MSHN

Mid-State Health Network

Assessment of Network Adequacy

2025

Reviewed by MSHN Leadership: April 2026

Reviewed by Provider Network Committee, Customer Service Committee, Clinical Leadership Committee, Regional Consumer Advisory Council, and Quality Improvement Council: April 2026

Approved by MSHN Operations Council: April 2026

Updated Plan Submitted to MDHHS: April 2026

Reviewed by MSHN Board of Directors: May 2026

Contents

Definitions 1
Background 1
Scope 2
COVID-19 Assessment 3
Individuals Served 3
Provider Closures 4
Assessment Updates 6
Meeting the needs of enrollees: expected service provisions 6
Appropriateness of the range of services 7
Independent CMHSP Network Analysis 7
Specialty Services within MSHN 10
Assertive Community Treatment 10
Case Management 11
Clubhouse Psychosocial Rehabilitation Programs 12
Community Living Supports 13
Crisis Services: Crisis Intervention 13
Crisis Services: Crisis Residential Services 13
Crisis Services: Intensive Crisis Stabilization Services (ICSS) 15
Enhanced Medical Equipment Supplies 16
Financial Management Services (FMS)/Fiscal Intermediary (FI) 17
Health Services: Medication Training 17
Health Services: Nutrition 18
Health Services: RN Services 18
Homebased Services 19
Homebased Services: Family Training Support 19
Homebased Services: Wraparound 20
Inpatient Psychiatric - Local Psychiatric Hospital 20
Occupational or Physical Therapy 22
Outpatient Partial Hospitalization 22

Peer Directed and Operated Support Services 23
Personal Care in Licensed Specialized Residential Setting 23
Prevention Services 24
Private Duty Nursing 25
Psychiatric Evaluation and Medication 25
Respite 26
Skill Building/Out-of-Home Non-Vocational Habilitation 26
Speech and Language Therapy 27
Supported Employment Services 27
Transportation 28
Treatment Planning 28
Parent Support Partners 29
Youth Peer Services 30
Single Case Agreements 30
Evidence Based Practices – Mental Health 31
Behavioral Health Treatment Services/Applied Behavioral Analysis 33
ABA Behavior Identification Assessment (97151) 34
Comprehensive Diagnostic Evaluations 34
Substance Use Disorder Services 36
ASAM Level of Care Analysis 36
Adolescent ASAM Level Detail: 00-17 years-of-age at time of service 36
Adult ASAM Level Detail: 18+ years-of-age at time of service 39
Service Location: 41
SUD Assessment 43
Medication for Opioid Use Disorder (MOUD) 44
SUD MOUD Regional Capacity (OTPs & OBOTs) 45
SUD Outpatient 45
SUD New and Established Patient Evaluation and Management 46
SUD Peer Services/Recovery Supports 46
SUD Residential Services 47
SUD Withdrawal Management 48
Evidenced Based Practices - SUD 48

Numbers and types of providers (training, experience, and specialization) 50
Trauma Informed Care 51
Recovery Oriented Systems of Care (SUD) 51
Adequacy of Services for Anticipated Enrollees 51
Medicaid/Healthy Michigan enrollment 51
Disenrollments 54
Service Population Penetration Rates 54
Community Needs Assessments: Priority Needs and Planned Actions 56
Consumer Satisfaction 58
Anticipated changes in Medicaid eligibility or benefits 58
Home and Community Based Services 58
Sufficiency of Network in Number, Mix and Geographic Distribution 59
Sufficiency of Number of Providers: Access Timeliness and Inpatient Follow-up 59
Timely Appointments 60
FY23 Maximum Time and Distance Standards 61
FY24 - FY25 Maximum Time and Distance Standards 63
Sufficiency of Number of Providers: HCBS/Independent Assessment 64
Sufficiency of Number of Providers: Autism Spectrum Disorder Capacity 66
Sufficiency of Mix of Providers: Cultural Competence 67
Sufficiency of Mix of Providers: Diversity, Equity, and Inclusion 69
Sufficiency of Mix of Providers: Consumer Choice 70
Accommodations 70
FY25 Health Home Expansion 72
Certified Community Behavioral Health Clinics 72
Substance Use Disorder Health Home (Formerly Opioid Health Home) 72
Behavioral Health Home 73
Appendix A – CMHSP Delegated Efforts to Expand Service Capacity 75
FY25 Recommendations: 87
FY26 Recommendations: 88

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(i) State Plan Amendment (SPA) services, services for adults with developmental disabilities enrolled in the Habilitation Supports Waiver program, and specialty behavioral health (mental health and substance use disorder) services under the Healthy Michigan Plan.

The 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, Respite Care, Skill-Building Assistance, Specialized Medical Equipment and Supplies, Supported Integrated Employment and Vehicle Modification. [1]

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 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.

Consistent with MSHN's strategic priority of "better equity," MSHN now includes within the scope of its Network Adequacy Assessment (NAA) efforts to determine if its provider networks are helping reduce health disparities or if they are reinforcing them. MSHN recognizes, for example, that national studies have identified disparities in Opioid Treatment Providers (OTPs) between White and Black patients in methadone dosing, drug tests and discharges. Therefore, the definition of network adequacy needs to

[1] www.michigan.gov/bhdda

extend beyond the number of providers, levels of care, and distance to any consumer living in Region 5 to include race, ethnicity and potential or actual barriers to equitable access to care. Network adequacy is not race-blind as evidenced, for example, in significant Region 5 disparities between Black and White patients following up after a psychiatric hospitalization (FUH) or between Black and White patients following up after an Emergency Department visit related to a substance misuse issue (FUA). It is within the scope of this NAA to investigate if MSHN's network adequacy includes offering providers who bring cultural competence and/or cultural humility to their interactions with all demographic groups within the region.

COVID-19 Assessment

Fiscal Year 2020 presented unique and unprecedented challenges for Mid-State Health Network (MSHN), Community Mental Health Service Providers (CMHSP), Substance User Disorder (SUD) providers and persons served, from the COVID-19 global pandemic. For many services, at the onset of the pandemic in Michigan in early 2020, utilization temporarily dropped; for other services, utilization increased. From 2020 through March 2023, Medicaid enrollment realized significant increases due to the hold on Medicaid redeterminations. As of April 2023, states had 14 months to complete a renewal for all individuals enrolled in Medicaid, the Children's Health Insurance Program, and the Basic Health Program. Therefore, enrollment progressively decreased from July 2023 however, individuals served increased.

Individuals Served

Figure 1: Individuals Served CMHSP

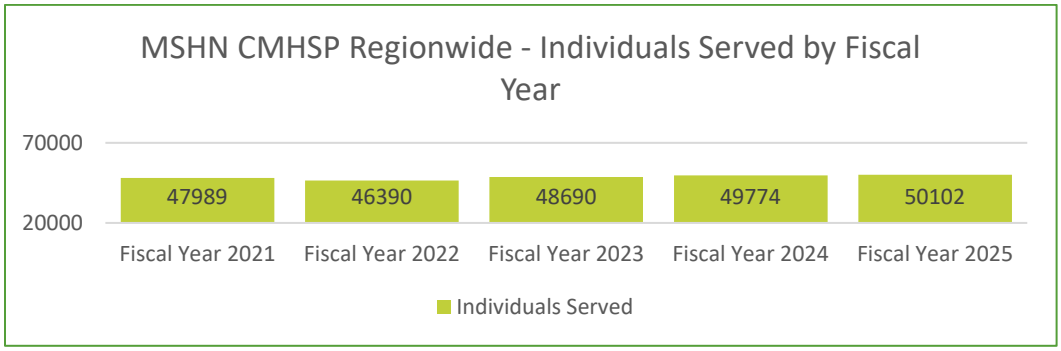
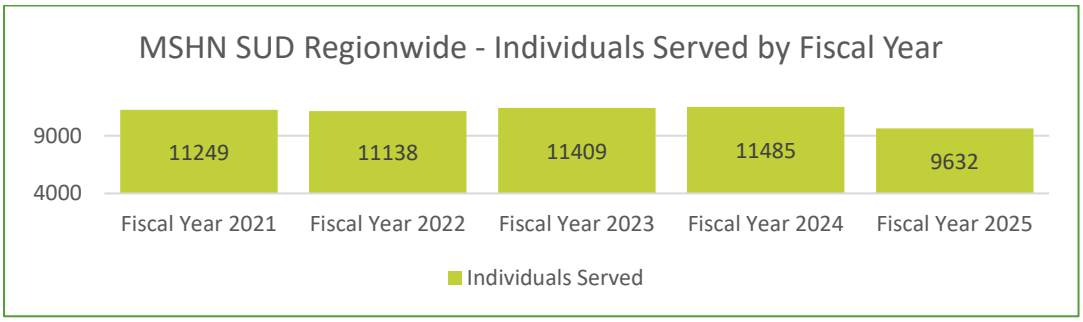


Figure 2: Individuals Served SUD



Provider Closures

MSHN monitors provider closures throughout the year assessing the impact related to beneficiaries served, transition of service providers and network capacity. The table below indicates the providers that closed during FY25, the type of provider, individuals in service at the time of closure notice and any impact on network adequacy. As noted in previous NAA results, children's crisis residential services continue to be a concern with limited network capacity.

Table 1: Provider Closures

MSHN FY 25 Network Adequacy Assessment

Provider Closures/Terminations Effective After 10/1/2024

Name of Provider	Date of Closure	Services Provided	Individuals Served	Impact on Network
Beacon Home at Sandhurst	3/14/2025	Crisis Residential	47	Assessing capacity to determine whether another RFP
Samaritas	11/24/2024	CLS / Respite	11 - 15	No Impact
Michigan Rehabilitation Services	10/1/2024	Employment Supports	45	
PPPS - Lansing Only	10/2/2024	SUD Outpatient	0	No Impact. Provider Location had not been able to support staff for an extended period of time.
Wedgwood Christian Services	4/1/2025	SUD Residential	2	Transferred Care to other SUD provider if applicable
Salvation Army	7/15/2025	SUD Resi - Withdrawal Mgt	6	Transferred Care to other SUD provider if applicable
List Psychogical - Pigeon	7/31/2025	SUD Outpatient	12	Transferred Care to other Provider locations if applicable
KPEP (Berrien and Calhoun)	1/7/2026	SUD Outpatient	0	No Impact: Provider locations have not served consumers for more than 1 year
Hope Network Behavioral Health-Robert Brown Crisis	6/30/2025	Adult Crisis Residential		
Hope Network- New Passages-Genessee CRU	9/4/2025	Adult Crisis Residential	1	
Milestones ABA Clinic of Michigan, LLC	12/6/2024	ABA Services	0	No impact.
Aidaly Care	1/4/2025	CLS	0	No impact.
Serenity House Residential Care Services	5/5/2025	Residential Type A	1	No impact.
Disability Network of Mid-Michigan	5/31/2025	CLS	16	No impact. Transferred to other providers.
Rose Hill Center, Inc.	8/25/2025	Residential Type A	2	No impact.
Acorn Health of Michigan LLC	8/31/2025	ABA Services	2	No impact.
Hickory Hollow Specialized Residential	9/30/2025	Residential Type A	1	No impact.
Disability Network of Mid-Michigan	5/31/2025	CLS	16	
BF Autism	6/13/2025	ABA Services	6	No impact. Transferred to other ABA providers, if applicable
Hopkins	9/30/2025	Residential Type B	7	No impact. Transferred to other providers.
REAL Results Autism Center	4/30/2025	ABA Services	5	No impact. Transferred to other providers.
RISE Center for Autism - CLS	6/13/2025	CLS/Respite	0	No impact.
Trisha Fenby	8/1/2025	Independent Facilitation	3	Continuing to work on expanding IF availability if CMHCM region
Poplar AFC	7/27/2025	Residential Type A	2	No impact. Transferred to other providers.
Pelcher II AFC	5/8/2025	Residential Type B	2	No impact. Transferred to other providers.
Personal Assistance Options	11/30/2025	CLS/Respite	22	No impact. Transferred to other providers
Owens AFC	12/31/2025	Residential Type A	2	No impact. Transferred to other providers.

MSHN FY 25 Network Adequacy Assessment				
Provider Closures/Terminations Effective After 10/1/2024				
ABA Connections	12/10/2025	ABA Services	9	No impact. Transferred to other providers.
Total Spectrum	11/7/2025	ABA Services	12	No impact. Transferred to other providers.
DBT Institute of MI, PLCC DBA DBT Institute	3/29/2025	Partial Hospitalization	0	No Impact as this is short term treatment. We refer to other providers. (Termination)
Strudwick & Strode Adult Foster Care Inc. - Strudwick AFC #5	9/4/2025	Residential	1	No impact. Transferred to other providers. (Termination)
Hope Network Behavioral Health Services - Cherry Valley	8/24/2025	Residential	0	No Impact. No CEI residents lived there at time of closure. (Closure)
Flatrock Manor, Inc. - Flatrock Manor of Whistle Stop	7/8/2025	CLS/Respite (SIP)	2	No Impact, only change was becoming licensed.
McLaren Health Care Corporation - McLaren Greater Lansing	4/1/2025	Inpatient Hospital	0	No Impact, location has new owner (Closure)
Havenwyck Hospital Inc. DBA Cedar Creek Hospital - St. Johns PHP	3/27/2025	Partial Hospitalization	0	No Impact as this is short term treatment. We refer to other providers.
Community Alliance	1/31/2026	Fiscal Management Services	115	
McLaren Health Care Corporation - McLaren Bay Region	9/30/2025	Inpatient Hospital	0	No impact. SCAs can be used. Provider did not close, but chose to not renew their agreeement due to "lack of volume."
McLaren Health Care Corporation - McLaren Flint	9/30/2025	Inpatient Hospital	0	No impact. SCAs can be used. Provider did not close, but chose to not renew their agreeement due to "lack of volume."
McLaren Health Care Corporation - McLaren Lapeer Region	9/30/2025	Inpatient Hospital	0	No impact. SCAs can be used. Provider did not close, but chose to not renew their agreeement due to "lack of volume."
McLaren Health Care Corporation - McLaren Macomb	9/30/2025	Inpatient Hospital	0	No impact. SCAs can be used. Provider did not close, but chose to not renew their agreeement due to "lack of volume."
McLaren Health Care Corporation - McLaren Northern Michigan	9/30/2025	Inpatient Hospital	0	No impact. SCAs can be used. Provider did not close, but chose to not renew their agreeement due to "lack of volume."
McLaren Health Care Corporation - McLaren Oakland	9/30/2025	Inpatient Hospital	0	No impact. SCAs can be used. Provider did not close, but chose to not renew their agreeement due to "lack of volume."
McLaren Health Care Corporation - McLaren Port Huron	9/30/2025	Inpatient Hospital	0	No impact. SCAs can be used. Provider did not close, but chose to not renew their agreeement due to "lack of volume."
Adventure USA Consultancy LLC - Lennox Hill Living	9/30/2025	Residential	3	Provider chose not to renew their agreement.
Abound Rehabilitation Services, Inc.-Abound Rehabilitation Services I	9/30/2025	Residential	0	No impact. No individuals were served at the time the contract was not renewed.
Abound Rehabilitation Services, Inc.-Lincoln Park	9/30/2025	Residential	0	No impact. No individuals were served at the time the contract was not renewed.
Jessica Wilcoxen	9/30/2025	Independent Facilitation	0	No impact. CMHA-CEI still holds one other contract for Independent facilitation. Provider chose to no renew.
ABA Connections	12/10/2025	ABA Services	3	No impact. Transferred to other providers.

Assessment Updates

MSHN updates its assessment of provider network adequacy on an annual basis as required by MDHHS. 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 within the time and distance standards
- 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 service provisions

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[2]. 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[3]. 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 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: Behavioral and Physical Health and Aging Services Administration (BPHASA) revised its network adequacy standards to address new requirements issued by Centers for Medicare and Medicaid Services (CMS), dated January 30, 2025, which states, at a minimum, each state must set time and distance standards. In January 2025 MDHHS revised the Network Adequacy Standards[4], which removed the requirement for PIHPs to conduct time and distance standards, indicating

[2] 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."
[3] 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."

[4] https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/BH-DD/Reporting-Requirements/ProcedureMDHHSNetworkAdequacyStandardsMedicaidSpecialityBehavioralHealthServices

MDHHS would be completing the analysis for the entire state of Michigan. Therefore, the time and distance standards utilized during this review are based on results received from MDHHS' analysis during 2025.

MDHHS has established population density standards for Assertive Community Treatment (ACT), Clubhouses, Crisis Residential, Home-Based Services and Wraparound for children, Opioid Treatment Programs, Intensive Crisis Stabilization Services, Respite Services, Parent Support Partners and Youth Peer Services, with additional standards added in 2026 (as informational only) for Community Living Supports, Skill Building, Partial Hospitalization, Targeted Case Management, Preadmission Screening, Outpatient and Autism service and evaluation, which have been 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; Children's Waiver Program; Children with Serious Emotional Disturbance (SED)
- Autism Benefit (EPSDT)
- SUD services funded by Public Act 2 and Block Grants

Independent CMHSP Network Analysis

MSHN has analyzed the independent CMHSP Provider Network sufficiency to ensure all Medicaid Specialty services are available as determined medically necessary. The following grid depicts the availability of services within each CMHSP network.

* Prevention Direct Service models noted in the graph below: The Michigan Mental Health Code indicates that the public mental health system "may" offer prevention services and does not specify how many or what types of "prevention direct services" must be offered by the PIHPs. Some of these services are also identified in the Medicaid Provider Manual as "…a State Plan EPSDT service when delivered to

[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."

children birth-21 years." Per MDHHS, they are evaluating the current Medicaid Provider Manual language and considering clarifications to policy requirements for prevention direct services.

Findings: After reviewing the CMHSP services grid below, MSHN finds that each CMHSP meets the expectations to provide services either directly, contracted or through a single case agreement as outlined in the Medicaid Provider Manual and as required by the Network Adequacy Standards. Some of the CMHSPs have been affected by staffing levels in their ACT programs. MSHN and those CMHSPs are working with MDHHS through exception request reports and corrective action planning to bring these programs back into compliance and consistency with the evidence-based practice.

Future expansion: While noted capacity exists within each CMHSP area, the following CMHs are in the process of a Request for Proposal (RFP).

- In FY25, TBHS had RFPs for Speech-Language Pathologist (SLP), Community Living Supports (CLS), Respite, Equine therapy, and music therapy.

Table 2: Mental Health Services Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GIHN	HBH	TRD	LifeWays	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	Per request	(Staffing low)
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
Child Therapeutic Foster Care			Grant		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
Community Transition Services *Coordinating when MDHHS is providing	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Intervention	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Residential Services	X	X	X	X	X	X	X	X	X	X	X	X
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	Per request											
Family Support and Training	X	X	X	X	X	X	X	X	X	X	X	X
Family Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Fiscal Intermediary Services	X	X	X	X	X	X	X	X	X	X	X	X

	BABH	CEI	CMHCM	GIHN	HBH	TRD	LifeWays	MCN	NCMH	SCCMHA	SHW	TBHS
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	Contract	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			Per request									
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
Non-Family Training	Per request	X	Per request	X	Per request	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	Per request	X	X	X	X	X	X
Out-of-Home Non-Voc Habilitation	Per request	X	X	X	X	X	X	X	Per request	X	X	X
Outpatient Partial Hospitalization Services	X	X	X	X	X	X	X	X	X	X	X	X
Overnight Health and Safety Support	X	X	X	X	X	X	X	X	X	X	Per request	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	Per request	Per request	Per request
Physical Therapy	X	Per request	X	X	X	Per request	X	Single case	X	X	Per request	X
Prevention Direct Service Models	X	X	X		X	X	X	X	X	X	X	X
• Child Care Expulsion Prevention		X	X							X		
• School Success Program *Youth intervention Specialist			X								X	
• Infant Mental Health-Prevention	X	X	X	X		X	X	X	X	X	X	X
• Parent Education	X	X	X		X	X	X	X	X	X	X	X
Pre-Vocational Services	X	X	X	N/A	X	X	X	X	Per request	X	X	X
Private Duty Nursing	X	X	X	SCA	X	X	X	X	Per request	X	X	X
Respite Care	X	X	X	X	X	X	X	X	X	X	X	X

	BABH	CEI	CMHCM	GIHN	HBH	TRD	LifeWays	MCN	NCMH	SCCMHA	SHW	TBHS
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	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
Therapeutic Overnight Camp	SCA	X	X	SCA	X	X	X	SCA	Per request	X	Per request	Per request
Transportation	X	X	X	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 FY21-FY25 for each specialty service. The information was collected from encounters reported or directly reported figures by the CMHSPs. **Programs below include an analysis where MDHHS has required a specific adequacy standard. For all others, the utilization trends will be combined as part of the analysis to determine adequacy.**

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 Team). MSHN's FY25 Ratio: 399,989 Total Adult Medicaid Enrollees to 13 teams. In order to meet the requirement, MSHN would need to have a total of 13.3 teams in-region. Average enrollees of 380,921 would require 12.7 teams. MSHN considers this requirement met with the exceptions noted above.**

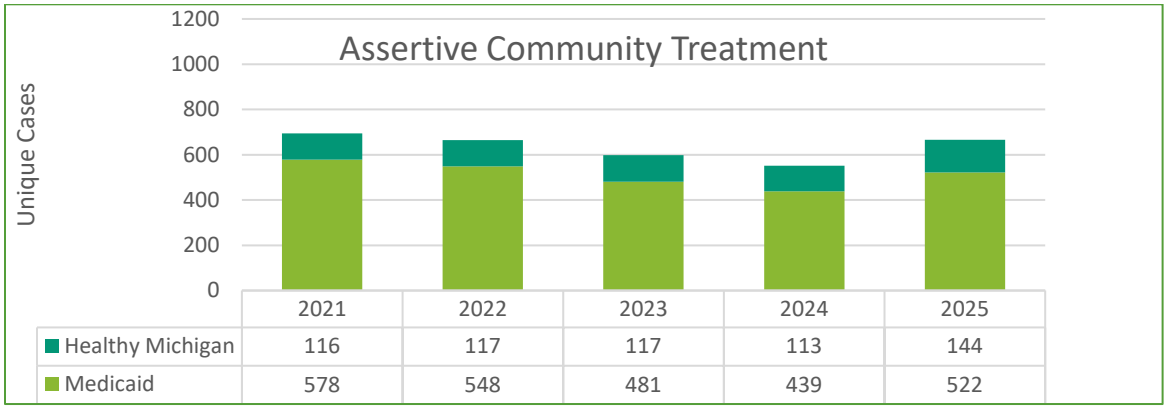
Four CMHSPs in the MSHN region do not directly provide ACT services; However, they have written agreements in place with other CMHSPs or other subcontractors that provide ACT services to ensure the availability of this evidence-based practice in each of their catchment areas. ACT is but one service that 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.

MSHN has experienced in parts of its region where, due to staffing shortages, the continued need for an exception to the ACT staffing model. Bay-Arenac Behavioral Health (BABH) and CMH Authority for Clinton, Eaton, and Ingham Counties (CEI) worked with MSHN to ensure that MDHHS received the exceptions requests. BABH had their full-time nurse leave the agency and their nurse manager provided

temporary coverage. Additionally, integrated dual disorder treatment was affected by the absence of a MCBAP-accredited staff. Efforts were made to find a staff person who met those requirements with at least a minimum of an approved MCBAP development plan. CEI also experienced a drop in staffing that resulted in combing their two ACT teams into one temporarily until qualified staff could be successfully recruited.

Lastly, data shows unique cases receiving ACT services are on the rise. FY25 reached the highest annual number served for persons covered by the Healthy Michigan Plan. Since FY21, this represents a 19% increase and since FY24, a 22% increase. While Medicaid numbers served steadily declined 32% since FY21, this trend was reversed in FY25, where there was a 16% increase. It is very likely that the increase in persons served was due to a few different factors. The demand for psychiatric hospitalizations, increased intensive community follow-up, and the lingering effects of the pandemic all contributed. Staffing shortages have compounded the issue but the CMHSPs have continued to aggressively identify and address core issues to continue serving persons who meet the level of care criteria for ACT services.

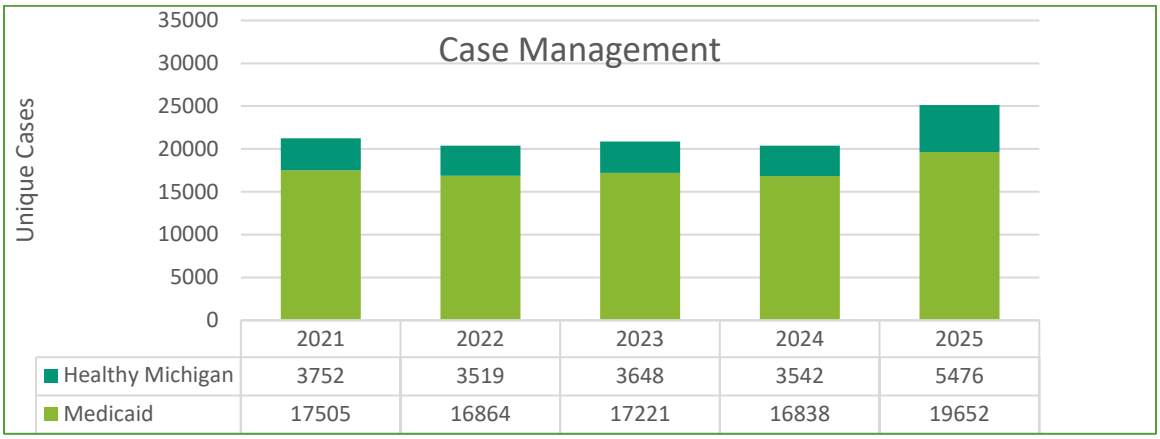
Figure 3. Assertive Community Treatment



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. Case management numbers served had been relatively stable/unchanged with a flat pattern over at least the last nine years between Healthy Michigan Plan (HMP) and Medicaid. However, in FY25, both coverages spiked. HMP was up 55% in FY25 compared to FY24 and Medicaid was up 17% in the same comparison. Since FY21, unique cases served by case management have gone up 63% for HMP and 26% for Medicaid. Originally, it was thought that this could have been due to number of persons being served was settling back into pre-COVID numbers, which was shown to not be the case. There have been a number of trends influencing this spike. It appears that case management related to Applied Behavior Analysis (ABA), Intensive Care Coordination with Wraparound (ICCW) and Certified Community Behavioral Health Clinics (CCBHCs) have impacted this increase. Through the CCBHC, participating CMHSPs note an increase via the mild to moderate population.

Figure 4. Case Management



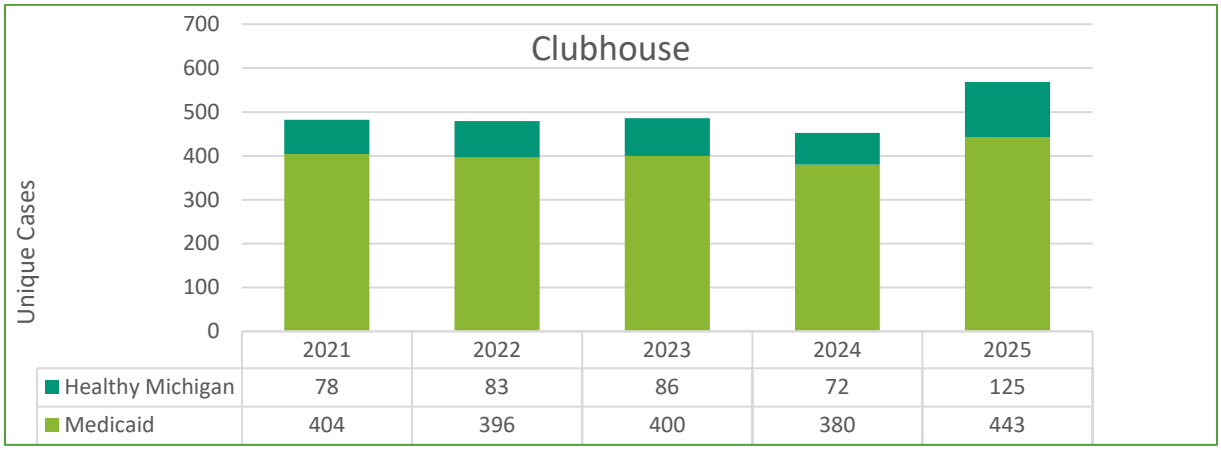
Clubhouse Psychosocial Rehabilitation Programs

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 8.9 clubhouse programs in the region, based on the number of *adult* enrollees. Currently, six CMHSPs have accredited clubhouse programs.**

While clubhouse is offered by six of the twelve CMHSPs, one of the six operates a second clubhouse program for a total of seven (Central operates two) in the region. Therefore, **MSHN's FY25 Ratio: 399,989 Adult MH Medicaid Enrollees to 7 Providers.**

Alternatively, ten of the twelve CMHSPs offer Drop-In Center activity with four CMHSPs offering both. For those CMHSPs without a clubhouse program (six) drop-in centers are offered. There were no new clubhouses added in FY25, but MSHN has implemented the clubhouse spenddown grant since FY21. This grant has focused on increasing opportunities for individuals with Medicaid spenddown to participate in clubhouse programming without any disruption to the important psychosocial rehabilitation service. Throughout implementation of this grant, the clubhouses have been asked to address what is going well and what has needed to be addressed in service delivery. This steady improvement and investment in improving processes have very likely had an effect that has included an increase in attendance.

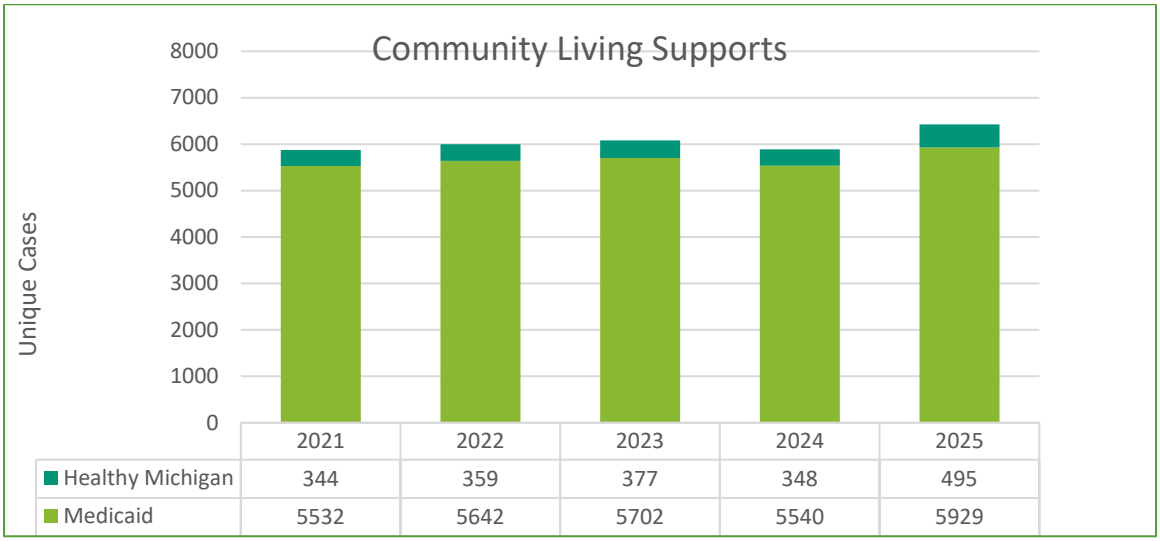
Figure 5. Clubhouse Psychosocial Rehabilitation Programs



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.

