Assessment of Network Adequacy

2018

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Mid-State Health Network

Assessment of Network Adequacy

Contents

Definitions 2
Background 2
Appropriateness of the range of services 4
Numbers and types of providers (training, experience, and specialization) 11
Adequacy of services for anticipated enrollees 18
Medicaid/Healthy Michigan enrollment 19
Service population penetration rates 19
Community Needs Assessments: Priority Needs and Planned Actions 20
Anticipated changes in Medicaid eligibility or benefits 26
Autism Spectrum Disorder Services 26
Home and Community Based Services 26
Veteran's Access, Choice and Accountability Act of 2014 28
Intensive Crisis Stabilization Services 29
Independent Facilitation Services 29
Independent Assessment 30
Meeting the needs of enrollees: expected utilization of services 31
Sufficiency of network in number, mix and geographic distribution 34
Sufficiency of number of providers – access timeliness and inpatient follow-up 34
Sufficiency of number of providers – autism spectrum disorder capacity 35
Sufficiency of mix of providers – IDD, SED 36
Sufficiency of mix of providers - SUD 37
Sufficiency of mix of providers – cultural competence 37
Sufficiency of mix of providers – consumer choice 37
Accommodations 38
Population Health and Integrated Care 39
Economies of scale in purchasing or rate setting 44
Recommendations/Conclusions 44

Figure 1: **"No Wrong Door" Approach for Substance Use Services** 11
Figure 2: **BHT Supervisor Capacity per CMHSP** 14
Figure 3: **Average Number of Weekly ABA Hours in the MSHN Region** 14
Figure 4: **Proportions of Medicaid/Non-Medicaid Populations and Total Regional Population** 19
Figure 5: **Medicaid and Health Michigan Service Penetration Rates** 19
Figure 6: **Location of VA Medical Centers and Clinics in MSHN Region** 29
Figure 7: **Percent Agree by Subscale, Home-Based Services** 33
Figure 8: **Percent Agree by Subscale, Assertive Community Treatment** 33
Figure 9: **SUD Satisfaction Survey** 34
Figure 10: **FY18 Inpatient Rates** 44

Table 1: **State Plan Mental Health Services (1915(b) Waiver) Available in the MSHN Provider Network** 5
Table 2: **Medicaid Funded Substance Use Disorder Services Available in the MSHN Provider Network** . 6
Table 3: **Trend of Overdose Deaths by Cause in the MSHN Region** 6
Table 4: **Habilitation and Support Waiver Slots for MSHN Region** 8
Table 5: **1915c Habilitation and Support Waiver Services Available in the MSHN Provider Network** 8
Table 6: **1915(b)(3) Services Available in the MSHN Provider Network** 8
Table 7: **1915(i) Autism Benefit Services Available in the MSHN Provider Network** 9
Table 8: **Healthy Michigan Plan Services Available in the MSHN Provider Network** 9
Table 9: **Autism Qualified Licensed Practitioners per CMHSP** 13
Table 10: **Total Monthly Autism Evaluations in the MSHN Region 2018** 13
Table 11: **SIS Assessment Population and Interview Status** 15
Table 12: **Examples of Evidence Based Practices Utilized by CMHSP Participants in the MSHN Region** 15
Table 13: **Examples of Evidence Based Practices Utilized by SUD Providers in the MSHN Region** 16
Table 14: **Community Needs Assessment Priorities FY17** 20
Table 15: **Individuals Served by CMHSPs w/Autism Spectrum Disorders and ABA Service Utilization** .. 26
Table 16: **HCBS Compliance Status for Residential and Non-Residential Sites** 28
Table 17: **Independent Facilitation Contracts and Utilization in the MSHN Region** 30
Table 18: **Service Utilization by CMHSP** 31
Table 19: **HBS, TCM, and HSW Service Utilization** 32
Table 20: **State Performance Indicators for Access Timeliness and Inpatient Follow-Up** 34

Table 21: **Rate of Change of Autism Benefit Enrollees per CMHSP** 35
Table 22: **Individuals with Autism Waiting Longer than 90 Days for a Plan of Service**..... 36
Table 23: **Inpatient Psychiatric Denials per CMHSP in the MSHN Region** 36

Appendix A: **SUD Medication Assisted Treatment Geo-Map**
Appendix B: **SUD Withdrawal Management Geo-Map**
Appendix C: **SUD Residential Geo-Map**
Appendix D: **SUD Outpatient Geo-Map**
Appendix E: **Crisis Services Geo-Map**
Appendix F: **Inpatient Psychiatric Geo-Map**
Appendix G: **MDHHS Network Adequacy Standards Plan**

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 Subcontractors: Individuals and organizations directly under contract with a CMHSP to provide behavioral health services and/or supports.
3. Provider Network: MSHN CMHSP Participants and SUD Providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. For CMHSP Participants, services and supports may be provided through direct operations or through the subcontracts.
4. Substance Use Disorder (SUD) Providers: Individuals and organizations directly under contract with MSHN to provide substance use disorder treatment and prevention programs and services.

Background

As a Pre-Paid Inpatient Health Plan (PIHP), Mid-State Health Network (MSHN) must assure the adequacy of its network 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. Like other PIHPs in the state, MSHN continues to encounter challenges in gaining timely access to psychiatric inpatient and autism services which meet the needs of all clinical populations served.

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 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 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 (CMHA-CEI)
- CMH for Central Michigan (CMHCM)
- Gratiot Integrated Health Network (GIHN)
- Huron Behavioral Health (HBH)
- The Right Door for Hope, Recovery and Wellness (for Ionia Co.)
- LifeWays CMH (LCMHA)
- Montcalm Care Network (MCN)
- Newaygo County Mental Health (NCMH)
- Saginaw County CMH Authority (SCCMHA)
- Shiawassee Health & Wellness (SHW)
- Tuscola Behavioral Health Systems (TBHS)

MSHN also has responsibility for managing substance use disorder (SUD) treatment and prevention services funded under Medicaid, Public Act 2 and related Block Grants having been transferred to the PIHP's in Michigan.

Scope

Since CMHSP Participants have their own subcontracted and direct operated provider networks, primary responsibility for assessing local need and establishing the scope of non-SUD behavioral health services remains with the CMHSP's. MSHN works with the CMHSP Participants to ensure adequate networks are available and has primary responsibility for SUD service capacity.

The MSHN Assessment of Provider Network Adequacy is intended to support CMHSP 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 act upon these opportunities 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 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 SUD Provider, 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 Supports Waiver program, and specialty behavioral health (mental health and substance use disorder) services under the Healthy Michigan Plan. The scope also includes Block Grant and PA2 funded substance use disorder treatment and prevention 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 provider network is a relatively resource independent process. In other words, an objective assessment of beneficiaries' 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 updates its assessment of provider network adequacy 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 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 beneficiaries 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 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 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 beneficiaries, 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.

[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."

The array of State Plan mental health services covered under the 1915(b) Waiver are to be provided based upon the needs of the seriously emotionally disturbed children, adults with mental illness and individuals with intellectual/ developmental disability populations in each community, but MSHN must assure equity and appropriateness in service availability across the region. Table 1lists the service array and which services are provided by each CMHSP Participant in the MSHN region, based on local needs.

Table 1: **State Plan Mental Health Services (1915(b) Waiver) Available in the MSHN Provider Network**

	BABH	CMHA-CEI	CMHCM	GIHN	HBH	TRDFHRW	LCMHA	MCN	NCMH	SCCMHA	SHW	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	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
Family Therapy	X	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
Home-Based Serv. – Infant Mental Health	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	X	X					X		X		X
ICF Facility for IDD												
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	X	X	X	X	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
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	X	X
Transportation		X	X	X	X		X		X	X	X	
Treatment Planning	X	X	X	X	X	X	X	X	X	X	X	X

PIHP's and CMHSP participants are required by MDHHS to offer a continuum of adult services including case/care management, outpatient therapy, and psychiatric services that can be used in varying intensities and combinations to assist beneficiaries in a recovery-oriented system of care. The beneficiary's level of need and preferences must be considered in the admission process. Assertive Community Treatment (ACT) is the most intensive non-residential service in the continuum of care within the service array of the public behavioral health system. Based upon this requirement and the need for intensive community-based service options to preclude avoidable inpatient psychiatric admissions, the MSHN Operations Council determined ACT should be available in all counties in the region. Those CMHSP's in the region lacking ACT services have since added the service to their provider network.

Substance Use Disorder Services: Table 2 shows the array of services for treatment of substance use disorders and which services are delivered by SUD Providers under the auspices of their contracts with MSHN. MDHHS enrolls providers based upon the intensity of services offered. The intensities correspond to the frequency and duration of services established by the American Society of Addiction

Medicine (ASAM) levels of care, as shown below. The association of provider sites/services with levels of care will provide a framework for MSHN to understand the range of service options available across the region.

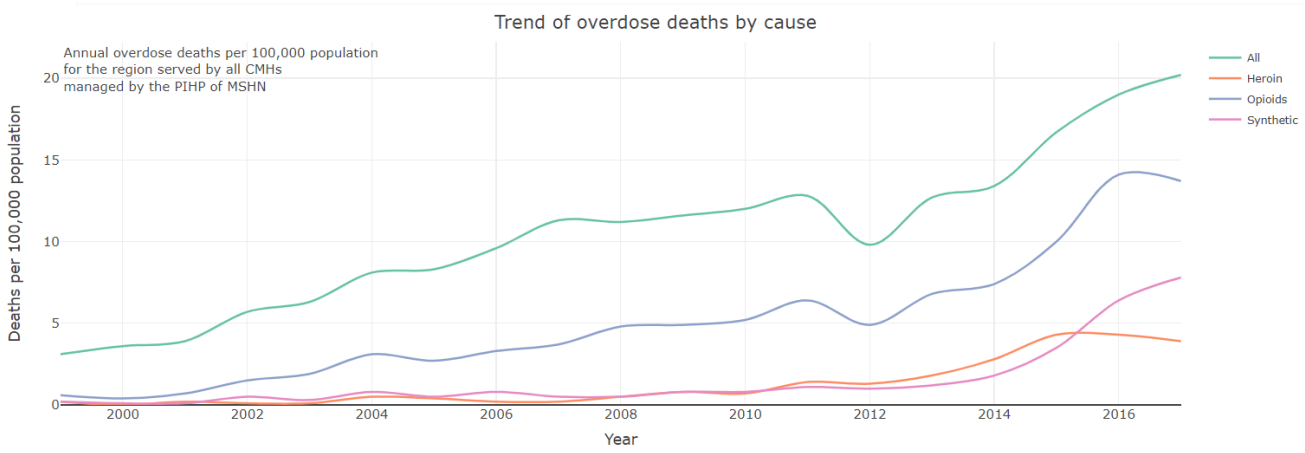
Table 2: **Medicaid Funded Substance Use Disorder Services Available in the MSHN Provider Network**

	Outpatient				Residential				Withdrawal Mgt.		OTP
County	0.5	1.0	2.1	2.5	3.1	3.3	3.5	3.7	3.2	3.7	Level 1
Arenac	X	X									
Bay	X	X	X								
Clare		X									
Clinton		X									
Eaton	X	X	X								
Gladwin		X									X
Gratiot	X	X									
Hillsdale		X					X				
Huron	X	X									
Ingham	X	X	X		X	X	X		X	X	X
Ionia		X									
Isabella		X							X		X
Jackson	X	X	X	X			X	X		X	X
Mecosta		X									
Midland		X					X				
Montcalm		X									
Newaygo	X	X	X								
Osceola		cb*	cb*								
Saginaw	X	X	X		X	X	X		X	X	X
Shiawassee	X	X									
Tuscola	X	X									
Out of Network	X	X	X		X	X	X	X	X	X	X

*cb (Community Based Services) are services in which a provider sends a clinician to the county to provide services in home and/or community settings.

The opiate addiction and overdose epidemic continues with MSHN's attention to regional capacity to provide detox services, Medication Assisted Treatment (MAT) including Suboxone and Vivitrol, and MAT's associated ancillary outpatient treatment and recovery supports. Table 3 shows regional opioid, heroin and all drug overdose deaths, based upon the most recent information available from MDHHS.

Table 3: **Trend of Overdose Deaths by Cause in the MSHN Region**[2]



[2] Michigan SUD Data Repository

Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.

As shown in Appendices A, B, C and D identify the location of SUD providers relative to the location of individuals who received those services. Much of the MSHN region is covered relative to the availability of outpatient and medication assisted treatment services; however, the region would like to expand capacity as 60 min/60 miles can be a barrier for consumers in need of services, particularly with daily dosing. As part of the FY19 State Opioid Response (SOR) grants, MSHN was chosen as a recipient of funding to support the purchase and implementation of a mobile care unit. Mobile care units are retrofitted vans/buses that will bring counseling, therapeutic, and physical health services to SUD patients. The unit will have an area for intake and scheduling, a restroom to incorporate urine screening, and at least one private room for counseling. Harm reduction activities including syringe services, overdose education, and naloxone distribution will also be provided. The unit will also have telehealth capabilities to incorporate MAT supports as needed. Locations of access for the mobile care unit will be evaluated by MSHN. While MSHN has established contracts outside the region for the provision of residential and withdrawal management services to address the needs of consumers in bordering counties, it should further assess the need for added services within the region. As for urban communities, MSHN complies with the 30 min/30 miles requirement (Lansing, Saginaw, Jackson).

In addition to the geographic accessibility of services, MSHN continues to address MAT guidelines adopted by the MDHHS, which promote the availability of Methadone, Vivitrol, and Suboxone at all MAT locations. Research supports different medications for different stages of disease and is dependent on the consumer's individualized needs. It is preferable to have a continuum of medication options within the scope of each MAT provider's capacity. This will not be possible at all MAT locations, but MSHN intends to work toward this goal. During FY2018, four (4) existing providers added Suboxone-assisted treatment in Genesee, Clare, Muskegon, and Tuscola counties. Note: out-of-network locations are at times more accessible to enrollees living in bordering communities.

MSHN continues to make the overdose reversal medication, naloxone (brand name Narcan) available. MSHN, in concert with the twelve CMHSPs, established Narcan kit distribution hubs using grant monies, and continues to supply all CMHSP partners with the availability of this medication for distribution within the community. MSHN has also distributed injectable naloxone kits to MAT providers in the region for distribution within the community to anyone in need of a naloxone kit.

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.

Recovery housing for consumers with SUD was added as a covered service by MDHHS and can be funded using block grant funds in conjunction with treatment services if integral to the treatment process. Several substance use disorder providers have begun to offer recovery housing and supportive services (outpatient, case management and peer recovery) in select counties across the MSHN region. MSHN continues to work with existing providers to develop recovery housing programming. MSHN shall assess needs in communities across the region and continues to work with the State to identify appropriate funding sources for this service. During FY18, MSHN conducted an RFP in Ionia and Eaton Counties for the provision of outpatient services and Hillsdale for the provision of men's residential services to fill gaps and/or offer choice. This resulted in a new outpatient provider in Ionia with a women's specialty designation and Suboxone waivered physician and a residential provider in Hillsdale. We continue to seek additional providers in Eaton County.

Habilitation Supports: Michigan's 1915(c) Habilitation Supports 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.

MSHN monitors utilization of HSW enrollments closely to ensure individuals with the commensurate level of need take advantage of this resource. Current enrollment screening strategies include ranking of applicants by Supports Intensity Scale standard score and regional review for appropriateness. Table 4 shows the utilization of HSW slots in the region at the time of this assessment and Table 5 shows the HSW services available in the region:

Table 4: **Habilitation and Support Waiver Slots for MSHN Region**

	September 2017		August 2018	
	Count	Percent	Count	Percent
HSW Slots Filled	1585	96.8%	1611	98.4%
HSW Slots Available	52	3.2%	26	1.6%

Table 5: **1915c Habilitation and Support Waiver Services Available in the MSHN Provider Network**

	BABH	CMHA-CEI	CMHCM	GIHN	HBH	TRDFHRW	LCMHA	MCN	NCMH	SCCMHA	SHW	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	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			X	X	X
Personal Emergency Response Systems	per request		X	per request	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		per request	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
Supported Employment	X	X	X	X	X	X	X	X	X	X	X	X

B-3 Services: 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 Table 6.

