MSHN

Mid-State Health Network

Assessment of Network Adequacy

2023

Reviewed by MSHN Leadership: March 2024

Reviewed by Provider Network Committee, Customer Service Committee, Clinical Leadership Committee, Regional Consumer Advisory Council, and Quality Improvement Council: March 2024

Approved by MSHN Operations Council: May 2024

Updated Plan Submitted to MDHHS: May 2024

Reviewed by MSHN Board of Directors: May 2024

Contents

Definitions

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

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

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

Provider Network: MSHN CMHSP Participants and SUD Providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. For CMHSP Participants, services and supports may be provided through direct operations or through the subcontracts.

Substance Use Disorder (SUD) Providers: Individuals and organizations directly under contract with MSHN to provide substance use disorder treatment and prevention programs and services.

Background

As a Pre-Paid Inpatient Health Plan (PIHP), Mid-State Health Network (MSHN) must assure the adequacy of its network to provide access to a defined array of services for specified populations over its targeted geographical area. This document outlines the assessment of such adequacy as performed by MSHN. This assessment of the adequacy of its provider network demonstrates MSHN has the required capacity to serve the expected enrollment in its 21-county service area in accordance with Michigan Department of Health and Human Services (MDHHS) standards for access to care.

MSHN is a free-standing entity, but it was formed on a collaborative basis by twelve Community Mental Health Service Programs (CMHSP Participants). MSHN entered agreements with the CMHSP Participants to deliver Medicaid funded specialty behavioral health services in their local areas, so the twelve CMHSP Participants also comprise MSHN's Provider Network. Each CMHSP Participant in turn directly operates or enters subcontracts for the delivery of services, or some combination thereof. There are twelve CMHSP Participants for the 21 counties, as follows:

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

The counties in the MSHN service area include:

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

Scope

Since CMHSP Participants have their own subcontracted and direct operated provider networks, primary responsibility for assessing local need and establishing the scope of non-SUD behavioral health services remains with the CMHSP's. MSHN works with the CMHSP Participants to ensure adequate networks are available and has primary responsibility for SUD service capacity funded under Medicaid, Healthy Michigan, Public Act 2, and related Block Grants.

The MSHN Assessment of Provider Network Adequacy is intended to support CMHSP and MSHN efforts by generating regional consumer demand and provider network profiles that may precipitate adjustments to local provider arrangements. MSHN and the CMHSPs act upon these opportunities as warranted.

Therefore, this assessment is a global document for provider network capacity determinations and is intended to generate dialogue between the PIHP and the CMHSP participant regarding the composition and scope of local networks and ensure that the region is meeting its obligations as a specialty Medicaid Health Plan. In some instances, the response to an identified gap in services could result in the implementation of new and creative service delivery models that may not be possible for a single CMHSP or SUD Provider, such as a collaborative initiative to provide a regional level crisis response program, similar to the MDHHS statewide model for positive living supports or a regional effort to build therapeutic and non-therapeutic recovery-oriented housing.

The focus of this assessment of provider network adequacy is both MSHN's mental health and substance use disorder provider networks. The scope of services is Medicaid funded specialty behavioral health services, including 1915(b) State Plan and Autism services, the 1915(i) State Plan Amendment (SPA) services, services for adults with developmental disabilities enrolled in the Habilitation Supports Waiver program, and specialty behavioral health (mental health and substance use disorder) services under the Healthy Michigan Plan. Effective 10.1.19, changes were made to the 1915 services, see Figure 1.

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

[1]

The 1915(c) which now includes waiver programs for children with developmental disabilities and serious emotional disturbance (SED) and 1915(i) services must be Home and Community Based Services (HCBS) compliant. Services included under the 1915(i) include: Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support and Training, Fiscal Intermediary, Housing Assistance, Respite Care, Skill-Building Assistance, Specialized Medical Equipment and Supplies, Supported Integrated Employment and Vehicle Modification. [2]

[1] www.michigan.gov/bhdda

[2] www.michigan.gov/bhdda

The scope also includes Block Grant and PA2 funded substance use disorder treatment and prevention programs. Excluded are those services which are exclusively the focus of the CMHSP system through direct contract with MDHHS, such as services financed with General Funds.

MSHN assumes the process of assessing the adequacy of its provider network is a relatively resource independent process. In other words, an objective assessment of beneficiaries' needs is performed that is not tempered by the availability or lack of resources to fulfill that need. Acting upon the results of the assessment to establish and fund a provider network is a separate and distinct process, and, of course, is directly tied to the availability of resources.

Consistent with MSHN's new strategic priority of "better equity," MSHN now includes within the scope of its Network Adequacy Assessment (NAA) attempts to determine if its provider networks are helping reduce health disparities or if they are reinforcing them. MSHN recognizes, for example, that national studies have identified disparities in Opioid Treatment Providers (OTPs) between white and Black patients in methadone dosing, drug tests and discharges. Therefore, the definition of network adequacy needs to extend beyond the number of providers, levels of care, and distance to any consumer living in Region 5 to include race, ethnicity and other variables tied to diversity, equity, and inclusion. Network adequacy is not race-blind as evidenced, for example, in significant Region 5 disparities between Black and White patients following up after a psychiatric hospitalization (FUH) or between Black and White patients following up after an Emergency Department visit related to a substance misuse issue (FUA). It is within the scope of this NAA to investigate if MSHN's network adequacy includes offering culturally competent providers for key demographics within the region.

COVID-19 Assessment

Fiscal Year 2020 presented unique and unprecedented challenges for Mid-State Health Network (MSHN), Community Mental Health Service Providers (CMHSP), Substance User Disorder (SUD) providers and persons served. The challenges stem from the COVID-19 global pandemic response. MSHN staff has operated in a nearly 100% remote environment since March 2020 to meet Michigan Department of Health and Human Services (MDHHS) epidemiology guidelines to ensure safety and mitigate the risk of COVID-19 transmission. Many CMHSPs in our region have operated in a similar remote manner for staff not providing in-person services. To assist with the challenges and risks associated with in-person service delivery during the pandemic the federal Centers for Medicare & Medicaid Services (CMS) and Michigan Department of Health and Human Services (MDHHS) adjusted many contract requirements, operational requirements, and service delivery standards (including telehealth rules which require a two-way audio/video platform and allowed audio only contacts).

Even with adjusted performance and service delivery expectations, the pandemic has impacted the number of services provided to consumers for various reasons. For example, the complexities of treatment while maintaining safety guidelines during the pandemic led to reduced numbers of withdrawal management and residential bed capacity to provide social distancing, adapted individual and group treatment via telehealth while an individual may be quarantining, staff shortages which translated to admissions holds and reduced service delivery, etc. Effective April 1, 2020, MDHHS developed Fiscal Provider Stabilization mandates to ensure provider networks were able to continue as ongoing concerns persisted. Although MDHHS mandated Provider Stability payments, the expectation was for PIHPs to cover the expenditures through existing Per-Eligible Per Month funding. MSHN disbursed FY 23 stabilization payments totaling $2.5 M for behavioral health and $878k for SUD providers. These payments assisted providers still experiencing utilization issues from the Public Health Emergency (PHE). In addition, to address statewide staffing issues, MSHN's region disbursed more than $14 M in

stabilization with $8 M of that total coming from prior year savings. Lastly, Direct Care Workers (DCW) premium payments were required for staff delivering specified in-person services.

Almost innumerable adjustments to operational requirements, service delivery policies, and thousands of other considerations in relation to the behavioral health systems' response to the COVID-19 pandemic have been coordinated within and between regions. For many services, at the onset of the pandemic in Michigan in early 2020, utilization temporarily dropped; for other services, utilization increased. For residentially based services, many providers reduced capacity in order to implement social distancing requirements, resulting in decreased utilization and increased demand. Risks of infection, actual infection, and potential for spread of the virus to their family members have impacted our regional workforce, especially those working in residential settings, making delivery of some required services strained as unprecedented retention, recruitment and replacement of affected workforce members has continued to worsen during the pandemic period.

In relation to COVID-19 impacts specific to Provider Network Adequacy Assessment, MSHN has monitored the count of individuals served (Figure 2-3) and the impact on provider sustainability (Figure 4).

