Use Disorder Programs by the Michigan Department of Licensing and Regulatory Affairs (LARA). Individual clinicians, specifically

[2] 42CFR438.206(b)(iii) "The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services."

treatment supervisors, specialists and practitioners, as well as prevention supervisors and professionals are required to hold certification through the Michigan Certification Board of Addiction Professionals, such as a Certified Addiction and Drug Counselor.

The credentialing requirements for Autism Benefit Services are highly specific and have triggered provider network capacity concerns across the MSHN region, as well as other areas of the state. Diagnosis of Autism Spectrum Disorders must be performed by a child mental health professional (CMHP) and validated by a physician (preferably a child psychiatrist) and/or a fully licensed psychologist. Oversight of interventions calls for Behavior Analysts and Assistants certified by the Behavior Analyst Certification Board, which requires an extended period to accomplish. This has created shortages of qualified clinicians in the state, which the MSHN CMHSP Participants are managing as much as possible through assertive recruitment strategies. This remains a priority for MSHN into FY16.

In 2014 MDHHS introduced a new clinical assessment/survey for individuals with intellectual and developmental disabilities (IDD), called the Support Intensity Scale or SIS, which the PIHP's are required to administrate. MSHN elected to say this was a clinical service and delegated it to the CMHSP Participants. MSHN must have an adequate number of trained assessors in the region to provide this service for all IDD consumers aged 18-64 within a 3 year time period. MSHN determined five full time assessors were needed. CMHSP Participants are contractually required to have adequate capacity to complete SIS assessments. Currently the MSHN region is 50% behind for scheduled assessments. MSHN is setting productivity targets and does not plan to add capacity at this time. This will remain an area of focus into FY16.

MSHN and its CMHSP Participants have developed a Training Plan, which is being expanded to include minimum training standards to ensure a base level of competency across the provider network.

All of the CMHSP Participants and many of the provider agencies in the region are accredited by nationally recognized bodies, including The Joint Commission, CARF and the Council on Accreditation. Achievement of accreditation indicates standards of quality and experience beyond the minimum expectations defined by Medicaid are being met. The following table illustrates the accreditation status of the CMHSP Participants:

CMHSP Participant Accrediting Bodies

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
The Joint Commission (TJC)			X									
Commission on Accreditation of Rehabilitation Facilities (CARF)	X	X		X		X	X	X	X	X	X	X
Council on Accreditation (COA)					X							

SUDSRE's are not required to be accredited as entity, but their sub-contracted service providers are required to have their programs accredited as alcohol and/or drug abuse programs. Most providers utilize similar accrediting bodies to the CMHSP Participants and their subcontracted mental health service providers, as follows:

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

Specialization

In addition to pursuit of accreditation, CMHSP programs must meet MDHHS program certification requirements for certain specialty programs as outlined in the Michigan Medicaid Manual. The certification process entails meeting additional criteria such as mandatory service components, minimum staff credentials, ongoing training requirements and minimum staffing patterns. MDHHS Certification is maintained by the CMHSP Participants for the following programs:

CMHSP Participant Program Certifications through MDHHS

- Assertive Community Treatment
- Clubhouse Psychosocial Rehabilitation Programs
- Crisis Residential Programs
- Day Program Sites
- Drop-In Programs
- Home Based Services
- Wraparound
- Intensive Crisis Stabilization Services

Sub-contracted substance use disorder service providers of the SUDSRE's must be licensed by the State of Michigan as Substance Abuse Programs. Each CMHSP participant provides selected specialty services or treatments based upon evidence-based practice models they have adopted in accordance with local needs. The following are some examples of the many evidence based (or best) practices currently offered by CMHSP participants in the region:

Examples of Evidence Based Practices Deployed by CMHSP Participants in the MSHN Region

	Pop.	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Alternative for Families Cognitive Beh Therapy	Families in Danger of Physical Violence										X		
Applied Behavioral Analysis	I/DD-Autism	X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	MIA	X	X	X		X	X	X	X	X	X	X	X
Brief Behavior Activation Therapy	Adults w Depression			X									

	Pop.	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Brief Strategic Family Therapy	Families	X		X	X								
Clubhouse	MIA	X						X	X		X		
Cognitive Behavioral Therapy	All	X	X	X	X	X	X	X	X	X	X		X
Communities That Care	All										X		
Dialectical Behavioral Therapy	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Family Psycho-Education	Families	X	X	X	X	X		X	X		X	X	X
Infant Mental Health	Parents	X	X	X	X	X	X	X	X	X	X	X	X
Integrated Dual-Diagnosed Treatment	Dual SUD/MIA	X	X	X	X	X		X	X	X	X	X	X
Mobile Urgent Treatment Team	Families										X		
Motivational Interviewing	All	X	X	X	X	X	X		X	X	X	X	X
Multi-Systemic Therapy	Juvenile offenders			X	X			X					
Nurturing Parenting Program	Parents			X			X						
Parent-Child Interaction Therapy	Parents			X					X				
Parent Mgt Training – Oregon Model	Parents	X	X	X	X		X			X	X	X	X
Parenting Through Change	Parents			X									X
Parenting Wisely	Parents							X			X		
Peer Mentors	I/DD										X	X	
Peer Support Specialists	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Picture Exchange Communication System	I/DD-Autism										X		
Positive Living Supports	I/DD	X	X		X	X						X	
Prolonged Exposure Therapy	Adults w PTSD			X		X			X				
Schema-Focused Therapy	Couples			X									
Seeking Safety Trauma Group	SUD & PTSD	X		X		X	X				X	X	X
Self-Management and Recovery Training	MIA, SUD	X		X									
Seven Challenges	SUD Adolescents										X		
Supported Employment	Adults	X	X	X	X	X	X	X	X	X	X	X	X
Thinking for a Change	SUD Offenders										X		
Trauma Focused Cognitive Beh. Therapy	Children	X		X		X	X	X		X	X		X
Trauma Recovery Empowerment Model	Adults			X						X	X		
Whole Health Action Management	Adults			X		X	X		X	X	X		
Wellness Recovery Action Planning	Adults	X		X					X	X	X		
Wraparound	SED Families	X	X	X	X	X	X	X	X	X	X	X	X

The sub-contracted service providers of the SUDSRE's also utilize evidence based practices, particularly prevention models. Recovery focused approaches are prevalent, and some providers employ staff trained in motivational interviewing, integrated dual-diagnosis treatment, trauma informed and other techniques commonly employed by CMHSP's. The following are evidence-based practices deployed by various sub-contracted service providers in the MSHN region:

Focal Area	EBP Practice
TREATMENT	Cognitive Behavioral Therapy (CBT)
	Correctional Therapeutic Community for Substance Abuse
	Dialectical Behavior Therapy (DBT)
	Drug Court
	Eye Movement Desensitization
	Functional Family Therapy
	Mindfulness
	Motivational Enhancement Therapy
	Motivational Interviewing
	Methadone Treatment (Includes Opioid Maintenance)
	Partners for Change Outcome Measurement System
	Recovery Coaches
	Recovery Focused Treatment Practices
	Relapse Prevention
	Substance Abuse Treatment for Persons with Co-occurring Disorders
	Thinking for a Change
	Trauma Focused Treatment Practices
PREVENTION	All Stars
	Active Parenting Now
	A Second Look
	Life Skills Training
	Mapping-Enhanced Counseling
	Positive Action
	Project Alert
	Project EX
	Parenting Now
	Second Step
	Start Taking Alcohol Risk Seriously (STARS)
	Teen Intervene
	Too Good For Drugs (TGFD)
	Too Good For Violence (TGFV)
	Community Intervention: Helping Teens Overcome Problems with Alcohol, Marijuana and Other Drugs.
	CMCA – Communities Mobilizing for Change on Alcohol.
	Community Trials
	PALs – Peer Assisted Leaders
	Social Norming/Marketing and Media Campaigns
	Nurturing Parents
	Strengthening Families
	Choices
	Children of Addicted Parents
	Project Cope
	Student Assistance Program
	Minor in Possession Program
	Diversionary Programs
	Law Enforcement and Civilian Compliance Checks
	Alcohol and Tobacco Vendor Education
	TIPS Training
	Michigan Model for Health
	Party Patrols
	Protecting You/Protecting Me

Focal Area	EBP Practice
	Communities that Care
	Prescription Take Back Programs
	Permanent Drug Disposal Box Initiatives
	Conflict Resolution
	Lions Quest Skills for Adolescents
	Systematic Training for Effective Parenting – STEP
	Early STEP
	SMART Leaders/SMART Moves
	Families and Schools Together – FAST
	Anger Management
	OJJDP :Strategies for Success
	Step Bullying Prevention
	Steps to Respect
	Promoting Alternative Thinking Strategies
	Seeking Safety

In addition to specialized organizational certifications and deployment of research-based service delivery models, individual clinicians often obtain specialized credentials, some of which are required by MDHHS for the delivery of specialty services. As an example, many clinical staff in the region providing services within CMHSP participant direct operated programs and contracted service provider agencies hold substance abuse treatment credentials including Certified Advanced Alcohol and Drug Counselor (CAADC) and Certified Alcohol and Drug Counselor (CADC). Substance use disorder service provider staffs offering prevention services are required to hold certifications as Certified Prevention Specialists.

The SUDSRE's are required to prepare a three year Strategic Plan for Substance Use Disorder Prevention, Treatment and Recovery Services. The MSHN SUD Strategic Plan for FY2015-2017 identified a plan for implementation of (the evidence based) Recovery-Oriented System of Care (ROSC) which includes specific objectives for expansion of programs that are gender competent and women's specialty programs, among other goals, in order to promote individual's recovery from substance use disorders.

