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From the Chief Executive Officer's Desk

Joseph Sedlock

The COVID-19 pandemic has had many ramifications for our industry – especially on operations and service delivery. As the pandemic has raged on, beneficiaries and staff alike have had to evaluate the risk to their health and safety in receiving or delivering services like at no other period in our lifetimes.

Medical and pandemic science and public health best practices all indicate vaccination against COVID-19 is the number one strategy for containing and reducing infections, along with wearing masks, practicing social distancing, rigorous hand washing, and avoiding non-household member gatherings for eradicating the virus and virus-associated illness in communities. Preventing infection (and contagion) is the focus of public health efforts in Michigan and across the country.

Anecdotal information on COVID-19 vaccination uptake rates among the public behavioral health workforce in Michigan is startling: some areas of the State are reporting uptake rates (the ratio of individuals receiving the vaccine vs. those refusing the vaccine) as low as 40%. Most public health literature identify uptake rates above 70% as essential for virus eradication and the development of broad spread (sometimes called “herd”) immunity.

As behavioral health professionals and members of the broader healthcare delivery eco-system, I believe we have a responsibility to properly educate beneficiaries and workforce members so that they make well-informed decisions about whether to participate in vaccination and, if so, which vaccination to choose. These decisions are, of course, up to the individual. But we are calling for a fact – science-based education, so these decisions are not based on misinformation, fear, or political rhetoric.

Voluminous information is available to the public, but I think we have a special obligation to ensure our system – including payors, providers, service participants, their guardians, their circles of support, and the communities in which they live – delivers science and fact-based information.

To this end, Mid-State Health Network highlights the following scientific sources for information about vaccines and their safety and effectiveness. Please use these materials for your education and decision-making and share them broadly with colleagues, beneficiaries, and communities to improve the vaccination uptake to benefit everyone. Public health measures work when the public cooperates with and practices protective and preventative measures.

Centers for Disease Control and Prevention – COVID-19 Vaccination Sources:

- Link: *Recipient Education Information*
- Link: *Long Term Care Facility Toolkit (FAQs)*
- Link: *Fact Sheet about COVID-19 Vaccines*
- Link: *Vaccine-Manufacturer Specific Details - Pfizer*
- Link: *Vaccine-Manufacturer Specific Details - Moderna*
- Link: *Vaccination Communication Toolkit (for agencies/clinicians)*
- Link: *Building Healthcare Personnel’s Confidence in COVID-19 Vaccines*

Michigan Vaccination Sources:

- *Vaccination Prioritization Guidance* and *Michigan’s COVID-19 Vaccination Plan*
- *Comprehensive COVID-19 Vaccine Provider Guidance and Educational Materials*

As of this writing, about 500,000 Michigan residents have received at least one dose (two doses required) of the COVID-19 vaccines. Mid-State Health Network encourages all readers of this newsletter to consider the facts and to participate in vaccination and encourage your families, support systems, and service providers to do so. Michigan data shows that Michigan females are being vaccinated at almost twice the rate as Michigan males. Throughout the MSHN region, vaccine supply has not kept pace with citizen eligibility for vaccines, which is an issue the State is working to correct.

Our plea is for these individual decisions to be based on facts – not fear or opinion. Please do whatever you can to support public health strategies to mitigate, prevent, vaccinate against, and otherwise to do our part – as citizens – to eradicate the virus and the illnesses – and deaths – that result.

Please contact Joe at Joseph.Sedlock@mistatehealthnetwork.org with any questions, comments or concerns related to the above and/or MSHN administration.

Organizational Updates

Amanda Ittner, MBA
Deputy Director

Unenrolled Population & Integrated Care Services

Early in 2019, the Michigan Department of Health and Human Services (MDHHS) intent was to issue a Request for Proposal that included the management of the unenrolled population, also known as Fee for Service (FFS). This group of citizens is not enrolled in a Medicaid Health Plan (MHP) but does receive managed behavioral healthcare through the PIHP system.

The unenrolled population represents 40% of the statewide ‘spend’ but only 30% or so of the revenue. Michigan spends approximately $4 billion on physical and behavioral health combined for the specialty services population. Of that amount, $2.7 billion goes towards behavioral health and $1.3 billion for physical fitness. Of the $4 billion, $1.4 billion is expended for the unenrolled population for behavioral health and physical health combined.