Individuals Served

Figure 2: Individuals Served CMHSP

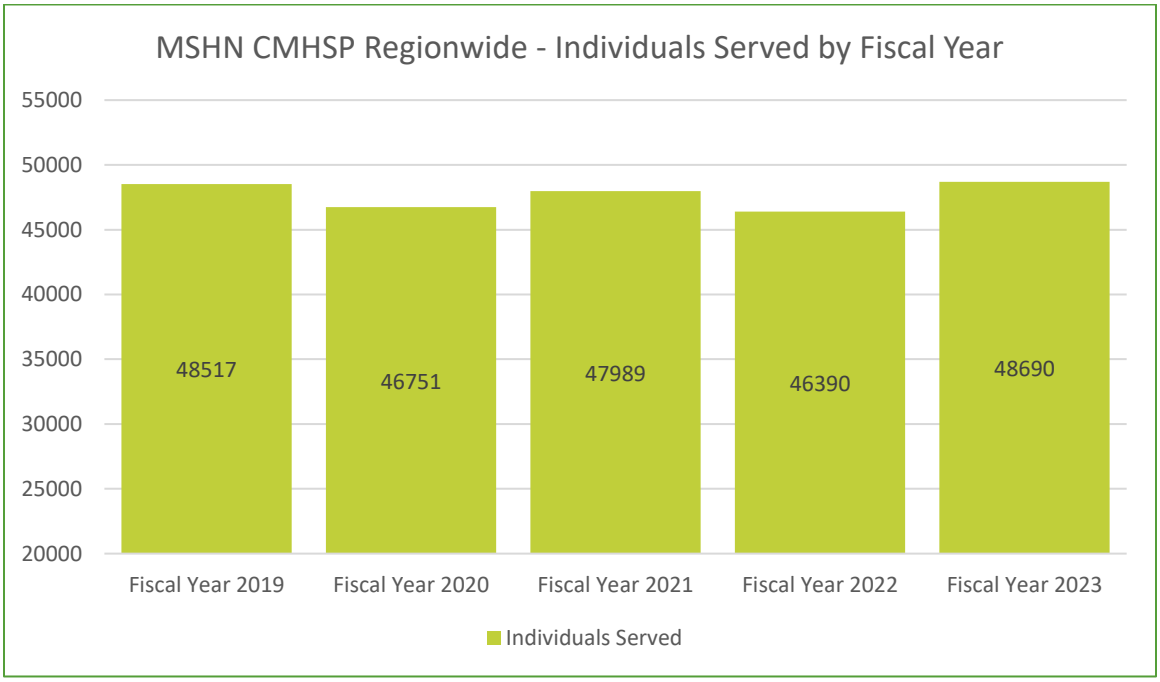


Figure 3: Individuals Served SUD

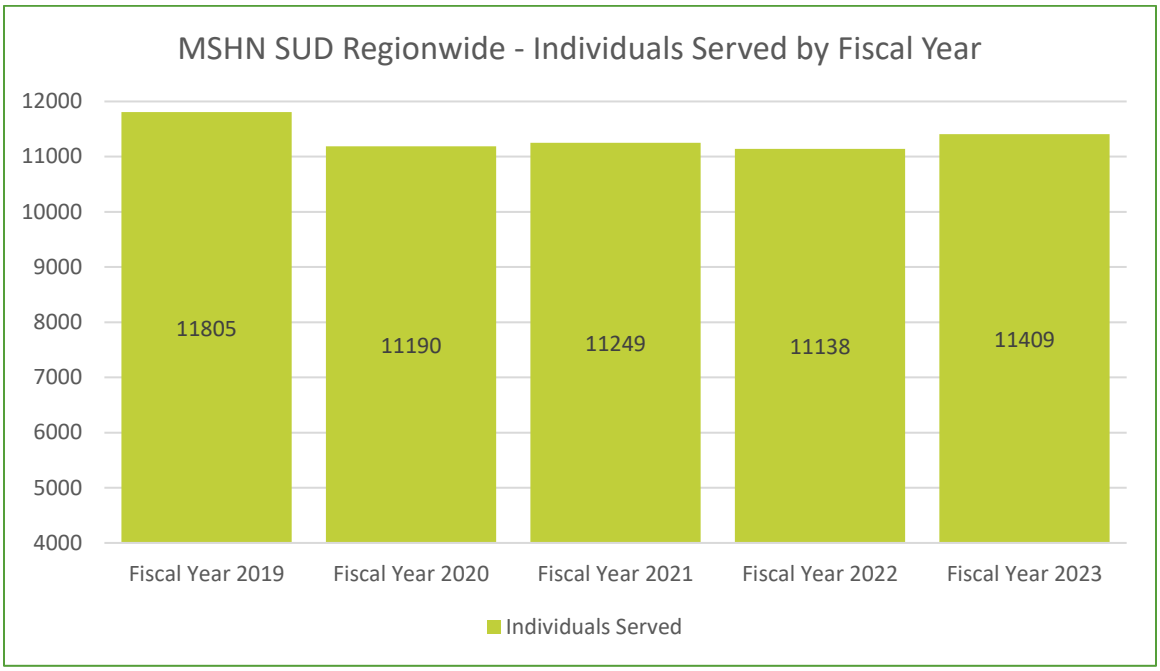


Figure 4: Provider Closures

MSHN PROVIDER STABILIZATION REPORTING THROUGH JANUARY 31, 2024				
SUD Provider Closures Effective After 10/1/2022				
Name of Provider	Date of Closure	Services Provided	Individuals Served	Impact on Network
Addiction Solutions Counseling	10.1.22	SUD Outpatient	154	No impact. New provider added; existing providers supported needs
Great Lakes Bay Health Center	10.1.22	SUD Prevention	564	No Impact
Mindful Therapy (2 locations)	10.1.22	SUD Outpatient		
Ithaca			75	No impact. Exisitng provider expanded to Gratiot County to support.
St. Johns			13	No impact. Existing provider in Clinton County increased capacity.
Salvation Army Turning Point	4.9.23	MAT Services only		Only MAT terminated - other services continued
Wedgwood (2 locations)	12.31.22	SUD Outpatient/MAT		
Ionia			68	No impact. The Right Door began CCBHC & contracted with an existing SUD provider to support SUD outpatient and MAT in Ionia County.
Remus			15	No impact. Existing provider able to meet need.
Catholic Charities of Jackson & Lenawee	12/26/2023	SUD Outpatient	0	No impact. Provider has not had sufficient staffing for almost a year and been referring to other area providers to support needs.
Family & Childrens Services of Mid-Michigan	1/31/2024	SUD Outpatient	3	No impact. Provider utilization low; existing providers able to support.
Newaygo RESA	10.1.22	SUD Prevention	520	No Impact- new provider taking over the same services

Assessment Updates

MSHN updates its assessment of provider network adequacy on an annual basis as required by MDHHS. Through the assessment process the PIHP must prospectively determine:

- How many individuals are expected to be in the target population in its geographic area for the upcoming year
- Of those individuals, how many are likely to meet criteria for the service benefit
- Of those individuals, what are their service needs

- The type and number of service providers necessary to meet the need within the time and distance standards
- How the above can reasonably be anticipated to change over time

Once services have been delivered, the PIHP must retrospectively determine:

- Whether the service provider network was adequate to meet the assessed need
- If the network was not adequate, what changes to the provider network are required

Meeting the needs of enrollees: expected service provisions

MSHN must maintain a network of providers that is sufficient to meet the needs of the anticipated number of Medicaid beneficiaries in the service area[3]. A determination of whether the network of providers is sufficient would typically be made through analysis of the characteristics and health care needs of the populations represented in the region[4]. However, the unique nature of the Medicaid Managed Specialty Supports and Services Program in Michigan complicates the assessment of network sufficiency beyond the scope of a simple analysis of clinical morbidity or prevalence among Medicaid beneficiaries.

MSHN is required to serve Medicaid beneficiaries in the region who require the Medicaid services included under the 1115 Demonstration Waiver, 1915(i); who are *eligible* for the 1115 Healthy Michigan Plan, the Flint 1115 Waiver or Community Block Grant; who are *enrolled* in the 1915(c) Habilitation Supports Waiver; 1915(c) Children Waivers (SEDW and CWP) who are *enrolled* in program; or for whom MSHN has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. MSHN must also ensure access to public substance use disorder services funded through Medicaid, Public Act 2, and substance use disorder related Block Grants. Furthermore, MSHN is required to limit Medicaid services to those that are *medically necessary* and appropriate, and that conform to accepted standards of care. Services must be provided (i.e., available) in sufficient amount, duration, and scope to reasonably achieve the purpose of the service.

Population Density Standards/Geographic Accessibility: BHDDA established network adequacy standards to address new requirements issued by CMS through the 2016 revisions to the managed care rules (Part 438 of Title 42). At a minimum, each state must set time and distance standards. Michigan has established population density standards for ACT, Clubhouses, Crisis Residential, Home-Based Services and Wraparound for children, and Opioid Treatment Programs and are incorporated in this assessment.

Appropriateness of the range of services

MSHN must offer an appropriate range of specialty behavioral health services that is adequate for the anticipated number of beneficiaries in the service area.[5] MSHN assesses the "appropriateness" of the range of services by comparing the service array available within the region to the array determined to be appropriate by MDHHS for the target population(s).

[3] 42CFR438.207(b)(2) "Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."
[4] 42CFR438.206(b)(ii) "The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the PIHP."
[5] 42CFR438.207(b)(1) "Offers an appropriate range of preventative, primary care and specialty services that is adequate for the anticipated number of enrollees in the service area."

The service array is articulated by MDHHS in the *Medicaid Managed Specialty Support and Services Program(s), the Health Michigan Program and Substance Use Disorder Community Grant*. MSHN is contractually obligated by MDHHS to provide the services described in the contract boilerplate and its attachment, for which additional specifications and provider qualifications are articulated for Medicaid funded services in the Michigan Medicaid Provider Manual, Mental Health-Substance Use Disorder section:

- Michigan 1115 Demonstration Project Healthy Michigan Plan (HMP) mental health and substance use disorder services authorized through the Affordable Care Act provisions for Medicaid expansion programs
- Michigan 1915(i) State Plan Amendment (iSPA), formerly (b)(3)
- Michigan 1915(c) Habilitation and Support Waiver (HSW) services; Children's Waiver Program; Children with Serious Emotional Disturbance (SED)
- Autism Benefit (EPSDT)
- SUD services funded by Public Act 2 and Block Grants

Independent CMHSP Network Analysis

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

* Prevention Direct Service models noted in the graph below: The Michigan Mental Health Code indicates that the public mental health system "may" offer prevention services and does not specify how many or what types of "prevention direct services" must be offered by the PIHPs. Some of these services are also identified in the Medicaid Provider Manual as "…a State Plan EPSDT service when delivered to children birth-21 years." Per MDHHS, they are evaluating the current Medicaid Provider Manual language and considering clarifications to policy requirements for prevention direct services.

Findings: After reviewing the CMHSP services grid below, MSHN finds that each CMHSP meets the expectations to provide services either directly, contracted or through a single case agreement as outlined in the Medicaid Provider Manual and as required by the Network Adequacy Standards.

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

- CEICMH: Respite homes and residential homes
- CMHCM: ABA providers and Children's Therapeutic Foster Care
- LifeWays: ABA and CLS providers
- Newaygo: Employee recruitment and retention

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

	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Applied Behavioral Analysis	X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	X	X	X	X	X	X	X	X	X	X	X	X
Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Assistive Technology	Provided on a per request basis.											
Behavior Treatment Review	X	X	X	X	X	X	X	X	X	X	X	X
Child Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Child Therapeutic Foster Care		Contract	Grant		Contract		Contract					
Clubhouse Psychosocial Rehabilitation	X	X	X				X	X		X		
Community Living Supports	X	X	X	X	X	X	X	X	X	X	X	X
Community Transition Services *Coordinating when MDHHS is providing	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Intervention	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Residential Services	X	X	X	X	X	X	X	X	X	X	X	X
Drop-In Centers (Peer Operated)		X	X	X	X	X	X		X	X	X	X
Enhanced Medical Equipment & Supplies	X	X	X	X	X	X	X	X	X	X	X	X
Enhanced Pharmacy	X	X	X	X	X	X	X	X	X	X	X	X
Environmental Modifications	Per request											
Family Support and Training	X	X	X	X	X	X	X	X	X	X	X	X
Family Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Fiscal Intermediary Services	X	X	X	X	X	X	X	X	X	X	X	X
Goods & Services	Per request											
Health Services	X	X	X	X	X	X	X	X	X	X	X	X
Home-Based Services	X	X	X	X	X	X	X	X	X	X	X	X
Home-Based Serv. – Infant Mental Health	X	X	X	X	X	X	X	X	X	X	X	X
Housing Assistance	Per request											
Individual and Group Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Inpatient Psychiatric Hospital Admission	X	X	X	X	X	X	X	X	X	X	X	X
Intensive Crisis Stabilization Services	X	X	X	X	X	X	X	X	X	X	X	X
ICF Facility for IDD												
Medication Administration	X	X	X	X	X	X	X	X	X	X	X	X
Medication Review	X	X	X	X	X	X	X	X	X	X	X	X
Non-Family Training		X		X	Per request			X		X	X	X
Nursing Facility Mental Health Monitoring	X	X	X	X	X	X	X	X	X	X	X	X
Occupational Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Out-of-Home Non-Voc Habilitation	X	X	X	X	X	X	X	X	Per request	X	X	X
Outpatient Partial Hospitalization Services	X	X	Contracted	X	X	X	X	X	X	X	X	X

