MSHN

Mid-State Health Network

Assessment of Network Adequacy

2020

Approved by MSHN Operations Council: April 19, 2021

Approved by MSHN Board of Directors: May 4, 2021

Contents

Definitions

The following are definitions for key terms used throughout the assessment of provider network adequacy:

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

CMHSP Participant Subcontractors: Individuals and organizations directly under contract with a CMHSP to provide behavioral health services and/or supports.

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.

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 MSHN. 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.

MSHN 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)	LifeWays CMH (LCMHA)
CMH of Clinton-Eaton-Ingham Counties (CEI)	Montcalm Care Network (MCN)
CMH for Central Michigan (CMHCM)	Newaygo County Mental Health (NCMH)
Gratiot Integrated Health Network (GIHN)	Saginaw County CMH Authority (SCCMHA)
Huron Behavioral Health (HBH)	Shiawassee Health & Wellness (SHW)
The Right Door for Hope, Recovery and Wellness (TRD)	Tuscola Behavioral Health Systems (TBHS)

The counties in the MSHN service area include:

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

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 funded under Medicaid, Healthy Michigan, Public Act 2, and related Block Grants.

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 CMHSPs 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. Effective 10.1.19, changes were made to the 1915 services, see Figure 1.

Figure 1: Transition from 1915(b)(3) to 1915(i)SPA

[1]

Part of this transition requires PIHPs and CMHSPs to meet quality requirements, including conducting reviews and satisfaction surveys as well as providing technical assistance. Contracted entities are also responsible for pinpointing areas for improvement and regularly improving services provided. The 1915(c) which now includes waiver programs for children with developmental disabilities and serious emotional disturbance (SED) and 1915(i) services must be Home and Community Based Services (HCBS) compliant. Services included under the 1915(i) include: Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support and Training, Fiscal Intermediary, Housing Assistance,

[1] www.michigan.gov/bhdda

Respite Care, Skill-Building Assistance, Specialized Medical Equipment and Supplies, Supported Integrated Employment and Vehicle Modification. [2]

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.

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 a biennial 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

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[3]. 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[4]. 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 1115 Demonstration Waiver, 1915(i); who are *eligible* for the 1115 Healthy Michigan Plan, the Flint 1115 Waiver or Community Block Grant; who are *enrolled* in the 1915(c) Habilitation Supports Waiver; 1915(c) Children Waivers (SEDW and CWP) who are *enrolled* in program; or for whom

[2] www.michigan.gov/bhdda

[3] 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."

[4] 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."

MSHN has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. MSHN 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.

Population Density Standards/Geographic Accessibility: BHDDA established network adequacy standards 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 and are incorporated in this assessment.

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.[5] 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 Program(s), the Health Michigan Program and Substance Use Disorder Community Grant*. 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 Use Disorder section:

- 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
- Michigan 1915(i) State Plan Amendment (iSPA), formerly (b)(3)
- Michigan 1915(c) Habilitation and Support Waiver (HSW) services; Childrens Waiver Program; Children with Serious Emotional Disturbance (SED)
- Autism Benefit (EPSDT)
- SUD services funded by Public Act 2 and Block Grants

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.

Mental Health Services:

The array of State Plan mental health services covered under the 1115 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. 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

[5] 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."

beneficiary's level of need and preferences must be considered in the admission process. Table 1 lists the service provided by each CMHSP Participant in the MSHN region.

Table 1: Mental Health Services Available in the MSHN Provider Network

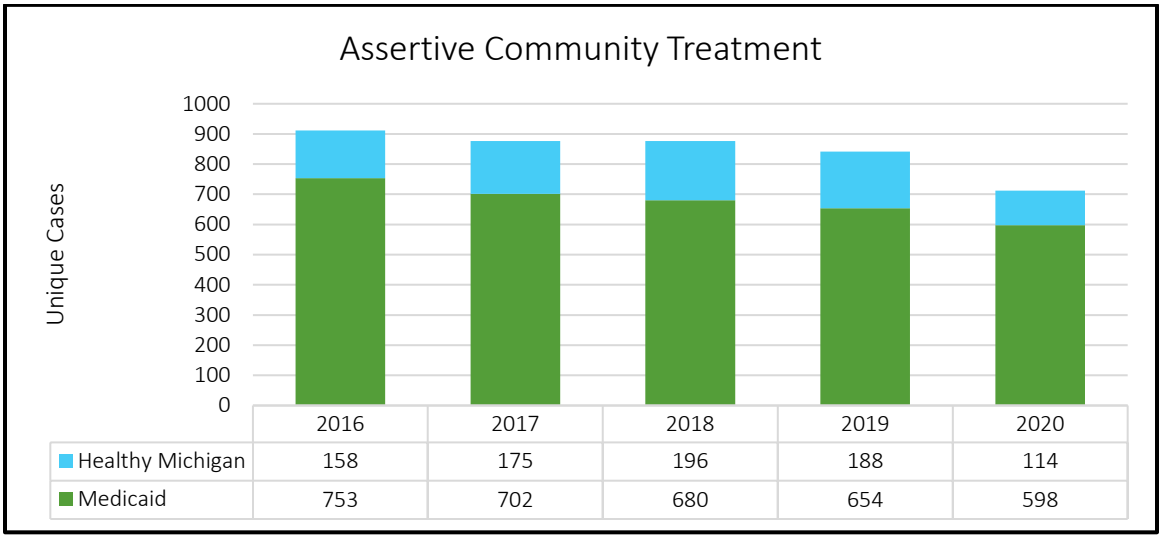
	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Applied Behavioral Analysis	X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	X	X	X	X	X	X	X	X	X	X	X	X
Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Assistive Technology	Provided on a per request basis											
Behavior Treatment Review	X	X	X	X	X	X	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		
Community Living Supports	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Interventions	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Observation Care		X										
Crisis Residential 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
Enhanced Medical Equipment & Supplies	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
Environmental Modifications	Provided on a per request basis											
Family Support and Training	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
Fiscal Intermediary Services	X	X	X	X	X	X	X	X	X	X	X	X
Goods & Services	Provided on a Per Request Basis											
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	X
Housing Assistance	Provided on a Per Request Basis											
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	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
Out-of-Home Non-Voc Habilitation	X	X	X	X	X	X	X			X	X	X
Outpatient Partial Hospitalization Services	X	X	X	X	X	X	X	X	X	X	X	X
Peer Specialist Services	X	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
Personal Emergency Response	Per request	Per request	X	Per request	Per request	Per request		Per request		Per request		Per request
Physical Therapy	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
• Parent Education		X	X		X		X	X	X	X	X	X
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
Skill Building Assistance	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		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
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	X	
Treatment Planning	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

Specialty Services within MSHN

MSHN offers an appropriate array of specialty services provided by the CMHSPs. The following graphs illustrate the number of unique cases served from FY16-FY19 for each specialty service. The information was collected from Medicaid Utilization and Net Cost reports (MUNC). The purpose of these reporting requirements is multifold. The reports provide comprehensive CMHSP/ PIHP administration cost information, greater transparency of administrative costs, satisfy benefit plan administration cost requirements as well as identify the organizations and administrative costs. The MUNC reports provide an equitable and comparable basis for cost analysis and identifies opportunities for efficiency.[6]

Assertive Community Treatment

Assertive Community Treatment (ACT) is a community-based approach to comprehensive assertive team treatment and support for adults with serious mental illness. It provides continuous team-based care 24 hours a day, 7 days a week. ACT is the most intensive non-residential service in the continuum of care within the service array of the public behavioral health system. MDHHS has established an adequacy standard for ACT programs (30,000:1 Medicaid Enrollee to Provider Ratio). Four CMHSPs in the MSHN region do not directly provide ACT services; however, have 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. 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.

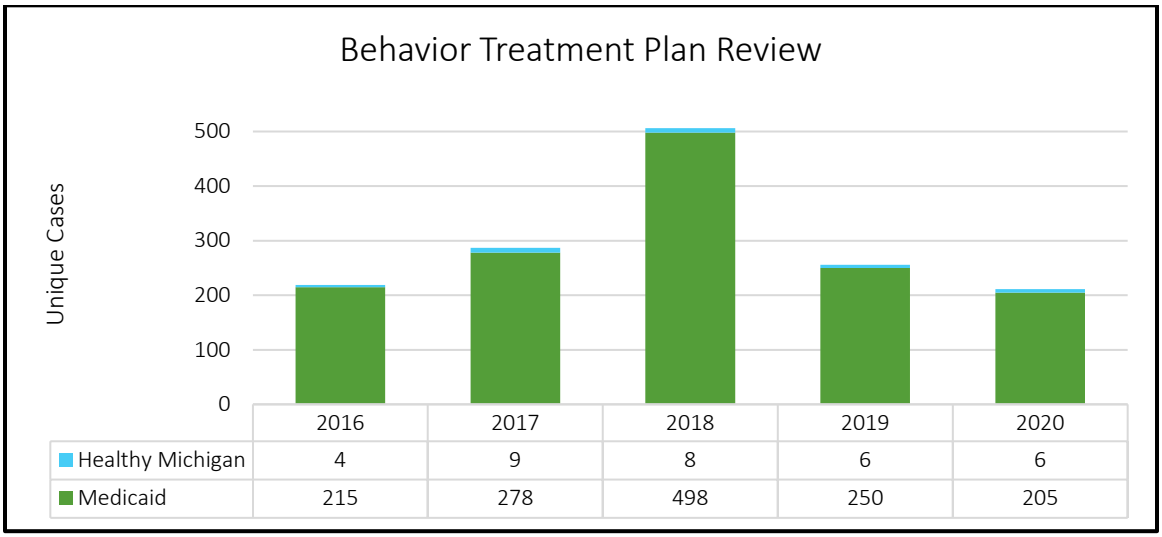


	2016	2017	2018	2019	2020
Healthy Michigan	158	175	196	188	114
Medicaid	753	702	680	654	598

[6] https://www.michigan.gov/documents/mdch/FY12_CMHSP-PIHP_Admin_Exp_Rptg_Instr_final_2-7-13_411752_7.pdf

Behavior Treatment Plan Review

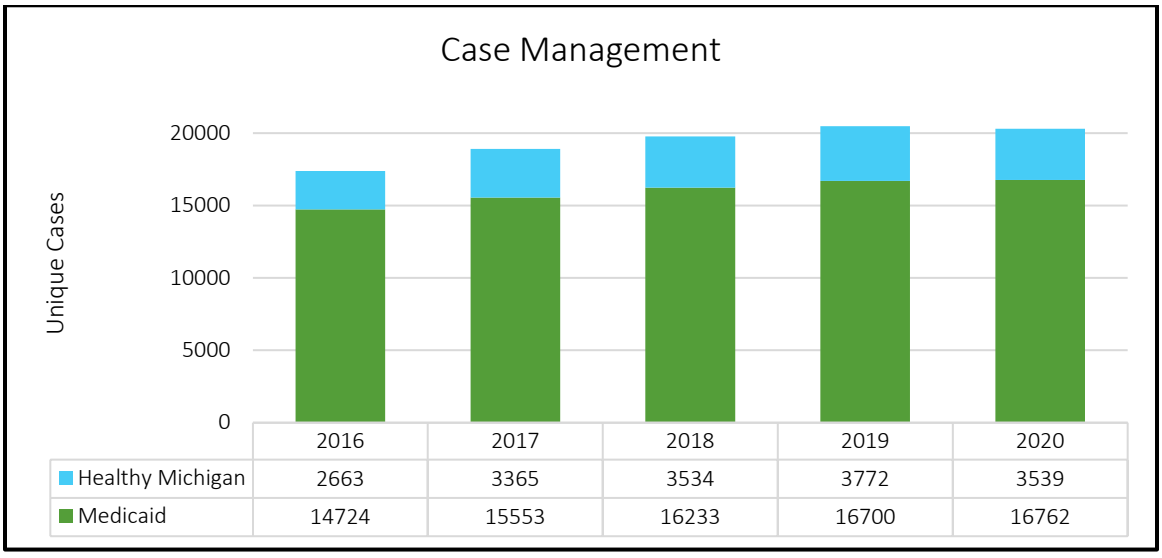
MDHHS requires all publicly supported mental health agencies have a review process for behavior treatment plans that include restrictive or intrusive interventions. This is a comprehensive multidisciplinary review by a committee, commonly called a "behavior treatment plan review committee." This committee determines whether a behavior treatment plan is appropriate and either approves or disapproves the interventions in the behavior treatment plan. Individuals with a positive support plan in place do not require a BTPR. The drop in behavior treatment plan reviews from 2018 to 2019 should be reviewed further to determine contributing factors for the drop. However, the 2019 numbers are in line with 2016 and 2017, therefore, it is also appropriate to consider reviewing reasons for a sharp rise in review from 2017 to 2018 (44% increase).



	2016	2017	2018	2019	2020
Healthy Michigan	4	9	8	6	6
Medicaid	215	278	498	250	205

Case Management

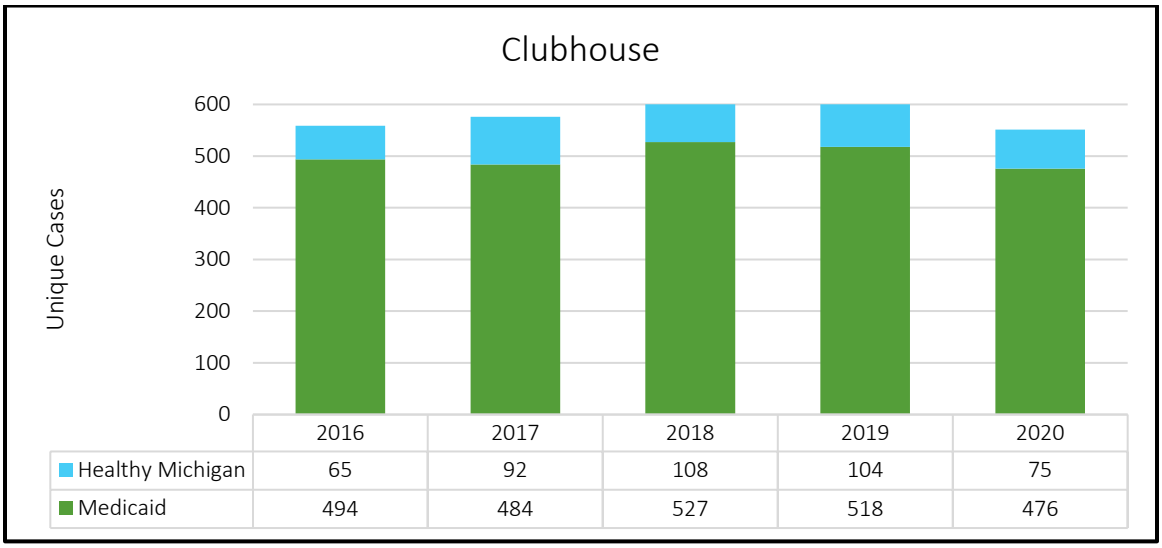
For the purpose of the assessment, case management refers to supports coordination and targeted case management. These two services are combined in the following graph. Targeted case management helps with obtaining services and supports. Its focus is goal oriented and individualized. Supports coordination works with waiver beneficiaries in home and community-based settings.



	2016	2017	2018	2019	2020
Healthy Michigan	2663	3365	3534	3772	3539
Medicaid	14724	15553	16233	16700	16762

Clubhouse Psychosocial Rehabilitation Programs

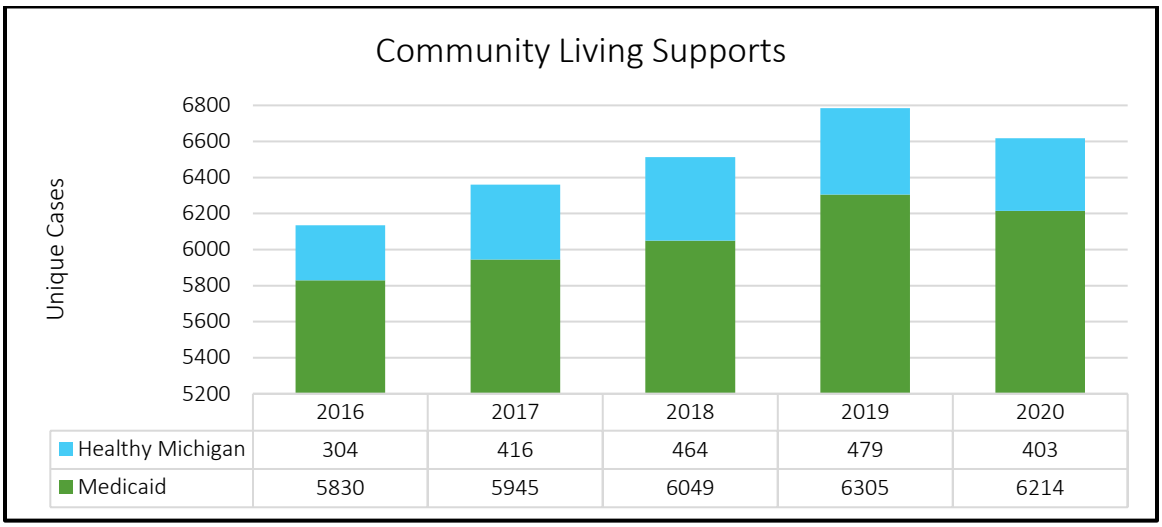
A Clubhouse is a community-based program designed to support Individuals living with mental illness. Participants work alongside staff to gain skills in employment, education, housing, community inclusion, wellness, community resources, advocacy, and recovery. Clubhouse Psychosocial Rehabilitation Program accreditation by the International Center for Clubhouse Development (ICCD) is required by MDHHS. Additionally, MDHHS has established an adequacy standard for Clubhouse programs (45,000:1 Medicaid Enrollee to Provider Ratio) which requires 6 clubhouse programs in the region, based on the number of adult enrollees. Currently, six CMHSPs have accredited clubhouse programs, meeting the published standard.