Table 6: **1915(b)(3) Services Available in the MSHN Provider Network**

	BABH	CMHA-CEI	CMHCM	GIHN	HBH	TRDFHRW	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Assistive Technology	Provided on a per request basis											
Crisis Observation Care		X										
Housing Assistance	Provided on a per request basis											
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

Prevention Direct Service Models	X	X	X	X	X	X	X	X	X	X	X	X
• **Child Care Expulsion Prevention**											Per request	
• **School Success Program**												
• **Children of Adults w/ MI/ Integ. Serv.**												
• **Infant Mental Health-Prevention**	X	X	X	X				X	X	X	X	X
• **Parent Education**		X	X	X	X		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

Autism Services: The Michigan Medicaid Autism Benefit went into effect on April 1, 2013 and provides children ages 18 months to 21 years of age 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 shown in Table 7:

Table 7: **1915(i) Autism Benefit Services Available in the MSHN Provider Network**

	BABH	CMHA-CEI	CMHCM	GIHN	HBH	TRDFHRW	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Screening Referral	**Performed by pediatrician or family physician as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Service**											
Comprehensive Diagnostic Evaluation	X	X	X	X	X	X	X	X	X	X	X	X
Determination of Eligibility	**Performed by MDHHS**											
Behavioral Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Behavioral Intervention	X	X	X	X	X	X	X	X	X	X	X	X
Behavioral Observation and Direction	X	X	X	X	X	X	X	X	X	X	X	X

Healthy Michigan: 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 SUD Providers, have expanded network capacity to provide HMP services in the past few years. Limited change has been required because many HMP enrollees were previously served by CMHSP Participants through general funds. The behavioral health services shown in Table 8 are available for HMP enrollees in the region:

Table 8: **Healthy Michigan Plan Services Available in the MSHN Provider Network**

	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Osceola	Saginaw	Shiawasse	Tuscola
Assertive Community Treatment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessments	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assistive Technology																			X		
Behavior Treatment Review	X	X	X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X
Clubhouse Psychosocial Rehabilitation	X	X	X	X	X	X		X		X		X	X	X	X	X		X	X		
Community Living Supports	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Enhanced Pharmacy	X	X	X	X	X	X	X	X		X		X	X	X	X			X	X		
Environmental Modifications	X	X	X			X						X		X	X			X	X		
Family Support and Training	X	X	X			X	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	X	X	X		X	X	X	X	X
Hospital Based Psychiatric Services	X	X	X			X	X		X		X	X		X	X		X	X	X	X	
Housing Assistance	X	X	X			X	X	X	X		X	X	X	X	X		X	X	X	X	X
ICF for Individuals w/DD																					
Medication Administration	X	X	X	X	X	X	X	X	X	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	X	X	X	X	X	X	X	X	X
Occupational Therapy	X	X	X	X	X	X	X	X		X	X	X	X	X	X		X	X	X	X	X
Outpatient Counseling and Therapy	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

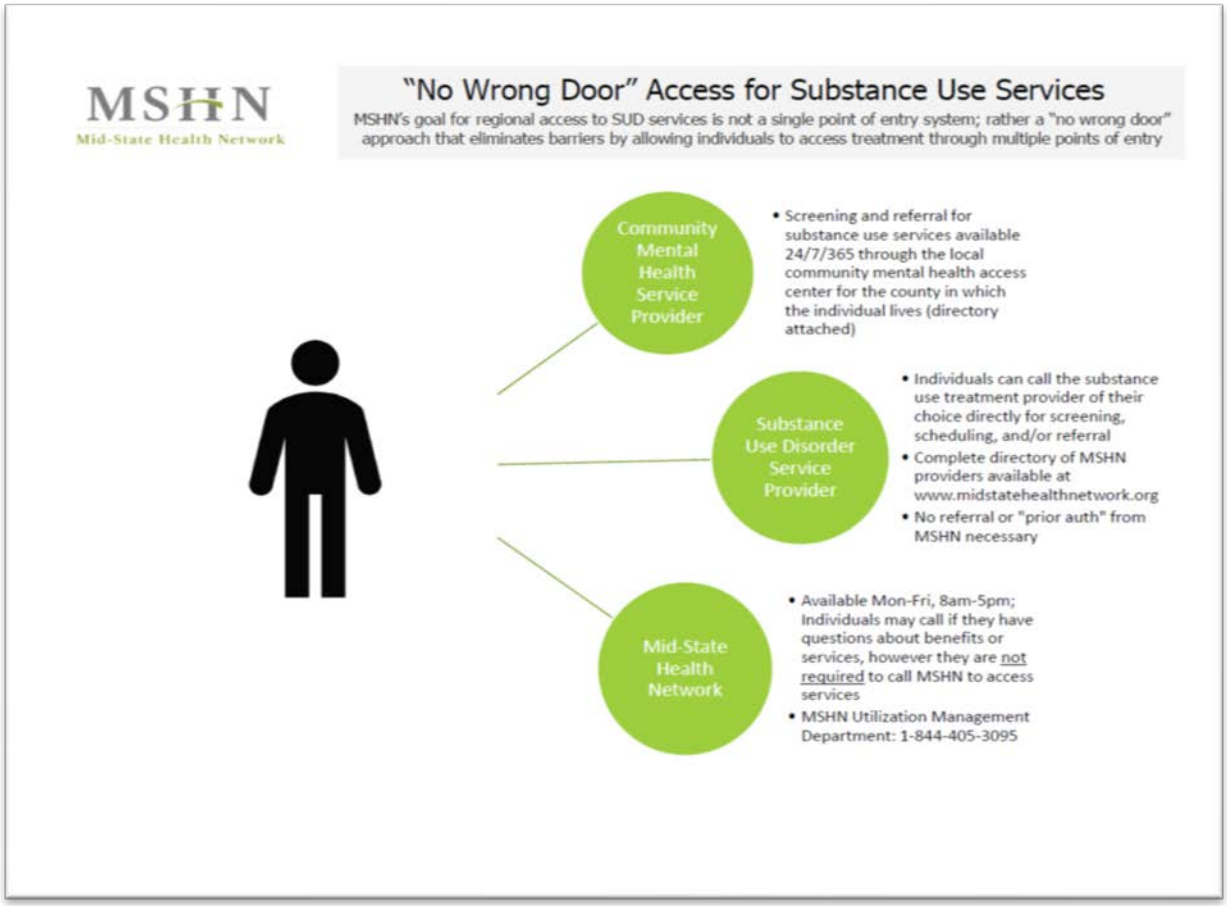
Peer Delivered/Operated Support Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peer Specialist Services (Recovery Coach)	X	X					X	X	X		X		X				X		X	X	X
Personal Care in Licensed Spec. Residential	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Physical Therapy	X	X	X			X						X		X	X		X	X	X		
Prevention – Direct Service Model	X	X	X			X	X	X	X			X	X	X	X			X	X	X	
Residential SUD Treatment	X	X		X	X			X	X	X			X						X		
Respite Care	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Skill Building Assistance	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Speech, Hearing and Language Therapy	X	X	X			X					X	X		X	X			X	X		
Sub-Acute Detoxification	X	X		X	X		X		X	X									X		
Support and Service Coordination	X	X	X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X
Supported/Integrated Employment Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Targeted Case Management	X	X	X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X
Transportation	X	X	X			X	X	X	X			X	X	X	X		X	X	X	X	X
Treatment (DPT/CSAT) Approved Pharmacological Supports	X	X		X	X					X									X		
Treatment Planning	X	X	X	X	X	X	X	X	X	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	X	X	X	X	X	X	X	X	X	X
Crisis Residential	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Home Based	X	X	X			X	X		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	X	X	X	X	X	X	X	X	X
Outpatient Partial Hospitalization	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X

Access to Services: In addition to the services for mental health and SUD populations described above, MSHN is required by MDHHS to establish 24-hour access system for all target populations. The region has established a multi-portal access system – a 'no wrong door' approach, with 24/7/365 access for individuals with a primary SUD concern. MSHN, CMHSP Participants and SUD Providers have met the following goals and continue to maintain network capacity to:

1. Establish, enhance, or expand relationships between the CMHSP and the SUD Provider system within the service are of the CMHSP so that:
    a. SUD service provider phone systems either link directly to the CMHSP access system during non-business hours or their automated response systems instruct callers to contact the CMHSP access system during non- business hours.
    b. The CMHSP and SUD service providers establish a written after-hours protocol for handling referrals during non-business hours.
    c. Local first responder systems (i.e. police, sheriff, jail, emergency medical, etc.), hospitals and other potential referral sources are informed of the availability of after-hours availability of access services for individuals in need of substance use-related supports and services.
2. Engage in community coalitions and other substance use disorder prevention collaborative by:
    a. Identifying and assigning responsibility for one or more CMHSP-employed individuals to perform the function;
    b. Identify opportunities where existing mental health [prevention efforts can be expanded to integrate and/or support primary SUD prevention'
    c. With MSHN support general community education and awareness related to behavioral health prevention, access and treatment including outreach (note that a regional goal is to increase the number of persons served, with emphasis on SUD and persons with HMP).

The “no wrong door” approach for individuals with a primary SUD concern is demonstrated by Figure 1 below:

Figure 1: **"No Wrong Door" Approach for Substance Use Services**



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 [3] in the MSHN region can be assessed through review of the direct operated and contracted service provider networks established by the CMHSP Participants.

MSHN and its CMHSP Participants have developed regional training requirements, which establish minimum training standards to ensure a base level of competency across the provider network.

Each of the CMHSP participant agencies in the region have extensive experience in the behavioral health care industry, as have many of their contracted service providers. Practitioners and staff employed or contracted by the CMHSPs 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,

[3] 42CFR438.206(b)(iii) “The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.”

Licensed Bachelor's Social Workers, Full and Limited License Psychologists, Board Certified Behavioral Analysts 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), Qualified Behavioral Health Professional (QBHP) or a Qualified Mental Health Professional (QMHP).

CMHSPs also employ or contract with individuals who are on their own course of recovery as Peer Specialists, working particularly with people recovering from mental illnesses. Peer Specialists are certified by the state.

Similar credentialing procedures are in place for SUD Providers. Provider agencies must be licensed as Substance Use Disorder Programs by LARA. Individual clinicians, specifically 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 Advanced Addiction and Drug Counselor (CAADC) and Certified Alcohol and Drug Counselor (CADC). Substance use disorder service provider staff offering prevention services are required to hold certifications as Certified Prevention Specialists (CPS). LARA has recently propagated new licensing rules requiring a higher level of credentialing for SUD providers. It is likely that these rules will have an impact on the adequacy of the SUD provider network in the future. In addition, MSHN also encourages all SUD Recovery Coaches to seek certification through the state's newly designed 'Peer Recovery Coach program' if the Coach qualifies under State requirements. This state-offered certification program allows recovery coaches the opportunity upon graduation to pursue other funding sources for reimbursement (ex: Medicaid system).

ABA Providers: The credentialing requirements for the evaluation and provision of Behavioral Health Treatment Services (BHT)/Applied Behavior Analysis (ABA) under the Autism Benefit are highly specific and have triggered provider network capacity concerns across the MSHN region, as well as other areas of the state. The Michigan Medicaid Provider Manual provides that "eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing the ADOS-2 and symptom rating using the DD-CGAS."[4] A qualified licensed practitioner (QLP) must be one of the following:[5]

- a physician with a specialty in psychiatry or neurology;
- a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline;
- a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
- a psychologist;

[4] Michigan Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Section 18.5

[5] Michigan Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Section 18.3

- an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health;
- a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
- a clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.

At present, the number of autism evaluations completed in any given month in the MSHN region is high relative to the number of QLPs authorized to provide them. Table 9 below demonstrates the number of QLPs actively conducting evaluations for the Autism Benefit in each CMHSP as of the end of the second quarter of FY18, while Table 10 details the total number of monthly autism evaluations, both initial and re-evaluations, for the MSHN region for the first half of 2018. It should be noted that some QLPs conduct autism evaluations within multiple CMHSP regions.

Table 9: **Autism Qualified Licensed Practitioners per CMHSP**

	BABH	CMHA-CEI	CMHCM	GIHN	HBH	LCMHA	MCN	NCMH	TRDFHRW	SCCMHA	SHW	TBHS
QLPS	3	6	2	1	1	5	2	3	2	6	1	7

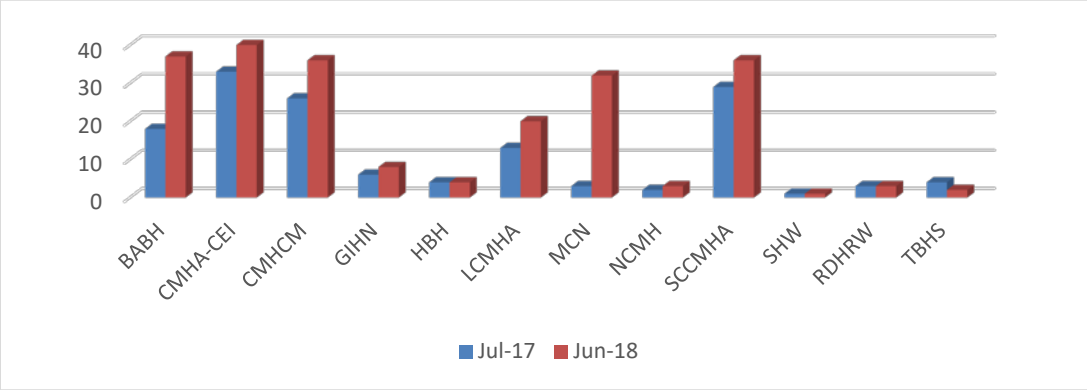
Table 10: **Total Monthly Autism Evaluations in the MSHN Region 2018**

	January	February	March	April	May	June
Autism Evaluations	141	104	126	145	185	167

Individuals who provide BHT/ABA services following the determination of eligibility must meet their own set of qualifications. PA 403 of 2016 amended the Public Health Code to require licensure of Behavior Analysts effective April 3, 2017. Rules must be promulgated by April 3, 2019 to establish the minimum standards for licensure as a behavior analyst. The Medicaid Provider Manual indicates that "BHT services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services. BHT services must be provided under the direction of a BCBA, another appropriately qualified LP or LLP, or a Master's prepared QBHP."[6] Collectively, the Board Certified Behavior Analysts (BCBAs), Board Certified Assistant Behavior Analysts (BCaBAs), and Qualified Behavioral Health Professionals (QBHPs) responsible for the provision of BHT/ABA services are known as BHT supervisors. Eight (8) CMHSPs in the MSHN region increased their BHT supervisor capacity from mid-2017 to mid-2018, three (3) sustained current capacity, and only one (1) CMHSP reduced capacity, as shown in Figure 2 below:

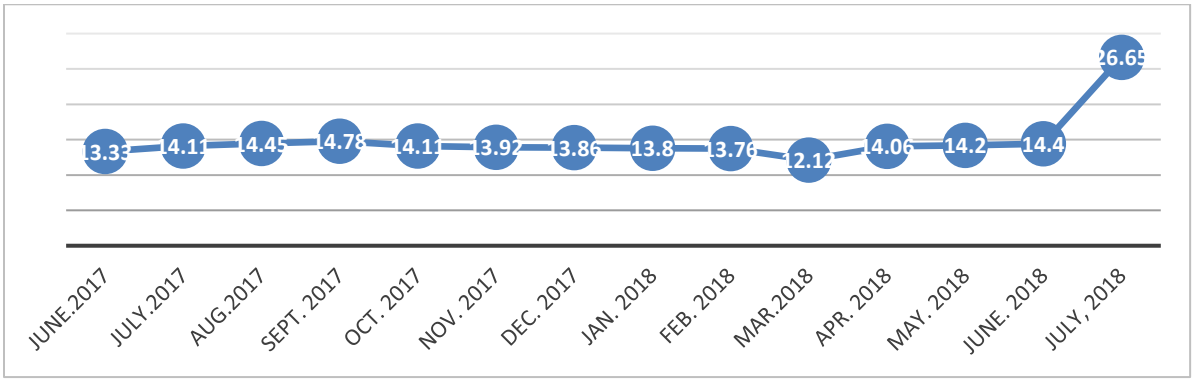
[6] Michigan Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Section 18.12

Figure 2: **BHT Supervisor Capacity per CMHSP**



BHT supervisor adequacy will require ongoing monitoring, as the number of enrollees in BHT services continues to rise (see Table 11 below). The rise in BHT service enrollment has corresponded with a concomitant increase in the demand for weekly ABA hours. Figure 3 below indicates that the average number of weekly ABA hours in the MSHN region nearly doubled between mid-2017 and mid-2018. Apart from heightened service demands, this increase is also indicative of improved system monitoring, system capacity, and programs using time without school in session to maximize treatment intensity when appropriate.

Figure 3: **Average Number of Weekly ABA Hours in the MSHN Region**



MSHN will be monitoring the potential impact on provider network capacity for applied behavior analysis services for individuals with autism spectrum disorders.

Support Intensity Scale: MDHHS requires PIHP's to administrate a clinical assessment/survey for individuals with Intellectual and Developmental Disabilities (IDD), called the Supports Intensity Scale or SIS. MSHN has delegated completion of the SIS to the CMHSP Participants. MSHN is responsible to assure that a proportioned number of SIS assessments are completed each year so that all are complete within a three-year cycle. The SIS Assessors are to complete the SIS assessment for all Medicaid eligible adults with an intellectual or developmental disability (IDD). MSHN must ensure an adequate cadre of qualified SIS assessors exists across the region to ensure that all individuals are assessed in the required timeframe.

The number of required assessments at any given point in time fluctuates. The numbers in the table below represent the original estimate of required assessments, per MSHN community mental health. In response to the demands of the system, the MSHN region has determined that nine (9) SIS Assessors would be an appropriate group to complete all assessments in any given three-year cycle. A typical rate

of completion per assessor per week is five (5) to eight (8) assessments. If each assessor completed five (5) assessments per week over a 48-week period, this would equate to 2,160 assessments per year and 6,480 per 3-year cycle, thus meeting the MSHN PIHP goal using nine (9) assessors. The point of caution is that this is straight-line, conservative logic not accounting for refusals, closures, or other factors that will affect the eligible assessment counts.

Table 11: **SIS Assessment Population and Interview Status**

CMHSP	Total SIS required*	Interviews Required/Week	CMHSP	Total SIS required*	Interviews Required/Week
BABH	658	5	**CMHCM**	1,403	9
HBH	173	1	**CEI**	1,250	8
TBH	223	2	**GIHN**	197	1
MCN	165	1	**TRDFHRW**	218	2
SHW	227	2	**NCMH**	177	1
LifeWays	707	5	**SCCMH**	915	6
			MSHN	6,313	43

*These numbers change regularly and will not remain static. Assume 48 weeks.

Clubhouse: Clubhouse Psychosocial Rehabilitation Program accreditation by the International Center for Clubhouse Development (ICCD) is now being required by MDHHS and programs must be compliant as of September 30, 2018. Six CMHSPs have been awarded accreditation.

Evidence Based Practices: Each CMHSP Participant provides selected specialty services or treatments based upon evidence-based practice models they have adopted in accordance with local needs. Table 12 lists some examples of the many evidence based (or best) practices currently offered by CMHSP participants in the region.