	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Overnight Health and Safety Support	X	X	X	X	X	X	X	Contracted	X	X	X	X
Peer Specialist Services	X	X	X	X	X	X	X	X	X	X	X	X
Personal Care in Licensed Spec. Residential	X	X	Contracted	X	X	X	X	X	X	X	X	X
Personal Emergency Response	Per request	Per request	X	Per request	Per request	Per request	Per request	Per request	Per request	Per request	Per request	Per request
Physical Therapy	X	Per request	X	X	X	Single case	X	Single case	X	X	Per request	X
Prevention Direct Service Models	X	X	X		X	X	X	X	X	X	X	X
• Child Care Expulsion Prevention		X	X							X	Per request	
• School Success Program *Youth intervention Specialist	X		X									
• Children of Adults w/ MI/ Integ. Serv.												
• Infant Mental Health-Prevention	X	X	X	X	X	X	X	X	X	X	X	X
• Parent Education	X	X	X		X		X	X	X	X	X	X
Pre-Vocational Services	X	X	X	SCA	X	X	X	X	Per request	X	X	X
Private Duty Nursing	X	X	X	SCA	X	X	X	X	Per request	X	X	X
Respite Care	X	X	X	X	X	X	X	X	X	X	X	X
Skill Building Assistance	X	X	X	X	X	X	X	X	X	X	X	X
Speech, Hearing and Language Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Supports Coordination	X	X	X	X	X	X	X	X	X	X	X	X
Supported Employment	X	X	X	X	X	X	X	X	X	X	X	X
Targeted Case Management	X	X	X	X	X	X	X	X	X	X	X	X
Telemedicine	X	X	X	X	X	X	X	X	X	X	X	X
Therapeutic Overnight Camp		Contract	Contract			Contract	Contract	SCA		X		Per request
Transportation	X	X	X	X	X	X	X	X	X	X	X	X
Treatment Planning	X	X	X	X	X	X	X	X	X	X	X	X
Wraparound Services	X	X	X	X	X	X	X	X	X	X	X	Contract

Specialty Services within MSHN

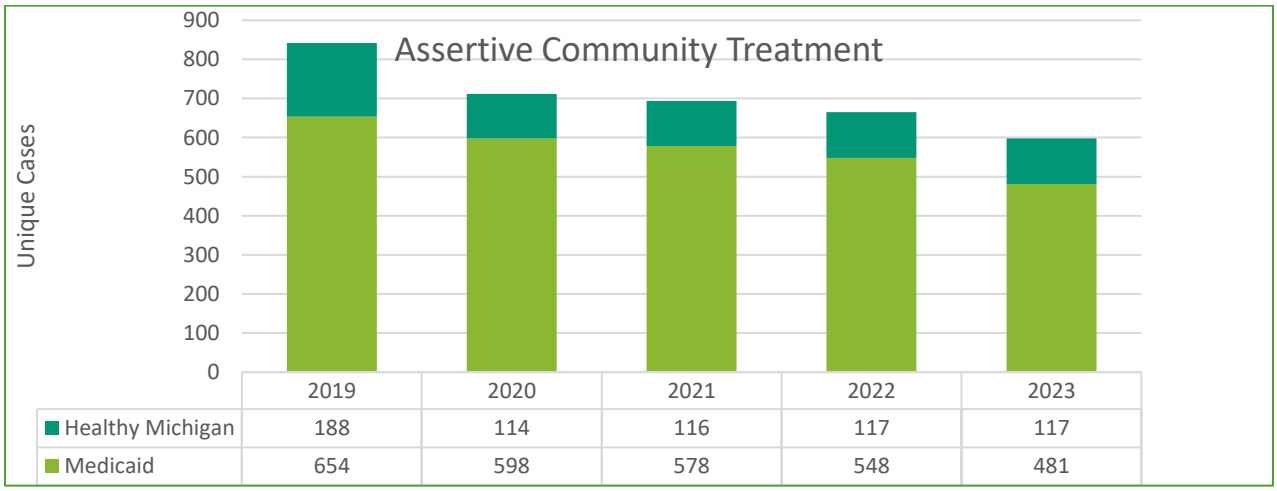
MSHN offers an appropriate array of specialty services provided by the CMHSPs. The following graphs illustrate the number of unique cases served from FY18-FY23for each specialty service. The information was collected from Medicaid Utilization and Net Cost reports (MUNC). **Programs below include an analysis where MDHHS has required a specific adequacy standard. For all others, the utilization trends will be combined as part of the analysis to determine adequacy.**

Assertive Community Treatment

Assertive Community Treatment (ACT) is a community-based approach to comprehensive assertive team treatment and support for adults with serious mental illness. It provides continuous team-based care 24 hours a day, 7 days a week. ACT is the most intensive non-residential service in the continuum of care within the service array of the public behavioral health system. **MDHHS has established an adequacy standard for ACT programs (30,000:1 Medicaid Enrollee to Provider Ratio). MSHN's FY23 Ratio: 567,553 Total Medicaid Enrollees to 15 providers. In order to meet the requirement, MSHN would need to have a total of 19 teams in-region. Using Average enrollees per month MSHN's FY23 Ratio 499,598/30,000 = 16.7. As of March 2024, MSHN's Total Enrollees = 422,973, therefore, future planning would require 14.1. MSHN's current provider capacity of 15 would be sufficient.** Four CMHSPs in the MSHN region do not directly provide ACT services; However, have written agreements in place with other CMHSPs or other subcontractors that provide ACT services to ensure the availability of this evidence-based practice in each of their catchment areas. ACT is but one service that might meet the level of intensity required to address the recipient's care needs. It is often true that individuals who meet the eligibility criteria for ACT often choose other (non-ACT) services or combinations of services more suitable to their individual circumstances. MSHN concluded that as alternatives to ACT, combinations of services and supports that often parallel the services in the ACT service bundle, are available and routinely provided to recipients in the region, including at CMHSPs that do not currently have enrolled ACT Programs and at those that do. MSHN is satisfied that the arrangements in place at the CMHSPs that do not have enrolled ACT programs are adequate to ensure that if/when ACT services are desired by the recipient, they can and will be provided.

MSHN has experienced in parts of its region where, due to staffing shortages, the need to submit ACT program exception requests to MDHHS in FY23. Bay-Arenac Behavioral Health (BABH) and Tuscola Behavioral Health Systems (TBHS) worked with MSHN to ensure that MDHHS received the exceptions requests. BABH was given an exception and will use a six-month period to April 2024 to determine if the corrective measures successfully addressed the issues affecting the ACT program. TBHS will continue to work on improving their ACT staffing levels so as to come back into compliance with ACT requirements. Until that time, TBHS will provide enhanced-intensity services to its beneficiaries meeting the ACT criteria.

Figure 5. Assertive Community Treatment

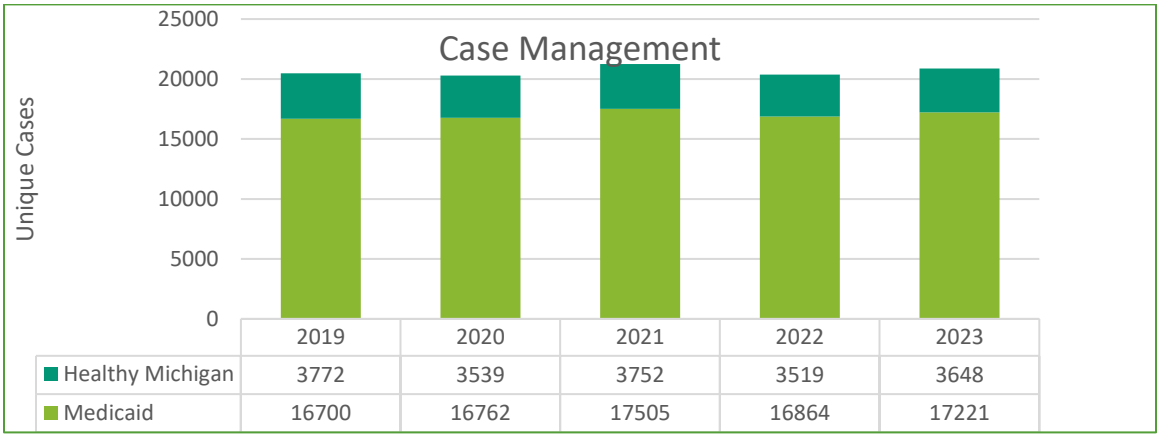


Case Management

For the purpose of the assessment, case management refers to supports coordination and targeted case management. These two services are combined in the following graph. Targeted case management helps

with obtaining services and supports. Its focus is goal oriented and individualized. Supports coordination works with waiver beneficiaries in home and community-based settings.

Figure 6. Case Management

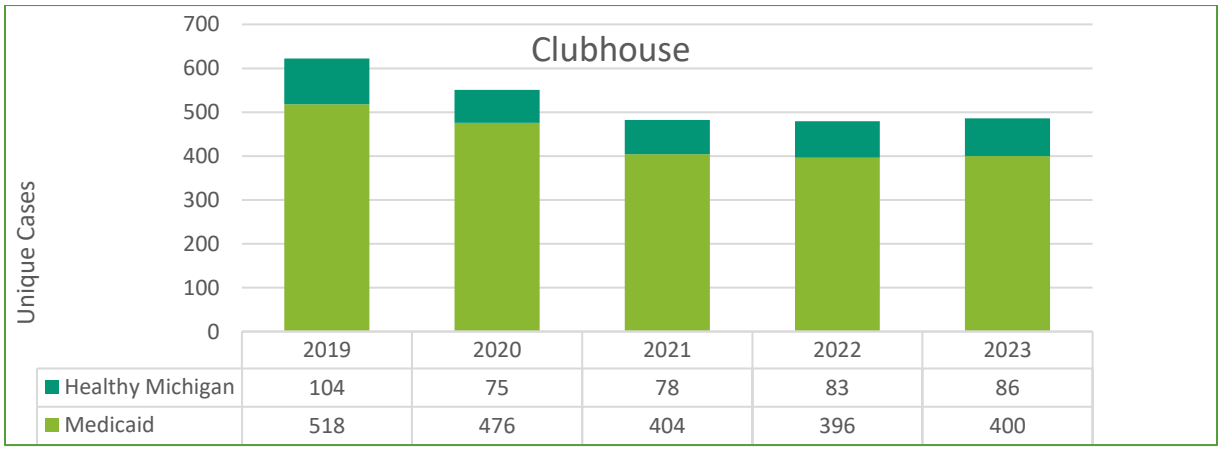


Clubhouse Psychosocial Rehabilitation Programs

A Clubhouse is a community-based program designed to support Individuals living with mental illness. Participants work alongside staff to gain skills in employment, education, housing, community inclusion, wellness, community resources, advocacy, and recovery. Clubhouse Psychosocial Rehabilitation Program accreditation by the International Center for Clubhouse Development (ICCD) is required by MDHHS. Additionally, **MDHHS has established an adequacy standard for Clubhouse programs (45,000:1 Medicaid Enrollee to Provider Ratio) which requires 12.6 clubhouse programs in the region, based on the number of adult enrollees. Currently, six CMHSPs have accredited clubhouse programs.**

While clubhouse is offered by six of the twelve CMHSPs, one of the six operates a second clubhouse program for a total of seven (Central operates two) in the region. Therefore, **MSHN's FY23 Ratio: 567,553 Total MH Medicaid Enrollees to 7 Providers. In order to meet the MDHHS requirements, MSHN would need to increase capacity by an additional 5 programs. Using Average enrollees per month MSHN's FY23 Ratio 499,598/45,000 = 11.1. As of March 2024, MSHN's Total Enrollees = 422,973, therefore, future planning would require 9.4.** Alternatively, ten of the twelve CMHSPs offer Drop-In Center activity with four CMHSPs offering both. For those CMHSPs without a clubhouse program (six) drop-in centers are offered.