Because this group inherently has more physical health comorbid conditions, services, and costs, PIHPs and their respective CMHSPs and substance use disorder providers have already provided varying levels of care coordination/management for both physical and behavioral health care for decades.

In March 2020, the Pre-paid Inpatient Health Plans (PIHP) submitted a concept paper to MDHHS, signed by all 10

PIHPs, offering a comprehensive plan for managing services for the unenrolled population statewide.

The concept/design includes a separate, non-risk based PIHP contract with MDHHS for PIHPs to provide Complex Care Management (CCM) for the Medicaid unenrolled fee for service specialty service populations with prospectively identified health services utilization reduction strategies and health status positive outcomes measures.

This proposal is consistent with the contractual responsibility of PIHPs to conduct population health improvement activities. Under the proposal, PIHPs would:

- Identify, stratify and then conduct outreach to Medicaid beneficiaries in FFS status with at least one specialty services behavioral health disorder and at least one physical health co-morbidity;
    - Individuals already in specialty behavioral health services would continue to be served by their Community Mental Health Services Program (CMHSP)
    - PIHPs would conduct outreach and complex care management for individuals meeting the stratification criteria currently participating in specialty behavioral healthcare services.
- Detail the additional roles and functions of the PIHPs in providing CCM;
- Quantify the resources required such that adequate other prospective non-risk payments are made to PIHPs for CCM services;
- Monitor the health status and utilization of physical health services for assigned individuals and quantify the favorable impacts; and
- Provide the physical health expense savings and physical health improvement performance bonus awards with proceeds earned by PIHPs as local funds.

MSHN receives a feed of up-to-date information on every unenrolled person in the region, by county, including chronic health conditions and other analytics to provide CCM more efficiently/timely with these beneficiaries, who have never had these services in the past.
MSHN intends to leverage physical health data provided by MDHHS, increased health information exchange venues, and MSHN's data analytics platform. For the MSHN region, approximately 79,000 individuals are not enrolled with a Medicaid Health Plan, with 8,500 being served currently by the PIHP (both Mental Health and Substance Use) for a total cost of $73 million, allowing for a sufficient subpopulation to provide CCM.

Despite the ongoing COVID-19 pandemic, PIHPs continued working towards a design document to provide Complex Care Management for the unenrolled specialty populations. MSHN presented this proposal to the CMHSPs in the region before finalization and submission to MDHHS in November of 2020. The CMHSPs fully supported MSHN to continue to pursue and negotiate with MDHHS to improve health outcomes and reduce health disparities for beneficiaries in the region. The PIHPs are awaiting a meeting with MDHHS to discuss the proposal. MSHN is hopeful that MDHHS will view the Complex Care Management proposal as a step forward to ensuring this population has coordinated and integrated behavioral and physical health care.

To view the full proposal, see the link here: *PIHP Complex Care Coordination Pilot for Unenrolled*

For further information or questions, please contact Amanda at Amanda.Ittner@midstatehealthnetwork.org

Information Technology

Forest Goodrich
Chief Information Officer

Mid-State Health Network and CMHSP technology staff have spent time understanding the changes needed in reporting as it relates to Encounter Quality Initiative (EQI) per Michigan Department of Health and Human Services (MDHHS) requirements. This is a significant change in reporting.

At the same time, technology staff have been working on reconciling all reporting for fiscal year 2020 and what is in the MDHHS data warehouse to make sure that it represents exactly what the MSHN region reported, as this information will be used for MDHHS reporting and rate setting.

MSHN exceeded the 95% standard for reporting BH-TEDS and exceeded the 85% standard for volume and timeliness reporting of encounter.

MSHN and the CMHSP participants are working with Michigan Health Information Network (MiHIN) to meet the requirements for sending information to the health information exchange (HIE). This initiative meets a contractual performance incentive for MSHN and improves data exchange opportunities with MiHIN and healthcare providers that participate in the MiHIN exchange.

