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From the Chief Executive Officer's Desk

Joseph Sedlock

Some thoughts on the current “redesign” discussion in our State

The current proposals to “redesign” (read “deconstruct”) the public behavioral health system weigh heavily on the minds of our staff, boards, partners, providers, beneficiaries, and communities. If our legislative leaders were interested in “redesign” they would be listening to individuals, families, communities, and professionals to first identify and then address the issues, problems and gaps faced by them.

Paraphrasing a recent board member comment, we keep asking legislative redesign advocates to define the problem(s) they are trying to address and getting no real answers. The “redesign” proposals do not seem informed by a depth of knowledge of the current system or even awareness of the issues individuals, families and communities *really* experience other than as anecdotes. Drivers for redesign, by some, seem motivated by a desire for a legacy or a desire to shape a future system that is advantageous to their individual desires, political contributors, or future political or other aspirations.

Even if I’m wrong in this opinion, the process our system is going through is wrong and dangerous. The structure of the existing public behavioral health system came about directly as a result of state and federal legislative and executive branch actions. The structure works exactly as it was designed. Mid-State Health Network (MSHN) has provided almost $12M in local resources to our Community Mental Health Services Provider (CMHSP) partners as a result of its performance bonus earnings and every single dollar of revenue over expenses stays with and is invested in services and support for beneficiaries in the region. Hundreds of thousands of our friends, families and neighbors benefit from the services and supports this system delivers every single year. A colleague recently commented that when a house is falling apart because of design flaws, do we criticize the homeowner? The builder? Or the architect? And how often is the solution demolishing the structure and starting over?

MSHN, and our Community Mental Health Services and Substance Use Disorder Prevention, Treatment and Recovery providers, are committed to and are achieving some of the best health integration outcomes in the State. Please see our Population Health and Integrated Care web page.

MSHN, by almost all measures, is a very successful region and Prepaid Inpatient Health Plan (PIHP). What makes this region successful is at least in part due to the commitment of all in the region to focus on and improve the health, care, value, provider systems, and equity – the value – we produce. And to address the physical, mental, emotional, spiritual, and social determinants of health, wholistically. Almost nowhere in the current discourse is there a focus on diagnosing the problem(s), using measures and metrics, and then develop solutions. Instead, the current dialog starts with the statement that “the system is broken”, followed quickly with “and should be replaced.” It is not and should not be. MSHN will continue its persistent focus on what matters to beneficiaries, communities, and our provider partners in these five areas.

The mild/moderate behavioral health benefit has been integrated in the Medicaid Health Plan (MHP) contracts for almost 20 years. Why isn’t anyone asking about the integrated health outcomes associated with this already financially integrated aspect of behavioral healthcare? Why are some policy makers just blindly assuming “it’s better over there?” As practitioners in this field, we see – daily – that it often isn’t. We see all too often the failures to address and improve behavioral health issues for individuals living with mild to moderate forms of mental illness which often worsen to the extent many individuals need the specialty behavioral health services we exist to provide because their mild/moderate condition was not successfully treated. In recent testimony before the Senate Government Operations Committee, it was pointed out that the MHPs provided an average of four outpatient mental health visits to enrollees with mild/moderate mental health diagnoses. The Health Plan Association countered with a statement along the lines of “that was when the outpatient benefit was capped at 20 visits.” That rebuttal doesn’t make any sense (shouldn’t it be closer to what the cap was?) but was never questioned.

When we go to our primary care provider with a complaint, we expect to be asked questions to help them diagnose the problem. The questions get more and more specific until the provider has enough information to form a conclusion (diagnosis) and then to develop a plan to treat the condition (problem). It never happens the other way around – except in these ill-conceived public behavioral health system “redesign” initiatives.

We should demand the same professional – common sense, really – approach to improving or changing the

specialty behavioral health system. And the process should be informed by individuals, families, communities, providers, and payers – FIRST. This is the problem identification (diagnosis) phase. Then and only then should proposals be developed to address the diagnoses or problems (the action plan).