Table 82: **Examples of Evidence Based Practices Utilized by CMHSP Participants in the MSHN Region**

	Pop.	BABH	CMHA-CEI	CMHCM	GIHN	HBH	TRDFHRW	LCMHA	MCN	NCMH	SCCMHA	SHW	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	X
Auricular Acupuncture (NADA Protocol)	**Dual SUD/MIA**										X		
Brief Behavior Activation Therapy	**Adults w Depression**			X		X							
Brief Strategic Family Therapy	**Families**	X		X									
Clubhouse	**MIA**	X	X	X				X	X		X		
Cognitive Behavioral Therapy	**All**	X	X	X	X	X	X	X	X	X	X	X	X
DASH (Dietary Approaches to Stop Hypertension) Diet	**MIA**										X		
Dialectical Behavioral Therapy	**MIA**	X	X	X	X	X		X	X	X	X	X	X
Eye Movement Desensitization	**PTSD**	X			X		X	X	X	X	X		X
Family Psycho-Education	**Families**		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
Mobile Urgent Treatment Team	**Families**		X	X		X					X	X	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			X				
Parent Mgt Training – Oregon Model	**Parents**	X	X	X	X	X	X		X	X	X	X	X
Parent Support Partners	**Parent**		X	X	X	X	X	X		X	X	X	X
Parenting Through Change	**Parents**	X		X	X						X		X
Parenting Through Change-R	**Parents**										X		
Parenting Wisely	**Parents**							X			X		
Parenting with Love and Limits	**Parents**										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	~~X~~	
Prolonged Exposure Therapy	**Adults w PTSD**			X		X			X				
Resource Parent Trauma Training	**Parents**										X		
Schema-Focused Therapy	**Couples**												
Seeking Safety Trauma Group	**SUD & PTSD**	X	X	X	X	X	X		X		X	X	X
Self-Management and Recovery Training	**MIA, SUD**	X		X		X							
SOGI Safe	**All**										X		
Supported Employment	**Adults**	X	X	X	X	X	X	X	X	X	X	X	X
Trauma Focused Cognitive Beh. Therapy	**Children**	X	X	X	X	X	X	X	X	X	X	X	X
Trauma Recovery Empowerment Model	**Adults**			X	X					X	X		
Whole Health Action Management	**Adults**		X	X	X	X			X	X	X		
Wellness Recovery Action Planning	**Adults**	X	X	X	X			X	X	X	X		
Wraparound	**SED Families**	X	X	X	X	X	X	X	X	X	X	X	X
Youth Peer Support											X		

SUD Providers also utilize evidence-based practices in the context of prevention, treatment and recovery 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. Table 13 lists evidence-based practices employed by various SUD Providers in the MSHN region:

Table 93: **Examples of Evidence Based Practices Utilized by SUD Providers in the MSHN Region**

Focal Area*	**EBP Practices**	**Focal Area***	**EBP Practices**
P	Active Parenting Teen	T	Motivational Enhancement Therapy
P	Active Parenting Now	T	Motivational Interviewing
T	Acupuncture	T/P	Nurturing Parents
P	Alcohol and Tobacco Vendor Education	P	OJJDP: Strategies for Success
P	Botvins Life Skills	P	Peer Assisted Leaders (PALs)
T/P	Alternative Routes	P	PATHS
T/P	Anger Management	T	Partners for Change Outcome Measurement System
P	Cross Age Mentoring Programming	P	Party Patrols
P	Choices	P	Permanent Drug Disposal Box Initiatives
P	CMCA – Communities Mobilizing for Change on Alcohol	P	Positive Action
T	Cognitive Behavioral Therapy (CBT)	P	Prescription Take Back Programs
P	Communities that Care	P	Project Alert

P	Community Intervention: Helping Teens Overcome Problems with Alcohol, Marijuana and Other Drugs	P	Project EX
P	Community Trials	P	Prime for Life
P	Conflict Resolution	P	QPR Gatekeeper Training for Suicide Prevention
T	Correctional Therapeutic Community for Substance Abuse	P	Protecting You/Protecting Me
T	Dialectical Behavior Therapy (DBT)	T	Screening, Brief Intervention, Referral to Treatment (SBIRT)
P	Diversionary Programs	P	Second Step
P	Early STEP	T	Seeking Safety
T	Eye Movement Desensitization and Re-Processing	P	SMART Leaders/SMART Moves
P	Families and Schools Together (FAST)	P	Social Norming/Marketing and Media Campaigns
T	Family Psycho-Education	P	Stay It Straight
T	Functional Family Therapy	P	STEP-Early Childhood
P	Guiding Good Choices	P	STEP-Teen
T	Helping Women Recover/Helping Men Recover	T/P	Strengthening Families
P	Mentoring	P	Strengthening Families Home
P	Law Enforcement and Civilian Compliance Checks	P	Systematic Training for Effective Parenting (STEP)
P	Life Skills Training	T	Tobacco Cessation
P	Mentoring	P	Teen Intervene
P	Mentoring Programs	T	Thinking for a Change
P	Michigan Model for Health	P	TIPS Training
T	Mindfulness	P	Too Good for Drugs (TGFD)
P	Minor in Possession Program	P	Too Good for Violence (TGFV)
T	Moral Reconation Therapy	T	Trauma Informed Care
T	Self-Management & Recovery Training (SMART)	T	Trauma Recovery & Empowerment Model (TREM)
T	Narrative Therapy	T	Medication Assisted Treatment (MAT)
T	Contingency Management (CM)	T	Living In Balance (LIB)
T	Adolescent Community Reinforcement Approach (A-CRT)	T	Motivational Enhancement Therapy (MET)
P	Program to Encourage Active, Rewarding Lives (PEARL)	P	Eight Dimensions of Wellness
P	Incredible Years	P	Not on Tobacco
P	Project M.A.G.I.C.	P	Project Success
P	Project Toward No Drug Use	P	Signs of Suicide
P	SURF	P	Too Smart to Start
P	What's Good About Anger	P	Whole School, Whole Community, Whole Child

*T=Treatment; P=Prevention

Trauma Informed Care: The MDHHS Trauma Policy requires PIHPs to ensure their provider networks have the capability to provide trauma informed care (TIC) and sensitive treatment for individuals with mental health and substance use disorders who have experienced or are experiencing trauma. In addition to requiring the use of trauma screening and assessment tools, the policy mandates the completion of organizational or environmental assessments of service sites for trauma sensitivity. MSHN assesses competency and compliance through annual audits. In FY17, MSHN SUD treatment providers were also asked to conduct a self-assessment regarding trauma-informed competence. For FY19, SUD treatment providers are required to develop five TIC goals for their organizations to assist in their development of becoming more trauma informed in the supports they provide SUD treatment providers

in FY19 will also have the opportunity to engage in trauma training hosted by MSHN and supported by grant funding to ensure trauma competence within the SUD provider network.

Recovery Oriented Systems of Care: MSHN has drafted a plan and submits a report annually on action and progress toward implementation of Recovery-Oriented Systems of Care (ROSC) Recovery Implementation and Enhancement. The ROSC philosophy focuses on holistic and integrated services beyond symptom reduction, that is person-driven, trauma informed and culturally responsive, ensures continuity of care, and incorporates evidence and strengths-based practices. Across the 21-county region, MSHN supports three regional ROSC groups known as East, West, and South ROSC. Regional ROSC initiatives have focused on reducing the stigma of substance use disorders, sober family events, and working with community partners to assist people on their path to recovery.

Project ASSERT is one vehicle by which MSHN is empowering its SUD provider panel to pursue Screening, Brief Intervention and Referral to Treatment (SBIRT). Communities using Project ASSERT report increased connections between behavioral health and primary health care integration. Currently Project ASSERT programs exist in Clare, Gladwin, Midland, Gratiot, Mecosta and Osceola counties. Project ASSERT is being developed in FY19 in the additional counties of Ingham, Hillsdale, Montcalm, Ionia, and Newaygo. It is the intent of MSHN in using OROSC Opioid funds and Strategic Targeted Response (STR) funds to incorporate the use of Project ASSERT throughout the entire MSHN region over the next several years.

MSHN seeks to increase the number of qualified recovery coaches throughout the region, particularly peers, and is funding Connecticut Community of Addiction Recovery (CCAR) training through STR funds. This training qualifies individuals with a minimum of two years' sobriety to earn credentials to be offered employment by MSHN SUD providers seeking to add recovery supports to their service array. One component of this funding is to increase the number of recovery coaches within treatment drug courts and MSHN hopes to offer this opportunity to other interested MSHN counties in the next two programming years based upon multiple requests from other counties and initial success. At present, MSHN is supporting through OROSC RFI grant funds recovery coaches in treatment drug courts in Ionia, Montcalm, and Ingham counties.

MSHN has supported the increased network of Families Against Narcotics (FAN) programs that have been implemented within the past year as well as a variety of other 12 step and non-traditional supports. Throughout the region, Smart Recovery, Life Ring, Celebrate Recovery and others are promoted within and among a network of peers supported by MSHN SUD programs in addition to traditional programs such as AA, NA and Al-Anon. In addition, MSHN has increased recovery housing options for people in recovery – thereby increasing opportunities for long-term success in recovery.

Adequacy of services for anticipated enrollees

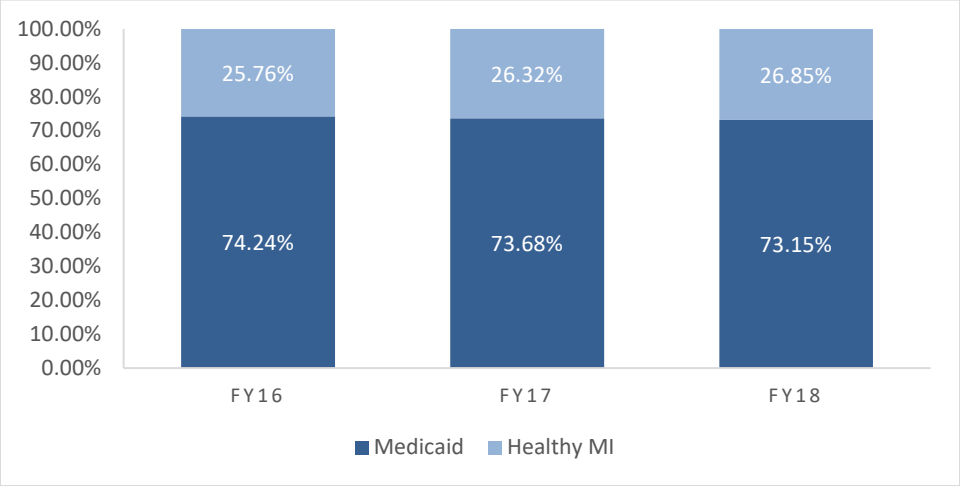
In addition to ensuring the appropriateness of the range of specialty behavioral health services, MSHN must also determine that services are adequate for the anticipated number of Medicaid Beneficiaries in the service area.[7] Medicaid enrollment, service penetration rates and community demand are key factors to consider.

[7] 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/Healthy Michigan enrollment

The past couple of years, enrollment in Medicaid and Healthy Michigan has shown signs of plateauing. Based on enrollment alone, this suggests that MSHN does not need to expand its provider network system.

Figure 4: Proportions of Medicaid/Healthy Michigan Populations



Service population penetration rates

While the number of Medicaid enrollees is relatively stable, the number of enrollees seeking services is increasing. 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. This suggests service capacity should remain at or above existing levels and should not be reduced. 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 and is addressed on an ongoing basis by the MSHN Utilization Management Committee. The goal is to determine if the variance is commensurate with community need or if action by the Operations Council is warranted relative to network capacities.

MSHN identified greater variance in service penetration rates for HMP Medicaid beneficiaries across the MSHN region during the early years of the Medicaid expansion program. Figure 5 shows the Medicaid and Healthy Michigan penetration rate per CMHSP by fiscal year.

Figure 5: **Medicaid and HMP Service Penetration Rates**[8]

Medicaid	FY16	FY17	FY18		HMP	FY16	FY17	FY18
BABH	10.93%	10.44%	10.86%		**BABH**	5.21%	5.00%	7.19%
CEI	4.76%	4.65%	5.60%		**CEI**	1.14%	1.72%	4.10%
CMHCM	7.90%	7.54%	8.09%		**CMHCM**	4.12%	4.12%	5.53%
GIHN	7.29%	6.89%	7.33%		**GIHN**	5.56%	4.13%	5.16%
HBH	8.81%	8.33%	9.57%		**HBH**	5.74%	4.83%	6.29%
Lifeways	6.08%	6.04%	6.88%		**Lifeways**	3.43%	3.54%	5.79%

[8] Source: MSHN REMI Penetration Report

MCN	4.86%	4.89%	5.84%		**MCN**	3.06%	3.31%	4.75%
NCMH	5.53%	5.16%	6.07%		**NCMH**	3.57%	3.47%	4.79%
SCCMH	5.59%	6.15%	7.18%		**SCCMH**	2.09%	2.65%	4.19%
SHW	5.44%	5.71%	6.58%		**SHW**	3.14%	3.42%	4.60%
TRDFHRW	5.66%	5.52%	6.56%		**TRDFHRW**	3.63%	4.18%	5.32%
TBH	5.95%	5.54%	5.96%		**TBH**	2.65%	2.52%	3.57%
MSHN	**6.31%**	**6.22%**	**7.04%**		**MSHN**	**2.95%**	**3.16%**	**4.98%**

Community Needs Assessments: Priority Needs and Planned Actions

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. In aggregate, the Needs Assessments are also informative regarding regional provider network adequacy. The CMHSP Participants in the MSHN region completed either new community stakeholder surveys to assess community needs this year or provided an update of their last assessment. A regional composite of CMHSP Needs Assessment Priority Needs is shown in Table 14.

Table 14: **Community Needs Assessment Priorities FY18**[9]

Based on the Top Five Priorities per CMHSP Only

Community Needs	Composite Regional Priority	BABH	CMHA-CEI	CMHCM	GIHN	HBH	TRDFHRW	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Services for Individuals with SUD/ Co-Occurring Disorders	1	1	1	3	1		1		2	3	2		3
Community education/ prevention activities/ community outreach	2		4	4	5	5	2	2		1		2	2
Integrated healthcare and health outcomes	3			2	2	4			3	5	1	3	
Ease of access to MH care	4					3		3	1	4	3	1	
Services for children	5		3	1			3	1					1
Effect of Trauma	6	2					5		5	2			4
Social Determinants of Health	7			4		1					4		
Access to Psychiatric Services	8-10												5
Transportation to MH services	8-10	3									5		
Direct Care Worker Recruitment/Retention	8-10			5									
Affordable and appropriate housing; Homelessness	11-12		5					4					
Services to individuals with mild/ moderate mental health needs; the underinsured	11-12	5							4				
Veteran's Outreach	13-15						4						
Alternatives to inpatient psychiatric services	13-15	4											
Autism Services	13-15				4								

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

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

occurrence and CMHSP preparations to increased integration of mental health and SUD services. The second highest priority across the region was community education/prevention activities/community outreach, with integration of healthcare and improving health outcomes~~,~~ coming in for a close third. Ease of access to mental health care was the fourth highest priority across the region and fifth, services for children, with an emphasis on community stakeholder collaboration and coordination of services.

Of these top five regional unmet community needs, all are already addressed in this assessment in various ways, with the exception of children's services. The following list summarizes CMHSP Participant efforts to expand service capacity for families and children and increase the number accessing services, as described in their community needs assessment updates:

- BABH
  - Development of Children Mobile Response Team to provide in-home crisis intervention and supports to children and families.
  - Development of Children's Crisis Stabilization services to support the child and family post inpatient discharge.
  - Implementation of Juvenile Detention Center mental health services for youth and families.
  - Operate an autism clinic and expanded the service provider network specific to autism services
  - Engaging in community outreach with schools, courts, community corrections, and DHS
  - Screening children in the Juvenile Court to determine if mental illness exists, to prevent children with mental illness from being involved in the juvenile system.
  - Providing school-based outpatient services in Arenac County school district to improve service access for youths and families.
  - Collaborating and partnering with DHHS to address trauma screening for children
- CMHA-CEI
  - Piloting the Therapeutic Foster Care Oregon (TFCO) program.
  - Developed a mobile crisis team and became certified. It includes mobile Parent Support Partners as well.
  - Added additional Telepsychiatry for youth.
  - Added additional Evidenced Based Clinicians in TFCBT, PMTO and DBT.
  - Provided Signs of Suicide follow up with schools and students in collaboration with Eaton Regional Education Service Agency.
  - Continuing to work on the "Tri-County Lifesavers" coalition to address Suicide awareness in tri-county area.
  - Offered Various Youth Mental Health First Aid courses.
  - In the process of adding Transitional Youth Services.
  - Hosted a Children's Mental Health Awareness Event.
  - Began a Critical Incident Stress Management Team and responded to multiple organization and community events.
  - Implemented Care Coordination projects in clinical programs addressing asthma, hypertension, diabetes, and high Emergency Department Utilization.
  - The Information Integration Committee continued to increase the knowledge, understanding, and use of health-related data for care coordination across the organization.
  - Worked with Tri-County Crisis Intervention Team Steering Committee to implement additional rounds of 40 - hour training sessions for Officers. 162 Law Enforcement Officers from across Clinton, Eaton, and Ingham Counties were trained as of 2018.
  - Continued to provide and expand various points of entry into services through Primary Care Physicians; Crisis Services and Crisis Response Team and Urgent Care/Emergency Rooms as well as the addition of several positions with navigator responsibilities such as the Veterans Navigator, Youth Prevention Therapist, Peer Recovery Coaches and Central Access Staff Outreach.
  - Continued expansion of Access Department outreach for assisting consumers with SUD to locate appropriate level of treatment; addition of Recovery Coaches for Admission, Transfer and assisting individuals in their effort to get to treatment programs, working with the local Provider Network on admissions and transfers.

  - Continue providing Naloxone Kits at three CMHA-CEI SUD programs and to law enforcement agencies in each county with assistance from the PIHP.
  - Partnering with Ingham County Sheriff on the Rapid Response Team to provide immediate access to treatment services to individuals who have experience a recent drug overdose.
  - Provide ongoing follow up to the Sequential Intercept Mapping project held in 2017 resulting in the development of reentry services for each county jail targeting special needs populations.
  - Continued collaboration and expansion of work with Lansing Landlords to house consumers with mental illness
  - Added additional Applied Behavioral Analysis provider contracts to increase capacity to meet demand.
- CMHCM
  - Identified focusing on increasing services to children as part of the strategic plan
  - Will co-locate staff in local schools
  - Have significantly increased the number of children on an SED Waiver
  - Continuing to promote additionally staff trained on TF-CBT, PMTO, PCIT
  - Working with TBD Solutions to determine feasibility of a children's therapeutic foster care
  - Added an additional Wraparound staff (total 7 agency-wide)
  - Supporting staff training on SUD to increase the number of staff with CAADC or CADC credentials
  - Charged a work team with studying the areas of training needs for individuals with a COD
  - Participating in education with community partners on Naloxone
  - Co-location of MAT services in 3 offices with plans to expand to the remaining 3
  - Met with the local Methadone provider for increased collaboration
  - Lean Process with MDHHS in 4 counties with plans to add the other 2 counties
  - Michigan Collaborative Care Program
  - Transforming Research into Action to improves the lives of students
  - Increasing Multi-Systemic Therapy
  - Increased Baby Court
  - Continuing to promote ongoing training with the core EBPs (PMTO, BSFT, PCIT, TF-CBT, adolescent DBT, Nurturing Parenting Program, Parenting Through Change, Seeking Safety)
  - Increased training on SUD, Opioid addiction, distribution of Naloxone kits, and met with the local Methadone Provider to increase collaboration and coordination of care
  - Met with Hope Network regarding bringing a CRU to the area
  - Approved the addition of a wraparound coordinator in the Mecosta/Osceola area
- GIHN
  - Co-Located Clinician in local Schools
  - Co-Located Clinician providing Therapy at Child Advocacy
  - Nurse Practitioner located at St. Louis satellite office providing physical health care services
  - Co-located clinician in the court system and jail
  - Co-located clinician in the Emergency Department
  - Expansion of Autism Services with an Autism Center located in the St. Louis satellite office
  - Staff Trained in TF-CBT
  - Member of the Great Start Collaborative
  - Three staff trained in Parenting through Change (PTC).
  - Health Department co-located in the St. Louis medical clinic providing WIC and immunizations.
  - Provide Youth Mobile Crisis Response
  - Trained community members in Adult and Youth Mental Health First Aid.
  - Brought in a speaker on bullying and suicide prevention.
  - Participates in back-to-school events.
  - Provided basic Motivational Interviewing to all clinical staff and advanced MI, including recording and coaching, for SUD team members and all therapists
  - Addition of FASD Screening at Access
  - Critical Incident Stress Debriefing Team
  - Member of School Safety Alliance

- HBH
  - Participate in the Great Starts Collaborative; composed of many providers in the community that work with families and children to provide support and education to parents
  - Active in community events where outreach to families can occur to assist with education and linkages to needed services or supports to strengthen parenting skills
  - Have an active Wraparound program
  - Expansion of Autism services and working with contractual provider to increase the timeliness and meet the increased demand for ABA and evaluative services;
  - We screen for trauma in each clinical program and have completed an organizational self-assessment on trauma-informed care capabilities;
  - Continuing work with MSHN on care coordination for high utilization cases, and have developed clinical tracking projects for persons with diabetes and cardiac issues
  - Continuing promotion of staff training in TF-CBT, PMTO, DBT and FPE
  - Have a Children's Intensive Mobile Crisis Team available for families
  - Participate in on-going meetings with DHHS, court staff, ISD, attorneys and Prosecutor staff to improve cross-agency collaboration on shared children/ family cases.
  - Staff and community partners have been trained on Trauma Informed Care and screening
  - Have an active Wrap-around collaborative
  - On-going training for community members on the use/application of Naloxone and distribution of rescue kits
  - Trained community partners, and community-at-large members in Youth Mental Health First Aid
  - Federally Qualified Health Center co-located at HBH for one-half day per week
  - Provision of same-day/next day service
- TRDFHRW
  - Have a full-time School Outreach Worker to increase the collaboration and referral rate from schools
  - Partnered with Ionia Schools and have three Masters level staff providing social work services to two Ionia elementary schools and Ionia Middle School.
  - Participate in Great Start Collaborative in Ionia County.
  - We have expanded our Wraparound service provision and now contract to provide this service to Montcalm Care Network.
  - Participate in School Readiness Advisory Council.
  - Assisting another current ABA Aid employee in obtaining their BCBA to expand capacity of ABA services. This staff will tentatively receive her BCBA in November of 2018. We are providing ABA services to Montcalm Care Network. We have homegrown 3 BCBAs.
  - Providing screening at the court house to juvenile offenders.
  - Child psychiatrist provides consultation to primary care providers and provides his personal cell phone number.
  - Are a licensed child-placing agency.
  - Provide treatment foster care.
  - Opened State of the Art ABA Center in June 2017.
  - We have staff trained in and providing TF-CBT, Nurturing Parenting and Love and Logic.
  - We have an OPT therapist staffed one day a week in a local middle school/high school in Lakewood.
  - We are an active participant in the Children's Advocacy Center for Montcalm/Ionia Counties.
  - Extensive collaboration with DHHS to provide coordination of care for children aging out of the Foster Care system.
  - Partnered with Montcalm, Newaygo and Gratiot to provide Children's Mobile Crisis Response.
  - Collaborated with Ionia Public Schools to provide Meet and Eats – a lunch time program where students can come in the summer to get a meal and participate in groups with topics like: anger management, CBT skill building and yoga.
  - Participate in ICAN.
  - Provide outreach at numerous housing complexes in Ionia County.
  - Participate with the Ionia County Substance Abuse Coalition.

