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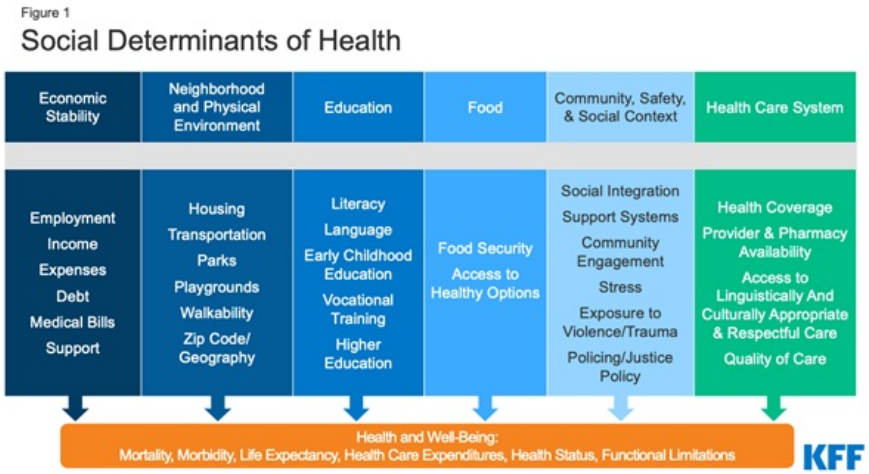
From the Chief Executive Officer's Desk

Joe Sedlock with contributions from Capitoline Consulting and Skye Pletcher

One proposal that Mid-State Health Network will make during our regional and board strategic planning discussions will be the adoption of a fifth strategic priority: Better Equity.

In a behavioral health context, better equity means more equal access to, utilization of, and benefit from the services and supports we offer so that all populations and subpopulations have proportionately equal representation on these (and other) measures.

For many populations that are served through the public behavioral health system, social determinants of health have significant impacts on health equity. The following graphic published by the Kaiser Family Foundation (KFF) shows the relationship between social determinants of health on health and well-being.



The KFF has published a briefing entitled *One Year into the Pandemic: Implications of COVID-19 for Social Determinants of Health* which is available at the link provided. This brief provides an overview of social determinants of health and a look at how adults are faring across an array of measures one year into the pandemic. Key findings include:

--**Across a wide range of metrics, large shares of people are experiencing hardship.** Since the start of the pandemic, shares of people reporting hardship across various measures has been relatively constant, with a slight peak for the December reporting periods. For the most recent period, February 3-February 15:

- Nearly half adults (47%) reported that they or someone in their household had experienced a loss of employment income, and one in five applied for Unemployment Insurance (UI) benefits since March 2020;
- More than six in ten (61%) adults reported difficulty paying for usual household expenses in the past 7 days, and 27% used credit cards or loans to meet household spending needs;
- More than 7% of adults had no confidence in their ability to make next month's housing payment (across renters and owners), and 11% reported food insufficiency in their household;
- Three in ten (30%) adults reported delaying medical care in the last four weeks due to the pandemic and 39% reported symptoms of depression or anxiety.

--**Black and Hispanic adults fare worse than White adults across nearly all measures, with large differences in some measures.** For example, just over 75% of Black and Hispanic adults reported difficulty paying household

expenditures compared to 53% of White adults; about 13% of Black and Hispanic adults reported no confidence in their ability to make next month's housing payment compared to 5% of White adults, and 20% of Black adults and 18% of Hispanic adults reported food insufficiency in the household compared to 8% of White adults.

--**While variation across age and gender was not as stark, in general younger adults (ages 18 to 44) and women fared worse on most measures compared to older adults and men.** For example, higher shares of younger adults and women reported symptoms of anxiety and depression as well as difficulty paying for usual household expenses. Higher shares of younger adults reported food insufficiency in their household and higher shares of women reported delaying medical care in the last four weeks due to the pandemic. As with race/ethnicity, some of these differences in social determinants were present even before the pandemic, but understanding them in the context of heightened levels of need over the past year highlights these differences and who may benefit most from assistance.