Systems testing has occurred with a few Substance Use Disorder (SUD) providers to supply new methods to post data, documentation, and other needed reporting, through the managed care information system (named REMI). This functionality is being called "provider management module" and allows more flexibility to SUD providers for gathering and reporting. This is in the beginning stages and will provide several new features for CMHSP participants, including posting datasets for special projects and the ability to manage security and features available to staff.

Contact Forest with any questions, comments or concerns related to the above and/or MSHN Information Technology at forest.goodrich@midstatehealthnetwork.org

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN's Finance Team have been working diligently to support its Community Mental Health Services Programs (CMHSPs) and Substance Abuse Prevention and Treatment (SAPT) providers. In April 2020 MSHN developed regional guidance based on MDHHS directives below.

- Direct Care Workers (DCW) Wage Increases – MDHHS provided Fiscal Year (FY) 2021 funding through February 28, 2021 to MSHNs for DCW Premium Pay. The intent of the continued funding, which began 10/1/2020 allows DCWs to receive a $2 per hour temporary pay increase and funds an additional 12% to cover associated provider administrative expenses such as taxes. CMHSP networks as well as SAPT Residential and Withdrawal Management workers are eligible for premium pay when rendering approved MDHHS service codes. MSHN and its CMHSPs have identified issues with DCW staff retention, training new staff, and deploying new employees during a pandemic. Because of the factors, MSHN's Board of Directors approved a recommendation to fund DCW premium pay through July 9, 2021. Depending on available funding, MSHN staff may seek Board approval to cover DCW premium pay for the remainder of FY 2021 4th quarter. Further, MSHN is reimbursing Personal Protection Equipment (PPE) expenses purchased in the identified settings. MSHN and its CMHSP partners will conduct payroll record audits to ensure employees received the temporary increases.
- SAPT Provider Network Fiscal Assistance – MSHN issued over $2 M to its SAPT network for FY 2020 to ensure continued operations and stabilized the network for provision of ongoing consumer service needs. Granting of funds were contingent on completion of a cash advance request form, reasonableness determination of the amount requested, and continuation of rendering medically necessary services. Providers receiving other federal funding to cover the same expenses and same period were not eligible for a MSHN stabilization payment. MDHHS mandated FY 2021 provider stabilization payments

however there are no additional funding provisions as the expectation is to use current per eligible per month (PEPM) dollars. MSHN's FY 2020 financial position was sufficient to meet stabilization payment needs. We also anticipate adequate FY 2020 savings to meet FY 2021 needs.

MDHHS has continued its practice of relaxing telehealth service delivery during the COVID-19 pandemic. Typical telehealth services require two-way communication consisting of audio and video between the clinician and consumer. The relaxed rules allow audio only telehealth which means a simple phone call to a consumer is acceptable for service delivery. The relaxed standards have allowed clinicians, peers, and consumers to safely engage in treatment. In addition, Medicaid funds may be used to cover dual eligibles (Medicare/Medicaid) when the telehealth service does not meet the Medicare requirements. Clinicians must appropriately document the service in the consumer's medical record.

MSHN's submitted its Interim FY 2020 Financial Status Report (FSR) to MDHHS in November 2020. Based on fiscal information contained in this report, MSHN will end the fiscal year with a fully funded Internal Service Fund (ISF) of approximately $46 M and more than $33 M in savings to support FY 2021 operations. I anticipate similar results for fiscal year-end reporting due to MDHHS February 2021.

MSHN Finance Team are also engaged in its FY 2020 Financial Audit being conducted by Roslund Prestage & Company (RPC).

Contact Leslie with any MSHN Finance related questions, comments at Leslie.Thomas@midstatehealthnetwork.org

Behavioral Health

Dr. Todd Lewicki, PhD, LMSW, MBA
Chief Behavioral Health Officer

MSHN's Waiver Programs and Autism Benefit Continue to See Enrollment Growth

Mid-State Health Network (MSHN) oversees the Children's Waiver Program (CWP), the Habilitation Supports Waiver (HSW) program, the Waiver for Children with Severe Emotional Disturbance (SEDW), and the Autism Benefit. MSHN has overseen the HSW and Autism benefit since the Pre-Paid Inpatient Health Plan's (PIHP) inception in 2014 and the CWP and the SEDW since October 1, 2019. The waivers and the Autism Benefit but continue to see steady growth, serving MSHN's most vulnerable populations. Collectively, these waivers and benefit serve populations are at risk of a higher level of care (i.e., institutional level) without these services being provided. MSHN completes initial and ongoing recertification reviews to ensure eligibility.