- LCMHA
  - Increased the availability of BHT services to meet the needs of the Autism expansion
  - Has a Prevention & Wellness Program including participation on the Jackson Substance Abuse Prevention Coalition, which includes the Most Teens Don't effort
  - Partner in the Intermediate School District Project AWARE, bringing Youth Mental Health First Aid to school staff and establishing mental health supports in into pilot schools; includes a Teen Advisory Team, committed to breaking down the stigma of seeking mental health supports
  - Facilitating Youth Mental Health First Aid for the Community-at-large
  - Participated in the iChallengeU by South Central Michigan Works where students were tasked with providing strategies to help teens engage in services when needed
  - Children's ICSS will soon be operational; adult mobile crisis available in place of ICSS
- MCN
  - Initiative to provide community training in Mental Health First Aide Training for Youth
  - Implementation of SAMHSA Drug Free Communities Grant with focus on prevention of underage substance use
  - Expansion of Medicaid Autism services benefit
  - Implementation of integrated health services for children with serious emotional disturbances
  - Expansion of TF-CBT services including training addition clinicians and partnering with DHHS on the parenting group to target children in foster care.
  - Increased collaboration with DHHS in relation to reunification for children in placement or foster care and Family Team Meeting participation for children and youth with active Children's Protective Services cases.
  - Implemented a Children's Mobile Crisis Team to prevent inpatient admissions and connect families to necessary services.
  - Participating in Trauma-Informed Community initiative to raise awareness about the impact of ACEs and identify children and families in need of support.
- NCMH
  - Participating in community collaborations, such as NC3, wraparound, Families Together, and Headway for substance abuse (NCMH staff chairs Headway committee).
  - Part of the Great Starts Collaborative; composed of many providers in the community that work with families and children to provide support and education to parents.
  - Active in community events where outreach to families can occur to assist with education and linkages to needed services or supports to strengthen parenting skills—including annual participation in Tools for School Event, Family Expo, Health & Wellness Expo, Training provided to all area Head Starts in the county (includes parents and Head Start staff).
  - Have a youth team staff designated as a liaison between CMH and DHHS specific youth services. CMH staff attends monthly staff meetings for foster care and protective services staffs at the local DHHS office and educates on CMH services, the referral process, assists with the SED waiver enrollment.
  - Have a contract with juvenile court to provide home based services to adjudicated children in the court system who do not have Medicaid and would not typically qualify for CMH services.
  - Facilitating Youth Mental Health First Aid for the Community-at-large.
  - Have an active Wraparound program and have hired an additional (full time) wraparound facilitator to meet the increased demand of referrals to this process.
  - Developed a pilot program to offer "Breaking the Silence" curriculum in the upper elementary, middle and high schools (taught in gym and health classes) within Newaygo County to education community youth about mental health issues and help to reduce stigma.
  - CMH staff is a member of the Teen Pregnancy Prevention Initiative recently started in the county.
  - NCMH participates in local Families Against Narcotics (FAN) chapter.
- SCCMHA
  - Awarded PA2 funds for the expansion of prevention funding with the Parents as Teachers home visiting model
  - Specific marketing with 'Many Challenges. One Call' brochure and disseminated widely in community to partners (3,900 copies) and available on the website as well.

  - Added a Youth Transition Program
  - Added additional Case Management team for Adults with Mental Illness
  - Added additional Supports Coordination team for individuals with Intellectual and Developmental Disabilities
  - Added full time mental health clinicians in 10 Saginaw City School Elementary and Middle School sites
  - Added mental health services for integrated care at CMH CMU Medical School Family Practice Clinic
  - Initiated a community Saginaw Hoarding Task Force with treatment beginning FY 2017
  - Facilitating Open Table and Mentoring services through the Children's System of Care Expansion grant
  - Revision of SCCMHA website
  - Application for funding to continue Mental Health First Aid/Youth First Aid Training
  - Central Access & Intake/Crisis Intervention Services remodel and living room model
  - Provision of same day/next day service
  - Expansion of autism services
  - SCCMHA co-location in CMU Health Pediatric site
  - Mobile Urgent Treatment Team expansion for both children/families and adults
  - SOGI (Sexual Orientation and Gender Identity) Training and Champions and graduated 50+ staff considered SOGI safe workers
  - Creation of Access, Stabilization for Children (ASC) project and improved front door response for children and families
  - Neonatal Abstinence Project Leadership by SCCMHA funded by MHEF via MPHI
- SHW
  - Engaging in community outreach with schools, courts, community corrections, and DHS
  - Participating in the Great Start collaborative and health and human services coalition
  - Board representative for Child Advocacy Center
  - Partnership with Shiawassee Community Health Center (Patient-Centered Medical Home) providing integrated health care in both the primary care setting and behavioral health setting
  - Same-day Access
  - Added Telehealth services
  - Added ABA contract provider
  - Partnership with DHS in providing continuing education for foster parents
  - Partnership with the ISD and other community agencies in providing trauma-focused care
  - Co-located early childhood staff with ISD, DHS, public health, early on
  - Added Mobile crisis teams for adults and youth
  - CISM team available to primary and secondary schools if needed
  - Increased the availability of BHT services to meet the needs of the Autism expansion
  - Robust respite program for children
  - Participating in TF-CBT
  - Efforts to expand service capacity for families and children to increase the number accessing services, as identified in the community needs assessment.
- TBHS
  - Participate in Great Start Collaborative as well as subcommittees providing education, support and services to children and families.
  - Participate in a court collaboration process which primarily focuses on multi-agency involvement in providing services to children and families.
  - Added screening tools to the intake process for all children.
  - Participating in multiple EBPs such as PMTO, PTC, TF-CBT, TF-CBT Caregiver Education (which has also been offered externally as a part of prevention services).
  - Active in community events where outreach to families occurs.
  - Provide ongoing presentations and education as requested by community agencies (local hospitals, DHHS, courts, etc.).
  - Active in Child Death Review Board to evaluate service delivery as well as services offered, gaps, etc. to assist in preventing county wide child deaths.
  - Have ~~three~~ two staff trained in Mental Health First Aid Youth with one more scheduled for training.

- Participating in a prevention group called Start Now which primarily focuses on providing services to children and families despite eligibility criteria, as well as looking at a trauma informed work force.
- Hired a Parent Support Partner to work with parents.
- Started Intensive Crisis Stabilization Services for Children.

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 relative to the adequacy of provider network capacity.

Autism Spectrum Disorder Services

MDHHS expanded eligibility for Autism services to age 21 effective January 2016. Table 15 shows the growth in volumes for Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) services as demand has risen for these relatively new Medicaid services.

Table 105: **Individuals Served by CMHSPs with Autism Spectrum Disorders and ABA Service Utilization**

CMSHP	FY16		FY17		FY18	
	Individuals Served with an ASD diagnosis	**Individuals Enrolled in the BHT Benefit**	**Individuals Served with an ASD diagnosis**	**Individuals Enrolled in the BHT Benefit**	**Individuals Served with an ASD diagnosis**	**Individuals Enrolled in the BHT Benefit**
BABH	234	49	290	95	212	99
CMHA-CEI	600	122	610	208	504	267
CMHCM	377	57	462	126	407	161
GIHN	80	25	100	37	88	50
HBH	35	2	32	10	48	15
TRDFHRW	340	13	433	23	118	28
LCMHA	117	100	152	155	316	215
MCN	90	13	116	37	102	46
NCMH	454	14	550	16	82	16
SCCMHA	143	112	156	167	432	205
SHW	123	17	155	24	89	38
TBHS	78	12	103	34	85	37
MSHN	**2,671**	**536**	**3,159**	**932**	**2,483**	**1,178**

Since the MSHN region had encountered difficulties previously in meeting the existing demand for services by children aged 18 months through 5 years, there was 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 specialized services with limited qualified professionals in local job markets. The section on sufficiency of number of providers below will demonstrate that MSHN and its CMHSP Participants have been successful in increasing BHT/ABA provider capacity. However, it is also clear that some quality issues remain. Additionally, recent state legislative reductions in ABA service reimbursement rates may impact the ability of some providers to offer BHT/ABA services in Michigan.

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. In the final rule, CMS is moving toward defining home and community-based settings by the nature of quality of individuals' experiences. The changes related to

clarification of home and community-based settings and will maximize opportunities for participants in HCBS programs to have access to the benefits of community living, receive services in the most integrated setting, and effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions. Home and community-based settings are required to be in compliance with the HCBS rule by March 2019.

MSHN and its CMHSP Participants are actively participating in MDHHS system assessments, individual consumer surveys, residential and non-residential service setting surveys, heightened scrutiny work, and corrective action plans. In FY17 MDHHS delegated increased responsibility for completion of the surveys to PIHPs. From these surveys and the work stemming from them, compliance with the HCBS rules is being assessed and corrective action plans are being constructed. Since FY17, providers have been receiving notice of the results of the surveys. Surveying has been completed for sites serving Habilitation Waiver beneficiaries, but the Behavioral Health b(3) services surveys have been delayed pending CMS clarification that these services fall under the HCBS rule. As a result, MDHHS has announced plans to allow providers of b(3) services additional time to comply with the rule. Sites found not to be in compliance with the HCBS rule may be placed under heightened scrutiny if they commit to working with the state to achieve full compliance. Heightened scrutiny is a review process required by CMS for services that are not HCBS compliant to ascertain whether the services can become compliant. Sites may choose not to undergo heightened scrutiny, in which case they will be found out of compliance and will be unable to provide services to HCBS recipients. Some providers have chosen not to be in compliance, potentially leading to the closure of programs or sites or the need for HCBS recipients to change to a compliant provider. The provider network could experience minimal impact if providers are found to be in out-of-compliance status and therefore cease to function as HCBS providers. MDHHS has also indicated that existing providers who have been determined to be under heightened scrutiny are not permitted to expand their services until they achieve compliance. This latter requirement is creating some additional concern regarding regional capacity to add services or sites within the established provider network when enrollee demand warrants expansion. This issue will be addressed by MSHN and the CMHSP Participants.

New providers may receive provisional approval to provide HCBS services. A new provider is one who does not have a contractual agreement to provide services to the MSHN PIHP region prior to October 1, 2017. Provisional approval allows the PIHP/CMHSP to contract with new providers who do not have a current HCBS participant receiving services in their setting to ensure that providers are not institutional or isolating in nature. Provisional approval is required before the provision of any HCBS services can be provided to a Medicaid participant. Completion of the provisional approval process is required of all new HCBS providers effective October 1, 2017.

Providers may receive provisional approval to provide HCBS services based upon the satisfactory completion of a Provisional Approval Application, an on-site assessment of the setting, and submission of applicable policies and procedures to support the HCBS rule. The approval status will remain in place until the provider and the individual receiving services complete the comprehensive HCBS survey. Providers and individuals receive the comprehensive HCBS survey within 90 days of the original provisional approval. The provider must complete this survey as a step toward determining compliance with the HCBS Rule and to provide HCBS services. Failure to complete the approval process toward determining HCBS compliance will result in the suspension of the provider's ability to provide HCBS services to applicable Medicaid recipients.

Table 16 show~~s~~ the volume of sites, both residential and non-residential, determined to require heightened scrutiny of their compliance with HCBS rules based upon the results of the surveys and actions that have been completed up to this point. It should be noted that compliance and heightened

scrutiny numbers are fluid and subject to ongoing dynamic activity on the part of multiple actors in the HCBS transition plan process.

Table 116: **HCBS Compliance Status for Residential and Non-Residential Sites**

	Res	Non-Res		Res	Non-Res		Res	Non-Res
BABH	79	14	**HBH**	15	0	**SCCMH**	32	24
CMHA-CEI	78	16	**LifeWays**	44	1	**SHW**	22	0
CMHCM	144	100	**MCN**	13	6	**TRDFHRW**	6	1
GIHN	22	0	**NCMH**	15	0	**TCMH**	18	1
MSHN	**489**	**163**						

On September 12, 2018, MDHHS issued an "L-Letter" to clarify HCBS timelines. The letter upheld the March 17, 2019 HCBS compliance deadline for most home and community based settings and confirmed MDHHS's commitment to working with providers to move "toward full compliance with the HCBS rule as specified in the approved Statewide Transition Plan (STP)."[10] However, MDHHS acknowledged that "certain conditions may affect the ability of MDHHS to complete the compliance work by March 17, 2019,"[11] noting the following:

- The Behavioral Health b(3) services surveys were delayed pending CMS clarification that these services fall under the rule. Providers of b(3) services will be allotted additional time to comply with the HCBS rule.
- MDHHS recognizes that heightened scrutiny work will continue beyond March 17, 2019.
- HCBS providers should have a corrective action plan underway before March 17, 2019. MDHHS will honor the 90-day CAP remediation period as needed for those providers who initiate the CAP after December 17, 2018.
- MDHHS will allow providers a reasonable length of time to remediate identified issues as specified in their CAP as long as the provider is making progress and provides regular updates to the waiver agency or PIHP HCBS contact person. MI Choice waiver agencies and the PIHPs represent MDHHS and are responsible for approving the provider's CAP.

Veteran's Access, Choice and Accountability Act of 2014

Improved access to behavioral health care for veterans is a priority for the State of Michigan and MSHN added a similar strategic priority to its action plan in 2015. In addition, the federal Veteran's Access, Choice and Accountability Act of 2014 allows those veterans who are unable to schedule an appointment within 30 days or if their place of residence is more than 40 miles from the closest Veteran's Administration health care facility, to elect to receive care from eligible non-VA health care entities or providers.

CMHSP Participants and SUD Providers may be the closest available behavioral health service provider in some areas of the region, since CMHSPs are located in each county in the region. Depending upon the level of demand, portions of Huron County to the east, Osceola, Clare, Mecosta and Isabella Counties to the northwest, and Newaygo and Montcalm Counties to the west, could see increases in demand for services. Figure 6 shows the location of Veteran's Administration (VA) Medical Centers and Clinics relative to the MSHN region.

[10] Source: MDHHS L-Letter re: Centers for Medicare & Medicaid Services (CMS) Extension of Transition Period for Compliance with the Home and Community Based Settings (HCBS) Requirement, September 12, 2018.

[11] Source: MDHHS L-Letter re: Centers for Medicare & Medicaid Services (CMS) Extension of Transition Period for Compliance with the Home and Community Based Settings (HCBS) Requirement, September 12, 2018.

Figure 6: **Location of VA Medical Centers and Clinics in MSHN Region**

MSHN has begun preliminary analysis of baseline levels of service penetration among the veterans' population in the region. In FY18 less than 2% (n=504) of the individuals receiving behavioral treatment in the region were identified as veterans. CMHSPs responding to a need for VA services are required to meet the same qualifications as required by Medicare and the service array is primarily psychiatric services and outpatient therapies. LifeWays Community Mental Health operates a clinic in Jackson County which provides behavioral health services to veterans. LifeWays is currently in the process of contracting with TriWest Healthcare Alliance which is part of the Community Care Network in collaboration with Magellan Healthcare to serve veterans in their area. There is also a clinic in the Lansing area. Saginaw CMH met with the state Veteran's Liaison and will be meeting with the new regional navigator, has promoted their information system wide, and added a Veteran's section to their website. Saginaw CMH is also attempting to finalize a memorandum of understanding with the Veteran's Administration hospital located in Saginaw.

In 2017 MSHN added a Veteran Navigator, a grant-funded position that is charged by MDHHS with increasing access to behavioral health and SUD services and identifying resources/community supports for Veteran and Military Families in the region. The Navigator assists CMHSP's with making appropriate referrals to resources, coordinating care, and providing follow up. Coordination is also provided for volunteer peer supports for V/MFs such as Buddy-To-Buddy, Vet-to-Vet, Homefront Strong, and other peer programs that may exist in the community. The VN has begun to network with regional Community Based Outpatient Clinics (CBOCs), Veteran Community Action Teams (VCATs), Veteran's Treatment Courts, MSHN's CMHSP's, and will be reaching out to the SUD provider network. The region will continue to monitor the demand for and adequacy of its capacity to serve veterans and military families.

Intensive Crisis Stabilization Services

In September 2017 MDHHS modified Medicaid standards to require that Intensive Crisis Stabilization Services (ICSS) be available for children (i.e., birth to 21 years of age) effective 10/1/17. This includes children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD) including autism, or co-occurring SED and substance use disorder (SUD). In March 2018, all CMHSPs in the region received verification from MDHHS that ICSS services meet Medicaid requirements for ICSS services. However, as of September 2018, only half of the CMHSPs in the MSHN region report that they are actively providing ICSS services. Intensive crisis stabilization services will soon be operational in one additional CMHSP, LifeWays. The remaining five (5) CMHSPs will need to work toward having operational ICSS programs in order to be in compliance with current Medicaid standards.