--**Across most measures, adults with children in their household fared worse compared to overall adults.** For example, 53% of adults with children in the household experienced loss of employment income in the household compared to 47% of adults overall, and just over two-thirds of adults with children in the household reported difficulty paying for household expenses compared to the overall population of 61%. Notably, adults in households with children were more likely to report food insufficiency than the general population."

As the board and region considers establishing a "Better Equity" strategic priority, one important aspect of achieving better equity is effectively addressing social determinants of health. An additional important point is that health disparities have exited long before the pandemic. There are, of course, other important aspects to addressing equity, including implicit and explicit racial and ethnic bias, social justice, diversity, inclusion, social marginalization and stigma of individuals, groups and communities, and many more.

Michigan Public Act 653 of 2006 directed the Michigan Department of Health and Human Services (MDHHS) to develop strategies to reduce racial and ethnic disparities. In 2010 MDHHS published a comprehensive strategic plan the Michigan Health Equity Roadmap and in 2011 the Michigan Medicaid Health Equity Project was established. The Michigan Medicaid Health Equity Project gathers and publishes data related to health disparities among recipients of physical health Medicaid services on an annual basis. All Michigan Medicaid Health Plans are required to participate, including the use of quality performance metrics to evaluate reductions in health disparities from year to year. In 2018, (the most recently published Michigan Medicaid Health Equity Report), **there were still significant racial disparities for African American Medicaid beneficiaries compared to White Medicaid beneficiaries on 9 of the 13 quality measures the project evaluates each year.**

Beginning in FY21 MDHHS included requirements for reducing health disparities in the PIHP contract for the first time. The baseline data provided by MDHHS revealed that the health disparities on behavioral health quality measures were even more pronounced than many physical health quality measures, underscoring the necessity of improving health equity for recipients of behavioral health and SUD services in the same way health disparities have been addressed in the Medicaid physical health sector for the last 10 years. The establishment of a "Better Equity" strategic priority aligns with, and builds upon, MDHHS strategic priorities and initiatives. Mid-State Health Network is committed to improving health equity (as well as diversity and inclusion) through as many means as the region has available to it.

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

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 anticipated implementation start date of October 1, 2021. The demonstration award is restricted to only the 14 prospective CCBHC Demonstration Sites included in the 2016 application. In the MSHN region, that means the following Community Mental Health Service Programs (CMHSP) could continue their efforts to 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

In addition, Substance Abuse Mental Health Services Administration (SAMHSA) has awarded CCCBHC funding directly to organization in Michigan referred to as Expansion Grants. MSHN was pleased to hear

that LifeWays Community Mental Health (Jackson & Hillsdale Counties) was awarded funding from SAMHSA.

MDHHS plans to develop a multi-disciplinary team-based structure based on a collaborative care model that includes the prospective CCBHS site and the applicable PIHP. While the PIHP role in supporting the CCBHC model is still being developed, the below PIHP responsibilities are being proposed including but not limited to:

- Customer services/Information Dissemination
- Assignment/Enrollment of CCBHC Beneficiaries (Medicaid & Non-Medicaid)
- Process Prospective Payment System (PPS) to the CCBHC site
- Cost and Quality Reporting
- Monitor, Collect, And Report Grievance, Appeal, And Fair Hearing Information
- Collect and report access data
- Collect CCBHC "Encounters" for the Non-Medicaid Population
- Coordinate Crisis/Referral Services

MSHN has an internal team that continues to work with MDHHS and the CCBHC sites to ensure appropriate support and preparation for successful implementation. MDHHS has indicated the state-based certification process will begin in July 2021, award by September 2021, and implementation effective October 2021.

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

Information Technology

Forest Goodrich
Chief Information Officer

MSHN and the CMHSP participants are actively working with Michigan Health Information Network (MiHIN) to establish more use cases being made available in the region by using the health information exchange (HIE). CMHSP participants will be working throughout this quarter and fiscal year to prepare their systems to receive this information. Some of this type of data was previously available through Great Lakes Health Connect (GLHC) and is being migrated to MiHIN's tool (MI Gateway) where it can be transformed into CMHSP electronic medical record systems. These use cases are: Orders and Results Delivery, Radiology Studies, Transcribed Document Delivery, and Lab Orders – Results.