The near constant calls for "redesign" that are seemingly uninformed by the many unified voices of recipients and plentiful performance data from the public behavioral health systems is more than frustrating – it's infuriating – but then, doesn't seem to be what the current dialog is really about. It has been focused on integrated financing – money – and who benefits from "redesigning" the system. The beneficiaries are largely private stakeholders and the profit margins of the plans themselves. And maybe legacy. And maybe other considerations peripheral to the needs of recipients and communities.

The state's behavioral health system, along with other industries, faces a serious workforce crisis. The current dialogue is incredibly destabilizing for the people and communities we support and for the staff that deliver services and supports – including MSHN employees. MSHN Leadership is incredibly proud of our boards, MSHN staff, and our partners and their staff across the region for staying focused on excellence in carrying out our responsibilities to achieve better health, better care, better provider systems, better equity, and better value amid all of these "redesign" discussions.

Please join MSHN in demanding that our elected leaders adopt a focused strategy to identify gaps and problems and then propose a course of action instead of proposing solutions in search of problems to solve. Please join with beneficiaries and communities across the region and state in working to improve, but not destroy, the public behavioral health system. Please join MSHN in opposing the current proposals by countering them with facts, some of which can be found in our Population Health and Integrated Care page linked above and some of which can be found in our Impact Report at this link. In the current dialog, fact-based conversation is largely absent and maybe even irrelevant. Facts and performance data should be at the center of the dialog and included in our advocacy.

For further information or questions, please contact Joe at Joseph.Sedlock@midstatehealthnetwork.org

Organizational Updates

Amanda Ittner, MBA
Deputy Director

Substance Abuse Disorder (SUD) Oversight Policy Board (OPB) Update

Welcome New SUD Board Members

Sandra Bristol, from Clare County has been recently appointed to join MSHN's Oversight Policy Board and Montcalm County has appointed Scott Painter to replace Tom Lindeman. Mr. Lindeman has been on the MSHN SUD OPB since its inception in 2015. Please join me in welcoming our newest SUD Oversight Advisory Board members as well as our appreciation to Tom Lindeman for his participation and dedication as a long-standing board member.

NEW COVID Funding from Substance Abuse and Mental Health Services Administration (SAMHSA)

Per SAMHSA's recently issued guidance to apply for COVID testing and mitigation; "People with mental illness and substance use disorder are more likely to have co-morbid physical health issues like diabetes, cardiovascular disease, and obesity. Such chronic illnesses are associated with higher instances of contracting coronavirus disease (COVID-19) as well as higher risk of death or a poor outcome from an episode of COVID-19. To address this concern, the U.S. Department of Health and Human Services (HHS), through SAMHSA, will invest $100 million dollars to expand dedicated testing and mitigation resources for people with mental health and substance use disorders." To view the full guidance, see link here.

Michigan Department of Health and Human Services (MDHHS) received the SAMHSA Notices of Award (NOA) to provide COVID-19 testing and mitigation to persons with Substance Use and Mental Health Disorders in Michigan through the Prepaid Inpatient Health Plans (PIHPs). The NOAs include $1.43 Million for the Substance Use Disorder Block Grant and $1.44 Million for the Mental Health Block Grant. To draw down the funding, PIHPs had to submit a spending plan and budget to SAMHSA for approval by October 1, 2021.
MSHN submitted the below strategies for MDHHS consideration that would be distributed through our SUD Provider Network.

- Provide onsite COVID-19 testing
- Develop & implement strategies to address consumer hesitancy around testing
- Promote behaviors that prevent the spread of COVID-19 and other infectious diseases

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

Information Technology

Forest Goodrich
Chief Information Officer

As the end of another fiscal year approaches, Mid-State Health Network technology staff focus on making sure that the region will meet the standards for reporting established by the Michigan Department of Health and Human Services (MDHHS).

Volume and timeliness of encounter submissions is an important standard because it is used for rate setting and other MDHHS reporting needs. MSHN is reporting at a 99.1% rate. The standard is 85% of encounters submitted within 90 days of service delivery.

BH-TEDS compliance reporting is measured at a minimum of 95% of persons with encounters will have BH-TEDS records submitted. MSHN reports at 95.7% for mental health and 99.9% for substance use disorders.
The following graph shows percentages by region for mental health.