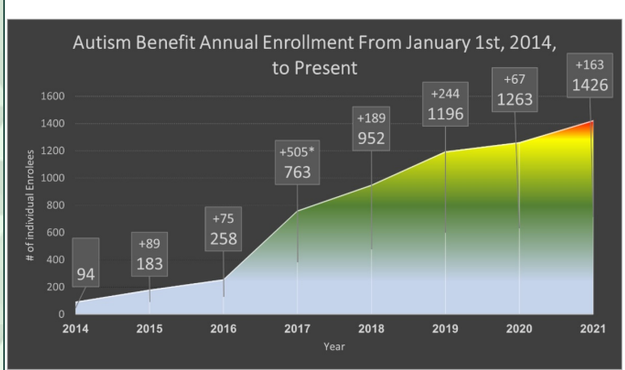
The CWP is an intensive in-home, active treatment and support program designed to assist families in the care and treatment of their significantly disabled child, allow them to remain in the family home, develop skills, and eventually become more independent. In the last quarter of Fiscal Year (FY) 20, enrollment rose 14%, to 65 cases. Since October 1, 2019, the benefit has increased an overall 10%. CWP beneficiaries, beginning at age 18, are considered immediately eligible for the HSW, and thus, MSHN ensures that there is appropriate transition activity and slot availability for the HSW.

The HSW is an intensive home and community-based, active treatment and support program designed to assist individuals with severe developmental disabilities to live independently with supports in their community of choice. MSHN has a total slot allocation of 1,637. The graph below shows that at the end of the first quarter of FY21, slot utilization was at 96.6%, the highest total since the previous year. This waiver covers eligible individuals from age 18 throughout the lifespan, as appropriate. The HSW serves 1,581 enrollees, and MSHN manages monthly processes related to initial eligibility and ongoing monthly recertification of all on the HSW.

The SEDW enables Medicaid to fund necessary home and community-based services for children with serious emotional disturbance who meet the criteria for admission to the state inpatient psychiatric hospital (Hawthorn Center) and are at risk of hospitalization without waiver services. SEDW participation has increased by 60% since MSHN assumed responsibility for the program on October 1, 2019. Currently, 9 CMHSPs in the MSHN region have at least one child/family on the SEDW. The SEDW has grown 33% in the most recent 13-month timeframe, from 106 in December 2019 to 141 in December 2020.

Lastly, coverage of Applied Behavior Analysis (ABA) services is provided for Medicaid eligible children under 21 years of age who are diagnosed with Autism Spectrum Disorder (ASD) and who meet medical necessity criteria. ABA is a Medicaid covered service under Behavioral Health Treatment within the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Michigan's Autism Insurance Reform legislation (PA 99 and PA 100 of 2012) went into effect on October 15, 2012. The PIHPs began to operationalize and implement the benefit in 2014, first for children aged 1.5 to 5 years, then expanded through age 20.

The table below shows the rate of Autism Benefit growth since 2014. While growth was significantly affected by the expansion of eligible ages, the benefit adds approximately 2%-5% each month.



MSHN recognizes the value in the month to month added eligibility of persons on the waivers and Autism Benefit. This means that MSHN's penetration of persons into needed areas of care for Michigan's most vulnerable is reaching more who can benefit from those supports and services.

The MSHN region continues to be a leader in the state in the rate of assisting beneficiaries in obtaining access to eligible and appropriate services.

Contact Todd with any questions, comments or concerns related to the above and/or MSHN Behavioral Health at Todd.Lewicki@midstatehealthnetwork.org.

Utilization Management & Integrated Care

Skye Pletcher-Negrón, LPC, CAADC
Director of Utilization and Care Management

One of the primary responsibilities of the regional Utilization Management Committee (UMC) is to ensure that individuals in our region have access to an equitable array of services to address their needs regardless of which county they live in. To achieve this, it is vital for MSHN and its CMHSP participants to utilize standardized, evidence-based assessment tools and ensure that medical necessity criteria are being applied consistently in their authorization decision-making. At the same time, no particular assessment tool or list of criteria should ever be the determining factor with regard to service authorization; individuals' choices and preferences must be honored and supported through the person-centered planning process.