	2016	2017	2018	2019	2020
Healthy Michigan	65	92	108	104	75
Medicaid	494	484	527	518	476

Community Living Supports

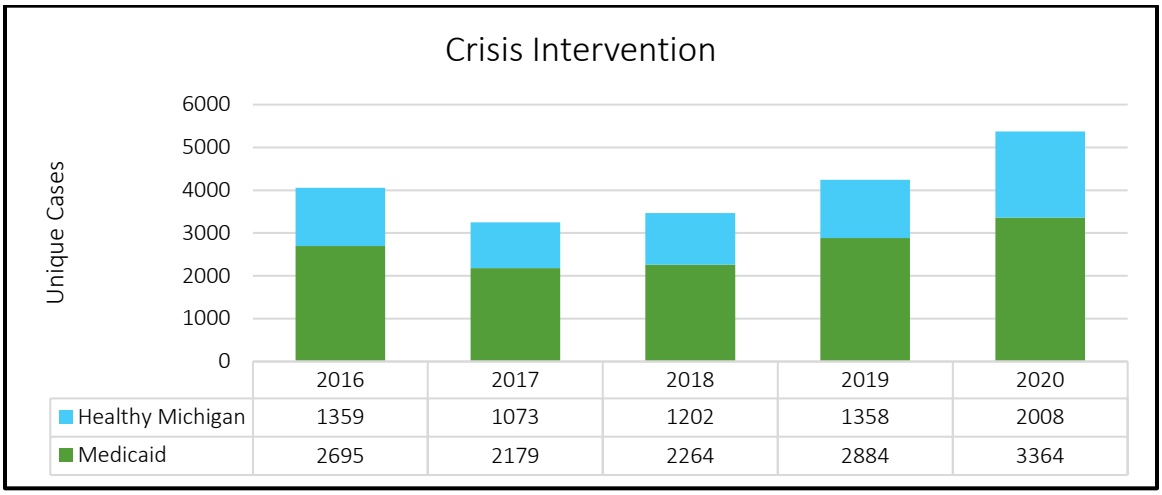
Community Living Supports (CLS) are designed to increase an individual's independence, productivity, promote inclusion and participation. These services can be provided in a person's home or in a community setting. There continues to be a steady increase of CLS services.



	2016	2017	2018	2019	2020
Healthy Michigan	304	416	464	479	403
Medicaid	5830	5945	6049	6305	6214

Crisis Services: Crisis Intervention

A service for the purpose of addressing problems/issues that may arise during treatment and could result in the beneficiary requiring a higher level of care if intervention is not provided.

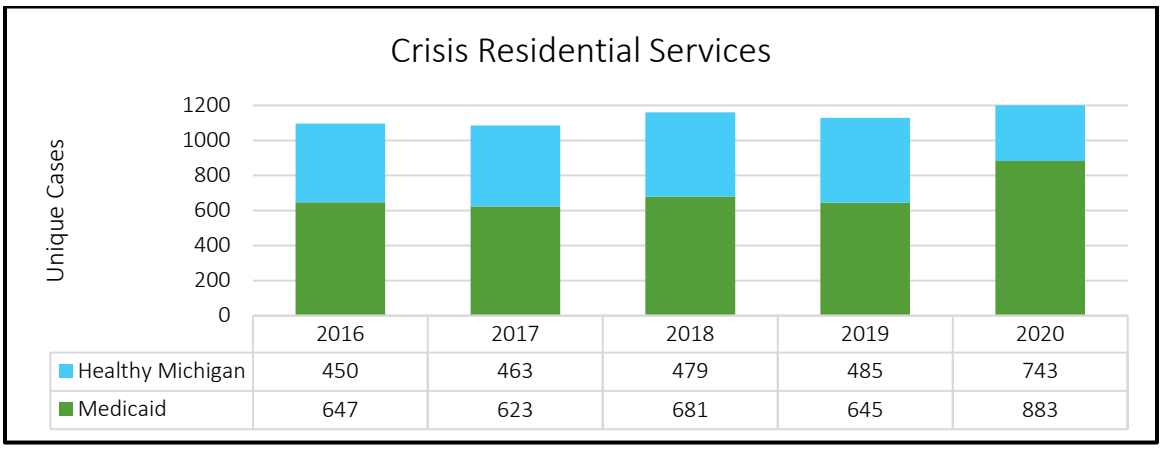


	2016	2017	2018	2019	2020
Healthy Michigan	1359	1073	1202	1358	2008
Medicaid	2695	2179	2264	2884	3364

Crisis Services: Crisis Residential Services

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay. MDHHS has established an adequacy standard (16 adult beds per 500,000 total population and 8-12 pediatric beds per 500,000 total population). 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. MSHN is collaborating with other CMHPs and a crisis residential provider to establish an additional adult CRU within the MSHN region, with an RFP being released in March of 2021.

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 is collaborating with a crisis residential provider to establish a pediatric CRU within the MSHN region; however, a recommendation for consideration by our State partners was offered in our response to BHDDA.



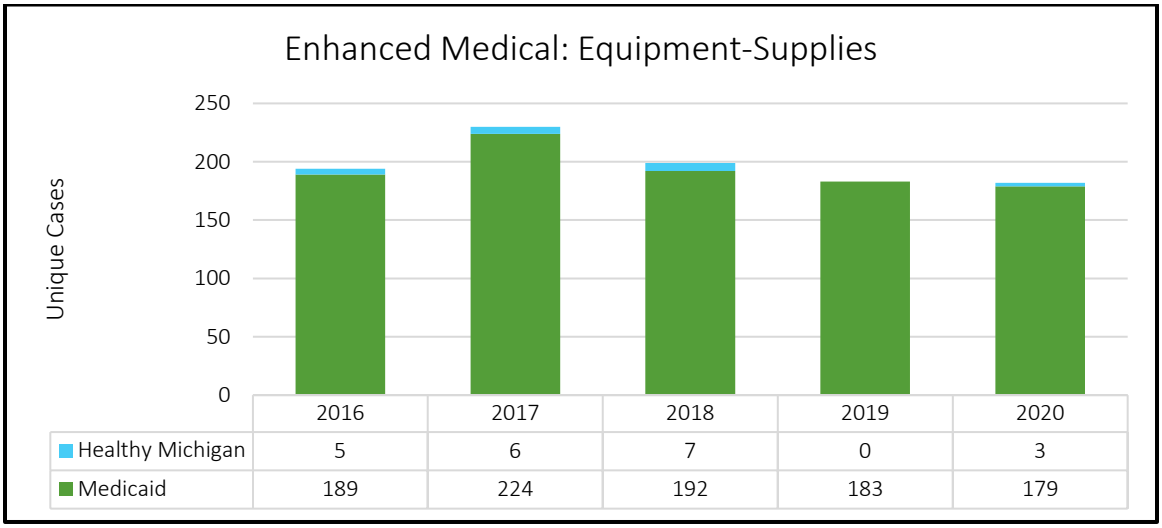
	2016	2017	2018	2019	2020
Healthy Michigan	450	463	479	485	743
Medicaid	647	623	681	645	883

Crisis Services: Intensive Crisis Stabilization Services (ICSS)

Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated. Childrens ICSS are provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement. These services must be available to 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). Encounter data is not available (H2011 TJ, HB, HC and previously S9484). This warrants investigation to ensure accurate reporting.

Enhanced Medical Equipment Supplies

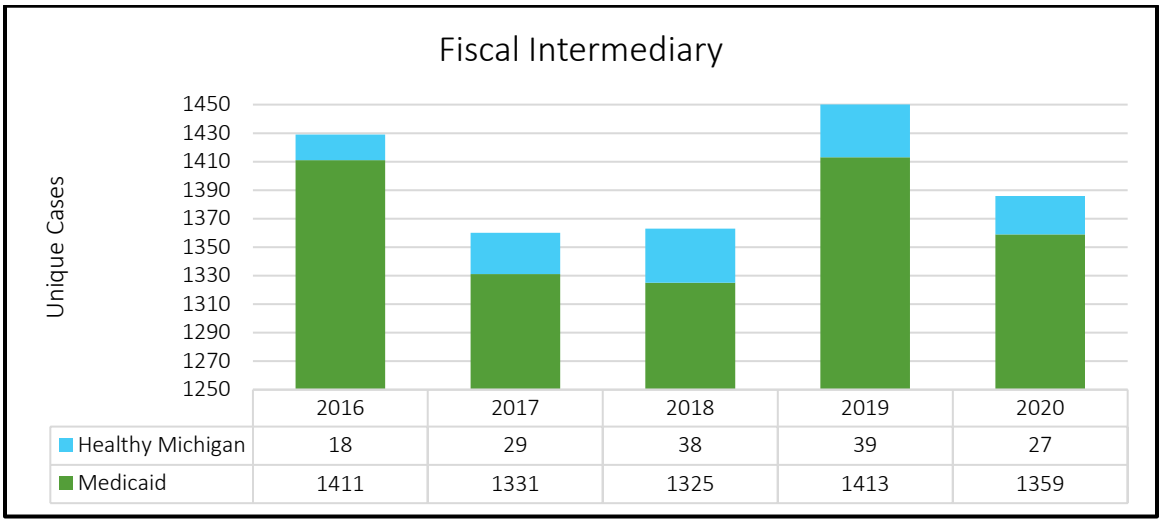
Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances. All enhanced medical equipment and supplies must be specified in the plan of service and must enable the beneficiary to increase his abilities to perform activities of daily living; or to perceive, control, or communicate with the environment.



	2016	2017	2018	2019	2020
Healthy Michigan	5	6	7	0	3
Medicaid	189	224	192	183	179

Financial Mangement Services (FMS)/Fiscal Intermediary (FI)

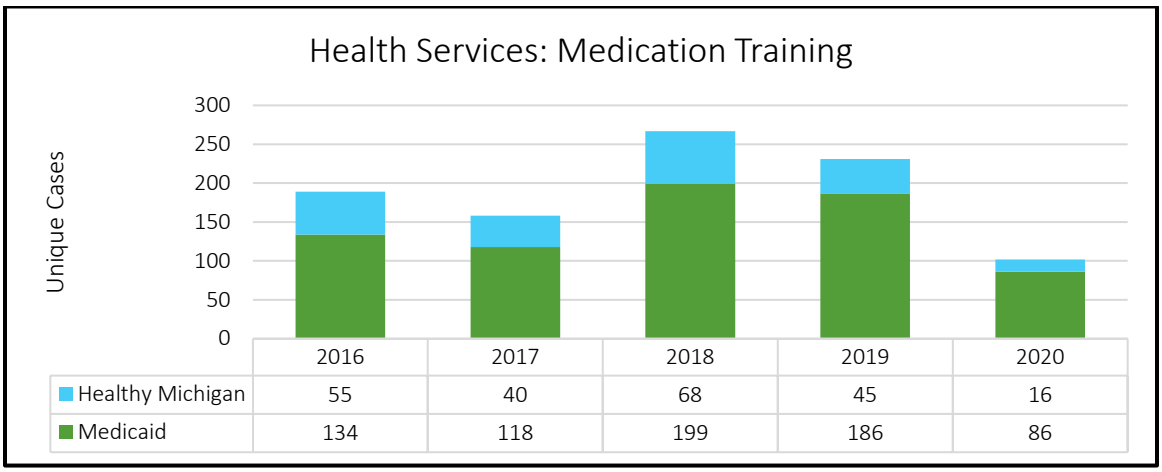
A financial management service/fiscal intermediary is an independent legal entity – organization or individual - that acts as the fiscal agent of the CMHSP for the purpose of assuring fiduciary accountability for the funds authorized to purchase specific services identified in the consumer's individual plan of service (IPOS) under a self-determination arrangement. The self-direction technical requirement and implementation guideline published October 2020 states that *each PIHP must ensure there are at least two FMS providers within the region and ensure access to all impaneled FMS providers*[7]. MSHN meets this requirement.



	2016	2017	2018	2019	2020
Healthy Michigan	18	29	38	39	27
Medicaid	1411	1331	1325	1413	1359

Health Services: Medication Training

Medication Training and Support involves face-to-face contact with the person and/or the person's family or nonprofessional caregivers to monitor medication compliance, educate on medication and medication side effects.

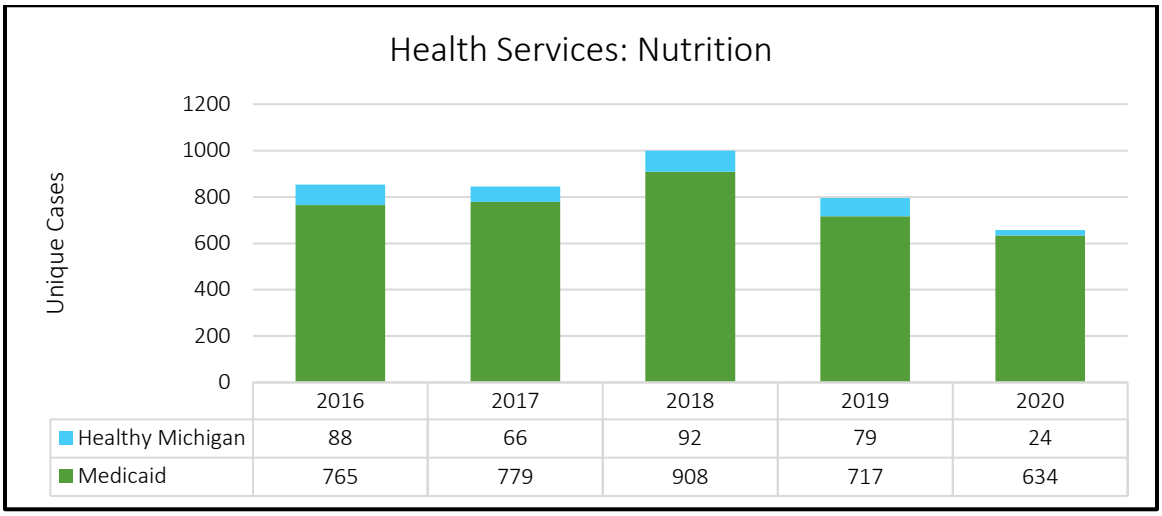


	2016	2017	2018	2019	2020
Healthy Michigan	55	40	68	45	16
Medicaid	134	118	199	186	86

[7] Source: MDHHS Self-Direction Technical Requirement Implementation Guide

Health Services: Nutrition

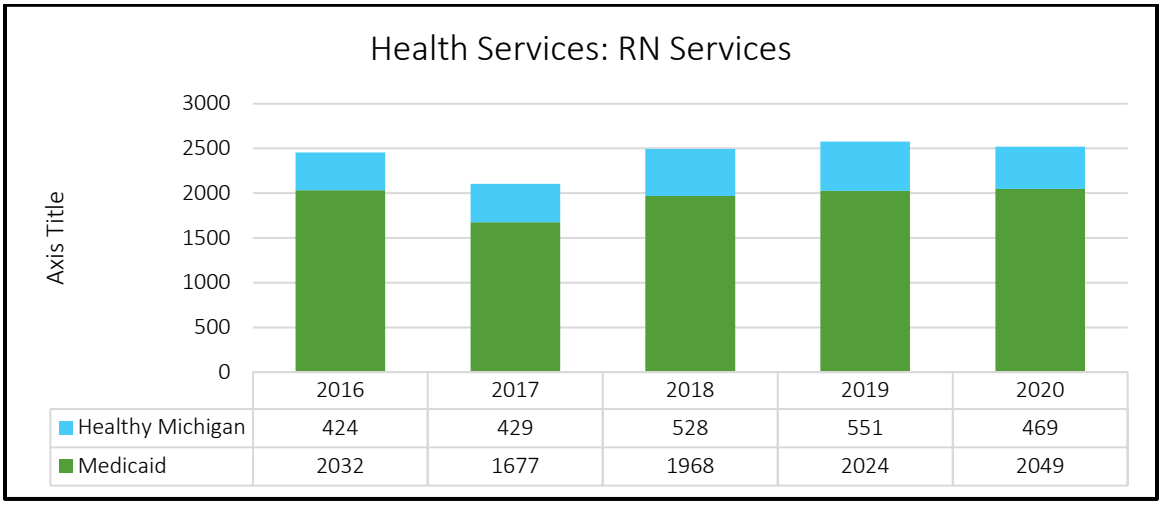
Nutrition services include the management and counseling for individuals on special diets for genetic metabolic disorders, prolonged illness, deficiency disorders or other complicated medical problems. Nutritional support through assessment and monitoring of the nutritional status and teaching related to the dietary regimen.



	2016	2017	2018	2019	2020
Healthy Michigan	88	66	92	79	24
Medicaid	765	779	908	717	634

Health Services: RN Services

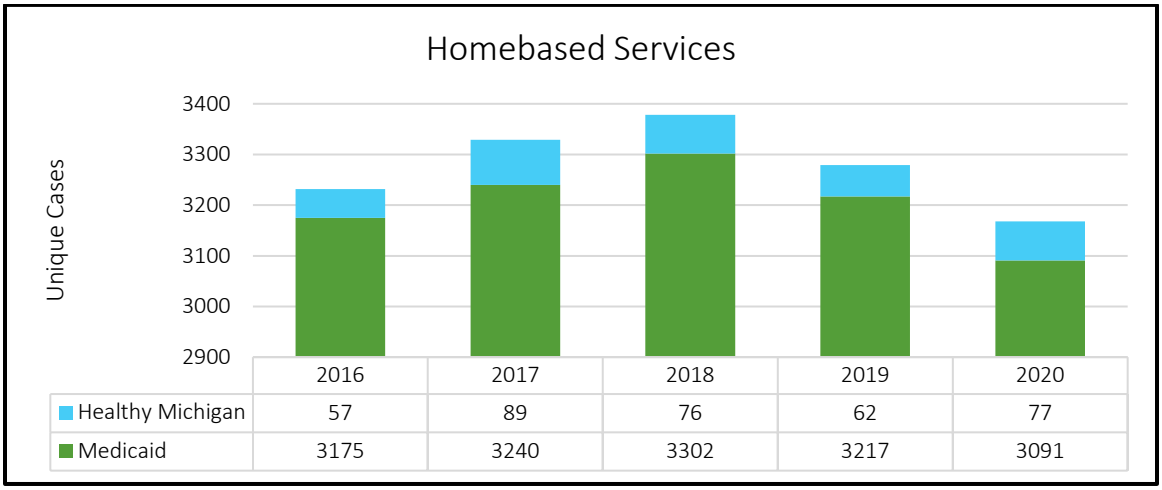
Nursing services are covered on an intermittent basis. These services must be provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN.