Independent Facilitation Services

Independent facilitation occurs when CMHSPs secure the services of an independent, external entity to assist in and facilitate the person-centered planning process. The Person-Centered Planning Policy of the Michigan Department of Health and Human Services directs CMHSPs to "contract with a sufficient

number of independent facilitators to ensure availability and choice."[12] Although MDHHS does not provide specific parameters regarding what constitutes availability and choice, the language of the Person-Centered Planning Policy points to the need for individuals receiving services to select from and access multiple independent facilitation alternatives should they so choose. Table 17 delineates the number of independent facilitator contracts available within each CMHSP, as well as the number of individuals utilizing independent facilitation services:

Table 17: **Independent Facilitation Contracts and Utilization in the MSHN Region**

	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRDFHRW	TBHS
# IF Contracts	2	0	4	2	2	0	0	1	1	1	0	1
# Individuals Utilizing IF	6	0	84	0	0	0	0	1	14	5-8	1-2	6

At the present time, only four (4) CMHSPs in the MSHN region provide a choice of at least two independent facilitator entities. Another four (4) contract with one only, and the final four (4) have no current independent facilitator contracts. In several instances, CMHSPs report that they have no one currently utilizing these services, that demand for them has historically been low, that single case agreements are available upon request, that steps are being taken to establish and award contracts, and/or that current networks are sufficient to meet demand. However, the absence of sufficient contracts presently appears to be widespread in the MSHN region and may therefore implicate issues of availability and choice for these services. This will merit further attention and additional consideration going forward.

Independent Assessment

In November 2017, MDHHS released a new Medicaid Provider Manual Home and Community Based Services chapter to address the implementation of the CMS HCBS Final Rule. In its new HCBS guidance, MDHHS instructs that the HCBS Final Rule "provides requirements for independent assessment. This is a face-to-face assessment, conducted by a conflict-free individual or agency. The assessment is based on the individual's needs and strengths and is part of the person-centered planning process."[13] This guidance has prompted inquiries among the CMHSP Participants regarding the nature of the independent assessment requirement and its potential impact on network adequacy. MSHN is currently in the process of seeking clarification on this guidance from the state, but the language does appear at very least to highlight the necessity of conflict-free case management and of clinical assessment and person-centered planning free of conflicts of interest. The CMS Federal Rule provides that "the assessor must be independent; that is, free from conflict of interest with regard to providers, to the individual and related parties, and to budgetary concerns."[14] The degree to which this expectation impacts network adequacy will depend on its implementation, but it is certainly plausible that CMHSPs will need to take steps to insure the clinical assessment process against problematic conflicts and opposing interests moving forward.

[12] Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration, Person-Centered Planning Policy, June 5, 2017

[13] Michigan Medicaid Provider Manual, HCBS Section 1 – General Information, 1.1, bullet point 6

[14] Michigan Medicaid Provider Manual, HCBS Section

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 Medicaid beneficiaries in the service area[15]. A determination of whether the network of providers is sufficient would typically be made through analysis of the characteristics and health care needs of the populations represented in the region[16]. 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 beneficiaries.

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 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.

Table 18 shows the number of consumers serviced, units provided, and count of services during FY17 and FY18 as of 8/31/18. The number of people served has remained largely stable and the count of services appears on par to be relatively stable thus far this fiscal year, as well.

Table 1812: **Service Utilization by CMHSP**[17]

CMHSP	FY17			FY18 as of 8/31/18		
	Number Served	Units Provided	Units/ Consumer	Number Served	Units Provided	Units/ Consumer
BABB	4,779	2,320,011	485	5,019	1,923,255	383
CMHA-CEI	7,453	4,892,630	656	8,713	4,313,876	495
CEI	7,605	6,138,441	807	8,153	5,000,915	613
GIHN	1,361	296,562	218	1,387	276,190	199
HBH	894	460,616	515	1,033	437,724	424
LifeWays	5,882	2,040,972	347	6,587	2,012,843	306
MCN	1,644	484,708	295	1,788	482,553	270
NCMH	1,471	267,391	182	1,822	219,540	120
SSCMH	5,416	3,687,382	681	6,341	3,486,701	550
SHW	1,712	1,459,440	852	1,923	1,160,268	603
TRDFHRV	1,602	253,462	158	2,293	263,247	115
TBH	1,113	399,866	359	1,026	246,539	240

[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."

[16] 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."

[17] Data Source: REMI Outbound encounters

MSHN TOTAL	**40,932**	**22,701,481**	**555**	**46,209**	**19,918,850**	**2,431**

Table 19 shows the number of consumers served for Home-Based Services (HBS), Targeted Case Management (TCM), and Habilitation Supports Waiver (HSW) for the same time periods. Demand has likewise been largely stable.

Table 19: **HBS, TCM, and HSW Service Utilization**[18]

CMHSP	HBS Number Served		TCM Number Served		HSW Number Served	
	FY17	FY18 as of 8/31/18	**FY17**	FY18 as of 8/31/18	**FY17**	FY18 as of 8/31/18
BABH	173	184	1300	1352	178	179
CMHA-CEI	1013	928	3194	3411	239	255
CMHCM	471	457	1451	1858	495	497
GIHN	117	109	414	362	57	57
HBH	76	88	236	247	46	46
LCMHA	597	470	1991	2196	254	258
MCN	311	320	508	615	32	32
NCMH	130	145	647	823	24	25
SCCMHA	9	5	2317	2383	145	157
SHW	101	113	227	206	74	74
TRDFHRW	222	316	395	581	46	53
TBHS	137	136	45	34	71	88
MSHN Total	**3357**	**3271**	**12725**	**14068**	**1661**	**1721**

Consumer Satisfaction: Consumer satisfaction with services is an important consideration when evaluating the adequacy of a provider network. MSHN previously assessed consumer perception of care for adults with mental illness utilizing Assertive Community Treatment services 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 regional Perception of Care Surveys conducted as recently as 2016 are shown in Figures 7 and 8. Generalization of survey results has been difficult due to historically low survey response rates, which results in a lower than desired confidence level in the findings. MDHHS also did not require the completion of the MHSIP or YSS for FY17/18, so this data was not available for those years. Keeping those limitations in mind, the responses to the Access (to services) subscale for Home-Based and ACT services were relatively favorable, with less than 10% of youth and 15% of adults expressing concern about access to services. An even higher level of satisfaction remains a goal for the MSHN region.

[18] Data Source: REMI Outbound encounters

Figure 7: **Percent Agree by Subscale, Home-Based Services**

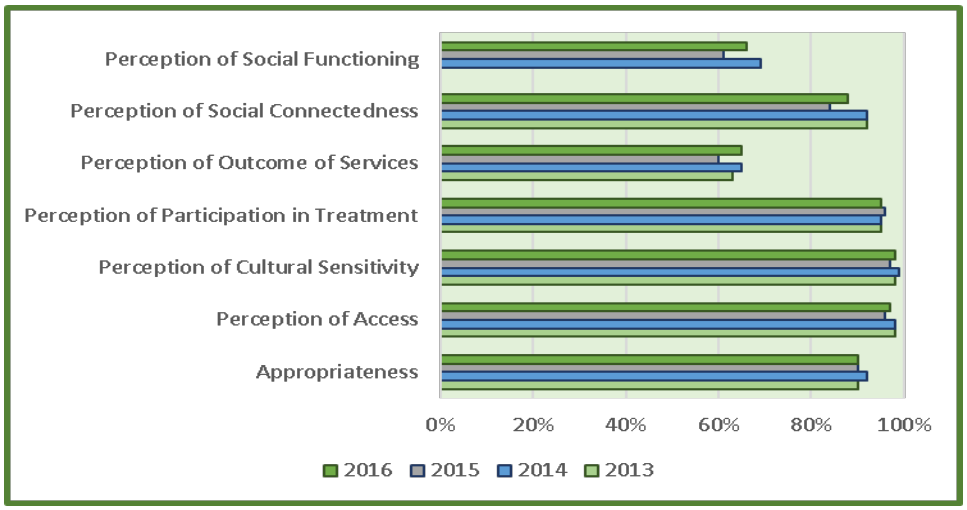
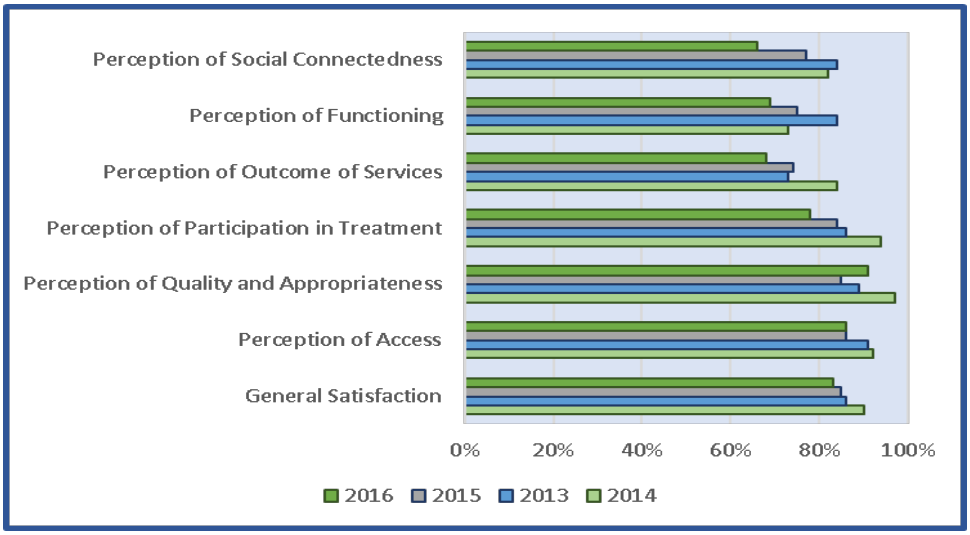
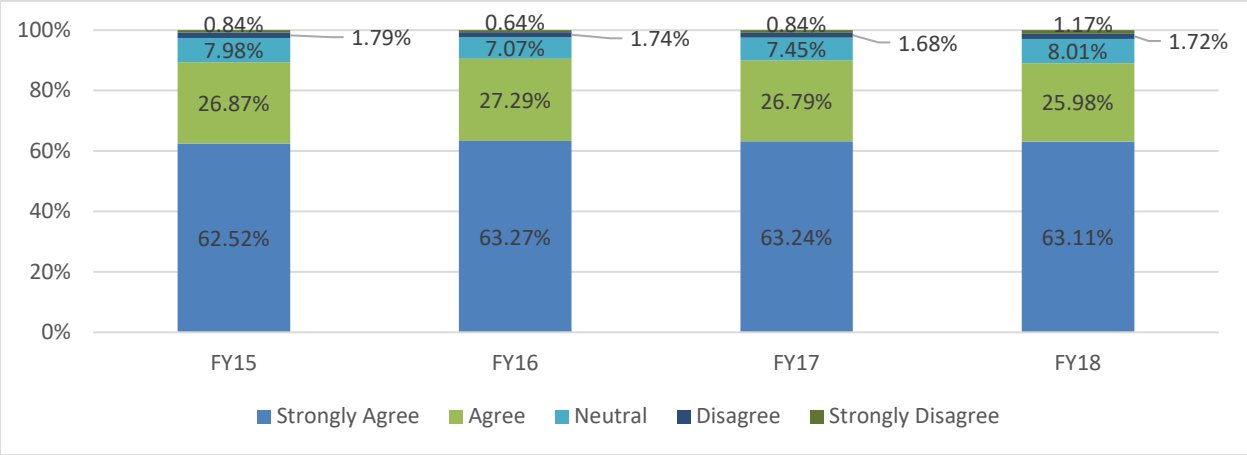


Figure 8: **Percent Agree by Subscale, Assertive Community Treatment**



During FY18, the SUD network administered a consumer satisfaction survey. Consumers were asked to rate satisfaction on a 5-point scale with 5 being "strongly agree" and high level of satisfaction. Results were relatively stable from previous FY17, with most consumers being satisfied with their treatment provider and the treatment they receive.

Figure 9: **SUD Satisfaction Survey – Comprehensive Response Results**



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 beneficiaries in the service area[19]. The effectiveness of the number of providers in the network may be evaluated by past performance.

Sufficiency of number of providers – access timeliness and inpatient follow-up

MDHHS requires PIHPs to report indicators of access timeliness and inpatient follow-up. Table 20 shows the recent year-to-year performance of the 21-county region. MSHN's performance is above state thresholds, indicating beneficiaries are generally accessing services in a timely fashion.

Table 20: **State Performance Indicators for Access Timeliness and Inpatient Follow-Up**

	Population	MSHN Score FY16 Q3	MSHN Score FY17 Q3	MSHN Score FY18 Q3
New persons receiving face to face assessment w/in 14 days of non-emergency assessment (Standard: ≥95%)	MI-Children	98.72%	98.51%	99.05%
	MI-Adults	99.29%	99.26%	98.98%
	DD-Children	100.00%	97.30%	98.73%
	DD-Adults	98.82%	100.00%	100.00%
	Medicaid SA	98.96%	98.39%	99.12%
New persons starting on-going service w/in 14 calendar days of a non-emergent assessment (Standard: ≥95%)	MI-Children	96.83%	96.98%	96.18%
	MI-Adults	97.55%	98.25%	98.31%
	DD-Children	96.36%	100.00%	100.00%
	DD-Adults	96.36%	98.48%	100.00%
	Medicaid SA	100.00%	100.00%	97.19%
Persons discharged from psychiatric inpatient unit/ substance abuse detox unit seen for follow-up care w/in 7 days (Standard: ≥95%)	Children	99.14%	99.22%	96.18%
	Adults	97.03%	96.97%	97.38%
	Medicaid SA	100.00%	97.51%	98.78%
Persons readmitted to an inpatient psychiatric unit w/in 30 days of discharge	Children	6.31%	11.88%	7.29%
	Adults	9.35%	11.10%	9.59%

[19] 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."

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. Appendix F and G demonstrate location of providers in relation to the location of consumers who received respective services. Both areas are being addressed by MSHN, which will be expected to help with inpatient recidivism as well.

Sufficiency of number of providers – autism spectrum disorder capacity

Last year's assessment found that CMHSP Participants were finding it difficult to secure adequate providers to provide Behavioral Health Treatment/Applied Behavioral Analysis services for individuals 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. As discussed previously in this assessment, however, MSHN and its CMHSP Participants have worked diligently to address the issue of BHT supervisor capacity over the course of the previous year. Since July 2017, the region has established contracts with an additional 16 ABA providers. Despite the addition of many new ABA contracts in the MSHN region, the rate of enrollees has climbed precipitously in many CMHSPs over the past year. Table 21 shows that most CMHSPs have experienced significant increases in Autism Benefit service enrollment in the past year:

Table 21: **Rate of Change of Autism Benefit Enrollees**

CMHSP	Rate of Change	# Enrollees 3/1/17	# Enrollees 7/1/18	CMHSP	Rate of Change	# Enrollees 3/1/17	# Enrollees 7/1/18
BABH	12%	88	99	**LifeWays**	60%	126	202
CEI	56%	159	248	**MCN**	44%	36	52
CMHCM	40%	107	147	**NCMH**	-52%	31	15
GIHN	30%	37	48	**SCCMH**	44%	138	199
HBH	225%	4	13	**SHW**	71%	21	36
TRDFHRW	11%	22	24	**TBH**	23%	26	32
MSHN Total	**40%**	**795**	**1115**				

Furthermore, although the issue of ABA contract providers is being addressed, quality and compliance issues continue to require monitoring and further intervention. For instance, the number of individuals who have been found eligible for Autism Benefit services and are still waiting for a plan of service after 90 days has decreased notably over the past year (see Table 22). Nonetheless, several new cases each month continue to surpass the 90-day threshold for start of services. This demonstrates the need for continued efforts to work with ABA providers to get assessments completed and individuals into services more quickly. MSHN has plans to provide information to the Autism Workgroup about pulling reports prior to 90-day benchmarks, with the intention of developing internal tracking systems to ensure that individuals are getting into services in a timely fashion. MSHN will work further to streamline and manage compliance and performance issues through workgroup activities. There is also a need to address issues such as frequent provider changes and how to access and utilize current providers more effectively. CMHSP Participants will continue to work within their purviews to address gaps in provider network capacity for autism benefit services.

Table 22: **Individuals with Autism Waiting Longer than 90 Days for a Plan of Service**

	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRDF-HRW	TBHS	MSHN
As of 10/1/17	28	34	31	9	2	43	6	1	15	5	4	9	**192**
As of 7/1/18	3	15	23	4	0	19	12	1	10	9	0	1	**97**

Sufficiency of mix of providers – IDD, SED

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 access to psychiatric inpatient 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.

The issues causing this network capacity concern appear to be the result of a convergence of several factors. Some hospitals are reporting a lack of capacity, but anecdotal evidence suggests capacity is only a barrier in limited geographic areas or for certain specialty populations. The slackening economy in Michigan in the past several years appears to have triggered restricted staffing in some hospitals, thereby limiting their capacities.

In December 2017, Michigan Public Health Institute (MPHI) released a report of statewide denial data (July-December 2017). Table 23 represents Number of individuals (adults and children), denial events, and denials by CMHSP in the MSHN region.

Table 23: **Inpatient Psychiatric Denials per CMHSP in the MSHN Region**

CMHSP	# of individuals	# of denial episodes	# of denial events	Average denials/ episode	Medicaid Population (Dec 2017)	Rate of denial per 1,000
BABH	15	17	152	8.9	22,271	0.76
CMHA-CEI	209	243	4393	18.1	71,127	3.42

CMHCM	16	19	173	9.1	45,962	0.41
GIHN	12	12	70	5.8	7,751	1.55
HBH	14	17	179	10.5	5,264	3.23
LifeWays	271	333	3470	10.4	38,510	8.65
MCN	47	55	622	11.3	12,699	4.33
Newaygo	10	10	102	10.2	10,846	0.92
Saginaw	128	136	1681	12.4	42,698	3.19
Shiawassee	18	23	161	7.0	12,310	1.87
TRDFHRW	31	34	674	19.8	10,075	3.37
Tuscola	4	4	61	15.3	10,499	0.38

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.

Sufficiency of mix of providers - SUD

The sufficiency of SUD providers has been impacted by MDHHS's selection of the Global Assessment of Individual Need (GAIN) as its universal state-mandated SUD assessment tool. To meet the federal requirements of the 1115 Waiver, the GAIN was selected because it is the only standardized assessment tool that incorporates ASAM which is required for passage of the 1115 Waiver. Among the impacts related to network adequacy for MSHN's SUD provider network are the implications of Masters-level clinicians being the sole administrators allowed to utilize the GAIN assessment.

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 an area of focus for the region.

Sufficiency of mix of providers – cultural competence

Each CMHSP participant includes training for staff regarding cultural competence. Providers are empaneled in areas with concentrations of ethnic or cultural groups, such as the Latino counseling services available through the CMHA-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.