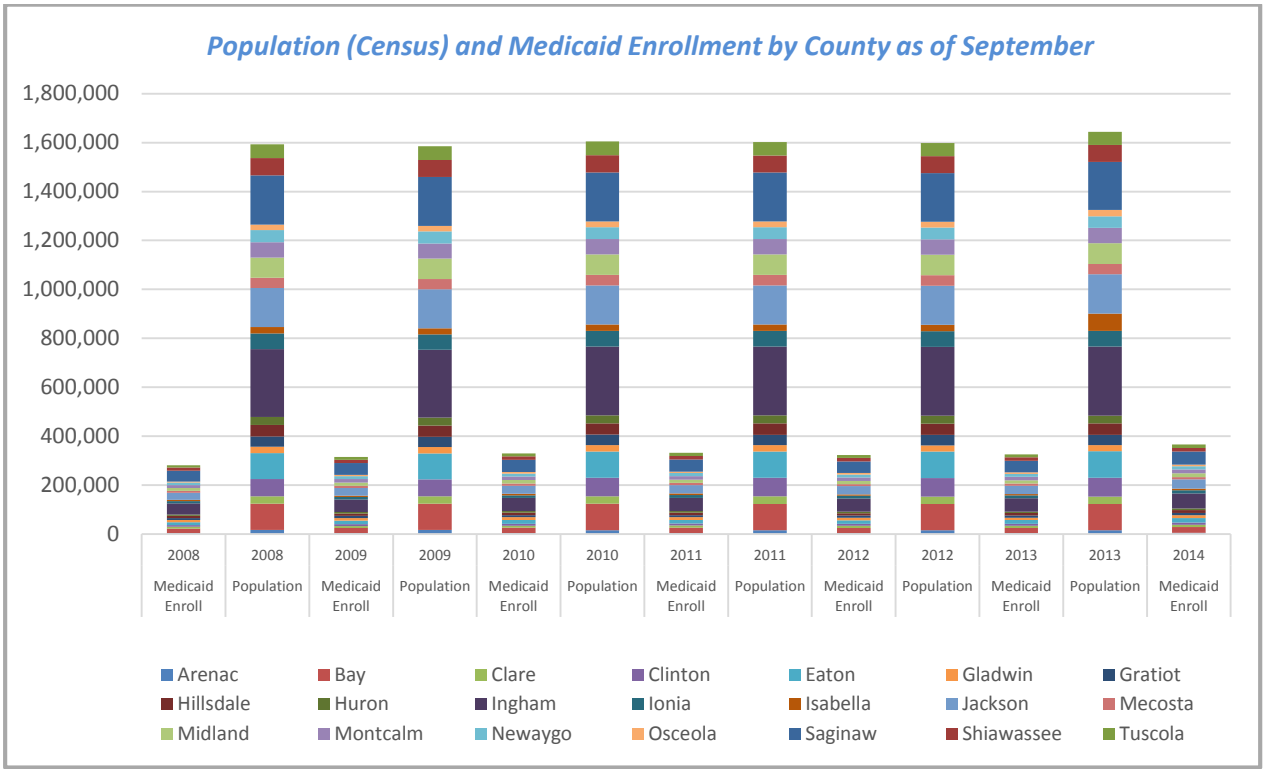
Adequacy of services for anticipated enrollees

In addition to ensuring the appropriateness of the range of specialty behavioral health services, MSHN must also determine that services are adequate for the anticipated number of enrollees in the service area.[3] Medicaid enrollment, service penetration rates and community demand are key factors to consider.

[3] 42CFR438.207(b)(1) "Offers an appropriate range of preventative, primary care and specialty services that is adequate for the anticipated number of enrollees in the service area."

Medicaid enrollment

Medicaid enrollment in Michigan has been climbing in the past decade, most likely due to a general deterioration in the state's economy. In the past couple of years enrollment has shown signs of plateauing. Medicaid enrollments in the counties comprising the MSHN region still remain relatively high with MSHN Medicaid remaining near 20% of the total population, based upon CMHSP Participant Data (see graph and table below)[4]. Higher Medicaid enrollment is associated with a relatively greater number of potential consumers of specialty behavioral health services. This suggests the size of the MSHN provider network should remain at least at the existing level for the upcoming year.



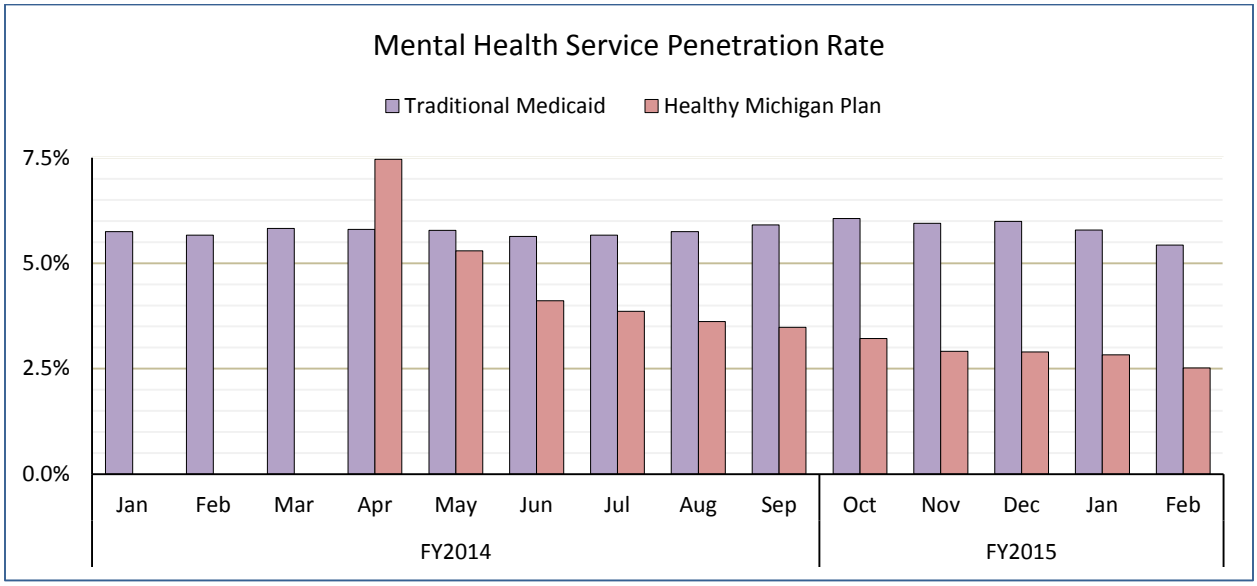
Medicaid Enrollment as Percentage of Total Population as of September

	2008	2009	2010	2011	2012	2013
Mid-State Region	17.67%	19.90%	20.55%	20.70%	20.18%	19.82%

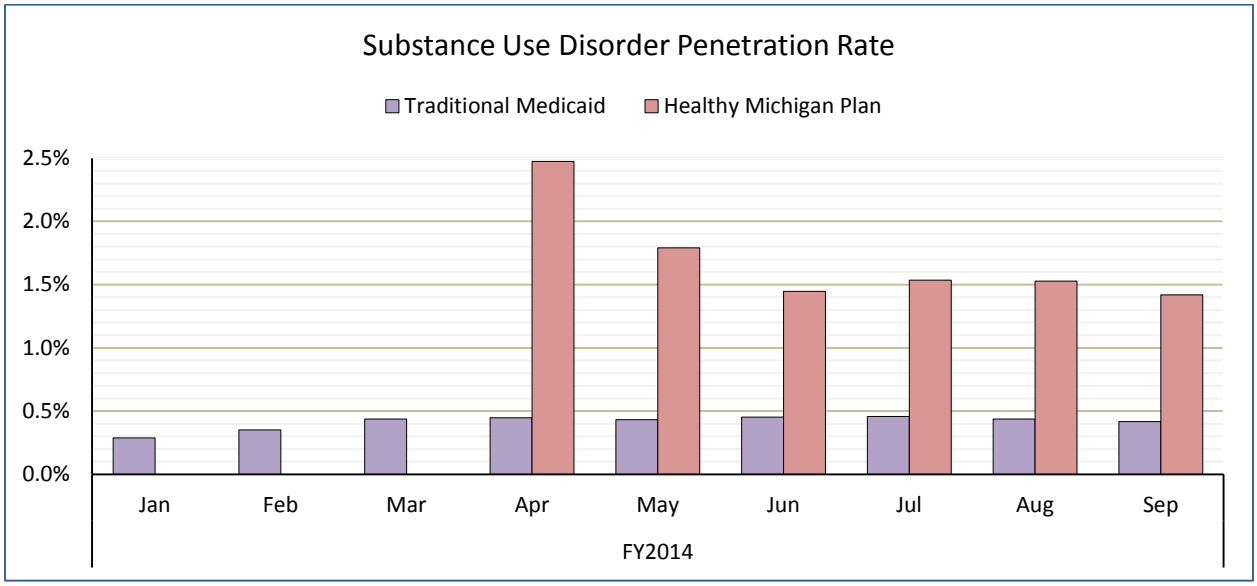
[4] Population census data and Medicaid enrollments taken from Community Needs Assessment Community Data Sets worksheets provided by each CMHSP.

Service population penetration rates

The number of Medicaid enrollees residing in the region who received specialty behavioral health services meets or exceeds the state average for most of the counties in the region. Again, this suggests service capacity should remain at or above existing levels and should not be reduced. The following figures compare "the mental health service penetration rate of traditional Medicaid and Health Michigan Plan by month. An item to note is the drastic increase in penetration rate of Healthy Michigan Plan active enrollees and the following decrease. Further analysis is needed to understand the mechanism of the increase":[5]



[5] Analysis of Mid-State Health Network Penetration Rate: January 2014 to February 2015 ("TM HMP Report"; prepared by M. Lee)



Variability does exist among the CMHSP Participants in the region relative to population penetration rates, which is being reviewed at the executive level by the MSHN Operations Council to determine if the variance is commensurate with community need or if action by the Council is warranted relative to network capacities.

Each CMHSP is required by MDHHS to complete a Community Needs Assessment each year. The needs assessment addresses service requests and their disposition, the use of service access waiting lists and other community demand information. This assessment informs decision making related to the sufficiency and adequacy of the provider network to address local needs and priorities.

Community Needs Assessments: Priority Needs and Planned Actions

The CMHSP Participants in the MSHN region completed either new community stakeholder surveys to assess community needs or provided an update on their last assessment. Across the region, services for individuals with substance use disorders or co-occurring mental health and SUD disorders was the number one priority relative to unmet need, both due to increasing rates of occurrence and CMHSP preparations to increased integration of mental health and SUD services. The second highest priority across the region was integration of healthcare and improving health outcomes, and third, services for children, with an emphasis on community stakeholder collaboration and coordination of services. Of the top three regional unmet community needs, both are already addressed in this assessment, with the exception of children's services.