The UMC is engaged in many activities to address standardization and consistency in our operations while also

ensuring person-centered philosophy and self-directed services are woven through all aspects of utilization management. Efforts and achievements in these areas include:

- During FY20, regional service packages were completed, which offer guidelines regarding the type and amount of services typically used by individuals with similar needs. The service packages are designed to be used as a starting point for case holders when developing person-centered plans with individuals and families. Still, they can be amended as needed to fit individual circumstances. Data is monitored quarterly to identify if services are being delivered relatively consistently throughout the region or if there are significant variances that require further understanding.
- Members of the UMC and Clinical Leadership Committee formed a workgroup to explore differences in how case management and supports coordination are delivered throughout the region. The workgroup aims to develop best practice guidance for the region on how these services are delivered, including considerations for caseload sizes and measuring outcomes.

The UM Committee's upcoming goals during FY21 will continue to focus on refining our process for monitoring regional service utilization. It is to be expected that variations will (and should) occur in the way services are delivered to ensure individuals receive treatment tailored to their needs. By applying standardized utilization management practices, we can achieve improved consistency without sacrificing individual and family-driven services.

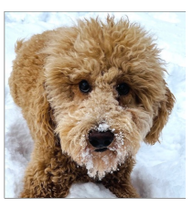
Contact Skye with any questions, comments or concerns related to the above and/or MSHN Utilization Management and Care Coordination at Skye.Pletcher@midstatehealthnetwork.org.

Treatment and Prevention

Dr. Dani Meier, PhD, LMSW
Chief Clinical Officer

Stress Symptoms due to COVID

It may seem overly obvious to focus on stress related to the global COVID pandemic, to say nothing of the stress compounded by months of political upheaval and disturbing images at the U.S. Capitol just weeks ago. However, recent evidence suggests that as we approach a year since things were reasonably normal, chronic stress symptoms are getting worse and are likely contributing to rising rates of depression, anxiety, suicides, substance abuse and overdose deaths.
Many are reporting physical symptoms, including a rise in disrupted sleep, excruciating headaches, gastrointestinal problems, and autoimmune flares (lupus episodes, for example, rose 12% in 2020 compared to the same time in 2019 (January to August). Anti-insomnia medications increased 15% in the early months of the pandemic, and even dentists are seeing an increase in patients with teeth grinding, tooth fractures, and TMJ issues. Chronic stress correlates with severe problems like heart disease, and even shrinking of the brain's hippocampus is associated with memory and learning. If part of one's experience during the pandemic is "COVID fog," disorientation, and increased forgetfulness, this is a normal stress response.



The good news is that these changes are entirely reversible, and everyday stress management strategies can help: exercise, walking outdoors (bundle up!), learning new things (for me, it was ukulele), meditation, and mindfulness. Human connections are also essential to offset social isolation. We can't gather as we usually do; connecting via phone or video chat or even old fashioned cards and letters go a long way. And, of course, connecting with 4-legged friends helps a lot. With vaccines starting to roll out, there's light at the end of the tunnel, but in the months ahead, we're all encouraged to find ways to reduce stress, get lots of rest, and take care of ourselves.

Contact Dani with questions, comments or concerns related to the above and/or MSHN SUD Treatment and Prevention at Dani.Meier@midstatehealthnetwork.org.

Provider Network

Carolyn Tiffany, MA
Director of Provider Network Management Systems

Financial Management Service/Self-Determination Arrangements

In October 2020, the Michigan Department of Health and Human Services released a new Self-Direction Technical Requirement and Implementation Guide, which will provide methods to control and direct how the services and supports in Individual Plan of Service (IPOS) are implemented for those in a self-determination arrangement. In the MSHN region, self-directed services are a partnership between the Community Mental Health Service Participant (CMHSP) and the individual, as a delegate of network management. The person-centered planning process will drive self-determination, develop an IPOS, and explore self-directed services. The CMHSP is required to develop and maintain a system that supports people who choose to use any method of the self-directed options (i.e., direct-employment, purchase of service, agency-supported self-direction). The CMHSP must actively educate people about the option to direct services, ensure all CMHSP staff are aware of self-directed services, the different levels of control available, and the methods to exercise that control.