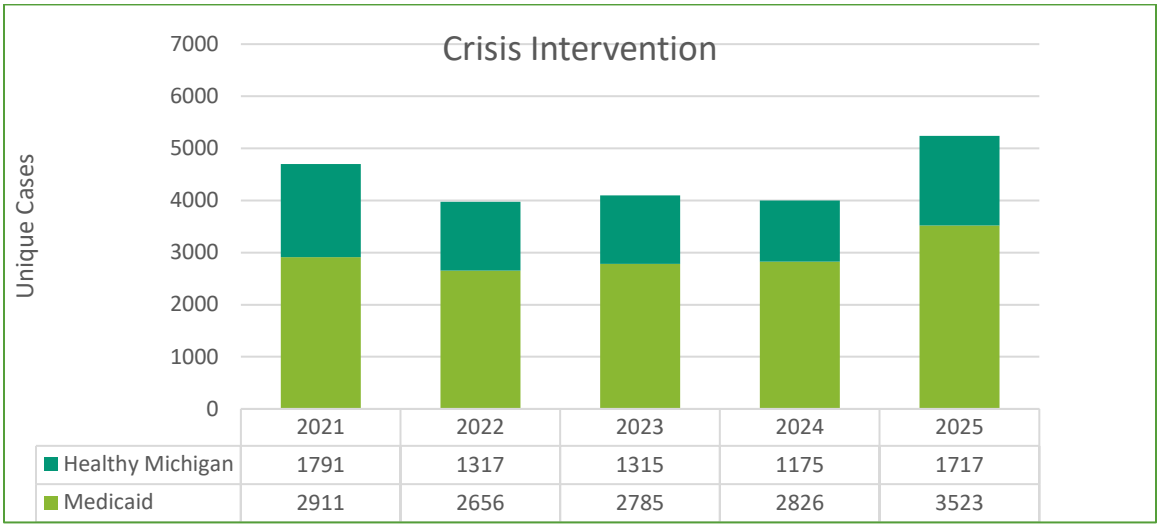
Figure 6. Community Living Supports



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.

Figure 7: Crisis Intervention



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 total population = 1,654,288 (2025 census), so the standard for MSHN is 53 adult beds and 26 - 40 pediatric beds.

MSHN has an inventory of 18 contracted crisis residential providers, with a total of 120 adult beds and of those 24 beds are designated pediatric. As a result, MSHN considers its adult capacity to be compliant with the published standard but just under the standard for pediatric beds. MSHN increased its adult capacity by 32 beds and pediatric capacity by 6 beds from FY24. However, as noted below is a closure of 6 beds for pediatric capacity.

MSHN continued its collaboration with Healthy Transitions, which is located in Alma, Michigan. In FY25, MSHN and Healthy Transitions focused on stability of its daily census as well as instituting a set of performance measures after a period of benchmarking their data. There are ongoing marketing efforts to ensure the region is aware of Healthy Transitions and is using them as appropriate. Bay-Arenac Behavioral Health, one of MSHN's CMHSP partners, has developed and is now using a six-bed crisis residential setting in Bay City, MI. This facility has been successfully licensed and approved to operate crisis residential services and has been open since October 2024. CEI CMH continues its work on a crisis stabilization unit which is underway and under development throughout FY25.

Pediatric Crisis Residential Beds: In FY25, this continued to be 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. In FY24, MSHN contracted with three Pediatric Crisis Residential Settings, including Beacon Crisis Residential Treatment Program at Sandhurst, Hope Network Safehaus, and Samuel's house. Each setting provides services to children and adolescents aged 5-17 SED primary and/or co-occurring. Beacon Sandhurst closed in early 2025, leading to the current regional deficit for adolescent/youth crisis residential services. In FY25, MSHN began work with a provider to develop a youth crisis residential program. This work was ultimately unsuccessful as the provider chose to take a different direction with its treatment program. Youth crisis residential services will continue to be a focus of the MSHN region.

Figure 8: Adult Crisis Residential Services

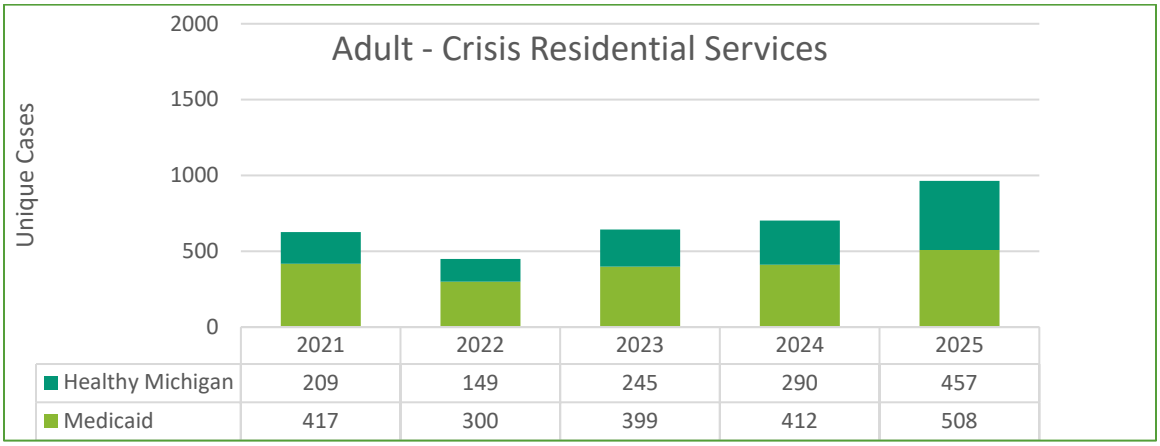
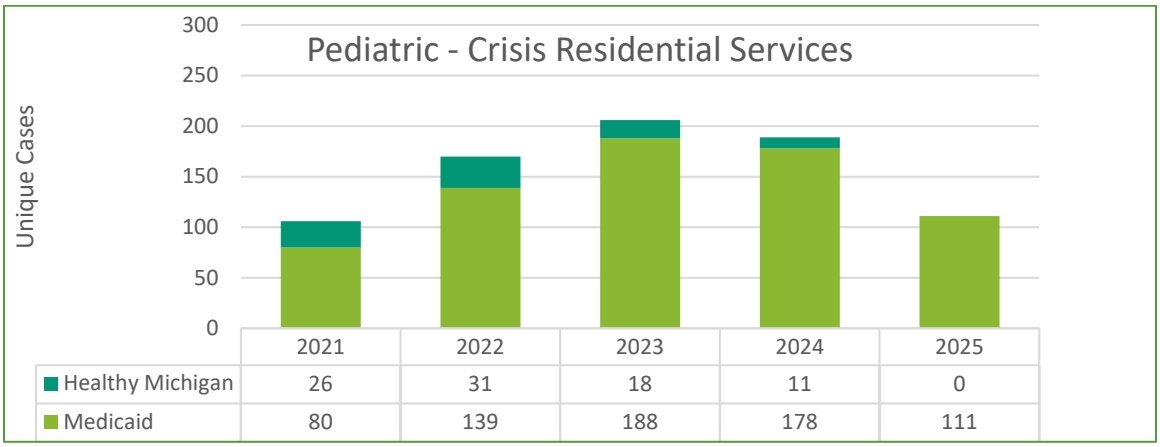


Figure 9: Pediatric Crisis Residential Services

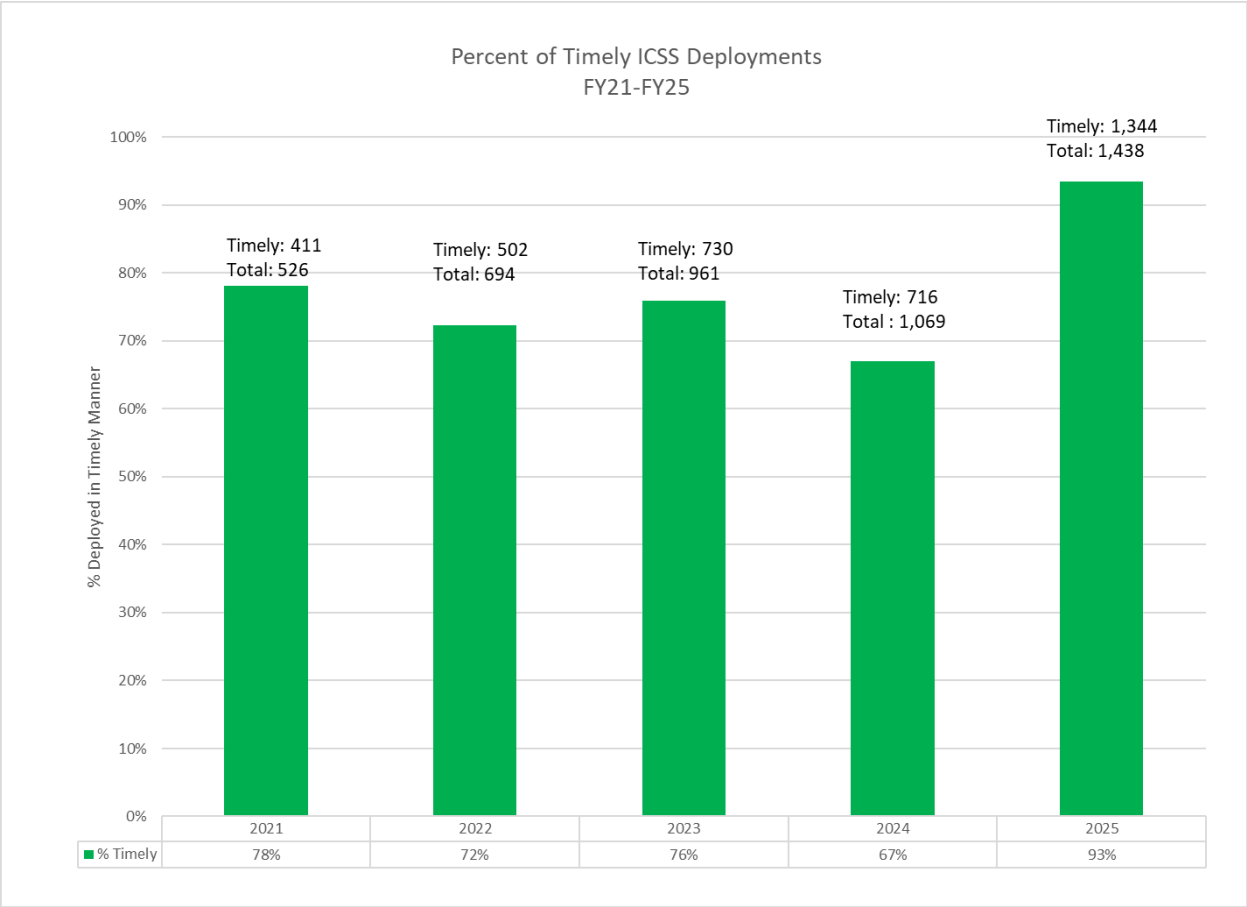


Crisis Services: Intensive Crisis Stabilization Services (ICSS)

Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term crisis alternative to inpatient psychiatric services. Services may be used to avert psychiatric admission or to shorten the length of an inpatient stay when clinically indicated. Children's ICSS are provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation 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). The region's CMHSPs submit annual ICSS data to MSHN on the performance of the program. Since formal data collection began in 2021, total calls received, and total calls deployed have increased each fiscal year, including FY25. Deployments were up 26% in FY25 and have increased 173% since FY21. For deployed calls, the standards are one hour for urban areas and two hours for rural areas. **The MSHN region's mean percentage of meeting the deployment timeframes was 94% for FY25.** The analysis of the data showed that performance was relatively stable with CMHSPs contributing slight drops in performance and one CMHSP contributing a higher drop. There was an improvement in timely deployments as well, with a 26.5% response rate. The region's CMHSPs are now sharing quarterly data about timeliness of ICSS deployments to requests in urban and rural settings to continue addressing timeliness of deployments.

MDHHS does not currently have an established adequacy standard, however in FY24, MDHHS added required reporting of monthly average Full-Time Equivalents (FTEs) and number of teams as informational only. MSHN reported 58.7 monthly average FTE's and 21.5 response teams in FY24. In FY25, MSHN reported 59.97 monthly average FTE's and 18 response teams.

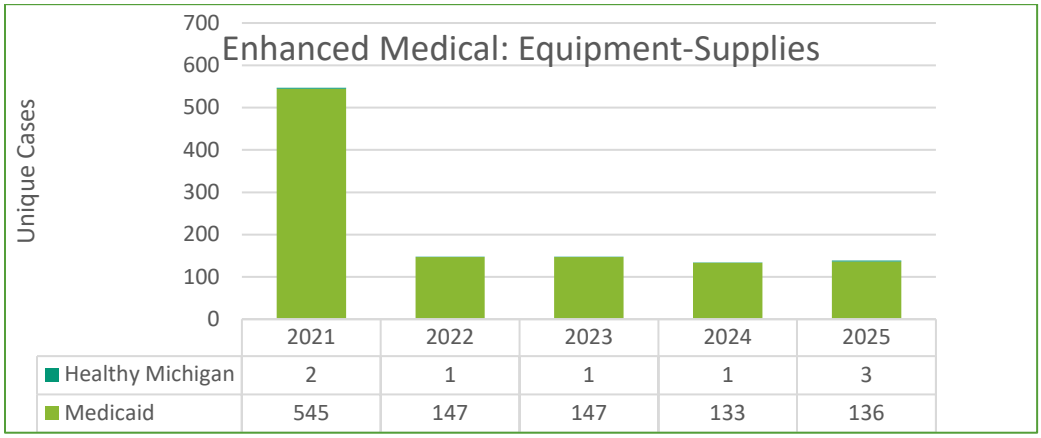
Figure 10: Intensive Crisis Stabilization Services



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 the person's abilities to perform activities of daily living; or to perceive, control, or communicate with the environment.

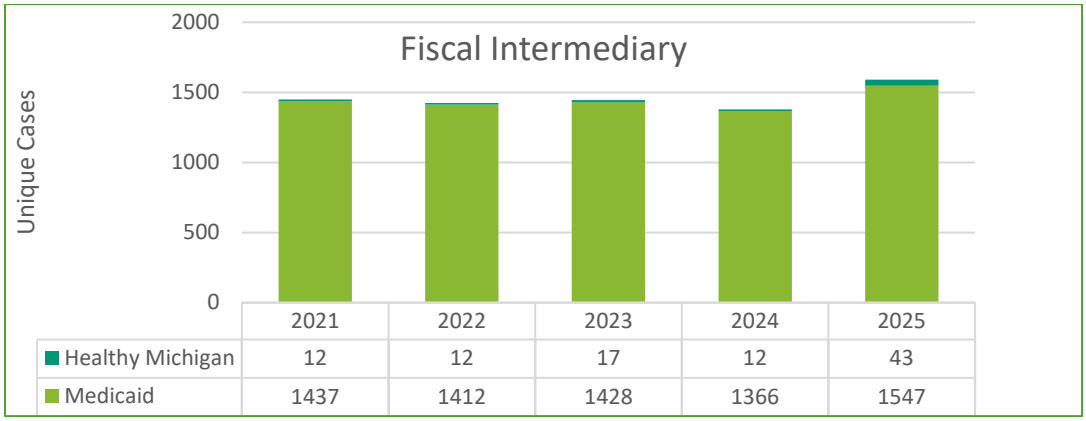
Figure 11: Enhanced Medical Equipment-Supplies



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

A financial management service/fiscal intermediary is an organization or individual independent of the CMH system that assists employers to manage the self-directed budgets. The FI 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-directed arrangement. The self-directed services technical requirement (January 2022) and implementation guideline published January 2022 states that *each CMHSP is required to contract with an FMS provider. Additionally, the PIHP must ensure there are two FMS providers within the region and ensure access to all impaneled FMS providers*[6]. MSHN meets this requirement with each CMHSP having one or more contracts with a FMS provider and the region has a total of 3 FMS providers.

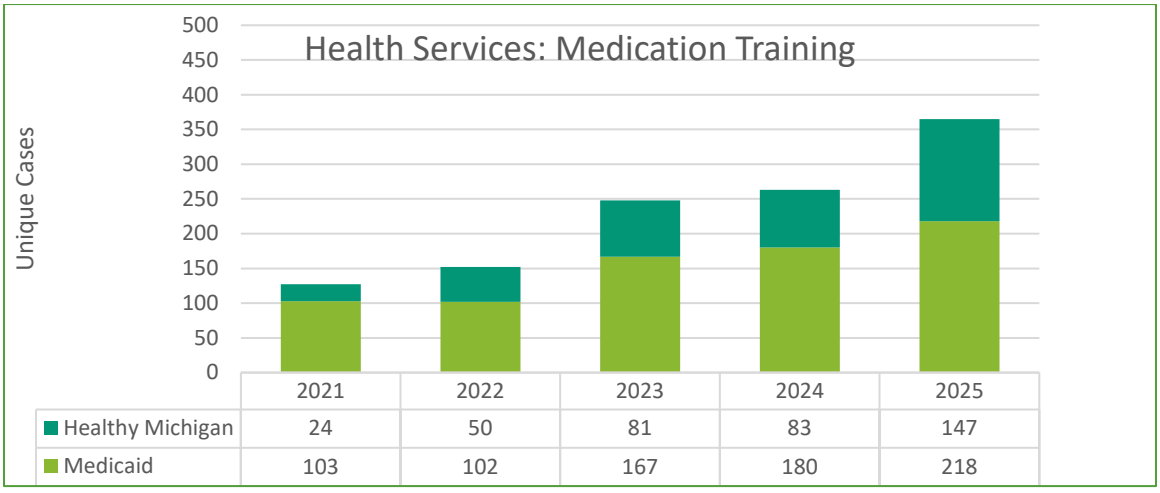
Figure 12: Fiscal Intermediary



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, education on medication and side effects.

Figure 13: Health Services: Medication Training

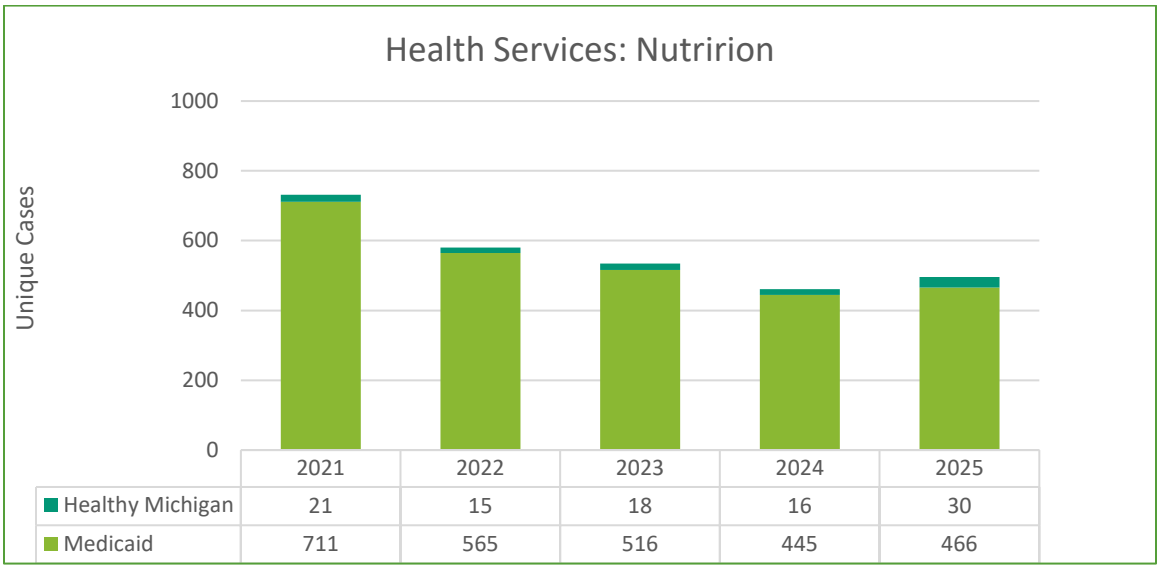


[6] Source: MDHHS Self-Directed Services Technical Requirements and MDHHS Self-Direction Technical Requirement Implementation Guide

Health Services: Nutrition

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

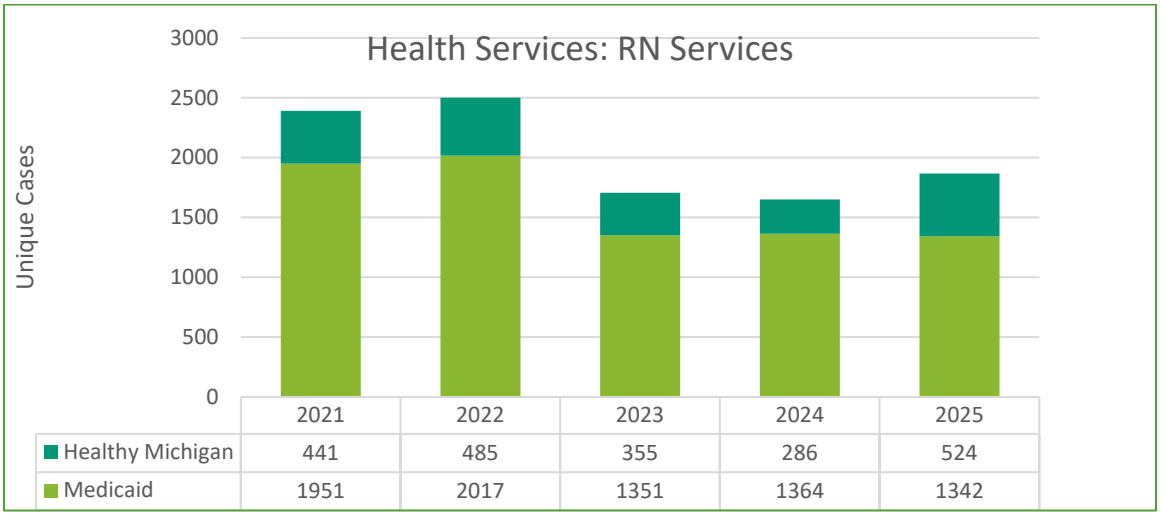
Figure 14: Health Services: Nutrition



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.

Figure 15: Health Services: RN Services



Homebased Services

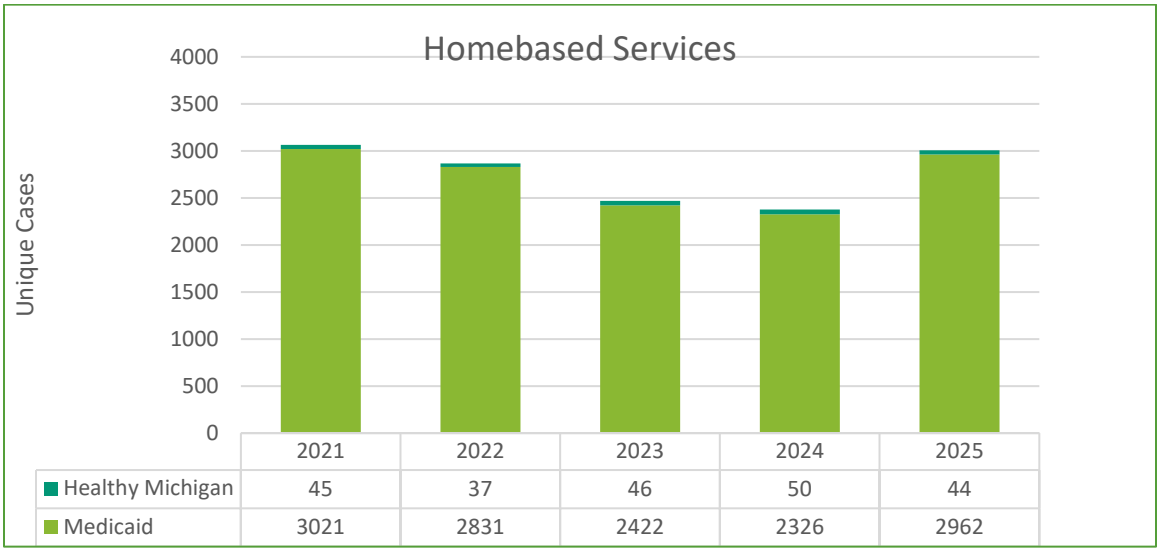
Homebased services provide assistance to children and their families with multiple service needs. The goals are to meet children's developmental needs, support families, reunite families and prevent out of home placement. **MDHHS has an established adequacy standard (2,000:1 Medicaid Enrollee to Provider Ratio). Home-Based services were verified through provider enrollment information to ensure compliance with educational standards of licensure and FTE designations. The published standard reporting for Homebased Services requires 88.78 FTEs Homebased therapists and staff for FY25. MSHN's FY25 Ratio: 177,562 Total Children Medicaid Enrollees to 160.25, which is over the required ratio of 88.78 FTEs.**

In April 2023, the CMHSPs underwent Home-Based program approvals through the MiCAL Customer Relations Management (CRM) system. Home-Based programs will continue to use the CRM for special program certifications against the three-year cycle. Program recertification is anticipated to occur again soon.

The MSHN partner CMHSPs have 13 Home-Based programs (LifeWays CMH operates two Home-Based programs), and of those 13, 1 (Montcalm) continues under provisional status despite undertaking many different strategies to stabilize their staffing situation.

Montcalm Care Network (Montcalm) remains under provisional status due to short-staffing situation, resulting in caseload ratios exceeding the acceptable standard of 12:1 (or 15:1 if there are families transitioning out of Home-Based services). They have also continued to institute a corrective action plan to ameliorate the deficit through case review and determining whether families are ready for program discharge, posting position availability at multiple sites and with universities, as well as enhanced loan forgiveness, competitive pay, staff support (i.e. culture of support), and internship program development. The 12 other MSHN CMHSP programs have continued to operate stably.

Figure 16: Homebased Services



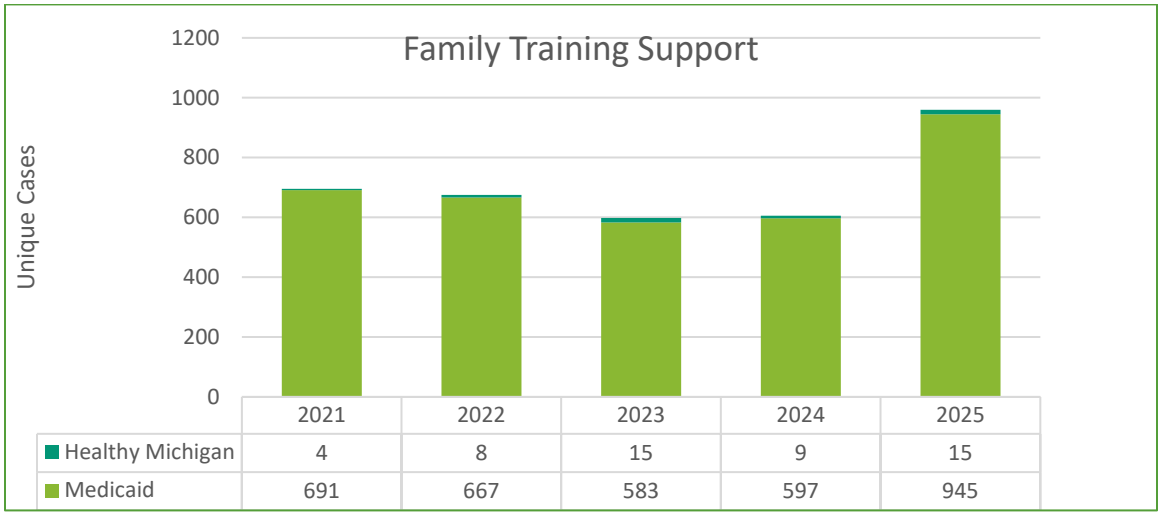
	2021	2022	2023	2024	2025
Healthy Michigan	45	37	46	50	44
Medicaid	3021	2831	2422	2326	2962

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.

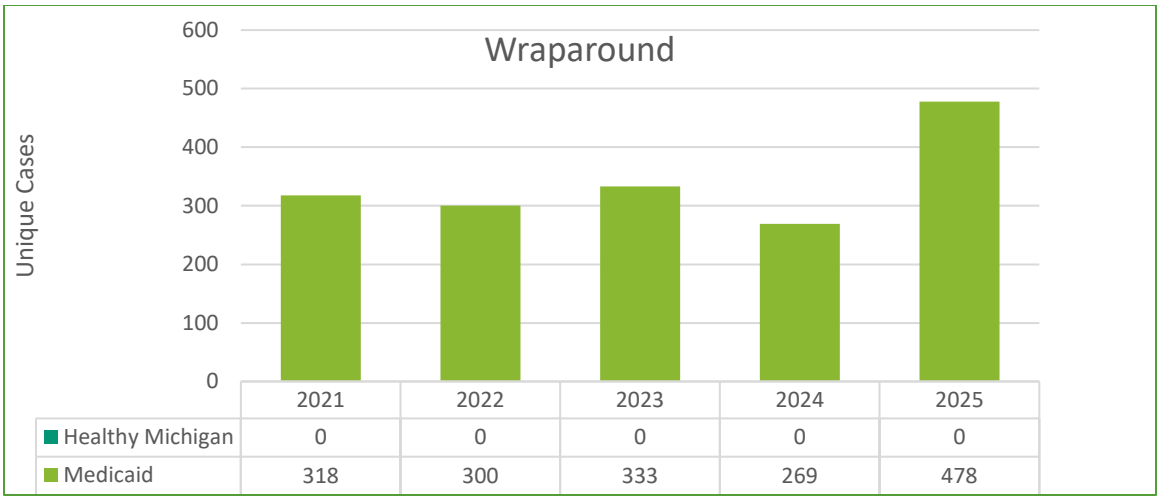
Figure 17: Family Training Support



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's FY25 Ratio: 177,562 Total Children Medicaid Enrollees to 43.32 FTEs, is over the required 35.51 FTEs**

Figure 18: Wraparound



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.

