Mid-State Health Network | 530 W. Ionia Street | Lansing, MI 48933 | 517.253.7525| F: 517.253.7552 | www.midstatehealthnetwork.org

Mid-State Health Network December 2024

From the Chief Executive Officer's Desk

Joseph Sedlock

The term “social drivers of health” is replacing the term “social determinants of health.” Following is an excerpt drawn from the National Association of Community Health Centers about why.

> Social needs. Social risks. Social barriers. Social determinants of health. These terms are used interchangeably when it comes to describing the strengths, challenges and barriers related to the health and well-being of our communities. But when it comes to advancing health equity, these terms can be confusing, alienating, and even demeaning.
>
> When addressing policies, systems, and structures that fuel racial inequities in areas that influence a person’s health, such as health care, housing, access to healthy food and transportation, “social drivers of health” is more accurate. When using the term “determinants” it can have a sense of finality, stripping individuals of their agency to manage their own health and well-being, and minimizing accountability amongst policymakers and those in power for the social and political decisions that create these inequities—as though struggles to access food or housing are predetermined and thus cannot be changed.
>
> Recent research suggests that “drivers” is a more accessible, understandable term that communities prefer. The National PRAPARE® Team is moving forward with adopting the term “social drivers of health” in lieu of “social determinants of health,” as this more accurately describes the ability for policy-makers, communities, and individuals to affect change on the factors negatively impacting health and well-being.
>
> In our work to advance health equity, it is important to use standardized SDOH-related needs data, like the PRAPARE® risk screening tool, to understand the factors that result in poor health outcomes. This data is needed to address immediate needs of individuals and families, which can then be aggregated to understand the harmful impact of policies and systems on the health of a community.
>
> Using the term “social drivers of health” reflects the National PRAPARE® Team’s collective goal of using SDOH-related needs data with community voices to inform upstream efforts related to health equity while allowing health centers to understand and describe their role in advocating for policies to improve health and well-being in their local communities.

Mid-State Health Network and our provider partners across the region are deeply engaged in health equity work and addressing social drivers of health. This engagement should improve individual and community health outcomes but requires collaboration across all healthcare and public policy systems. According to the Michigan Center for Rural Health of Michigan State University, social drivers of health are grouped into five domains:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

The intersections between social drivers of health and health outcomes is complex at the individual and community levels. Together, this region is addressing significant barriers to achieve better health and better equity for all people.

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

MSHN Staffing Update

MSHN is pleased to announce the following staffing changes and new hires effective through December. Please join me in congratulating our staff and welcoming our newest members to the MSHN team.

- Tacara Pitchford and Elise Parker joined MSHN as Access Screeners in November through Kelly Services temp staffing solutions to support the Access department conducting access screening and intake.
- Marc Irish will be joining MSHN as the Access Specialist on December 2, 2024. Marc comes to us with a Master's in Clinical Counseling and years of experience, most recently from Northern Michigan Regional Entity [Pre-paid Inpatient Health Plan (PIHP)] where he was the Access Specialist/Care Manager and prior experience working with Ten16 Recovery Network.
- Sarah Winchell-Gurski will be joining MSHN as the Access Specialist on December 2, 2024. Sarah comes to us with a master's in social work and years of experience working for Saginaw Chippewa Indian Tribe, most recently as the SUD Residential Treatment Manager.
- Jodie Smith has accepted the Treatment Specialist position that will be effective December 4, 2024. Jodie Smith currently holds the Data & Grant Coordinator position for MSHN and will be working on a transition plan to the new position through December. In preparation for her transition, MSHN has posted the Data & Grant Coordinator position to our website under careers.

Universal Credentialing Kick-Off - Region 5

Public Act 282 of 2020 required Michigan Department of Health and Human Services (MDHHS) to create a Universal Credentialing program. MDHHS' was tasked to establish, maintain, and revise, as necessary, a uniform community mental health services credentialing program. This program is intended to create uniformity in the state to streamline providing community mental health services and to enhance workforce development, training education, and service delivery. The Universal Credentialing program adheres to national standards from accrediting bodies that have been approved by the department and complies with the national certification standards for community mental health counselors and professionals. The Universal Credentialing program must be used for the following health care professionals: Physicians; Physician's assistants; Psychologists; Licensed master's social workers; licensed bachelor's social workers; social service technicians as defined in section 18501 of the public health code; social workers granted a limited license under section 18509 of the public health code; Licensed professional counselors; nurse practitioners; registered nurses; licensed practical nurses; occupational therapists; occupational therapist assistants; physical therapists; physical therapists assistants; Speech language pathologists, as well as Organizational providers, except Residential Providers.

The Universal Credentialing process was built into the MDHHS Behavioral Health Customer Relationship Management (MDHHS BH CRM) system. This system houses many PIHP and Community Mental Health Service Program (CMHSP) behavioral health business processes such as American Society of Addiction Medicine (ASAM) Level of Care, Critical Incident Reporting, and CMHSP Certification. For the Universal Credentialing process, the CRM allows both individual and organizational providers to electronically submit their credentialing applications. The BH CRM houses the applications which are viewable to CMHSPs and PIHPs. The Universal Credentialing CRM process was developed, reviewed, and tested by a collaborative workgroup of representatives from various CMHSPs and PIHPs across the state. The workgroup membership includes 11 agencies, of which MSHN and Bay-Arena Behavioral Health participate from our region. MSHN staff have worked with Ten16 and Victory Clinic Services, as SUD providers, to test the application, submission, verifications and approval process.

MSHN was the first region to work with MDHHS for the rollout of the universal credentialing process. In October, MDHHS held the first training session for the MSHN region. CMHSPs along with MSHN staff have participated in additional training throughout November trying to understand the complexities of both the individual and organizational credentialing process. Many questions on the process and workflow are still outstanding. In response, MSHN has offered to create an in-region manual to assist the CMHSPs, while we continue to work with MDHHS on refinement.