	2016	2017	2018	2019	2020
Healthy Michigan	424	429	528	551	469
Medicaid	2032	1677	1968	2024	2049

Homebased Services

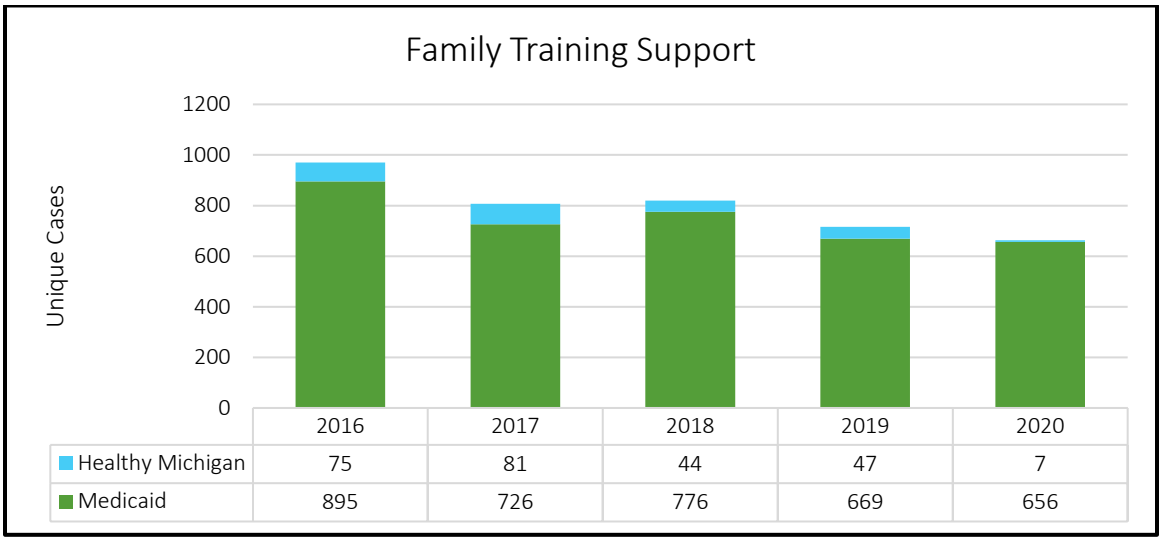
Homebased services provide assistance to children and their families with multiple service needs. The goals are to meet children's developmental needs, support families, reunite families and prevent out of home placement. MDHHS has an established adequacy standard (2,000:1 Medicaid Enrollee to Provider Ratio). Home-Based services were verified through provider enrollment information to ensure compliance with educational standards of licensure and FTE designations. MSHN meets published standard with 144 FTEs.



	2016	2017	2018	2019	2020
Healthy Michigan	57	89	76	62	77
Medicaid	3175	3240	3302	3217	3091

Homebased Services: Family Training Support

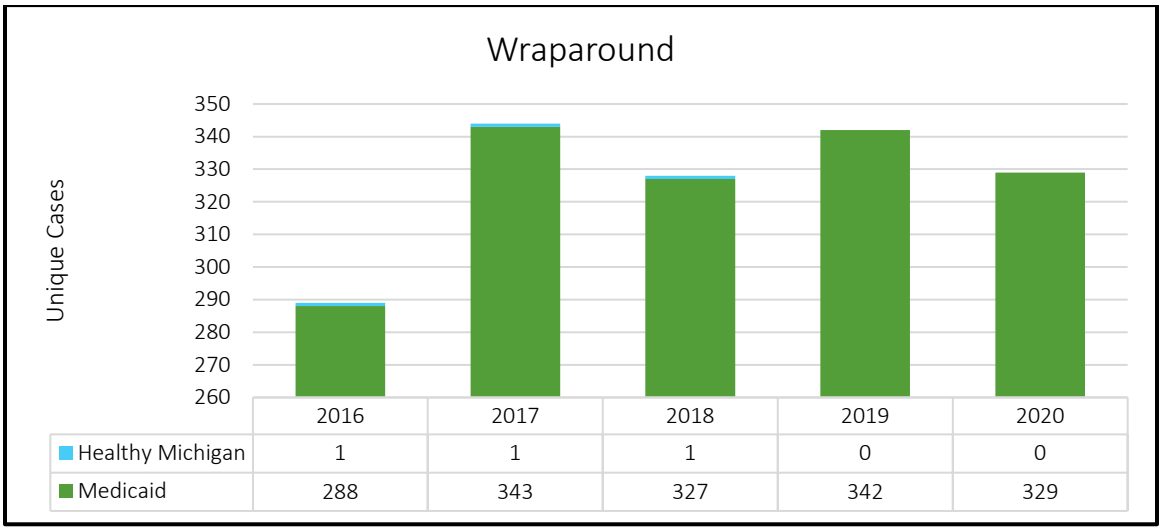
Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance, or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services.



	2016	2017	2018	2019	2020
Healthy Michigan	75	81	44	47	7
Medicaid	895	726	776	669	656

Homebased Services: Wraparound

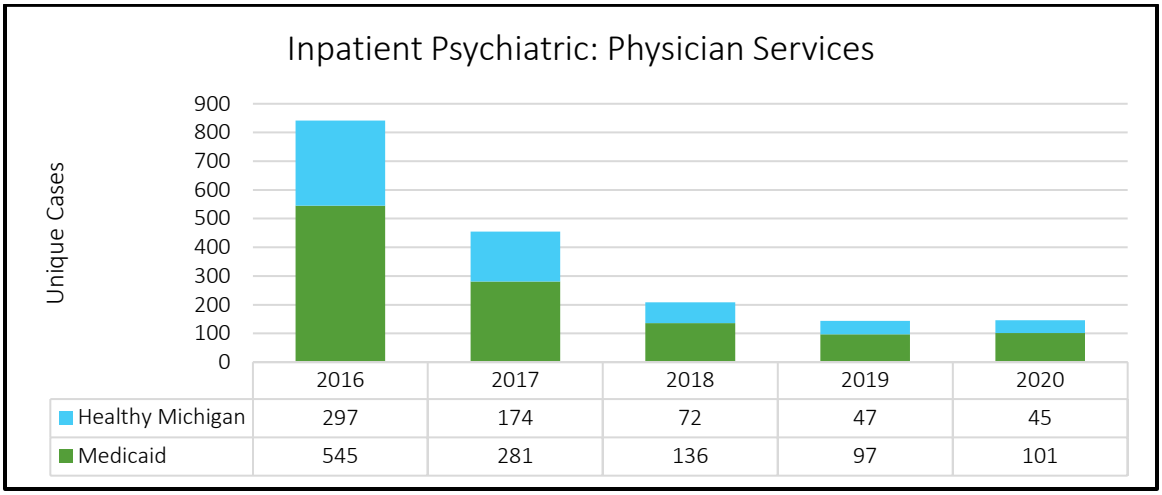
Wraparound services for children and adolescents are highly individualized planning processes facilitated by specialized supports coordinators. MDHHS has an established adequacy standard (5,000:1 Enrollee to Provider Ratio). Wraparound services are verified through provider enrollment information to ensure compliance with educational standards of licensure and FTE designations. MSHN region meets published standards with 58 FTEs.



	2016	2017	2018	2019	2020
Healthy Michigan	1	1	1	0	0
Medicaid	288	343	327	342	329

Inpatient Psychiatric - Physician Services

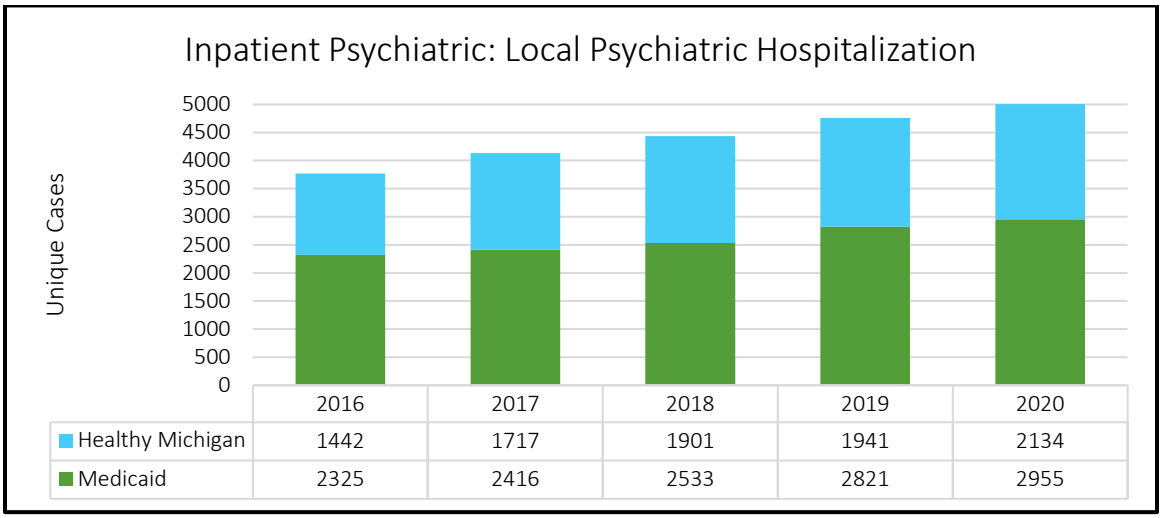
Physician services to hospital inpatients that are medically necessary. The following services fall into this category: Ventilation management, critical care, respiratory care, standby services, global surgery, and vision procedures. The decline in physician services is likely due to the use of the code 0100, which is the all-inclusive code for community inpatient hospitalization and includes physician services in the per diem.



	2016	2017	2018	2019	2020
Healthy Michigan	297	174	72	47	45
Medicaid	545	281	136	97	101

Inpatient Psychiatric - Local Psychiatric Hospital

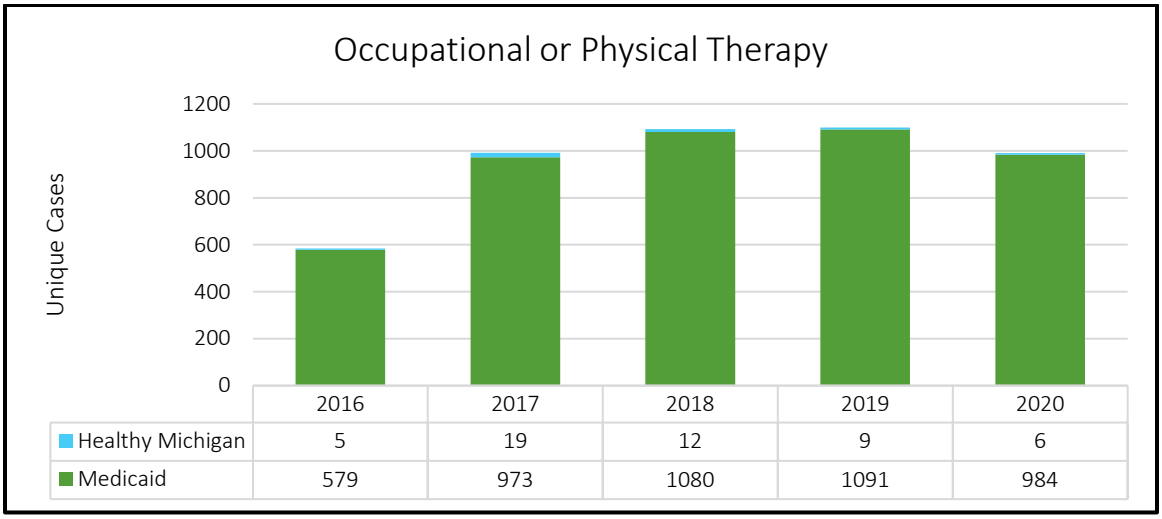
Any community-based hospital that CMHSPs contract with to provide inpatient psychiatric services. Like other PIHPs in the state, MSHN continues to encounter challenges in gaining timely access to psychiatric inpatient and autism services which meet the needs of all clinical populations served.



	2016	2017	2018	2019	2020
Healthy Michigan	1442	1717	1901	1941	2134
Medicaid	2325	2416	2533	2821	2955

Occupational or Physical Therapy

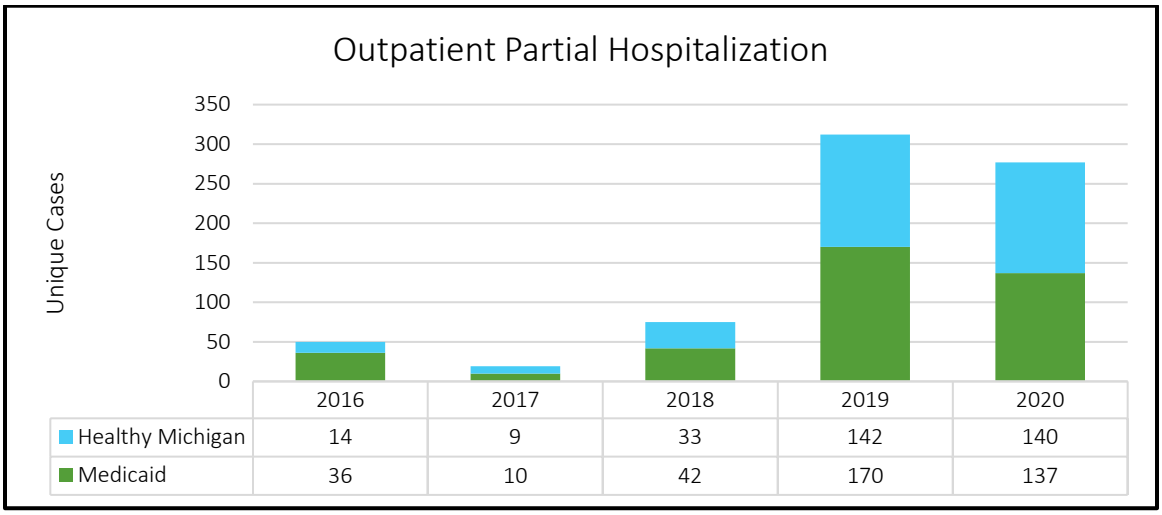
Occupational and habilitative services are services to help a person keep, learn, or improve skills and functioning for daily living.



	2016	2017	2018	2019	2020
Healthy Michigan	5	19	12	9	6
Medicaid	579	973	1080	1091	984

Outpatient Partial Hospitalization

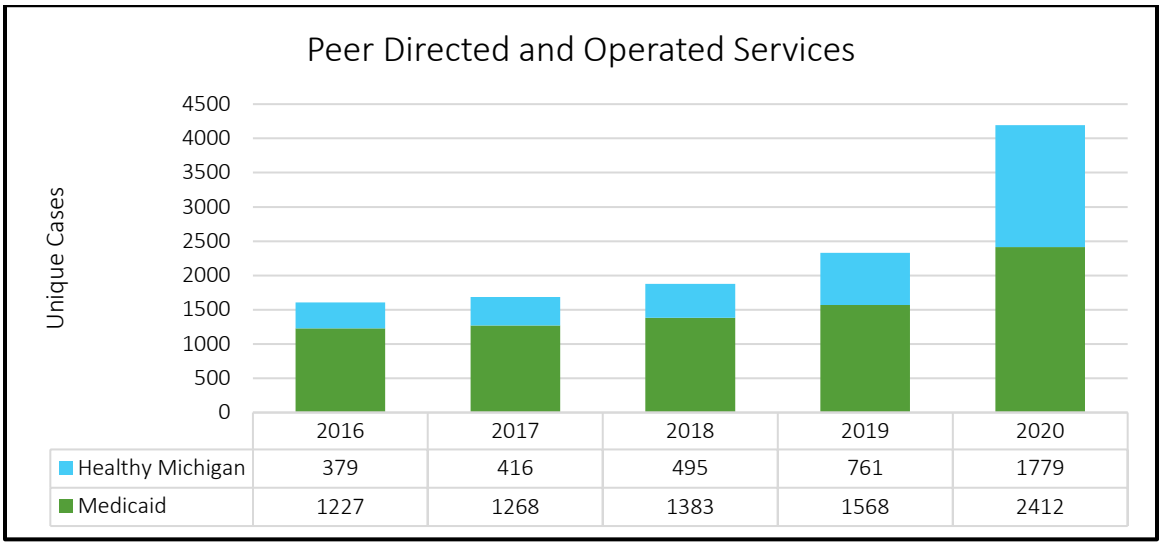
Partial hospitalization is used when an individual does not meet the need for inpatient hospitalization but requires more than traditional outpatient mental health services. Partial hospitalization services may be used to treat an individual with a mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Services are provided more than six hours per day, five days per week. Partial hospitalization utilization went markedly up in 2019 due to the service becoming available to a number of MSHN CMHSPs; however, the increase was primarily attributed to two CMHSP participants utilizing this service.



	2016	2017	2018	2019	2020
Healthy Michigan	14	9	33	142	140
Medicaid	36	10	42	170	137

Peer Directed and Operated Support Services

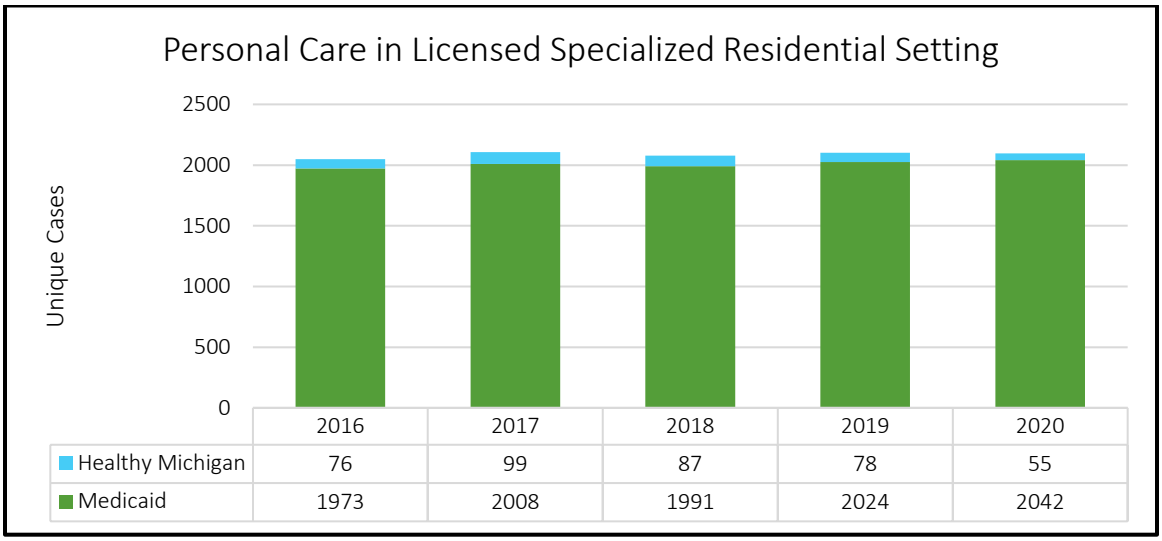
Peer directed services for youth and adults with mental illness and intellectual/developmental disabilities. Peer run drop-in centers are also included.