Figure 19: Inpatient Psychiatric: Local Psychiatric Hospitalization

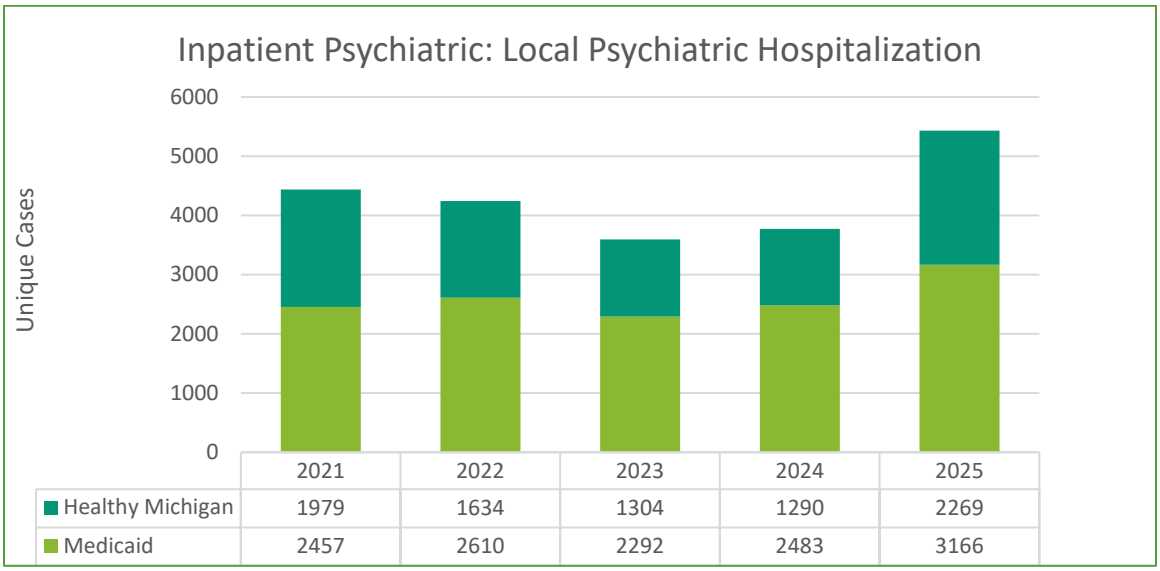


Figure 19a: Preadmission Screening for Inpatient - Adult

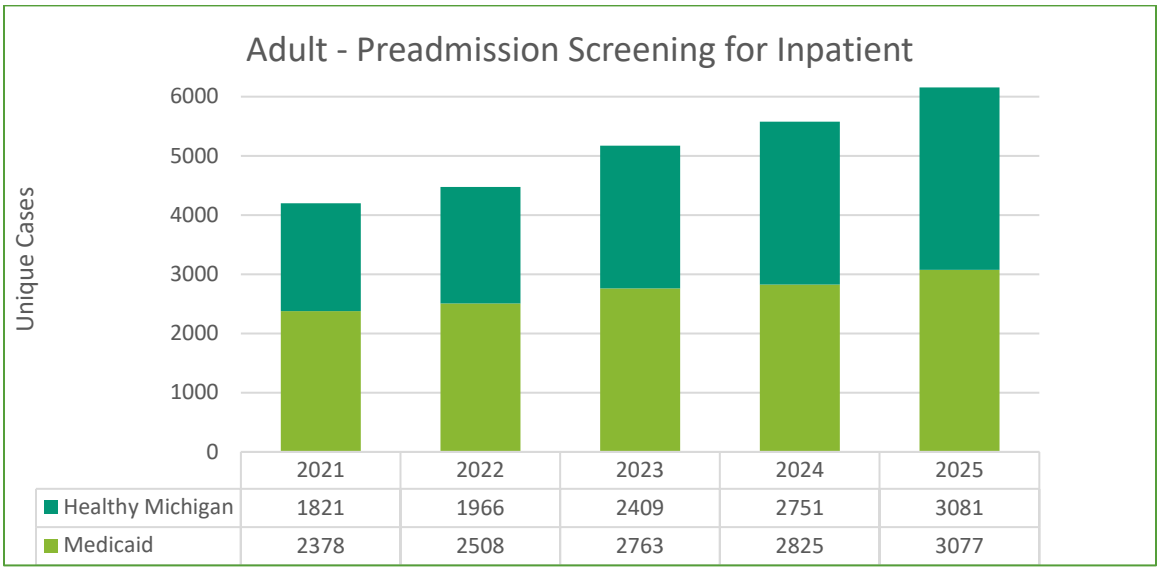
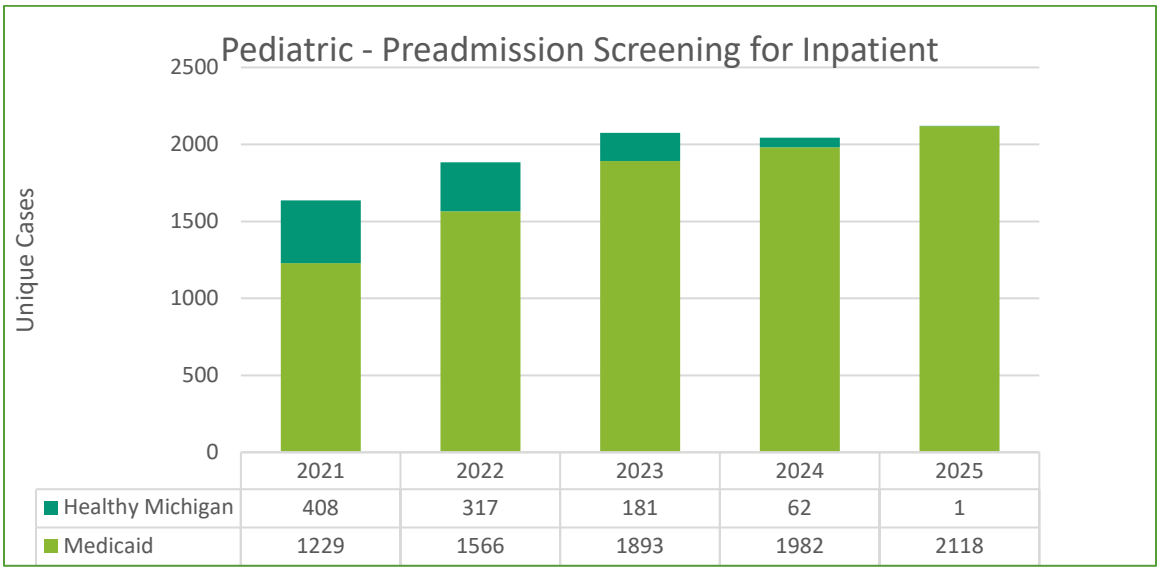


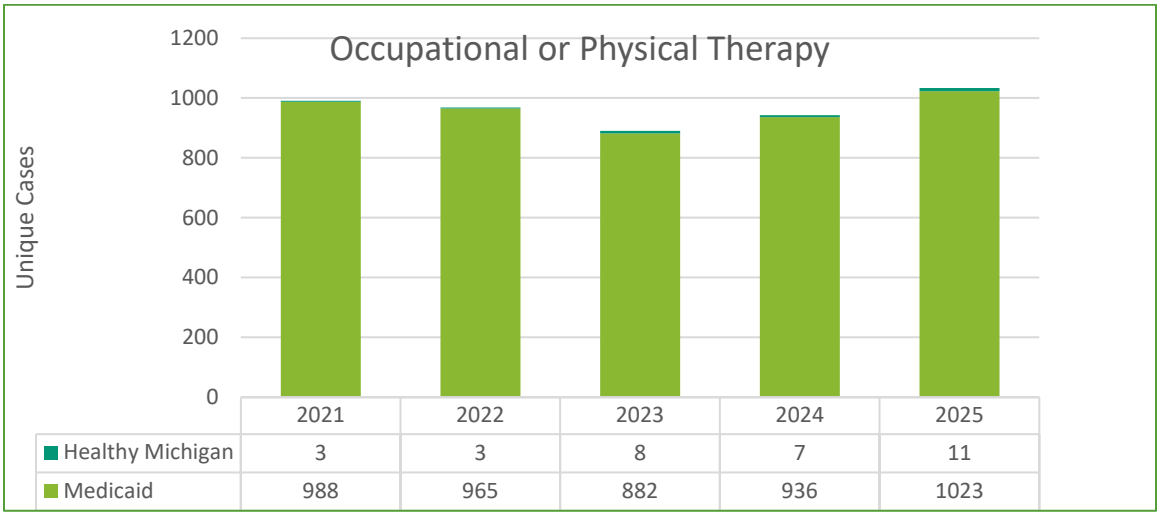
Figure 19b: Preadmission Screening for Inpatient - Pediatric



Occupational or Physical Therapy

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

Figure 20: Occupational or Physical Therapy

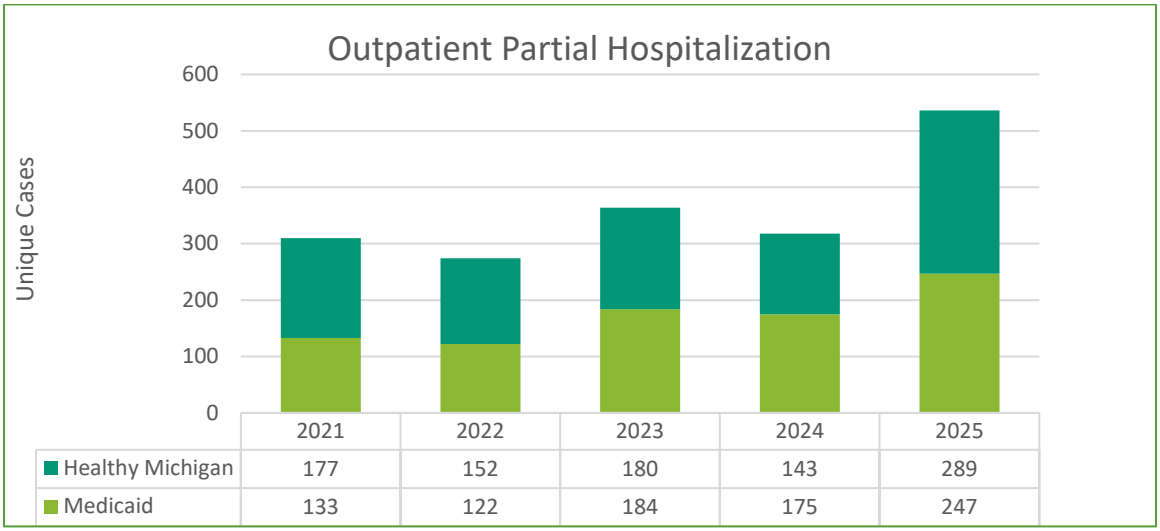


Outpatient Partial Hospitalization

Partial hospitalization program (PHP) 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. There has been an increasing trend where inpatient psychiatric units have been asking for PHP as a step down for some of their patients. Midland opened a PHP and there have been more requests. There is more awareness of this as an option and

crisis staff use it as an alternative when appropriate. LifeWays also added PHP between FY24 and FY25 which also increased cases.

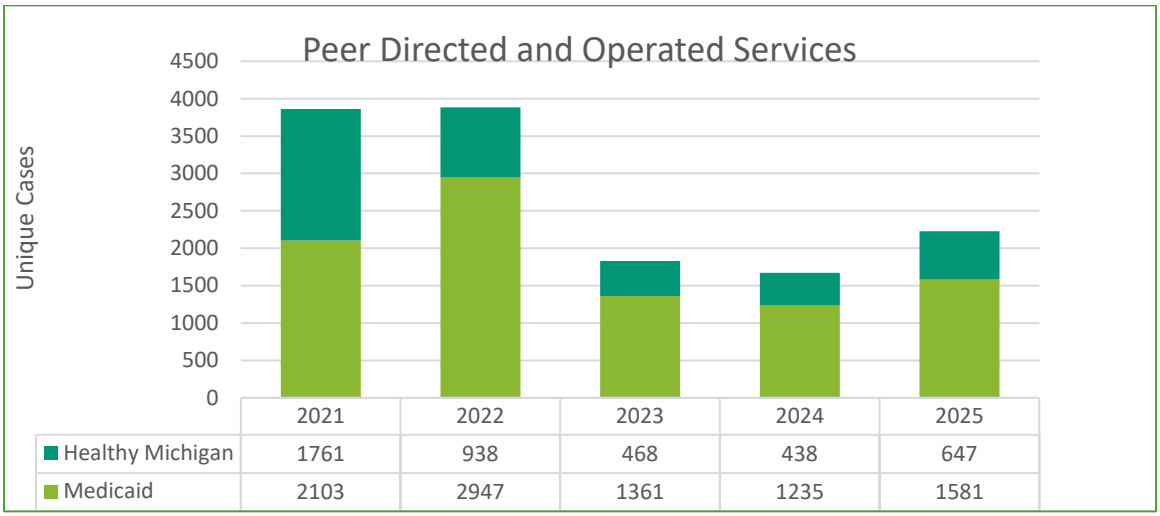
Figure 21: Outpatient Partial Hospitalization



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.

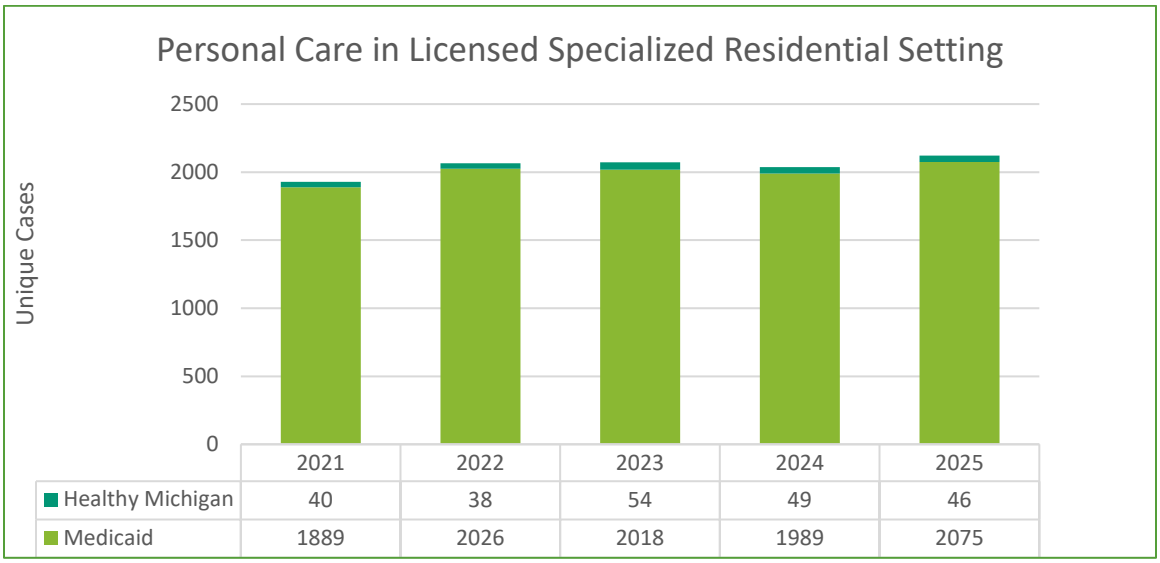
Figure 22: Peer Directed and Operated Support Services



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.

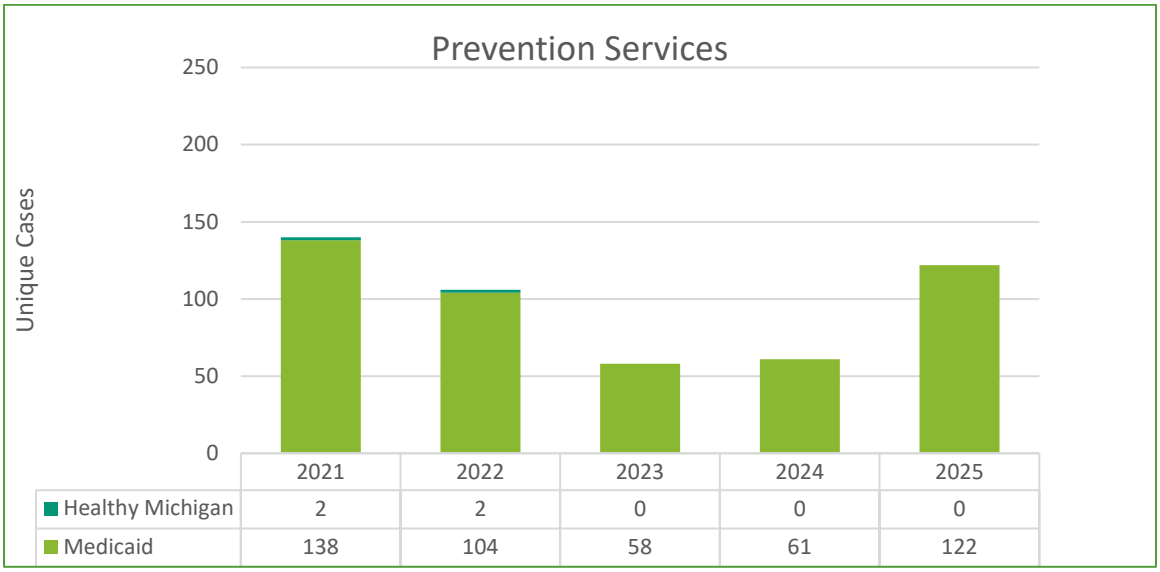
Figure 23: Personal Care in Licensed Specialized Residential Setting



Prevention Services

Services include school success, avoiding childcare expulsion, infant mental health, and parent education. There has been a continued decline in prevention services-direct model since the pandemic. The public mental health system can offer prevention services but there is no direction on how many or what types of services must be offered by the PIHPs. Additionally, some of these services are also identified in the Medicaid Provider Manual as "…a State Plan EPSDT service when delivered to children birth-21 years." In FY24, there was a greater emphasis on connecting youth and families to EPSDT services. The CMHSPs have focused on their specialty services especially due to staffing issues.

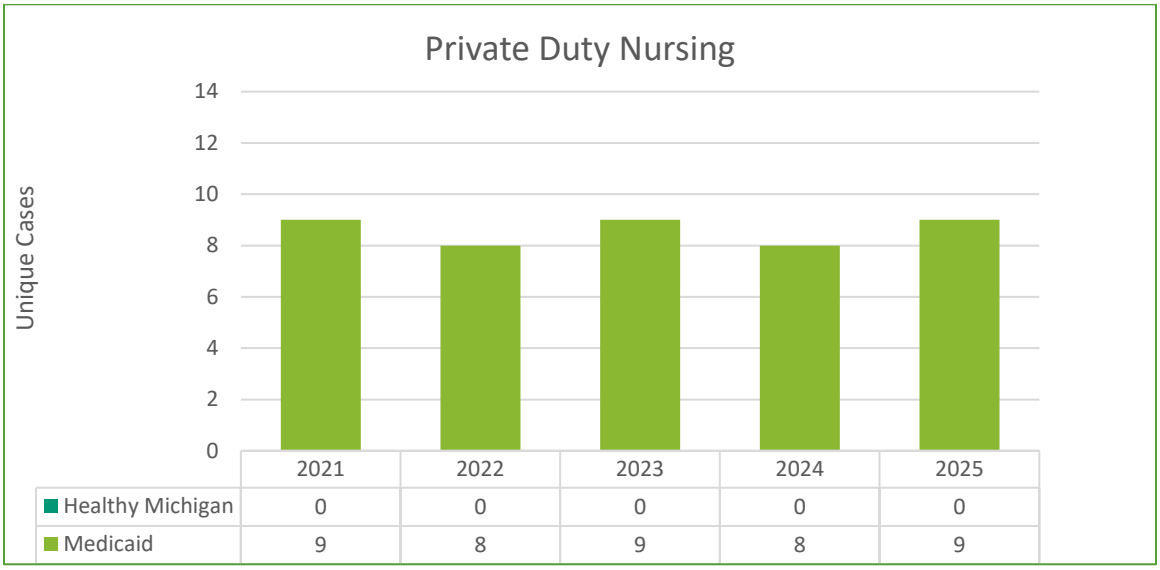
Figure 24: Prevention Services



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.

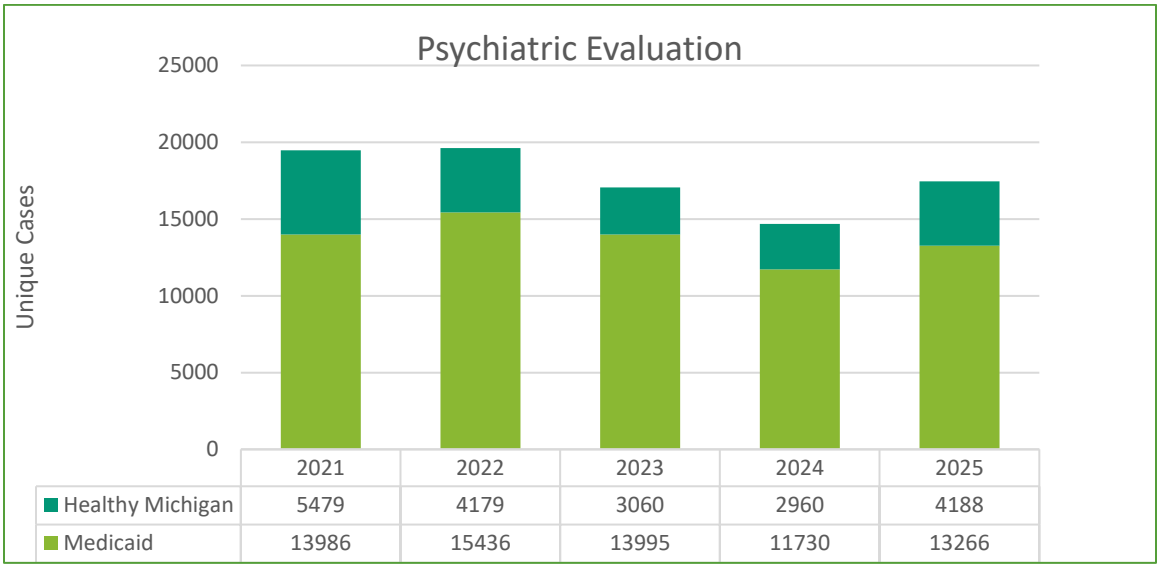
Figure 25: Private Duty Nursing



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.

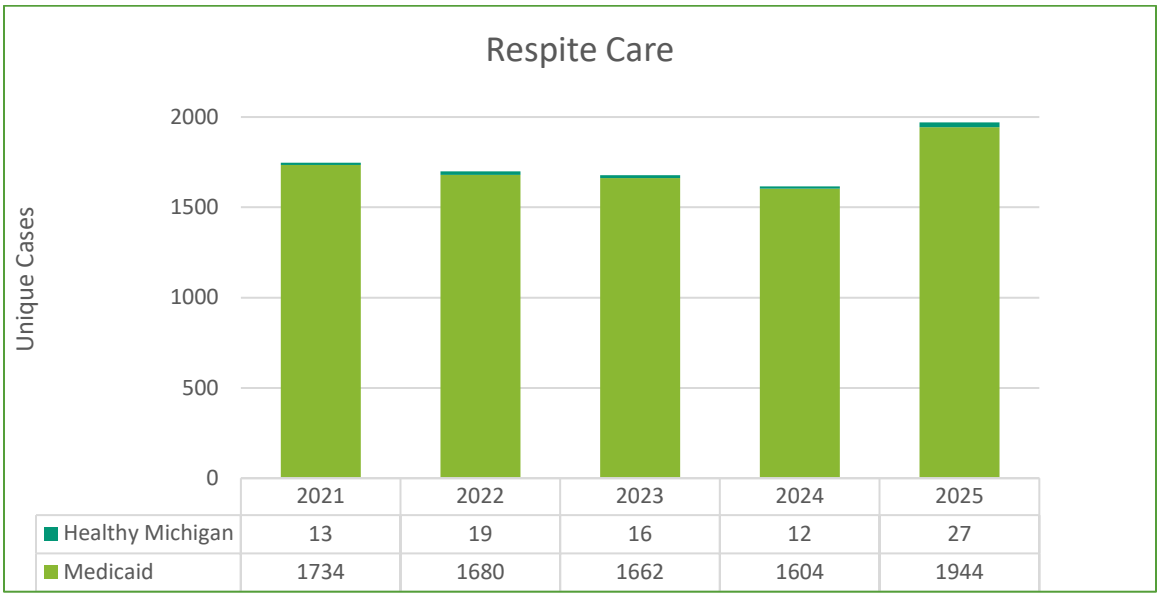
Figure 26: Psychiatric Evaluation



Respite

This includes daily respite care in out-of-home and in-home settings as well as therapeutic camping. **MDHHS does not currently have an established adequacy standard, however in FY24, MDHHS added required reporting of monthly average FTEs for direct care workers and total number of facility-based provider beds as informational only which has continued into FY25 reporting. MSHN reported 187.34 monthly average respite FTEs and 497 respite bed count.**

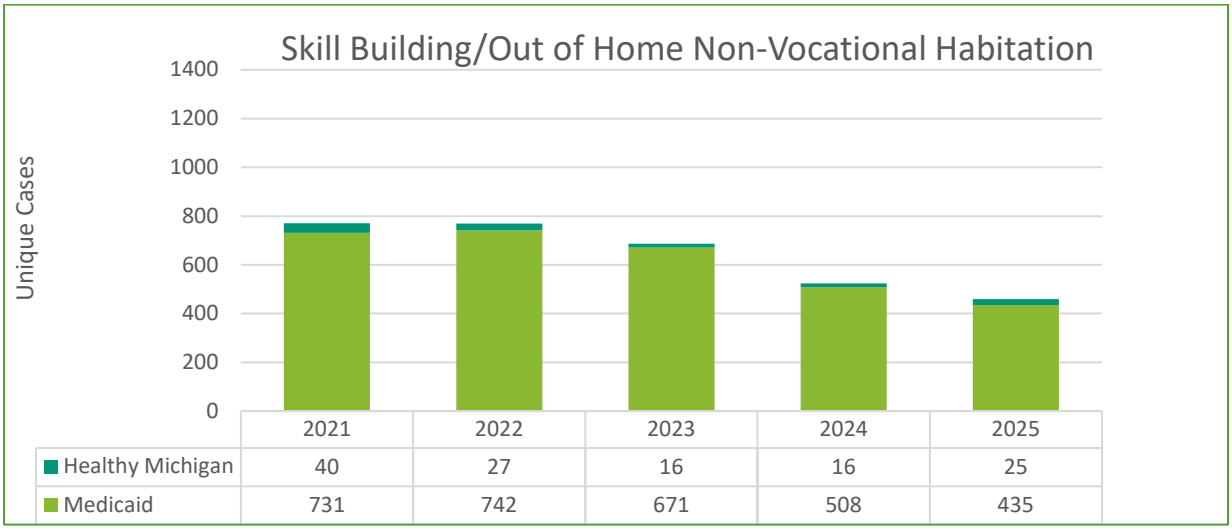
Figure 27: Respite



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. Since 2019, there has been a dramatic drop in use of skill building/out of home non-vocational habilitation services. This has been due to many different reasons, including HCBS Rule transition, pandemic effects (telehealth and staffing shortages), Medicaid changes relative to skill building being a time-limited service, shifts out of skill building due to medical necessity reviews and advancing to supported/integrated employment, and individual case reviews on whether services were in the community and the type of programming received.

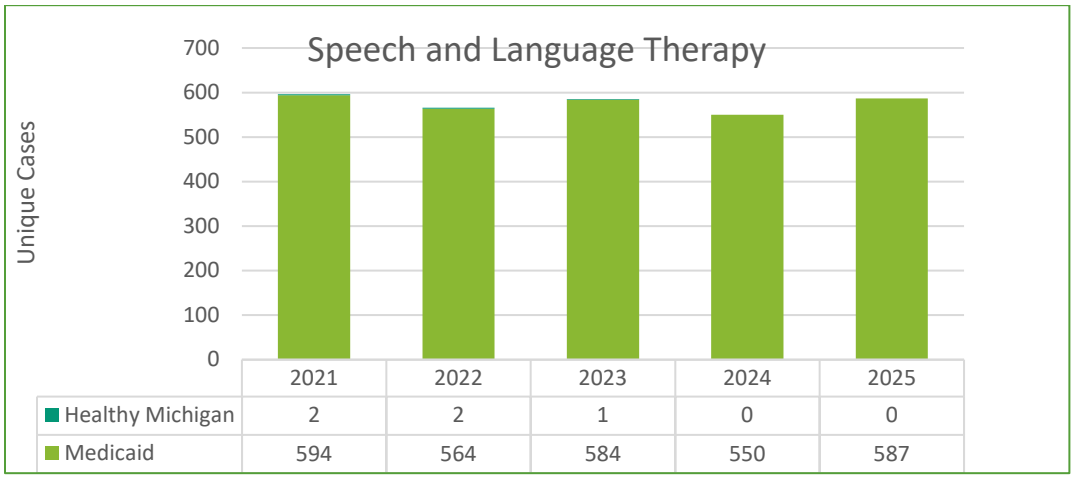
Figure 28: Skill Building/Out of Home Non-Vocational Habilitation



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.

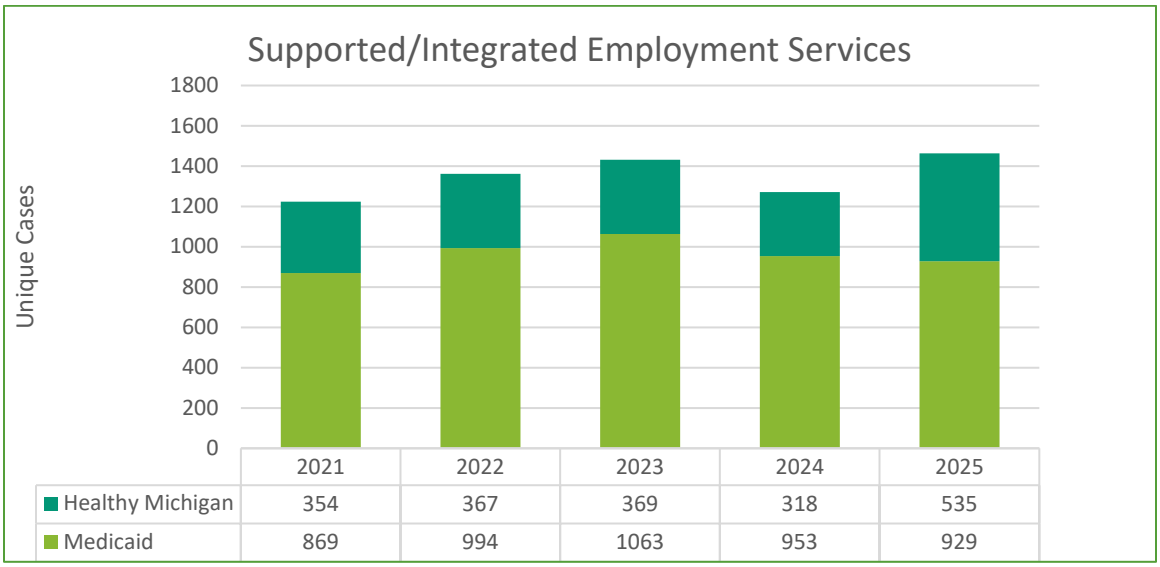
Figure 29: Speech and Language Therapy



Supported Employment Services

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

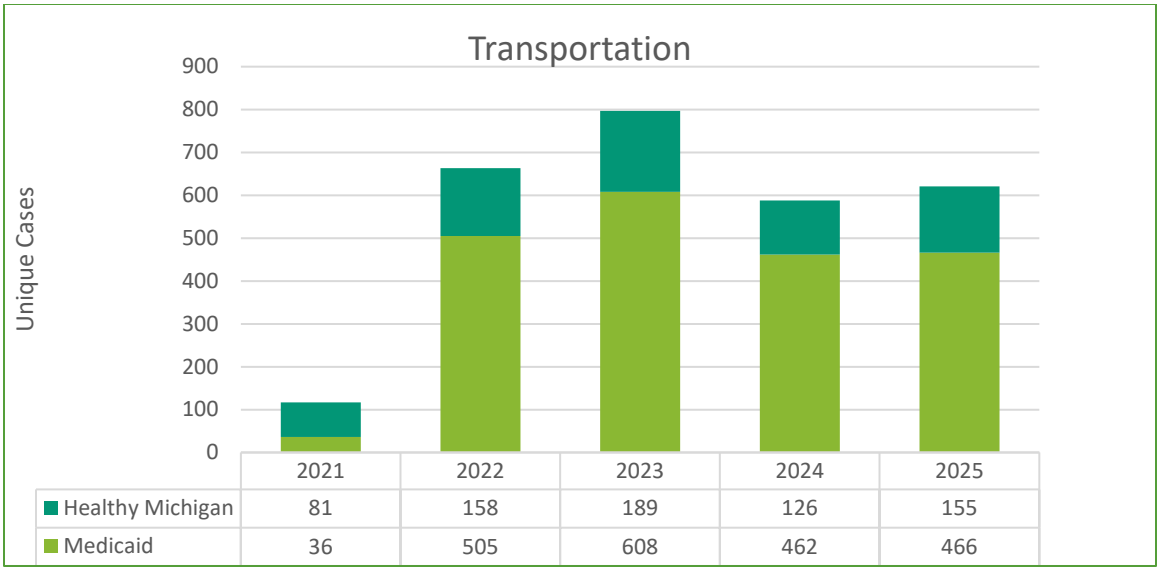
Figure 30: Supported/Integrated Employment Services



Transportation

Transportation is used to transport individuals to/from services other than daytime activity, skill building, clubhouse, supported employment, or community living activities. Transportation has been on the increase since the low point in 2021, principally affected by the pandemic. However, MSHN CMHSPs have been using transportation more. Explanations include where some providers separated transportation out from bundled rates, as well as improved fleet vehicle counts due to beneficiary surveys showing transportation to services as a major barrier to service access.