Priority Rankings[6]

Top Five CMHSP Priorities Only; High (1) to Low (5)

Community Needs	Composite Regional Priority	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Services for Individuals with SUD/ Co-Occurring Disorders	1	1	3		3	1	1		2	4		2	1
Integrated healthcare and health outcomes	2		4	3					3	3	2	1	2
Services for children	3	2			2	3	3	4			3		3
Ease of **access to MH care**	4							5	1	1	1	4	
Services to individuals with mild/ moderate mental health needs; the underinsured	5	3	1					1	4		4	5	
Access to Psychiatric Services	6			1	1	2							
Community education/ prevention activities/ community outreach	7	5			5		2			5			5
Alternatives to inpatient psychiatric services	8			2					5			3	4
Effect of Trauma	9	4								2	5		
Affordable and appropriate housing; Homelessness	10-11		5			4		3					
Transportation to MH services	10-11				4			2					
Jail Diversion	12		2				5						
Services for the elderly	13-14												
Veteran's Outreach	13-14						4						
Poverty	15					5							

Similarly the SUDSRE's are required to prepare a three year Strategic Plan for Substance Use Disorder Prevention, Treatment and Recovery Services, which analyzes community needs. The MSHN SUD Strategic Plan for FY2015-2017 needs assessment analyzes trends in the primary substance in use at time of admission, rates of alcohol use, and mortality rates due to poisoning. Please see the Plan for detailed data and analysis.

Through the MSHN SUD Strategic Plan needs assessment, it was determined an increased provider network capacity for opiate and medication assisted treatment was needed in the region. MSHN and the SUDSRE's issued a request for proposals early in 2015. The proposals received did not result in new providers joining the network so MSHN plans to continue to work with existing providers to enhance regional capacity to meet consumer needs.

Waiting Lists

CMHSP Participants may establish waiting lists for certain services but are not permitted to use waiting lists for Medicaid services. The SUDSRE's may place a hold on admission referrals to a program if that provider exceeds capacity. MSHN and its SUDSRE's and CMHSP Participants

[6] Source: CMHSP Participant Annual Submission and Community Needs Assessment; Attachment E: Priority Needs and Planned Actions

may elect to seek or add providers to regional provider networks to meet existing or new needs of consumers.

Anticipated changes in Medicaid eligibility or benefits

Consideration of anticipated changes in Medicaid eligibility or benefits in the near term and an assessment of their anticipated impact on enrollment in the region is an important consideration.

Medicaid expansion

On April 1, 2014 the state of Michigan implemented a new program, the Healthy Michigan Plan (HMP), for purposes of expansion of Medicaid eligibility to the medically uninsured and underinsured.

MDHHS indicated in its press releases for the HMP that 322,000 low income residents in Michigan were expected to qualify. In December of 2013 the MSHN region had 16% of the state's Medicaid enrollees living within its borders, which suggested 51,520 people in the MSHN region may meet criteria to participate. In May of 2014 the Michigan Primary Care Association published estimates of the number of uninsured people who may be eligible for HMP benefits, projecting 74,519 potential new enrollees for the counties in the MSHN region.7

HMP enrollment as of August 2014 was 57,036 people for the 21 counties comprising the MSHN region, as shown in the table below:

Enrollees in Healthy Michigan Plan as of August 2014[8]

County	Estimate	County	Estimate	County	Estimate
Arenac	710	Hillsdale	1,385	Midland	2,554
Bay	3,877	Huron	969	Montcalm	2,279
Clare	1,598	Ingham	10,666	Newaygo	2,043
Clinton	1,261	Ionia	1,884	Osceola	837
Eaton	2,523	Isabella	2,072	Saginaw	8,088
Gladwin	1,144	Jackson	5,949	Shiawassee	2,341
Gratiot	1,329	Mecosta	1,508	Tuscola	2,019

In Fiscal Year 2014, MSHN, it's CMHSP Participants and Substance Abuse Coordinating Agencies (still in operation at that time) served 6,650 Healthy Michigan Plan enrollees, or 11.66% of the

[7] Figures obtained from Michigan Primary Care Association: HMP Enrollment Report by County 5-5-14; based upon Uninsured estimated HMP eligible provided by Census Bureau SAHIE, Ages 18-64, <=138% FPL, All Races, Both Sexes; http://www.census.gov/did/www/sahie/data/interactive

[8] Michigan Primary Care Association: Health Michigan Enrollment Report; http://c.ymcdn.com/sites/www.mpca.net/resource/resmgr/Outreach_and_Enrollment_HMP/HMP_Enrollment_Report_by_Cou.pdf

57,036 or so HMP enrollees in the region at that time. Detail is shown for this initial and partial year of service delivery (i.e., April 2014-September 2014) in the following table:

MSHN FY14 Healthy Michigan Plan (HMP) Unique Cases Served[9]

	BABH (inc. RCA)	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	NMSAS	SCCMHA (inc. SCPHD)	SHIACMH	TBHS
Total HMP Cases & Costs (MH/DD/SA)	960	1,495	1,009	253	101	115	817	120	199	575	686	152	168
Total HMP MH/DD Cases & Costs	593	1,495	1,009	253	101	115	817	120	199	--	548	--	168
HMP Substance Abuse Cases & Costs	455	--	--	--	--	--	2	--	--	575	237	--	--

Since August of 2014, HMP enrollment in the MSHN counties has increased 69% to 96,604 as of May 2015, exceeding initial projections from the Michigan Primary Care Association.

As passed by the Legislature and signed into law by the Governor in September, 2013, Michigan's Medicaid expansion, the Healthy Michigan Plan, requires submission of a 2nd waiver by September 1, 2015, and the approval of this 2nd waiver by December 31, 2015. In the absence of the 2nd waiver approval by this date, Healthy Michigan ends in April 30, 2016. The changes to the current Healthy Michigan Plan required by the law are to allow individuals in Healthy Michigan between 100 – 133% of the federal poverty level to choose one of the following options:

- Purchase private insurance through the federal Marketplace, or
- Remain in the Healthy Michigan Plan with increased cost sharing up to 7%.

Individuals in the Healthy Michigan Plan with income between 100 – 133% represent approximately 20% of the total Healthy Michigan Plan enrollment.[10]

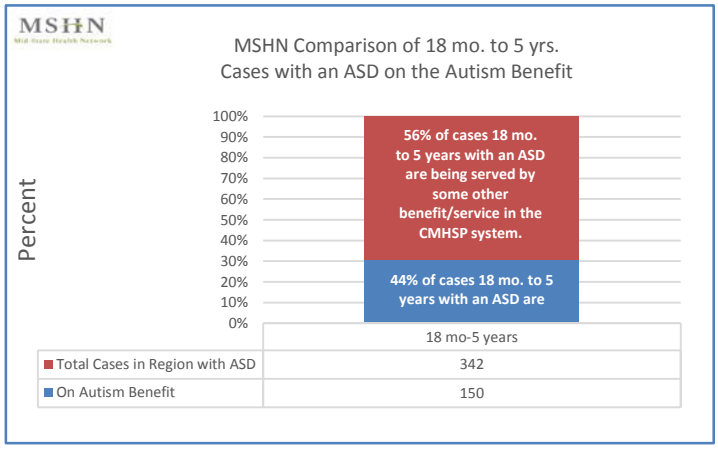
MSHN continues to monitor HMP eligibility criteria, enrollment trends and the region's capacity to meet enrollee needs.

[9] Source: 2014 MUNC Report for MSHN Healthy Michigan Plan
[10] Source: MACMHB June-July 2015 Director's Report

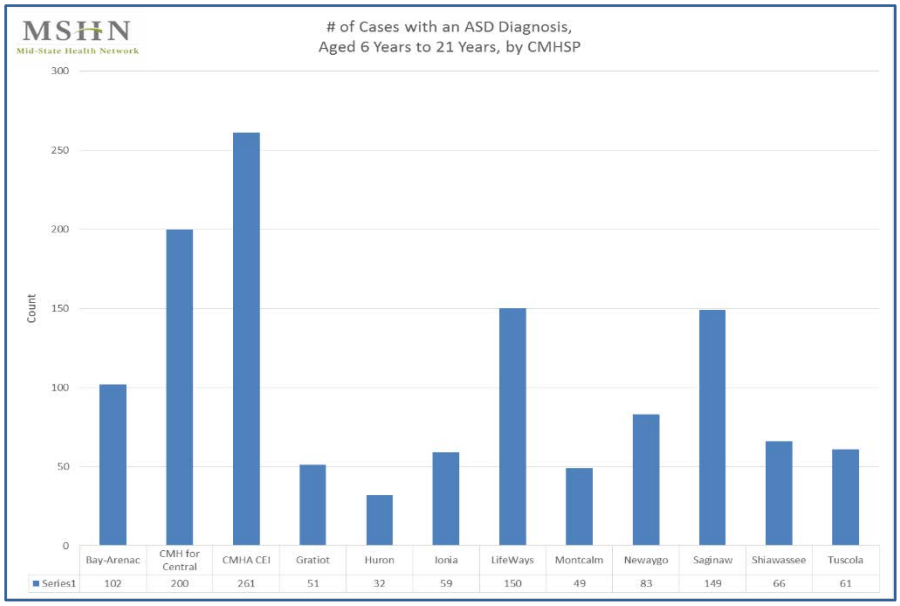
Autism Services

The MDHHS has announced its intention to expand eligibility for Autism services to age 21 effective January 2016.

MSHN has analyzed the potential impact on the number of children and adolescents likely to be eligible for services, as shown in the accompanying tables[11].



As of March 2015, 342 children aged 18 months to 5 years receiving services through MSHN's CMHSP Participants were diagnosed with autism spectrum disorders, with 44% of the children being served funded through the Autism benefit. Also as of March 2015, MSHN was serving an additional 1,221 children and adolescents aged 6 to 21 years who are diagnosed with autism spectrum disorders, suggesting the presence of a potential 257% increase in demand.