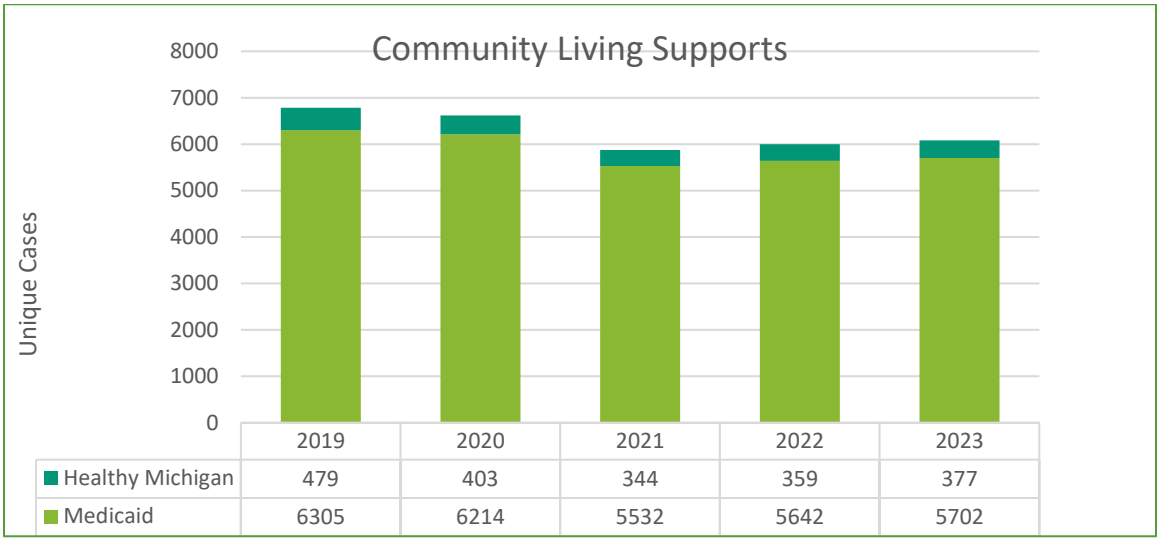
Figure 7. Clubhouse Psychosocial Rehabilitation Programs



Community Living Supports

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

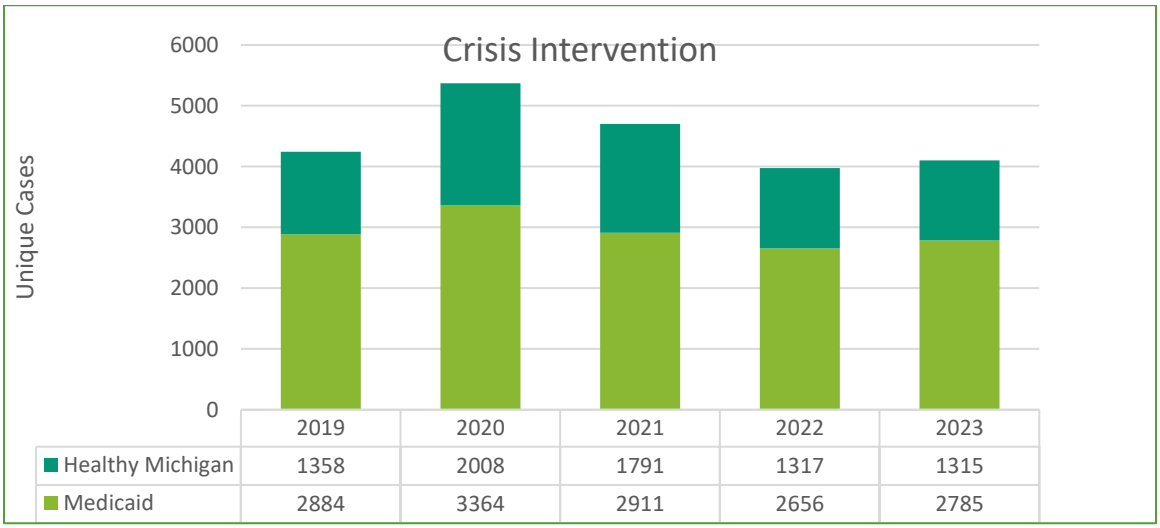
Figure 8. Community Living Supports



Crisis Services: Crisis Intervention

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

Figure 9: Crisis Intervention



Crisis Services: Crisis Residential Services

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay. MDHHS has established an adequacy standard (16 adult beds per 500,000 total population and 8-12 pediatric beds per 500,000 total population). MSHN total population = 1,658,326 (2024 census), so the standard for MSHN is 53 adult beds and 26 pediatric beds (min 8 bed).

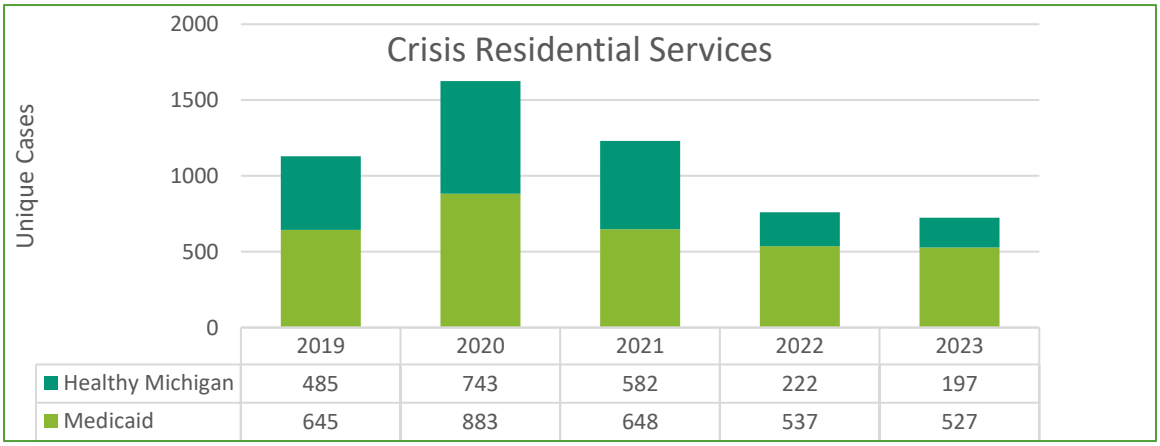
MSHN has an inventory of 14 contracted crisis residential providers, with a total of 145 beds. Of those in-region 18 beds are designated pediatric. As a result, MSHN considers its adult capacity to be compliant with the published standard but under the standard for pediatric beds.

MSHN is collaborating with other CMHPs and a crisis residential provider to establish an additional adult Crisis Residential Unit (CRU) within the MSHN region, scheduled to be open by March 2024. This will add six beds to the MSHN region.

Lastly, one of MSHN's CMHSPs (Bay-Arenac) is beginning development of a six-bed crisis residential setting, which is planned to be open at an as of yet undetermined date in FY24. This facility is in the process of changing its license and ensuring its special application to MDHHS is in order for approval to operate.

Pediatric Crisis Residential Beds: The most significant deficit in the MSHN region is the absence of any in-region crisis residential beds for children and adolescents. Based on information provided through the Crisis Residential Network, this appears to be a statewide issue as there are only approximately six child crisis residential facilities in Michigan out of 20 total crisis residential facilities. In FY23, MSHN contracted with three Pediatric Crisis Residential Settings, including Beacon Crisis Residential Treatment Program at Sandhurst, Hope Network Safehaus, and Samuel's house. Each setting provides services to children and adolescents aged 5-17 SED primary and/or cooccurring. Beacon at Sandhurst services are designed for children and youth with mental illness, or children with both a mental illness and another concomitant disorder. However, the primary reason for services must be mental illness.

Figure 10: Crisis Residential Services



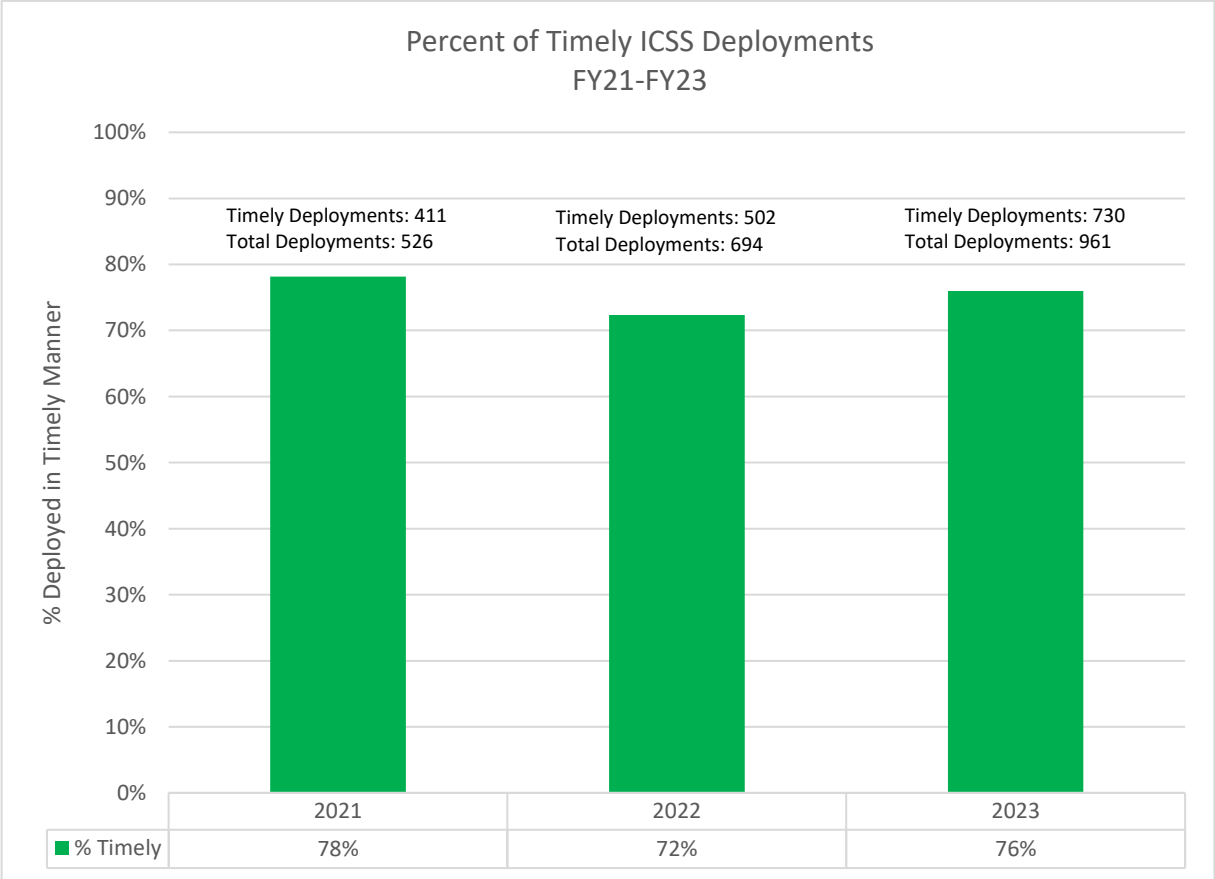
Crisis Services: Intensive Crisis Stabilization Services (ICSS)

Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term crisis alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated. Children's ICSS are provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement.

These services must be available to children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD). Encounter data is not available (H2011 TJ, HB, HC and previously S9484). This warrants investigation to ensure accurate reporting.

However, the region's CMHSPs submit annual ICSS data to MSHN on the performance of the program. Since formal data collection began in 2021, total calls received, and total calls deployed increased each fiscal year. For deployed calls, the standards are one hour for urban areas and two hours for rural areas. **The MSHN region's mean percentage of meeting the deployment timeframes was 76% for FY23.** The analysis of the data shows that there were two CMHSPs that affected performance. The region's CMHSPs are now sharing quarterly data about timeliness of ICSS deployments to requests in urban and rural settings to ensure timely deployment occurs.

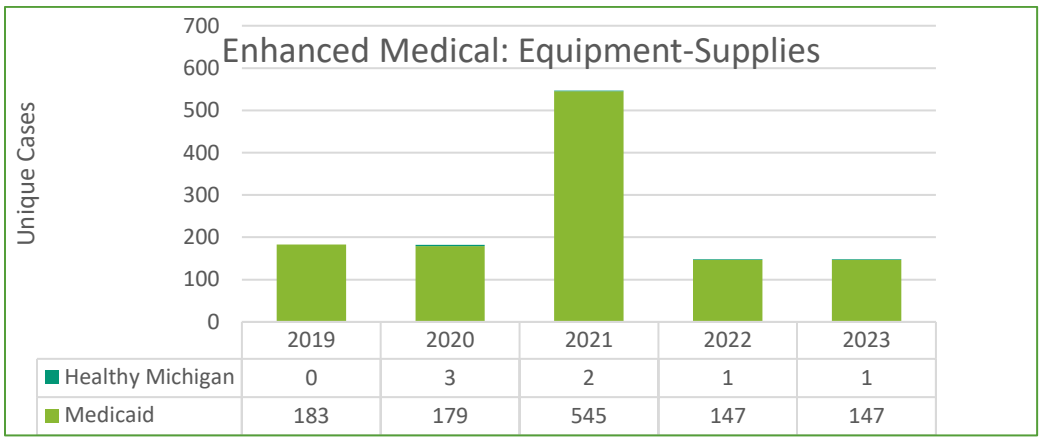
Figure 11: Intensive Crisis Stabilization Services



Enhanced Medical Equipment Supplies

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

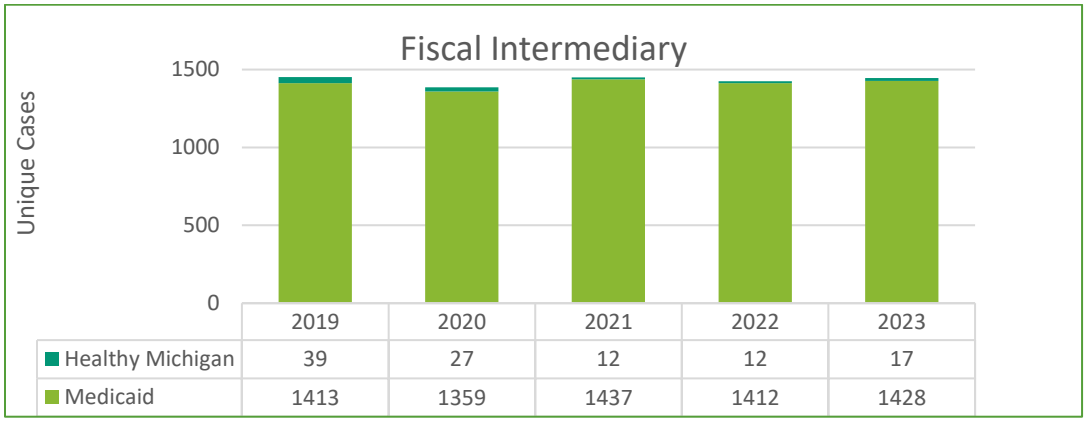
Figure 12: Enhanced Medical Equipment-Supplies



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

A financial management service/fiscal intermediary is an organization or individual independent of the CMH system that assists employers to manage the self-directed budgets. The FI acts as the fiscal agent of the CMHSP for the purpose of assuring fiduciary accountability for the funds authorized to purchase specific services identified in the consumer's individual plan of service (IPOS) under a self-directed arrangement. The self-directed services technical requirement (January 2022) and implementation guideline published January 2022 states that *each CMHSP is required to contract with an FMS provider. Additionally, the PIHP must ensure there are two FMS providers within the region and ensure access to all impaneled FMS providers*[6]. MSHN meets this requirement with each CMHSP having one or more contracts with a FMS provider and the region has a total of 4 FMS providers.

Figure 13: Fiscal Intermediary

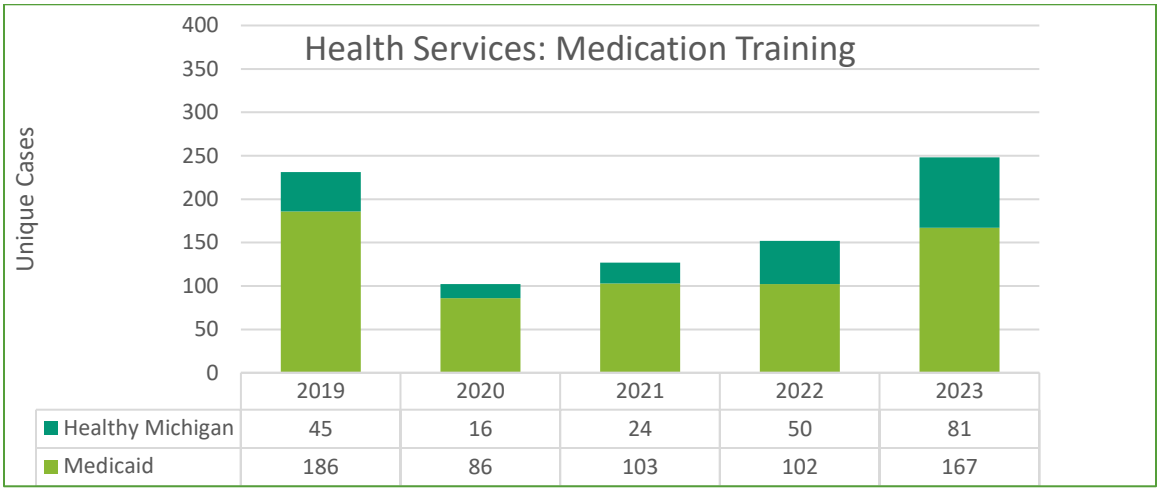


[6] Source: MDHHS Self-Directed Services Technical Requirements and MDHHS Self-Direction Technical Requirement Implementation Guide

Health Services: Medication Training

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

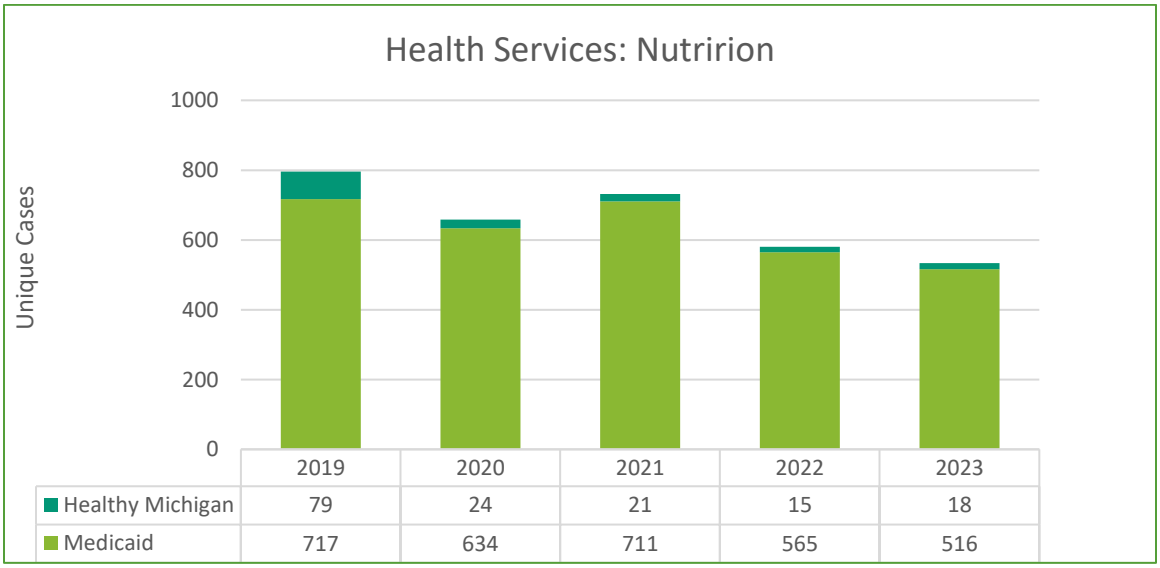
Figure 14: Health Services: Medication Training