Figure 31: Transportation

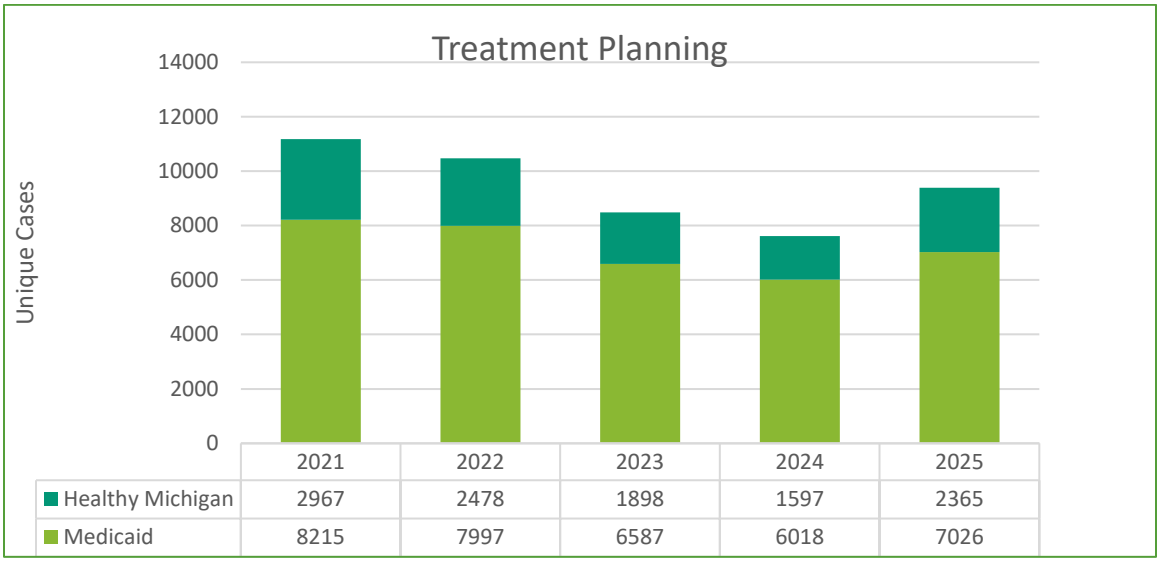


Treatment Planning

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. There

has been a progressive decrease in the use of the treatment planning code. The MDHHS EDIT group has clarified use of this code and how reporting has changed and staff often use other codes as required. This has been connected to the use of other codes, such as the T1017 (case management) or home-based, etc. It appears through this transition of code use, the treatment planning code has experienced a drop as services like case management and home-based have increased.

Figure 32: Treatment Planning



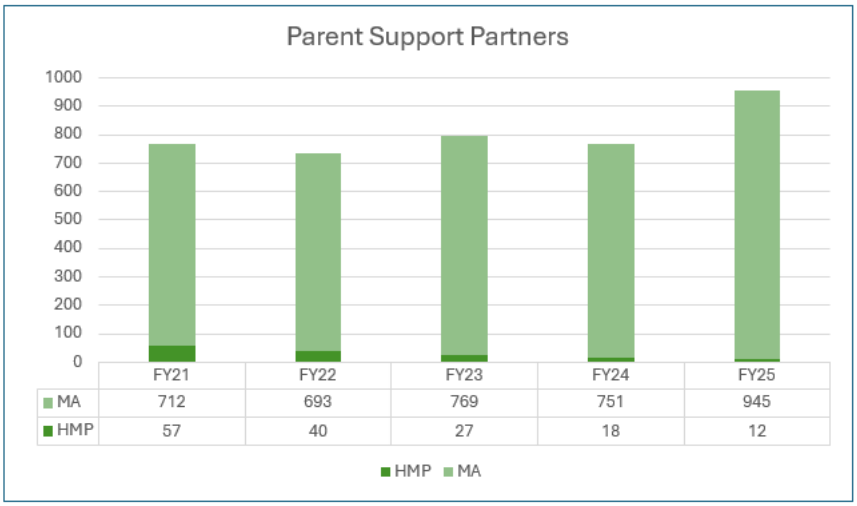
	2021	2022	2023	2024	2025
Healthy Michigan	2967	2478	1898	1597	2365
Medicaid	8215	7997	6587	6018	7026

Parent Support Partners

The Parent Support Partner (PSP) Medicaid service is an intervention-based approach to support families whose children receive services through a community mental health service provider.

The purpose of the Parent Support Partner Project or service is to increase family involvement and engagement within the mental health treatment process and to equip parents with the skills necessary to address the challenges of raising a youth with special needs thus improving outcomes for youth with SED, serious emotional disturbance or intellectual/developmental or I/DD, involved with the public mental health system. **MDHHS does not currently have an established adequacy standard, however in FY24, MDHHS added required reporting of monthly average FTEs as informational only, which continued into FY25. MSHN reported 25.2 monthly average parent support partner FTEs, a significant increase from FY24 of 15.2.**

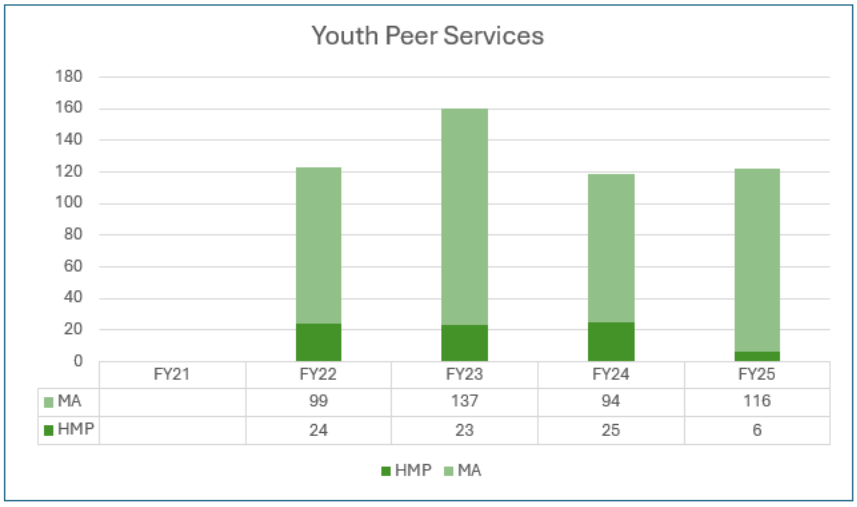
Figure 33: Parent Support Partners



Youth Peer Services

The Youth Peer Support Medicaid Service is designed to support youth with a serious emotional disturbance through shared activities and interventions, supporting youth empowerment, assisting youth in developing skills to improve their overall functioning and quality of life, and, working collaboratively with others involved in delivering the youth's care. **MDHHS does not currently have an established adequacy standard, however in FY24, MDHHS added required reporting of monthly average FTEs as informational only, which continued into FY25. MSHN reported 5.4 monthly average youth peer supports FTEs.**

Figure 34: Youth Peer Services



Single Case Agreements

During FY25, the CMHSPs contracted out via single case agreements approximately for 177 services down from 211 services in FY24, with the majority of SCA's (72%) for inpatient services. MSHN utilizes the analysis of SCA's to determine adequacy capacity within region. As noted above under crisis services,

MSHN is expanding its capacity to address areas of need. There has been a large increase in use of SCAs for inpatient due to hospitals demanding them and refusing to accept the non-contract rate. These are established where there is no existing contract. Another significant contributor to an increase in SCAs includes local hospitals denying admissions requests and the CMHSPs responding by looking to other, further away facilities to ensure proper care availability is covered.

Table 3: Single Case Agreements

	FY 24	FY 24	FY25	FY25
Inpatient	127	60%	128	72%
Crisis Residential	5	2%	13	7%
Partial Hosp	15	7%	14	8%
Other	64	31%	22	12%
Total	211	100%	177	100%

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 4 lists many evidence-based (or best) practices currently offered by CMHSP participants in the region. CMHSPs continue to implement Evidence Based Practices (EBPs).

Table 4: 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								
Brief Behavior Activation Therapy	Adults w Depression			X									
Brief Strategic Family Therapy	Families			X	X								
Clubhouse	MIA	X	X	X				X	X		X		
Child Parent Psycho Therapy	Young Children	X	X	X				X	X		X		
Cognitive Behavioral Therapy	All	X	X	X	X	X	X	X	X	X	X	X	X
CBT for Psychosis	MIA		X										

Cognitive Processing Therapy			X										
DASH (Dietary Approaches to Stop Hypertension) Diet	MIA		X						X		X		
Dialectical Behavioral Therapy	Children		X										
Dialectical Behavioral Therapy	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Eight Dimensions of Wellness	MIA				X								
Eye Movement Desensitization	PTSD	X	X		X		X	X	X	X	X	X	X
Family Psychoeducation	Families	X	X	X		X	X	X	X	X	X	X	X
Individual Placement Supports	Adult M Vocational	X											
Infant Mental Health	Parents	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	X	X	X	X
Motivational Interviewing	All	X	X	X	X	X	X	x	X	X	X	X	X
Multi-Systemic Therapy	Juvenile offenders			X				X					
Nurturing Parenting Program	Parents			X									
Parent-Child Interaction Therapy	Parents		X	X					X				
Parent Mgt Training – Oregon Model	Parents	X	X	X	X	X	X	X			X		X
Parent Support Partners	Parent		X	X	X	X	X			X	X	X	X
Parenting Through Change	Parents	X	X	X	X		X		X		X	X	X
Parenting Through Change-R	Parents		X								X		X
Parenting Wisely	Parents							X					
Peer Mentors	I/DD		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					X				X		X
Positive Living Supports	I/DD	X	X			X							
Prolonged Exposure Therapy	Adults w PTSD	X		X	X	X			X			X	
Resource Parent Trauma Training	Parents	X									X	X	
Seeking Safety Trauma Group	SUD & PTSD		X	X			X		X	X	X		
SMART Recovery	Adults with SUD				X								
SOGI Safe	All										X		
Strengths & Strategies	Families for Youth with FASD				X								
Supported Employment	Adults	X	X	X	X	X	X	X	X	X	X	X	X
Transition Independence Process Model (TIP)							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			

Wellness Recovery Action Planning	Adults	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	X		X	X	X	X

*Staffing limitations affected this CMHSP's ACT program operations and has sought and received an exception through MSHN and MDHHS. Operations expected to return when staffing stabilizes.

Behavioral Health Treatment Services/Applied Behavioral Analysis

Michigan Medicaid Autism services provides coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age diagnosed with Autism Spectrum Disorder (ASD). Services are contracted or directly delivered by the CMHSP Participants as shown in Table 5.

Table 5: Autism 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 6 shows the growth in volumes for Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) services as demand has notably risen for these Medicaid services. As the region continues to work to increase network capacity to address current growth and needs for autism services, there are significant threats to availability of qualified providers of autism services for FY25. Those threats include: Ending of Qualified Behavioral Health Professional (QBHP) allowance 9.30.2025, emphasis on use of Board Certified Behavior Analysts (BCBAs) for writing of behavior treatment plans for all individuals served, proposal to include and allow for Medicaid Autism Services to be provided within the identified school day, and advocacy for removal of the age cap of 21 for autism services.

Table 6: Individuals Served by CMHSPs with Autism Spectrum Disorders and ABA Service Utilization

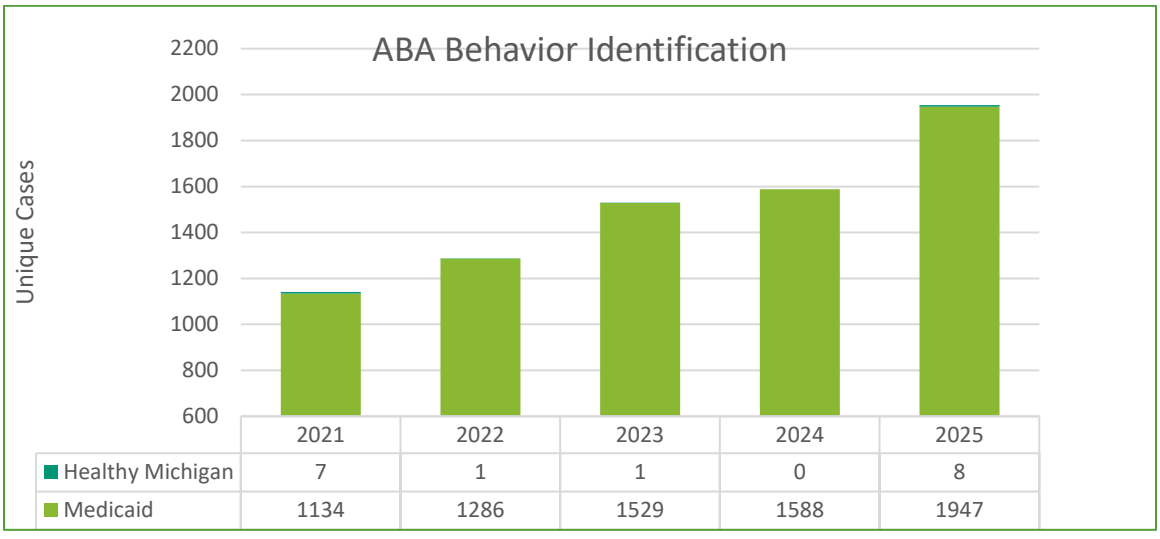
	FY21		FY22		FY23		FY24		FY25	
	ASD diagnosis	Enrolled in the BHT Benefit	ASD diagnosis	Enrolled in the BHT Benefit	ASD diagnosis	Enrolled in the BHT Benefit	ASD diagnosis	Receiving Autism Services	ASD daignosis	Receiving Autism Services
BABH	290	135	379	146	444	199	515	204	494	240
CEI	862	423	958	444	1,088	471	1,169	510	1093	613

CMHCM	685	273	792	336	851	382	915	416	875	427
GIHN	131	67	146	64	151	71	175	71	132	86
HBH	57	14	88	20	100	14	88	15	78	19
LCMHA	604	274	615	252	669	288	718	348	745	399
MCN	239	89	308	111	369	151	394	87	320	88
NCMH	119	14	137	12	132	19	145	27	132	26
SCCMHA	667	239	850	269	862	311	930	311	905	397
SHW	158	57	201	66	222	84	197	97	208	107
TBHS	118	52	157	33	148	58	237	59	171	62
TRD	145	26	170	59	198	37	160	52	165	41
MSHN	**4075**	**1663**	**4801**	**1812**	**5,234**	**2,085**	**5,643**	**2197**	**5318**	**2505**

ABA Behavior Identification Assessment (97151)

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. The information from this process is the basis for developing the individualized behavioral plan of care with the individual, family, and treatment planning team while identifying strengths and weaknesses across domains and potential barriers to progress. The increase in the delivery of 97151 for FY25 is directly linked to the increase in overall eligible enrollees for autism services.

Figure 35: ABA Behavior Identification



Comprehensive Diagnostic Evaluations

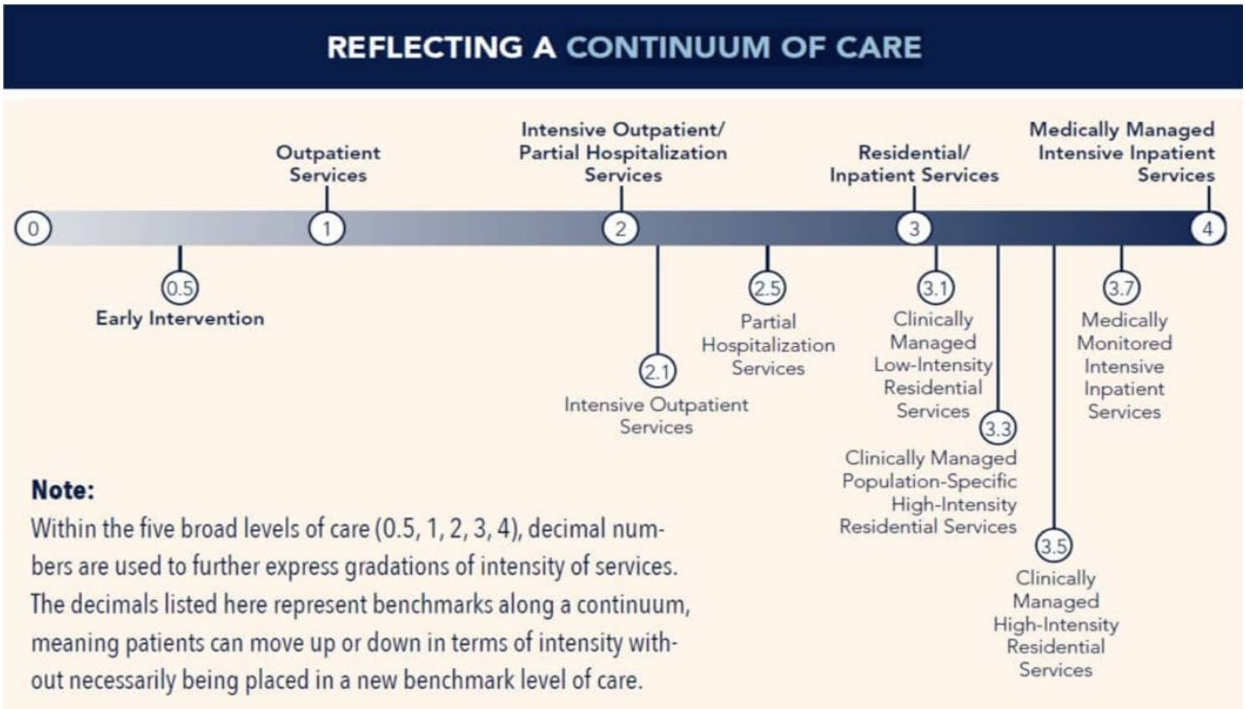
Services include non-medical assessments, psychological testing, and mental health assessments by non-physicians. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. The

diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD.

Figure 36: ABA Other Services

Substance Use Disorder Services

Table 9 and 12 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 for adolescents and adults. 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.



ASAM Level of Care Analysis

Adolescent ASAM Level Detail: 00-17 years-of-age at time of service

Unduplicated count of adolescents served by ASAM Level

Table 7: This displays the unduplicated number of adolescents (00-17) that were served at each ASAM level of care. Note that an individual may be counted in each ASAM level of care within the same fiscal year. Also note that the ASAM levels displayed are the only ASAM levels that services were provided for in the displayed fiscal year, if another ASAM level service was provided it would be displayed; no ASAM levels were excluded from the report, therefore all levels are reported. The displayed ASAM levels do not mean that other ASAM levels are not available to the adolescent population.

Fiscal Year	ASAM Level	Unduplicated Individuals
2021	1.0 Outpatient	37
2021	3.5 Clinically-Managed High Intensity Residential	23
2022	1.0 Outpatient	25
2022	3.5 Clinically-Managed High Intensity Residential	14
2023	1.0 Outpatient	48
2023	3.5 Clinically-Managed High Intensity Residential	11
2024	1.0 Outpatient	77
2024	3.5 Clinically-Managed High Intensity Residential	13
2025	1.0 Outpatient	80
2025	3.5 Clinically-Managed High Intensity Residential	5

Table 7: Data source – MSHN Encounters; REMI backup ASAM tables

Unduplicated Count of adolescents served

Table 8: This displays the unduplicated number of adolescents (00-17) that were served within each fiscal year. This was calculated by looking at the distinct count of case numbers for individuals under the age of 18 at the time of service that received a service within the respective fiscal year.

Fiscal Year	Unduplicated Individuals
2021	50
2022	34
2023	59
2024	88
2025	85

Table 8: Data source – MSHN Encounters

Findings: There were no Single Case Agreements (SCA) for an individual under the age of 18 for MSHN during the 2021 - 2024 fiscal years (Data source: Provider Network – Contracts). MSHN did execute one SCA for an individual under the age of 18 in FY 2025. At present, the adolescent ASAM levels of care for withdrawal management and residential 3.1 and 3.7 do not exist within the State of Michigan with existing SUD treatment providers. This is an area that has been discussed with MDHHS-Substance Use, Gambling and Epidemiology (SUGE) and the SUD Directors workgroup. A primary challenge to supporting the adolescent services across the State has been the low level of utilization by this population, which does not translate to sustainability for providers who support the programs. MSHN supported a Request for Proposal (RFP) to add/expand adolescent SUD services across the region in FY24. The RFP included

the ASAM LOC's for residential (3.1 and 3.7), withdrawal management (3.2 and 3.7), and outpatient (0.5, 1.0, 2.1). MSHN was successful in identifying one provider to support expanded SUD outpatient services in 7 additional counties.

In FY25, one of the two adolescent residential providers available in the State, Wedgwood, discontinued their contract with MSHN indicating that the rates the PIHPs were able to reimburse for services for this population were too low to cover costs and citing a needed rate of $1,100 a day per adolescent to sustain the program.

To support development of a full continuum of ASAM Levels of Care for adolescent services in the State of Michigan, MSHN advocated and led an SUD Directors workgroup in FY25 to develop a proposal to MDHHS to 1) strengthen existing providers who support residential LOCS, 2) develop a new provider to support all ASAM LOC's for adolescents, and 3) provide specialized adolescent EBP trainings for existing providers as this is a complex population to support in SUD treatment and the level of staff turnover is high, as well as occurrence of new staff being less seasoned and fresh out of school in need of supervision, training, and support. During the process of developing this proposal, the group was notified by MDHHS – SUGE that funds would not be available to support this initiative, so the workgroup was discontinued.

As an additional note, the area of SUD early intervention services (ASAM 0.5 LOC) is also supported via the regional SUD prevention provider network with a variety of evidence-based curriculums that are provided to schools and communities across the region. The number of adolescents supported with this type of intervention is harder to discern as the Michigan Prevention Data System (MPDS) system is utilized to track this data. In FY25, the MSHN SUD prevention providers supported approximately 10,878 activities in the MSHN region directed toward youth and adolescents ages 0-17 years.

Table 9: Substance Use Disorder Services Available in the MSHN Provider Network – Adolescents

County	Outpatient				Residential				Withdrawal Mgt.	
	0.5	1.0	2.1	2.5	3.1	3.3	3.5	3.7	3.2	3.7
Arenac										
Bay	X	X*								
Clare		X*								
Clinton		X								
Eaton		X*	X							
Gladwin		X*								
Gratiot										
Hillsdale										
Huron	X	X*								
Ingham		X*								
Ionia		X								
Isabella		X*								
Jackson	X	X	X							
Mecosta										
Midland		X*								
Montcalm		X*	X							
Newaygo	X	X								

Osceola										
Saginaw	X	X*								
Shiawassee		X*								
Tuscola	X	X	X							
Out of Network	X	X*	X		X		X			
*OP Program offer MAT (Suboxone/Vivitrol)										

Adult ASAM Level Detail: 18+ years-of-age at time of service

Unduplicated count of adults served by ASAM Level

Table 10: This displays the unduplicated number of adults (18+) that were served at each ASAM level. Note that an individual may be counted in each ASAM level within the same fiscal year. Also note that the ASAM levels displayed are the only ASAM levels that services were provided for in the displayed fiscal year, if another ASAM level service was provided it would be displayed; no ASAM levels were excluded from the report.

ASAM Level	Unduplicated Individuals				
	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
1.0 Outpatient	4375	3926	3908	2763	1793
1.0 Outpatient: Medication Assisted Treatment	3737	3505	3301	2816	2187
2.1 Intensive Outpatient	434	408	469	331	211
2.5 Partial Hospitalization	43	33	50	36	16
3.1 Clinically-Managed Low Intensity Residential	573	598	611	479	313
3.2 Clinically-Managed Withdrawal Management	51	50	64	57	30
3.3 Clinically-Managed Population Specific	7	3	2	2	1
3.5 Clinically-Managed High Intensity Residential	2535	2442	2617	2029	1324
3.7 Medically-Monitored Residential	29	24	17	11	12
3.7 Medically-Monitored Withdrawal Management	167	149	175	133	91

Table 10: Data source – MSHN Encounters; REMI backup ASAM tables

Adult Single Case Agreements by Fiscal Year

For SUD provider network services, a total of 39 single case agreements (SCAs) were utilized in FY24 and 8 SCAs for FY25.

Table 11:

Fiscal Year	Count of SCA's
2021	8
2022	21
2023	95
2024	39
2025	8

The breakdown by level of care consists of:

FY22

1.0: 21

Findings: Based on the number of single case agreements (SCAs) in FY22 for 1.0 Outpatient Services, MSHN continued the efforts to expand outpatient capacity within the region as noted in the FY22 Follow up on Recommendations and Updates - 1a.

FY23

1.0: 89 (Bear River)

3.5: 6 (Ascension Eastwood)

Findings: During FY23, MSHN observed an increase in requests for individuals to continue treatment at Bear River Health for services like ASAM 1.0 LOC, that MSHN did not previously contract for with this provider. MSHN has sufficient network adequacy for ASAM 1.0 LOC services within its geographic region as demonstrated by previous time and distance standards study outcomes, so therefore did not support this level of care in the majority of out of region providers. With the occurrence of the increased number of people in services requesting this level of care at Bear River, MSHN has worked with Bear River to expand their contracted services to support ASAM 1.0 LOC options for individuals who wish to relocate and support their pathway to recovery in that local area.

FY24

1.0: 20 (Bear River)

3.7 & 3.5: 4 (Ascension Eastwood)

3.1 & 3.5: 2 (Indiana Center for Recovery)

1.0: 13 (Sunrise Centre)

Findings: During FY24, MSHN observed a decrease in requests for individuals to receive ASAM 1.0 LOC services with Bear River Health. MSHN has sufficient network adequacy for ASAM 1.0 LOC services within its geographic region and worked with Bear River Health on discharge planning practices to ensure that individuals were connected to appropriate services in their home communities upon discharge from Bear River Health residential programs. MSHN observed an increase in requests for individuals to receive ASAM 1.0 LOC services with Sunrise Center. MSHN worked with Sunrise Centre to complete single case agreements for those individuals that requested to relocate to the Alpena area upon completion of residential treatment with Sunrise Centre.

FY25

3.5 & 3.7: 3 (Ascension Eastwood)

1.0: 5 (Sunrise Centre)

Findings: During FY25, MSHN received several requests for individuals to receive ASAM 1.0 LOC services with Sunrise Center. MSHN continues to work with Sunrise Centre to complete single case agreements for those individuals that request to relocate to the Alpena area upon completion of residential treatment with Sunrise Centre. Additionally, MSHN received requests for individuals to receive ASAM 3.7-WM and 3.5 LOC services with Ascension Eastwood Behavioral Health. MSHN has sufficient network adequacy for ASAM 3.7-WM and 3.5 LOC services within its geographic region, however MSHN completes single case agreements whenever possible to accommodate beneficiary preference for choice of provider.

Service Location:

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. 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 12: Substance Use Disorder Services Available in the MSHN Provider Network - Adults

County	Outpatient				Residential				Withdrawal Mgt.		OTP	Women's Specialty Services	Recovery Housing	CCBHC - DCO	SUD - Health Home
	0.5	1.0	2.1	2.5	3.1	3.3	3.5	3.7	3.2	3.7	Level 1	D or E	III or IV	1.0	
Arenac	X	X*													
Bay	X	X*	X									D & E			X
Clare	X	X													
Clinton		X												X	
Eaton	X	X*	X									D		X	
Gladwin	X	X*													
Gratiot		X													
Hillsdale		X*					X					D		X	
Huron	X	X*													
Ingham	X	X*	X		X		X		X	X	X	E	X	X	X
Ionia		X*										D		X*	
Isabella	X	X*	X		X		X				X				X
Jackson	X	X*	X				X			X	X	E		X	X
Mecosta	X	X													
Midland	X	X*					X						X		
Montcalm		X*	X									D	X		
Newaygo	X	X*	X									D			
Osceola															

Saginaw	X	X*	X		X		X		X	X	X	D & E	X	X	X
Shiawassee		X*										E			X
Tuscola	X	X*	X									D			
Out of Network	X	X*	X	X	X	X	X	X	X	X	X	D			X
*OP Program offer MAT (Suboxone/Vivitrol) D = Designated WSS Program E = Enhanced WSS Program															

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 services that often includes Medication for Opioid Use Disorder (MOUD), formerly referred to as Medication Assisted Treatment or MAT. However, the region continues to expand capacity as distance can be a barrier for consumers in need of services. Though the opioid overdose epidemic saw declines in overdose rates for White residents of Region 5 in 2023, the death rates for Black men and Native Americans are rising. MSHN's attention to regional capacity persists, therefore, in providing broad access to withdrawal management services, Medication for Opioid Use Disorder (MOUD) including buprenorphine and naltrexone, and MOUD's associated outpatient treatment and recovery supports. It should be noted that Substance Abuse and Mental Health Services Administration (SAMHSA)'s 42 Code of Federal Regulation (CFR) Part 8 Final Rule in 2024 requires a medication-first approach in which MOUD medications should not be contingent on negative drug screens or engagement in counseling. MSHN is working with its MOUD treatment providers to fully adopt these SAMHSA medications-first principles.

During FY25, MSHN observed increased utilization across multiple substance use disorder service categories, including assessment, outpatient, residential, withdrawal management, and medication for opioid use disorder (MOUD). This increase corresponds with structured system enhancements implemented during the fiscal year and reflects improved access, capacity, and care coordination across the region.

Effective October 1, 2024, MSHN expanded its centralized SUD Access process to include standardized screening and ASAM level-of-care determination for withdrawal management, residential treatment, and recovery housing services. By consolidating intake and routing functions, the system reduced referral delays, improved matching to providers with available capacity, and minimized loss of individuals during the intake process. This streamlined workflow increased successful admissions to higher levels of care and contributed directly to increased residential and withdrawal management utilization.

During the same period, MDHHS transitioned the Opioid Health Home model to a broader Substance Use Disorder Health Home structure and expanded eligibility to include individuals with alcohol and stimulant use disorders. MSHN supported expansion of this model across additional counties and provider locations. The enhanced Health Home infrastructure strengthened care coordination, outreach, and follow-up, improving engagement and retention in outpatient and MOUD services. Broader eligibility and improved navigation likely increased assessment volume and sustained outpatient participation.

FY25 also marked measurable growth in residential and withdrawal management capacity within the MSHN region. Expansion of ASAM 3.1 and 3.5 residential beds and restored withdrawal management admissions following provider relocation and staffing stabilization reduced prior capacity constraints. With increased bed availability, individuals who may previously have experienced delays were able to access services in a more timely manner, resulting in higher admission volumes.

In addition, implementation of the SAMHSA 42 CFR Part 8 Final Rule, with compliance required by October 2, 2024, supported a lower-barrier approach to MOUD delivery. Provisions allowing medication initiation following screening, removal of counseling prerequisites, and permanent take-home flexibilities reduced administrative and clinical barriers to treatment entry. These regulatory updates enhanced timely engagement in MOUD and strengthened outpatient and OTP service utilization.