FY21 MH Encounters w/BH-TEDS records

Encounters: 10/01/2020 - 07/31/2021*			BH-TEDS: 07/01/2019 - 09/24/2021	
		Distinct Count of Individuals With		
Region Name	Submitter ID	Non-H0002 & Non-Crisis, Non-OBRA Assessment & Non-Transportation Encounters	Non-H0002, Non-Crisis, Non-Health Home, Non-OBRA Assess-ment & Non-Transportation Encounters But NO BH-TEDS Record Since 07/01/2019	Current Completion Rate
CMH Partnership of SE MI	00XT	9,280	204	97.80%
Detroit/Wayne	00XH	55,057	3,990	92.75%
Lakeshore Regional Entity	00ZI	17,801	704	96.05%
Macomb	00GX	10,709	255	97.62%
Mid-State Health Network	0107	37,703	1,621	95.70%
NorthCare Network	0101	5,615	33	99.41%
Northern MI Regional Entity	0108	11,925	213	98.21%
Oakland	0058	16,969	194	98.86%
Region 10	0109	16,324	20	99.88%
Southwest MI Behavioral Health	0102	18,891	722	96.18%
Statewide		200,274	7,956	96.03%

Key	
95.00+ = Compliant	*Encounters = All MH encounters **excluding**: A0080, A0090, A0100, A0110, A0120, A013, A0140, A0170, A0425, A0427, H0002, H2011, S0209, S0215, S0280, S0281, S9484, T1023, T2001-T2005 ,90839, 90840, 99304-99310
90.00-94.99	
85.00-89.99	
<85.00	

MSHN was successful in submitting a Veterans Navigator and BH-TEDS referral comparison summary and Behavioral Health ADT summary reports for MDHHS performance incentive projects.

MSHN technology staff have been working to understand and implement the changes needed to its managed care information system so that it can process information and reports for the Certified Community Behavioral Health Center (CCBHC) rollout in the first quarter of 2022.

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 expanded in the month of August to now include Contract Management functions. The previous Contract Specialist was promoted to Contract Manager and this change was due to organizational restructuring after the departure of MSHN's Director of Provider Network Management. Another change in the Finance Department includes the transition of the current Financial Specialist to focus more on Certified Community Behavioral Health Center (CCBHC) tracking. We anticipate an intense level of fiscal scrutiny and monitoring is needed to ensure CCBHC revenue covers administrative expenses associated with additional PIHP responsibilities. MSHN will post for a second Financial Specialist to backfill the open position.

Contract Management
MSHN disseminated FY 22 Substance Abuse Prevention and Treatment (SAPT) contracts and Community Mental Health Service Provider (CMHSP) Medicaid Subcontracting Agreements.

Financial Management
The financial staff will work on evaluating the Michigan Department of Health and Human Services (MDHHS) final Rate Certification Letter received September 17, 2021. The purpose of the analysis is to provide CMHSPs with updated revenue figures to assist with proper fiscal management processes. Preliminary rate estimates indicate a significant revenue increase which will likely be offset by CMHSP spending increases especially related to staff retention efforts. In addition, the new rates and subsequent MDHHS payments will shed light on the impact of CCBHC revenue to the three sites participating in the State's demonstration project. CCBHC demonstration sites are The Right Door, CEI, and Saginaw CMH and the program's anticipated go-live date is October 1, 2021. Lifeways is a Substance Abuse and Mental Health Services Administration (SAMHSA) direct CCBHC grantee. An amended budget will be brought forward to MSHN's Board in January 2022.

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

Behavioral Health

Todd Lewicki, PhD, LMSW, MBA

Chief Behavioral Health Officer

The 1915(i) State Plan Benefit

In response to guidance from the Centers for Medicare & Medicaid Services (CMS), Michigan transitioned all the specialty behavioral health services and supports that had been covered under the 1915(b)(3) ("B3" services) authority, to an 1115 Behavioral Health Demonstration and 1915(i) Home and Community-Based Services (HCBS) state plan benefit effective October 1, 2019. Michigan developed the HCBS benefit to meet the specific needs of its behavioral health and developmental disabilities priority populations. Now referred to as the 1915(i) State Plan Amendment (1915(i)SPA), it establishes the provision of behavioral health community-based services along with the evaluation and re-evaluation of eligibility through the Prepaid Inpatient Health Plans (PIHP). Services covered under the 1915(i)SPA include: Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support & Training, Fiscal Intermediary, Housing Assistance, Respite Care, Skill-Building Assistance, Specialized Medical Equipment & Supplies, Supported/Integrated Employment, and Vehicle Modification.