MDHHS announced identified issue resolution by January 2025. At that time, MDHHS expects the MSHN region to fully implement use of the Universal Credentialing System for all individual and organizational credentialing.

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

Information Technology

Steve Grulke
Chief Information Officer

How is Artificial Intelligence (AI) used in Behavioral Healthcare?

Artificial Intelligence (AI) is increasingly being integrated into behavioral healthcare to improve the quality of care, enhance patient outcomes, and streamline various processes. Here are some of the key ways AI is being used in this field:

1) Diagnostic Support and Early Detection
AI can help clinicians diagnose mental health disorders more accurately by analyzing large volumes of data, including patient histories, speech patterns, and even facial expressions. For example:

- **Predictive Modeling:** AI can analyze data from electronic health records (EHRs) and other sources to predict the likelihood of conditions like depression, anxiety, or psychosis, even before symptoms become overt.
- **Natural Language Processing (NLP):** NLP algorithms can be used to analyze patient conversations, therapy session notes, or social media posts to detect signs of mental health issues like depression or anxiety. They can identify subtle language patterns that might be missed by clinicians.

2) Personalized Treatment Plans
AI can analyze data from a variety of sources to help create personalized treatment plans that are tailored to the unique needs of each patient. By analyzing patient history, demographic data, and treatment responses, AI can help predict which therapies or interventions are most likely to be effective.

3) Therapeutic Chatbots and Virtual Therapists
AI powered virtual assistants and chatbots are being developed to provide therapy and support for patients, especially for those who may not have access to traditional in-person care. These technologies can be used in a variety of ways:

- **Cognitive Behavioral Therapy (CBT):** Virtual therapists can guide patients through CBT techniques, providing support for individuals dealing with anxiety, depression, or stress. Some apps use AI to offer personalized CBT-based exercises and track progress.
- **24/7 Support:** AI chatbots can provide patients with on-demand, anonymous support, reducing the stigma associated with seeking help and offering assistance in between therapy sessions.

4) Monitoring and Engagement
AI can be used to monitor patient behavioral and engagement in their treatment plan:

- **Wearables and Mobile Apps:** AI can analyze data from wearable devices (like smartwatches) or mobile apps to track sleep patterns, physical activity, and other behaviors that impact mental health. For example, changes in activity levels or sleep disruption can indicate worsening depression or anxiety.
- **Real-Time Feedback:** By analyzing data from these sources, AI can provide real-time feedback to both patients and clinicians, alerting them to any potential problems before they escalate.

5) Behavioral Predictive Analytics
AI tools can analyze large datasets to predict the future behavior or needs of individuals with mental health issues. This can help in:

- Risk Stratification: AI can predict which patients are at higher risk for suicide, self-harm, or relapse, allowing healthcare providers to intervene earlier and allocate resources more effectively.
- Identifying Patterns: AI algorithms can detect patterns or triggers in patient behavior, helping clinicians understand what factors contribute to mental health crises or lapses in treatment adherence.

6) Treatment Adherence and Medication Management
AI can help improve treatment adherence by monitoring medication usage and providing reminders or feedback to patients.

- **Medication Management Systems:** AI can predict the likelihood of a patient not adhering to their prescribed medication schedule and offer reminders or alternative strategies to improve compliance.
- **Side Effect Prediction:** AI models can analyze the efficacy and side effects of medications in different patient populations, helping clinicians make more informed decisions when prescribing medications.

7) Crisis Intervention and Suicide Prevention
AI-based systems can be used to monitor and assess patients at high risk of suicide or in crisis situations. This might include:

- **Real-time Monitoring:** AI can analyze text or voice data for signs of distress or suicidal ideation, allowing for immediate intervention.
- **Automated Alerts:** If a patient is at significant risk, AI systems can automatically alert healthcare providers or emergency services to provide timely assistance.

8) Administrative Efficiency
AI can help reduce administrative burdens in behavioral healthcare settings, which can free up time for clinicians to focus on direct patient care. AI can help with the documentation of patient interactions, progress notes, and treatment plans by transcribing and organizing clinician-patient conversations or notes.

Challenges and Considerations:
While AI has the potential to transform behavioral healthcare, there are several challenges and considerations to keep in mind:

- **Ethical and Privacy Concerns:** AI tools often require large amounts of personal data, which raises concerns about patient privacy, data security, and informed consent.
- **Bias in Algorithms:** AI systems are only as good as the data they're trained on, and biased data can lead to biased outcomes, potentially exacerbating health disparities.
- **Human AI Collaboration:** AI should be viewed as a tool to support clinicians rather than replace them. Effective integration of AI into behavioral healthcare requires careful oversight and collaboration between AI systems and human providers.

Conclusion:
AI in behavioral healthcare offers exciting opportunities for enhancing diagnosis, treatment, and patient engagement. It can help clinicians provide more personalized, timely care while addressing the shortage of mental health professionals. However, as with all new technologies, careful attention to ethical considerations, data security, and human oversight is essential to ensure AI benefits patients and healthcare systems equitably and responsibly.

MSHN Status:
MSHN is currently researching areas where we might be able to use this new functionality and reviewing to ensure

security and privacy protections.

This article was generated by ChatGPT.

For further information or questions, please contact Steve at Steve.Grulke@midstatehealthnetwork.org

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

As reported in October 2024, MSHN's Finance Team is continuing Fiscal Year 24 close-out activities.