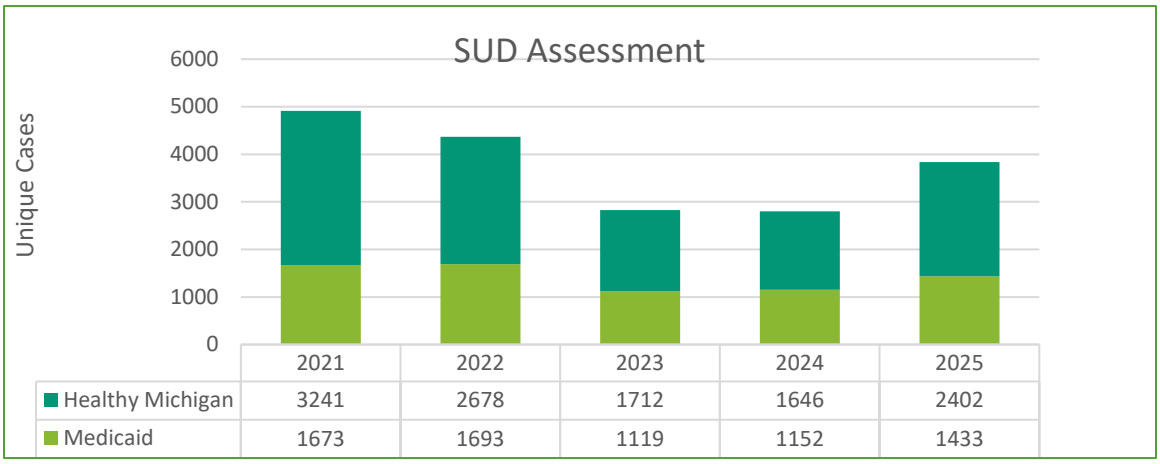
Finally, FY25 Opioid Settlement Fund investments supported transportation to treatment, outreach initiatives, harm reduction infrastructure, and service navigation roles across multiple counties. By addressing non-clinical access barriers and increasing community touchpoints, these investments improved linkage to care and intake completion rates.

Collectively, these operational, regulatory, and capacity improvements enhanced system responsiveness and reduced barriers to care. The observed FY25 increase in SUD utilization reflects strengthened network functionality and improved access to appropriate levels of care, consistent with federal and state network adequacy standards under 42 CFR 438.68 and MDHHS specialty behavioral health requirements.

SUD Assessment

Assessment includes an evaluation by a qualified practitioner that investigates clinical status including: presenting problem, history of presenting illness, previous medication history, relevant personal and family history, personal strengths and assets, and mental status examination for the purposes of determining eligibility for specialty services and supports, and the treatment needs of the beneficiary. While the MSHN region experienced a decline in assessments during FY23 and FY24, there was a significant increase observed in FY25. During FY25, the MSHN region supported 1,037 more assessments than the previous fiscal year. This increase could be attributed to a number of factors that include regional attention to providers supporting BHTEDS “S” record updates at annual reassessments, providers moving towards low barrier and same day access for intakes when possible, expansion of SUD Health Homes to more locations around the region, as well as the first year of MSHN supporting the majority of access functions directly for the region for withdrawal management, residential, and recovery housing services with prioritizing provider options that have immediate capacity and access.

Figure 37: SUD Assessment



Medication for Opioid Use Disorder (MOUD)

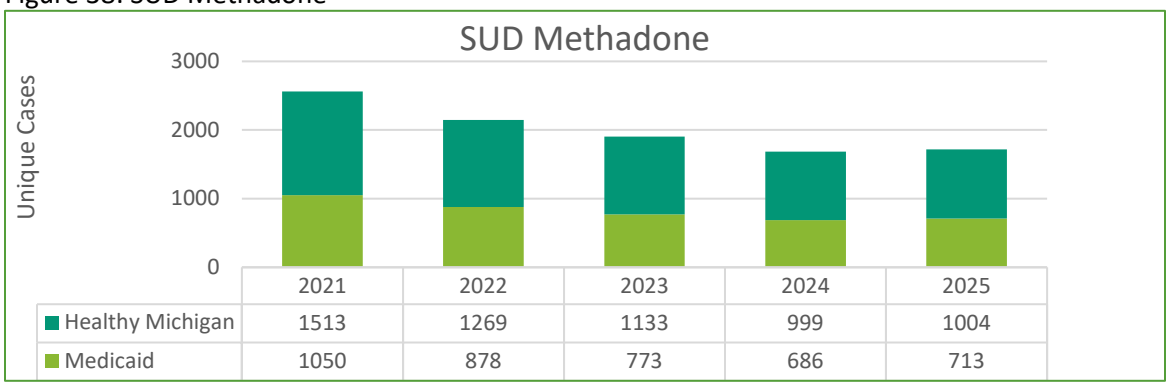
MOUD is the standard of care for individuals living with an Opioid Use Disorder and has been demonstrated to decrease overdose deaths and to increase individuals' likelihood of recovery. The Federal Drug Administration (FDA) has approved four medications for this purpose: methadone, buprenorphine (brand name Suboxone or Brixadi - injectable), and naltrexone (brand name Vivitrol). Buprenorphine and naltrexone can be prescribed by licensed medical professionals in hospitals, Federally Qualified Health Centers (FQHCs) primary care and/or other healthcare settings. These Office-Based Opioid Treatment (OBOT) settings may or may not be attached to broader SUD outpatient treatment services. Methadone, on the other hand, can only be delivered through licensed Opioid Treatment Providers (OTPs) that are highly regulated by the Drug Enforcement Administration (DEA) and SAMHSA under 42 CFR Part 8.11. Many OTPs also prescribe buprenorphine and naltrexone, but they are primarily focused on the delivery of methadone which requires daily dosing. Determination of which medication is appropriate for each patient should be individualized and guided by medical necessity.

42 CFR Part 8 establishes federal regulatory standards for Opioid Treatment Programs (OTPs) to ensure safe, effective, and accessible treatment for individuals with opioid use disorder (OUD). Updates finalized by SAMHSA in February 2024 (effective April 2, 2024, with compliance required by October 2, 2024) introduce regulatory flexibilities designed to reduce barriers to treatment, improve timely access to medications for opioid use disorder (MOUD), and support recovery-oriented and harm reduction approaches. These changes have direct implications for network adequacy, provider capacity, and beneficiary access within the PIHP service system.
Key provisions supporting network adequacy and access standards include:

- Improved timely initiation of treatment: Authorization to begin MOUD following initial screening, with comprehensive assessments completed within 14 days, supports rapid engagement consistent with access and timeliness expectations.
- Expanded service capacity and beneficiary access: Removal of counseling as a prerequisite for medication access and elimination of prior duration-of-use and withdrawal attempt requirements reduce administrative and clinical barriers, allowing providers to serve a broader population more efficiently.
- Enhanced geographic accessibility and continuity of care: Permanent take-home medication flexibilities reduce daily attendance requirements, supporting participation for individuals facing transportation, employment, or rural access challenges.
- Strengthened care coordination: Acceptance of verified external medical examinations promotes integration with community providers and supports continuity across service settings.
- Individualized clinical decision-making: Updated drug testing guidance and revised initial dosing parameters (up to 50 mg on day one when clinically indicated) align care delivery with patient-centered practices while maintaining safety standards.

Collectively, these regulatory updates enhance system responsiveness, improve access to appropriate levels of care, and increase provider flexibility to meet demand. Implementation of these provisions supports compliance with federal and state expectations for network adequacy by improving timely service initiation, expanding treatment availability, and strengthening continuity and accessibility of OTP services across the provider network.

Figure 38: SUD Methadone



SUD MOUD Regional Capacity (OTPs & OBOTs)

The MSHN region had a decline in individuals seeking OTP services in the last 4 years which can be attributed to post-pandemic factors like increased isolation, mistrust of the medical system, the burden on work and transportation associated with daily dosing, as well as the advent of FDA approved oral and injectable Buprenorphine medications that can be managed by the person and monitored by a physician at regular intervals. Greater flexibility in federal and state-level OTP dosing guidelines in FY25 will likely result in increased utilization of OTPs in FY26 and beyond. For OTPs, MDHHS has an established adequacy standard of 35,000:1 Medicaid Enrollee to Provider ratio. MSHN currently contracts with 2 OTP providers across 5 sites in the region. MSHN also expanded its MOUD options with new OBOT providers in FY25 increasing to 13 OBOT providers in the region. Additionally, MSHN contracts with five (5) OTP providers out of its geographic region for services to in-region residents. MSHN's Ratio: 399,989 Adult Total Medicaid Enrollees to 5 OTP locations which is under the required 11.43.

MSHN has been working with a new OTP provider, Quality Behavioral Health, to support mobile methadone implementation since the beginning of FY25. QBH has been evaluating several counties in the MSHN region (Newaygo, Mecosta, Osceola, Shiawassee, Jackson, and Hillsdale) for OTP service implementation. In January 2026, QBH communicated that they acquired an office space in Big Rapids in Mecosta County and would be renovating the space to support OTP and SUD outpatient services. MSHN will continue to work with QBH to identify further locations in counties without OTP resources to support further location expansions in the future.

SUD Outpatient

Outpatient treatment is a non-residential treatment service that can take place in an office-based location or a community-based location with appropriately educated/trained/licensed clinical professionals who are educated/trained in providing alcohol and other drug (AOD) treatment. Individual, family, and group therapy, case management, peer supports, and monitoring services may be provided individually or in combination.

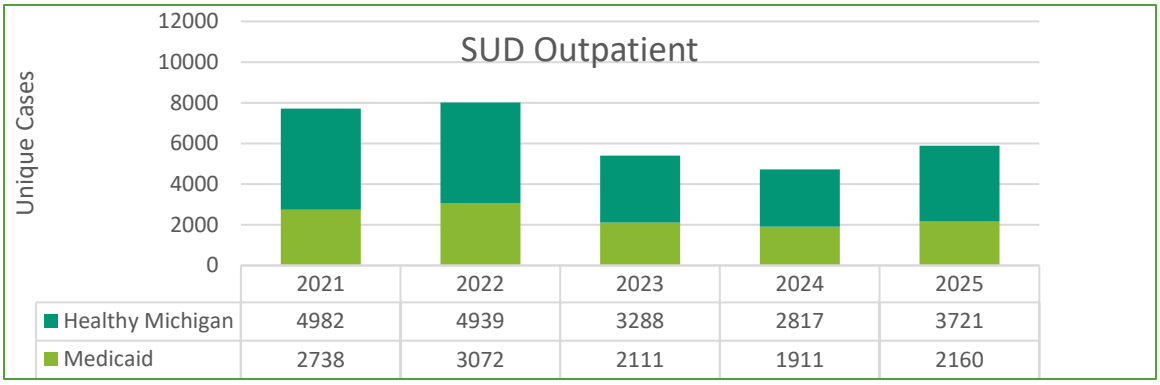
In FY25 the MSHN region observed an increase in SUD outpatient services in comparison to FY24. Data indicates the MSHN region supported 1,153 more people in FY25 than in FY24. This occurrence could be due to a few factors including:

- expansion of SUD Health Home providers/locations across the MSHN region, as well as expansion of eligibility criteria within the Health Home model to support not just OUD, but also stimulant use disorders, and alcohol use disorders.

- provider flexibility with telehealth to support staff shortages in one location with staff capacity in another location,
- providers moving towards more harm reduction approaches and low barrier access to services, and
- provider networking with colleges and universities to support bachelors and master's level interns to build service capacity.

In addition to outpatient services offered through the MSHN SUD provider network, individuals can also access outpatient SUD treatment through any of the four (4) Certified Community Behavioral Health Clinics in the region: CEI CMH (Clinton, Eaton, Ingham counties), LifeWays (Jackson and Hillsdale counties), The Right Door (Ionia County), and Saginaw CMHA (Saginaw County). Data indicates that 1,317 unique individuals received an outpatient SUD service through a CCBHC during FY25. This amounts to a combined total of 7,198 unique individuals receiving an outpatient SUD service in FY25 compared to 6,111 unique individuals in FY24, amounting to a 15.2% increase from FY24 to FY25.

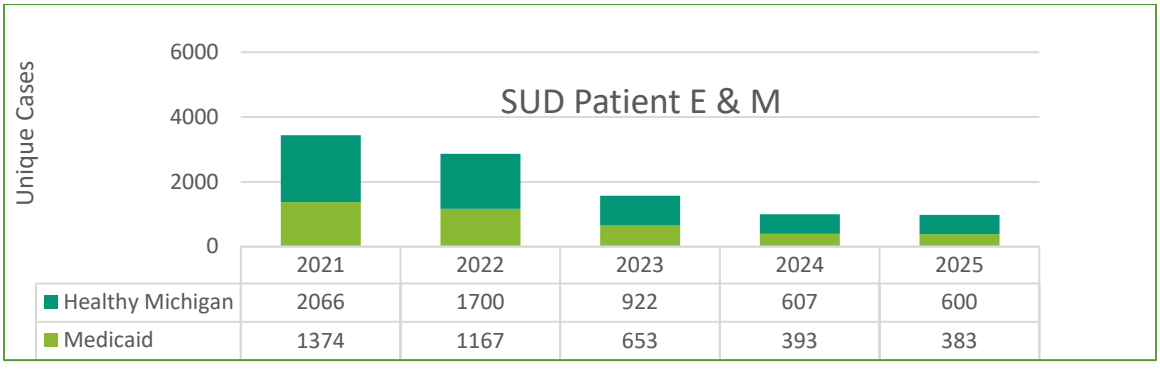
Figure 39: SUD Outpatient



SUD New and Established Patient Evaluation and Management

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.

Figure 40: SUD Patient Evaluation and Management

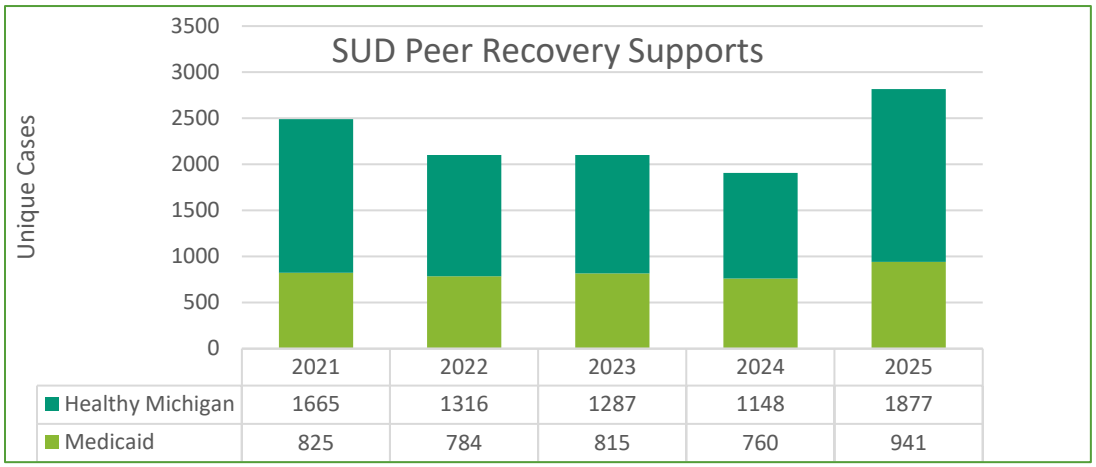


SUD Peer Services/Recovery Supports

Peer Recovery Supports (PRS) are non-clinical services that assist individuals and families to recover from substance use disorders and to maintain their recovery after treatment. 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. Community Recovery activities are tracked in MPDS. In FY25, the Community Recovery providers supported 7,645 activities for 11,829 people.

Figure 41: SUD Peer Recovery Supports



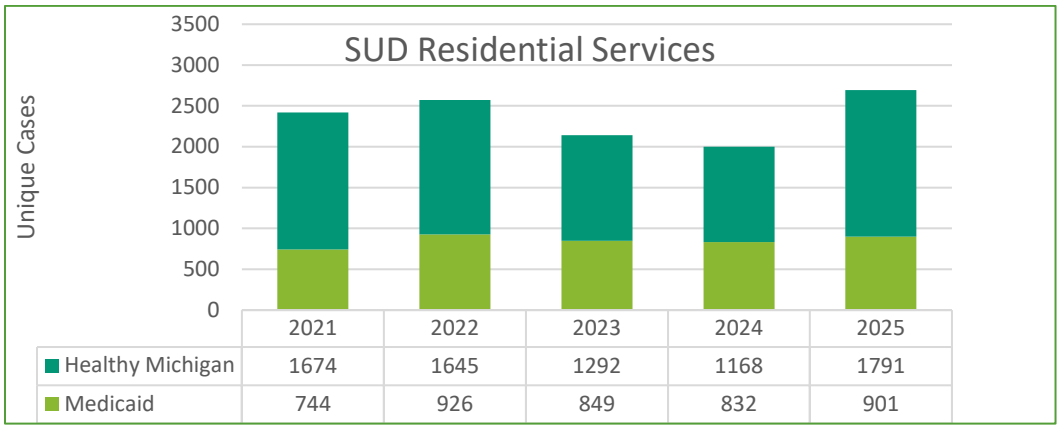
	2021	2022	2023	2024	2025
Healthy Michigan	1665	1316	1287	1148	1877
Medicaid	825	784	815	760	941

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 more intensive treatment. The length of stay varies based upon the client's individualized needs.

In FY25, MSHN supported 692 more unique people with accessing SUD residential services than in FY24. Please note that FY25 was the first year that MSHN was supporting an in-house Access Team to support a brief assessment and connection of people seeking SUD services to the appropriate level of care with a provider with open/immediate capacity. This was also the year that Bear River Health supported implementation of SUD residential services in June 2025 at a new location in Isabella County in the MSHN region. The new location can support up to 75 individuals with SUD residential services for ASAM 3.1 and 3.5 LOC needs. This was the first time MSHN was able to add SUD residential bed capacity in the geographic region in a number of years. In FY25, Flint Odyssey House moved locations which allowed them to increase their bed capacity to accommodate 96 women and 96 men. This occurrence further supported increased SUD residential bed capacity for the MSHN region.

Figure 42: SUD Residential Services



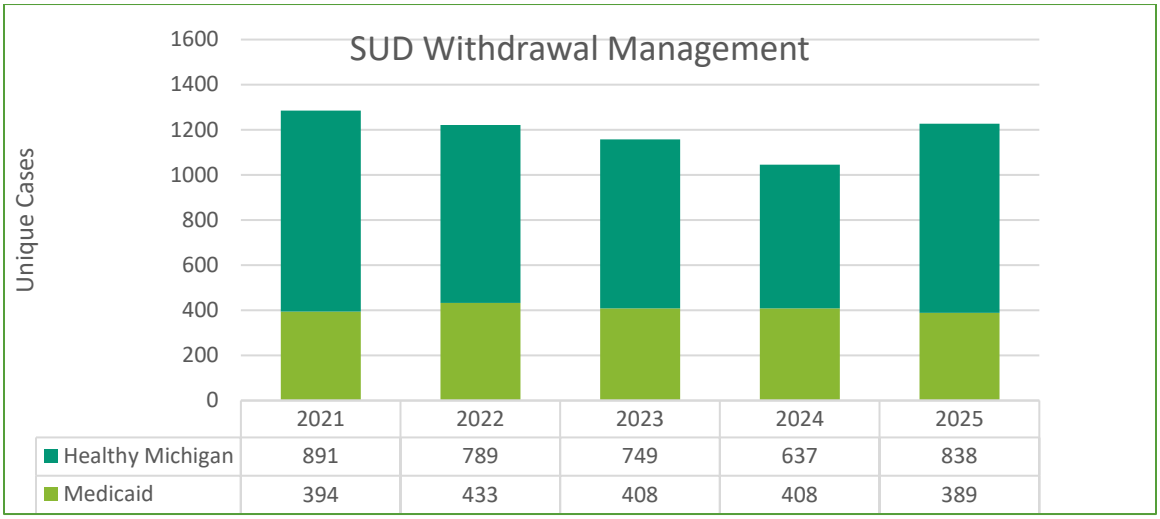
	2021	2022	2023	2024	2025
Healthy Michigan	1674	1645	1292	1168	1791
Medicaid	744	926	849	832	901

SUD Withdrawal Management

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

MSHN supported 182 more people with connection to withdrawal management services in FY25 than in FY24. Withdrawal management is one of the levels of care the MSHN Access Team supported in FY25, which likely assisted individuals seeking services with connecting with a provider with available capacity around the region. Provider capacity for withdrawal management services also increased due to Flint Odyssey House moving locations and having more space to support greater bed capacity in FY25. Odyssey is now able to support 24 beds for withdrawal management. During FY25, Healthsource was also able to address staffing issues that had temporarily paused admissions in FY24 and were able to re-open their 7-bed program in June of 2025 to support admissions.

Figure 43: SUD Withdrawal Management



Evidenced Based Practices - SUD

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

Table 13: Evidence Based Practices Utilized by SUD Providers in the MSHN Region

*T = Treatment; P = Prevention, R = Recovery & Community Recovery

Focus	Evidenced Based Practices	Focus	Evidenced Based Practices
R	24/7 Dads	P	PALS- Peer Assisted Leaders
P	Above The Influence	P	Photo Voice
P	Active Parenting	P	Positive Action
T	Acupuncture	P	Prescription Disposal/Drug Drop Off Boxes
T	Adolescent Community Reinforcement Approach	P	Prevention PLUS Wellness

P	Alcohol and Tobacco Vendor Education	P	Prime for Life, Prime for Life 420
T	Alternative Routes	T	Prime Solutions
P/T	Anger Management	P	Program to Encourage Active, Rewarding Lives (PEARL)
T	Art Therapy	T	Progressive Exposure Therapy
P	Be A Star	P	Project Alert
T	Beyond Trauma	P/T	Project ASSERT
P	Big Brothers Big Sisters	P	Project Success
P	Botvin LifeSkills	P	Project Toward No Drug Abuse
P	Bully Proof	P	QPR Gatekeeper Training for Suicide Prevention
P	Catch My Breath	P	Quick Response Team (QRT)
R	CCAR Peer Recovery Training	P	Rainbow Days Youth Connection
P/R	Chronic Pain PATH	P	Retailer/Server Education (TIPS)
T	Cognitive Behavioral Therapy (CBT)	P	Safer Smarter Teens
R	Community-Based Support Group	P	Sanford Harmony SEL
T/R	Contingency Management (CM)	R/T	Screening, Brief Intervention, Referral to Treatment (SBIRT)
T	Correctional Therapeutic Community for SUD	T/R	Seeking Safety
P	Cross Age Mentoring Program	R/T	Self-Management and Recovery Training (SMART)
T	Dialectical Behavior Therapy (DBT)	P	SMART Leaders/SMART Moves
T	Eye Movement Desensitization and Re-Processing (EMDR)	R	SMART Recovery
P	Families and Schools Together (FAST)	T	Solution Focused Brief Therapy (SFBT)
T	Family Psychoeducation	P	SPORTPLUS Wellness
T	Feedback Informed Treatment	P	Stanford Cannabis Awareness & Prevention
T	Functional Family Therapy	P	Step Bullying Prevention
T	Gottman Couples Therapy	P/T	Strengthening Families
P	Guiding Good Choices	P	Student Assistance Programs
T	Healthy Sexual Relationships in Recovery	P	Synar Compliance Checks
T	Helping Women Recover/Helping Men Recover	P	Systematic Training for Effective Parenting (STEP)
P	INDEPTH	P	Teen Court
P	In-School Probation: Early Intervention	P	Teen Intervene
P	Interactive Journaling	T	Thinking for a Change
P	It's All About Being A Teen	P	This Is Not About Drugs
P	Letting Go of Anger	T	Tobacco Cessation
T	Living in Balance	P	Too Good for Drugs
T	Matrix Model	P	Too Good for Violence
R	MDHHS State Certified Peer Recovery Coach Training	P	Total Trek Quest

T	Medication Assisted Treatment (MAT) / Medication for Opioid Use Disorder	T	Trauma Informed CBT
T	Mindfulness	T	Trauma-Focused Yoga
T/R	Modified Therapeutic Community (MTC)	T	TREM
T/R	Moral Recognation Therapy	T	Voices: Self-Discovery and Empowerment
T	Motivational Enhancement Therapy (MET)	P	Wellness Initiative for Senior Education (WISE)
T/R	Motivational Interviewing	P	What's Good About Anger
T	M-TREM	P	Wise Owl
T	Narrative Therapy	T/R	Women's Way Through the 12-Steps
P	NOT on Tobacco	T	Young Men's Guide to Self-Mastery
T	Nurturing Fathers	P	Youth Empowerment Program
P	Nurturing Parenting		

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 [7] 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 accordance 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.

[7] 42CFR438.206(b)(iii) "The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services."

Similar credentialing procedures are in place for SUD Providers. Provider agencies must be licensed as Substance Use Disorder Programs by LARA, unless provided by a CMHSP which isn't required to have a LARA license. 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 (MCBAP), such as a Certified Advanced Addiction and Drug Counselor (CAADC) and Certified Alcohol and Drug Counselor (CADC). Substance use disorder service provider staff offering prevention services are required to hold certifications as Certified Prevention Specialists (CPS). In addition, MSHN encourages all SUD Recovery Coaches to seek certification through the state's '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). Peer Recovery Coaches (PRC) are also able to become certified through the Connecticut Community for Addiction Recovery (CCAR) curriculum to provide supportive PRC services in the MSHN region.

Trauma Informed Care

The MDHHS Trauma Policy requires PIHPs to ensure their provider networks have the capability to provide trauma informed care (TIC) and treatment when working with individuals with mental illness and/or 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.

Recovery Oriented Systems of Care (SUD)

MSHN maintains an expectation that providers participate in Recovery-Oriented Systems of Care (ROSC) which focuses on holistic and integrated services that are person-driven, trauma informed, culturally responsive, ensure continuity of care, and incorporate 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.

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.[8] 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, with a slight decline in FY25. Figures 44 and 45 show the Medicaid and Health Michigan enrollment trends for the mental health and SUD populations.

[8] 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."

Figure 44: Total Enrollees vs. Served – MH/SUD and Adult/Child

Figure 44a: Average Enrollees and Individual Served, FY22-FY25

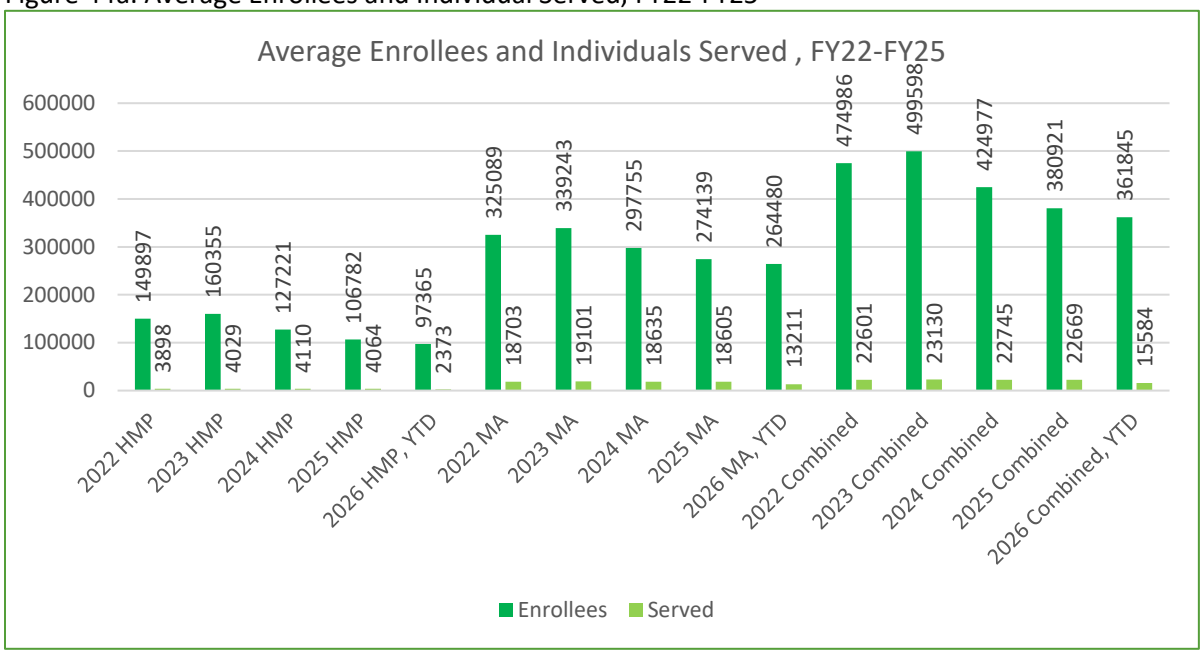


Figure 44b: Average Enrollees by adult/adolescent

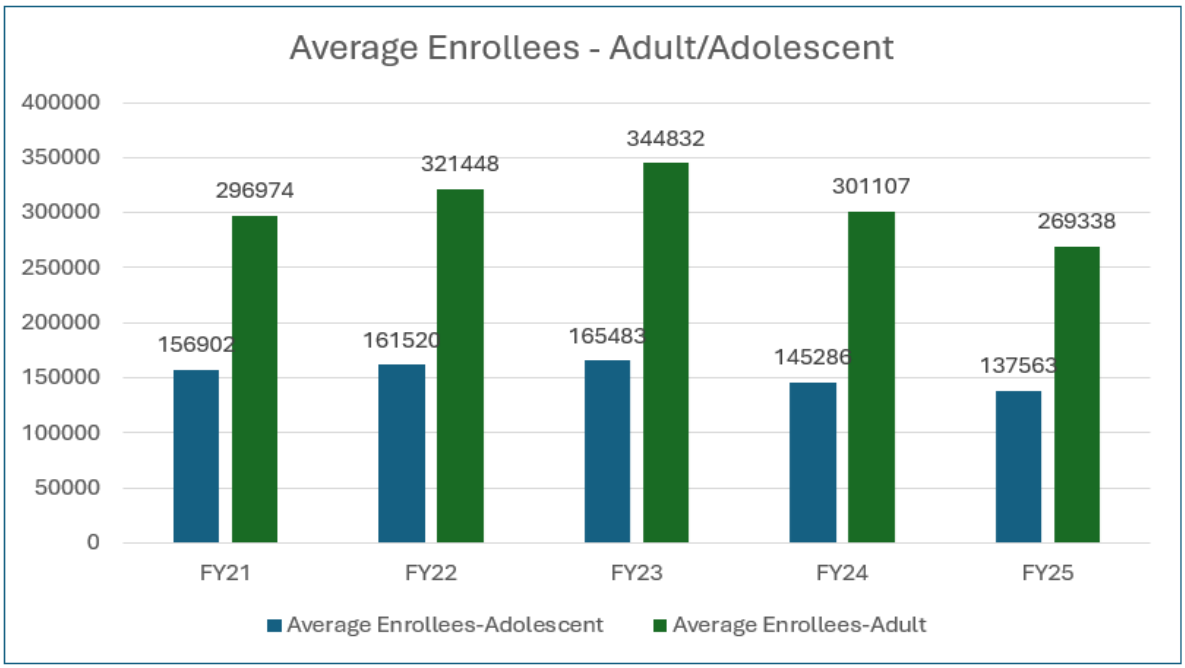
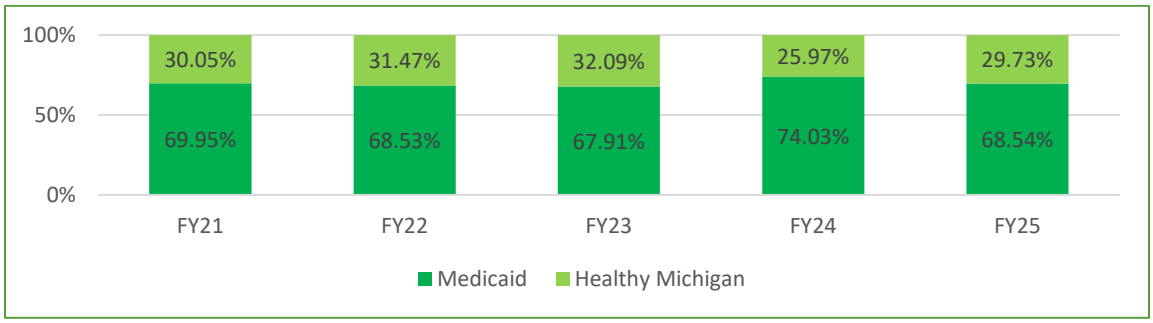


Figure 45: Proportions of Medicaid/HMP Populations



Disenrollments

Effective June 2023, MDHHS began the Medicaid and Healthy Michigan renewals as part of the Public Health Emergency end of continuous enrollment. MSHN has been monitoring the disenrollments to ensure and assist individuals with maintaining coverage where appropriate. Disenrollments may also affect those eligible for services. As of June 2024 (the date of Medicaid annual redeterminations), MSHN has seen a decline in Medicaid and Healthy Michigan, with 116,701 individuals losing coverage.