Sufficiency of mix of providers – consumer choice

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.

Population Density Standards/Geographic Accessibility: The MDHHS is working with the PIHP's in the state to address new requirements issued by CMS through the 2016 revisions to the managed care rules (Part 438 of Title 42). At a minimum, each state must set time and distance standards. Michigan has established population density standards for ACT, Clubhouses, Crisis Residential, Home-Based Services and Wraparound for children, and Opioid Treatment Programs. Refer to Appendix E – MSHN's draft plan to address the standards.

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.

Substance use disorder providers also continue to add specialized transportation services to meet the needs of MSHN region. One example is added home based services for women with children, which is an enhanced women's specialty service, to address geographic limitations/ transportation problems individuals were having in trying to access clinic-based services.

In accordance with revisions to the managed care rules, the availability of triage lines or screening systems must also be considered in state provider network adequacy standards. Most of the CMHSPs in the region have used or would use tele-medicine services for key services which are in short supply, such as psychiatric care. All the CMHSPs use emergency services hotlines to receive and triage calls from Medicaid beneficiaries and other members of the community. Some CMHSPs also use telephone based pre-screening programs for determination of medical necessity for psychiatric inpatient care and/or for preliminary eligibility screenings for specialty behavioral health and SUD services.

Accommodations

All CMHSP Participants offer services in locations with physical access for Medicaid beneficiaries 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 CMHSPs and SUD providers 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.

Each CMHSP Participant and SUD provider 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.

As of the date of this assessment, Ingham County has 5% non-English speaking individuals, while 13 counties have greater than 1% but less than 3% non-English speaking individuals. 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

[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."

sign interpreters for persons with hearing impairments and audio alternatives for people with vision limitations.

Interpreter services, although available across the region in accord with MDHHS standards, are less than adequate for crisis intervention services, where a timely clinical response is critical and wait times for access to an interpreter may delay treatment. The region will monitor the impact of this issue on crisis response capacity.

MSHN requested that CMHSPs and SUD Providers ensure accommodations are available as required for individuals accessing services who experience hearing or vision impairments and that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services. This has been addressed during site reviews by the MSHN audit team. Based on MSHN audits, providers are in compliance with these requirements.

Population Health and Integrated Care

MSHN and its CMHSP Participants have developed and approved a regional Population Health and Integrated Care Plan[21]. The plan includes the increased MDHHS contractual requirements to integrate and coordinate care and identifies the current efforts related to monitoring population health activities and increase the overall health of the enrollees in the region.

MDHHS continues to include and increase contractual requirements regarding PIHP and Medicaid Health Plan Coordination with specific measurements and expectations related to obtaining a performance incentive bonus. MSHN meets monthly with the eight (8) Medicaid Health Plans in the region to prioritize and identify individuals that will receive care coordination as identified in the joint risk stratification criteria.

MSHN uses a data analytics software that includes both physical and mental health Medicaid claims data for the enrollees in the region. Joint performance metrics are reviewed monthly by MSHN and the CMHSP Participants. MSHN also provides for data exchange with hospitals in our region to receive admit, discharge and transfer information that is monitored by the region for follow up care.

While the PIHP and Medicaid Health Plans work together on the care coordination at the plan level, the CMHSP Participants and the SUD Provider system coordinate care at the provider/consumer level. As care coordination improves, MSHN expects this will increase utilization of CMHSP resources and provider network services.

The following list summarizes CMHSP Participant efforts to increase healthcare integration, as described in their community needs assessment updates:

- BABH
  - Key partner for Saginaw Valley State University and Bay County Health Department HRSA grant to add a behavioral health team to a nurse practitioner primary care clinic
  - Enhanced nursing model to expand access to healthcare; embedded questions in social work assessments focused on typical chronic co-morbid conditions to identify consumers for referral to nursing staff for health assessment and enhanced coordination of care with primary care providers; embedding questions in person centered planning process regarding health risk profile
  - Participating in a performance improvement project involving diabetes screening and coordination with primary care physicians

[21] MSHN Population Health and Integrated Care Plan, 2018-2020

- Providing funding for the Community Health Assessment
- Pilot site for MDHHS, MiHIN and PCE for development of embedding of CC 360 in EHR
- Working with Zenith for potential embedding of the Integrated Health Care Platform in EHR, including risk analysis for poor health outcomes
- Providing wellness classes run by nursing staff
- Utilizing electronic lab ordering and receipt of test results with multiple labs
- Contracted with Great Lakes Health Connect for information exchange with regional health center and primary physician clinics
- Collaborative effort to implement a Vivitrol program in the jail with Bay County Jail leadership, Sheriff's Dep't, Courts (judges), Public Health Dep't and SUD providers

- CMHA-CEI
  - CMHA-CEI has Behavioral Health Consultants (BHCs) placed in two MSU/Sparrow Family Medicine Residency Programs and one McLaren Family Medicine Practice to review screenings based on the Bright Futures Screening Protocol, and consult with patients and provide brief treatment at the clinic. Additionally, BHCs continue to provide onsite behavioral health interventions, including both brief intervention as well as ongoing treatment.
  - CMHA-CEI's Families Forward Program, in partnership with Michigan Child Collaborative Care (MC3) is offering pediatricians and OB/GYNs psychiatric consultation with University of Michigan psychiatry staff. Currently, over 300 local providers have been enrolled into MC3.
  - CMHA-CEI has partnered with the Ingham Community Health Centers to develop and implement a model of Primary Care Behavioral Health for its network of health centers.
  - CMHA-CEI has Behavioral Health Consultants embedded in 6 Ingham County Federally Qualified Health Center (FQHC) locations, and provides clinical supervision to 8 behavioral health staff employed by the FQHC.
  - Ingham County Health Department (ICHD) and CMHA-CEI have established protocols for electronic exchange of Health Records for shared consumers.
  - All clinical programs within CMHA-CEI have developed integrated care pilots to further promote integrated care for consumers of CMHA-CEI.
  - ICHD operates the Birch Health Center (FQHC) located inside our CMHA-CEI Jolly Road building with both a CMHA-CEI Behavioral Health Consultant and CMHA-CEI Psychiatric Nurse Case Manager embedded in the clinic.
  - In partnership with McLaren-Greater Lansing, CMHA-CEI has a Crisis Services Mental Health Therapist embedded in the McLaren-Greater Lansing Hospital Emergency Department on a daily basis from 2pm to 2am.
  - CMHA-CEI's Wellness Counseling Center provides adult behavioral health services and is co-located in the Ingham County Health Department Forest Community Health Center.
  - CMHA-CEI's Wellness Counseling Center provides adult behavioral health services within the Cristo Rey Community Center's Primary Care Clinic.
- CMHCM
  - Co-locating five therapists
  - Participating in the Michigan Health Improvement Alliance collaborating with other agencies to achieve a community of health excellence
  - Meeting with Great Lakes Health Information Exchange about integrating lab and available physical health data into the EMR
  - Accessing State of Michigan web portal, Care Connect 360 that provides population health and data analytics information was pursued. Work will continue this year on these initiatives.
  - Meeting with all hospitals in the area and collaborating on several fronts
  - Medical Director is now adjunct prof at CMU and is teaching with their med students.
  - Having CMU's 3rd and 4th year psych residents with us as a placement site
  - Full-time staff located on site at the new Emergency Department that Mid-Michigan Health is building here in Mt. Pleasant
  - Meeting with the Mid-Michigan Regional Medical Center and sharing the CC360 data
  - Strategizing on how to approach the highest ED users

  - Continued development of the MDHHS Integrated Health grant
  - Established an Outpatient Orientation session to help educate consumers about the relationship between mind/body
  - Promoting use of MI skills for integrated health changes
  - Applying for Michigan Health Endowment grants
  - Medical Director continues to meet with local Health Plans to explore services to shared consumers
- GIHN
  - Nurse Practitioner providing Physical Health Care services to consumers and general public in St. Louis satellite office.
  - Care Manager analyzing ICDP data, and networking with primary staff on care alerts.
  - Electronic Medical Record designed to add health and wellness reports
  - Member of Live Well Gratiot – County wide health and wellness committee
  - Peer led smoking cessation classes
  - Host site for Medical Residents, Medical Interns, and Psychiatric Interns and RN students.
  - Crisis Therapist co-located in the ED of Mid-Michigan Medical Center –Gratiot.
  - Therapist located in St. Louis clinic providing therapy to mild-to-moderate population
  - Participating in performance improvement projects involving diabetes and cardiovascular screening.
  - Nurses attend medical appointments with consumers who struggle with knowledge of their medical condition and/or understanding of the course of treatment
  - Increased integrated SUD services to include Medically Assisted Treatment (MAT)
- HBH
  - Have a co-located FQHC provider at the CMH site
  - CMH staff work in the emergency department of local hospitals for Emergency Services provision
  - Actively discussing better integrated care efforts with area hospitals
  - Psychiatric consultation is provided to primary care sites
  - Providing healthy lifestyle education
  - Integrating wellness and recovery principles into services
  - Participating in a performance improvement projects involving diabetes and cardiovascular screening
  - Nursing staff in conjunction with clinical staff provide health & wellness classes for consumers focusing on healthy lifestyle changes
  - Initiated access into the State of Michigan web portal, Care Connect 360, as well as ICDP, that provides population health and data analytics information.
  - Hosting students working on their advanced nursing degrees (pursuing nurse practitioner certification)
  - Implemented a tobacco-free campus (all locations) and provide Tobacco Education/Support
  - Assisting consumers who do not have a primary care provider connect to a physician by connecting them to either the local FQHC clinic or a private primary care provider of their choice
  - Medical Director provides consultation to community primary care physicians as requested.
- TRDFHRW
  - The Board of Directors established consumer-based outcomes related to wellness: 85% of Medicaid Population (Healthy Michigan, Medicare/Medicaid, Medicaid) served are seen annually by a primary care physician OR receive an annual health screen with a nurse from The Right Door for Hope, Recovery and Wellness.
  - Strategically providing “physician outreach” whereby the psychiatrist, nurses and clinical leaders meet with local primary care providers to educate, provide consultation and address high utilizing patients.
  - Have formal coordination of care agreements with most all Rural Health Clinics in Ionia County; including Sparrow Medical Group Clinic in Ionia and various physician practices.
  - Providing educational lunches for primary care providers in Ionia County with our Medical Director at least annually.
  - Providing the Medical Director’s personal cell phone number to community primary care providers for direct consultation.
  - In addition to sending medication reviews and evaluation notes, also share lab values with primary care providers to coordinate care.
  - Publishing a quarterly newsletter on best practices and coordination of care for primary care providers.

- Consumers seen by the Medication Services team ~~has~~ have their BMI, waist circumference, AIMS testing, and lab orders completed.
- Visiting primary care offices twice monthly with education in form of material, lunch discussions or speakers.
- All primary care referrals receive a health screen to bring both medical and mental health together.
- Primary care offices working with us by providing topics from groups for their consumers.
- One time consults by our providers at the request of the primary care provider.
- Nurses attend doctor appts with consumer when consumer struggles with knowledge of their medical condition.
- Helping consumers who do not have a primary care provider connect to a new primary care provider by calling their office and setting up first appt.
- Integrated Health Block Grant funded for 2 years, will be funded 2 additional years to provide education, referrals, healthy food pantry.

- LCMHA
  - Providing Care Management services to consumers enrolled in PBHCI SAMHSA Grant – coordinating care with primary care physicians and specialists
  - Co-Location of the Federally Qualified Health Center on site at the LifeWays building
  - Participation in our Health Improvement Organization aimed at conducting a community health assessment and developing a community action plan to improve overall health of our community.
  - Providing Wellness Wednesday, Learning about Healthy Living – Tobacco and You, Nutrition Exercise Wellness and Recovery (NEW-R) classes, and Stress less events aimed at improving overall health of our consumers.
- MCN
  - Opened Wellness Works in partnership with Dartmouth University, a combination community fitness facility, program location for In-SHAPE and transitional employment work site; Dartmouth is reporting and benchmarking outcomes; MSU Extension provides nutrition classes.
  - Adding a Pediatric Nurse and Children's Case Manager to increase integrated healthcare for children.
  - Training Children's staff in health and wellness protocols; targeting obesity and reducing emergency room overuse.
  - Co-sponsoring health prevention classes at the Wellness Center with community hospital partners (United Lifestyles) on topics such as Diabetes Education.
  - Offering consultation and training to mid-level practitioners on psychiatric conditions and prescribing to increase the Primary Care Community's comfort level in treating persons with mild/moderate mental health conditions; sponsoring education on prescription drug abuse.
  - Implemented a Health Stratification system and Care Pathways for persons with chronic health conditions to identify at risk individuals and target strategies to increase self-management.
  - Producing a health outcome dashboard for stake holders to track population health impact.
- NCMH
  - Co-locating clinicians into physical health settings
  - Co-locating a clinician into an OBGYN clinic
  - Participating in a Process Improvement Project to identify individuals who may need a diabetic screening and linking them back to their PCP.
  - Collaborating with a local health care provider and non-profit organization to develop a care model to meet the needs of those with complex mental and/or physical health concerns who are seeking heat/energy assistance.
  - Providing education on MATP to local health providers.
  - Providing multidisciplinary team care as medically necessary to patients with high behavioral and physical health needs
- SCCMHA
  - Co-located primary health services; renovating building in fall of FY 2016 to offer pharmacy, lab and primary care; relocated psychiatry, nursing and enhanced health services a new Wellness Center to optimize provider networking

- Have two NADA certified staff for auricular acupuncture
- In year ~~3~~ 4 of the PBHCI grant, actively working in conjunction with MDHHS to identify strategies to continue funding of care coordination services; performing walk-in on site lab drawing services for consumers.
- Awarded a SAMHSA expansion grant for behavioral health consultation in primary care
- Actively utilizing the MSHN Zenith Data Analytics program as well as CC360 to identify at risk groups as well as at risk individuals
- Using SCCMHA EMR and ZENITH/ADT information to improve consumer engagement and prioritization of needs for daily consumer appointments and addressing open care alerts
- Added behavioral health services to CMU Medical School's Medical Services Family Practice Clinic
- All adults are screened at the front door using ZENITH/ICDP to identify ~~for~~ chronic health conditions
- When indicated, new consumers are administered a lipid and A1C screening in addition to establishing a wellness goal
- Added a mental health consultant to ~~a~~ two co-located primary care sites
- EMR dashboard now also includes biometrics
- Selected as national site participant in the Master Cancer Control Community of Practice with National Council and National Behavioral Health Network for Tobacco Use Reduction
- MDHHS block grant funds are being used to provide services to uninsured Saginaw residents with hoarding disorder

- SHW
  - Using Care Connect 360 data to demonstrate improvement in both outcome and process measures for one chronic disease identified as a HEDIS measure
  - Continuing to work with the PIHP on the HSAG developed PIP r/t monitoring of A1C for individuals prescribed anti-psychotic medications
  - Collaborating with local hospital and EMR vendor to support HL7 electronic transfer/upload capabilities for all laboratory and test results; functionality is currently in place with Quest Labs
  - Nurse or Medical Assistant performs a brief assessment (including vitals) for all newly enrolled consumers and those coming in for medication reviews
  - Nursing supervisor/medical staff provide "brown bag" trainings to case holders related to physical health and integration
  - Strong partnership with Shiawassee Community Health Center (patient-centered medical home), who is co-located in SHW, and provides primary care on site to just under one-hundred shared consumers
  - Participating in workgroup through Great Start, which is looking at partnering with OB/GYNs and pediatricians to do maternal screening
  - SHW Medical Director provides ongoing psychiatric consultation with Shiawassee Community Health Center (patient-centered medical home)
  - Nursing staff is partnering with Drop-in Center staff and doing wellness classes
  - Social worker becoming trained in smoking cessation and will ultimately offer groups at both the FQHC and CMHSP
- TBHS
  - Have an integrated primary health and behavioral care clinic on site
  - Have staff trained as a behavioral health consultant
  - Sponsored wellness initiatives for service recipients aimed at improving overall health via grant funding
  - Plan to include additional healthcare providers onsite, behavioral healthcare consultation services at primary healthcare locations, and expanded health related initiatives
  - Have conducted two meetings with administration from Caro Community Hospital, including the CEO, CFO, and VP of Nursing. Currently negotiations remain ongoing as it relates to the expansion of the TBHS Wellness Clinic to include Caro Medical Clinic as a provider at this time. Full integration is anticipated within the next 3-6 months.

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. One initiative is already in process; specifically, an analysis of inpatient rates for purposes of identifying opportunities for better value through collaborative rate setting. Figure 10 shows the inpatient rates collected by the state and reported by CMHSP Participants in FY18:

Figure 10: **FY18 Inpatient Rates**

Hospital Name	City	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	Montcalm	Newaygo	Saginaw	Shiawassee	Tuscola	Max	Min	Avg	Median
BCA StoneCrest Center	Detroit			795	825		721				736	728		825	721	761	736
Forest View Psychiatric Hospital (Some have tiered rates)	Grand Rapids	900		900	900	900	900	900		870	900	900		900	870	897	900
Harbor Oaks Hospital	New Baltimore	725		700		575	600	750			636	635		750	575	660	636
Havenwyck Hospital	Auburn Hills	710		725		550	675				768	700		768	550	688	705
Pine Rest Christian Hospital	Grand Rapids			996	1,025		1,064	1,064	1,064	1,064	1,064			1,064	996	1,051	1,064
Behavioral Health Center of MI	Warren					515								515	515	515	515
Allegiance Health	Jackson						675							675	675	675	675
Alpena General Hospital	Alpena	900				850								900	850	875	875
Bay Regional Medical Center	Bay City	775				631				631		670		775	631	677	651
Borgess Hospital	Kalamazoo									843				843	843	843	843
Chelsea Community Hospital	Chelsea						854							854	854	854	854
Community Health Center of Branch County	Coldwater						757							757	757	757	757
Detroit Receiving Hospital	Detroit					800								800	800	800	800
Gratiot Medical Center	Alma				875	875						875		875	875	875	875
Healthsource Saginaw	Saginaw	820		760	815	830	830		830	760	804	760	760	830	760	797	809
Henry Ford Macomb Hospital	Clinton Township												800	800	800	800	800
Hillsdale Community Health Center	Hillsdale						660				640			660	640	650	650
Holland Community Hospital	Holland			785										785	785	785	785
Lapeer Regional Hospital	Lapeer					720							720	720	720	720	720
McLaren Regional Medical Center	Flint			870										870	870	870	870
Memorial Healthcare	Owosso					800	960				860	886	965	965	800	894	886
Mercy Health Partners - Hackley Campus	Muskegon			912		912	950		950	964			964	964	912	942	950
MidMichigan Medical Center - Midland	Midland	875		875	875	875	875		875		875		875	875	875	875	875
Oaklawn Hospital	Marshall						800							800	800	800	800
Port Huron Hospital	Port Huron												680	680	680	680	680
St. Mary Mercy Hospital	Livonia			996										996	996	996	996
St. Mary's Health Care (Grand Rapids)	Grand Rapids				1,025		1,025	1,025		1,064	1,064	1,064		1,064	1,025	1,045	1,045
University of Michigan Health System	Ann Arbor					900								900	900	900	900

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.