Since the MSHN region has already encountered difficulties in meeting the existing demand for services by children aged 18 months to 5 years, there is concern across the region's CMHSP Participants regarding the adequacy of the network's capacity to absorb such a marked increase in demand for these highly specialized services with limited qualified professionals in local job markets.

[11] MSHN Autism Spectrum Disorder Presentation

Community Safety Net Services

As a primarily publicly funded system of care, MSHN and the CMHSP Participants are expected to provide core community mental health safety net services, such as 24 hour emergency services and care for the indigent. CMHSP's must assist police departments and jails with their inmate's mental health needs. Each CMHSP receives state funding for this purpose, as well as to cover the cost of inpatient psychiatric and state facility care for residents of the CMHSP's counties.

Management of these funds is not within the scope of authority of MSHN, but the same resources are expended by CMHSP Participants to absorb the cost of uncovered services for Medicaid enrollees who have been assigned a monthly spend-down amount in order to meet eligibility criteria, which they are not able to afford.

Recent funding reductions implemented by MDHHS in conjunction with the roll-out of HMP have impacted CMHSP Participant's ability to function as a community safety net provider and ensure an adequate provider network for core services required by the Mental Health Code. The greatest gaps in coverage are for individuals with Medicaid spend-down thresholds. MDHHS has reinstated some portion of these funds, but some CMHSP Participants continue to encounter demand for service which exceeds their capacity.

Mild to Moderate (Non-Specialty) Behavioral Health Needs

For those individuals with non-specialty behavioral health service needs (i.e. mild to moderate mental health needs), the Medicaid or Medical Health Plans contracted by the MDHHS are expected to provide the mental health benefit. In some counties in the MSHN region, the availability of such services are limited or non-existent due to service capacity issues, low reimbursements or other barriers. A 2014 informal survey by MSHN of the CMHSP Participants in the region yielded the following results:

Mid-State Health Network: CMHSP – MHP Service Access and Coordination Survey 3/13/14

1. Do consumers in your county/counties have difficulty accessing Medicaid Health Plan outpatient services for mild/moderate mental health needs?
   Yes, Always: 3
   Yes, sometimes: 6
   I am not sure: 1

2. If yes, which county/counties?	3. If yes, are access difficulties because?
Arenac, Huron, and Gratiot	The MHP has no mental health outpatient providers in our county/counties (other than CMHSP if contracts are established).
Shiawassee, Mecosta, Osceola, Clare, Gladwin, Clinton, Eaton, Ingham, and Hillsdale	The MHP(s) have a limited mental health outpatient providers and there are long waits.
Montcalm	No MHP Psychiatric providers after 6.1.2014
Newaygo	Services and limited out of Grand Rapids. The CMHSP is the only provider.

Note: The survey results are inclusive of feedback from 10 or 12 CMHPS.

MDHHS has re-introduced quarterly meetings of PIHP Medical Directors and an area of concern identified by the group was consumer access to MHP mental health benefits, with lack of information regarding service access procedures, lack of availability of MHP network providers and transportation issues noted as critical points of concern for PIHP's and CMHSP's.

Home and Community Based Services

The Centers for Medicare and Medicaid Services (CMS) released new rules in 2014 for Home and Community Based Services (HCBS) waivers, of which Michigan has several related to mental health services. The rules set new expectations for services delivered in community and home settings based on individual experience and outcomes, rather than service setting locations in order to maximize opportunities to integrate with their communities and realize the benefits of community living.

MSHN and its CMHSP Participants have begun a self-assessment process to determine if the regional provider network is operating in a manner consistent with the new rules. MDHHS will be performing system assessments through the remainder of 2015. MSHN anticipates the bulk of any required transition planning would begin late in 2015 and carry over into FY16.

Michigan Public Act 200

In June of 2014, Michigan Public Act 200 amended Chapter 2A (Substance Abuse Disorder Services) of the Mental Health Code to allow a court to order involuntary treatment for an adult who had a substance use disorder, under particular circumstances. The person would be guaranteed an independent expert evaluation and legal counsel. A judge could order treatment for up to 72 hours or until a hearing could be held.

MSHN and the SUDSRE's are still determining the potential impact on service demand and provider network capacity this new Act will entail.

Meeting the needs of enrollees: expected utilization of services

MSHN must maintain a network of providers that is sufficient to meet the needs of the anticipated number of enrollees in the service area[12]. A determination of whether the network of providers is sufficient would typically be made at through analysis of the characteristics and health care needs of the populations represented in the region[13]. However, the unique nature of the Medicaid Managed Specialty Supports and Services Program in Michigan complicates the assessment of network sufficiency beyond the scope of a simple analysis of clinical morbidity or prevalence among Medicaid enrollees.

MSHN is required to serve Medicaid beneficiaries in the region who *require* the Medicaid services included under the 1915(b) Specialty Services Waiver; who are *enrolled* in the 1915(c) Habilitation Supports Waiver; who are enrolled in the Autism Benefit; or for whom MSHN has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. The PIHP must also ensure access to public substance use disorder services funded through Medicaid, Public Act 2, MI-Child and substance use disorder related Block Grants. Furthermore, MSHN is required to limit Medicaid services to those that are *medically necessary* and appropriate, and that conform to accepted standards of care. Services must be provided (i.e., available) in sufficient amount, duration and scope to reasonably achieve the purpose of the service.

Since eligibility and medical necessity for service involves factors beyond the determination of a diagnosis, prevalence may not be best predictor of future demand. Service utilization may serve as a better proxy for consumer demand. Service utilization data will be incorporated into this assessment in FY16.

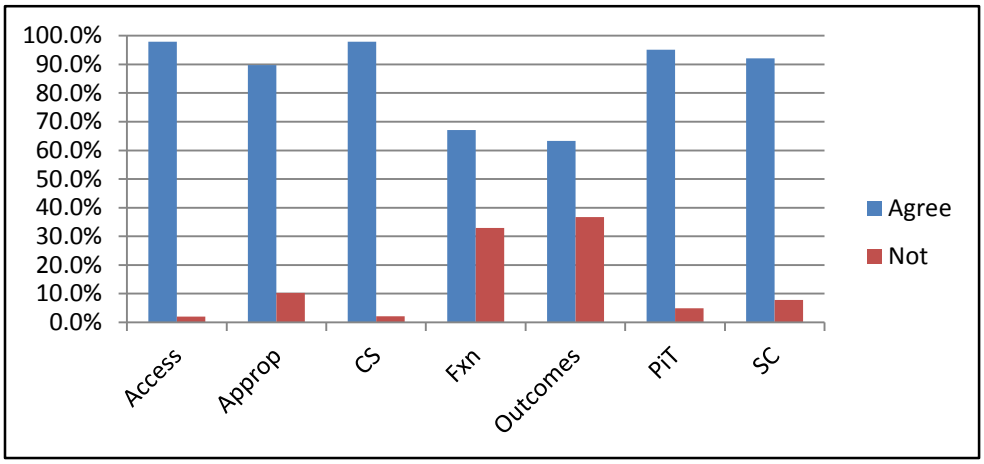
[12] 42CFR438.207(b)(2) "Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."
[13] 42CFR438.206(b)(ii) "The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the PIHP."

Consumer satisfaction with services is an important consideration when evaluating the adequacy of a provider network. MSHN completed its first assessments of consumer perception of care during 2014 for adults with mental illness utilizing Assertive Community Treatment and children with serious emotional disturbance receiving Home Based Services. Although not necessarily representative of all consumer populations, these high need groups have been repeatedly identified by MDHHS as key stakeholders for solicitation of feedback and therefore are used here as proxies for the satisfaction of MSHN recipients of service.

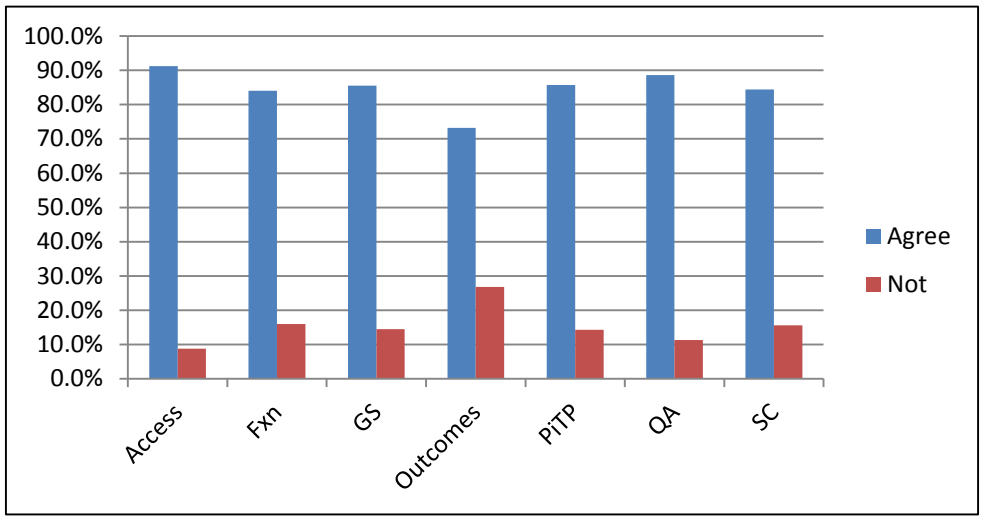
Results of the MSHN 2013 Baseline Perception of Care Survey conducted in 2014 are shown in the tables below for the subscales Access, Quality/Appropriateness (Approp or QA), General Satisfaction (GS), Functioning (Fxn), Outcomes, Participation in Treatment Planning (PiT) and Social Connectedness (SC)[14]. The percentage of individuals responding favorably on the General Satisfaction subscale were quite high, as were the favorable responses to the Access to services subscale, with less than 10% of either population expressing concern about access to services.

[14] MSHN QAPIP 2013 Baseline Perception of Care Report

Percent Agree by Subscale, Home-Based Services



Percent Agree by Subscale, Assertive Community Treatment



Sufficiency of network in number, mix and geographic distribution

MSHN must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area[15]. The effectiveness of the number of providers in the network may be evaluated to a great extent by past performance.