Service Population Penetration Rates

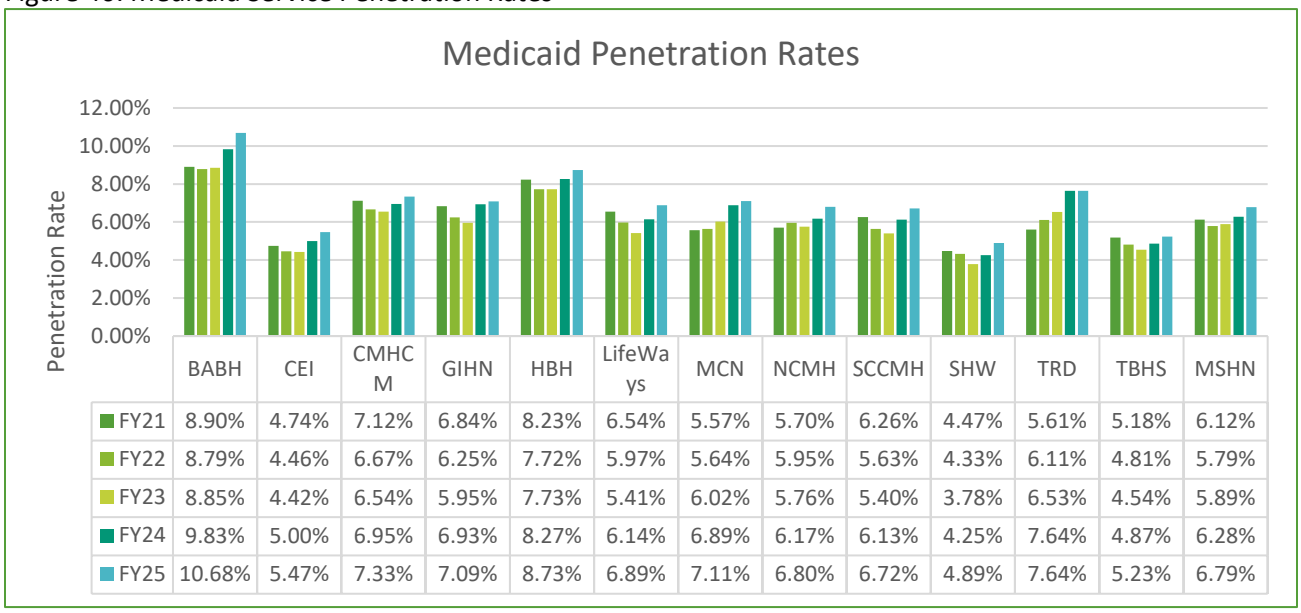
Medicaid enrollees since FY21 increased from the intentional hold on any eligibility loss due to COVID-19. Eligibility reviews began at the end of FY23 resulting in a continued decrease in Medicaid enrollment. Variability does exist among the CMHSP Participants in the region relative to population penetration 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. Figures 46 and 47 show the Medicaid and Healthy Michigan penetration rate per CMHSP by fiscal year. Figure 48 shows the number of consumers serviced.

Compared to FY21, CMHSPs have exceeded Medicaid penetration rates in FY25 and have continually increased individuals served. As of the end of FY25, (MDHHS Michigan's Mission-Based Performance Indicator System (MMBPIS) PIHP, July 1, 2025 - September 30, 2025)[9] MSHN had the fourth highest penetration rate at 8.69% out of the 10 PIHPs.

During FY25, MSHN observed increased utilization across multiple substance use disorder (SUD) service categories, including assessments, outpatient treatment, residential services, withdrawal management, and medication for opioid use disorder (MOUD). This increase aligns with several system enhancements that improved access, capacity, and care coordination across the region. Effective October 1, 2024, MSHN expanded its centralized SUD Access process to include standardized screening and ASAM level-of-care determinations for withdrawal management, residential treatment, and recovery housing, reducing referral delays and improving matching to providers with available capacity. During the same period, MDHHS transitioned the Opioid Health Home model to a broader Substance Use Disorder Health Home structure and expanded eligibility to include individuals with alcohol and stimulant use disorders, strengthening care coordination and engagement in outpatient and MOUD services. FY25 also included growth in residential and withdrawal management capacity through expansion of ASAM 3.1 and 3.5 residential beds and restored admissions following provider relocation and staffing stabilization. Implementation of the SAMHSA 42 CFR Part 8 Final Rule further reduced barriers to MOUD treatment by allowing medication initiation following screening, removing counseling prerequisites, and expanding

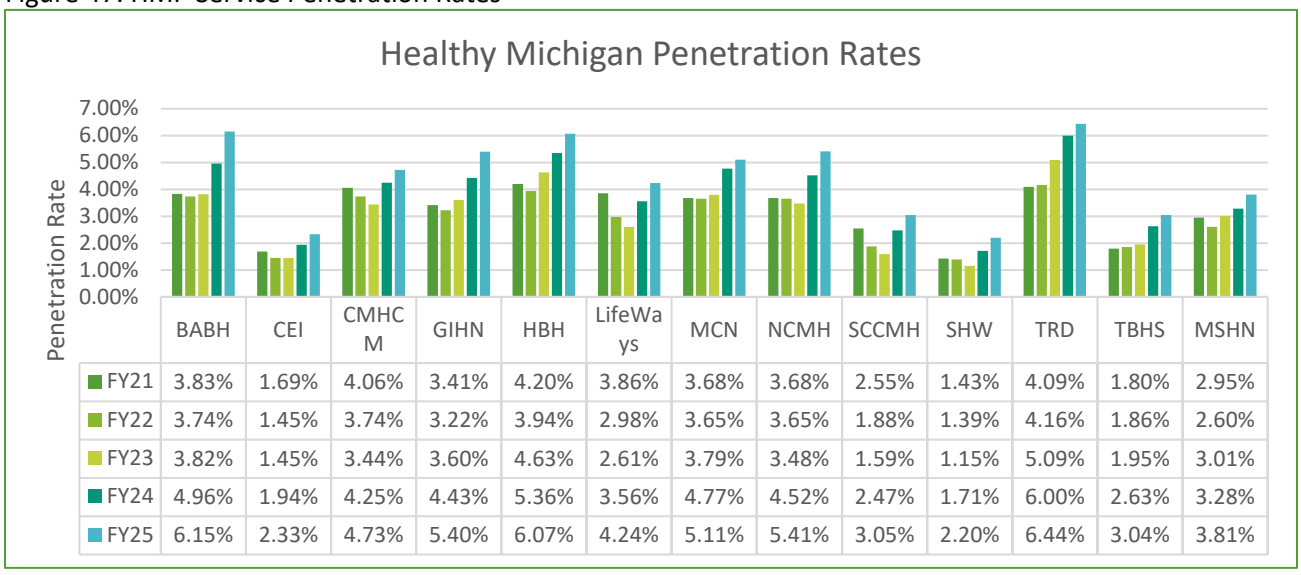
take-home flexibilities. Opioid Settlement Fund investments also supported transportation, outreach, harm reduction infrastructure, and service navigation roles that improved linkage to care and intake completion rates. Additionally, recognizing that the COVID-19 pandemic disproportionately impacted communities of color and that overdose deaths have risen most steeply among Black and Native American populations, MSHN implemented the Equity Upstream Learning Collaborative with seven (7) SUD providers, where targeted outreach, expanded use of Peer Recovery Coaches, and cultural humility training helped increase engagement and service penetration among people of color. Collectively, these operational, regulatory, and equity-focused efforts contributed to increased SUD service utilization and strengthened network access across the region.

Figure 46: Medicaid Service Penetration Rates[9]



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS	MSHN
FY21	8.90%	4.74%	7.12%	6.84%	8.23%	6.54%	5.57%	5.70%	6.26%	4.47%	5.61%	5.18%	6.12%
FY22	8.79%	4.46%	6.67%	6.25%	7.72%	5.97%	5.64%	5.95%	5.63%	4.33%	6.11%	4.81%	5.79%
FY23	8.85%	4.42%	6.54%	5.95%	7.73%	5.41%	6.02%	5.76%	5.40%	3.78%	6.53%	4.54%	5.89%
FY24	9.83%	5.00%	6.95%	6.93%	8.27%	6.14%	6.89%	6.17%	6.13%	4.25%	7.64%	4.87%	6.28%
FY25	10.68%	5.47%	7.33%	7.09%	8.73%	6.89%	7.11%	6.80%	6.72%	4.89%	7.64%	5.23%	6.79%

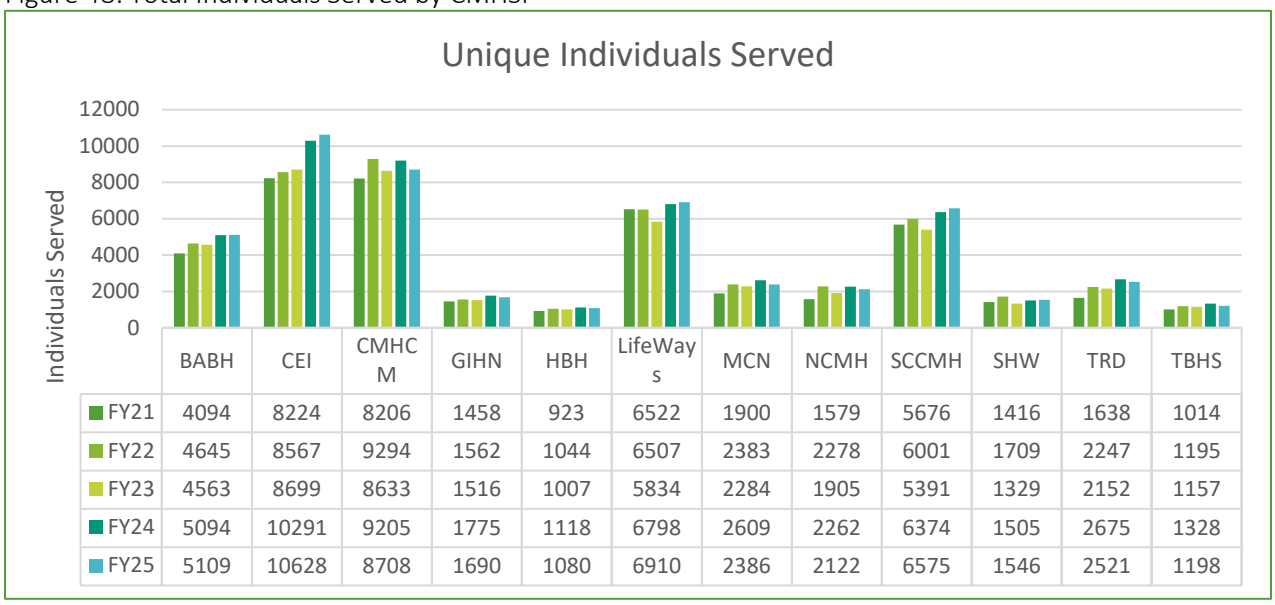
Figure 47: HMP Service Penetration Rates[10]



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS	MSHN
FY21	3.83%	1.69%	4.06%	3.41%	4.20%	3.86%	3.68%	3.68%	2.55%	1.43%	4.09%	1.80%	2.95%
FY22	3.74%	1.45%	3.74%	3.22%	3.94%	2.98%	3.65%	3.65%	1.88%	1.39%	4.16%	1.86%	2.60%
FY23	3.82%	1.45%	3.44%	3.60%	4.63%	2.61%	3.79%	3.48%	1.59%	1.15%	5.09%	1.95%	3.01%
FY24	4.96%	1.94%	4.25%	4.43%	5.36%	3.56%	4.77%	4.52%	2.47%	1.71%	6.00%	2.63%	3.28%
FY25	6.15%	2.33%	4.73%	5.40%	6.07%	4.24%	5.11%	5.41%	3.05%	2.20%	6.44%	3.04%	3.81%

[9] Source: MDHHS FY25Q4 PIHP Consultation Draft
[10] Source: MSHN REMI Penetration Report

Figure 48: Total Individuals Served by CMHSP[11]



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS
FY21	4094	8224	8206	1458	923	6522	1900	1579	5676	1416	1638	1014
FY22	4645	8567	9294	1562	1044	6507	2383	2278	6001	1709	2247	1195
FY23	4563	8699	8633	1516	1007	5834	2284	1905	5391	1329	2152	1157
FY24	5094	10291	9205	1775	1118	6798	2609	2262	6374	1505	2675	1328
FY25	5109	10628	8708	1690	1080	6910	2386	2122	6575	1546	2521	1198

Community Needs Assessments: Priority Needs and Planned Actions

Each CMHSP is required by MDHHS to complete a Community Needs Assessment each year. The needs assessment addresses service requests and their disposition, the use of service access waiting lists and other community demand information. This assessment informs decision making related to the sufficiency and adequacy of the provider network to address local needs and priorities. In aggregate, the Needs Assessments are also informative regarding regional provider network adequacy. The CMHSP Participants in the MSHN region completed either new community stakeholder surveys to assess community needs this year or provided an update of their last assessment. A regional composite of CMHSP Needs Assessment Priority Needs is shown in Table 14.

[11] Source: MSHN REMI Penetration Report

Table 14: Community Needs Assessment Priorities (Based on the Top Five Priorities per CMHSP Only)[12]

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			5	3	3	1		3	2	2	2	3
Community education, prevention, outreach	5		5	3	4				5	4		4	
Access to Inpatient and/or Residential Placements	10-11	2	3			2					1		4
Services for Children	2-3					4	3			4			2
Integrated healthcare and health outcomes	2-3		4	4		4				2			
Ease of access to MH care	4		2			2	4	4	4	5	4	3	
Suicide Prevention	6-7	5				5	2	1			3	1	
Effect of Trauma	6-7										3		
Staff Recruitment/Retention	8	1				3		2	1	5		5	1
Social Determinants of Health	9			1		1		3	2	2			5
Affordable and Appropriate Housing; Homelessness	12-13	3	1	2		1	5			2/3	3		
Services to mild/mod MH needs; uninsured	12-13							5		1			
Alternatives to Inpatient Psychiatric Services	10-11	4							1	1/2	5		
Youth Suicide	10-11						2						
Transportation to MH services	12-13									2/3			
System Navigation, Referral Coordination, and Continuity of Care					4								
Address Workforce Capacity and Resource Limitations					5								
Expand Youth and School-Based Mental Health Supports					2								
Access to Timely Mental Health Services and Treatment Capacity for Individuals with Private insurance					1								

Across the region, services for individuals with substance *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

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

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 a key factor in evaluating the adequacy of a provider network. MSHN conducts an annual assessment of consumer perceptions of care for individuals receiving services funded by the PIHP. This assessment utilizes the Mental Health Statistics Improvement Program (MHSIP) and Youth Satisfaction Survey (YSS) tools depending on the service population. These surveys gather feedback on the quality, availability, and accessibility of care for adults and children receiving long-term support and services for mental illness, developmental disabilities, and/or substance use disorders. Survey results are analyzed both regionally and locally by various service programs. These programs include, but are not limited to, Assertive Community Treatment, Outpatient Therapy, Targeted Case Management/Supports Coordination Services, Home-Based Services, Residential Services, and Withdrawal Management. Surveys are distributed through multiple methods, including mail, phone, electronic platforms, and face-to-face surveying efforts.

Responses to the Perception of Access to Services subscale indicated favorable ratings of 93% for youth and 89% for adults. Additionally, 87% of youth and 91% of adults reported that the services they received were appropriate in addressing their treatment needs. Among individuals receiving services for a substance use disorder, 92% reported services were appropriate for their needs. Overall, general satisfaction remains high, with 91% of adults receiving mental health services and 90% of individuals receiving substance use disorder services reporting positive experiences. While these ratings exceed the satisfaction benchmark of 80%, MSHN remains committed to continuous improvement in consumer satisfaction across the region.

Consumer satisfaction results are reviewed by the MSHN Quality Improvement Council, the MSHN Clinical Leadership Committee, and the Regional Consumer Advisory Council. MSHN's QIC group assesses trends and determines whether regional improvements or individualized local improvement efforts are necessary. Improvement efforts are prioritized for areas where satisfaction rates fall below 80% or where a significant decline is observed compared to previous survey years. Priority areas are also identified based on input from 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 has defined home and community-based settings by the presence of opportunities the individual has to make his or her own choices, come

and go as they choose, interact in their community, and move freely and access public areas of their home. 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 has continued to work with its CMHSPs and MDHHS around priority areas, including updating the provider and beneficiary survey processes, provisional meetings, and further defining the IPOS eight elements and the distinctness from behavior treatment plan processes. CMS visited Michigan in July 2024 which resulted in a corrective action plan to address individual provider findings as well as systemic level changes affecting all PIHP regions. MSHN and partner CMHSP staff visit contracted residential and non-residential sites throughout the region to address ongoing HCBS Rule compliance and to ensure that requirements are operationalized.

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[13]. 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. Beginning on 10/1/2024, MSHN introduced a new partially-centralized access process for individuals seeking withdrawal management, SUD residential treatment, or recovery housing services. Individuals seeking those services can call the MSHN Access Center 24/7/365. MSHN contracts with a professional after-hours behavioral health call center, Protocall, to provide after-hours coverage for the MSHN Access Center. MSHN continues to delegate access responsibilities for all other SUD services to its CMHSP Participants and SUD Providers. 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 area 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.

[13] 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."

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).

Timely Appointments

MDHHS requires PIHPs to report indicators of access timeliness and outcomes related to 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 do not exclude any individuals and 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 indicators that measure persons being seen for a follow up within 7 days of a discharge from inpatient or detox do not exclude those who chose an appointment outside of the required timeframe or chose not to engage in treatment following a request. MSHN should continue to monitor access to timeliness to treatment. Table 15 shows the recent year-to-year performance of the 21-county region.

Ongoing conversations took place within the MSHN Quality Improvement Council (QIC) to address indicators falling below performance standards throughout FY25. A focus was made on reviewing data collection/processes within each of the CMHSPs to ensure consistency in the process of categorization of MMBPIS as well as reviewing improvement interventions to determine best practice. In reviewing, it was found that not all CMHSPs were utilizing consistent omission/exclusion criteria for indicators 2 and 3 as identified by MDHHS and this was updated in FY25Q4. All other MMBPIS indicators (outside of Indicator 2) have been discontinued for reporting to MDHHS in FY26, however, indicators 1 and 3 will continue to be collected for other required MSHN projects. For FY25, the indicators identified in red below with lower percentages are primarily due to the elimination of exception methodology by MDHHS, with consumer choice (no shows, cancellations, appointments requested outside of the time frames by consumers) accounting for the largest portion of out-of-compliance reasons for these indicators.

Table 15: State Performance Indicators for Access Timeliness and Inpatient Follow-Up

	Population	MSHN Performance Rate FY21	MSHN Performance Rate FY22	MSHN Performance Rate FY23	MSHN Performance Rate FY24	MSHN Performance Rate FY25
The percentage of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (Standard: ≥95%)	MI-Children	99.58%	97.69%	98.52%	98.73%	98.87%
	MI-Adults	99.22%	98.96%	98.89%	99.44%	99.58%
The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergent request for service. (Standard: No	MI-Children	69.31%	64.26%	59.91%	65.28%	61.81%
	MI-Adults	63.69%	61.42%	62.76%	66.47%	63.05%
	DD-Children	65.30%	57.77%	44.54%	50.11%	43.19%
	DD-Adults	72.74%	67.77%	57.52%	65.99%	57.42%
	Total	67.39%	62.29%	60.72%	64.97%	60.89%

established standard for populations, >62.3% for Total)						
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 (Standard: No established standard for populations, >72.9% for Total).	MI-Children	68.29%	59.24%	58.83%	60.17%	60.79%
	MI-Adults	72.62%	64.01%	62.17%	65.49%	66.30%
	DD-Children	78.33%	73.26%	80.64%	80.52%	78.63%
	DD-Adults	68.01%	65.58%	62.56%	66.46%	67.71%
	Total	71.34%	63.08%	62.45%	65.00%	65.70%
The percentage of new persons during quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergent request for services. (SUD Only) (Standard: >75.3%)	Medicaid SUD	83.52%	75.48%	73.66%	73.33%	77.78%
The percentage of discharges from psychiatric inpatient unit/substance use disorder detox unit seen for follow-up care within 7 days. (Standard: ≥95%)	Children	98.90%	97.44%	97.79%	97.82%	96.56%
	Adults	97.02%	96.17%	95.76%	96.14%	95.95%
	Medicaid SUD	96.68%	97.19%	97.46%	93.98%	93.52%
The percentage of readmissions to an inpatient psychiatric unit within 30 days of discharge. (Standard: <15%)	Children	7.97%	5.50%	8.72%	8.38%	9.52%
	Adults	12.62%	10.08%	12.36%	11.48%	11.49%

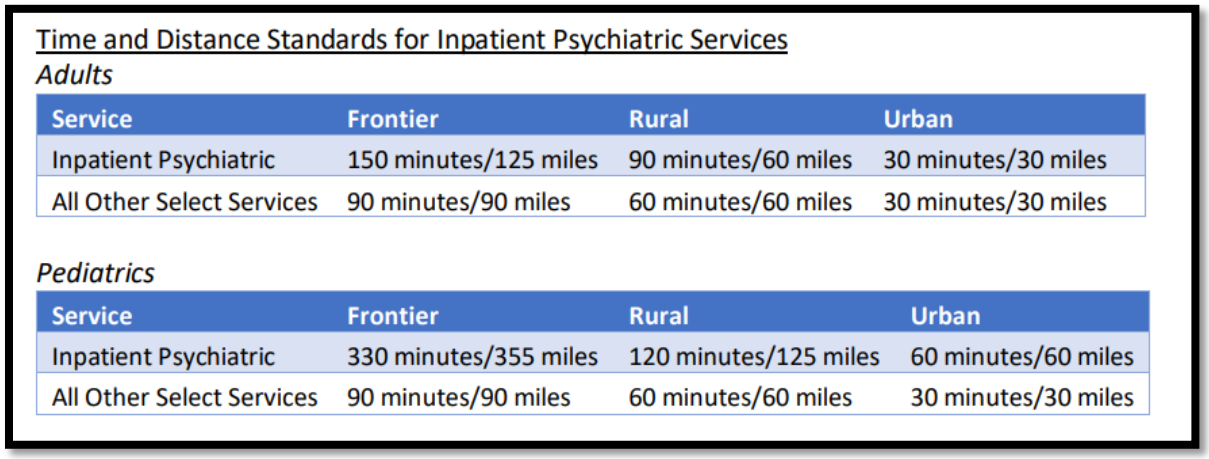
FY23 Maximum Time and Distance Standards

Understanding the locations of behavioral health providers in relation to the people needing services is the first step in addressing distance challenges associated with network adequacy. **In FY23, MSHN employed the following methodology to understand network adequacy. Please note that as of FY24, MDHHS completes the analysis of PIHPs time and distance standards.**

Data from the 2020 Census allows MSHN to estimate the population centers within the region. Population centers are the estimated number of individuals residing within a custom-mile hexagonal boundary. There are thousands of these population centers across MSHN's region. Each population center is assigned to its nearest provider. The nearest provider is determined by finding the provider location with the shortest straight-line distance (in miles) to the population center of interest.

Once all population centers were assigned to their nearest provider, network adequacy was calculated by measuring the proportion of the population centers that fall below a certain acceptable mile-distance threshold. For instance, if the maximum allowable distance to the nearest provider is 30 miles, and 933 out of our estimated 1,000 residents travel less than 30 miles to reach their nearest provider, then 93.3% of the population falls within acceptable coverage. For this example, the county network adequacy is 93.3%.

Figure 49: FY23 Time and Distance Standards for Inpatient Psychiatric Services



Time and Distance Standards for Inpatient Psychiatric Services

Adults

Service	Frontier	Rural	Urban
Inpatient Psychiatric	150 minutes/125 miles	90 minutes/60 miles	30 minutes/30 miles
All Other Select Services	90 minutes/90 miles	60 minutes/60 miles	30 minutes/30 miles

Pediatrics

Service	Frontier	Rural	Urban
Inpatient Psychiatric	330 minutes/355 miles	120 minutes/125 miles	60 minutes/60 miles
All Other Select Services	90 minutes/90 miles	60 minutes/60 miles	30 minutes/30 miles

Figure 50: FY23 Overview of Time and Distance Standards Results

	SUD Outpatient	Outpatient	Homebased	ACT	Clubhouse	Wraparound	Psych Inpatient Children	Psych Inpatient Adults	SUD Residential	SUD Withdrawal Management	Crisis Residential
Rural Stadard	60 min/60 miles	60 min/60 miles	60 min/60 miles	60 min/60 miles	60 min/60 miles	60 min/60 miles	120 min/125 miles	90 min/60 miles	90 min/60 miles	90 min/60 miles	90 min/60 miles
Urban Standard	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	60 min/60 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles
% of Total Population Standard Met	100%	100%	100%	100%	99.63%	99.90%	86.00%	99.00%	94.90%	99.70%	95.19%

Based on the key findings in Figure 50, MSHN focused efforts related to recruitment of providers for SUD residential, psychiatric inpatient for children, and crisis residential. In FY23, MSHN supported an RFP for SUD residential and withdrawal management services, as well as outpatient SUD services (with option of MAT/MOUD). MSHN identified a provider in FY23 to support the SUD residential and withdrawal management services with focus in Isabella County, and services were finally implemented in June 2025 to support increased capacity of 75 SUD residential beds in the MSHN geographic region. MSHN also identified providers to support SUD outpatient services during FY23. This included a provider in Montcalm County to support SUD outpatient and MAT/MOUD services, as well as another to support SUD outpatient in Isabella County where needs were identified outside of the time and distance standards.

As previously noted, MSHN supported a FY24 Request for Proposals (RFP) to expand adolescent substance use disorder (SUD) services across the region, including withdrawal management, residential, and outpatient levels of care. Through this initiative, one provider expanded SUD outpatient services with medication-assisted treatment (MAT) into seven additional counties, improving regional access and service availability.

In FY25, MSHN pursued youth crisis residential service certification with a provider which ultimately did not occur as the provider withdrew. MSHN has continued to review opportunities to strengthen its crisis response system and will continue these efforts into FY26.

Adolescent SUD services remained a significant network need in FY25, particularly following the loss of one of two contracted adolescent residential providers due to rate differentials. This development highlighted ongoing system capacity challenges and prompted continued collaboration between MDHHS

and the statewide SUD Directors group. MSHN led a dedicated subgroup tasked with developing strategic recommendations to strengthen adolescent service capacity across the state.
The subgroup advanced a three-pronged proposal focused on:

1. Stabilizing existing adolescent SUD residential capacity through appropriate reimbursement structures and targeted workforce training.
2. Developing a centrally located adolescent SUD provider offering the full continuum of care, including telehealth access to support statewide PIHP utilization.
3. Expanding evidence-based training and workforce development opportunities to strengthen clinical capacity among adolescent providers, particularly given the relatively early-career composition of the workforce.

During proposal development, MDHHS notified the subgroup that funding would not be available to advance the initiative at that time. As a result, implementation activities were paused pending future funding opportunities.

FY24 - FY25 Maximum Time and Distance Standards

MDHHS updated the Network Standards related to Time and Distance in FY24 and remained unchanged for FY25. Time/distance standards are now categorized by Large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations (CEAU). MDHHS has also set a minimum threshold for Time and Distance compliance:

- At least 85 percent of the beneficiaries residing in counties classified as micro, rural, or counties with extreme access considerations (CEAC) have access to at least one provider/facility of each specialty type within the published time and distance standards. 42 CFR 422.116 (d)(4)(i)
- At least 90 percent of the beneficiaries residing in large metro and metro counties have access to at least one provider/facility of each specialty type within the published time and distance standards. 42 CFR 422.116 (d)(4)(ii)

MDHHS will utilize PIHPs Provider Directories to calculate compliance with the time and distance standards, providing the results to the PIHPs. The results from MDHHS for FY24 are included in the attached Appendix 1 and listed results under Figure 51a & b. FY25 results are expected in the spring/summer of FY26.

Figure 51: FY25 Time and Distance Standards

Service	CEAU	Rural	Micro	Metro	Large Metro
Inpatient Psychiatric[2]	155 minutes/140 miles	90 minutes/75 miles	100 minutes/75 miles	70 minutes/45 miles	30 minutes/15 miles
All Other Services	118 minutes/105 miles	75 minutes/60 miles	70 minutes/53 miles	45 minutes/30 miles	20 minutes/10 miles

Figure 51a: Adult Services

Service	Time/Distance Percentage Rate		Provider to Enrollee Ratio Met or Unmet
Assertive Community Treatment (1:30,000)			Met (1:19,006)
Crisis Residential Programs (16 Beds Per 500,000 Total Population)	96.1%	87.9%	Met (127:1,643,130)
Opioid Treatment Programs (1:35,000)	100%	99.5%	Met (1:12,008)
Psychosocial Rehabilitation Programs (1:45,000)	99.3%	93.8%	Met (1:38,011)
Inpatient Psychiatric Services	99.6%	94.9%	

*Time/Distance percentage rates above are based on the PIHP's overall percentages. Specific CMH/Counties not meeting the compliance percentages are reported in appendix 1.

Figure 51b: Pediatric Services

Service	Time/Distance Percentage Rate		Provider to Enrollee Ratio Met or Unmet	Baseline Data Results
Inpatient Psychiatric Services	86.1%	66%		
Crisis Residential Programs (8-12 Beds Per 500,000 Total Population)	50%	33%	Met (30:1,643,130)	

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 language highlights 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.