The efforts with MiHIN will continue as MSHN is involved in developing a pilot project for electronic consent with MDHHS and its web application (Care Connect 360).

Quarterly comparison of Medicaid beneficiaries enrolled and served

	Fiscal 2020 Quarter 4	Fiscal 2021 Quarter 1	Percentage Change
Medicaid beneficiaries enrolled	411830	425293	3.26%
Medicaid beneficiaries served	22118	22051	-0.3%

(monthly average within the quarter and includes Healthy Michigan)

In addition, encounter reporting to MDHHS is a contractual requirement that MSHN and the CMHSPs perform at a high level. Millions of transactions get processed every year. We reconcile every transaction to make sure to account for all encounters. Medicaid enrollment and persons served changes are reviewed quarterly at IT council meetings. To the left is a comparison of two quarters of Medicaid enrollment and encounter submissions. Note: MDHHS has not been disenrolling persons from Medicaid during the pandemic.

For further information or questions, please contact Forest at forest.goodrich@midstatehealthnetwork.org

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN's Finance Team recently submitted fiscal year-end reports to MDHHS as follows:

- Financial Status Report (FSR) – This report illustrates the revenue and expense information by fund source (Medicaid, HMP, Block Grant, and PA2). In addition, the report shows spending for Behavioral Health services which are managed by MSHN's Community Mental Health Services Programs (CMHSPs) and Substance Use Disorder (SUD) services managed by the PIHP. Other aspects of this report include a tab designated for Internal Service Fund (ISF) activity and SUD detailed information. Based on the FSR, MSHN will retain $33 M and lapse $2.48 M to MDHHS. The amounts combined total $35.5 M and represent more revenue received than spent which is called savings. PIHPs may retain up to 5% of unspent revenue however savings amounts between 5-10% must be shared with MDHHS 50/50. Further, MSHN maintains a fully funded ISF at $45.9M (7.5% of revenue).

- Encounter Quality Initiative (EQI) – This report is new for Fiscal Year (FY) 2020 and replaces the Utilization Net Cost (UNC). The EQI report captures units and spending information by CMHSP and then further by service code. MDHHS implemented this change in reporting with an emphasis on improved understanding of PIHP and CMHSP cost variances. Beginning FY 21, EQI reports will be submitted three times throughout the period to identify encounter reporting discrepancies. The interim submissions allow PIHPs to address areas identified by MDHHS and correct them prior to the fiscal year-end report.

- Medical Loss Ratio (MLR) -a measure of the percentage of premium dollars that a PIHP spends on claims and quality improvements versus administrative costs. For PIHPs, dollars spent on services must total at least 85% of total spending. MSHN's FY 20 MLR is 89% for Medicaid and 96% for Healthy Michigan. The percentages exceed the MLR threshold.

MSHN Finance Team members are also engaged in its FY 2020 Financial Audit being conducted by Roslund Prestage & Company (RPC). In addition, the team is completing fiscal reviews for Direct Care Wage (DCW) premium pay and provider stabilization dollars. The goal with the special reviews is to ensure no overlapping of federal funds occurred for providers.

For further information or questions, please contact Leslie at Leslie.Thomas@midstatehealthnetwork.org