	2016	2017	2018	2019	2020
Healthy Michigan	379	416	495	761	1779
Medicaid	1227	1268	1383	1568	2412

Personal Care in Licensed Specialized Residential Setting

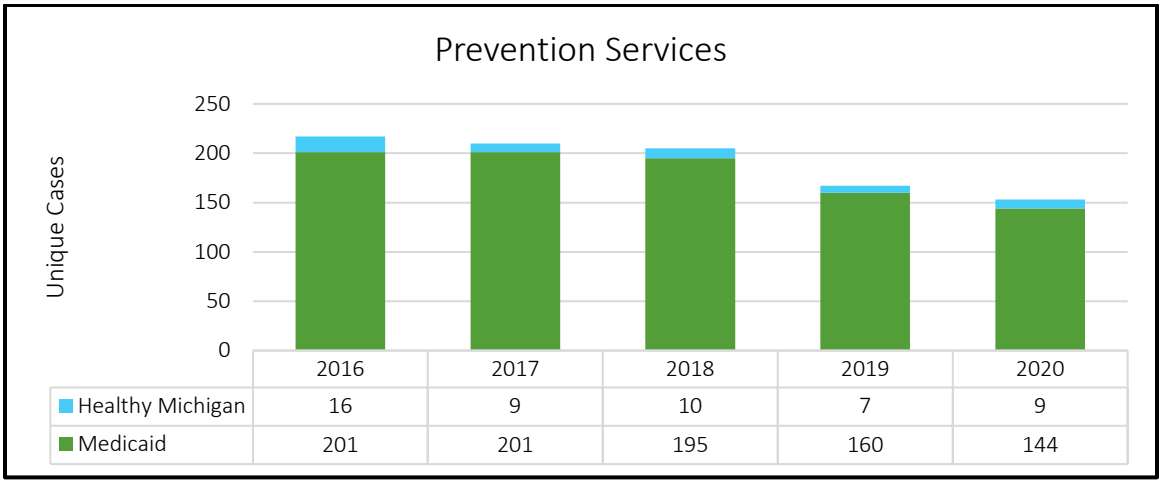
Services to assist an individual with performing their own personal daily activities. The following are allowable: food preparation, feeding/eating, toileting, bathing, grooming, dressing, transferring, assistance with self-administered medication.



	2016	2017	2018	2019	2020
Healthy Michigan	76	99	87	78	55
Medicaid	1973	2008	1991	2024	2042

Prevention Services

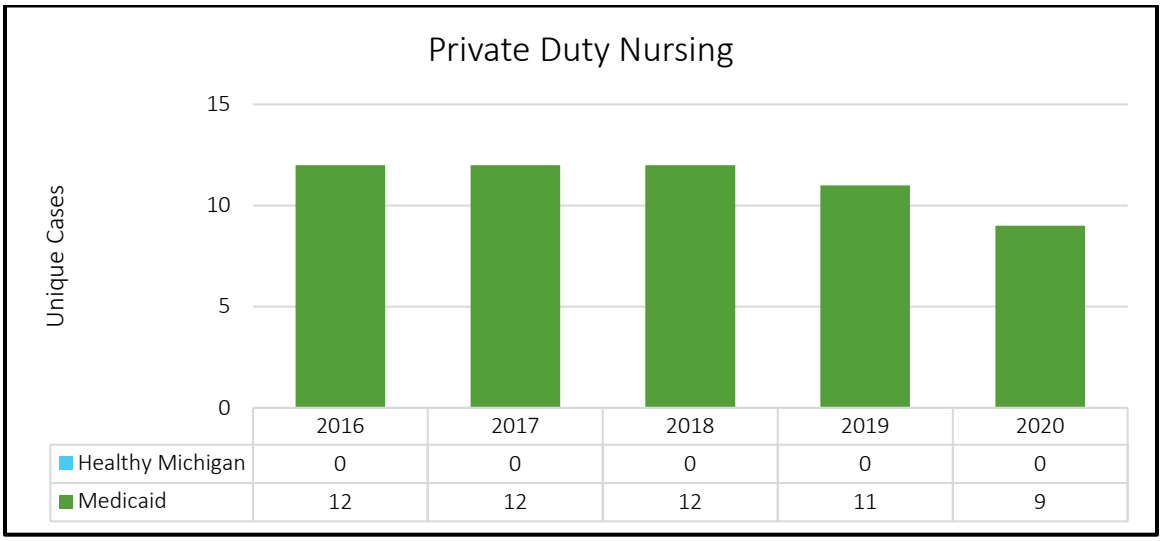
Services include school success, avoiding childcare expulsion, infant mental health, and parent education.



	2016	2017	2018	2019	2020
Healthy Michigan	16	9	10	7	9
Medicaid	201	201	195	160	144

Private Duty Nursing

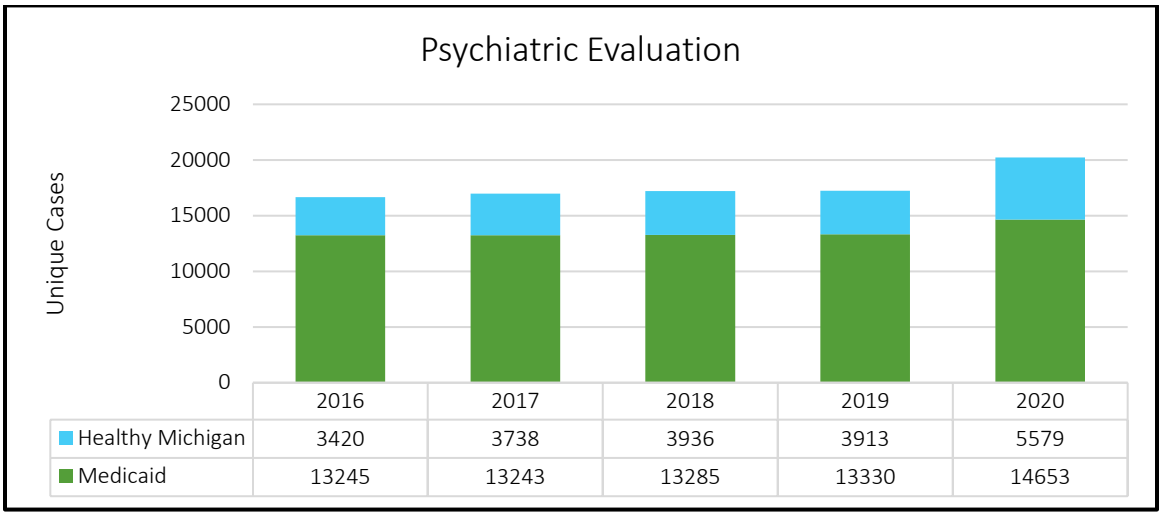
Private Duty Nursing is defined as nursing services for beneficiaries who require more individual and continuous care, in contrast to part-time or intermittent care, than is available under the home health benefit.



	2016	2017	2018	2019	2020
Healthy Michigan	0	0	0	0	0
Medicaid	12	12	12	11	9

Psychiatric Evaluation and Medication

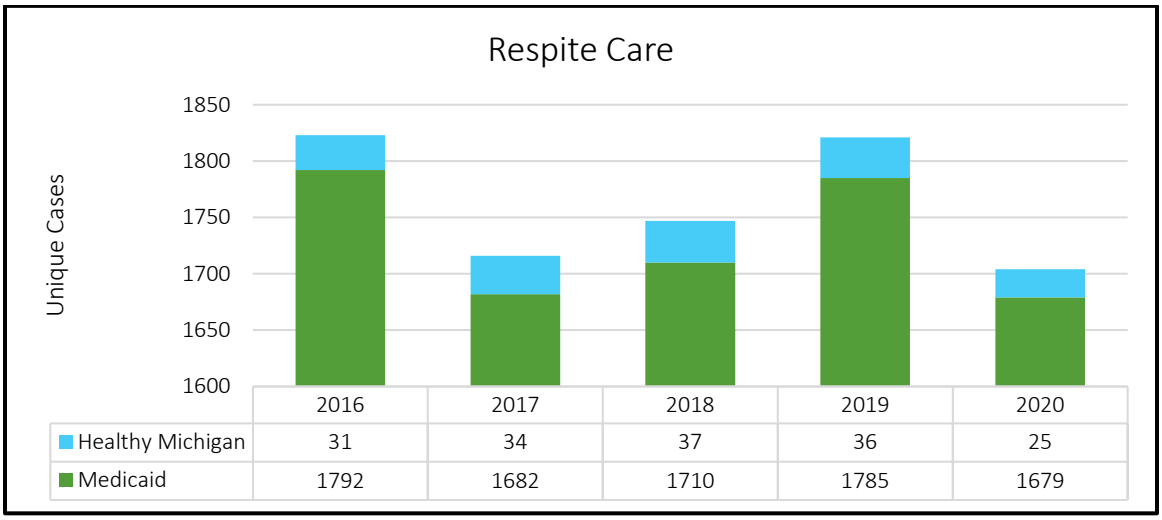
A comprehensive evaluation performed face-to-face by a psychiatrist, psychiatric mental health nurse practitioner, or appropriately trained clinical nurse specialist that investigates a beneficiary's clinical status, including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination.



	2016	2017	2018	2019	2020
Healthy Michigan	3420	3738	3936	3913	5579
Medicaid	13245	13243	13285	13330	14653

Respite

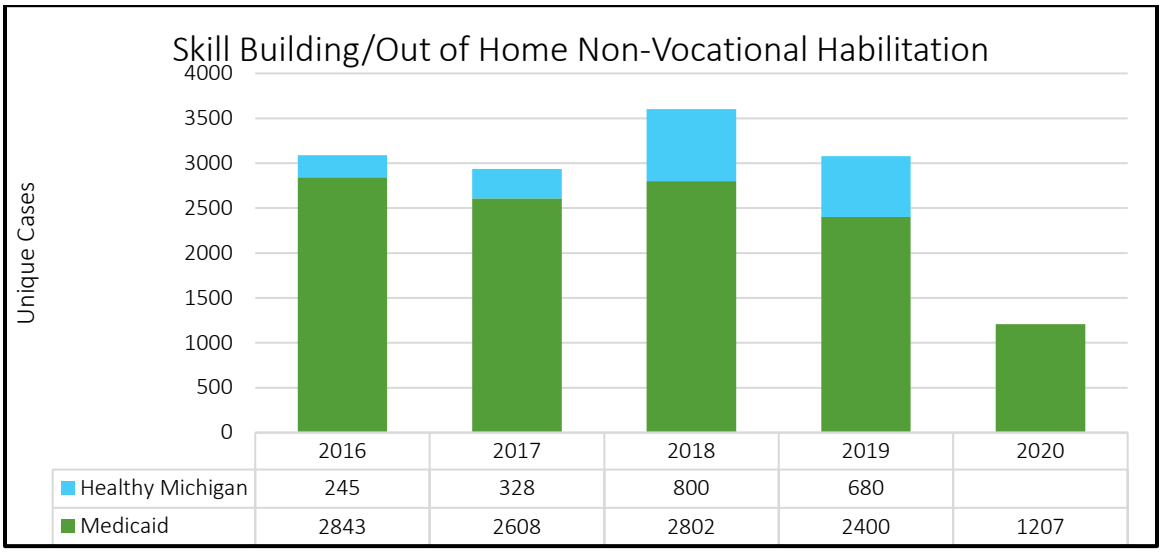
This includes daily respite care in out-of-home and in-home settings as well as therapeutic camping.



	2016	2017	2018	2019	2020
Healthy Michigan	31	34	37	36	25
Medicaid	1792	1682	1710	1785	1679

Skill Building/Out-of-Home Non-Vocational Habilitation

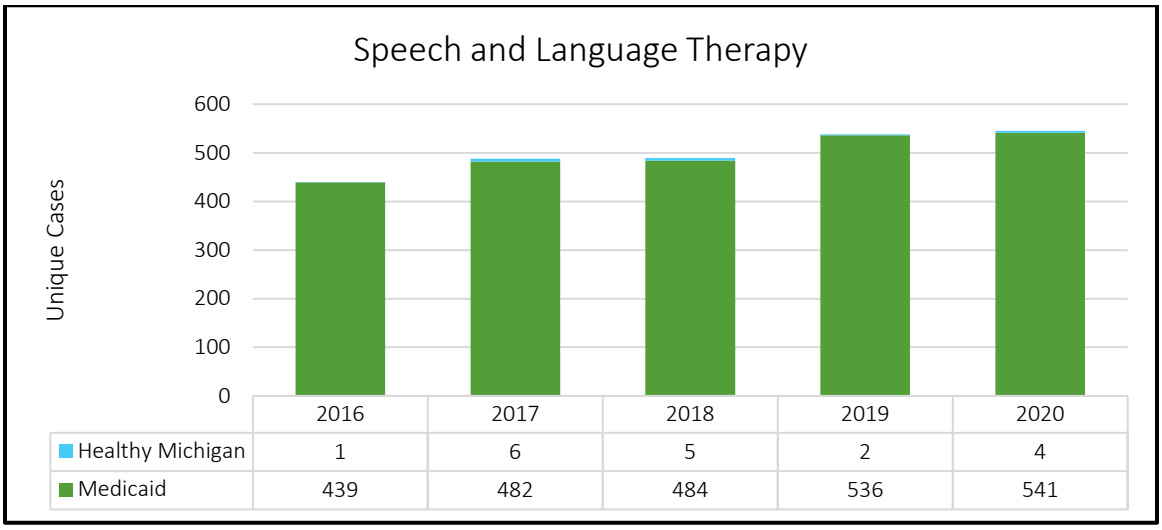
Skill-building assists a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. HCBS transition has had an impact on availability of services, but it is expected to stabilize or increase moderately as providers come into compliance.



	2016	2017	2018	2019	2020
Healthy Michigan	245	328	800	680	
Medicaid	2843	2608	2802	2400	1207

Speech and Language Therapy

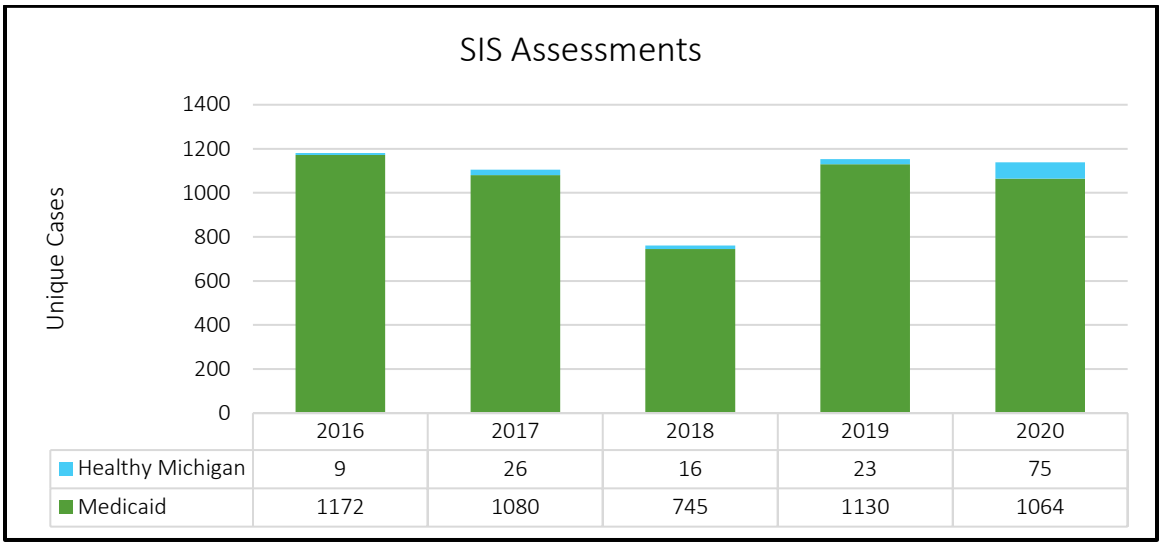
Services include: Group therapy provided in a group of two to eight beneficiaries, articulation, language, and rhythm, swallowing dysfunction and/or oral function for feeding, voice therapy, speech, language or hearing therapy, speech reading/aural rehabilitation, esophageal speech training therapy, speech defect corrective therapy, fitting and testing of hearing aids or other communication devices.