Mid-State Health Network (MSHN) will conduct reviews to ensure that individuals meet all eligibility requirements for the 1915(i) benefit and the Michigan Department of Health and Human Services (MDHHS) will independently determine if needs-based criteria have been met. This includes annually identifying and evaluating individual level of need, reviewing assessments related to the individual's functional abilities and to ensure that the appropriate services and supports are provided to help the individual reach the expected outcomes of community inclusion and participation, which are key HCBS cornerstones. The new process for the eligibility determination requirement oversight for the 1915(i) benefit will involve evaluation and determination of content provided through the MDHHS Waiver Support Application (WSA), a tool that MSHN has been using for over 7 years to assist appropriate individuals' initial and ongoing eligibility for other benefits, including the Habilitation Supports Waiver, Children's Waiver Program, the Waiver for Children with Severe Emotional Disturbance, and the Autism Benefit. All evaluations and re-evaluations of individuals enrolled in and/or seeking 1915(i) HCBS state plan service benefits will be completed by October 1, 2022. MSHN currently has approximately 12,500 individuals that meet this requirement.

MSHN Hosts Michigan Developmental Disabilities Institute (MI-DDI) Home and Community Based Services (HCBS) Trainers for Panel Presentation
By Todd Lewicki, PhD, LMSW, MBA
Chief Behavioral Health Officer and
Katy Hammack, M.Ed., QIDP, QMHP
HCBS Manager

Through the HCBS Rule transition, MSHN has continued to endeavor to improve the experience of individuals by enhancing access to the community, promoting the delivery of services in more integrated settings, and expanding the use of person-centered planning. The HCBS Rule involves improving opportunities for individuals who receive home and community-based services to be more integrated in their communities, have a right to privacy, dignity, respect, and to be afforded autonomy and choice. MSHN has witnessed significant and impactful changes in its region and values the opinions of individuals served as the highest in importance in knowing just how much the HCBS Rule Transition's effect has had on their system of care and in their lives.

On Friday, September 24, 2021, MSHN's HCBS Department and Regional Consumer Advisory Council (RCAC) partnered with the MI-DDI of Wayne State University to provide the MSHN region with a training opportunity entitled, **"Let's Talk About the Home and Community-Based Services (HCBS Rule)"** featuring a panel of five HCBS trainers. The aim of the HCBS trainers is to educate individuals and families on the importance of the HCBS Final Rule and its impact on services and supports. The HCBS trainers: Blake, Alex, Leonardo, Ray, and Julie are all individuals receiving HCBS within the Community Mental Health Service Provider (CMHSP) system. They are informed by policy, training materials, and their valuable lived experiences. The presentation discussed what the HCBS Final Rule is, why the HCBS Final Rule is important, who funds HCBS, how the HCBS Final Rule can help individuals receiving services to live a more fulfilled life, and shared ideas about how the HCBS Final Rule can be applied to the way people with disabilities work, live, and play. They have facilitated trainings across Michigan including presentations with self-advocates, people with disabilities and their family members, schools, Pre-Paid Inpatient Health Programs (PIHPs), CMHSPs, and advocacy agencies.

Their presentation included a glimpse into their personal world and how the HCBS Final Rule allows them to make choices in their lives, to have freedoms and rights, and how they enjoy being integrated within their communities in personally meaningful ways. The presentation was targeted towards individuals receiving HCBS, however there was a combination of individuals with a disability, guardians, advocates, HCBS providers and PIHP/CMHSP professional staff in attendance. The presentation allowed attendees to be interactive in exploring different ways in which the HCB Final Rule is important to individuals receiving services and supports in a home and community-based setting. After the presentation ended attendees had many accolades for the panel presenters. MSHN is grateful for their sharing of their time, experience, and insight.