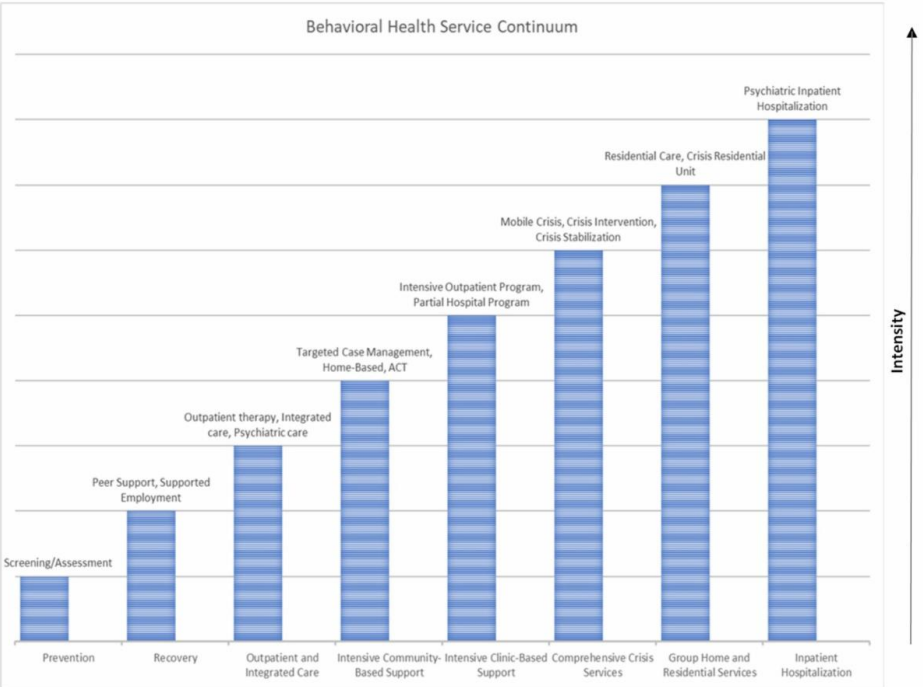
Behavioral Health

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

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

Expanding the Crisis Services Continuum of Care

In 2019 Mid-State Health Network (MSHN), developed a strategic objective to improve the emergency and crisis support continuum of care available throughout the region. Similarly, the Michigan Department of Health and Human Services (MDHHS) has been engaged in numerous initiatives to increase access and expand community-based crisis services statewide. In the behavioral health system, a continuum of care is intended to include services that range from outpatient services, such as prevention and culminating at inpatient psychiatric care. Services on the continuum move from less to more intensive. Dictated by individual needs and preferences, the services and treatment are provided all throughout the continuum to maximize medical necessity and address needs. Recent MDHHS and MSHN efforts have focused on strengthening access to crisis services. Crisis services help to mitigate intense behavioral health issues by greatly reducing the need for inpatient psychiatric care.



The Michigan Inpatient Psychiatric Admissions Discussion (MIPAD) started in 2017 with a goal of creating a list of recommendations to improve psychiatric care. From this, the Michigan Psychiatric Care Improvement Project (MPCIP) was established with the belief that statewide efforts to expand the crisis services continuum of care would help create a better system. These initiatives included MI-SMART Medical Clearance, Michigan Crisis Access Line (MiCAL) (PA 12 of 2020), and Psychiatric Bed Registry (PBR) (PA 658 of 2018). MSHN has also undertaken addressing the crisis services needs of individuals through development of a proposal for MSHN to operate a crisis residential unit (CRU) on behalf of all CMHSPs in the region.

MI-SMART Medical Clearance-MDHHS and the Michigan Health and Hospital Association convened a work group to develop a standardized medical clearance form to be used when an individual goes to a hospital emergency department in a behavioral health crisis and needs to be considered for admission to inpatient psychiatric care. The MI-SMART form is intended to focus and standardize the medical clearance process to reduce the amount of time the individual spends waiting in the emergency department. Montcalm Care Network, Newaygo CMH, and CMH for Central Michigan are 3 of the 10 CMHSPs in the state that have begun using MI-SMART. Statewide implementation is planned to continue throughout 2021 and 2022.

MiCAL (Michigan Crisis Access Line)-In accordance with legislative mandates PA12 of 2020 and PA 166 of 2020, the Michigan Crisis Access Line (MiCAL) will be a statewide "warm line" to assist all Michiganders with behavioral health and substance use disorder needs regardless of level of severity or insurance. MDHHS Strategic Initiative Specialists for the MiCAL project joined the MSHN Clinical Leadership Committee and Utilization Management Committee meetings in August and November of 2020 for planning discussions. MiCAL will pilot in 2 Pre-Paid Inpatient Health Plan (PIHP) regions (Oakland County and the Upper Peninsula) beginning April 2021 with statewide operational rollout planned for October 2022 through 2023.