Health Services: Nutrition

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

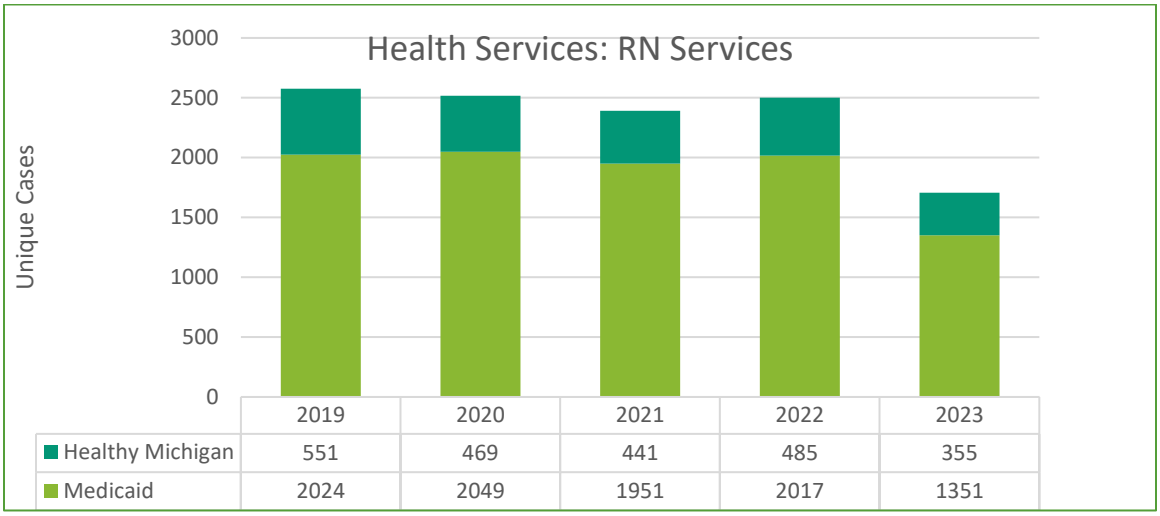
Figure 15: Health Services: Nutrition



Health Services: RN Services

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

Figure 16: Health Services: RN Services



Homebased Services

Homebased services provide assistance to children and their families with multiple service needs. The goals are to meet children's developmental needs, support families, reunite families and prevent out of home placement. **MDHHS has an established adequacy standard (2,000:1 Medicaid Enrollee to Provider Ratio). Home-Based services were verified through provider enrollment information to ensure compliance with educational standards of licensure and FTE designations. MSHN DOES NOT meet the published standard with 151.85 FTEs.** **MSHN's FY23 Ratio: 567,553 Total MH Medicaid Enrollees to 151.85, which is under the required ratio of 283.78 FTEs. Using Average enrollees per month MSHN's FY23 Ratio 499,598/2,000 = 249.80 FTEs. As of March 2024, MSHN's Total Enrollees = 422,973, therefore, future planning would require 211.49 FTE's.**

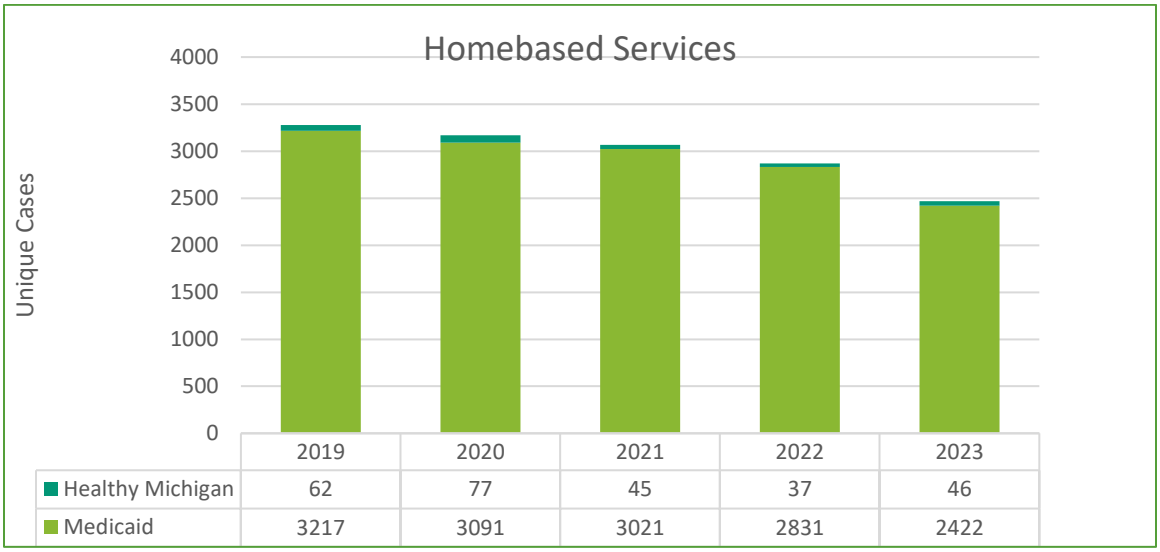
In April 2023, the CMHSPs underwent Home-Based program approvals through the MiCAL Customer Relations Management (CRM) system. Each CMH entered their information relative to the characteristics of their programs and MSHN reviewed these elements to ensure consistency with Home-Based program requirements. When complete, each online application was then shared with MDHHS for final review.

The MSHN partner CMHSPs have 13 Home-Based programs (LifeWays CMH operates 2 Home-Based programs), and of those 13, 4 were given provisional approval. Provisional approval is given when a program is not fully meeting all Home-Based program standards and they are given 6 months to implement corrective action to bring the program into compliance. MDHHS will then schedule a follow up meeting to explore progress.

The Right Door (Ionia), LifeWays (New Direction), Montcalm, and Newaygo CMH each received provisional approval, affecting four total programs. LifeWays CMH program run by New Direction is a brand-new Home-Based provider and was given provisional approval due to this, so monitoring will occur to ensure the program is adhering to program standards. The remaining CMHSPs, The Right Door, Montcalm, and Newaygo are under provisional status due to short-staffing situations, resulting in caseload ratios exceeding the acceptable standard of 12:1 (or 15:1 if there are families transitioning out

of Home-Based services). These CMHSPs are marginally over this limit at 13:1 or 14:1. They have also instituted corrective action to ameliorate the deficit through case review and determining whether families are ready for program discharge, posting position availability at multiple sites and with universities, as well as enhanced loan forgiveness, competitive pay, staff support (I.e. culture of support), and internship program development.

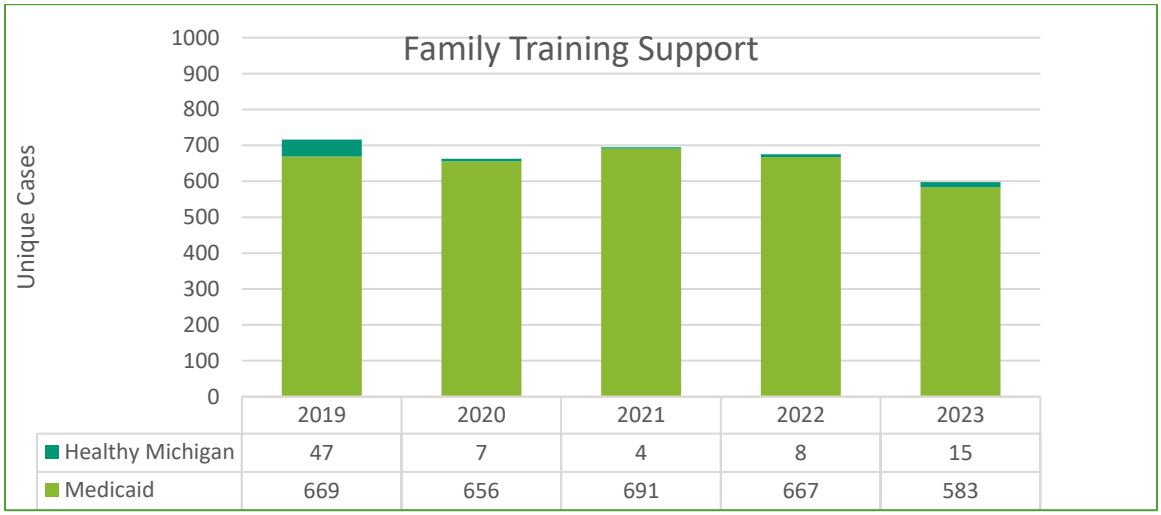
Figure 17: Homebased Services



Homebased Services: Family Training Support

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

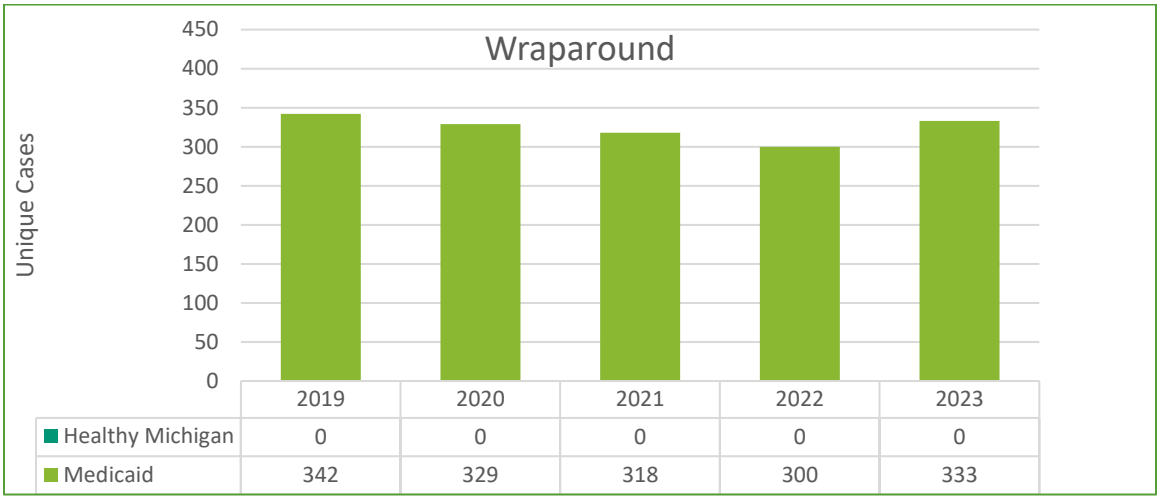
Figure 18: Family Training Support



Homebased Services: Wraparound

Wraparound services for children and adolescents are highly individualized planning processes facilitated by specialized supports coordinators. **MDHHS has an established adequacy standard (5,000:1 Enrollee to Provider Ratio).** Wraparound services are verified through provider enrollment information to ensure compliance with educational standards of licensure and FTE designations. MSHN's FY23 Ratio: 567,553 Total MH Medicaid Enrollees to 34.3 FTEs, which DOES NOT meet the required 113.51. Using Average enrollees per month MSHN's FY23 Ratio 499,598/5,000 = 99.92 FTEs. As of March 2024, MSHN's Total Enrollees = 422,973, therefore, future planning would require 84.59 FTE's.