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

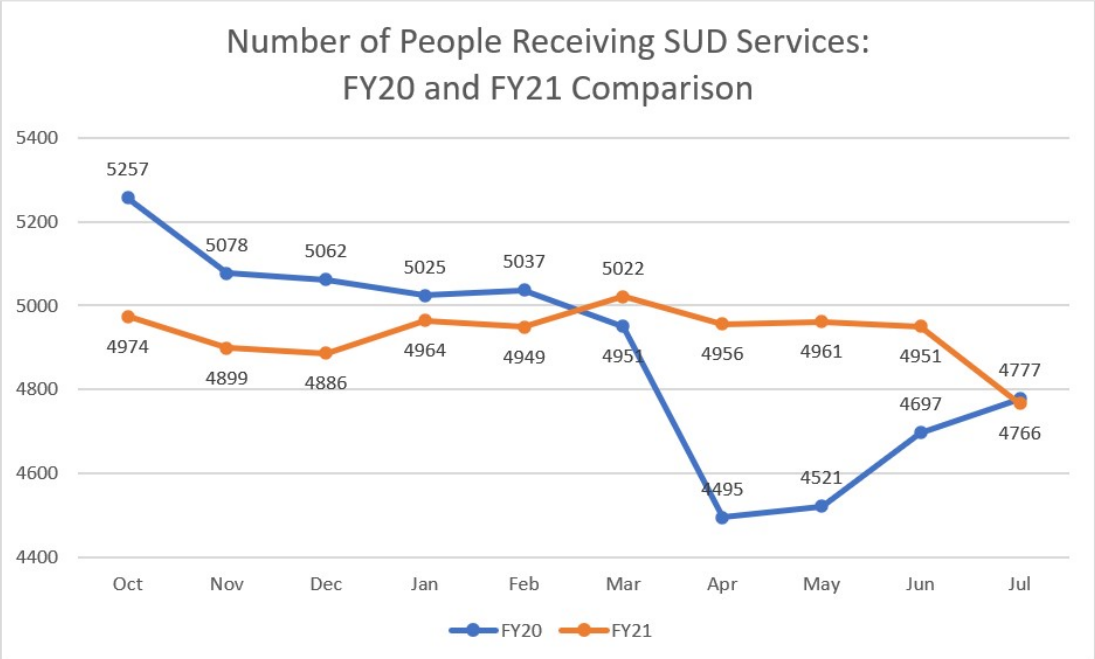
Utilization Management & Care Coordination

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

During FY21, there were 10,882 new admissions to MSHN-funded Substance Use Disorder (SUD) treatment services, a decrease of 543 new admissions from FY20. The following table represents the total number of admissions to treatment by the county of residence of persons served over the last 3 fiscal years:

County of Residence	FY21 Served	FY20 Served	FY19 Served
Arenac	62	71	56
Bay	855	976	1072
Clare	283	284	302
Clinton	218	258	291
Eaton	479	383	500
Gladwin	188	202	209
Gratiot	179	139	248
Hillsdale	229	229	159
Huron	118	143	121
Ingham	2533	2707	2615
Ionia	189	239	263
Isabella	341	347	467
Jackson	1272	1307	1302
Mecosta	311	384	311
Midland	446	480	394
Montcalm	436	503	477
Newaygo	267	353	430
Osceola	137	128	155
Saginaw	1544	1400	1473
Shiawassee	457	453	458
Tuscola	209	228	284
Unknown or Out of Region	149	211	148
Total Admissions to Treatment	**10,882**	**11,425**	**11,735**

There was a 2.64% decrease from FY19 to FY20 and a 4.75% decrease from FY20 to FY21, amounting to a 7.39% decrease in new admissions to SUD treatment from FY19 to FY21. The graph below shows a comparison of the number of people who received SUD services each month during FY20 and FY21, showing that although overall new admissions for the year decreased, the number of people being served each month returned to almost pre-pandemic levels throughout FY21.