	2016	2017	2018	2019	2020
Healthy Michigan	1	6	5	2	4
Medicaid	439	482	484	536	541

Supports Intensity Scale Assessments

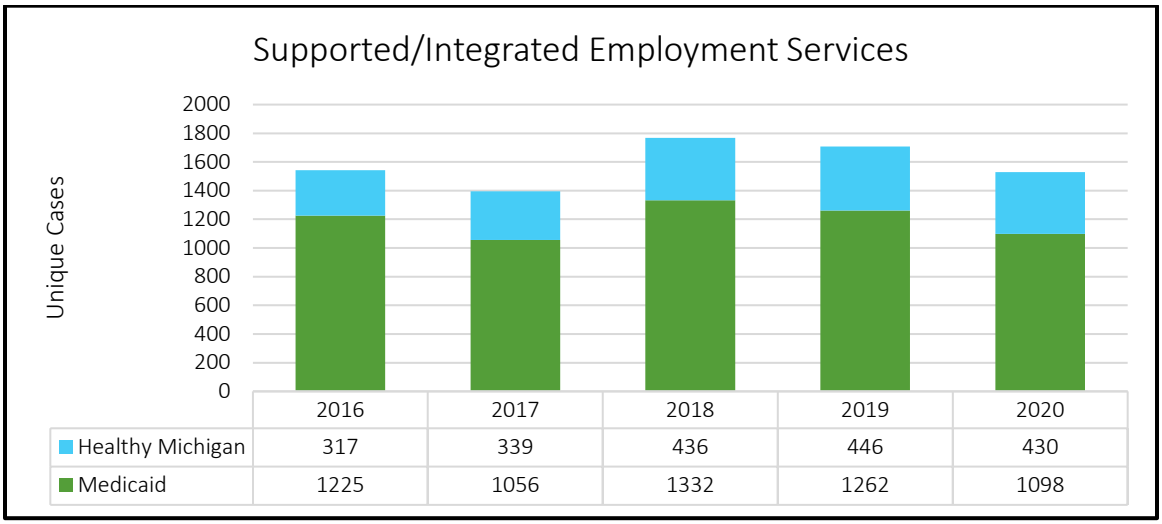
MDHHS requires PIHPs to administer a clinical assessment for individuals with intellectual and developmental disabilities (IDD) called the Supports Intensity Scale (SIS). MSHN has delegated completion of the SIS to the CMHSP participants. The SIS assessors are a group of staff certified to complete SIS assessments for all Medicaid eligible adults with an intellectual or developmental disability (IDD). MSHN must ensure an adequate cadre of assessors are in place to ensure that each eligible individual receives a SIS assessment at least once every three years. These qualified SIS assessors exist across the region to ensure that all individuals are assessed in the required timeframe.



	2016	2017	2018	2019	2020
Healthy Michigan	9	26	16	23	75
Medicaid	1172	1080	745	1130	1064

Supported Employment Services

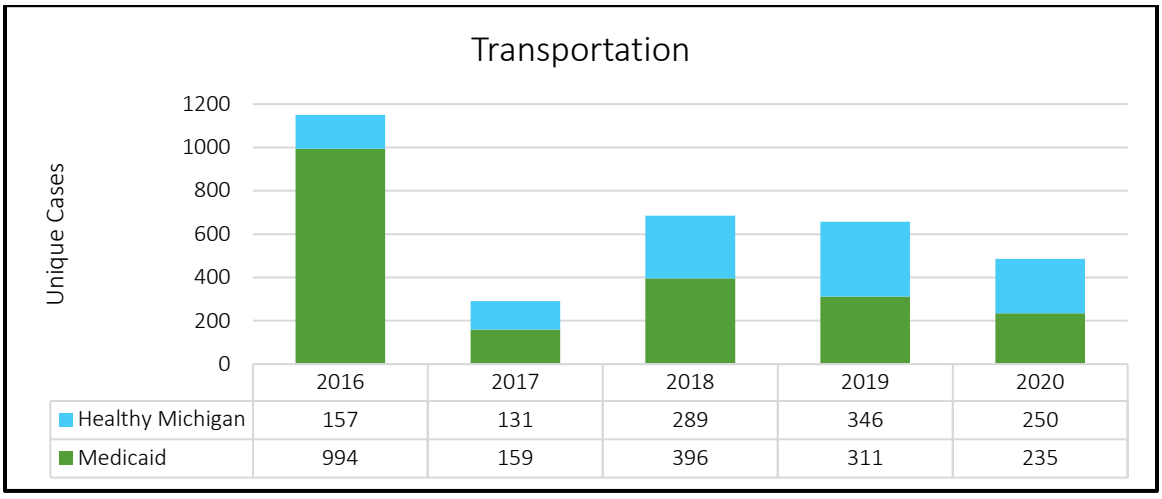
Supported employment is the combination of ongoing support services and paid employment that enables an individual to work in the community.



	2016	2017	2018	2019	2020
Healthy Michigan	317	339	436	446	430
Medicaid	1225	1056	1332	1262	1098

Transportation

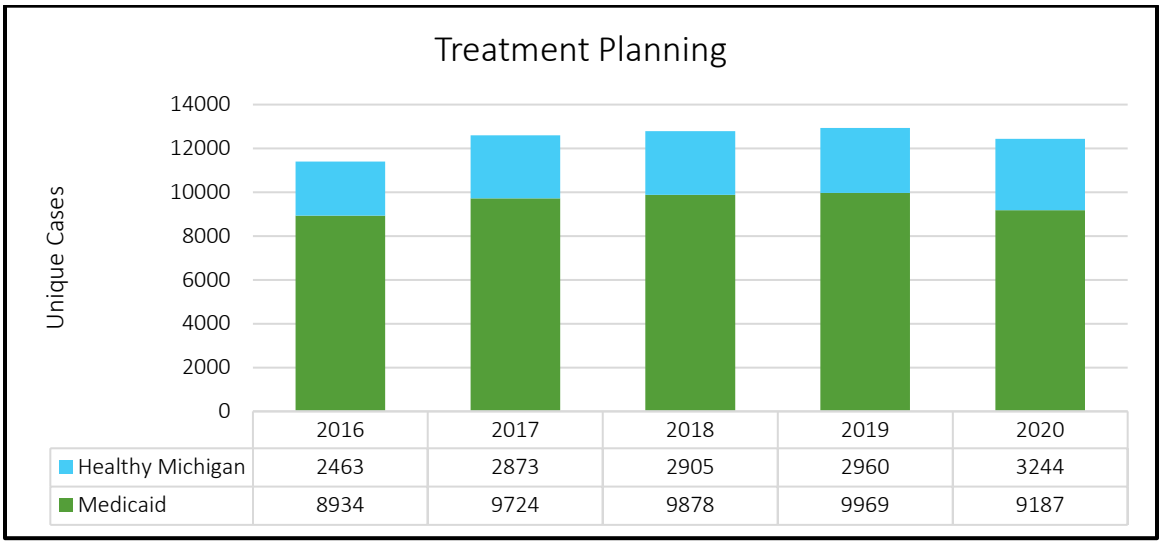
Transportation is used to transport individuals to/from services other than daytime activity, skill building, clubhouse, supported employment, or community living activities.



	2016	2017	2018	2019	2020
Healthy Michigan	157	131	289	346	250
Medicaid	994	159	396	311	235

Treatment Planning

Activities associated with developing an individual's plan of service. Also included is writing goals and objectives, measurement and monitoring goals and attending person centered planning meetings.



Evidence Based Practices – Mental Health

Each CMHSP Participant provides selected specialty services or treatments based upon evidence-based practice models they have adopted in accordance with local needs. Table 2 lists many evidence-based (or best) practices currently offered by CMHSP participants in the region. CMHSPs continue to implement EBPs.

Table 2: Evidence Based Practices Utilized by CMHSP Participants in the MSHN Region

	Pop.	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Alternative for Families CBT	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						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						X		X		
Dialectical Behavioral Therapy	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Eye Movement Desensitization	PTSD	X			X		X	X	X	X			X
Family Psychoeducation	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	X
Motivational Interviewing	All	X	X	X	X	X	X		X	X	X	X	X

Table 2: Continued…

	Pop.	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Multi-Systemic Therapy	Juvenile offenders			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	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~~	
Prolonged Exposure Therapy	Adults w PTSD			X		X			X				
Resource Parent Trauma Training	Parents										X	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 CBT	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			
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					X	X	

Autism Benefit (EPSDT)

The Michigan Medicaid Autism Benefit 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 3.

Table 3: Autism Benefit (EPSDT) Services Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GIHN	HBH	TRD	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	X	X	X	X	X	X	X	X	X	X	X	X
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

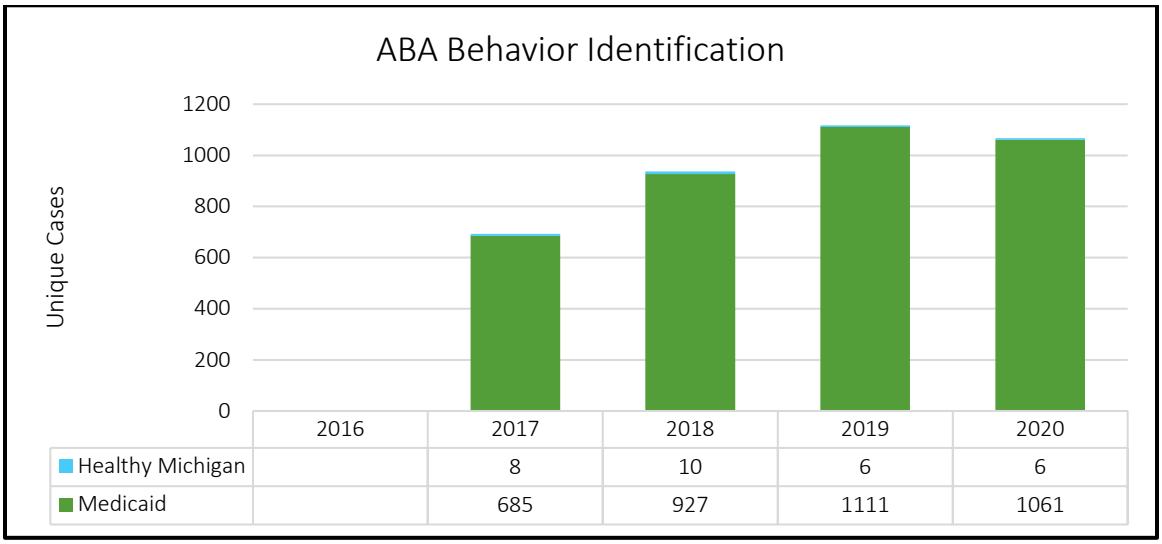
MDHHS expanded eligibility for Autism services to age 21 effective January 2016. Since the MSHN region had encountered difficulties previously in meeting the existing demand for services by children aged 18 months through 5 years, there was concern across the region's CMHSP Participants regarding the 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. MSHN and its CMHSP Participants have been successful in increasing BHT/ABA provider capacity. Table 4 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 4: Individuals Served by CMHSPs with Autism Spectrum Disorders and ABA Service Utilization

	FY16		FY17		FY18		FY19	
	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit
BABH	234	49	290	95	212	99	231	110
CEI	600	122	610	208	504	267	589	312
CMHCM	377	57	462	126	407	161	531	167
GIHN	80	25	100	37	88	50	114	63
HBH	35	2	32	10	48	15	50	11
LCMHA	117	100	152	155	316	215	462	192
MCN	90	13	116	37	102	46	177	67
NCMH	454	14	550	16	82	16	92	14
SCCMHA	143	112	156	167	432	205	525	209
SHW	123	17	155	24	89	38	115	32
TBHS	78	12	103	34	85	37	99	39
TRD	340	13	433	23	118	28	126	31
MSHN	**2,671**	**536**	**3,159**	**932**	**2,483**	**1,178**	**3111**	**1,247**

ABA Behavior Identification

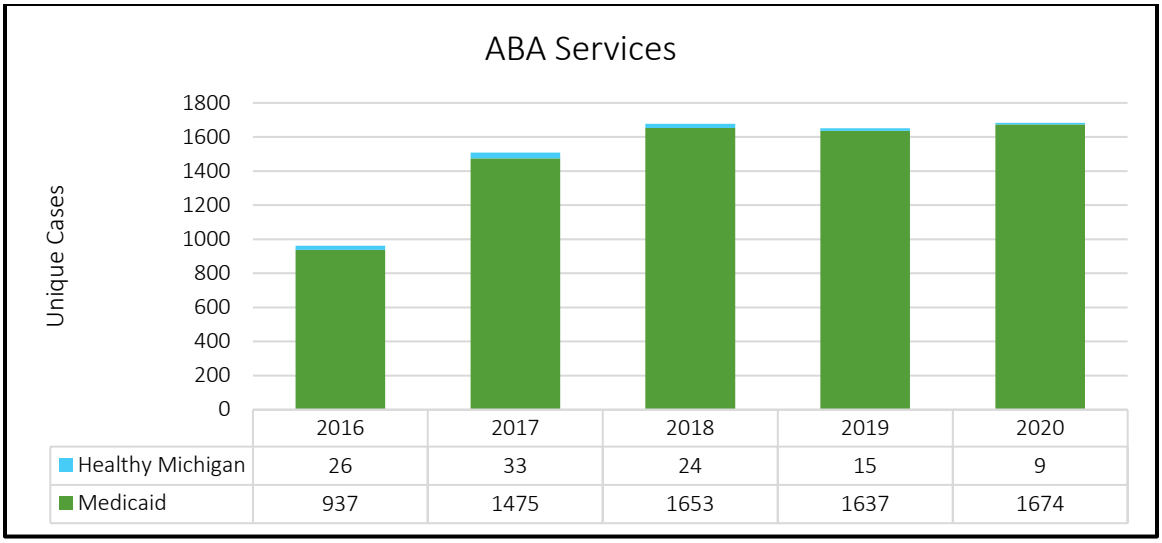
Behavior identification assessment by a qualified provider face to face with the individual and caregiver (s); includes interpretation of results and development of the behavioral plan of care. In 2019, there were additional ABA codes added, so the ABA Behavioral Follow-Up Assessment began to be billed, likely reducing the number of ABA Behavioral Identification Assessment codes.



	2016	2017	2018	2019	2020
Healthy Michigan		8	10	6	6
Medicaid		685	927	1111	1061

ABA Other Services

Services include non-medical assessments, psychological testing, and mental health assessments by non-physicians.



	2016	2017	2018	2019	2020
Healthy Michigan	26	33	24	15	9
Medicaid	937	1475	1653	1637	1674

Substance Use Disorder Services

Table 5 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 as it continues to expand its network and ensure access to all levels of care. 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. Substance use disorder covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings, and via telehealth.

Table 5: Substance Use Disorder Services Available in the MSHN Provider Network

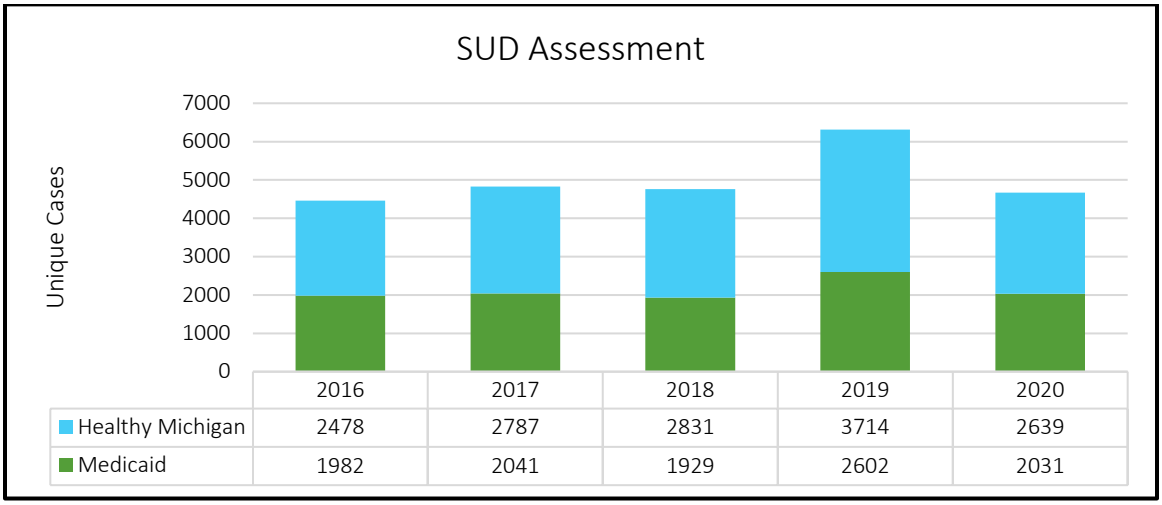
	Outpatient				Residential				Withdrawal Mgt.		OTP	Recovery Housing
County	**0.5**	**1.0**	**2.1**	**2.5**	**3.1**	**3.3**	**3.5**	**3.7**	**3.2**	**3.7**	**Level 1**	**III or IV**
Arenac	X - MCU	X - MCU										
Bay	X	X*	X									X
Clare		X										
Clinton		X										
Eaton	X	X*	X									X
Gladwin		X*									X	
Gratiot	X	X										
Hillsdale		X			X		X					X
Huron	X	X*										
Ingham	X	X	X		X	X	X		X	X	X	X
Ionia		X*										
Isabella		X*			X				X		X	X
Jackson	X	X	X	X	X		X	X		X	X	X
Mecosta		X										
Midland		X*					X					
Montcalm		X*										X
Newaygo	X	X*	X									X
Osceola		cb	cb									
Saginaw	X	X*	X		x	X	X		X	X	X	
Shiawassee	X	X*										X
Tuscola	X	X*										
Out of Network	X	X*	X	X	x	X	X	X	X	X	X	X
cb (Community Based Services)		*OP Program offer MAT (Suboxone/Vivitrol)					MCU – Mobile Care Unit					

Medicaid-covered services and supports must be provided, based on medical necessity, to eligible beneficiaries who reside in the region and request services. The Substance Use Disorder services below are authorized through MSHN. Much of the MSHN region is covered relative to the availability of outpatient and medication assisted treatment services; however, the region continues to expand capacity as 60 min/60 miles can be a barrier for consumers in need of services. MSHN owns a mobile care unit, a retrofitted vans/buses that brings counseling, therapeutic, and physical health services to SUD patients. The mobile unit has an area for intake and scheduling, a restroom to incorporate urine screening, a one private room for counseling. Harm reduction activities including syringe services, overdose education, and naloxone distribution will also be provided. The unit has telehealth capabilities to incorporate MAT supports as needed. Locations of access for the mobile care unit is evaluated by MSHN based on community need.

The opiate addiction and overdose epidemic continue 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.