Two items reported in October 2024 are highlighted directly below this month for ongoing efforts. Both items assist with financial planning and have demonstrated the importance of managing and reviewing the region's fiscal status at multiple times throughout the fiscal year to monitor fluctuations. The Interim Financial Status Report (FSR) (item 2) is utilized in calculating Interim cost settlement figures (item 1). As we continue evaluating MSHN's FY 24 fiscal picture, the additional revenue from the Michigan Department of Health and Human Services (MDHHS) FY 24 amended rates will offset the board approved deficit but to a lesser degree than originally believed. Estimates from the Interim MDHHS FSR is showing a likely deficit of close to $23 M instead of the $19 M calculated in September. MSHN will not have any FY 24 Medicaid Savings carryforward. Medicaid Savings is generated when the region's expenses [Community Mental Health Service Programs (CMHSPs) and Pre-paid Inpatient Health Plans (PIHPs)] are less than the current fiscal year's revenue.

1. MSHN and CMHSP Interim Cost Settlement - MSHN is obligated to cover allowable CMHSP Medicaid and Healthy Michigan Plan (HMP) expenses. Any dollars in excess of CMHSP expenses must be returned to MSHN. The region typically completes 85% of its preliminary cost settlement transactions in mid-November. If CMHSP expense exceeded revenue provided by MSHN, the PIHP is responsible for sending additional funds to cover the costs.
2. MSHN and MDHHS Interim Reporting – November is the month MSHN also submits an interim Financial Status Report (FSR) to MDHHS. This report includes a breakdown of Medicaid and HMP expenses by CMHSP and MSHN. It outlines revenue, expenses, potential savings amounts, and Internal Service Fund (ISF) calculations.

FY25
MSHN monitors its fiscal its fiscal position periodically throughout the fiscal year. The purpose of this monitoring is to not rely solely on the Financial Statements presented to the board as CMHSP expense lines generally represent per-eligible per month (PEPM) payments. Through ongoing monitoring, the PIHP collects anticipated CMHSP expenses as compared to MDHHS revenue and both components show an anticipated Savings or Deficit. Savings amounts are evaluated for contributions to the Region's ISF if it is not fully funded at the MDHHS allowable 7.5% maximum. As a reminder, Savings is not expected for FY 25 and there will likely be at least $10 M used from the ISF based on MDHHS rates received in late September.

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

Behavioral Health

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

MSHN Staff in the Home and Community Based Services Spotlight

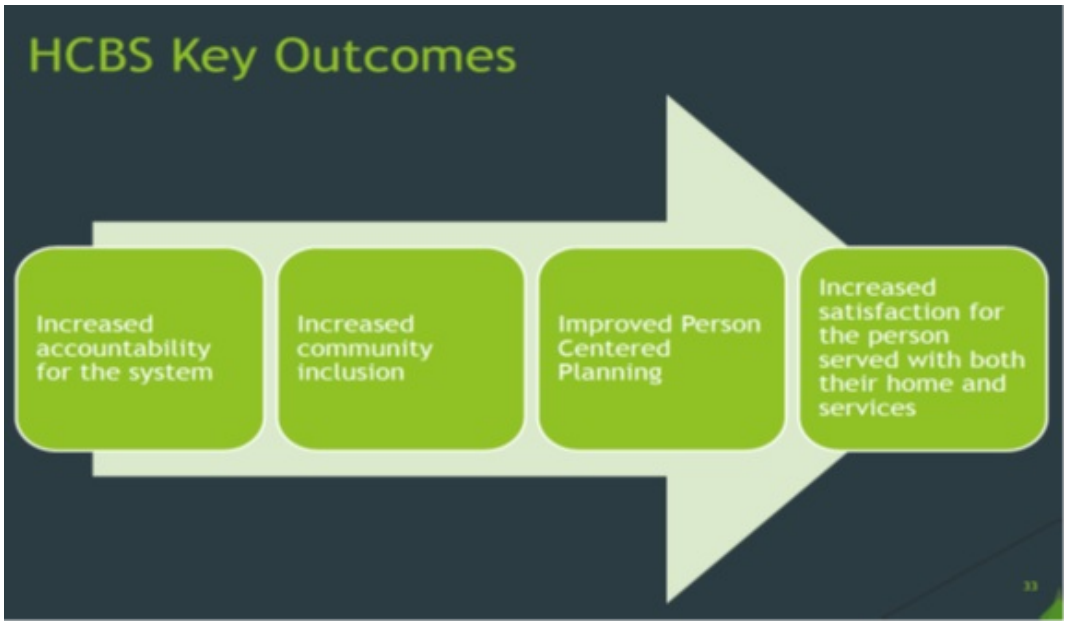
The Community Mental Health Association of Michigan (CMHAM) held its annual fall conference from October 21st through the 22nd, 2024. The fall conference continues to be a vital training and networking resource that brings together behavioral health and substance use disorder professionals, advocates, and stakeholders. The conference offers educational sessions, networking opportunities, exhibitors and sponsors, as well as workshops and panels. These opportunities offer contemporary education and updates on key issues affecting beneficiaries and families, Community Mental Health Service Program (CMHSP) agencies, Pre-paid Inpatient Health Plans (PIHPs), providers, and advocacy organizations. Simply put, the fall conference is a vibrant and robust setting where sharing the best ideas, thoughts, trends, and issues is the norm.

Mid-State Health Network (MSHN) has always been an active participant in the fall conference and has sent staff to present on important topics and share best practices implemented throughout the region. This most recent conference was no exception. MSHN staff Dalontrius Acacya, Mid-State Health Network (MSHN) Home and Community Based Services (HCBS) Waiver Coordinator, and Victoria ("Tori") Ellsworth, MSHN Waiver Coordinator for the Habilitation Supports Waiver, stepped in to provide one such workshop. The workshop, entitled, The Impact of HCBS Services and Ongoing Monitoring Solutions, examined the far-reaching implications of the HCBS Final Rule from both a systemic and individual perspective while also sharing and proposing strategies for ongoing monitoring.