In the late third quarter of FY24, MDHHS submitted for renewal by CMS, its three C-Waiver applications and 1915(i) State Plan Amendment (SPA). These applications were approved by CMS by late first quarter FY25. The applications stipulate the requirements for Conflict Free Access and Planning (CFAP) must separate organizationally who provides the access and planning function and the direct services (an HCBS service) function for individuals who receive home and community-based services. MSHN and its CMHSPs will complete an analysis of situations where the CMHSP provides both functions and to further plan and guide how adherence to CFAP will be reached. The implication for the MSHN region is to ensure that there are a sufficient number of HCBS providers to encourage choice, person-centeredness, and

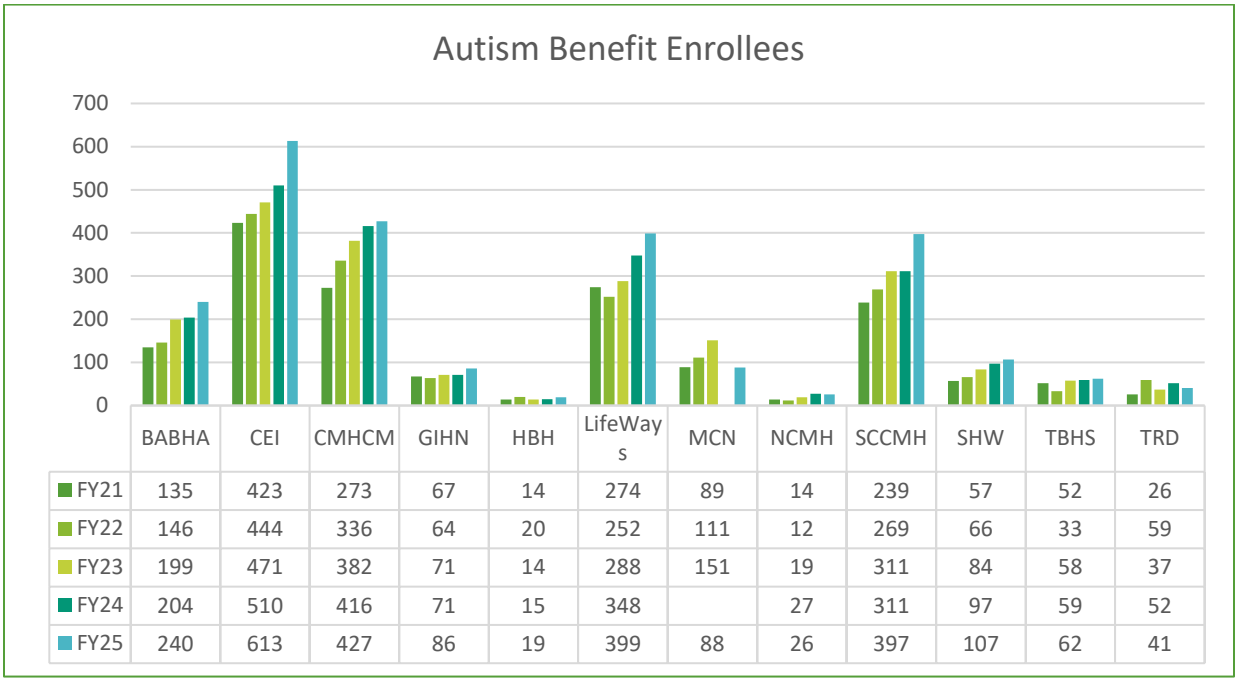
inclusion. MDHHS has identified the Only Willing and Qualified Provider (OWQP) status to address counties that, according to Federal standards, meet rural or critical access area criteria. If a county receives the OWQP designation, the affected CMH can provide both access and planning as well as direct services but must endeavor to bring in providers to address the gap.

While this planning was expected to occur in FY25 and into FY26, MDHHS issued a request for proposal (RFP) in an effort to reprocure Michigan's behavioral health system and condense from ten (10) PIHPs to three (3). Since CFAP was a part of the RFP, this created a pausing effect until details could be worked out, in light of a lawsuit contesting the merits of the RFP. Ultimately, in early FY26, the RFP was withdrawn after the judge ruled in favor of the CMHSPs. Lastly, shortly after the RFP withdrawal, MDHHS issued an amendment to the HSW application that is open until mid-March 2026. This amendment updated the CFAP language and will be promulgated through the approval process. The MSHN CMHSPs will begin planning around addressing this anticipated big system change. The majority of the MSHN system is conflict-free (i.e., functions are firewalled) but does not fully comport with the updated CFAP rule as envisioned by MDHHS.

Sufficiency of Number of Providers: Autism Spectrum Disorder Capacity

Previous years' assessments found that CMHSP Participants were finding it difficult to secure and maintain adequate providers to provide Behavioral Health Treatment/Applied Behavioral Analysis services for individuals with autism, due to the continued steady increase in enrollment numbers across the region, provider comfort and competence with service older youth with more significant behavioral challenges, the need for services outside of identified school hours, and reduction in available service providers. In preparation for the elimination of the allowance of QBHPs as of 10.1.25, MSHN and its CMHSP Participants have worked diligently to identify and support QBHPs towards full licensure as BCBAs/LBAs. With the current total of 55 ABA provider contracts (29 shared providers and 26 single CMHSP contracts), the region continues to work to support an increase in capacity from successful ABA Providers and to establish contracts with additional ABA providers since the rate of enrollees has continued to climb precipitously in many CMHSPs over the past year. Figure 52 shows that most CMHSPs have experienced significant increases in Autism Benefit service enrollment in the past few years.

Figure 52: Autism Benefit Enrollees[14]



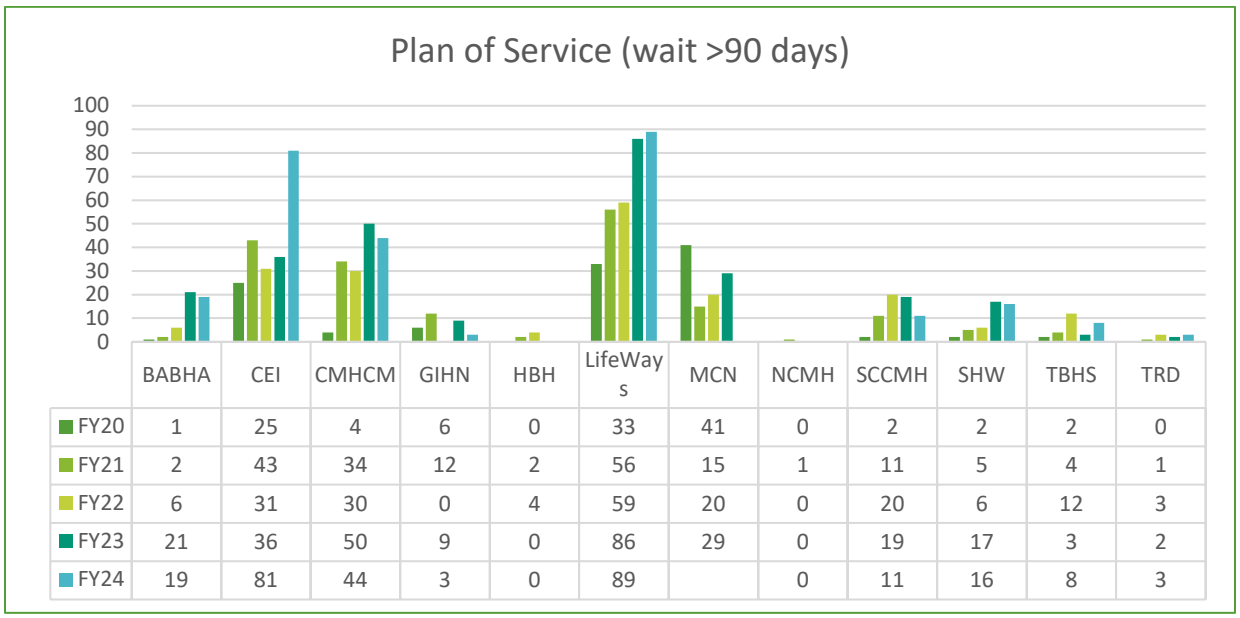
	BABHA	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TBHS	TRD
FY21	135	423	273	67	14	274	89	14	239	57	52	26
FY22	146	444	336	64	20	252	111	12	269	66	33	59
FY23	199	471	382	71	14	288	151	19	311	84	58	37
FY24	204	510	416	71	15	348		27	311	97	59	52
FY25	240	613	427	86	19	399	88	26	397	107	62	41

Following the MDHHS elimination of the WSA for autism tracking and monitoring in April 2023, MSHN worked with its CMHSPs to develop a new system for oversight outside of the WSA. Within that system, ABA quality and compliance issues were able to be highlighted in regular monthly reporting and shared with the CMHSPs. MSHN provided monthly notification to each CMHSP with data linked to referral date (date family requested services) to the current number of days pending completion of an initial comprehensive evaluation. MSHN also was able to send notification monthly to each CMHSP with data referencing all individuals with an Overdue Service Start Date. This measured the time from eligibility determination to start date of ABA services within the post WSA tracking system. Although effective for monitoring and oversight purposes, this process required intensive, daily, hand entry of hundreds of regional data points. As a result, the MSHN region voted to forgo this process and to stop the submission of data points to MSHN and to instead improve internal processes to collect this information within each

[14] Source: MSHN Autism Report

Electronic Medical Record (EMR). MSHN partnered with one CMHSP to pilot internal data entry processes in comparison to data points supplied in previous regional reporting. Once calibrated, the processes were shared across all MSHN CMHSPs which are now working with their EMR project managers to develop a similar structure for tracking and monitoring ABA data. Without access to this regional data, MSHN was not able to report on the number of those waiting longer than 90 days to start service for FY25.

Figure 53: Individuals Enrolled with an Overdue Service Start Date (Greater than 90 Days from Eligibility)[15]



	BABHA	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TBHS	TRD
FY20	1	25	4	6	0	33	41	0	2	2	2	0
FY21	2	43	34	12	2	56	15	1	11	5	4	1
FY22	6	31	30	0	4	59	20	0	20	6	12	3
FY23	21	36	50	9	0	86	29	0	19	17	3	2
FY24	19	81	44	3	0	89		0	11	16	8	3

Sufficiency of Mix of Providers: Cultural Competence

MSHN requires cultural competence training for staff and its provider network. Out of 1,410 provider listings in the region's Provider Directory, 97.87% indicated Cultural Competency training, which is a slight decrease from 97.9% reported in FY24.

Where MSHN providers are in geographic areas with high concentrations of ethnic or cultural groups, some offer culturally specific services such as the Latino counseling services available through the CEI provider network. The MSHN Provider Directory indicates where providers specialize in serving distinct ethnic or cultural groups. MSHN recognizes that in its SUD provider network, we do not have sufficient providers with diverse clinical staff that mirror the diversity of communities like Saginaw, Lansing, Jackson and Mt. Pleasant. This is likely a contributing factor in low penetration rates for Black, Hispanic and Native American communities. As part of a larger initiative to reduce health disparities, MSHN is encouraging providers to consider hiring practices that improve workforce diversity. This will be added to FY27 SUD annual planning that will allow for tracking in subsequent years.

MSHN collects and provides public information via MSHN's website related to the persons served by Race (Figure below). CMHSPs and SUD Providers collect information from individuals served related to specific cultural awareness/needs as identified during person centered planning.

[15] Source: MSHN Autism Report

Figure 54: Persons Open by Race FY2025

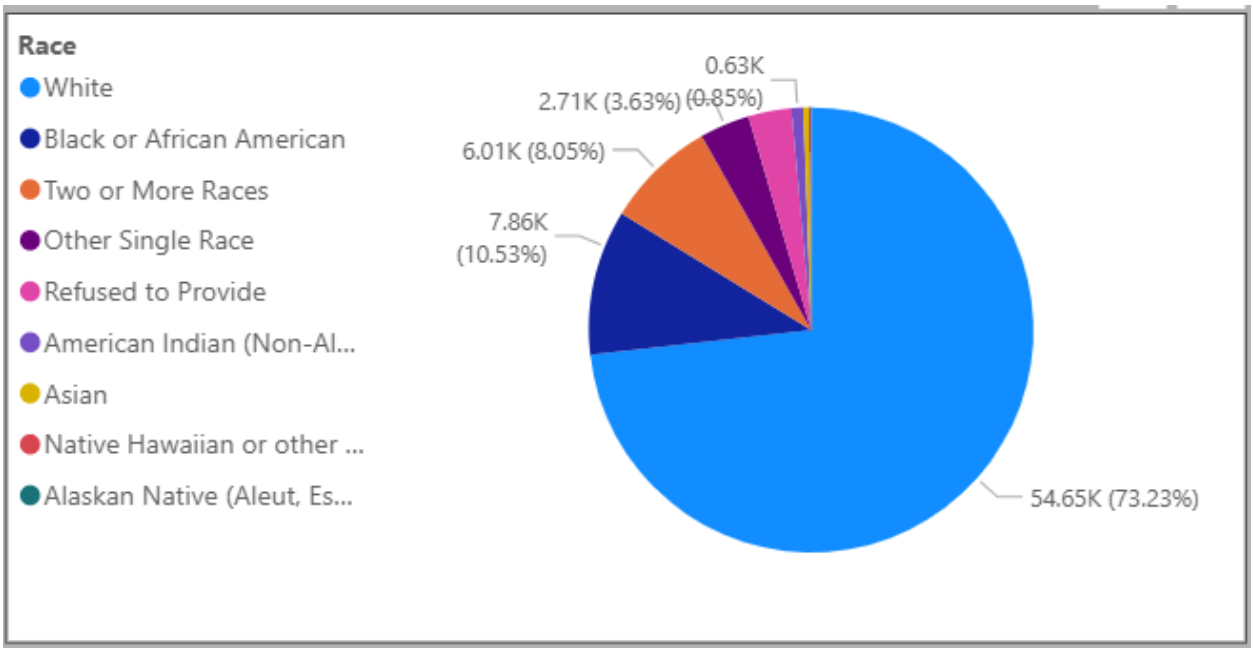
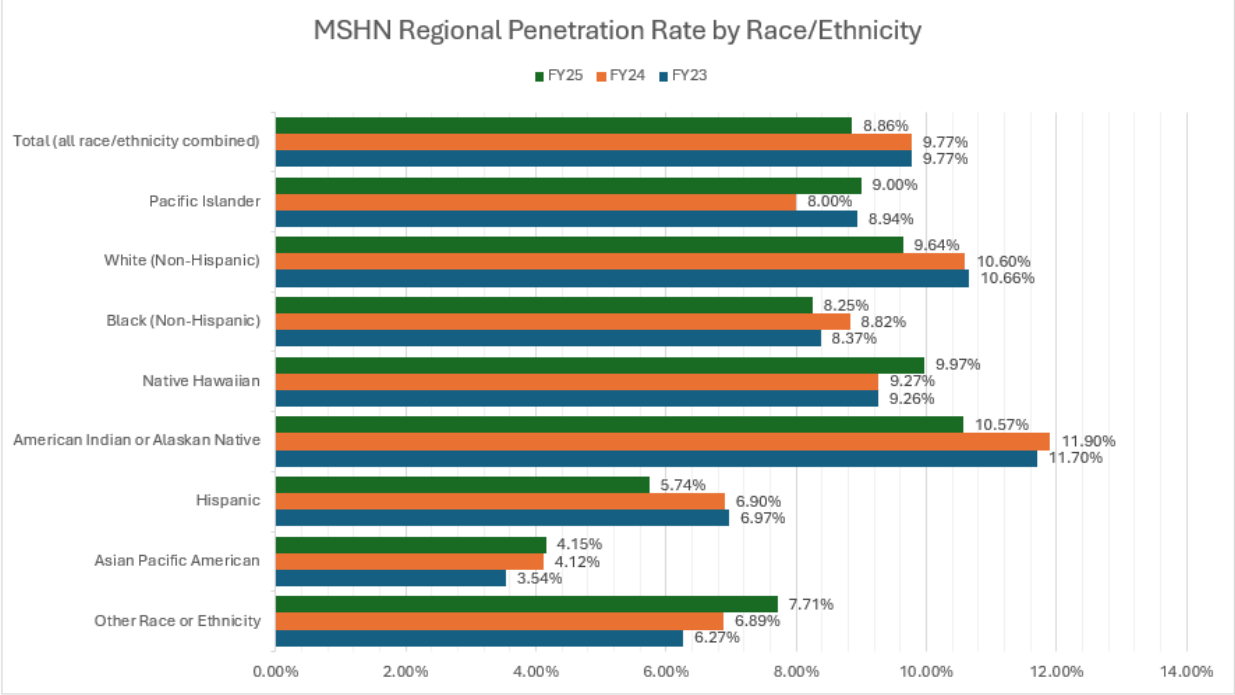
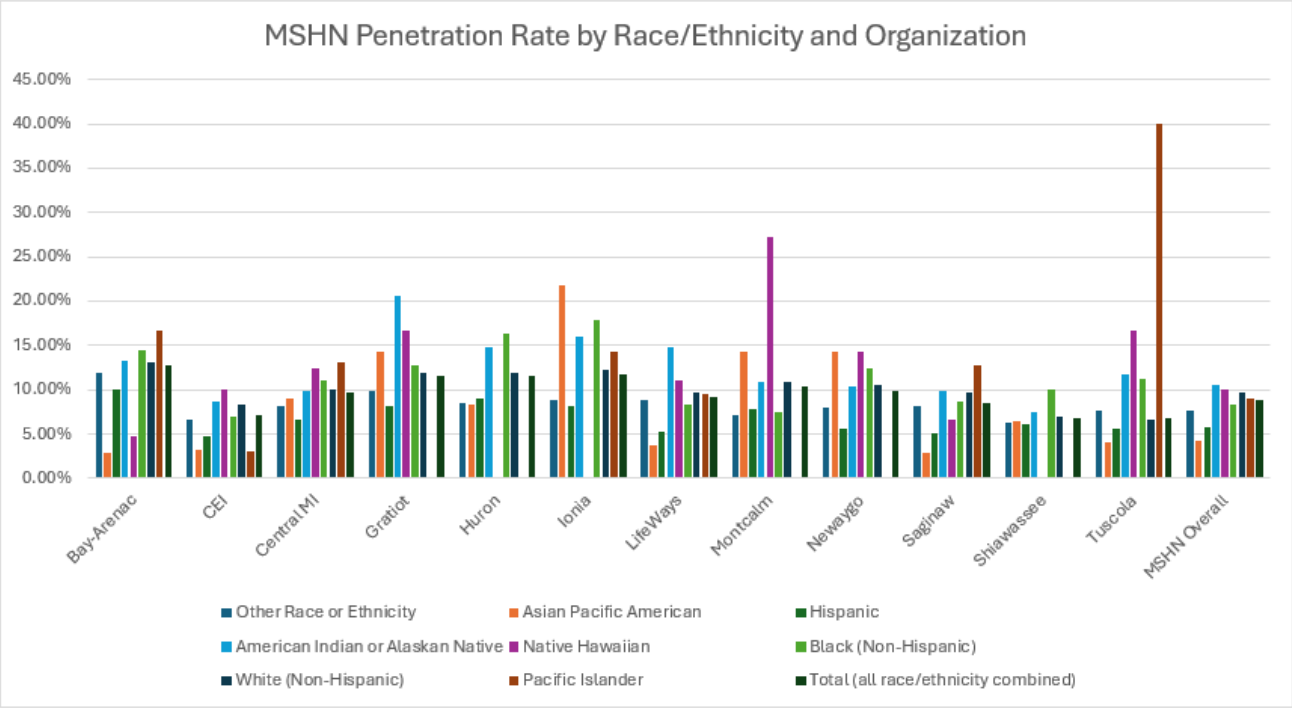


Figure 55: MSHN Regional Penetration Rate by Race/Ethnicity FY23-FY25



NOTE: Data excludes denominators with race/ethnicity as blank or unknown

Figure 56: Penetration Rate by Race/Ethnicity FY2025



Sufficiency of Mix of Providers: Diversity, Equity, and Inclusion

Mid-State Health Network is committed to finding intentional ways to achieve better equity in our organization and in our region, to diversify our workforce, stakeholders, and service participants, to grow in our understanding and inclusion of all residents of Region 5, and to eliminate bias, discrimination, and health disparities in the healthcare services we exist to support.

MSHN along with its CMHSP partners have developed plans and policies to address community specific areas of need in ways that reach all populations in our region, so none are excluded. Areas of focus are informed by locally identified needs for improvement, but regional themes that emerged include the below:

- Treatment services for specified target groups based on (age, ethnicity, race, gender, sexual orientation, language, military, religion/spiritual, and socioeconomic)
- Board & Governance
- Clinical Services & Accessibility
- Policy & Procedure Review
- Population Analysis & Trends
- Public Relations / Community Partnerships
- Agency Purpose Statement / Vision
- Quality & Performance Improvement
- Recruitment & Retention & Evaluation
- Social Determinates of Health & Other Health Disparities
- Staffing Analysis (compensation, discipline, etc.)
- Task Force/Workgroup/Workplan
- Training & Engagement Plan

MSHN is in the process of developing a plan to identify gaps and establish regional efforts to reduce health disparities, increase staff diversity within the network and ensure equitable service delivery across the region. MSHN will share lessons learned in the *Equity Upstream* Learning Collaborative pilot to all SUD providers and CMH partners to consider for implementation in their respective service areas.

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. MSHN also supports transportation to and from SUD levels of care for withdrawal management and residential in an attempt to eliminate this as a barrier to treatment for individuals.

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 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[16]. Out of 1,406 provider listings in the region's Provider Directory, 82.07% indicated accommodations in accordance with the Americans with Disabilities Act. Delivery of services in home settings, as well as telemedicine, 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.

[16] 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."

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.

Table 16: Limited English Proficiency

	Languages Spoken																		
COUNTY	Albanian	Arabic	Bengali, Bangla	Chinese	English	French	German	Hindi	Korean	Kurdish	Portuguese	Punjabi	Russian	Somali	Spanish	Swahili	Tigrinya	Turkish	Urdu	Vietnamese
ARENAC					99.70%			0.04%					0.02%		0.09%					
BAY		0.01%			99.56%										0.12%					
CLARE		0.04%			99.57%								0.07%		0.17%					
CLINTON	0.01%	0.18%	0.01%	0.03%	98.56%				0.01%				0.01%		0.51%				0.01%	0.01%
EATON		0.15%		0.01%	97.51%	0.05%				0.01%		0.01%			1.59%	0.12%			0.01%	0.02%
GLADWIN		0.01%			99.13%										0.44%					
GRATIOT					99.22%							0.01%			0.43%					
HILLSDALE		0.01%	0.01%		99.39%		0.03%				0.01%		0.01%		0.29%					
HURON		0.02%		0.01%	99.24%								0.01%		0.32%					
INGHAM	0.01%	0.73%		0.03%	96.64%	0.09%		0.02%	0.02%	0.01%		0.01%	0.05%	0.06%	1.31%	0.49%	0.01%	0.01%	0.01%	0.04%
IONIA		0.02%			99.27%	0.01%	0.01%	0.01%							0.44%	0.01%				
ISABELLA		0.01%		0.02%	99.00%										0.31%					
JACKSON		0.01%	0.01%	0.01%	99.15%										0.44%				0.01%	0.02%
MECOSTA		0.02%	0.01%	0.01%	99.44%										0.16%					
MIDLAND		0.01%	0.01%		99.08%							0.01%	0.01%		0.36%			0.01%	0.01%	0.01%
MONTCALM					99.48%	0.02%	0.01%								0.31%					
NEWAYGO		0.02%		0.01%	98.88%						0.01%	0.01%	0.01%		0.86%					
OSCEOLA		0.02%		0.01%	99.37%								0.01%		0.23%					
SAGINAW		0.03%		0.01%	99.19%						0.01%		0.01%		0.45%					0.01%
SHIAWASSEE				0.01%	99.49%										0.11%					
TUSCOLA					99.30%								0.01%		0.38%					

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 accordance with MDHHS standards, are less than adequate for crisis intervention services, where a timely clinical response is critical, and wait times to access 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.

As of the FY25 assessment, no MSHN county has more than 5% of non-English speaking individuals as identified in the above chart.

FY25 Health Home Expansion

Certified Community Behavioral Health Clinics

The Excellence in Mental Health Act demonstration established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs). CCBHCs provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals and are responsible for directly providing (or contracting with partner organizations to provide) services including:

- 24-hour crisis care
- utilization of evidence-based practices
- access to behavioral health care
- care coordination & integration with physical health care
- provide care regardless of ability to pay or Medicaid

The federal CARES Act of 2020 authorized two additional states—Michigan and Kentucky—to join the demonstration. As a result, MDHHS was approved for a two-year demonstration with an implementation start date of October 1, 2021. In the MSHN region, the following Community Mental Health Service Programs (CMHSP) participate as a CCBHC:

- Community Mental Health Authority of Clinton, Eaton and Ingham
- The Right Door for Hope, Recovery and Wellness (Ionia County)
- Saginaw County Community Mental Health
- LifeWays (Hillsdale, Jackson Counties)

As of September 30, 2025, MSHN enrollment in CCBHCs totaled 25,314 beneficiaries.

The CCBHC model eligibility criteria includes:

- All persons with a mental health and/or substance use disorder (SUD)
- Any person with a mental health or SUD ICD-10 diagnosis code is entitled to receive services through a CCBHC
- Severity of needs do not factor into eligibility (includes the Mild-to-Moderate)
- Individuals with an intellectual/developmental disability diagnosis may eligible provided they also have a mental health or SUD diagnosis
- Do NOT have to be Medicaid Eligible or have an ability to pay

As of October 1, 2025, all oversight and monitoring responsibilities for CCBHCs were transferred to MDHHS with PIHPs no longer having any oversight and monitoring responsibilities. Beginning in FY26 MSHN will no longer monitor sufficient provider capacity for CCBHCs as a result of this transition of responsibility.

Substance Use Disorder Health Home (Formerly Opioid Health Home)

MSHN successfully implemented the first Opioid Health Home (OHH) in the region during FY23 in partnership with Victory Clinical Services in Saginaw County. MSHN worked with four providers to implement five new OHH locations during FY24. Beginning in FY25, the OHH initiative became SUD Health Homes and eligibility for services was expanded to any individuals with an Opioid Use Disorder, Alcohol Use Disorder, -or- Stimulant Use Disorder. MSHN released a Request for Interest (RFI) during FY25 Q1 to gauge interest in new providers becoming SUD Health Homes to serve the expanded eligible population. As a result, four additional new SUD HH locations received approval and certification from MSHN and MDHHS during FY25. The following SUD HH locations are currently serving residents of the MSHN region as of 9/30/2025):

- Victory Clinical Services – Saginaw
- Victory Clinical Services – Lansing
- Victory Clinical Services – Jackson
- Recovery Pathways – Bay City/Essexville
- MidMichigan Community Health
- Isabella Citizens for Health
- Recovery Pathways – Corunna
- Sacred Heart Rehabilitation Center – Saginaw
- Sacred Heart Rehabilitation Center – Bay City
- LifeWays – Hillsdale
- Lifeways - Jackson

A Substance Use Disorder Health Home (SUD HH) is a model of care that provides comprehensive care management and coordination services to Medicaid beneficiaries with an Opioid Use Disorder, Alcohol Use Disorder, or Stimulant Use Disorder. The SUD HH functions as the central point of contact for directing patient-centered care across the broader health care system. SUD HH services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. Beneficiaries work with an interdisciplinary team of providers that includes a Health Home Director, Behavioral Health Specialist, Peer Recovery Coach/Community Health Worker/Medical Assistant, Medical Consultant, and Psychiatric Consultant. The SUD HH model is designed to increase access to health care, reduce unnecessary emergency room visits and unnecessary hospital admissions, increase hospital post-discharge follow up, elevate the role of peer recovery coaches and community health workers in particular to foster empathy, and improve overall health and wellness. Participation is voluntary, and enrolled beneficiaries may opt out at any time.

The SUD Health Home receives reimbursement for providing the following federally mandated core services:

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community and social support services

As of September 30, 2025, MSHN enrollment in SUD HH totaled 526 beneficiaries.

MSHN intends to release a Request for Interest (RFI) during FY26 Q1 to gauge interest in new providers becoming SUD Health Homes. MSHN will provide onboarding support to additional SUD HH providers during FY26 as determined by provider interest, community need, and resource requirements to support expansion.

Behavioral Health Home

MSHN successfully implemented the first Behavioral Health Homes in the region during FY23 in partnership with CMH for Central MI, Saginaw CMH Authority, Montcalm Care Network, Newaygo CMH, and Shiawassee Health & Wellness. Additionally, Gratiot Integrated Health Network implemented a

Behavioral Health Home program during FY24. There were no additional Behavioral Health Homes implemented in the MSHN region during FY25. The Behavioral Health Home (BHH) provides comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. For enrolled beneficiaries, the BHH functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model also elevates the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time.

Behavioral Health Home receives reimbursement for providing the following federally mandated core services:

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Support
6. Referral to Community and Social Service

As of September 30, 2025, MSHN enrollment in BHH totaled 344 beneficiaries.

MSHN will continue to offer support and technical assistance to other regional partners who have indicated potential interest in implementing a BHH during FY26.

Appendix A – CMHSP Delegated Efforts to Expand Service Capacity

BABH

- Continued partnership with the Juvenile Detention Center mental health services for youth and families via Juvenile Liaison position embedded in the local Juvenile Center.
- Continued expansion of service provider network specific to autism services.
- Working to add more psychiatry time.
- 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.
- Continued cohort participation for Trauma-Focused CBT training.
- Collaborating partnership with local DHHS to address t needs of children/families who may be at risk of home removal and/or lack of natural supports due to significant mental health issues.
- Enhancing collaborative partnership with courts, law enforcement, prosecutor, jail, and juvenile center to increase jail diversion activities.
- Participating member in local health and human services councils.
- Participating member in local opioid fatality review team.
- Implemented enhanced motivational interviewing training for clinical staff.
- Conducting EBP survey to focus efforts on increasing availability of multiple EBP's within the BABH provider network.
- Recruitment and retention planning to increase availability of outpatient therapy services and direct care workers.
- Continued collaboration with Arenac County community stakeholders to increase the availability of adequate substance use disorder services in the county.
- Narcan kits made available for distribution at all Bay-Arenac locations.
- Program planning to expand peer support services to include implementation of Parent Support Partner and Youth Peer Mentor.
- Increasing availability of crisis residential services, implemented in FY25.
- Implemented Alternative Outpatient Treatment (AOT) (grant funded) program for enhanced monitoring and support for individual on an AOT order.

CEI

- Added more staff in assessment units and in case management teams.
- Expanded the after-hours clinic.
- Added more providers for ABA, residential, and CLS/respite.
- Working to add more psychiatry time as well.
- Added more therapists certified in trauma.
- Added additional hours in the evening to serve youth and families.
- Truancy Intervention Program operates in all three of Clinton, Eaton, and Ingham Counties.
- Expanded the mobile crisis team and extended days/hours.
- Added additional Telepsychiatry for youth.
- Added additional Evidence Based Clinicians in Trauma-Focused Cognitive Behavioral Therapy (TFCBT), Parent Management Training- Oregon model (PMTO) and Dialectical Behavior Therapy (DBT).

- 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.
- Introducing QPR training opportunities to the community.
- Training all staff in QPR and clinical staff in ASIST as part of Zero Suicide Implementation.
- Offering Transitional Youth Services.
- Critical Incident Stress Management (CISM) Team, responded to multiple organization and community events.
- Implemented Care Coordination projects in clinical programs addressing asthma, hypertension, and.
- Worked with Tri-County Crisis Intervention Team Steering Committee to implement additional rounds of 40- hour training sessions for Officers. Provided training to 40 law enforcement personnel in 2025. Over 450 law enforcement personnel training in total since inception of program.
- 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.
- Continue providing Naloxone Kits at three CMHA-CEI SUD programs and to law enforcement agencies in each county with assistance from the PIHP.
- Expanded evening hours for Outpatient SUD services.
- 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 experienced 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.
- Participate in jail diversion meetings twice per year for tri-county area.
- One full-time staff working in the Ingham County 911 Dispatch Center.
- 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.
- Ongoing partnership with co-located FQHC with embedded nurse care manager.
- Behavioral Health Consultants embedded in several community clinics and primary care settings.
- Seeking certification for evidence based Individualized Placement and Support (IPS) with Vocational Services. Piloting with three teams serving individuals throughout CMHA-CEI including individuals with I/DD, MI and ITRS Outpatient Services.
- Continue working with Sparrow Hospital emergency department (ED) to assist in reducing beneficiary time spent in the ED.
- Increased psychiatry staffing for children and adults
- Increased staffing in homebased staff
- Increased staffing in children's crisis services
- Increased staffing and streamlined intake process across all clinical programs
- Added additional providers for CLS/respite care services. Increased providers for respite care (hourly) and have overnight respite back up and running.
- Increased nursing staff
- Added an after-hours clinic for mild/moderate population
- Expanded adolescent services.