The new requirements outlined in the technical guide will significantly impact CMHSP operations as many functions previously held by the Financial Management Service (FMS) provider, formerly known as Fiscal Intermediary, are the responsibility of the CMHSP and self-determination participation (aka Employer of Record). The FMS is an organization or person independent of the CMHSP system that assists employers (i.e., self-determination participants) to manage the funds in self-directed budgets and assist with hiring processes, including payroll processing. The Provider Network Management Committee, CMHSP training coordinators, and the FMS audit teams have been engaged in dialogue and planning related to contract changes and monitoring protocol changes, and expect to implement changes within the next month or two. Visit the following link for more information on the *Self-Direction Technical Requirement and Implementation Guide*.

Contact Carolyn with any questions, comments or concerns related to the above and/or MSHN Provider Network Management at Carolyn.Tiffany@midstatehealthnetwork.org.

Quality, Compliance and Customer Service

Kim Zimmerman, MBA-HC, LBSW, CHC
Director of Quality, Compliance and Customer Service

Annual Review of the Quality Assessment and Performance Improvement Program

The Michigan Department of Health and Human Services (MDHHS)/Behavioral Health and Developmental Disabilities Administration (BHDDA) is requiring the Pre-Paid Inpatient Health Plans (PIHP) to submit the FY2021 Quality Assessment and Performance Improvement Program (QAPIP) and FY2020 annual evaluation for review. Per Title 42 of the Code of Federal Regulations (CFR) §438.330(e), a State must review, at least annually, the impact and effectiveness of the quality assessment and performance improvement program (QAPIP) of each PIHP. While this requirement has been identified within the current and past PIHP/MDHHS contracts, the submission of the QAPIP plan and evaluation has not been requested prior to the PIHPs.

MDHHS has created a checklist to facilitate the review of each PIHP's QAPIP. The QAPIP Checklist includes the

primary activities identified in the Quality Assessment and Performance Improvement Program for Specialty Prepaid Inpatient Health Plans policy. It is anticipated that the PIHPs would have supportive policies, procedures, or other documents that would provide additional detail for each activity. MDHHS expects that each annual QAPIP plan includes a summary or description of each activity and quality initiative, including a performance goal(s) and/or objective(s) for each area in the QAPIP work plan; and include at least an annual analysis of the progress of each quality initiative or activity in the annual QAPIP evaluation. MDHHS will also evaluate how each PIHP uses the annual evaluation results to support the creation of goals and objectives for the upcoming QAPIP plan.

In addition to the checklist, MDHHS requires the submission of the governing body form. This form requires identifying the governing body members, the dates the governing body approved the annual QAPIP plan, and dates of routine reports provided to the governing body regarding the QAPIP. Since this is a new requirement by MDHHS, and the QAPIP must be submitted by January 31, 2021, the PIHPs can submit the QAPIP this year only without the governing body's review and approval. However, once the governing body approves the QAPIP plan, the PIHP will need to submit that to MDHHS.

The documents identified above have been shared with the PIHPs this year for informational purposes only. Once MDHHS completes its review of the annual QAPIP, the completed QAPIP checklist will be shared with each PIHP along with MDHHS' feedback. The feedback and recommendations are expected to be used as part of an evolution of our current Fiscal Year (FY) QAPIP and the development of future FY QAPIPs.

Contact Kim with any questions, comments or concerns related to MSHN Quality, Compliance and Customer Service at Kim.Zimmerman@midstatehealthnetwork.org

Our Mission:

To ensure access to high-quality, locally-delivered, effective and accountable public behavioral health & substance use disorder services provided by its participating members

Our Vision:

To continually improve the health of our communities through the provision of premiere behavioral healthcare & leadership. MSHN organizes and empowers a network of publicly funded community partnerships essential to ensure quality of life while efficiently, and effectively addressing the complex needs of the region's most vulnerable citizens.

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