The HCBS Final Rule was established by the Centers for Medicare & Medicaid Services (CMS) in January 2014 and set new standards for Medicaid-funded HCBS programs, aiming to enhance the quality of services and ensure that individuals receiving these services have full access to the benefits of community living (Home & Community Based Services Final Regulation | Medicaid). The Final Rule focuses on key aspects of improving services to individuals including person-centered planning, community integration, rights and protections, and provider and state compliance requirements.

Dalontrius and Tori (pictured below) shared the foundational building blocks of the HCBS Final Rule and illustrated MSHN's focus on present-day and future-looking efforts to continue to maintain ongoing adherence to the intricacies of the HCBS Rule and how to maximize outcomes for individuals being served. The goal of the HCBS Rule is to ensure that those persons receiving HCBS services have autonomy, choice, and control within their homes and have full access to the benefits of community living, while receiving services in settings integrated into the community. Further, it is fundamentally important to point out that the intent and focus of the HCBS Rule has always had a role in the healthcare, psychology, counseling, and social work fields (among many others) through the ethical principle of autonomy. The presence of this principle is ubiquitous throughout healthcare professions and reflects the recognition and respect of an individual's right to make choices about their life (whether they have a guardian or not); the HCBS Rule embraces this principle and amplifies it into practical application.

The PIHPs, CMHSPs, and providers in Michigan's behavioral health and substance use disorder treatment systems have a long and proud history of excellence in services to Michigan's most vulnerable citizens with a focus on continuous systemic and individual level quality improvement. As shown in the diagram below, key outcomes in HCBS Final Rule efforts not only relate to systems change, but to improved quality of life. Dalontrius and Tori are two staff among many valued PIHP employees at MSHN and their contribution to making individuals' lives better is recognized and appreciated.



For questions or more information, please contact Todd at Todd.Lewicki@midstatehealthnetwork.org

Utilization Management & Care Coordination

Skye Pletcher-Negrón, LPC, CAADC, CCS
Chief Population Health Officer

MSHN Centralized Access for Substance Use Disorder (SUD) Services

MSHN recently implemented a new regional centralized access process beginning 10/1/2024 for SUD withdrawal management, residential, and recovery housing services. There were many reasons which contributed to MSHN's

decision to implement a new process, however foremost was to improve the experience of individuals seeking services. Previously, individuals seeking those services could call any SUD provider to receive screening and be admitted to treatment. Unfortunately, that often led to individuals calling multiple providers looking for an open bed resulting in the person receiving duplicate screenings and having to repeat their story. The goal for centralized access is for a person to receive one screening from the MSHN access center, who then assists the person with securing an admission appointment and shares the information with the SUD provider with the person's consent.

MSHN conducted careful planning for a smooth transition to the new access process, however there have been significant unforeseen challenges despite our best efforts, largely due to factors that were unknown at the time of planning. MSHN has received communications from stakeholders, community members, and providers indicating concerns about various aspects of the new access process. MSHN Leadership and Staff fully acknowledge the issues, consequences, and impacts on beneficiaries, our provider partners, and community stakeholders. We take these concerns very seriously and are constantly working on improvements to address the identified issues. These efforts include:

- Increasing the level of staffing support to accommodate the volume of calls being received, including working with a temporary staffing agency to address immediate needs while the need for permanent staffing positions continues to be evaluated.
- Upgrading and reconfiguring the current phone system to increase the number of available phone lines for callers to reach a live person.
- All Community Mental Health (CMH) access centers within the MSHN region are providing assistance with referrals to withdrawal management and residential treatment for now as another door by which individuals can access these services.
- Providing flexibility to the SUD Provider network to schedule immediate admissions without prior approval from MSHN if a person has urgent health and safety concerns related to withdrawal management and cannot wait for a same-day callback from the MSHN access center.
- It is our intention to create the best process possible for beneficiaries and providers after a rough start. We welcome feedback from beneficiaries, providers, and stakeholders around areas where we can continue to improve the process. Please offer your feedback and input through our access email at access@midstatehealthnetwork.org.

Contact Skye with questions, comments or concerns related to the above and/or MSHN Population Health & Utilization Management at Skye.Pletcher@midstatehealthnetwork.org