**Complete data not yet available for August and September 2021*

The MSHN SUD Service Provider (SUDSP) network has gone to significant lengths to safely provide services to vulnerable individuals throughout the pandemic. Many SUDSPs have made physical modifications to their offices and buildings to protect the health of employees and persons served while providing crucial face-to-face services. Timely access to withdrawal management and residential treatment services continues to be a challenge in some portions of the region due to many facilities operating at reduced capacity to maintain adequate social distancing among residents throughout the COVID-19 pandemic. Additionally, many SUD Service Providers report being

profoundly impacted by staffing shortages which has also contributed to reduced service capacity. MSHN continues to offer provider stabilization funding and direct care worker premium pay to affected SUD Service Providers to support and stabilize the workforce and ensure individuals in the region have timely access to needed services. MSHN will continue to monitor the changing needs of the population and workforce throughout FY22 and explore options for increasing SUD service capacity where needed.

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

Treatment & Prevention

Dr. Dani Meier, PhD, LMSW
Chief Clinical Officer

Perspective from the Trenches: SUD & CMH Prevention & Treatment Successes

As a school social worker and a therapist in Jackson for over two decades, I worked with teens with a range of challenges: substance use, mild to severe mental illness, trauma, and autism. As a parent, I have also lived with substance abuse and mental illness in my own family, and I've had to help family members navigate the private and public systems.

In recent months, selected anecdotes have shaped a skewed narrative about how the public behavioral health system does not work. These are sad stories, but they obscure the big picture and what we see on the front lines. I also have stories (supported by data) of *many* successes thanks to the public system. Michiganders who have survived trauma and mental health crises and now are living their lives, contributing to society, and dealing with their mental illness or autism or addiction issues supported by our system. Many of those supports come from MSHN's network of Substance Use Disorder (SUD) and Community Mental Health (CMH) provider networks and community partners. A favorite story of mine is of a young man I worked with who got help from the current behavioral health system who today works through his local church in support of homeless people, veterans, and patients in nursing-homes. There are countless survivors and people in recovery like him who are alive and well today thanks in part to services and supports they received from our SUD and CMH partners.

On the other hand, working on the ground I also witnessed barriers to patients accessing mild-to-moderate mental health services. Crises would escalate and these individuals would often end up being served through *our* provider networks where, thankfully, the clinical staff in our system had the training and the skills to deal with the crises that had escalated due to failures in care under the Medicaid Health Plans (MHP) watch.

At MSHN, we seek evidence of collaborative integrated care between behavioral health and physical health care at the point of contact, in every client chart we review. Privatization and consolidation of health care financing under a global HMO umbrella represents "trickle-down health care," creating greater wealth at the top and expecting that to improve the quality of life for those living their lives in the communities we serve. With the MHPs administrative cost of 21% compared to the PIHPs 6%, that will result in hundreds of millions in dollars that will not trickle down to programs for the people we serve.

We can do better than that. We *already* do better than that.

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

Quality, Compliance & Customer Service

Kim Zimmerman, MBA-HC, LBSW, CHC
Chief Compliance and Quality Officer

Recovery Self-Assessment (RSA)

The Recovery Self-Assessment (RSA) is intended to assist the Community Mental Health Service Provider (CMHSP) Participants and Substance Abuse Treatment Providers (SATP) within MSHN's provider network develop a better understanding of the strengths and weaknesses in providing recovery-oriented care. The RSA is a voluntary self-reflective survey that is completed by administrators and providers that provide services to adults with a Mental Illness and/or Substance Abuse diagnosis within the region.

This year marks the sixth year of implementation for the CMHSP Participants for the RSA-R Administrators Assessment and the second year for the CMHSP Participants and SATP for the RSA-R Provider Assessment.

The RSA-R Administrator Assessment is completed by administrators who do not provide direct services to individuals. The RSA-R Provider Assessment is completed by providers who, in addition to their administrative functions, provide direct services to individuals.