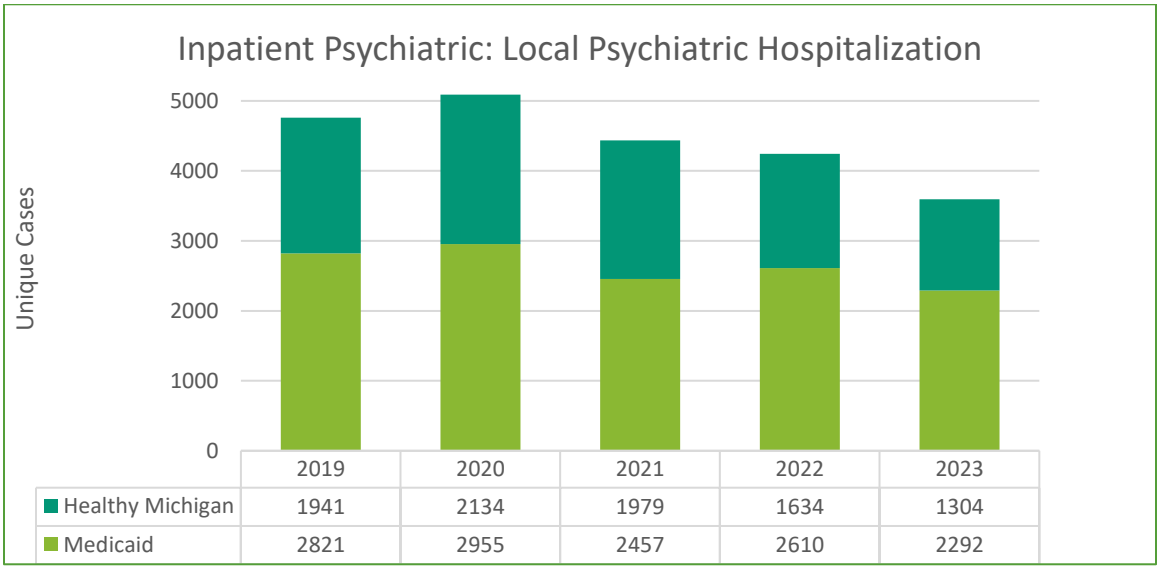
Figure 19: Wraparound



Inpatient Psychiatric - Local Psychiatric Hospital

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

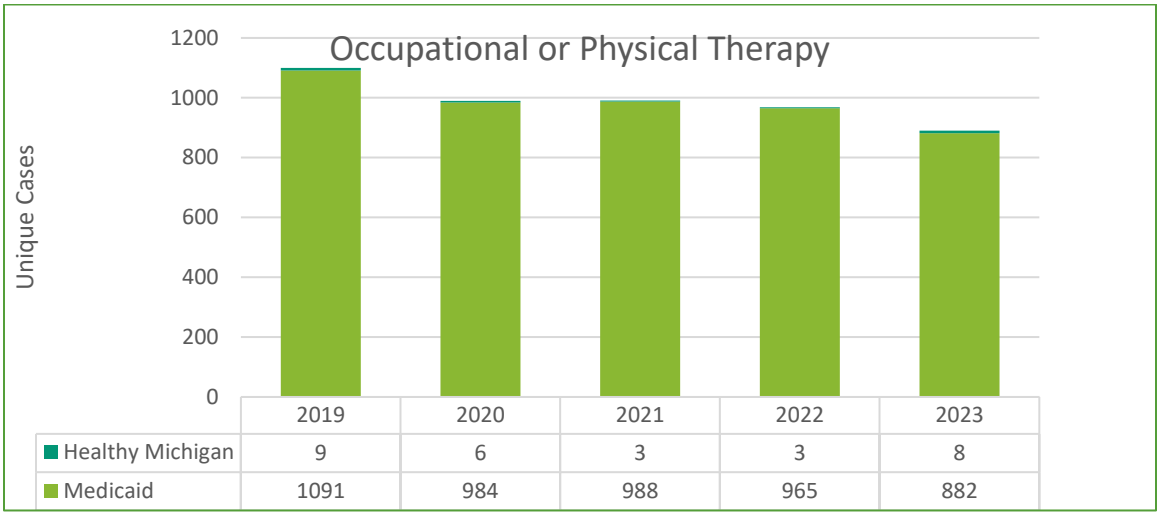
Figure 20: Inpatient Psychiatric: Local Psychiatric Hospitalization



Occupational or Physical Therapy

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

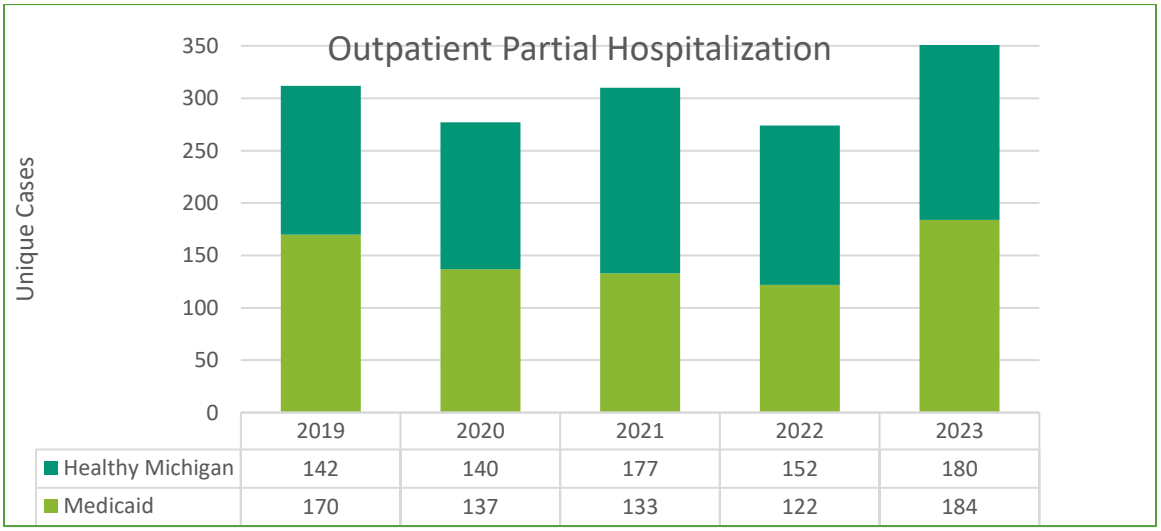
Figure 21: Occupational or Physical Therapy



Outpatient Partial Hospitalization

Partial hospitalization is used when an individual does not meet the need for inpatient hospitalization but requires more than traditional outpatient mental health services. Partial hospitalization services may be used to treat an individual with a mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Services are provided more than six hours per day, five days per week. Partial hospitalization utilization went markedly up in 2019 due to the service becoming available to a number of MSHN CMHSPs; however, the increase was primarily attributed to two CMHSP participants utilizing this service. In 2023, increased usage is noted and is tied to a broader use by more of MSHN's CMHSPs. This has been influenced by new partial programs becoming available, using partial as a means of diversion from inpatient hospitalization when appropriate, and a noted increase in marketing from the partial programs have all contributed to increased use of the service.

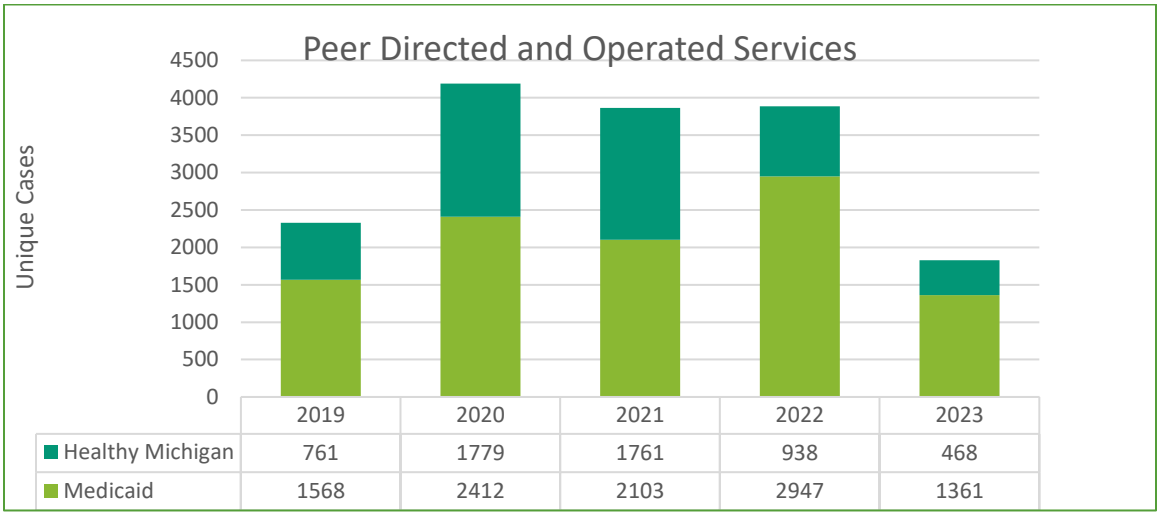
Figure 22: Outpatient Partial Hospitalization



Peer Directed and Operated Support Services

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

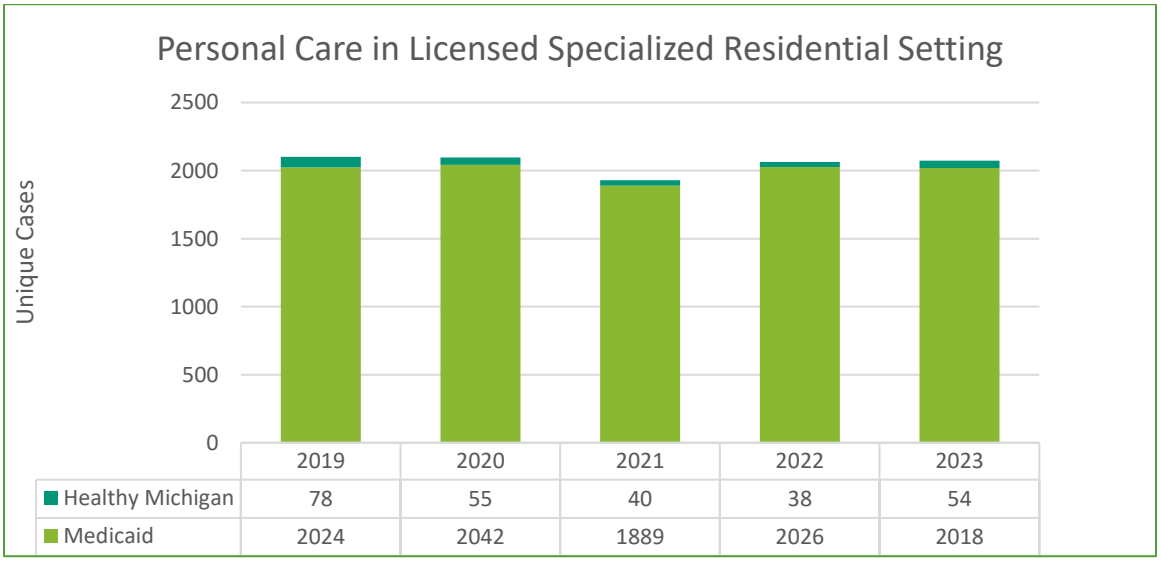
Figure 23: Peer Directed and Operated Support Services