SUD Assessment

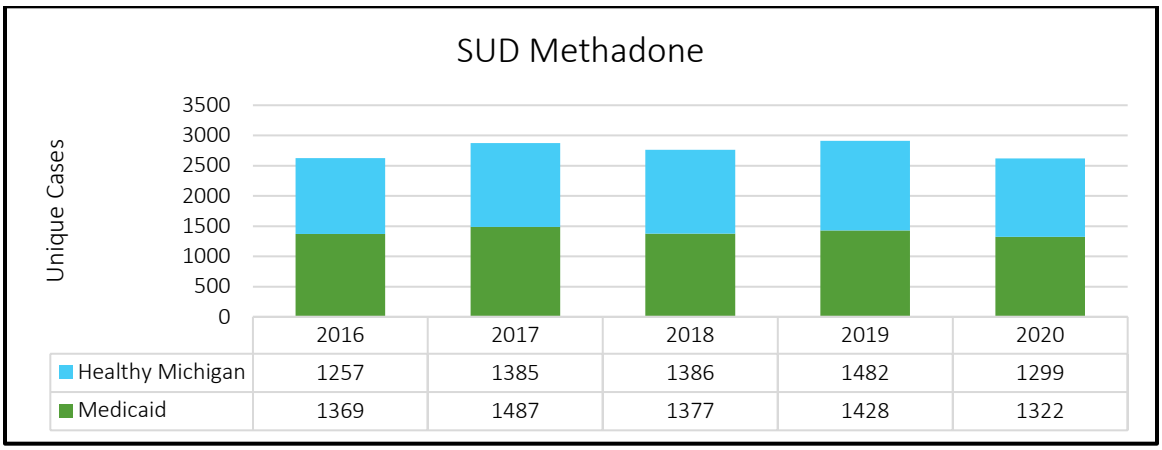
Assessment includes an evaluation by qualified practitioner that investigates clinical status including presenting problem, history of present illness, previous medication history, relevant personal and family history, personal strengths and assets, and mental status examination purposes of determining eligibility for specialty services and supports, and the treatment needs of the beneficiary.



	2016	2017	2018	2019	2020
Healthy Michigan	2478	2787	2831	3714	2639
Medicaid	1982	2041	1929	2602	2031

SUD Methadone

Methadone is an approved pharmacological support and an adjunct to the treatment of opiate dependence. Services must be provided under the supervision of a physician licensed to practice medicine in Michigan and licensed to prescribe controlled substances, as well as licensed to work at a methadone program.



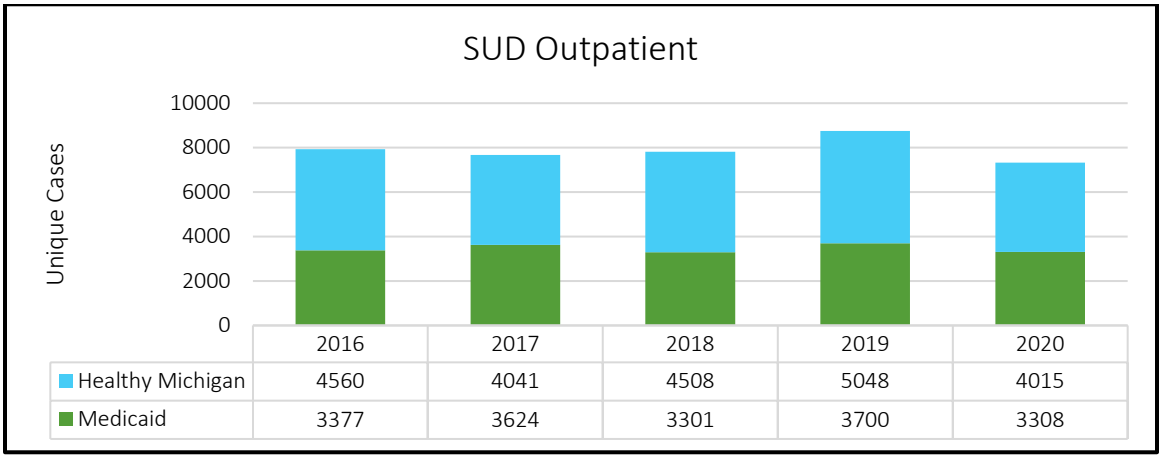
	2016	2017	2018	2019	2020
Healthy Michigan	1257	1385	1386	1482	1299
Medicaid	1369	1487	1377	1428	1322

SUD Opioid Treatment Programs (OTP)

OTPs are certified by SAMHSA under 42 CFR Part 8.11. MDHHS has an established adequacy standard (35,000:1 Medicaid Enrollee to Provider ratio). MSHN currently contracts with six providers in the region that meet this definition in the region. 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.

SUD Outpatient

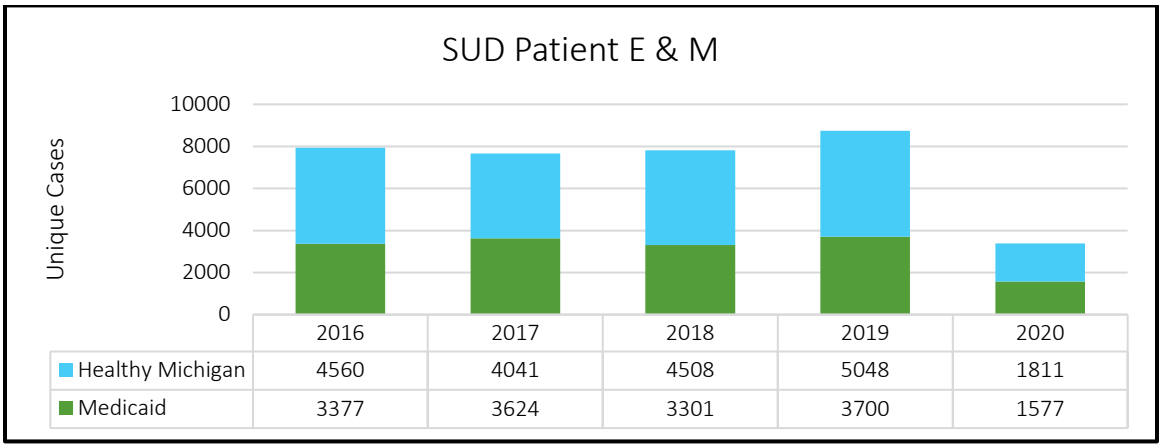
Outpatient treatment is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment or a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary, can total over 20 hours in a week. Individual, family, and group therapy, peer supports, and monitoring services may be provided individually or in combination.



	2016	2017	2018	2019	2020
Healthy Michigan	4560	4041	4508	5048	4015
Medicaid	3377	3624	3301	3700	3308

SUD New and Established Patient Evaluation and Mangement

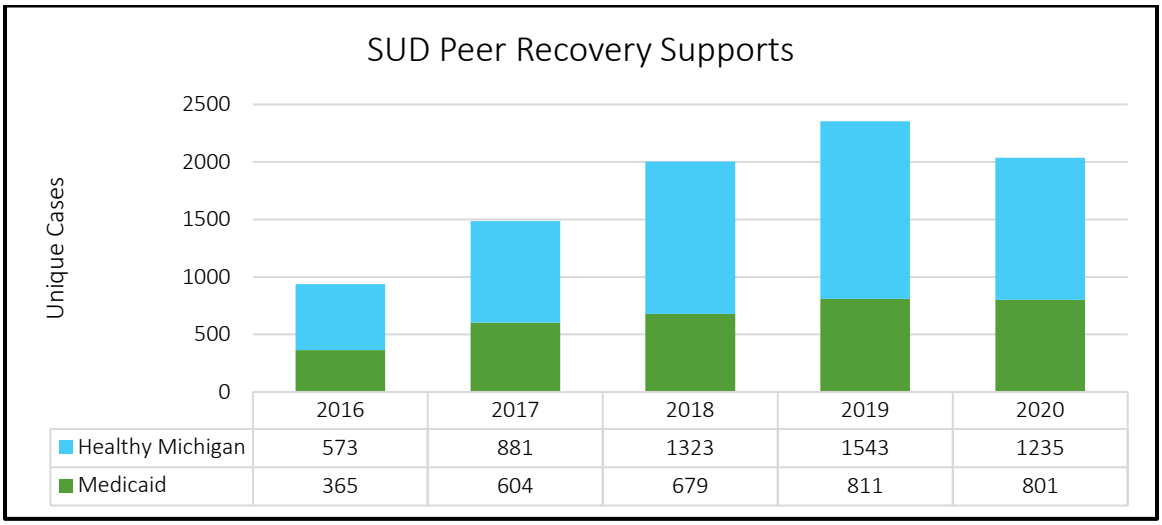
This includes patient evaluation and medication management by a physician (MD or DO), licensed physician's assistant, or nurse practitioner under their scope of practice.



	2016	2017	2018	2019	2020
Healthy Michigan	4560	4041	4508	5048	1811
Medicaid	3377	3624	3301	3700	1577

SUD Peer Services/Recovery Supports

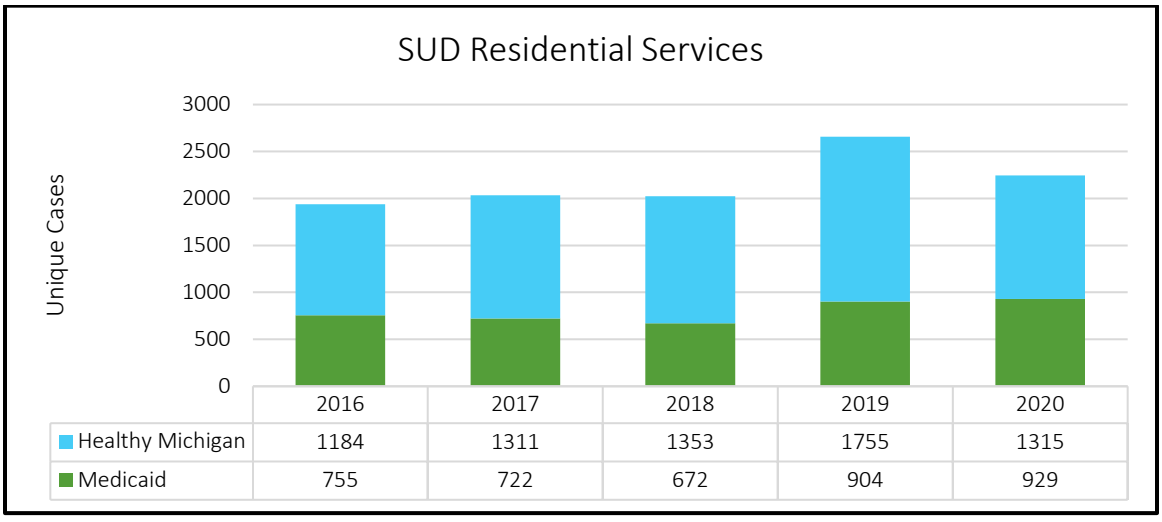
Peer Recovery Supports is a non-clinical service that assist individuals and families to recover from substance use disorders. They include social support, linkage to, and coordination among, allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. PRS may be provided in conjunction with treatment, or as separate and distinct services, to individuals and families who desire and need them. MSHN supports the SUD network by providing training funds, with over 200 individuals trained to serve as Peer Recovery Coaches, a vital part of MSHN's frontline services.



	2016	2017	2018	2019	2020
Healthy Michigan	573	881	1323	1543	1235
Medicaid	365	604	679	811	801

SUD Residential Services

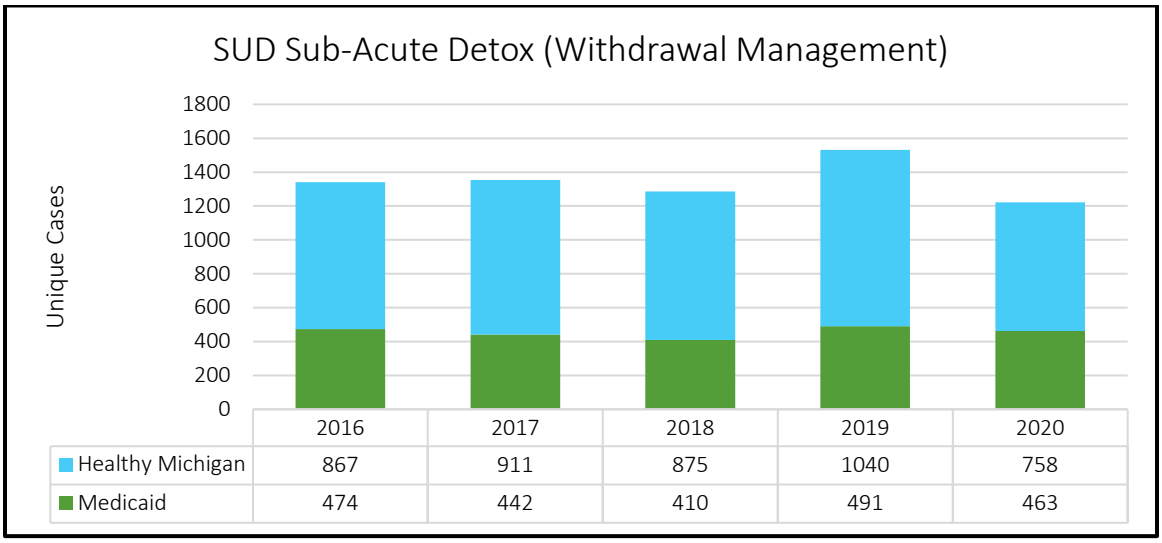
Residential Treatment is defined as intensive therapeutic service which includes overnight stay (24-hour setting) and planned therapeutic, rehabilitative, or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. Length of stay varies based upon the client's level of care needs.



	2016	2017	2018	2019	2020
Healthy Michigan	1184	1311	1353	1755	1315
Medicaid	755	722	672	904	929

SUD Sub-Acute Detox (Withdrawal Management)

Withdrawal management services provide safe withdrawal from the drug(s) of dependence consisting of three components: evaluation, stabilization, and fostering client readiness for and entry into treatment. Treatment generally takes place in a residential setting – clinically managed or medically managed.



	2016	2017	2018	2019	2020
Healthy Michigan	867	911	875	1040	758
Medicaid	474	442	410	491	463

Evidenced Based Practices - SUD

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 6 lists evidence-based practices employed by various SUD Providers in the MSHN region:

Table 6: Evidence Based Practices Utilized by SUD Providers in the MSHN Region

Focus	Evidenced Based Practices	Focus	Evidenced Based Practices
P	Active Parenting Now	P	Not on Tobacco
T	Acupuncture	P	Permanent Drug Disposal Box Initiatives
T	Adolescent Community Reinforcement Approach	P	Prescription Disposal/Drug Drop Off Boxes
P	Alcohol and Tobacco Vendor Education	P	Prime for Life 420
T	Alternative Routes	P	Program to Encourage Active, Rewarding Lives (PEARL)
T	Anger Management	P	Project Alert
P	Big Brothers Big Sisters	P	Project M.A.G.I.C.
P	Botvins Life Skills	P	Project Success
P	Choices	P	Project Toward No Drug Use
P	Communities Mobilizing for Change on Alcohol	P	Promoting Alternative Thinking Strategies
T	Cognitive Behavioral Therapy (CBT)	P	Protecting You/Protecting Me
P	Communities that Care	P	QPR Gatekeeper Training for Suicide Prevention
P	Community Intervention: Helping Teens Overcome Problems with Alcohol, Marijuana and Other Drugs	P	Retailer/Server Education (TIPS)
P	Community Trials to Reduce High Risk Drinking	P	Safe Prom and Graduation Initiatives
T	Contingency Management (CM)	P	SAMSHA - 8 Dimensions of Wellness
T	Correctional Therapeutic Community for SUD	P	SAMSHA - Prevention Messages at Schools
P	Cross Age Mentoring Programming	T	Screening, Brief Intervention, Referral to Treatment
T	Dialectical Behavior Therapy (DBT)	P	Second Step
P	Do Your Part-State Social Norm Campaign	T	Seeking Safety
P	Drug Take Back Events	T	Self-Management and Recovery Training (SMART)
P	Early STEP	P	Signs of Suicide
P	Eight Dimensions of Wellness	P	SMART Leaders/SMART Moves
T	Eye Movement Desensitization and Re-Processing	P	Social Norming/Marketing and Media Campaigns
P	Families and Schools Together (FAST)	P	SPEC Signs of Suicide
T	Family Psychoeducation	P	SPORTPLUS Wellness
T	Functional Family Therapy	P	Stay It Straight
T	Helping Women Recover/Helping Men Recover	P	Step Bullying Prevention
P/T	Incredible Years	P	STEP-Early Childhood
P	In-School Probation: Early Intervention	P	STEP-Teen
P	Life Skills Training	P/T	Strengthening Families
T	Living in Balance	P	Strengthening Families Home
T	Medication Assisted Treatment (MAT)	P	Student Assistance Programs
P	Mentoring	P	SURF
P	Mentoring Programs	P	Synar Compliance Checks
P	Michigan Model for Health	P	Systematic Training for Effective Parenting (STEP)
T	Mindfulness	P	TCU Mapping - Enhanced Counseling
P	Minor in Possession Program	P	Teen Intervene
T	Moral Reconation Therapy	T	Thinking for a Change
P	MOST Social Norming Campaign	P	TIPS Training
T	Motivational Enhancement Therapy (MET)	T	Tobacco Cessation

Table 6: Continued…

Focus	Evidenced Based Practices	Focus	Evidenced Based Practices
T	Motivational Interviewing	P	Too Good for Drugs (TGFD)
T	Narrative Therapy	P	Too Good for Violence (TGFV)
P/T	Nurturing Parents	P	Too Smart to Start
P	OJJDP: Strategies for Success	T	Trauma Informed Care
T	Partners for Change Outcome Measurement System	T	Trauma Recovery & Empowerment Model (TREM)
P	Party Patrols	P	Truancy Prevention and Intervention Eaton RESA
P	PATHS	P	Tutoring and Mentoring Services
P	Peer Assisted Leaders (PALS)	P	What's Good About Anger
P	Positive Action	P	Whole School, Whole Community, Whole Child
P	Prime for Life		

*T=Treatment; P=Prevention

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 [8] 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, 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

[8] 42CFR438.206(b)(iii) "The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services."

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). 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).

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. MSHNs CMHSPs and SUD treatment providers conduct a self-assessment regarding trauma-informed competence and develop goals for their organizations to become more trauma informed in the supports they provide. Providers participate 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 (SUD): MSHN maintains a plan for the implementation of Recovery-Oriented Systems of Care (ROSC) which 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. Initiatives included Project ASSERT, Peer Recovery Coach training and development, Community Recovery Networks, and Recovery Housing.