[15] 42CFR438.207(b)(2) "Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."

Sufficiency of number of providers

MDHHS requires PIHP's to report indicators of access timeliness and inpatient follow-up. Below is a table showing the baseline performance of the 21 county region, as calculated for purposes of this assessment in 2014, based upon the numerators and denominators reported by the PIHP's which were in operation prior to the formation of MSHN16. Data for MSHN's first year of operation have been added, as shown in the following table:

State Performance Indicators for Access Timeliness and Inpatient Follow-Up

	Population	MSHN Region Composite Score FY13 Q3	MSHN Score FY14 Q4	Difference	MDHHS Statewide Total	Difference
New persons receiving face to face assessment w/in 14 days of non-emergency assessment (Standard: ≥95%)	MI-Children	98.49%	99.46%	+0.97%	99.00%	+0.46%
	MI-Adults	99.34%	98.96%	-0.38%	98.50%	+0.46%
	DD-Children	100.00%	100.00%	0.00%	99.09%	+0.91%
	DD-Adults	100.00%	98.70%	-1.30%	99.27%	-0.57%
	Medicaid SA	99.47%	99.09%	-0.38%	98.34%	+0.75%
New persons starting on-going service w/in 14 calendar days of a non-emergent assessment (Standard: ≥95%)	MI-Children	96.54%	97.00%	+0.46%	97.43%	-0.43%
	MI-Adults	99.15%	97.00%	-2.15%	98.05%	-1.05%
	DD-Children	91.89%	100.00%	+8.11%	95.98%	+4.02%
	DD-Adults	94.64%	96.00%	+1.36%	95.97%	+0.03%
	Medicaid SA	100.00%	100.00%	0.00%	98.51%	+1.49%
Persons discharged from psychiatric inpatient unit/ substance abuse detox unit seen for follow-up care w/in 7 days (Standard: ≥95%)	Children	100.00%	100.00%	0.00%	99.17%	+0.83%
	Adults	97.58%	97.00%	-0.58%	98.15%	-1.15%
	Medicaid SA	100.00%	98.00%	-2.00%	96.45%	+1.55%
Persons readmitted to an inpatient psychiatric unit w/in 30 days of discharge	Children	4.82%	8.00%	+3.18%	10.71%	-2.71%
	Adults	9.63%	11.00%	+1.37%	13.05%	-2.05%

MSHN's performance is performing above state averages in most areas, but several CMHSP Participants are working on process improvements in order to meet access timeliness

[16] MDHHS State Fiscal Year 2013 Validation of Performance Measures; September 2013; prepared by Health Services Advisory Group

standards. At this point in time, only one of the CMHSP Participants identified a causal factor related to provider network capacity, which has already been addressed by the CMHSP.

MSHN has already identified network crisis response capacity and community psychiatric inpatient availability as areas of concern for the region's provider network, although MSHN performs better than state averages relative to inpatient recidivism. Both areas are being addressed by MSHN, which will is expected to help with inpatient recidivism as well.

As previously noted, MSHN and its CMHSP Participants have identified insufficiencies in the quantity of providers who are qualified to provide Autism benefit services, particularly Board Certified Applied Behavioral Analysts (BCBA's) to provide Applied Behavioral Analysis (ABA) services. MSHN conducted a survey of network capacity in the April of 2015, which yielded the following results:

MDHHS Medicaid/MI-Child Autism Spectrum Disorder (ASD) Capacity Survey

	BABH	CEI – 1	CEI - 2	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Adequate capacity for diagnostic services of ASD?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Capacity to assist additional children with diagnostic services for ASD?	No	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes
Capacity to provide ABA for additional children in addition to your community?	No	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	No	No	No
Number of BCBA's supervising ABA services	1 employed 2 contracted	13 employed	6 contracted	1 employed 4 contracted	2 contracted	1 contracted	2 employed	2 contracted	1 contracted	1 employed	4 – status not specified	1 employed	1 employed
Other qualified professionals supervising ABA services	None	12	5	4	None	None	None	2	None	None	3	None	None
Number of ABA aides	1 FT/ 8 PT[17] contracted	155 FT/ 52 PT employed	16 FT/ 18 PT contracted	0 FT/ 13 PT contracted	14 FT/ 10 PT contracted	0 employed 0 contracted	0 FT/ 4 PT employed	10 FT/ 3 PT contracted	1 FT/ 0 PT employed	0 FT/ 3 PT employed	6 FT employed Unknown # contracted	3 FT/ 3 PT employed	1 FT/ 3 PT employed
As of 3/31/15, number of children eligible for the benefit	17	180	48	29	13	0	5	31	2	5	51	10	7
Of those eligible, number receiving ABA services	15	150	48	24	10	0	4	23	2	5	38	8	5
Do you need assistance acquiring BCBA(s)?	Yes	Yes	No	Yes	No	No	No	No	No	No	Yes	Yes	No
Average length of time to start ABA services after referral (after initial contact w/ CMH for ASD services)	12 weeks	30 days	30 Days	8 weeks	3 weeks	Unknown	10 weeks	8 weeks	3 (?)	11 weeks	45 days	6 weeks	20 weeks

[17] FT is full-time; PT is part-time

The SUDSRE's identified some weaknesses in network capacity for substance use disorder services, as specified in the aforementioned multi-year strategic plan. The Saginaw SUDSRE is adding detox additional beds in Saginaw county due to lack of capacity to meet current demand and a methadone provider for Suboxone was replaced by CEI to maintain current provider volumes.

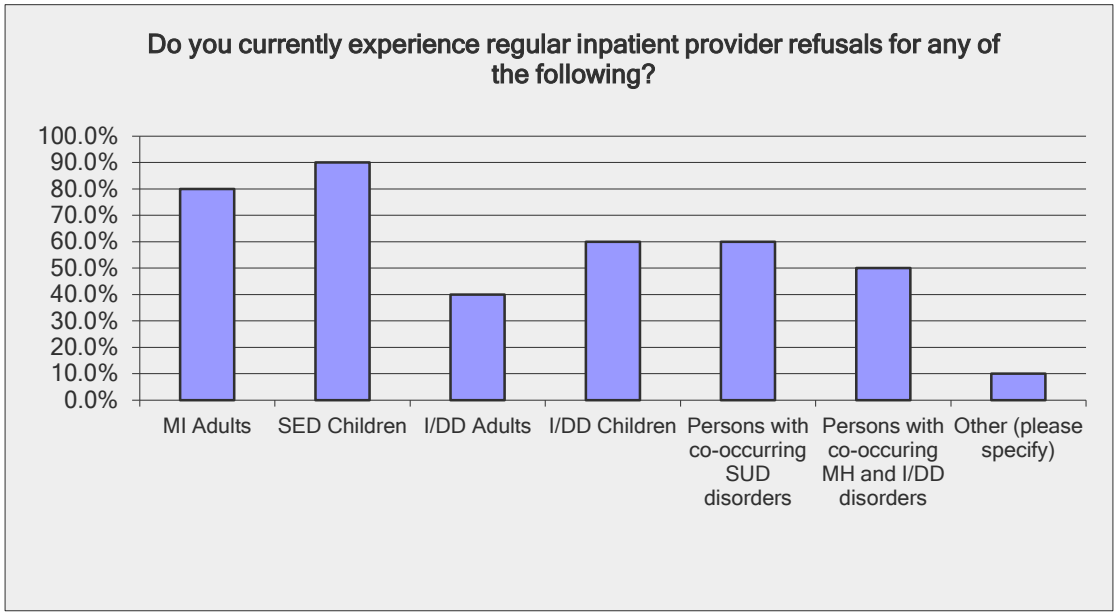
All CMHSP Participants are required via their contract with MSHN, and indirectly by MSHN's contract with MDHHS, to accept new Medicaid patients[18]. The same requirement applies to SUDSRE Medicaid services.

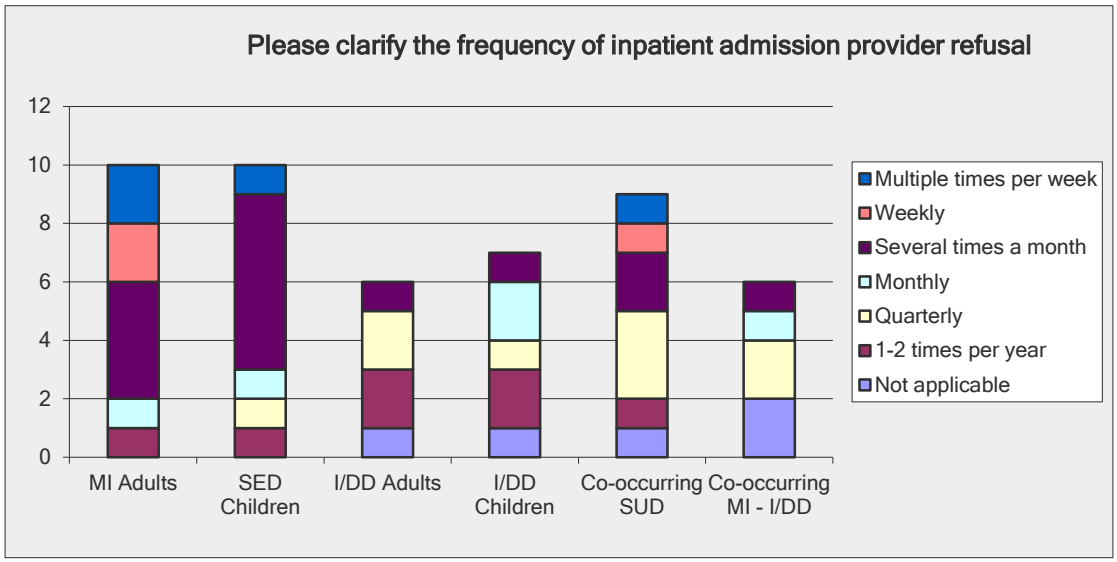
Sufficiency of mix of providers

MSHN is required to give priority to individuals with serious mental illness, serious emotional disturbance and developmental disabilities with the most serious forms of illness and those in urgent and emergent situations. Key services for individuals with urgent and emergent needs include inpatient psychiatric care and 24/7 emergency response capacity. Both services are available in all 21 counties in the MSHN region. However, MSHN has noted psychiatric inpatient capacity in the region may not be adequate to meet the needs of all consumers (at any given time) for whom a pre-screening has been completed and admission determined to be warranted. Initial concerns include the possible refusal of consumers with behavioral challenges or certain diagnoses. MSHN conducted a survey to identify specific barriers to inpatient admissions and gaps in bed capacity.