- Created a treatment clinic for children and youth with co occurring mental health and DD / IDD diagnoses and needs.
- Added an outpatient therapist for early childhood.
- Added Outpatient therapy positions.
- Expanded Behavioral Health Urgent Care Services to include a Nurse Triage and Psychiatry time.
- In the process of completing new Crisis Stabilization Units for youth (8 beds) and adults (13 beds) with plans to begin operations mid-2026.
- Pursuing a range of recruitment and retention efforts to expand and keep staffing, including student loan repayment, referral bonuses, and MSW program tuition coverage, among others.
- Summary of gaps in services or need:
- *Feedback from Community Services for Developmentally Disabled (CSDD):*
- Remain unable to keep up with requests for Autism screening due to lack of qualified assessors in the region (positions are funded, unable to hire).
- Despite delays in assessing individuals, we've been able to connect more individuals to Autism services and have adequate provider capacity. But we in turn need more clinicians and support staff to appropriately coordinate and monitor those increased services and compliance with MSHN standards.
- Increased the number of case managers while recognizing the continued need for an increased number of case managers within the Family Support unit (to facilitate the growing demand for intakes and, in part, as tied to the coordination of Autism services).
- Continue to build (through directly operated and contract providers) the need for more highly specialized, behaviorally oriented, residential care providers in the region. We continue to lack providers who can address acuity needs appropriately, as well as overall demand for this support type in the region.
- *Feedback from Adult Mental Health Services (AMHS):*
- Need to build out adult crisis mobile and secure staffing/therapists. CMHA-CEI is working on a Crisis Stabilization Unit (CSU).
- *Feedback from Quality, Customer Service, and Recipient Rights (QCSRR):*
- Need to focus on timeliness from inquiry to assessment and from assessment to start of service (PIs 2a and 3).
- *Feedback from Families Forward:*
- Need for Mental Health Therapist to provide Home Based and Outpatient Therapy and Evidence Based Treatments, Nurse Care Manager, and Psychiatry.

CMHCM

Services for Individuals with SUD/Co-Occuring Disorder (COD)

- We have membership on local opioid fatality review team(s) and other recovery councils.
- We have MAT services in our Isabella and Gladwin offices.
- We implemented process for MAPS use for all prescribers
- We have historically brought in training for staff on MAT, SUD, and COD.
- 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.)
- Narcan vending machines added to multiple CMHCM lobbies.
- We review 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 three of our jails so inmates can start MAT prior to release, with follow up care
- We partnered with a local substance awareness coalition to distribute harm reduction backpacks to inmates being released from jail.
- We have a new SUD detox and residential SUD program in Mt Pleasant, increasing diversion options for SUD primary concerns.
- Participate on local county Opioid Settlement workgroups.

Direct Care Worker Recruitment/Retention

- Executive Director has shared with MDHHS a proposed strategy for improved training and pay opportunities for all Direct Care Workers (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
- We have had an expansion in the choice of providers for CLS and Employment Services across our agency.
- We have access to comprehensive employment services for all adult populations.
- We have improved coordination and a cash match increase with Michigan Rehabilitation Services.
- We have a Michigan Rehabilitation Services (MRS) and CMHCM co-location to reduce barriers for individuals served.

Alternatives to inpatient psychiatric services

- We have strengthened our crisis intervention team to maintain our good outcomes with a high diversion rate
- We have a contract with Healthy Transitions CRU and SafeHaus.
- We are looking to bring a CRU to Mt Pleasant, in discussion with Bay City CRU.
- We have expanded our after-hours contract with a local hospital to include several new ED's to screen private pay individuals. As a result, relationships with ED providers and the perspective on diversion has shifted towards a better understanding of inpatient efficacy on mental health concerns.
- We've added an emergency psychiatric evaluation clinic to help in urgent cases to prevent unneeded placements.
- We've implemented Family Stabilization Specialists (FSS) in two of our counties, which has allowed for a work flow for urgent referrals and stabilization happening with youth.

Integrated healthcare and health outcomes

- We have membership on local health and human services councils.
- We have an adult block grant for an integrated health dashboard that shows outcomes and monitors health indicators over time for consumers
- We have strong partnerships with care management with FQHCs in our area
- We have a FQHC co-located in our Midland office.
- We have implemented healthy living opportunities in our local clubhouses
- CMHCM expanded Behavioral Health Home to additional counties.
- Exploring possibility of bringing a pharmacy into one of our buildings

Ease of access to MH care

- We expanded our service provider network specific to Autism services.
- We embedded Jail Diversion Specialists into our local jails.

- We have joined local hostage negotiation teams as mental health experts in two of the counties we provide services in.
- We implemented Same Day Access.
- We have piloted engagement strategies to engage individuals who may need early outreach.
- We have defined which individuals that will be opened using General Funds (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 piloted the early launch of the Michigan Child and Adolescent Needs and Strengths Tool ahead of full implementation.
- We have increased our marketing efforts
- We have Youth Intervention Specialists work with school districts in 4 of our counties to screen and refer youth with SED to mental health services.
- We have contracts with local school districts in two of our counties to provide school-based therapists within the schools.
- We are part of the Great Start Collaborative and many other collaboratives comprised of community partners that work with families and children.
- We have Infant and Early Childhood Mental Health Consultants in all 6 of our counties to provide behavioral consultation with preschools and daycares.
- We have continued efforts to implement Charting the Life Course principles in framework with the individuals we serve.

GIHN

- Addition of two trauma focused art groups for middle school and high school females
- Expand jail-based services from eight hours a week to 20 hours per week resulting in a substantial increase in individuals served
- Expand mobile response to serve adults and youth (transitioned from a youth only model)
- Expand crisis team to include an additional crisis intervention specialist and three crisis support peers.
- Partner with Alma Police Department to hire a behavioral health co-responder to accompany police on community calls
- Expand 31N therapy services to one additional elementary school
- Seeking additional Occupational and Speech Therapy providers
- Expand ABA Provider Network with addition of two new providers
- Expand specialized residential placement options with addition of two new providers

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, Intermediate School District (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 (LifeWays)

- Increased the availability of BHT services to meet the needs of the Autism expansion
- Added Mens Trauma Group M-TREM.
- Has a Prevention & Wellness Program including participation on the Jackson Substance Abuse Prevention Coalition, which includes the Most Teens Don't effort
- Facilitating Youth Mental Health First Aid for the Community-at-large
- We now offer DBT-A groups two times per week, expanded to Adolescent DBT
- Expanded both our jail services to include group work and our MAT services.
- SUD Recovery Incentives Continue
- Expanded CIT Training
- Expanded ACT programming to a Lifeways designated team.
- Added an infant mental health evaluation initiative to specifically target infant and youth entering services and progressively improve access to care.
- Children's ICSS is operational; adult mobile crisis available in place of ICSS. Was able to add one additional team and expand coverage in FY24. Continued growth through MDHHS Grant opportunity being sought.

MCN

- Continued growth in enrollments for our Behavioral Health Home for both the SMI and SED populations
- Accepted as Substance Use Health Home and kicking off implementation in 2026 Added DBT-Adolescent model, Parenting Through Change, trained all new clinical staff in basic Motivational Interviewing, and enrolled in another cohort for TF-CBT.
- Expanded school based mental health professionals with 31 N funding by 3 additional clinicians.
- Provided multiple internship placement to promote current staff completing Master's and Bachelor's degrees and promoted state loan forgiveness programs.
- Added a third Supported Independence Placement (SIP)
- Expanded number of families receiving Parent Support Partner services.
- Added a Family Skills Trainer to work with kids in SED and IDD children's case management with possible expansion to another.
- Expanded the number of coping skills groups for kids and parenting education groups available
- Obtained Opioid Settlement monies to support Recovery Coach services in the jail and community.
- Implemented DECIPHeR in BHH in partnership with University of Michigan using both individual and group modalities.

- Worked to improve ICSS services by moving to a Crisis Hub model under Protocall, applying to certifying the adult side of our Mobile Crisis services and beginning Crisis Professional training for the team.
- Expanded telehealth on-scene access for law enforcement to connect in real time to community crisis services using a dedicated doxy link.
- Enrolled 12 new persons in the HSW, which is a significant increase over the past several years.
- Hosted a summer carnival promoting MCN services to over 450 people in the community.
- Partnered to convert a current contracted AFC home into a high behavior home, specializing in persons at risk of elopement.
- Engaged in process improvement to bet track Medicaid redetermination dates and respond immediately when individuals fall off Medicaid with successful results in reducing the number of persons losing benefits.
- Received grant funding and other additional funds to support IDDT services, OBRA, jail-based services, and school-based services.
- Engaged in extensive education to our Provider Network on statewide threats to the publicly funded Community Mental Health system.
- Continued to implemented cost containment plans in order to live within the funding provided by MDHHS and to serve our priority population. This included focusing on staff productivity, reducing workforce, careful utilization management, and working with community providers to ensure those with mild/moderate needs are being served by their health plans. True expansion of service capacity in the present funding environment is rather limited. Instead we are working to ensure we are able to do the most possible with reduced resources and to be transparent with the community who counts on us.

NCMH

- Our Leadership team's continued focus around strengthening the agency's staff recruitment and retention plan.
- Began implementation of the newly developed process around interns/internships with the goal of being able to secure master's level interns and recruit them for employment when their internship is complete since adequate staffing is necessary to make any program or service expansion successful.
- Added additional psychiatric providers to our medication clinic who serve both adults and children.
- Added a Waiver Coordinator/case manager position who has significantly improved identification of persons who qualify for the waiver and provides better management of re-certifications for this program.
- Provide jail liaison services including case management and/or therapy services for inmates as well as assistance with coordination of services for those individuals preparing to be released but in need continued community resources and support.
- Collaborative relationship with our Sheriff's Department with a social worker embedded at their office who accompanies officers on community calls/ride along and provides referrals and resources to those whom officers have contact with.
- Collaboration with Newaygo County Court to establish Drug Court beginning February 2026
- Collaboration with our local jail specific to MAT services for inmates prior to their release with NCMH assisting with follow up care.
- Offer such Evidenced Based Practices such as EMDR, TF-CBT, DBT, Certified Play Therapist on staff.
- Currently participating in Ce-Cert Cohort for Supervisory staff.

- Ongoing collaboration with juvenile court probation, DHHS foster care and CPS workers specific to improved interventions and services for common youth served.
- Have 2 staff trained to provide Mental Health First Aid to the Community as needed.
- We have defined and expanded which individuals will be opened to services and for how long of a period of time served using General Fund dollars (GF) when Medicaid is not available
- Have partnered with our local DHHS to have one of their staff on site a few days each week to help us better track Medicaid Redeterminations and quickly address any issue or loss of Medicaid for our clients served.

SCCMHA

- Implementation of Mental Health First Aid throughout the community and continued promotion for participation of all community members in the identification of persons who may require mental health services.
- Currently offering Mental Health First Aid trainings once every 4 months for both Youth and Adult. Offer Mental Health First Aid training to Law Enforcement and Fire and Rescue personnel.
- 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.
- Expand current Mobile Response and Stabilization Services (MRSS) to extend hours of service. MRSS is now available 24/7/365 for all residents of Saginaw County.
- Working with the Saginaw Police Department to provide mental health assistance via the Crisis Connect Program. All Saginaw Law Enforcement agencies have been provided with mobile phones for each officer when they are on duty. Officers can use these phones to connect with our Crisis Intervention Services or Mobile Response and Stabilization Services teams for assistance with mental health emergencies while in the field.
- Working with consumer stakeholders in focused access assessment and quality improvement projects.
- Medicaid Health Plans and Saginaw DHHS provide transportation so that persons served can go to and from their mental health appointments. Collaboration occurs between these resources to ensure that SCCMHA is the payor of last resort while ensuring transportation is provided so that appointments are being attended.
- Data from our Access and Stabilization for Children team (ASC), revealed significant increase in family engagement in services. This program continues to operate to allow families to receive services until they are ready to be assigned to a formal primary team.
- Movement to value-based purchasing for supported employment.
- We continue to provide respite services to support families.
- 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 Post-Traumatic Stress Disorder (PTSD).
- We added Eye Movement Desensitization as an evidence-based practice. Recently added Art Therapy as an available evidence-based practice as well.
- Improve our presence in Saginaw Community Schools to assist youth with mental health concerns with Co-located therapists.
- Participated in CCBHC expansion grant and CCBHC demonstration grant with MSHN. Now we are an established and approved CCBHC through MDHHS.
- Continue to have a co located primary healthcare clinic.

- Have co-located laboratory services to accommodate transportation barriers for persons served.
- Have a Veterans Navigator who works with Veterans and family members of Veterans. Outreach to Veterans occurs in Saginaw, as well as Bay City and Midland.
- A new Hispanic Outreach Worker has been hired to help bridge the gap to services for the Hispanic population.
- Saginaw CMH is a Behavioral Health Home.
- Early Childhood Court Program Implementation partnering with local DHHS and Family Court.
- A Peer Support Staff from Women of Colors has been hired who provides services at the Front Door by working with individuals who call or present to our Central Access and Intake Department.
- Ongoing TFCBT Training Cohort participation for children's clinical therapists
- Addition of a contracted BCBA to assist with Autism program/service management. Working on making this position in-house by hiring a BCBA who will be part of the Utilization Management team.
- A new area at our Hancock location has been established as an Outpatient Therapy Clinic. As more staff are hired for this location, the goal is to expand hours available for outpatient therapy beyond regular business hours to include evenings and weekends.

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
- Telehealth services
- ABA contract providers
- Partnership with DHS in providing continuing education for foster parents in the form of Caregiver Education and/or Parenting Through Change groups available
- 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
- Crisis Expansion Grant recipient. Adding Mobile crisis team for adults and expanding mobile crisis for youth
- Increased the availability of BHT services to meet the needs of the Autism expansion
- Robust respite program for children
- Participating in TF-CBT. Have a nationally certified TFCVT Supervisor. SHW accepts interns annually from MSU who are in the TFCBT track
- Efforts to expand service capacity for families and children to increase the number accessing services, as identified in the community needs assessment
- SHW became a Behavioral Health Home
- SHW applied to become an SUD Health Home and was granted provisional approval
- Increase preventative efforts including providing mental health first aid and Narcan distribution kits.
- Completed the Ce-Cert cohort through the Children's trauma initiative to help with staff secondary traumatic stress and burn out, to increase staff retention and wellness. One additional Supervisor is undergoing Ce-Cert through the Adult initiatives as well and is set to complete the cohort in Summer 2026
- Implementation of a Wellness Experience training series for Clinical Staff, to provide them with support and resources.

- Ongoing Eligibility training offered to community partners to help gain understanding about SHW and eligibility for CMH services.
- Approximately 10 non- licensed clinical staff completed the crisis professionals training offered through the partnership of Wayne State and MDHHS.
- Added provider contracts for Skill Building Assistance, Out-of-Home Non-vocational Habilitation, and Supported Employment
- Expanded the number of fully contracted inpatient hospitals, as well as those available for SCAs.

TRD

- Have one full-time and one part-time School Outreach Workers to increase the collaboration and referral rate from schools.
- Participate in School Readiness Advisory Council.
- We are providing Autism Assessment services to Montcalm Care Network.
- The Right Door has three homegrown BCBAs and have two BCBAs that came to us with their credentials. We have one person in BCBA in training.
- Child psychiatrist provides consultation to primary care providers and provides his personal cell phone number.
- We have staff trained in and providing TF-CBT, Nurturing Parenting, EMDR, Transition to Independence Model, Parenting Through Change and Love and Logic. PMTO and TRAILS provided in schools through School Outreach. Child-Parent psychotherapy cohort certification.
- Full running DBT fidelity team providing to up to 10 persons served at a time since 2024.
- 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.
- Directly providing 24/7 Adult and Children's Mobile Crisis for Ionia County.
- Provide outreach and groups at numerous housing complexes in Ionia County.
- Participate with the Ionia County Hope and Recovery- Substance Abuse Coalition.
- Executive committee member of the Ionia County Community Collaborative – the social services collaborative expanding service understanding and referrals.
- Certified CCBHC and expanded service providers in outpatient therapy, access, added care coordinators, nursing staff and peers. Provide Substance Use services to Ionia County through CCBHC – outpatient, case management, Intensive Outpatient, MAT services, and Peer services.
- Provide Motivational Interviewing basic and advanced trainings twice a year.
- Hold monthly meetings with local DHHS Partners
- Hold monthly meetings with Jail administrator for Ionia County.
- Hold monthly meetings with Ionia ISD and Local school administrators.
- Participate in school safety committee
- Attend quarterly LICC monthly for early learning collaborative.
- Host a booth for kid's day at Ionia County Fair
- Participate in Family Support and Wellness Committee
- Provide Youth Peer Services
- Two staff providing ASIST and SafeTalk trainings to staff and community.
- Parent support partner providing services to families.
- Outreach at community events to families.
- Jail Diversion clinician and groups provided at the Jail.
- 2025 and 2026 OPIOD Grant funds used to provide 2 part-time peer recovery coaches in Ionia County Jail.
- Medication Services expanded through CCBHC by increasing provider time and providers.
- Created Spravato clinic in 2025 for persons served in Medication services.

- Provide annual Walk, Run and Roll for Ionia County Community run by the Case Management team and includes a Health Fair.
- Provide annual movie night for all families.
- Provide twice a year Drab to Fab event for clothing and haircuts for adults.
- Provide annual Back to School Bash for open to the community for kids to get free backpacks, haircuts, hygiene products and school supplies. Partnered with community providers. In 2025 we had 400 people register for the event.
- Community Wraparound team coordinates on difficult cases once a month. This pulls together our Wraparound coordinators, homebased leadership, DHHS, schools, juvenile court and the ISD.
- Coordinating with DHHS on the MichiCANS and navigating getting people into services on Foster Care and SED Waiver for services through Foster Care.
- Onsite DHHS Worker once a week for access to services.
- Provide ongoing presentations and education as requested by community agencies (local hospitals, DHHS, courts, etc.).
- Participate in Mental Health Court and provide assessments
- Provide Mental Health First Aid – Youth
- Provide Emergency Food Bank in our Belding and Ionia office locations.
- Infant Mental Health staff participate in Reflective supervision monthly meetings for ongoing learning and collaboration on cases.
- Onsite Veterans Service Office twice a month.

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.
- Participating in multiple EBPs such as PMTO, PTC, TF-CBT.
- 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 staff trained in both Mental Health First Aid for adults and youth.
- Continued availability of Parent Support Partner services to work with parents.
- Ongoing availability of Youth Peer Support services.
- Continued 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 continues with the contracts with the seven (7) ABA providers; two (2) clinic-based, four (4) home/community-based providers, and one (1) who provides both clinic-based and services in the home.
- Continued to provide Wraparound services within TBHS.
- Treatment participation in the Juvenile Mental Health Court.
- Infant Mental Health staff participate in the Maternal Infant Health Program quarterly meetings for ongoing collaboration.
- Sponsor collaborative meetings with Tuscola MDHHS and TBHS staff to foster working relationships.
- Provide Parent and youth therapy groups for those under the supervision of juvenile probation.

- Re-initiated training and re-engagement efforts to offer Family Psychoeducation groups.
- Expanded collaboration with the local county jail.
- Held a collaborative training event with the Sheriff and local police departments, Probate Court, and CMHSP staff regarding Assisted Outpatient Treatment.
- Expanded psychiatric capacity to include a psychiatrist who is board certified in both adults and children.

FY25 Recommendations:

1. MSHN will continue to work with our CMHSPs on building appropriate network capacity to serve all individuals eligible for autism specific services within a timely manner (focus on LifeWays and CMHCM regions). (MSHN Lead: Chief Behavioral Health Officer)
    - Status Update: MSHN has focused on ensuring that there is an adequate network of providers and of staff with appropriate credentials. When appropriate, MSHN shared with its CMHSPs information on new and interested ABA providers. MSHN has focused on working with all of its CMHSP partners to address timely services delivered appropriate to established policy. MSHN also worked with its partners to assist its QBHPs in preparing to take the BCBA exam. This resulted in a number of QBHPs that became BCBAs prior to the QBHP credential being phased out. This had the effect of keeping the network more stable and maintaining continuity in the autism provider system.

2. For children's waiver programs, MSHN will continue to work to increase network provider capacity including but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite. (MSHN Lead: Chief Behavioral Health Officer)
    - Status Update: MSHN was able to successfully bring Equine Therapy as a service in Michigan. Equine providers came forward to share their interest and begin developing service structure, training, and requirements for the program. MSHN has also begun discussing service options for recreation and art therapy with more work to be done in FY26. MSHN also works through its focused workgroups on addressing CLS and respite providers.

3. MSHN will support implementation of ASAM Criteria 4th edition standards and updated MDHHS SUD Treatment Policies with the SUD provider network. (MSHN Lead: Director of SUD Operations)
    - Status Update: MSHN has supported communication and implementation of the revised/updated MDHHS Treatment Policies for SUD Outpatient, Residential, and Withdrawal Management services. During FY25, MSHN worked with the other PIHPs and MDHHS to develop an ASAM Criteria 4 implementation strategy. Implementation was very limited due to the PIHPs needing information from MDHHS to support the transition such as an ASAM Criteria version 3 to 4 crosswalk, updated code chart, updated ASAM Continuum, updated MiCAL system for ASAM designations, and determination of how ASAM levels of care that were changed/eliminated would be addressed in Michigan. These activities have started to be supported in FY26 with a full implementation planned by October 1, 2026 for FY27.
4. MSHN will continue to problem solve and consult on opportunities to expand capacity for adolescent SUD services within the region, and the State. This especially includes SUD residential and withdrawal management services. (MSHN Lead: Director of SUD Operations)
    - Status Update: MSHN supported a FY24 Request for Proposal (RFP) to expand adolescent substance use disorder (SUD) services across the region, including withdrawal management, residential, and outpatient levels of care. Through this initiative, one provider expanded SUD outpatient services with medication-assisted treatment (MAT) into seven additional counties, improving regional access and service availability. Adolescent SUD services remained a significant network need in FY25, particularly following the loss of one of two contracted adolescent residential providers due to rate differentials. This development highlighted ongoing system capacity challenges and

prompted continued collaboration between MDHHS and the statewide SUD Directors group. MSHN led a dedicated subgroup tasked with developing strategic recommendations to strengthen adolescent service capacity across the state. The subgroup advanced a three-pronged proposal focused on:

i. Stabilizing existing adolescent SUD residential capacity through appropriate reimbursement structures and targeted workforce training.
ii. Developing a centrally located adolescent SUD provider offering the full continuum of care, including telehealth access to support statewide PIHP utilization.
iii. Expanding evidence-based training and workforce development opportunities to strengthen clinical capacity among adolescent providers, particularly given the relatively early-career composition of the workforce.

During proposal development, MDHHS notified the subgroup that funding would not be available to advance the initiative at that time. As a result, implementation activities were paused pending future funding opportunities.

5. MSHN will continue to support the expansion of SUD and Behavioral Health Home providers to benefit beneficiaries across the region. (MSHN Lead: Chief Population Health Officer)
    a. Status Update: MSHN supported expansion of SUD HH during FY25 with the certification and approval of four new SUD HH locations. Beneficiary enrollment in SUD HH increased by 32% in FY25, with a total of 526 beneficiaries enrolled as of 9/30/2025.

    There were no new providers who expressed interest in joining the Behavioral Health Home initiative during FY25. MSHN provided technical assistance and monitoring to existing BHH providers with a focus on delivery of high-quality services that adhere to the BHH framework. This was accomplished through quarterly care plan monitoring reviews and collaborative efforts to identify and address areas of improvement. Beneficiary enrollment in BHH remained steady with a slight 2% increase in FY25, with a total of 344 beneficiaries enrolled as of 9/30/2025.

6. MSHN will evaluate and address the absence of pediatric crisis residential within the region and seek to increase bed availability. (MSHN Lead: Chief Behavioral Health Officer)
    - Status Update: In FY25, MSHN has advanced through the process of bringing a youth/adolescent crisis residential provider to the region. The effort was discontinued after the provider opted out given its service configuration was also running a Child Caring Institution for youth with intellectual and/or developmental disabilities and the programs could not be separated to ensure correct programming. MSHN will continue to explore options to establish a youth crisis residential facility within its region.

FY26 Recommendations:

1. MSHN will continue to problem solve and consult on opportunities to expand capacity for adolescent SUD services within the region, and the State. This especially includes SUD residential and withdrawal management services. (MSHN Lead: Director of SUD Operations)
2. MSHN will support implementation of ASAM Criteria 4th edition standards and updated MDHHS SUD Treatment Policies with the SUD provider network. (MSHN Lead: Director of SUD Operations)
3. MSHN will support expanding network provider capacity for opioid treatment programs in region (MSHN Lead: Director of SUD Operations)

4. MSHN will continue to work with our CMHSPs on building appropriate network capacity to serve all individuals eligible for autism specific services within a timely manner (focus on LifeWays and CMHCM regions). (MSHN Lead: Chief Behavioral Health Officer)
5. MSHN will evaluate and address the absence of pediatric crisis residential within the region and seek to increase bed availability. (MSHN Lead: Chief Behavioral Health Officer)
6. MSHN will continue to support the expansion of SUD and Behavioral Health Home providers to benefit beneficiaries across the region. (MSHN Lead: Chief Population Health Officer)

FISCAL YEAR 2024 NETWORK ADEQUACY REPORT RESULTS SUMMARY

The Michigan Department of Health and Human Services (MDHHS) has completed the time and distance and provider-to-enrollee ratio calculations for each region based on the submitted data provided by each Prepaid Inpatient Hospitalization Plan (PIHP). MDHHS will follow up with additional information related to preliminary results at a later date. Below is a summary of the compiled results.

PIHP: Mid-State Health Network

Adult Services

Service	Time/Distance Percentage Rate		Provider to Enrollee Ratio Met or Unmet
Assertive Community Treatment (1:30,000)			Met (1:19,006)
Crisis Residential Programs (16 Beds Per 500,000 Total Population)	96.1%	87.9%	Met (127:1,643,130)
Opioid Treatment Programs (1:35,000)	100%	99.5%	Met (1:12,008)
Psychosocial Rehabilitation Programs (1:45,000)	99.3%	93.8%	Met (1:38,011)
Inpatient Psychiatric Services	99.6%	94.9%	

*Time/Distance percentage rates above are based on the PIHP's overall percentages. Specific CMH/Counties not meeting the compliance percentages are reported in appendix 1.

FISCAL YEAR 2024 NETWORK ADEQUACY REPORT RESULTS SUMMARY

Pediatric Services

Service	Time/Distance Percentage Rate		Provider to Enrollee Ratio Met or Unmet	Baseline Data Results
Inpatient Psychiatric Services	86.1%	66%		
Crisis Residential Programs (8-12 Beds Per 500,000 Total Population)	50%	33%	Met (30:1,643,130)	
Home-Based Services (1:2,000)			Met (1:1,214)	
Wraparound (1:5,000)			Met (1:4,673)	
Intensive Crisis Stabilization				1:7,711
Respite Services				DCW Ratio 1:707 Beds 1:12,852
Parent Support Partner Services				1:10,281
Youth Peer Support Services				1:25,703

**MDHHS did not perform time/distance calculations on Home-Based, Wraparound, Parent Support Partner, and Youth Peer Support services due to variations in provider deployment procedures and service locations. MDHHS will continue to develop applicable standards for network adequacy reporting purposes.

FISCAL YEAR 2024 NETWORK ADEQUACY REPORT RESULTS SUMMARY

Timeliness

Service	Aggregate Average Percentage of enrollees starting services within 14 calendar days of assessment.	CMHSPs under 90%
Assertive Community Treatment	81.75%	BABH (57%) GIHN (not providing services) LifeWays (57%) MCN (not providing services) NCCMH (not providing services) SCCMH (50%) TRD (not providing services)
Home-Based Services	75%	BABH (61%) CMHCM (81%) CMHCEI (61%) GIHN (82%) HBH (70%) LifeWays (54%) MCN (78%) NCCMH (85%) SCCMH (80%) SHW (75%) TRD (80%)
Wraparound	77.5%	BABH (75%) CMHCM (77%) CMHCEI (64%) GIHN (67%) LifeWays (21%) NCCMH (75%) SCCMH (87%) TRD (64%

*Average percentages in red did not meet the 90% benchmark 42 CFR 438.68(e)(2)

Other

Aggregated Total percentage of reported providers accepting new enrollees	Aggregated Total percentage of providers with reported physical accessibility	Aggregated Total percentage of reported providers with cultural and linguistic capabilities
99.5%	99.5%	100%

American Society Addiction Medicine (ASAM) Level of Care (LOC)

Identified gaps in contracted network:

Outpatient ASAM LOC	Residential ASAM LOC	Withdrawal Management ASAM LOC
2.5 (Only available outside of catchment area)	3.3 (Only available outside of catchment area) 3.7 (Only available outside of catchment area)	1.0 WM 2.0 WM

MDHHS is requesting your review of this report by June 24, 2025. Any comments or feedback can be submitted to Sally Smolinski (smolinskis1@michigan.gov) by this date. MDHHS will follow up with PIHPs to address network gaps and areas of improvement as identified above.

Appendix 1

Time/Distance Deficiencies

Service	CMH	County	Time Percentage	Distance Percentage	Estimated Medicaid Population Coverage Gap
Clubhouse	Huron	Huron	77.1%	73.9%	1,573
Adult Crisis Residential	The Right Door	Ionia	60.7%	20.2%	4,983
Adult Crisis Residential	Huron	Huron	28.1%	28.3%	4,947
Adult Crisis Residential	Central Michigan	Mecosta	77.3%	47.5%	2,224
Adult Crisis Residential	Central Michigan	Osceola	71.2%	5.2%	1,690
Pediatric Crisis Residential	Saginaw	Saginaw	0%	0%	54,994
Pediatric Crisis Residential	Central Michigan	Midland Isabella Clare Gladwin	0%	0%	46,628
Pediatric Crisis Residential	Central Michigan	Osceola	44.4%	0%	3,267
Pediatric Crisis Residential	Bay-Arenac	Bay Arenac	0%	0%	28,626
Pediatric Crisis Residential	Tuscola	Tuscola	0%	0%	13,237
Pediatric Crisis Residential	Huron	Huron	0%	0%	6,879
Pediatric Crisis Residential	LifeWays	Jackson	54.7%	3.6%	17,730
Pediatric Crisis Residential	LifeWays	Hillsdale	21.3%	6.8%	8,482

Appendix 1

Time/Distance Deficiencies

Service	CMH	County	Time Percentage	Distance Percentage	Estimated Medicaid Population Coverage Gap
Pediatric Crisis Residential	Shiawassee	Shiawassee	81.7%	10.1%	2,677
Pediatric Inpatient Psychiatric Services	Central Michigan	Isabella	10.1%	0%	13,406
Pediatric Inpatient Psychiatric Services	Central Michigan	Clare	75.5%	3.8%	2,256
Pediatric Inpatient Psychiatric Services	Central Michigan	Osceola	63.5%	0%	2,144
Pediatric Inpatient Psychiatric Services	LifeWays	Jackson	74%	1.9%	10,162
Pediatric Inpatient Psychiatric Services	LifeWays	Hillsdale	18.9%	1.9%	8,742
Pediatric Inpatient Psychiatric Services	CEI	Eaton	72.6%	43.9%	5,608
Pediatric Inpatient Psychiatric Services	Huron	Huron	17.5%	20.8%	5,678

Estimated Medicaid population coverage gap is based on time compliance.

Appendix 1

*Counties meeting the time percentage compliance level (90% or greater for Large Metro/Metro and 85% or greater for Micro, Rural, CEAC) have been excluded from appendix 1 for preliminary reporting. Starting with the FY25 reporting period, both time and distance standards must be met according to the compliance levels published in the procedural document.