Substance Use Disorder Policy, Strategy and Equity

Dani Meier, PhD, LMSW, MA
Chief Clinical Officer

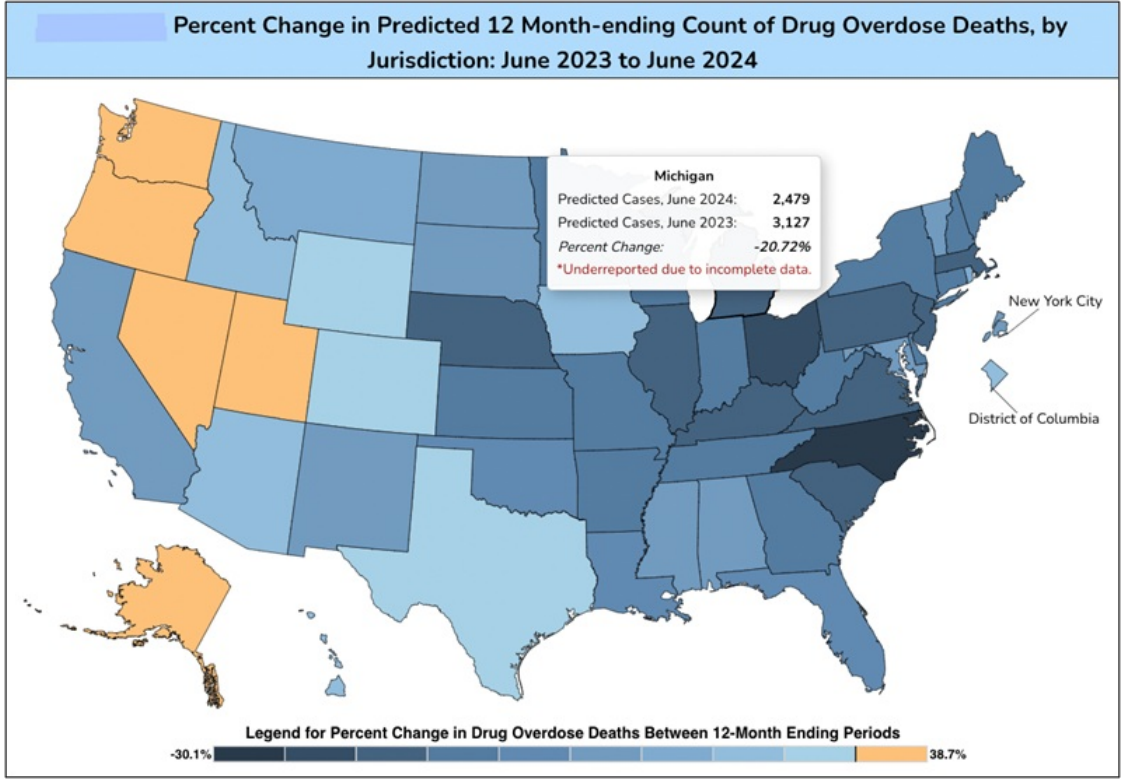
Policy & Funding Challenges for Substance Use Disorders Amid Leadership Changes

Following the 2024 political season, it's fair to say that our region, state, and nation will likely experience significant changes in 2025. In MSHN's domain within the public behavioral health system in particular, we've seen over the years how transitions in government can have a profound impact on healthcare policy. These shifts in priorities, regulatory approaches, and funding allocations have the potential to either support or impede MSHN's efforts in addressing substance use disorders (SUD). Change creates uncertainty which can provoke anxieties that we're hearing about from our SUD providers.

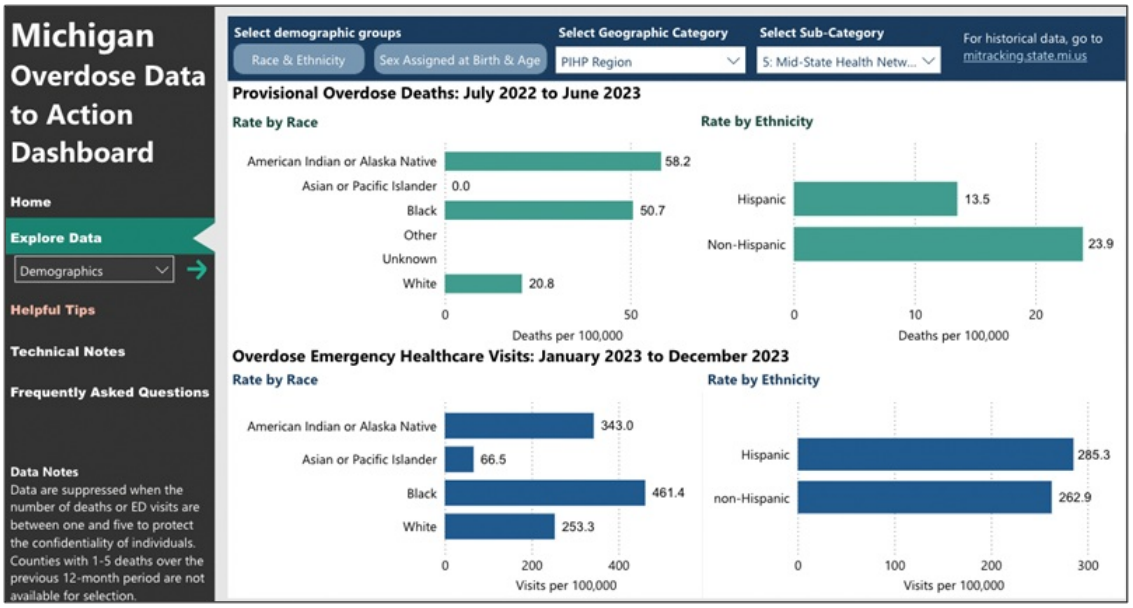
One major challenge lies in the uncertainty surrounding federal funding for substance use prevention, treatment, and recovery programs. Initiatives such as the State Opioid Response grants and programs supported by Substance Abuse and Mental Health Service Agency (SAMHSA) have historically relied on bipartisan support. Leadership changes could result in a reduction and/or reallocation of funding towards other areas, potentially cutting resources for crucial treatment options like Medication for Opioid Use Disorder (MOUD), prevention programs, and harm reduction efforts. Policy changes under new leadership may also impact Medicaid, a vital source of coverage for SUD treatment. While Medicaid expansion has improved access to care for millions, including those with substance use disorders, reforms or stricter eligibility requirements could limit access to treatment services for vulnerable populations.

Moreover, harm reduction policies, such as naloxone distribution and syringe exchange programs, may face scrutiny or rollback under new leadership. Despite their proven effectiveness in saving lives and reducing the spread of infectious diseases, these interventions remain controversial in some political circles. A shift towards the "old school" (and ineffective) punitive measures rather than public health and treatment approaches could undermine progress in reducing the harms associated with substance use.

The good news is that the Centers for Disease Control & Prevention (CDC) reported a significant decrease in overdose deaths—almost 21% in Michigan—thanks to increased access to MOUD and harm reduction approaches.