Psychiatric Bed Registry-Pursuant to PA 658 of 2018, MDHHS, through the MPCIP, established the psychiatric bed registry (PBR). The goals of the PBR are to reduce the wait time between initial referral and consumer acceptance for services and to reduce the number of referral contacts leading to decreased staff time spent on referrals. Accessible through MiCAL, the PBR will generate meaningful information on access issues to behavioral health treatment services including inpatient psychiatric services as well as combine with a broader integrated access system, electronic health records, and other service registries.

MSHN Regional Crisis Residential Unit (CRU)-At the request of the regional Clinical Leadership Committee, MSHN engaged TBD Solutions to conduct a crisis residential feasibility assessment which resulted in a recommendation for the creation of a new CRU in the region. Utilization data determined that the area of greatest need for a new CRU provider is in the North-central portion of the region including CMH for Central Michigan's catchment area and surrounding counties. With support from regional councils/committees, the Operations Council, and the MSHN Board of Directors, MSHN convened a workgroup to develop a Request for Proposal (RFP) led by Dr. Todd Lewicki, Chief Behavioral Health Officer for MSHN. The Crisis Residential Services RFP was published to the MSHN website on 3/29/2021 and can be viewed here: MSHN Request for Proposal Crisis Residential Services

As MDHHS and MSHN focus on strengthening crisis-oriented services, the eligible residents of the region will benefit in the reinvigorated array of these services at this part of the continuum. These efforts help to fulfill MSHN's mission to ensure access to high-quality, locally delivered, effective and accountable public behavioral health services provided by its participating members.

For any questions, comments or concerns related to the above and/or MSHN Behavioral Health, please contact Todd at Todd.Lewicki@midstatehealthnetwork.org and/or MSHN's Utilization Management and Care Coordination Director at Skye.Pletcher@midstatehealthnetwork.org.

Treatment and Prevention

Dr. Dani Meier, PhD, LMSW
Chief Clinical Officer

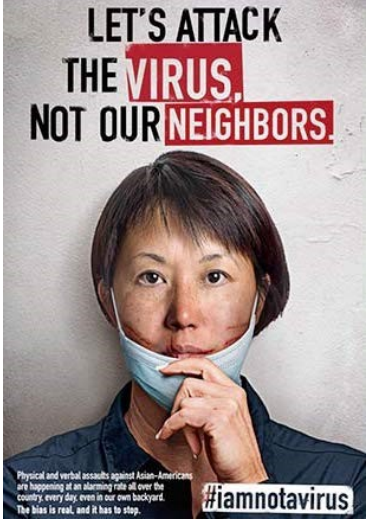
Let's Challenge Stigmatizing Language

Stigma is reinforced by words that objectify and dehumanize individuals living with mental illness, developmental disabilities and substance use disorders. For that reason, in our field we continue to work on eliminating words like "crazy," "retarded," and "being an addict" or "a drunk." Individuals are *not* their diagnosis. Similarly, in the context of a global pandemic that's traumatized our nation with a year of social isolation, major economic impacts, and nearly 550,000 deaths, it's critical that we not perpetuate stigmatizing language that scapegoats certain groups of people for the pain we've all suffered. Referring to the deadly coronavirus as the "China virus" or "Kung Flu" has shaped public opinion in ways that, since the pandemic's onset, parallel a 150% increase in attacks against Asian-Americans, most of them Chinese, but also Koreans, Vietnamese, Filipino and Japanese Americans. Over 3,800 anti-Asian hate crimes were reported in the past year on American soil against American citizens. Since last March, three in ten Asian-Americans describe being subjected to anti-Asian racial slurs and over 25% have felt fear that those slurs could escalate into violence. The tragic Atlanta shootings where eight Americans were killed, six of them Asian-American women, also highlights that women are more than twice as likely to be victims of anti-Asian violence.