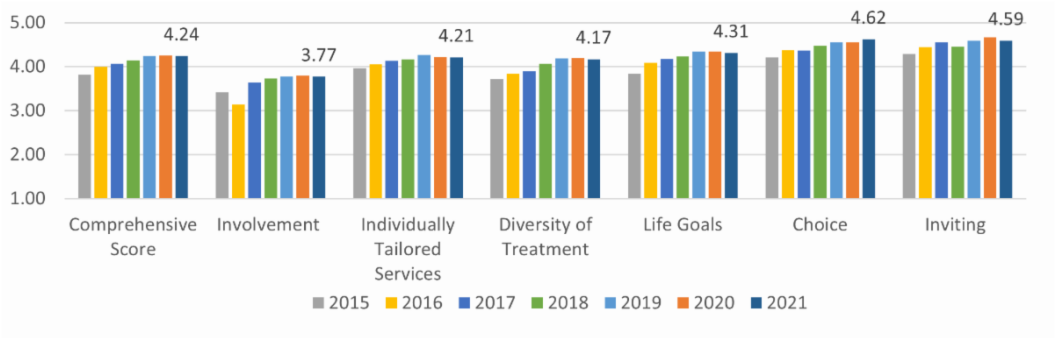
The responses from the Recovery Self-Assessments were scored as a comprehensive total, separately as six subcategories, and by individual question. The comprehensive score measures how the system is performing, and the subcategories measure the performance of six separate groups of questions. The six (6) subcategories included Inviting, Choice, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment.

The tool is intended to assess the perceptions of individual recovery and all items are rated using the same 5-point Likert scale that ranges from 1 = “strongly disagree” to 5 = “strongly agree.” A mean score of 3.50 or higher indicates agreement with the statements included in the measurement category.

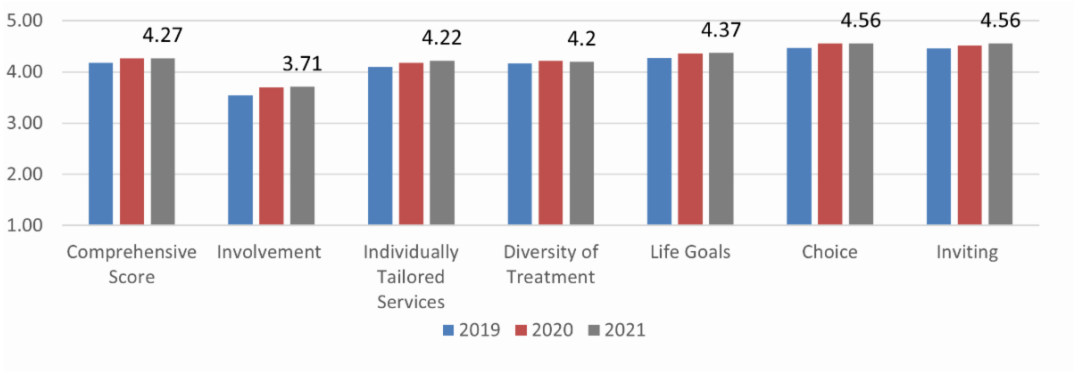
MSHN, inclusive of the CMHSP Participants and the SATP, demonstrated a decrease of .01 in the comprehensive score for the RSA-R Administrator Assessment for FY21. MSHN had no change in performance for the RSA-R Provider Assessment for FY21 compared to FY20.

The comprehensive score for each CMHSP Participant and SATP Administrator Assessment and the Providers Assessment shows performance above 3.50 indicating general agreement with the statements in the assessment.

MSHN RSA-R Administrator Assessment Comprehensive Score and Subcategory Comprehensive Scores



MSHN RSA-R Provider Assessment Comprehensive Score and Subcategory Comprehensive Scores



The questions that ranked the lowest in both the RSA-Administrator Assessment and the RSA-Provider Assessment from FY20, continued to be among the lowest for FY21. Growth areas to consider include subcategories or questions that perform below the 3.50 indicating disagreement or room for improvement.

The results will be reviewed further by the MSHN Quality Improvement Council, the SUD Provider Network, and the Regional Consumer Advisory Council. Areas of improvement will be targeted toward below average scores (based on the regional average of all scores) and priority areas as identified by review of committees and councils.

To view the full report on the website, please click here.

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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