[18] 42CFR438.206(b)(iv) "The numbers of network providers who are not accepting new Medicaid patients."

MSHN - Reported Experience Inpatient Hospital Refusal/Denial of Admission 2014
5/29/2014



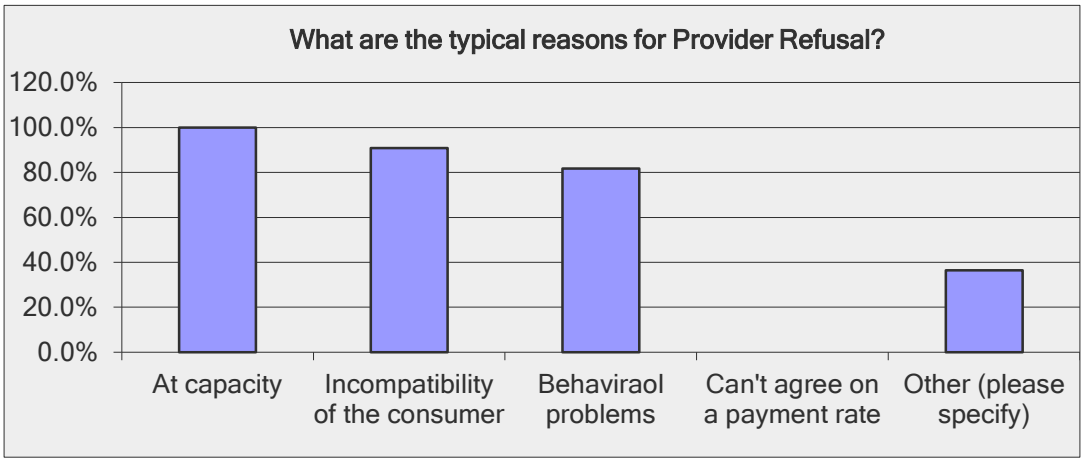


Please specify the hospitals you experience the highest rate of provider refusals with:

HOSPITAL	# of Respondents	HOSPITAL	# of Respondents
Pine Rest	6	Mid-Michigan Medical Center - Gratiot	
U of M		Coldwater	
White Pines	3	Owosso Memorial	2
Hillsdale		Havenwyck	2

Please specify the hospitals you experience the highest rate of provider refusals with:				
HOSPITAL	**# of Respondents**		**HOSPITAL**	**# of Respondents**
Lapeer Regional Medical Hospital			Forest View*	6
McLaren Bay Medical Center	2		Mid-Michigan Medical Center	2
Port Huron			Healthsource	3
Memorial Healthcare			Allegiance	
St. Mary's Med Psych			Sparrow/St. Lawrence	
Oaklawn	2		Hadley	

*MSHN UM Committee members report that Forest View has applied for a certificate of need for 30 child inpatient beds and has been approved to flex adult beds for children and adolescents.



MSHN CMHSP Participants and MSHN staff have noted that Inpatient unit rejections of admission requests for individuals with intellectual and developmental disabilities who experience behavioral challenges such as autism, are of particular concern, due to the lack of viable alternatives at this time. MSHN leadership in conjunction with its Provider Network Management Committee is working to address issues with access to inpatient care.

Community-based psychiatric treatment and behavioral intervention may be considered the next highest priority relative to stabilization of acute clinical symptoms for consumers in urgent and emergent situations. Both services are likewise available in all counties in the region. However, it is challenging to sustain adequate psychiatric capacity, particularly physicians with specialized certifications such as board certification in the treatment of adolescents and children.

Historically, CMHSP Participants been challenged with recruiting and maintaining ancillary health services such as occupational, speech language pathology and physical therapists,

especially in rural counties. Relatively recent transitions from social work registration to licensure has increased requirements for clinicians and lengthen the time required to secure full licensure, however, it is not evident this has created significant issues with network capacity.

In the past year or two, some CMHSP Participants and their direct operated and subcontracted service programs have found it difficult to secure adequate providers to provide applied behavioral analysis services for children with autism, due to the extensive training requirements for providers and the relative newness of the required credentials in the behavioral health industry and Michigan in particular.

In February 2014, MDHHS completed a survey of the Medicaid and MI-Child funded public mental health system's capacity to serve children with Autism Spectrum Disorders; results for the CMHSP Participants in the MSHN region are shown in the table below.

Capacity to Serve Children with Autism Spectrum Disorders

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Do you have adequate capacity for diagnostic services of ASD to serve your caseload?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Do you have the capacity to assist additional children w/ diagnostic services of ASD?	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No
Can you provide applied behavioral analysis to additional children in addition to your current caseload?	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes
Do you need assistance acquiring Board Certified Behavior Analyst's?	No	No	No	No	Yes	No	No	No	No	Yes	No	No
What is the average length of time for an individual to start ABA services after referral for services?	8 weeks	4 weeks	3 weeks	4 weeks	-	13 weeks	10 weeks	0 weeks	8 weeks	15 weeks	6 weeks	Unable to deter

With the recent implementation of the Healthy Michigan Plan, MSHN will need to monitor closely the availability of licensed substance abuse treatment providers to meet the potentially increased demand. MSHN will be working with its provider network, MDHHS, and substance use disorder licensing to address which SUD services must be offered by a licensed provider versus a MDHHS certified or MSHN credentialed behavioral health provider.

Similarly, MSHN must assure that the twelve CMHSP participants, in addition to network SUD service providers, have adequate capacity and competence to participate in an integrated service access process for individuals seeking treatment for both mental health and substance use disorders. Cross credentialing is a particular area of focus for the region. To that end, MSHN has established recovery oriented standards for the intake processes:

Standards to Inform CMHSP Intakes with Prospective SUD Consumers

To operationalize the integration of mental health and substance abuse treatment, the UM Subcommittee on Access recommends the following standards for CMHSP's in Region 5:

1. **Access Worker Training:** The CMHSP Access Person completing screening should have the necessary relevant training for SUD diagnostics, services, risk assessment, and necessary areas to have on the screening form.

2. **Welcoming Approach:** From the first moments of the intake, the consumer should feel welcomed and made to feel that he/she is in the right place to get help. Realization that an SUD concern/issue is primary rather than a mental health concern/issue should not interrupt the consumer's perception of being in the right place to receive help.

3. **Minimize Repetition:** Coordination should be used between CMHSP's and SUD providers regarding screening and assessment processes to avoid repetition of questions for the consumer.

4. **Explain What to Expect:** The SUD access process should be transparent and explained to the consumer so he or she will know what to expect regarding related access processes.

5. **Facilitate a Warm Handoff:** When a consumer, either in person or via phone, is being screened and an SUD concern/issue is identified as primary, the CMHSP Access Worker should make an effort to facilitate a "warm handoff" to the SUD provider of the consumer's choice. If the consumer agrees, a phone call to the selected SUD provider will be attempted while the consumer is still present or on the phone. This is to assure a follow-up appointment with the SUD provider is made. The CMHSP Access Worker should identify him/herself and inform the SUD provider he/she has someone on the call. For confidentiality reasons, the consumer should introduce him/herself to the SUD provider and request SUD services. It is highly recommended that a Release of Information form is signed by consumers who walk in and is faxed, along with the screening tool, to the SUD Provider with whom the consumer chose.

   If the SUD provider is closed or otherwise inaccessible by phone during the "warm handoff", the consumer should leave his/her name and phone number in a voice-mail message. The CMHS Access Worker is to inform the consumer the SUD provider will make contact with the consumer within one business day. The CMHSP Access Worker should provide the consumer with the SUD provider's phone number.

   If the consumer prefers not to go through the "warm handoff" process, the Access Worker is to provide the consumer with the phone number and hours of the SUD provider of the consumer's choice. This is for the consumer to contact the SUD provider him/herself. The CMHSP Access Worker is to follow up with the consumer within one business day to encourage and, if necessary, facilitate contact with the provider.

Community Education & Outreach: CMHSP's should do outreach to referral sources (courts, schools, community members) and potential consumers about how to access SUD services.

Each CMHSP participant includes training for staff regarding cultural competence. Providers are empaneled in areas with concentrations of particular ethnic or cultural groups, such as the Latino counseling services available through the CEI provider network. Each CMH is responsible for understanding the ethnic composition of their communities and adhering to requirements for publication of materials in different languages.

Consumers are offered a choice of provider whenever possible within the constraints of the local health care provider marketplace. Rural areas may not have adequate numbers of qualified provider agencies or independent practitioners available to permit CMHSP participants to offer a choice. Some locations in the region are designated by the State of Michigan as medically underserved areas, thereby qualifying for supplemental physician recruitment and training efforts.

Geographic accessibility

The MSHN region, although rural in some areas, is able to meet MDHHS standards for geographic accessibility, as follows:

- For office or site-based mental health services, the individual's primary service providers (e.g., case manager, psychiatrist, primary therapist, etc.) must be within 30 miles or 30 minutes of the recipient's residence in urban areas, and within 60 miles or 60 minutes in rural areas.

- For office or site-based substance abuse services, the individual's primary service provider (e.g., therapist) must be within 30 miles or 30 minutes of the recipient's residence in urban areas and within 60 miles or 60 minutes in rural areas.[19]

Transportation is a greater challenge for CMHSP Participants given the rural and small/medium city composition of the region. Public transit is limited to city centers and surrounding suburbs in most instances. Delivery of services in non-clinic settings and use of targeted transportation programs helps address any gaps in accessibility for consumers of services.

In 2015 one of the SUDSRE's (Riverhaven) added home based services for women with children, which is an enhanced women's specialty service, in order to address geographic limitations/ transportation problems individuals were having in trying to access clinic based services.