Despite progress, disparities persist in health outcomes for African American and Native American residents of our region with overdose death (ODD) rates at 2.4x and 2.8x respectively the ODD rates facing White residents of our region. MSHN continues to work on reducing these disparities through its *Equity Upstream* and population health initiatives (see Region 5 data below).



Though leadership changes may bring shifts in regulatory and funding priorities, MSHN will continue to operate through the lens of substance use disorders as a public health issue, we'll continue to support data-driven and evidence-based decision-making, and we'll sustain our advocacy efforts for continuity of robust policies and funding for SUD prevention, treatment and recovery hinges.

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

Substance Use Disorder Providers and Operations

Trisha Thrush, PhD, LMSW
Director of SUD Services and Operations

Alcohol Use Disorder in the MSHN Region

In the spring of 2024, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) released its strategic plan for fiscal years 2024–2028, Advancing Alcohol Research to Promote Health and Well-Being. The strategic plan considers the long-term priorities of the alcohol research field while remaining flexible to adapt to emerging public health needs and scientific opportunities. It charts a course for the next five years and outlines the goals and priorities that will guide NIAAA's research and mission. Specifically, the plan focuses on four research goals:

1. Elucidate the biological mechanisms and consequences of alcohol misuse
2. Identify patterns, trends, and public health impact of alcohol misuse
3. Prevent and reduce alcohol misuse, alcohol use disorder, and associated consequences
4. Improve diagnosis and expand treatment of alcohol use disorder and alcohol-related conditions

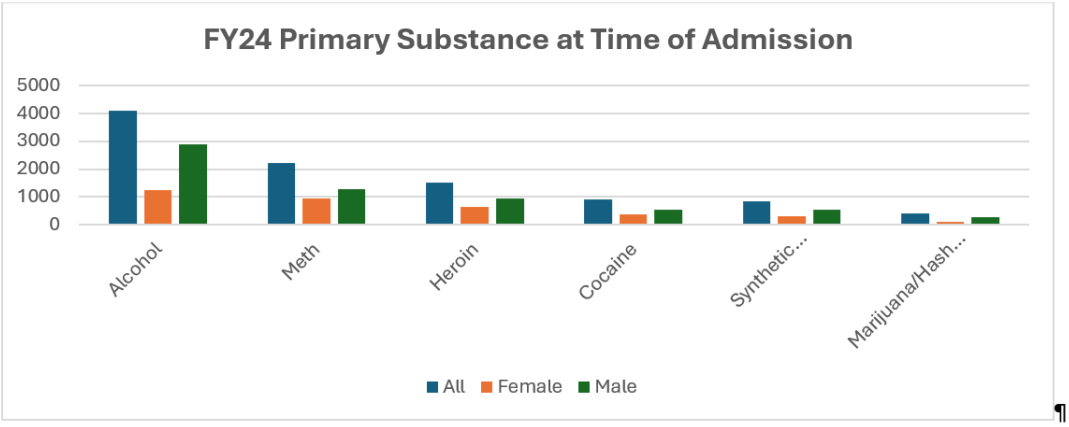
Several cross-cutting research themes are also covered in the plan:

- Advancing diversity, equity, inclusion, and accessibility in the alcohol research enterprise
- Advancing research on women's health
- Applying a life-course approach to alcohol research
- Encouraging a whole-person, integrated approach to health
- Innovating alcohol research and care through data science

The NIAAA Strategic Plan will be one of many resources utilized by the MSHN SUD clinical team moving forward to evaluate the needs of individuals in the region related to Alcohol Use Disorder.

In FY24, alcohol was the primary substance identified at the time of admission for 40% of people seeking services in the region (Table 1). The other most used substances were meth (22%), heroin (15%), cocaine (9%), and synthetic opiates and other opiates (8%). Of the individuals who identified alcohol as their primary substance, 49% also identified a secondary substance that most often included marijuana, cocaine/meth, and heroin/synthetic opiates. The age of first use of alcohol was most often before age 25 (97%), with the highest majority being before age 18 (75%).

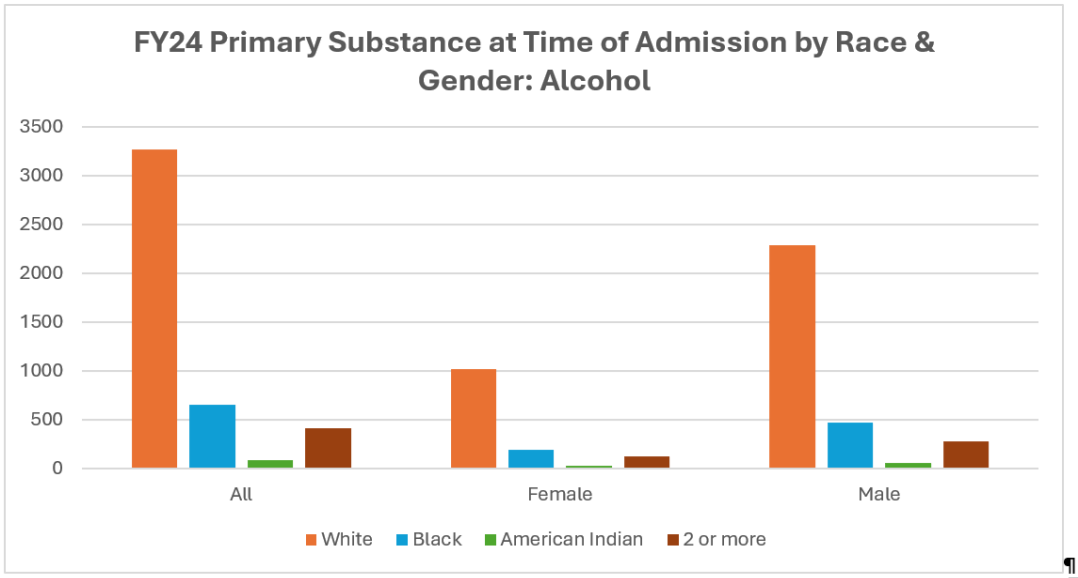
Table·1.¶



¶

Data also showed that when looking more closely at the data for alcohol as a primary substance at the time of admission by ethnicity and gender, individuals admitted to a MSHN paneled provider were most often white, with males having a higher occurrence than females (Table 2). Further examination of the admissions data by ethnicity shows further work is needed to increase penetration rates for Black, Indigenous, and People of Color (BIPOC) individuals across the region. Of the 4,038 individuals with alcohol as a primary substance 80% identified as White, 16% Black, 2% American Indian, and 10% two or more.