Racialized violence is contrary to peaceful human coexistence, to American values, and to MSHN's mandate to improve health in our 21 counties. Ingham County has Region 5's highest population of Asian-Americans at nearly 8%, but most of us have Asian-American neighbors, family and friends across our region (next door to me is a

Chinese-American MSU professor, his wife and their baby). Operating from a trauma-informed perspective, each of us can play a part in challenging stigmatizing and scapegoating language when we hear it, so that no individual or group in our region is further traumatized by COVID-19 based on how they look or what happens to be their country of origin.

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



Provider Network

Carolyn Tiffany, MA
Director of Provider Network Management Systems

New Provider Portal

In February, MSHN rolled out a new module in REMI (MSHNs managed care information system) to the SUD treatment provider network. The portal offers a dashboard of required reports and documents that must be submitted to MSHN, streamlines several processes, and allows provider more control over certain functions such as staff user account management. Three providers tested the portal and provided the following feedback:

"My feedback is that I enjoyed the portal. I am thinking it will be very helpful. I was nervous to see SPSI seems to have some outstanding pieces and I am excited to be able to monitor these things more carefully through the portal. I am a little fumbly with tech, so if that means anything, I found it quite user friendly and the instructions provided were very helpful."

"The changes made to the training have been nice and easy to follow. It allows us to add and delete users much quicker which is a great security measure. I like to be able to upload certificates and licenses in real time. The reports on users is so helpful. I think these changes will be a huge improvement. Can't wait to go live with this."

"This is great."

We continue to work with PCE to further develop the portal, with the next phase focused on direct entry of contractually required reports. This will have minimal impact to the provider system as they already submit reports to MSHN; however, it will streamline the process of submitting information to MSHN as well as the process of aggregating network reports to submit to MDHHS.

Provider Network Additions

MSHN would like to welcome the following providers/sites to its SUD Provider Network:

- Integrated Treatment and Recovery Services (CEI) in Lansing – Outpatient (Adult)
- Holy Cross St. Vincent in Saginaw – Residential (Adult and Adolescent)

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

Quality, Compliance and Customer Service

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

New MDHHS Reporting Requirements for Customer Service

The Michigan Department of Health and Human Services (MDHHS), in accordance with Title 42 of the Code of Federal Regulations (CFR) §438.66, is required to implement a monitoring system for all managed care programs that addresses all aspects of the managed care program. MDHHS must also use data collected from its monitoring activities to improve the performance of its managed care program. To assist with this, MDHHS has selected the program areas of member grievances, member appeals, provider credentialing and service authorizations to monitor and initiate reporting by the Pre-Paid Inpatient Health Plans (PIHPs).

MDHHS created two separate templates, one for grievances and one for appeals, that were disseminated to the PIHPs earlier this year to gather feedback on the PIHP system capabilities for reporting data elements. This information was then used for developing standardized templates for reporting of data to

comply with MDHHS reporting requirements. While MDHHS used the information provided by the PIHPs to develop the reporting templates, some of the requirements may be new, but are necessary for consistent reporting among all the plans in order for the State to aggregate and analyze data for all the PIHPs.

Fiscal year (FY) 2021 is being considered as an implementation year to allow the PIHPs to work through their internal processes to submit the required data in the reporting templates. MSHN's Customer Service and Rights Specialist is working with PCE Systems, which is the information management system used by MSHN, to integrate the required reporting elements into PCE's grievance/appeal report module. The Community Mental Health Service Participants who use PCE for their electronic health record (11 out of 12 in Region 5) as well as MSHN will have access to this reporting module that will generate a report with the required data elements that will increase efficiency and consistency with reporting.

Both reports will be required to be completed by the PIHPs and submitted to MDHHS on a quarterly basis beginning with the first grievance report being due to MDHHS for Quarters 1 and 2 on May 15th.

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

Our Mission:

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

Our Vision:

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

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Your copy should address 3 key questions: Who am I writing for? (Audience) Why should they care? (Benefit) What do I want them to do here? (Call-to-Action)

Create a great offer by adding words like "free" "personalized" "complimentary" or "customized." A sense of urgency often helps readers take an action, so think about inserting phrases like "for a limited time only" or "only 7 remaining!"