Standard Assessment (SUD): The pursuit of a single statewide substance use disorder assessment that is based on ASAM levels of care as defined under the CMS-approved 1115 waiver continues. Currently the GAIN I-Core is approved though training and certification is paused while the PIHPs await a response from BHDDA regarding the use of an alternative - the ASAM Continuum assessment. Using a collaborative, iterative process over the course of many months, the PIHP SAPTR Directors and PIHP CEOs conducted thorough research into the existing ASAM-compliant (or ASAM-based) adult assessment instruments across a number of key dimensions, the most important of which were a DSM diagnosis, ASAM Level of Care output, and standardized based on research. SAPTR Directors solicited and used Provider Alliance input as well as input from MDHHS/BHDDA/OROSC personnel and reached consensus on a recommendation for an alternative to the current GAIN-I Core standardized SUD assessment tool (adults) for statewide use. This final unanimous decision recommended to BHDDA was the ASAM Continuum which was approved by BHDDA. PIHPs must fully implement the assessment by October 1, 2021. MSHN will ensure an adequate training plan is established to ensure the provider network is qualified to administer the assessment.

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.[9] Medicaid enrollment, service penetration rates and community demand are key factors to consider.

Medicaid/Healthy Michigan enrollment

Over 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. Figures 2 - 4 show the Medicaid and Health Michigan enrollment trends for the mental health and SUD populations.

Figure 2: Total Enrollees vs. Served – MH

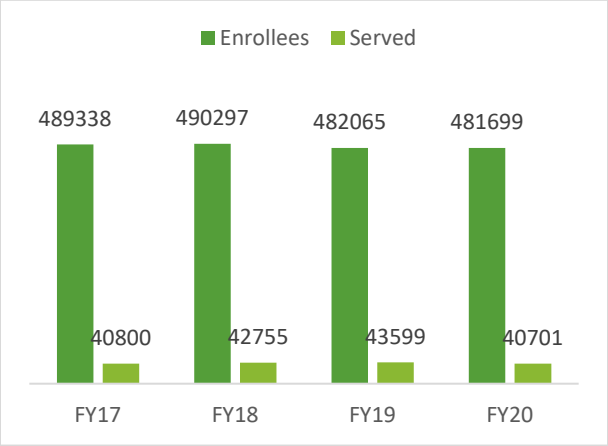


Figure 3: Total Enrollees vs. Served - SUD

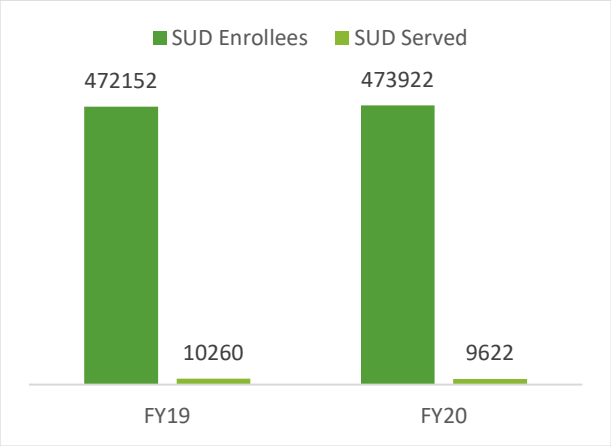
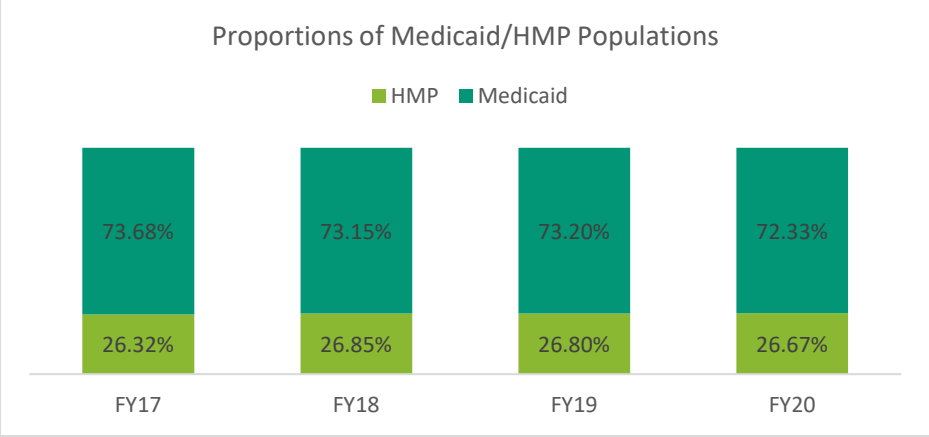


Figure 4: Proportions of Medicaid/HMP Populations

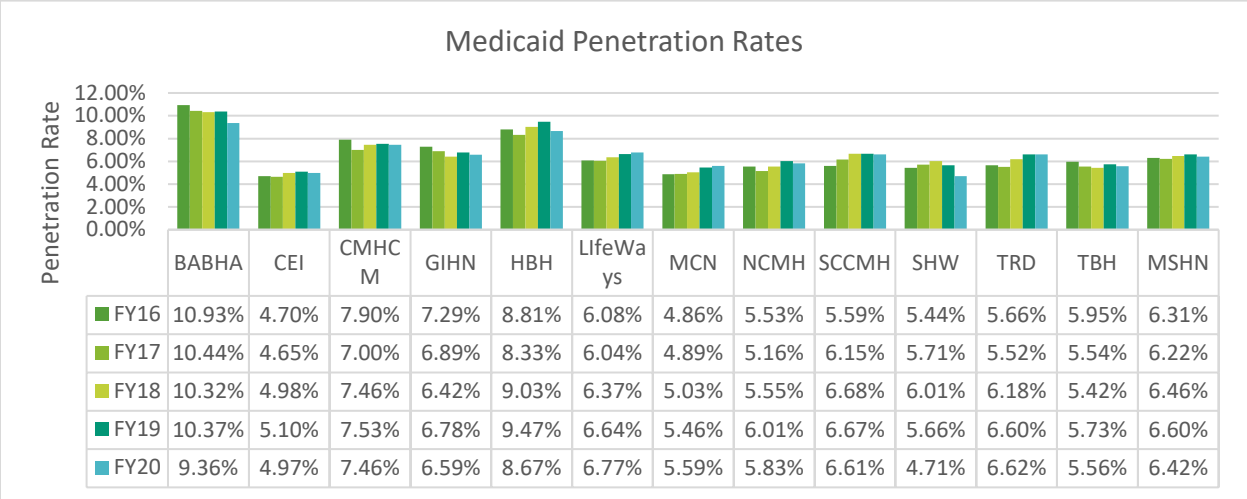


[9] 42CFR438.207(b)(1) "Offers an appropriate range of preventative, primary care and specialty services that is adequate for the anticipated number of enrollees in the service area."

Service Population Penetration Rates

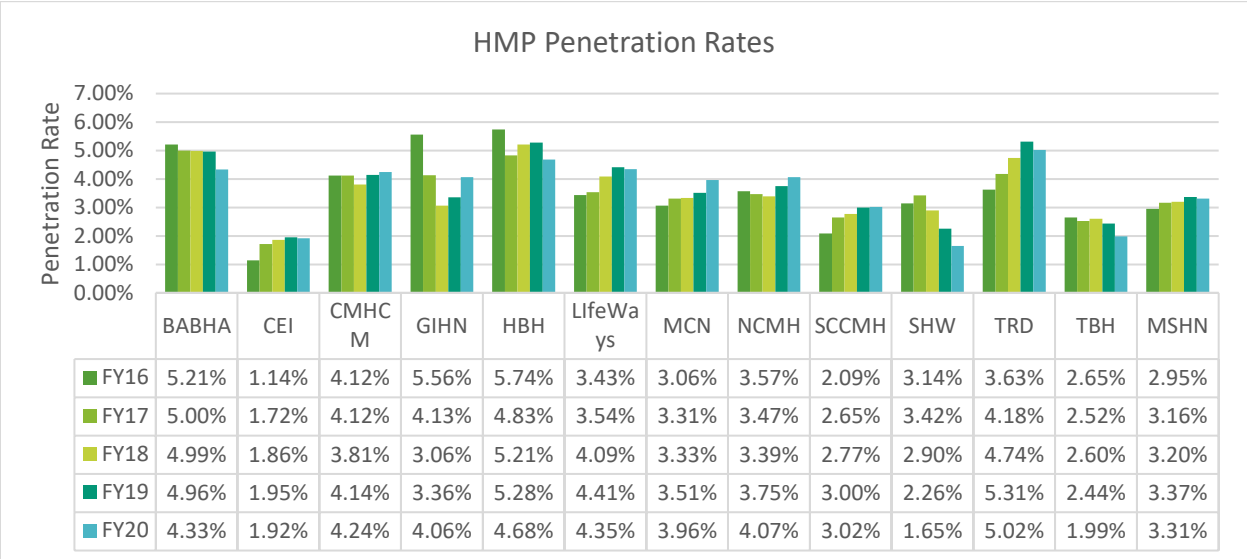
While the number of Medicaid enrollees is relatively stable, the number of enrollees seeking services is slightly increasing. This suggests service capacity should remain at or above existing levels and should not be reduced. Variability does exist among the CMHSP Participants in the region relative to population penetration rates, which is 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. Figure 5 and 6 shows the Medicaid and Healthy Michigan penetration rate per CMHSP by fiscal year. Figure 7 shows the number of consumers serviced.

Figure 5: Medicaid Service Penetration Rates[10]



	BABHA	CEI	CMHCM	GIHN	HBH	LIfeWays	MCN	NCMH	SCCMH	SHW	TRD	TBH	MSHN
FY16	10.93%	4.70%	7.90%	7.29%	8.81%	6.08%	4.86%	5.53%	5.59%	5.44%	5.66%	5.95%	6.31%
FY17	10.44%	4.65%	7.00%	6.89%	8.33%	6.04%	4.89%	5.16%	6.15%	5.71%	5.52%	5.54%	6.22%
FY18	10.32%	4.98%	7.46%	6.42%	9.03%	6.37%	5.03%	5.55%	6.68%	6.01%	6.18%	5.42%	6.46%
FY19	10.37%	5.10%	7.53%	6.78%	9.47%	6.64%	5.46%	6.01%	6.67%	5.66%	6.60%	5.73%	6.60%
FY20	9.36%	4.97%	7.46%	6.59%	8.67%	6.77%	5.59%	5.83%	6.61%	4.71%	6.62%	5.56%	6.42%

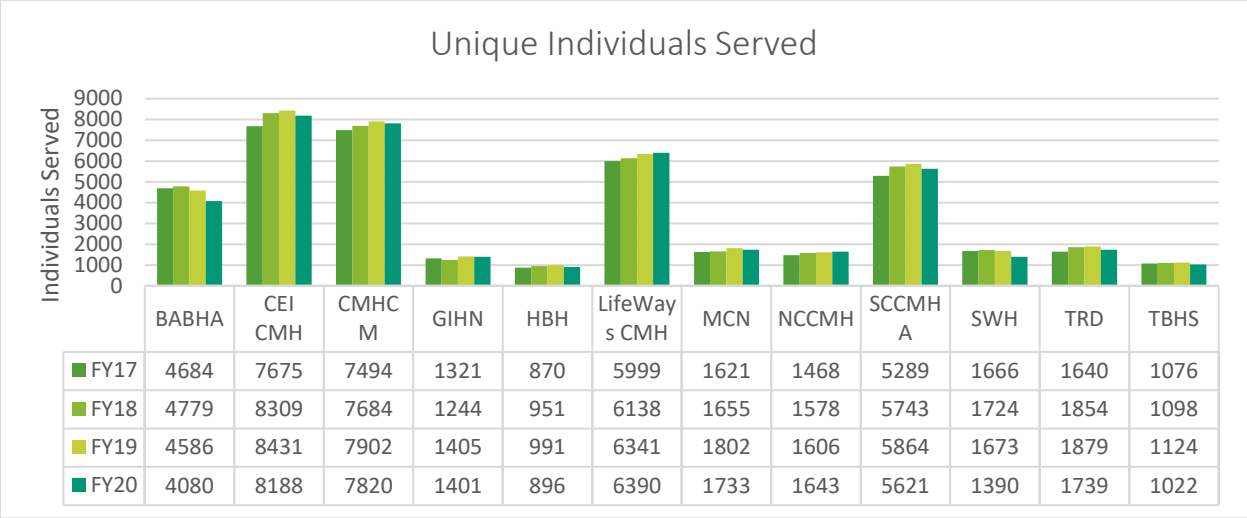
Figure 6: HMP Service Penetration Rates[11]



	BABHA	CEI	CMHCM	GIHN	HBH	LIfeWays	MCN	NCMH	SCCMH	SHW	TRD	TBH	MSHN
FY16	5.21%	1.14%	4.12%	5.56%	5.74%	3.43%	3.06%	3.57%	2.09%	3.14%	3.63%	2.65%	2.95%
FY17	5.00%	1.72%	4.12%	4.13%	4.83%	3.54%	3.31%	3.47%	2.65%	3.42%	4.18%	2.52%	3.16%
FY18	4.99%	1.86%	3.81%	3.06%	5.21%	4.09%	3.33%	3.39%	2.77%	2.90%	4.74%	2.60%	3.20%
FY19	4.96%	1.95%	4.14%	3.36%	5.28%	4.41%	3.51%	3.75%	3.00%	2.26%	5.31%	2.44%	3.37%
FY20	4.33%	1.92%	4.24%	4.06%	4.68%	4.35%	3.96%	4.07%	3.02%	1.65%	5.02%	1.99%	3.31%

[10] Source: MSHN REMI Penetration Report
[11] Source: MSHN REMI Penetration Report

Figure 7: Total Individuals Served by CMHSP[12]



	BABHA	CEI CMH	CMHCM	GIHN	HBH	LifeWays CMH	MCN	NCCMH	SCCMHA	SWH	TRD	TBHS
FY17	4684	7675	7494	1321	870	5999	1621	1468	5289	1666	1640	1076
FY18	4779	8309	7684	1244	951	6138	1655	1578	5743	1724	1854	1098
FY19	4586	8431	7902	1405	991	6341	1802	1606	5864	1673	1879	1124
FY20	4080	8188	7820	1401	896	6390	1733	1643	5621	1390	1739	1022

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 7.

Table 7: *Community Needs Assessment Priorities (Based on the Top Five Priorities per CMHSP Only)*[13]

Community Needs	Regional Priority	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Services for Individuals with SUD/ Co-Occurring Disorders	1	1	1		3	2			2	3	2	1	5
Community education, prevention, outreach	2-3		1	5	4/5		4	3		4		4	2
Services for Children	2-3		2	1	1	5	2						1
Integrated healthcare and health outcomes	4	4		2		4		1	3	5	1	5	
Ease of access to MH care	5		5			3			1	2	3	2	
Suicide Prevention	6				2		1				3	3	
Effect of Trauma	7	2			3				5	1			4
Staff Recruitment/Retention	8			3			5	2					3
Social Determinants of Health	9			4		1					4		
Affordable and Appropriate Housing; Homelessness	10		4				3						
Services to mild/mod MH needs; uninsured	11								4				
Alternatives to Inpatient Psychiatric Services	12-13	3											
Youth Suicide	12-13		3										
Transportation to MH services	14	5									5		

[12] Source: MSHN REMI Penetration Report

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

Across the region, services for individuals with substanc*e use disorders or co-occurring mental health and SUD disorders* continues to be the number one priority relative to unmet need, both due to increasing rates of occurrence and CMHSP preparations to increased integration of mental health and SUD services. *Community education, prevention, and outreach* and *Services for children* tied for the second priority. The third priority was *integrated healthcare and health outcomes*. *Ease of access to mental health care* was the fourth priority.

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. Appendix A 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.

Consumer Satisfaction

Consumer satisfaction with services is an important consideration when evaluating the adequacy of a provider network. MSHN assesses consumer perception of care for adults with mental illness utilizing Assertive Community Treatment, Outpatient Therapy, and Targeted Case management/Supports Coordination services and children with serious emotional disturbance receiving Home Based Services, Outpatient Therapy, and Case management/Supports Coordination. 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. The responses to the Access (to services) subscale for these services were relatively favorable, with less than 95% of youth and 91% of adults expressing satisfaction with access to services. An even higher level of satisfaction remains a goal for the MSHN region. The SUD provider network administers 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. With a comprehensive score of 4.58, this indicates general satisfaction with their treatment provider and the treatment they receive.

MSHN also conducts the Recovery Self-Assessment (RSA) to assist the provider network and other stakeholders develop a better understanding of the strengths and weaknesses in MSHN's recovery-oriented care. This report was developed utilizing voluntary self-reflective surveys completed by providers and administrators who provide treatment to individuals who experience mental illness and/or a substance use disorder. The assessments consisted of six (6) separate subcategories that included Inviting, Choice, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment. MSHN received a score of 3.50 or greater for each domain indicating satisfaction with the recovery environment.

Consumer satisfaction results are reviewed by the MSHN Quality Improvement Council, MSHN Clinical Leadership Committee, Provider Advisory Committee, and the Regional Consumer Advisory Council to determine if any trends are evident and if any regional improvement efforts would be recommended. Areas of improvement are targeted toward below average scores (>3.50) and/or priority areas as identified through review of the regional councils and committees.

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.

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 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.

MSHN and its CMHSP Participants are actively participating in MDHHS system assessments, individual participant surveys, provider surveys, heightened scrutiny work, provisional application processing, and corrective action plans. In FY17, MDHHS delegated increased responsibility for completion of the surveys to PIHPs. A combination of onsite and desk reviews is being completed to ensure ongoing HCBS compliance region wide. Sites found to be non-compliant with the HCBS rule must submit a corrective action plan to the PIHP to achieve full compliance by the March 2023 deadline; however, the state intends to stick to the March 2022 plan as identified in the State Transition Plan.