Accommodations

All CMHSP Participants offer services in locations with physical access for Medicaid enrollees with disabilities[20]. Delivery of services in home settings as well as telemedicine (now available in selected counties) can offset barriers to physical access where present.

The majority of the CMHSP's in the region are CARF accredited, which requires specific accommodations and accessibility evaluations or plans to ensure services are readily available to individuals with special needs.

[19] Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY13 Contract; 3.1 Access Standards

[20] 42CFR438.206(b)(vi) ". . . considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities."

Each CMHSP Participant endeavors to maintain a welcoming environment that is sensitive to the trauma experienced by individuals with serious mental illness and that is operated in a manner consistent with recovery oriented systems of care.

Interpreters/ translators are available at each CMHSP for persons with Limited English Proficiency (individuals who cannot speak, write, read or understand the English language at a level that permits them to interact effectively with health care providers) as required by Executive Order 13166 "Improving Access to Services for Persons with Limited English Proficiency"). This includes the use of sign interpreters for persons with hearing impairments and audio alternatives for people with vision limitations.

In late 2014/early 2015, the Michigan Department of Community Health, in conversation with advocates for individuals who experience deafness or consider themselves hard of hearing, as well as those with co-morbid blindness, determined a need to evaluate regional access, service provision and treatment supports for those who may require specialty behavioral health services. A survey was conducted by MSHN in the winter of 2015, which found the following:

Capacity to Serve Individuals with Deafness (D), Hard of Hearing (HOH) or Deaf/Blindness

How many DHOH/Deaf Blind consumers is your agency serving?

	Number of DHOH/Deaf Blind consumers
MSHN Total	2288
CMH Average	191

*One CMH stated that they are unable to determine the number of Hard of Hearing consumers.

Would the manner in which your agency provide DHOH services, in general, survive an ADA review (if one existed)?

	Number of CMH
Yes	5
No	0
Unknown	7

Does your agency have American Sign Language interpreters available to support the intake process?

	Number of CMH
Yes	12
No	0
Unknown	0

How many of your DHOH/Deaf Blind consumers depend on friends or family members to provide interpreting services?

	Number of CMH
MSHN Total	34
CMH Average	4

*The average was determined by averaging the response of nine CMHs. Three CMHs stated the data is unknown or unable to be determined. The three CMHs comprises 85% of the MSHN's DHOH/Deaf Blind population.

Who includes the DHOH/Deaf Blind population in cultural competency training?

	Number of CMH
Yes	7
No (not specific)	3
Unknown	2

What type of outreach is your agency doing for the DHOH/Deaf Blind population?

	Number of CMH
Social Media	1
Hospitals	1
Schools	2
Therapists	2
Nothing specific	8
Unknown	0

MSHN will be requesting that CMHSP's ensure accommodations are available as required for individuals accessing services who experience hearing or vision impairments and also that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services.

Public Policy Priorities

In its 2013 Application for Participation for PIHP's, MDHHS identified a series of public policy initiatives which reflected the state's priorities relative to maintaining an adequate provider network capacity for Medicaid beneficiaries.

Regional Crisis Response Capacity

It is expected by MDHHS that MSHN will have a crisis response capacity fully available by January 1, 2015 that includes clinical expertise that can be immediately accessed for mental health or behavioral crises. As stated in the MDHHS AFP guidance for AFP item 5.1 Regional Crisis Response Capacity:

> *That expertise may be a team or teams of clinicians who are available for telephonic consultation and on-site observation and consultation, and have the training and experience to address the needs of children and adults with serious mental illness (SMI/SED) and children and adults with intellectual/developmental disabilities (I/DD), and children and adults with co-occurring SMI/SED and I/DD. This crisis response capacity must also have a residential or inpatient component to which an individual can be transported, reside for a short period, and receive treatment or intervention until his/her crisis stabilizes.*
>
> *This capacity could be intensive crisis stabilization or crisis residential services in a free-standing licensed adult foster care facility and a free-standing licensed children's foster care facility, staffed with clinicians and workers who are specially trained to respond effectively to behavioral crises exhibited by adults or children with SMI/SED or adults with I/DD. This capacity could alternatively be an agreement with a regional inpatient psychiatric unit that is willing and able to receive any individual (SMI, SED or I/DD, adult or child) who is exhibiting a behavioral crisis. This capacity must include emergency admission.*

MSHN provided data regarding individuals considered at-risk of crisis placement, as presented in the following table:

Individuals at Risk of Crisis Placement

	911 Calls	Temporary placements in crisis home	On-site visit by CPLS mobile team	ER visit	Admission to psych inpatient unit	Request for inpatient admission to state facility
Child with SED	8	0	0	22	228	14
Adult with SMI 18-64	59	249	0	128	1567	69

	911 Calls	Temporary placements in crisis home	On-site visit by CPLS mobile team	ER visit	Admission to psych inpatient unit	Request for inpatient admission to state facility
Adult with SMI 65+	0	2	0	4	25	3
Child with I/DD*	4	1	1	3	5	5
Adult with I/DD* 18-64	25	11	3	24	58	11
Adult with I/DD* 65+	0	0	0	2	1	0

*People on the Autism Spectrum Disorder or people with co-occurring SMI/SED and I/DD in included this category

The MSHN Utilization Management Committee has initiated a focused review of inpatient utilization. The Utilization Management Committee will review the report during the next quarter and determine a process to ensure oversight and monitoring of inpatient utilization and need for improved access.

MSHN has established a policy requiring critical incident reporting. In addition, MSHN's Quality Assessment Performance Improvement Program (QAPIP) includes the reporting and follow up process required by the CMHSP's in the region regarding critical incidents. MSHN also requires through policy that the provider network (CMHSP's) either adopts the regional QAPIP or has a local QAPIP that is in compliance with the regional plan. As required, MSHN submitted critical incident reports for the month of January and February for our region. The QIC will review the data during their April meeting to determine further analysis and any recommendations for improvement.

Health and Welfare

MDHHS is seeking greater integration of systems of care to promote healthy behaviors and management of chronic conditions and all aspects of health: physical health, behavioral health, and habilitation. MDHHS expects that MSHN will assure that individuals being served receive appropriate, culturally-relevant and timely healthcare; that medical care providers are knowledgeable in how to approach and treat individuals with mental illness and/or intellectual/developmental disabilities; and that the PIHPs' provider networks are partners on the health care team for health care planning and monitoring purposes.

MSHN is focusing its health efforts on expanded competency and access to integrated health care information. Additionally MSHN recently completed a Mental Health Federal Block Grant to expand/enhance the availability of peer health coaches and to address regional infrastructure development for Trauma Informed Care.

MSHN staff is working with DCH to obtain access to Care Connect 360 and the Data Analytics. In addition, MSHN QIC and Information Technology Council are coordinating efforts to determine

what data will be extracted and utilized to ensure compliance with the state Performance Indicator Project and provide performance improvements opportunities that will create positive outcomes for individuals served in the region. MSHN has identified an epidemiologist we will use to support data analytic efforts.

Olmstead Compliance

Community Living

Title II's integration mandate of the Americans with Disabilities Act requires that the "services, programs, and activities" of a public entity be provided "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR 35.130(d). Such a setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 CFR 35, App. B at 673. MDHHS expects MHSN to ensure compliance with the Olmstead decision related to successful community living, appropriateness of placement and choice of housing.

The following tables' list data from MSHN regarding the housing arrangements/ current placements for selected individuals in the region, as reported in the 2013 AFP.

Individuals Living In Any Licensed Setting

	In Licensed Setting <6 Beds	# In Licensed Setting – 6 Beds	# In Licensed Setting 7-12 Beds	# In Licensed Setting 13+ Beds	# In Skilled Nursing Facilities	Total # Per Population	Percent Of Total Served
Children w/ SED	156	3	1	1	0	161	2.00%
Adults SMI 18-64	162	273	170	121	89	815	2.92%
Adults SMI 65+	53	60	44	20	167	344	16.9%
Children w/ I/DD	18	1	2	1	0	22	1.91%
Adults I/DD 18-64	378	810	221	111	37	1557	30.28%
Adults I/DD 65+	94	141	60	30	11	336	60.32%
Total	861	1288	498	284	304	3235	7.21%

Individuals Living In a Licensed Setting Outside of the PIHP Region as Of Dec. 31, 2012

	# in licensed setting <6 beds	# in licensed setting – 6 beds	# in licensed setting 7-12 beds	# in licensed setting 13+ beds	Total # Per Population	% of Total Served
Children w/ SED	14	0	2	3	19	0.24%
Adults SMI 18-64	13	17	14	19	63	0.23%
Adults SMI 65+	1	2	0	2	5	0.23%
Children w/ I/DD	3	0	1	0	4	0.34%
Adults I/DD 18-64	23	15	8	7	53	1.00%
Adults I/DD 65+	2	0	0	0	2	0.34%
Total	56	34	25	31	146	0.32%

Individuals Living Independently

	Independent w/o Supports	Independent w/ Supports	Independent w/ House/ Roommates	Independent w/o House/ Roommates
Adults SMI 18-64	**9594**	**1004**	**5376**	**4890**
Adults SMI 65+	**477**	**102**	**226**	**337**
Adults I/DD 18-64	**789**	**464**	**738**	**348**
Adults I/DD 65+	**76**	**70**	**104**	**26**

In the AFP MSHN committed to conducting an annual analysis of current capacity for offering alternatives to licensed settings. MSHN is in the process of gathering updated data from the CMHSP Participants for the above tables. The MSHN UM and Provider Network Management Committees will evaluate utilization patterns and consumer requests and satisfaction to determine the adequacy of current regional capacity. This exploration will include determining gaps within the MSHN continuum of care and areas where new living and support opportunities need to be developed. A workgroup with representation from sub-regional groups or all CMHSPs will be convened as necessary to assist with barrier identification and removal, local service/support development, and other network development activities.