Table·2.·

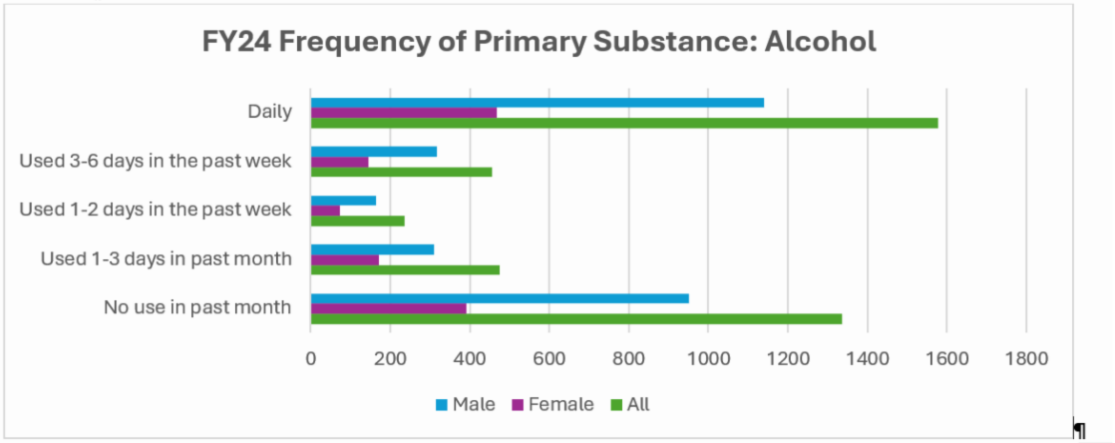


¶

When examining the frequency of use for people seeking services at the time of admission, daily use was noted the most, with no use in the past month noted second (Table 3). Please note, the no use in the past month category is impacted by individuals transitioning from one level of care to the next. Meaning an individual who was

supported in withdrawal management and residential services who is transitioning to outpatient supports may indicate at the time of admission to outpatient services that they did not have any use of the substance in the past month as they have been in SUD treatment services.

Table·3.¶



In FY25, the MSHN region has many opportunities to support NIAAA Strategic Initiatives that will benefit people with alcohol use disorder. One of the largest opportunities has been the expansion of the Michigan Department of Health and Human Services (MDHHS) Opioid Health Home to become a Substance Use Disorder (SUD) Health Home that will now be able to support, not just people with opioid use disorders, but also stimulant use disorders and alcohol use disorders. The MSHN region currently has four providers who support SUD Health Homes in Saginaw, Bay, Isabella, Jackson, and Lansing counties; and will be supporting expansion opportunities in the coming months.

To support increased penetration rates of BIPOC individuals being connected to treatment, MSHN is supporting both local – county level activities and broader regional initiatives. The SUD Clinical Team continues Diversity, Equity, and Inclusion (DEI) efforts with seven SUD prevention, treatment, and recovery providers to support targeted action plans in Saginaw, Ingham, and Jackson counties to increase connections to needed services for marginalized populations. On a regional level, the SUD Clinical Team continues to work with Red Head and Our Space to research and develop a media campaign to address stigma and opportunities to support BIPOC individuals to treatment.

Continued efforts to address youth interactions with alcohol were also a priority in FY24. MSHN prevention and community recovery providers supported 515 alcohol prevention activities across the region with youth under the age of 18 years as the focus.

Source: National Institute on Alcohol Abuse and Alcoholism Publishes New Strategic Plan

For source information or questions, please contact Trisha at Trisha.Thrush@midstatehealthnetwork.org

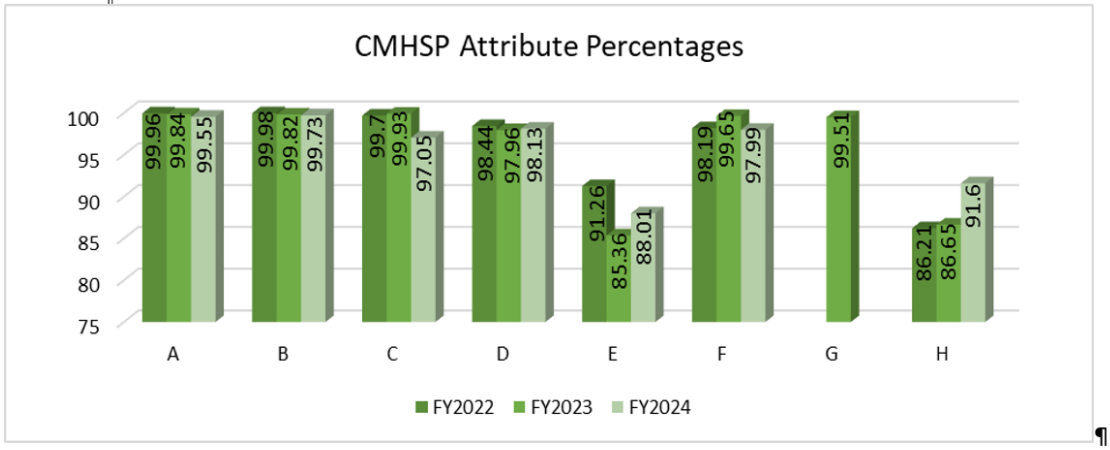
Quality, Compliance & Customer Service

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

MSHN conducts oversight of the Medicaid claims/encounters submitted within the region by completing either an onsite review or a desk review of the provider networks policy and procedures and the claims/encounters submitted for services provided for all twelve (12) of the Community Mental Health Service Providers (CMHSPs) and for all Substance Use Disorder (SUD) treatment providers who provide services using Medicaid funding.