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[14]. 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

In addition to the services for mental health and SUD populations described within this assessment, MSHN is required by MDHHS to maintain a 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. CMHSP Participants operate a 24-hour access system, either directly or through a contractual arrangement with other CMHSPs. MSHN, CMHSP Participants and SUD Providers have met the following goals and continue to maintain network capacity to:

Establish, enhance, or expand relationships between the CMHSP and the SUD Provider system within the service are of the CMHSP so that:

- 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.
- The CMHSP and SUD service providers establish a written after-hours protocol for handling referrals during non-business hours.
- 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.

Engage in community coalitions and other substance use disorder prevention collaborative by:

- Identifying and assigning responsibility for one or more CMHSP-employed individuals to perform the function.
- Identify opportunities where existing mental health [prevention efforts can be expanded to integrate and/or support primary SUD prevention.
- 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).

MDHHS requires PIHPs to report indicators of access timeliness and inpatient follow-up. MDHHS, in coordination with the PIHPs and CMHSP participants, developed and implemented two new indicators to be reported for FY20Q3. The new indicators measure the percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service, and the percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. The pandemic has impacted individual's ability to access services. MSHN should continue to monitor access to timeliness to treatment. Table 8 shows the recent year-to-year performance of the 21-county region.

[14] Source: 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."

Table 8: State Performance Indicators for Access Timeliness and Inpatient Follow-Up

	Population	MSHN Score FY16 Q3	MSHN Score FY17 Q3	MSHN Score FY18 Q3	MSHN Score FY19 Q3	MSHN Score FY20Q3
New persons receiving face to face assessment w/in 14 days of non-emergency assessment (Standard: ≥95%) *NEW: New persons receiving a completed biopsychosocial assessment w/in 14 days of non-emergent request (Standard: NA)	MI-Children	98.72%	98.51%	99.05%	98.68%	79.72%*
	MI-Adults	99.29%	99.26%	98.98%	97.17%	74.15%*
	DD-Children	100.00%	97.30%	98.73%	96.12%	69.05%*
	DD-Adults	98.82%	100.00%	100.00%	96.55%	81.13%*
	Medicaid SUD	98.96%	98.39%	99.12%	98.22%	NA
	Total			98.99	97.86%	75.52%*
New persons starting on-going service w/in 14 calendar days of a non-emergent assessment (Standard: ≥95%) *NEW: New persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment (Standard: NA).	MI-Children	96.83%	96.98%	96.18%	95.50%	70.83%*
	MI-Adults	97.55%	98.25%	98.31%	97.17%	77.61%*
	DD-Children	96.36%	100.00%	100.00%	95.74%	71.74%*
	DD-Adults	96.36%	98.48%	100.00%	98.51%	76.74%*
	Medicaid SUD	100.00%	100.00%	97.19%	97.66%	NA
	Total			97.48%	97.04%	75.57%*
New persons during quarter receiving a face-to-face service for treatment or supports within 14 days of non-emergent request (SUD Only) (Standard: NA)	Medicaid SUD	NA	NA	NA	NA	92.59%
Persons discharged from psychiatric inpatient unit/ substance use disorder detox unit seen for follow-up care w/in 7 days (Standard: ≥95%)	Children	99.14%	99.22%	96.18%	100%	98.17%
	Adults	97.03%	96.97%	97.38%	97.36%	96.77%
	Medicaid SUD	100.00%	97.51%	98.78%	97.14%	97.78%
Persons readmitted to an inpatient psychiatric unit w/in 30 days of discharge	Children	6.31%	11.88%	7.29%	11.24%	16.06%
	Adults	9.35%	11.10%	9.59%	13.10%	14.30%

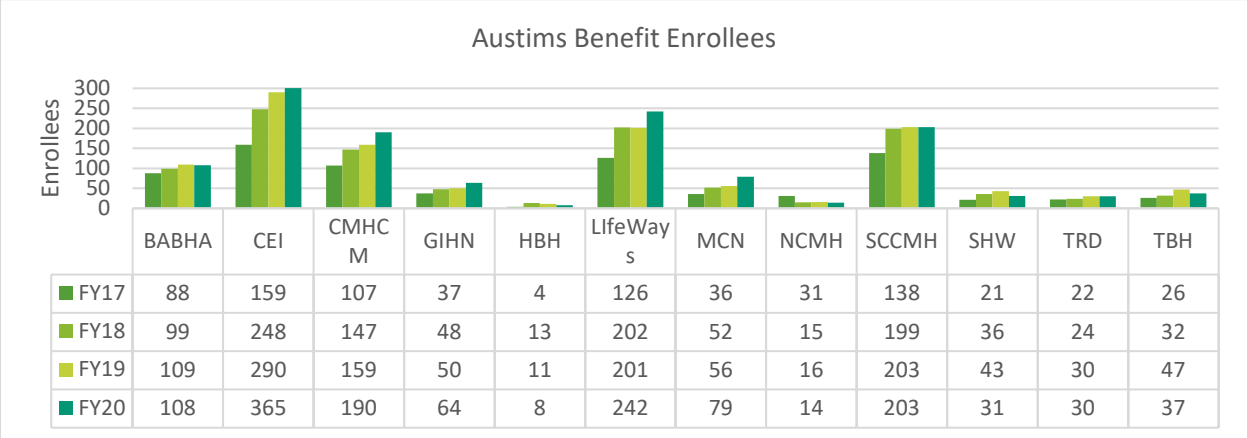
Sufficiency of Number of Providers: HCBS/Independent Assessment

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." 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." 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.

Sufficiency of Number of Providers: Autism Spectrum Disorder Capacity

Previous year's assessments 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. The region continues to establish contracts with additional 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. Figure 8 shows that most CMHSPs have experienced significant increases in Autism Benefit service enrollment in the past few years.

Figure 8: Autism Benefit Enrollees[15]

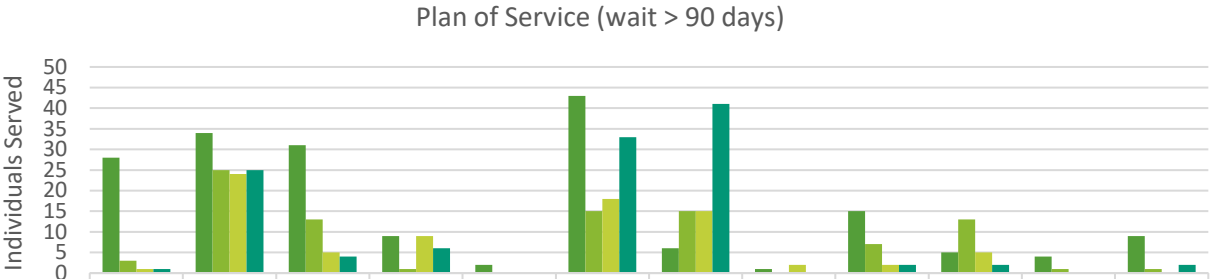


	BABHA	CEI	CMHCM	GIHN	HBH	LIfeWays	MCN	NCMH	SCCMH	SHW	TRD	TBH
FY17	88	159	107	37	4	126	36	31	138	21	22	26
FY18	99	248	147	48	13	202	52	15	199	36	24	32
FY19	109	290	159	50	11	201	56	16	203	43	30	47
FY20	108	365	190	64	8	242	79	14	203	31	30	37

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 Figure 9). 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.

[15] Source: MSHN Autism Report

Figure 9: Individuals with Autism Waiting Longer than 90 Days for a Plan of Service[16]



	BABHA	CEI	CMHCM	GIHN	HBH	LIfeWays	MCN	NCMH	SCCMH	SHW	TRD	TBH
FY17	28	34	31	9	2	43	6	1	15	5	4	9
FY18	3	25	13	1	0	15	15	0	7	13	1	1
FY19	1	24	5	9	0	18	15	2	2	5	0	0
FY20	1	25	4	6	0	33	41	0	2	2	0	2

Sufficiency of Mix of Providers: Cultural Competence

MSHN requires cultural competence training for staff and its provider network. Providers are empaneled in areas with concentrations of ethnic or cultural groups, such as the Latino counseling services available through the CEI provider network. Each CMH/SUD Provider 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.

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 telehealth services for key services which are in short supply, such as

[16] Source: MSHN Autism Report

psychiatric care. Additionally, the impact of the pandemic has resulted in the temporary expansion of allowable telehealth services. MSHN will continue to monitor telehealth expansion.

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

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 following these requirements.

Provider Wellness Profile

As part of the MSHN Strategic Plan, MSHN created forums for the MSHN Provider Network to discuss provider workforce concerns including but not limited to wellness/self-care, trauma (including secondary trauma and compassion fatigue), workforce safety, attraction, and retention of a well-qualified workforce. The Occumetrics survey was administered to the Substance Use Disorder (SUD) and Community Mental Health Service Participant (CMHSP) Provider Network in June of 2019. A total of 283 SUD provider employees and 1626 CMHSP employees (including subcontract providers) completed the survey, in part or whole. Subsequently, in July, Mental Health America of Franklin County conducted

[17] Source: 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."

several focus group forums around the region to delve into the survey results. A total of 37 SUD provider employees and 84 CMHSP employees (including subcontract providers) participated in the focus groups. MSHN will evaluate the results and feedback received through the various forums identified in the communication plan and develop regional priorities which will inform the strategic action planning relative to Better Provider Systems. The results may be found on the MSHN website.

Population Health and Integrated Care Plan

MSHN is committed to increasing its understanding of the health needs of individuals within its region and finding innovative ways to achieve the goals of better health, better care, better value, better provider systems, and better equity by utilizing informed population health and integrated care strategies. The MSHN population health and integrated care plan was developed to establish regional guidance and best practices in these areas as well as describe specific population health and integrated care initiatives currently underway in the MSHN region. The full plan may be found on the MSHN website.

Recommendations/Conclusions

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

1. 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.
2. Continue to assess and address the integration of mental health, substance use disorder and physical health care.
3. Continue to monitor and address changes to provider network capacity brought on by the implementation of the HCBS Final Rule and the State Transition Plan.
4. Continue to monitor SUD residential and withdrawal management needs in the region, more specifically Level of Care capacity.
5. Continue to discuss opportunities for regional action to address CMHSP identified issues with services for children.
6. Continue to support 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.
7. Continue to monitor network adequacy as it relates to the standardized SUD assessment; ensure an adequate training plan is established to ensure the provider network is qualified to administer the assessment.
8. Evaluate results from the Provider Wellness Profile to develop regional priorities which will inform the strategic action planning relative to Better Provider Systems.
9. Ensure accurate reporting of intensive crisis stabilization services to better assess capacity.
10. Monitor the impact of telehealth expansion.
11. Continue to monitor access to timeliness to treatment; ensure processes are established to accurately report data for new performance indicators.

Appendix A – CMHSP Efforts to Expand Service Capacity

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

CEI

- Added more therapists certified in trauma.
- Added prevention therapist.
- Added additional hours in the evening to serve youth and families.
- Created a Clinton Truancy Intervention Program.
- Piloting the Therapeutic Foster Care Oregon (TFCO) program, with four homes in operation
- Developed a mobile crisis team and became certified. It includes mobile Parent Support Partners. Added additional teams and days/hours.
- 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 including development of videos designed for parents who need access to emergency psychiatric care or other mental health services for their child.
- Offered Various Youth Mental Health First Aid courses.
- Introducing QPR training opportunities to the community.
- Convened a community group in a local community to address increased suicide rates of your adults from their community.
- Offering Transitional Youth Services.
- Hosted another Children's Mental Health Awareness Event.
- Trained additional staff on Critical Incident Stress Management, expanded the CISM Team and responded to multiple organization and community events.
- Implemented Care Coordination projects in clinical programs addressing asthma, hypertension, hepatitis, diabetes, and high Emergency Department Utilization.
- The Information Integration Committee developed and refined a Care Coordination Document for improved coordination with primary care physicians and 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. Over 200 Law Enforcement Officers from across Clinton, Eaton, and Ingham Counties were trained as of 2019.

- 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 maintenance 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.
- Participation on the MAT Team with Ingham County Health Department and Ingham County Sheriff Department on bringing MAT services to the jail.
- 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.
- Secured a Certified Community Behavioral Health Clinic Expansion Grant to expand care coordination and healthcare integration efforts.

CMHCM

Services for Individuals with SUD/COD

- We recently created an internal opiate workgroup to address better monitoring of opiate use disorders, medication management, safe medication storing and discarding
- We brought MAT providers into all 6 of our counties; 4 are co-located onsite
- We implemented process for MAPS use for all prescribers
- We have brought in training for staff on MAT, SUD, and COD, and will be bringing in additional training in the next fiscal year
- We have Narcan kits available and are giving them out to consumers who are at high risk of overdose. We also give them to community providers to have on hand (homeless shelter, universities, law enforcement, jails, etc.)
- We review all highest utilizers of emergency and crisis services, many of which are SUD/COD. We use a team approach for best practice and improved outcomes
- We implemented community treatment plans to have a consistent approach from multiple providers.
- We worked with local jails to bring in vivitrol to 3 of our jails so inmates can start MAT prior to release, with follow up care
- We are exploring possibility to contract for some recovery coach time in our offices and as part of our IDDT teams
- We are looking into having medication drop boxes in each of our office locations.

Direct Care Worker Recruitment/Retention

- Executive Director has shared with MDHHS a proposed strategy for improved training and pay opportunities for all DCWs
- We are exploring ways to improve training access for our DCWs
- We are working on being able to provide de-escalation management training to our provider network

Alternatives to inpatient psychiatric services
- We have strengthened our crisis intervention team to maintain our good outcomes with a high diversion rate
- We have contracted with more children and adult CRUs
- We used a consulting firm to do a feasibility study on bringing a CRU to our catchment area and did outreach with neighboring CMHSPs for potential partnerships
- We are working with local hospital system on potential arrangements for individuals who need care for symptoms related to SUD

Integrated healthcare and health outcomes
- We have an adult block grant for an integrated health dashboard that shows outcomes and monitors health indicators over time for consumers
- We have provided extensive training for our nurse care managers and case holders on integrated health practices, including case to care management
- We have implemented team huddles and will be working toward caseload alignment within our teams for improved team-based care
- We have utilized health data available from multiple platforms to address consumer needs
- We use ADT data and track it daily for follow up
- We have done outreach to our primary care practices to strengthen partnerships
- We have a co-located therapist in a local primary care office
- We have strong partnerships with care management with FQHCs in our area
- We have implemented healthy living opportunities in our local clubhouses

Ease of access to MH care
- We are looking at potential ways to improve our access system to be more consumer-friendly
- We have defined which individuals that will be opened using GF when Medicaid is not available
- We have done outreach to local providers, including universities, law enforcement, hospitals, EDs, community colleges to educate them about CMH services
- We have identified space in the community where we can see consumers afterhours to reduce unnecessary ED visits and for pre-booking jail diversion
- We are exploring other technology options to improve access to crisis services for individuals who do not have a telephone

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
- Contract with ACMH for a Youth Peer Support 20 hours per week
- Increase use of Mobile Children's Crisis through community education
- Increase school-based co-located therapist from 1 FTE to 2 FTE's and increase the number of schools served
- Collaborate with Gratiot/Isabella RESD and FQHC to utilize 31n funding to increase behavioral health in schools
- Promote new Critical Incident Stress Debriefing for Gratiot County
- Promote and increase consumers served for MAT
- Support staff SUD training and increase the number of staff with CADC and CAADC
- GIHN Service Committee continue reviewing high crisis and hospitalization services
- Complete an updated staff survey on Secondary Trauma
- Collaborate with Court, Jail etc. for treatment of juvenile and adults in legal system
- Enhance the GIHN Integrated Health Committee activities

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

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.
- Participating in Trauma-Informed Community initiative to raise awareness about the impact of ACEs and identify children and families in need of support.
- Expand number of children's clinicians trained in EDMR.
- Partner with local ISD under 31 N funding to bring additional mental health services into the school districts.

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

- Updating the SCCMHA website to bring suicide prevention up to the landing page for easy access
- Also participating with Covenant Health Care System in a suicide screening program and implementation of Mental Health First Aid throughout the community,

- Continue to participate in collaborative projects such as the MiHIA regional Opioid Taskforce, the regional Neonatal Abstinence Syndrome project and PA2 prevention project. for distribution of Naloxone
- Working with local resources to improve admission referral acceptance and to diversify crisis response options
- Additionally, SCCMHA has initiated a new QI workgroup to renew program of behavioral assessment and intervention with development of acute care protocol.
- Working with consumer stakeholders in focused access assessment and quality improvement projects.
- SCCMHA provides transportation to and from mental health appointments. However public transportation for all other daily life activities remains limited in this county. We will work with Alignment Saginaw the Saginaw Human Services Collaborative body to explore ways to improve access to transportation.
- Initiated a work group to impact the boarding of consumers in hospitals by working with two area hospitals to improve consumer wait time for hospital admissions.
- Data from our newly created Access and Stabilization for Children team (ASC), revealed significant increase in family engagement in services.
- Movement to value-based purchasing for supported employment.
- SCCMHA will be adding an additional children's team to help with increased need for services.
- We continue to provide respite services to support families.
- Added additional ABA providers to our network we went from seven providers to a panel of eleven.
- Participation in Child Parent Psychotherapy (CPP) training cohort. This is an intervention model for children ages 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including PTSD.

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.

TRD

- Have a full-time School Outreach Worker to increase the collaboration and referral rate from schools
- Partnered with Ionia Schools and have five master's 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.
  We are providing ABA services to Montcalm Care Network. We have homegrown three BCBAs and have one BCBA that came to us with their credentials. Total of four BCBAs
- Providing screening at the courthouse 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. PMTO, TRAILS provided in schools through School Outreach and School-based social workers. Child-Parent psychotherapy cohort certification.
- 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.
- Transitioning to direct providing Children's Mobile Crisis for Ionia County.
- 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 (Ionia County Council for the Prevention of Child Abuse). Parent partner available to families being served.
- Provide outreach at numerous housing complexes in Ionia County.
- Participate with the Ionia County Substance Abuse Coalition.

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 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.
- Additional staff have been trained in various Evidence-Based Practices for children.
- TBHS participates in case consultation meetings with Tuscola Probation every six weeks as it relates to coordinating treatment and care for children.
- TBHS expanded its ASD Provider Network to include an additional ABA provider.