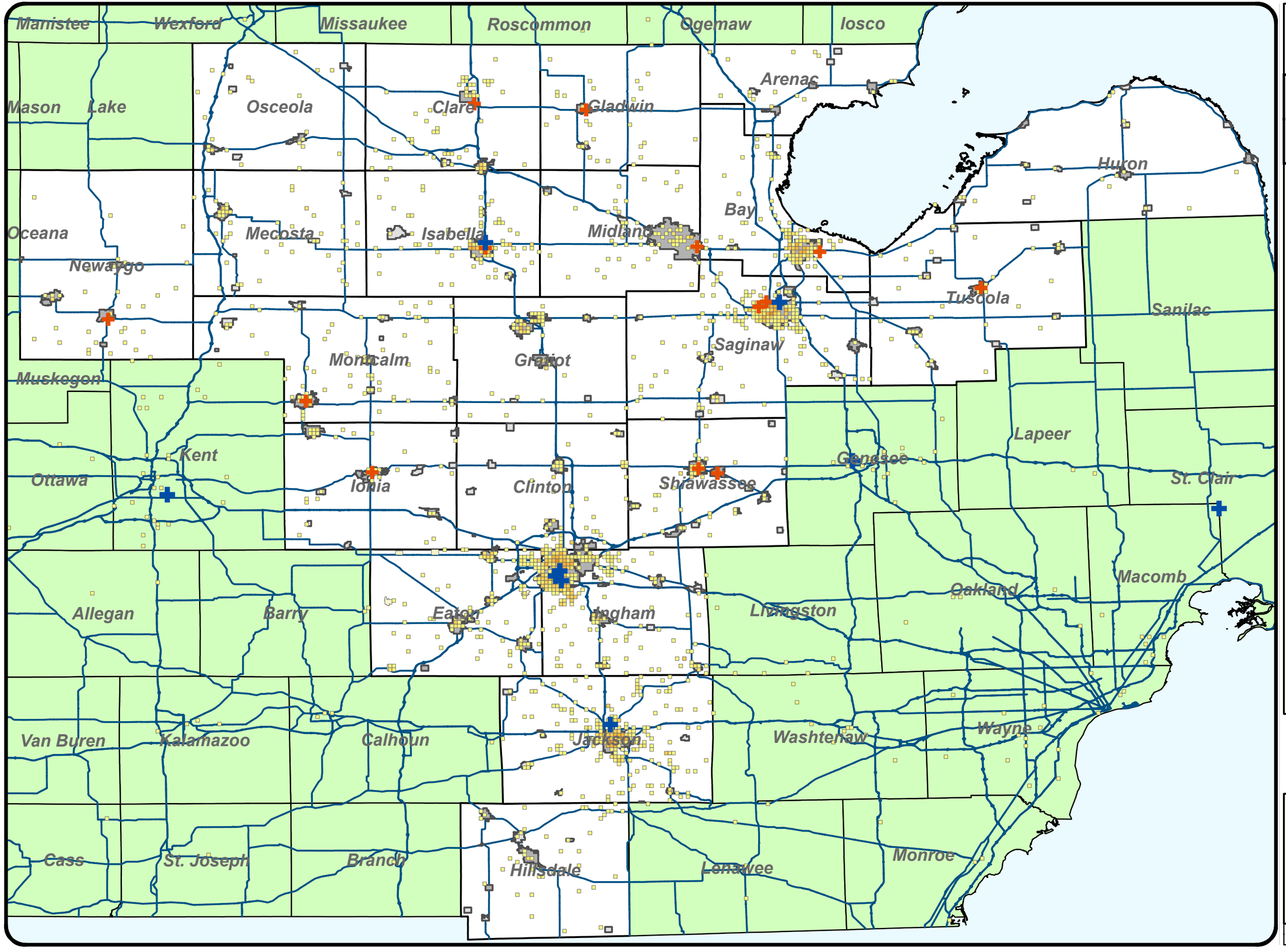
Recommendations/Conclusions

MSHN has approved the following priorities and initiatives to address the adequacy concerns delineated in this assessment:

1. Continue to support provider network capacity to offer key evidence-based programs, such as recovery and trauma informed programming, including ROSC.
2. Continue to advocate for and participate in statewide planning relative to inpatient access; assess for and develop alternative inpatient/crisis response options, particularly for individuals with intellectual and developmental disabilities (such as Autism) exhibiting behavioral challenges.
3. Address compliance and quality concerns as they relate to the provision of behavioral health treatment/applied behavior analysis services, including streamlining and managing compliance and performance issues through targeted workgroup activities.
4. Continue to assess and address the integration of mental health, substance use disorder and physical health care.
5. Continue to monitor and address changes to provider network capacity brought on by the implementation of the HCBS Final Rule, developing plans to promote residential, employment, and

other community living related services and assisting providers in navigating heightened scrutiny and provisional approval processes.

6. Evaluate SUD residential and withdrawal management needs in the region.
7. Continue to address network capacity for detox services and medication assisted treatment, including availability of Methadone, Vivitrol, and Suboxone at all MAT locations; Continue to support CMHSPs and SUD providers as Narcan kit distribution sites.
8. Continue to discuss opportunities if any for regional action to address CMHSP identified issues with services for children.
9. Continue to support the BHDDA veterans and military member strategic plan.
10. Evaluate the status of compliance with the enhanced requirements for trauma informed and sensitive treatment, including any changes that may be needed in provider network specializations; Continue to promote trauma informed care relative to SUD treatment and offer SUD providers opportunities for trauma competence training.
11. Continue to monitor Supports Intensity Scale (SIS) assessor capacity to ensure compliance with assessment requirements for individuals with intellectual/developmental disabilities.
12. Seek further clarification from MDHHS regarding HCBS requirements for independent assessment, including its relationship to conflict-free case management and the avoidance of conflicts of interest in person-centered planning.
13. Ensure the implementation of Intensive Crisis Stabilization Services throughout the region in compliance with MDHHS modified Medicaid standards for children; support initiatives as identified by MDHHS data collected during FY18.
14. Assess adequacy of independent facilitation provider availability; ensure the region is in compliance with independent facilitation services and address issues of availability and choice in the independent facilitator provider network.
15. Assess and monitor new MDHHS Network Adequacy standards specific to ACT, Clubhouses, Crisis Residential, Home-Based Services and Wraparound for children, and Opioid Treatment Programs (Appendix E).



MSHN

Provider Network

FY2017-18

Legend

map_FY2017_18_SUD_MAT

RecipientID_Count

- 1 - 2
- 3 - 5
- 6 - 10
- 11 - 25
- 26 - 50
- 51 - 75
- 76 - 100
- 101 - 200
- Prov_SUD_MAT
- Prov_SUD_SubOx_Viv

Please note the step sizes in the graduated symbols. They are not equal steps.

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Rev 2018-11-21

This map shows data on distribution of enrolled and/or served recipients at a detail level that may constitute Protected Health Information under HIPAA standards.

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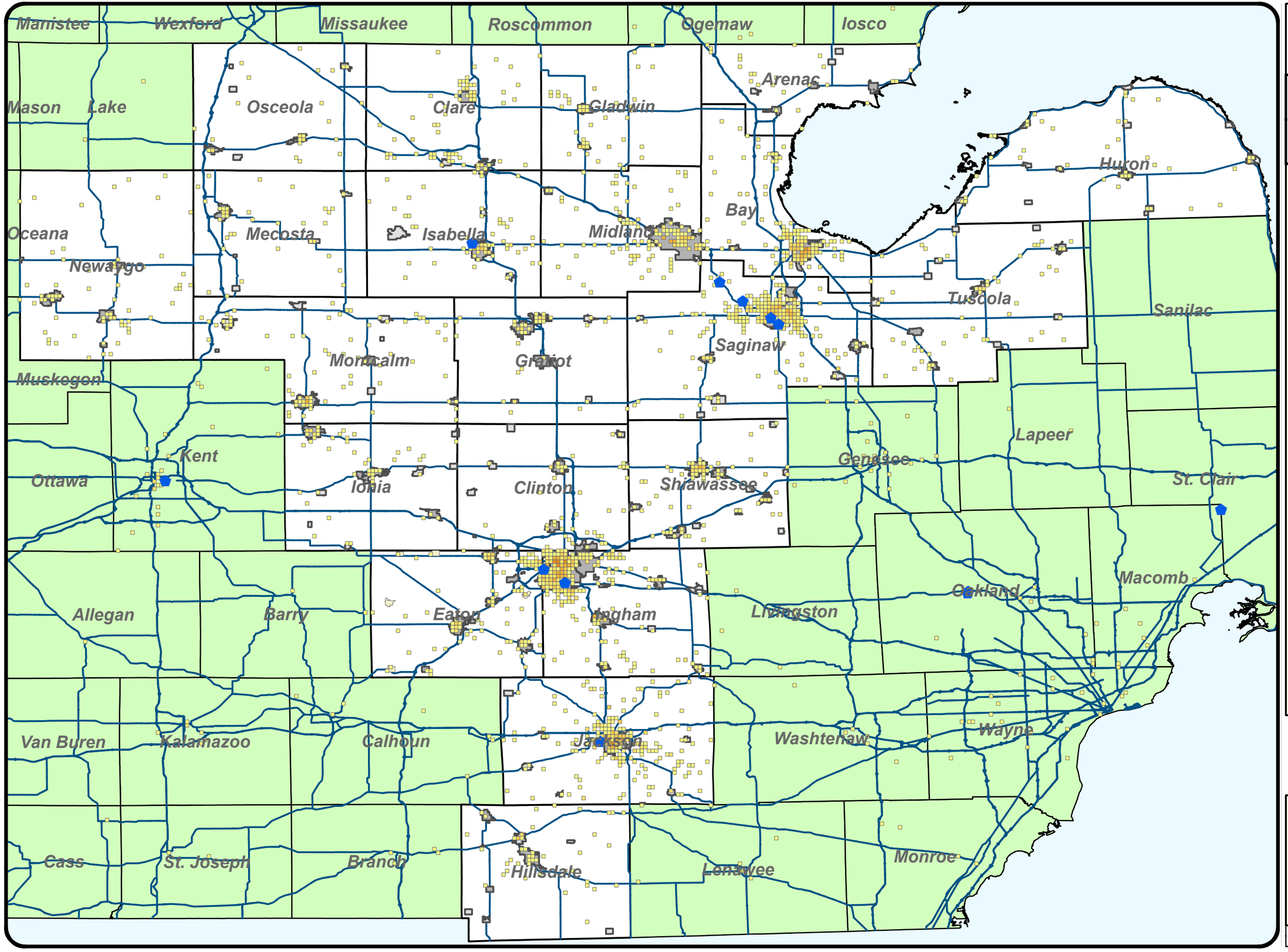

MSHN

Provider Network

FY2017-18

Legend

map_FY2017_18_SUD_Withd

RecipientID_Count

- 1 - 2
- 3 - 5
- 6 - 10
- 11 - 25
- 26 - 50
- 51 - 75
- 76 - 100
- 101 - 200

Prov_Withd

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MSHN

Provider Network

FY2017-18

Manistee
Wexford
Missaukee
Roscommon
Ogemaw
Iosco
Arenac
Mason
Lake
Osceola
Clare
Gladwin
Huron
Bay
Oceana
Mecosta
Isabella
Midland
Newaygo
Tuscola
Sanilac
Saginaw
Montcalm
Gratiot
Muskegon
Lapeer
Kent
Genesee
Ottawa
Ionia
Clinton
Shiawassee
St. Clair
Macomb
Allegan
Barry
Eaton
Ingham
Livingston
Oakland
Van Buren
Kalamazoo
Calhoun
Jackson
Washtenaw
Wayne
Cass
St. Joseph
Branch
Hillsdale
Lenawee
Monroe

Legend

map_FY2017_18_SUD_Resid
RecipientID_Count

- 1 - 2
- 3 - 5
- 6 - 10
- 11 - 25
- 26 - 50
- 51 - 75
- 76 - 100
- 101 - 200
- Prov_Resid

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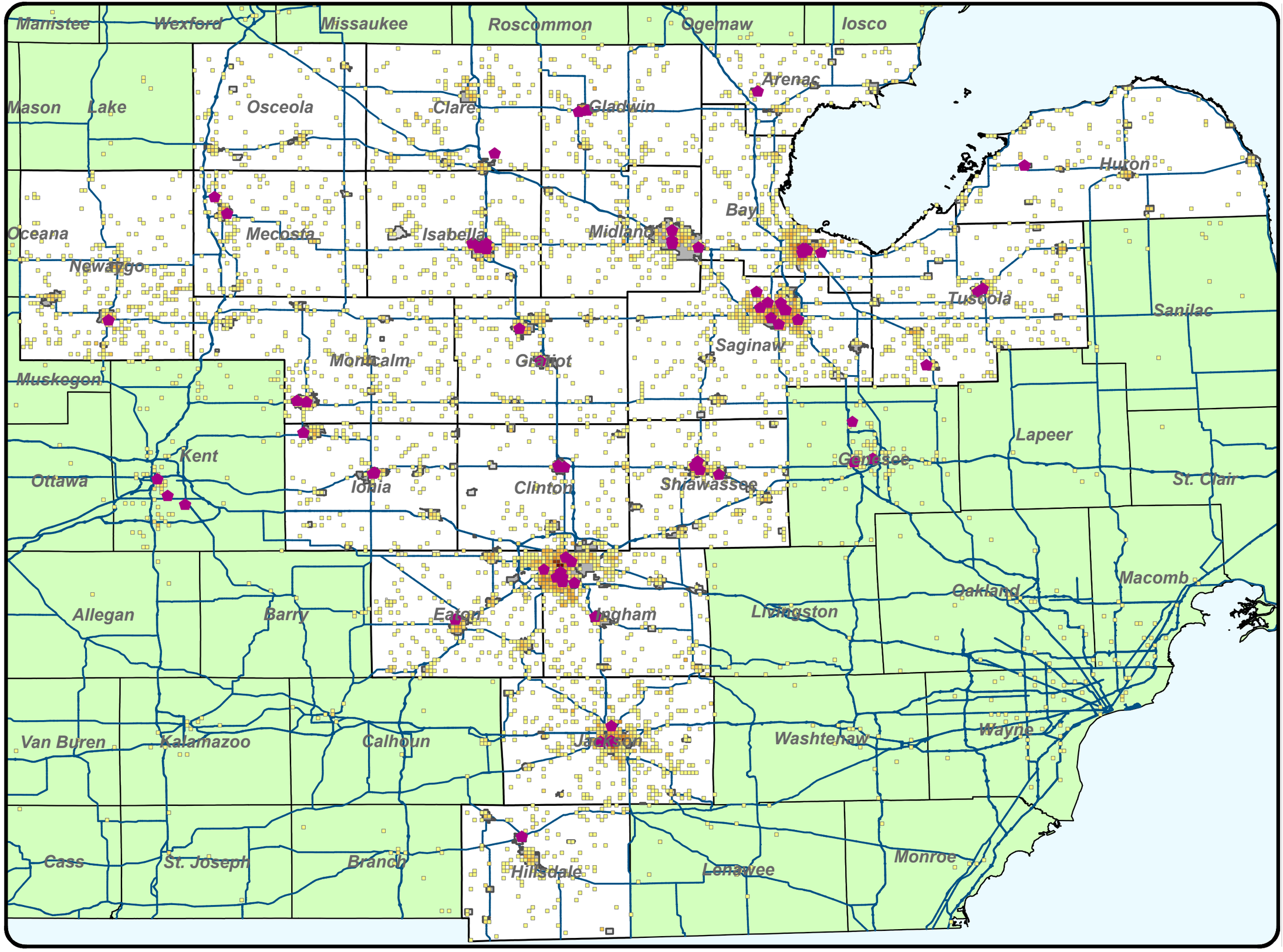

MSHN

Provider Network

FY2017-18

Legend

map_FY2017_18_SUD_OutPt
RecipientID_Count

- 1 - 2
- 3 - 5
- 6 - 10
- 11 - 25
- 26 - 50
- 51 - 75
- 76 - 100
- 101 - 200
- Prov_SUD_OutPt

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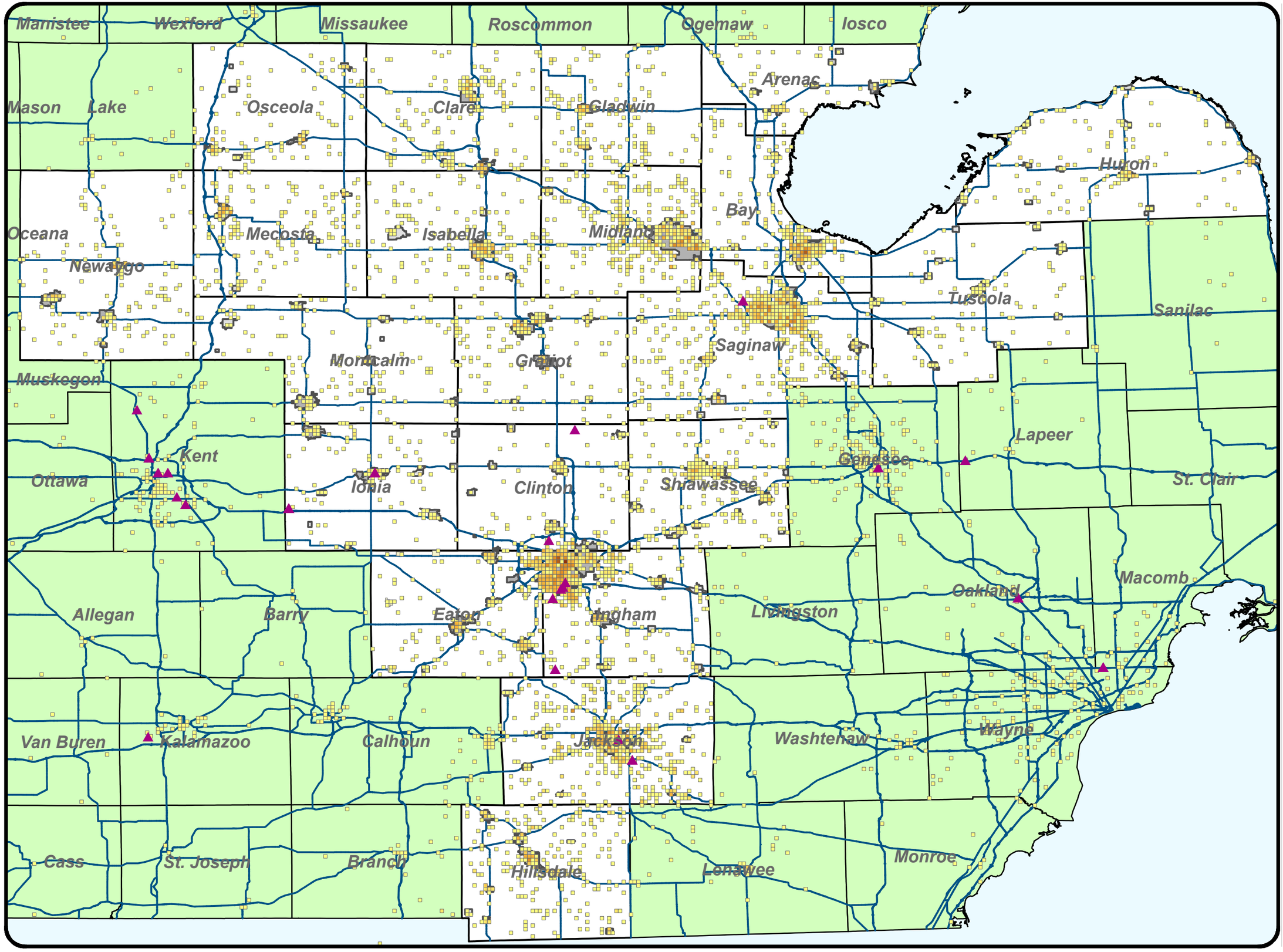