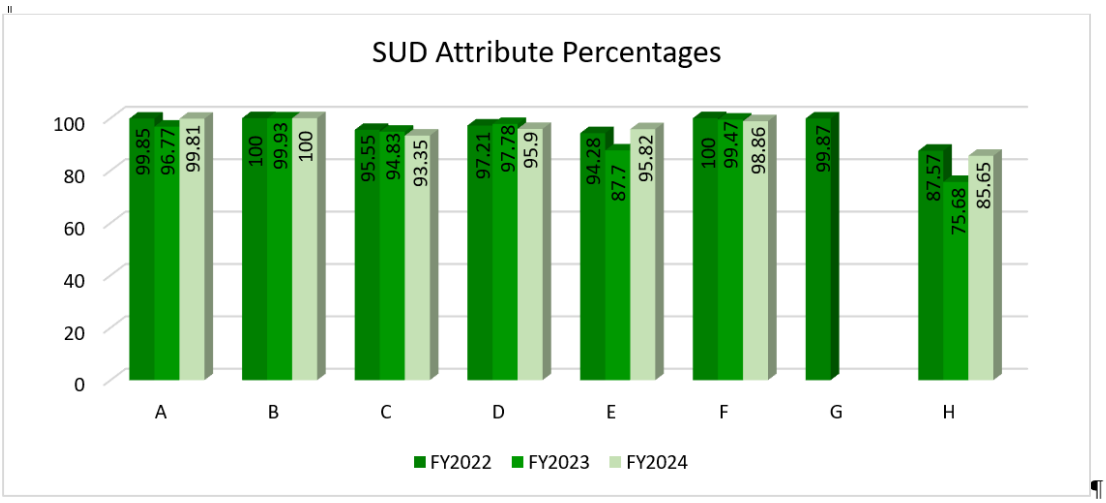
The attributes tested during the Medicaid Event Verification review include A.) The code is allowable service code under the contract, B.) Beneficiary is eligible on the date of service, C.) Service is included in the beneficiary's individual plan of service, D.) Documentation of the service date and time matches the claim date and time of the service, E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed, F.) Amount billed/paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the Healthcare Common Procedure Coding System (HCPCS) guidelines.

The CMHSP reviews are completed bi-annually (twice a year) for all twelve (12) CMHSPs. The following chart provides a comparison from FY2022 through FY2024 for the attributes tested.



Note:·In·FY22·there·were·7·(A-G)·attributes·tested·compared·to·8·(A-H)·in·FY23.·In·FY24,·MSHN·went·back·to·7·attributes·(A-G)·for·the·MEV·review.·For·the·purposes·of·this·graph,·FY22·and·FY24·data·for·attribute·G.)·Modifiers·are·used·in·accordance·with·the·HCPCS·guidelines·is·included·under·attribute·H.¶

The Substance Use Disorder Treatment Provider site reviews are completed annually. The following chart provides a comparison from FY2022 through FY2024 for the attributes tested.



Note:· The·above·chart·does·not·include·the·same·SUD·providers·from·year·to·year·but·is·representative·of·the·region.¶

Note:·In·FY22·there·were·7·(A-G)·attributes·tested·compared·to·8·(A-H)·in·FY23.·In·FY24,·MSHN·went·back·to·7·attributes·(A-G)·for·the·MEV·review.·For·the·purposes·of·this·graph,·FY22·and·FY24·data·for·attribute·G.)·Modifiers·are·used·in·accordance·with·the·HCPCS·guidelines·is·included·under·attribute·H.¶

The overall findings included a total dollar amount of invalid claims identified for CMHSP's direct and contractual services of $663,687.94 and $20,821.42 for substance use disorder treatment providers. Many of the invalid claims were corrected by submitting additional documentation and by resubmitting claims with correct modifiers, dates, times, etc. All invalid claims were corrected based on MSHN's established process.

Regionally the CMHSPs have shown slight improvements from FY2023 to FY2024 for the following attributes:

- Documentation of the service date and time matches the claim date and time of the service
- Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
- Modifiers are used in accordance with the HCPCS guidelines

Alternatively, the SUD providers have shown considerable improvements from FY2023 to FY2024.

- The code is an allowable service code under the contract
- Beneficiary is eligible on the date of service
- Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
- Modifiers are used in accordance with the HCPCS guidelines

These improvements may be attributed to an increased focus on improving the quality of documentation, improved staff training, ongoing monitoring and oversight, and increased education and technical assistance provided during the review process. In addition, the telehealth modifier was discontinued near the end of FY23 which had been a particularly common finding for CMHSPs and SUD treatment providers in the past. Furthermore, MSHN has safeguards in place to guard against duplicate and incomplete claims being submitted.

MSHN will continue to work with the provider network to improve the quality of the reviews and increase efficiencies where possible.

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.

Mid-State Health Network | 530 W. Ionia Street, Suite F |Lansing, MI| 48933
P: 517.253.7525 | F: 517.253.7552 | www.midstatehealthnetwork.org