In January 2014 the Centers for Medicare and Medicaid Services (CMS) published a final rule about Home and Community Based Services (HCBS) that ensures individuals receiving services through HCBS programs, which include MDHHS's 1915c and 1915i programs, have full access to the benefits of community living. MSHN anticipates the ruling will impact residential services,

as well as other community based programs. MSHN will work collaboratively with MDHHS, other regional entities and CMHSP's to develop an implementation plan due to the CMS in 2015. Full implementation of the rules and related capacity development is required by 2019.

Employment and Community Activities

CMS underscores that the competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is the optimal outcome of Pre-Vocational/Skill-building services. MDHHS expects that MSHN will embrace the above tenets and encourage its provider network to provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

The following table list data from MSHN regarding the employment and community activities for adults in the region, as reported in the 2013 AFP:

Adults in Employment and Community Activities

	Sheltered Workshop	Supported Employment*	Integrated Employment*	Volunteer job	No volunteer or paid work activity, includes retired	Total served
Adults SMI 18-64	157	164	3776	72	16093	27813
Adults SMI 65+	8	3	57	6	1326	2196
Adults I/DD 18-64	910	338	580	125	2456	5288
Adults I/DD 65+	86	8	17	4	318	585

MDHHS requires PIHP's to report data from which an employment rate can be calculated. Below is a table showing the performance of the 21 county region, as calculated for purposes of this assessment, based upon the information reported by the PIHP's which were in operation prior to the formation of MSHN[21].

State Performance Indicators for Competitive Employment

Time Period: 2012	Population	State Average	MSHN Region Composite Score	Difference
Percentage of adults competitively employed	MI-Adults	Not available	9.10%	n/a

[21] MDHHS State Fiscal Year 2013 Validation of Performance Measures; September 2013; prepared by Health Services Advisory Group

	DD-Adults	Not available	8.74%	n/a
	MI/DD Adults	Not available	6.71%	n/a

In the AFP MSHN committed to establishing a Provider Network workgroup with representatives from each CMHSP Participant to evaluate utilization patterns and consumer requests and satisfaction to determine current regional capacity. The MSHN Quality Improvement Council, the MSHN Utilization Management Committee and the MSHN Provider Network Management Committees will be addressing various aspects of this issue and determining gaps within our continuum of care and areas where new opportunities need to be developed. The new CMS ruling on home and community based services will also impact employment related services, so MSHN will be concentrating its efforts on 2015, when greater clarity regarding new federal and state expectations is expected.

Substance Use Disorder Prevention and Treatment

MDHHS is committed to a transformational change that promotes and sustains wellness and recovery for individuals, families, and communities. This change to a recovery-oriented system of care (ROSC) employs strategies to:

- Prevent the development of new substance use disorders.
- Reduce the harm caused by addiction.
- Help individuals make the transition from brief experiments in recovery initiation to sustained recovery maintenance via diverse holistic services.
- Promote good quality of life and improve community health and wellness.

MSHN is also tending to the needs of individuals with co-occurring substance use and mental health conditions by selecting a region-wide behavioral health recovery survey tool for implementation later this year. CMHSP Participants and MSHN have adopted recovery oriented language for inclusion in job descriptions. Recovery principles are being incorporated in the MSHN mission, vision and values. MSHN will be continuing to develop regional capacity to support consumer recovery over the next year.

Integration of mental health, substance use disorder and physical health care

MSHN and its CMHSP Participants are currently evaluating the state of integration of mental health, substance use disorder and physical health care publically funded systems of care. As noted previously, the CMHSP Participants identified integration of health care as one of their top priorities. The region currently has a performance improvement project which addresses

diabetes screening for individuals prescribed certain medications which are associated with exacerbation of metabolic disorders or predispositions.

MSHN has obtained access to Medicaid claims data for the region and has entered into a joint agreement with three other PIHP's for the purchase services from a data analytics vendor. Key measures have been identified for monitoring of the health status and wellness efforts of the region's Medicaid population.

Economies of scale in purchasing or rate setting

MSHN will explore economies of scale in purchasing, rate setting, regional capacity development and other efficiencies across the provider network. Two initiatives are already in process; specifically an analysis of inpatient rates for purposes of identifying opportunities for better value through collaborative rate setting; and a review of rates for Community Living Supports. The following tables show the results of initial survey activity conducted this year by MSHN and the CMHSP Participants:

Mid-State Health Network Inpatient Rate Assessment

HOSPITAL	CMHSP	Adult Per Diem	Child Per Diem	Notes
Allegiance Health	LifeWays	$675.00		
Alpena General	BABH	$750.00		
Bay Regional Med. Center (McLaren Bay Region)	TBHS/BABH	$650.00		
	Huron	$631.11		
	Saginaw	$631.00		
Behavioral Centers of America (BCA-Stone Crest)	TBHS	$700.00		
	CEI	$645.00		
	LifeWays	$650.00		
	Saginaw	$600.00	$625.00	
	Gratiot	$735.00		
Chelsea	LifeWays	$759.00		
Community Health/Branch Co.	LifeWays	$710.00		
Forest View	TBHS/CEI/Montcalm/Gratiot	$783.00	$814.00	
	Huron	$735.00		
	BABH	$790.00		
	Huron	$708.00	$737.00	
Harbor Oaks	LifeWays	$600.00		
	TBHS	$635.00		
Havenwyck	CEI	$572.00		
	BABH/LifeWays	$600.00		
	Saginaw	$550.00		
	Gratiot	$705.00		
Healthsource-Saginaw	TBHS	$702.27		
	BABH	$675.00		
	Montcalm	$820.00		Day 0ne

HOSPITAL	CMHSP	Adult Per Diem	Child Per Diem	Notes
	Montcalm	$760.00		Day Two +
	Saginaw	$675.00		
	Gratiot	$688.50		
Henry Ford Kingswood	TBHS	$650.00		
Herrick	LifeWays	$600.00		
Hillsdale Community Health	LifeWays	$660.00		
McLaren Lapeer Region	TBHS	$720.00		
Memorial Healthcare	TBHS	$775.00		FY 15 - $790.00
	Montcalm	$875.00		
	Saginaw	$775.00		
Memorial of Owosso	CEI	$805.00		
Mid-Michigan Midland/Saginaw	TBHS/BABH/Saginaw	$875.00		
	Gratiot	$838.00		
	Central	$875.00		
Oaklawn	CEI	$766.00		
	LifeWays	$800.00		
Pine Rest / St. Mary's	TBHS/ Lifeways/ CEI/ Montcalm/ Gratiot	$876.75	$909.75	
	Huron/Saginaw	$879.00		
Samaritan Hospital	CEI	$680.00		
	Saginaw	$630.00		
Sparrow / St. Lawrence	CEI	$771.00		Yr. 2: $789
Trinity Health / St Mary's HC	Saginaw	$847.50		
UM Health Systems	(not reported)	$900.00		
	Mean	$723.83	$771.44	
	Min	$550.00	$625.00	
	Max	$900.00	$909.75	

Community Living Services Rates

Mid State Health Network CLS Rates			Other CMH CLS Rates		
BABH	$3.35	Unit	Lenawee	2.50	Unit
CEI	$3.92	Unit	Northern Lakes	4.50	Unit
CMHCM	$4.03	Unit	North Country	3.59	Unit
GCCMHA	$3.87	Unit	Network 180	4.95	Unit
HBH	$3.86	Unit	Livingston	3.85	Unit
ICCMHA	$4.06	Unit	**Average Rate**	**$3.88**	**Unit**
LCMHA	$4.30	Unit			
MCBH	$3.16	Unit			
NCMHA	$4.57	Unit			
SCCMHA	$3.80	Unit			
ShiaCMH	$3.51	Unit			
TBHS	$2.68	Unit			
Average Rate	**$3.68**	**Unit**			

Through assessment of regional rates MSHN has determined significant variance exists from CMHSP to CMHSP when negotiating with certain provider types. MSHN and its CMHSP

Participants have agreed, where possible, to engage in regional rate negotiations. Joint planning and negotiation is intended to assure best value and to enhance/expand capacity of required services.

Recommendations/Conclusions

MSHN intends to use the Assessment of Network Adequacy as a dynamic plan, with data collection initiatives, plans, external requirements and other information incorporated throughout the year. Current priorities include Application for Participation focal points, opportunities to gain efficiency through regional collaboration and other areas warranting strengthening in order to optimize the provider network, as follows:

1. Plan for conversion from multiple SUDSRE model to a single SRE or direct performance of managed care functions for substance use disorder services, including MI-Child, PA 2 and Block Grant programs.
2. Seek guidance from MDHHS for Medicaid Expansion program (HMP) enrollees requiring concurrent mental health and SUD services
3. Continue to advocate for adequate coverage and funding for uninsured behavioral health populations.
4. Continue to support provider network capacity to offer key evidence based programs, such as recovery and trauma informed programming.
5. Determine next steps relative to inpatient admission refusals and additional regional crisis response/ inpatient alternative capacity options, particularly for individuals with intellectual and developmental disabilities (such as Autism) exhibiting behavioral challenges.
6. Continue to monitor and expand regional autism service capacity and utilization to ensure sufficient network capacity to meet consumer demand, particularly in preparation for the expansion of eligible consumers from age 5 to age 21.
7. Continue to develop provider network competency in the use of integrated health care information for action to improve population health outcomes.
8. Continue to assess and address the integration of mental health, substance use disorder and physical health care.
9. Once the system changes expected as a consequence of the HCBS Final Rule are more understood, develop a plan of action to alter provider capacity for residential, employment and other community living related services.
10. Monitor out-of-region placements for return to in-region services where feasible and appropriate.

11. Continue to address reciprocity between CMHSP Participants relative to requirements applied to sub-contracted service providers.
12. Set productivity standards for surveyors and continue to monitor regional capacity to perform the required number of trained SIS assessors for all IDD consumers aged 18-64 within a 3 year time period.
13. See the MSHN SUD Strategic Plan for FY2015-2017 for additional goals related to provider network capacity, particularly related to establishing a Recovery Oriented System of Care.
14. Continue to address network capacity issues for opiate and medication assisted treatment; work with existing providers to meet regional consumer need.
15. Discuss opportunities if any for regional action to address CMHSP identified issues with services for children.
16. Confirm during site reviews that required accommodations available for individuals accessing services who experience hearing or vision impairments, including that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services.