MSHN

Provider Network

FY2017-18

Legend

map_FY2017_18_MH_Crisis RecipientID_Count

- 1 - 2
- 3 - 5
- 6 - 10
- 11 - 25
- 26 - 50
- 51 - 75
- 76 - 100
- 101 - 200
- Prov_CMH_Crisis

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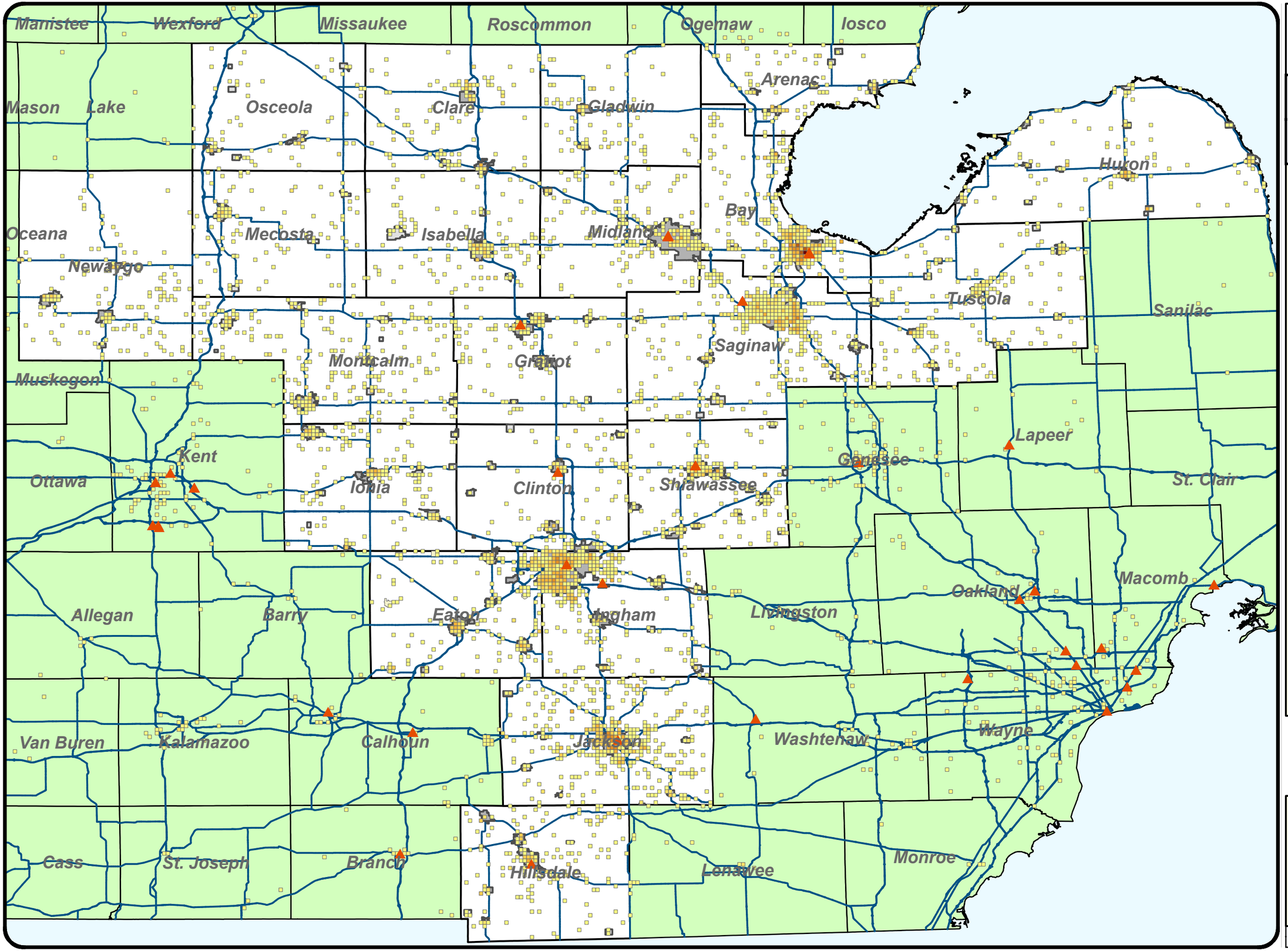

MSHN

Provider Network

FY2017-18

Legend

map_FY2017_18_MH_InPt_Psych

RecipientID_Count

- 1 - 2
- 3 - 5
- 6 - 10
- 11 - 25
- 26 - 50
- 51 - 75
- 76 - 100
- 101 - 200
- Prov_CMH_InPt_Psych

Please note the step sizes in the graduated symbols. They are not equal steps.

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Rev 2018-11-21

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MSHN
Mid-State Health Network

MID-STATE HEALTH NETWORK

NETWORK ADEQUACY PLAN TO MEET MDHHS 2018 NETWORK ADEQUACY STANDARDS

DRAFT PLAN

1) Introduction

This document serves as the required draft plan response of Mid-State Health Network (MSHN), the Pre-Paid Inpatient Health Plan (PIHP) covering 21 Michigan counties in the lower peninsula of Michigan, as it relates to Michigan Department of Health and Human Services (MDHHS) Network Adequacy Standard Policy (MSA 18-49) and the companion procedure document released by MDHHS on 10/29/2018.

The MDHHS has requested draft network adequacy standards compliance plans for the region covered by MSHN. The intent of this draft plan is to concisely identify current provider network status within the region, assess any areas not meeting the MDHHS standards, and to raise certain considerations and questions. The format for this draft plan was defined by MDHHS (numbered headings).

2) Description of Current Network Adequacy Relative to the MDHHS Standards

The MDHHS published procedures delineating its Network Adequacy Standards on 10/29/2018. For ease of reference/comparison, the current standards are depicted in Figure 1-1.

Figure 1-1: MDHHS Network Adequacy Standards

Adult Standards

Adult Services	Standard
Assertive Community Treatment	30,000:1 (Medicaid Enrollee to Provider Ratio)
Psychosocial Rehabilitation (Clubhouses)	45,000:1 (Medicaid Enrollee to Provider Ratio)
Opioid Treatment Programs	35,000:1 (Medicaid Enrollee to Provider Ratio)
Crisis Residential[1]	16 beds per 500,000 Total Population

Pediatric Standards

Children's Services	Standard
Home-Based	2,000:1 (Medicaid Enrollee to Provider Ratio)
Wraparound	5,000:1 (Medicaid Enrollee to Provider Ratio)
Crisis Residential[1]	8-12 beds per 500,000 Total Population

MSHN has conducted an analysis of its regional provider network system against the standards established by the MDHHS. It is important to note that the MDHHS has not published written definitions of some pertinent terms in the enumeration of its standards. As a result, MSHN contacted MDHHS requesting clarification of certain terms used in Figure 1-1.

Based on definitional clarification from MDHHS, MSHN used the following pertinent definitions to conduct its analysis:

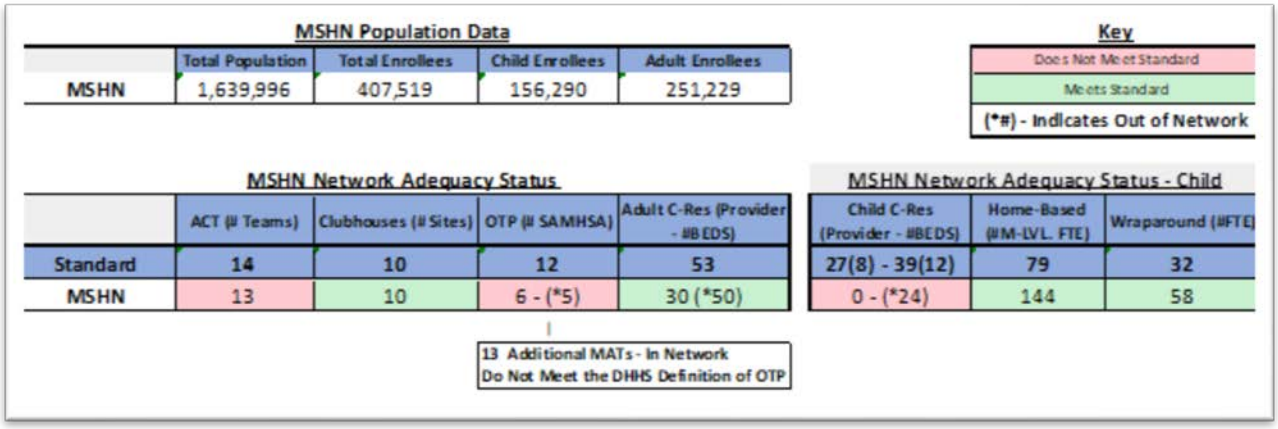
- Assertive Community Treatment (ACT): "Providers" means the number of enrolled ACT teams
- PSR/Clubhouse: Clubhouse programs with a physical address within the geographic boundary of the PIHP.
- Opioid Treatment Programs: the number of Substance Abuse and Mental Health Services Administration (SAMHSA) certified Opioid Treatment Programs (under 42 CFR Part 8.11) under contract to or within the PIHP region. (NOTE: While this definition was used in the calculation of regional compliance with the MDHHS-published standard, MSHN finds the definition unnecessarily restrictive and potentially less useful than a broader measure. See discussion below.
- Crisis Residential Unit (CRU): The number of MI-LARA licensed beds
- Home Based and Wraparound: Providers means full time equivalents (FTEs) for the Medicaid Manual-required level of credentialed staff.

Population data is based on the average of FY18 monthly enrollee data. The total population is derived from June 2017 Census Data by county for the MSHN Region. Population information used is shown in Figure 1-2 below.

All data presented herein has been verified, in most cases through multiple sources. ACT Teams were verified through the regional ACT/IDDT Survey and verified by each contributing Community Mental Health Services Program (CMHSP). Opioid Treatment Programs (OTPs) were verified by billing code through utilization data by billing code and compared against current provider directory information by credentialing and certification. Clubhouse data was verified by billing code through utilization data within the MSHN region. Crisis Residential Bed availability was verified based on a comparison of current contracts identifying Crisis Residential Services and comparing it against the number of licensed beds by provider and further broken down by age through utilization data. Home-Based and Wraparound services were verified through

provider enrollment information to ensure compliance with educational standards of licensure and FTE designations.

Figure 1-2: MSHN Network Adequacy Status as of 12/01/2018



MSHN Population Data

	Total Population	Total Enrollees	Child Enrollees	Adult Enrollees
MSHN	1,639,996	407,519	156,290	251,229

Key

Does Not Meet Standard
Meets Standard
(*#) - Indicates Out of Network

MSHN Network Adequacy Status

	ACT (# Teams)	Clubhouses (# Sites)	OTP (# SAMHSA)	Adult C-Res (Provider - #BEDS)
Standard	14	10	12	53
MSHN	13	10	6 - (*5)	30 (*50)

13 Additional MATs - In Network
Do Not Meet the DHHS Definition of OTP

MSHN Network Adequacy Status - Child

	Child C-Res (Provider - #BEDS)	Home-Based (#M-LVL. FTE)	Wraparound (#FTE)
Standard	27(8) - 39(12)	79	32
MSHN	0 - (*24)	144	58

Analysis of the MSHN provider network using the definitions provided by MDHHS results in four areas of network adequacy and three insufficient network adequacy within MSHN's region: ACT Teams, SAMHSA certified OTPs, and Pediatric CRUs (Figure 1-2).

3) Description of How the PIHP will Implement the MDHHS Standards

Assertive Community Treatment:

Four CMHSPs in the MSHN region do not directly provide ACT services. MSHN's July 31, 2017 memorandum in response to a MDHHS request for additional information indicated that in the case of each of these CMHSPs, there are written agreements in place with other CMHSPs or other subcontractors that provide ACT services to ensure the availability of this evidence-based practice in each of their catchment areas.

MSHN argued that ACT is but one service that might meet the level of intensity required to address the recipient's care needs. It is often true that individuals who meet the eligibility criteria for ACT often choose other (non-ACT) services or combinations of services more suitable to their individual circumstances.

MSHN concluded that as alternatives to ACT, combinations of services and supports that often parallel the services in the ACT service bundle, are available and routinely provided to recipients in the region, including at CMHSPs that do not currently have enrolled ACT Programs and at those that do. MSHN is satisfied that the

arrangements in place at the CMHSPs that do not have enrolled ACT programs are adequate to ensure that if/when ACT services are desired by the recipient, they can and will be provided.

Psychosocial Rehabilitation Services/Clubhouse:

Region meets published standard. No action planned

Opioid Treatment Programs (OTPs):

The definition for an OTP provided informally by MDHHS is restricted to SAMHSA certified OTPs (under 42 CFR Part 8.11). MSHN has reported that it currently contracts with six providers in the region that meet this definition in the region.

This definition is unnecessarily restrictive, and suggest a broader definition be applied to this category of services. In the informal communication from the MDHHS on this specific topic, the MDHHS indicated that this would "translate to LARA's 'Outpatient-Methadone' license, but the key is the SAMHSA certification as an OTP."

The state of the science delineated by SAMHSA (and others) for the treatment of Opioid Use Disorders includes several medications in addition to Methadone. MSHN has significantly expanded the availability of Medication Assisted Treatment (MAT) providers in the region, and currently contracts with eleven (11) MAT providers and, as indicated, six (6) SAMHSA certified OTPs. In addition, MSHN contracts with five (5) MAT providers out of its geographic region for services to in-region residents. MSHN has an additional 13 contracted provider locations in region that have physicians who can prescribe vivitrol and/or suboxone.

While MSHN is open to network expansion for any viable treatment for Opioid Use Disorders, it is recommended that the narrow definition used by the MDHHS be expanded to incorporate a broader definition so that it includes all forms of MAT as well as non-SAMHSA certified providers (unless the MDHHS is requiring SAMHSA certification for all MAT providers, in which case that policy should be properly promulgated). Until such definitional clarity is achieved, MSHN will continue to pursue network expansion to meet the urgency and need of our current opioid dependency crisis.

Adult Crisis Residential Beds:

MSHN has an inventory of 30 adult crisis residential beds within its region and contracts for approximately 50 additional crisis residential beds located outside of its geographic boundaries (utilization varies). As a result, MSHN considers its capacity to be compliant with the published standard. However, the MDHHS should consider

making a definitional decision as to whether total capacity should be considered in meeting the standard or just in-region assets.

A CMHSP participant in the MSHN region is collaborating with other CMHPs and a crisis residential provider to establish an additional adult CRU within the MSHN region. These efforts will continue.

Pediatric Crisis Residential Beds:

The most significant deficit in the MSHN region is the absence of any in-region crisis residential beds for children and adolescents. Based on information provided through the Crisis Residential Network, this appears to be a statewide issue as there are only approximately six child crisis residential facilities in Michigan out of 20 total crisis residential facilities. MSHN has no current capacity to address this insufficiency. However, a recommendation for consideration by our State partners is offered later in this document.

Home Based Services Providers:

Region meets published standard. No action planned

Wraparound Providers:

Region meets published standard. No action planned

4) Description of Barriers to Implementing the MDHHS Standards

As prudent stewards of public resources, MSHN recognizes its contractual and legal responsibility to ensure that all covered Medicaid services are available in the appropriate amount, scope and duration for eligible recipients that meet medical necessity criteria as determined through a person-centered planning process, this region considers multiple additional factors in network adequacy and development, including the federal parameters delineated in the MDHHS procedure.

Two especially important parameters are, generally, programmatic feasibility/sustainability (i.e., the anticipated enrollment and expected utilization of services, characteristics and healthcare needs of the population, the number and type of providers, and their availability from a time/distance perspective, and others) and fiscal feasibility/sustainability (cost/value).

For ACT, OTPs and CRUs for Adults and Children, the most significant barriers are unjustifiably high costs considering low population concentration resulting in unsustainably low utilization in many parts of the MSHN region.

By way of example only, in and before 2017, several CMHSP participants in the MSHN region reconfigured ACT services due to very high costs and very low utilization. These CMHSPs are primarily located in largely rural counties with low population density making sustainable programming fiscally impractical and programmatically unsustainable. A similar calculus applies to crisis residential beds for both adults and children.

In the case of adult, but especially pediatric CRU services, there are a myriad of risk management, licensing and location issues that are significant barriers to establishing and maintaining these services, as well as programmatic and fiscal feasibility concerns.

As discussed above, MAT has been significantly expanded in the MSHN region in the past 12-18 months and the definition for adequacy of the network relative to now OTPs to the proposed MAT Providers would be a more accurate portrayal of the inventory of providers focused on the treatment of Opioid Use Disorders.

5) Description of Strategies to Mitigate the Barriers to Implementing the MDHHS Standards

MSHN remains committed to ensuring that eligible recipients have access to the services and supports they require. MSHN will continue to pursue viable, sustainable options to fulfill network adequacy requirements. The solutions must be programmatically feasible, fiscally responsible, and sustainable considering the federal parameters required in the MDHHS policy.

6) Special Considerations for MDHHS

The published network adequacy standards are region specific, and because that is how the State contracts for managed care services with the PIHPs, that logic is clear. The development of providers and provider competency for some services, in particular pediatric CRUs, is very expensive, problem prone and risky. MSHN would suggest that the MDHHS consider a multi-regional approach to development of especially pediatric CRUs. This could involve State-level identification of locales across the state for pediatric CRU development, start-up financing assistance and procurement supports. Such an approach was under consideration by the MDHHS in

relation to Hawthorn patients moving to community-based Psychiatric Residential Treatment Facilities (PRTFs) for children.

MSHN requests MDHHS reconsideration of the definitions for "OTP" providers as articulated elsewhere in this draft response strategy.

MSHN requests that MDHHS revise its procedure to include definitions for providers or other pertinent terms as discussed above and throughout this document. //END

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MID-STATE HEALTH NETWORK

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