Personal Care in Licensed Specialized Residential Setting

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

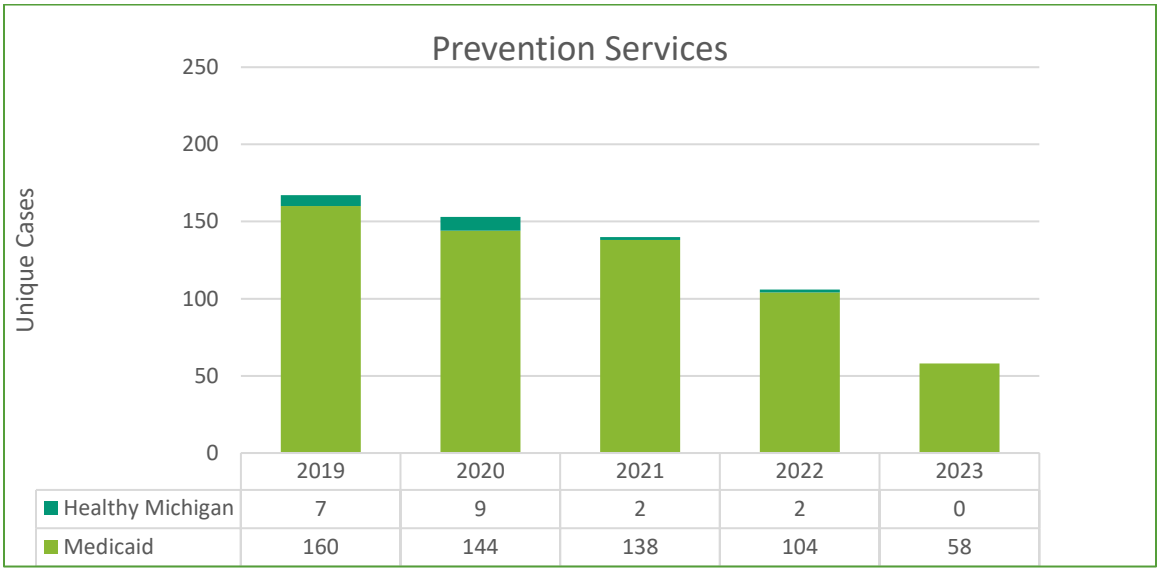
Figure 24: Personal Care in Licensed Specialized Residential Setting



Prevention Services

Services include school success, avoiding childcare expulsion, infant mental health, and parent education. There has been a continued decline in prevention services-direct model since the pandemic. The public mental health system can offer prevention services but there is no direction on how many or what types of services must be offered by the PIHPs. Additionally, some of these services are also identified in the Medicaid Provider Manual as "…a State Plan EPSDT service when delivered to children birth-21 years." In FY23, there was a greater emphasis on connecting youth and families to EPSDT services. The CMHSPs have focused on their specialty services especially due to staffing issues.

Figure 25: Prevention Services

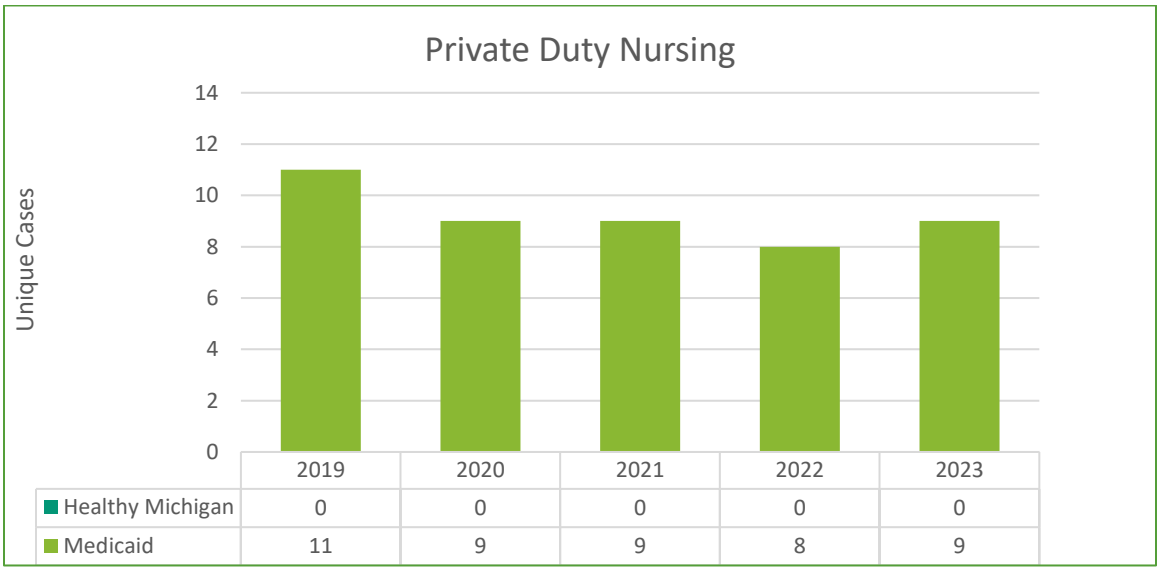


	2019	2020	2021	2022	2023
Healthy Michigan	7	9	2	2	0
Medicaid	160	144	138	104	58

Private Duty Nursing

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

Figure 26: Private Duty Nursing

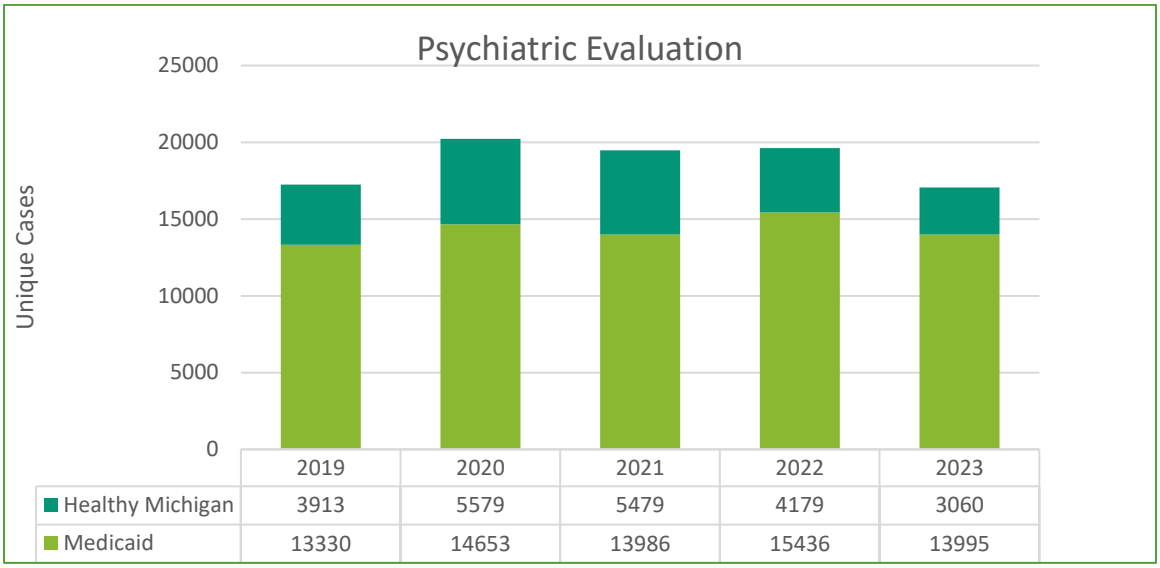


	2019	2020	2021	2022	2023
Healthy Michigan	0	0	0	0	0
Medicaid	11	9	9	8	9

Psychiatric Evaluation and Medication

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

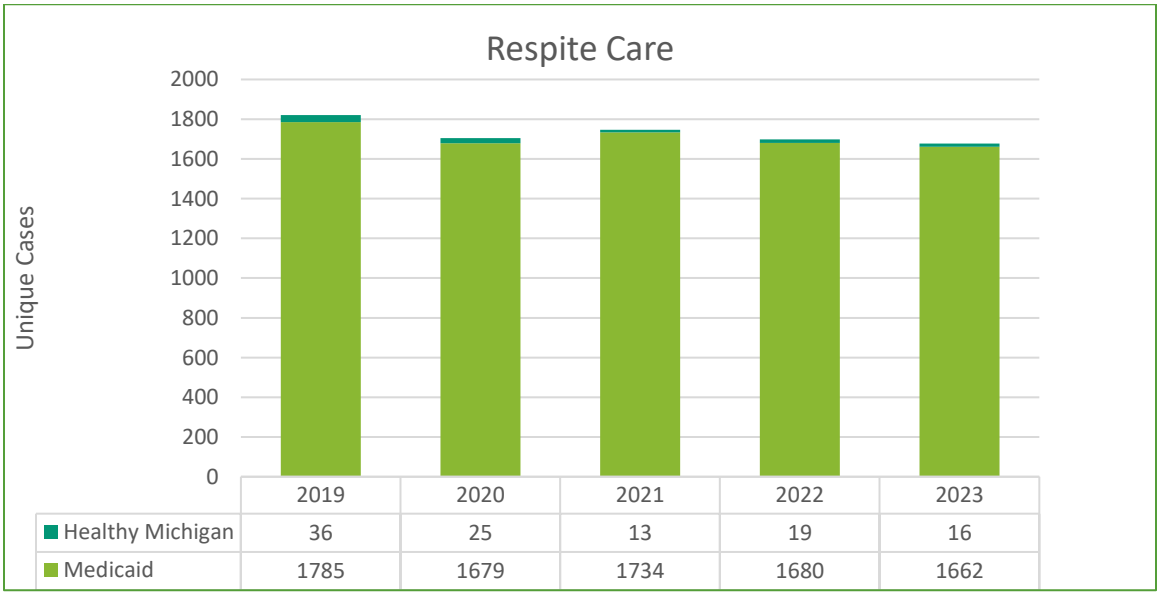
Figure 27: Psychiatric Evaluation



Respite

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

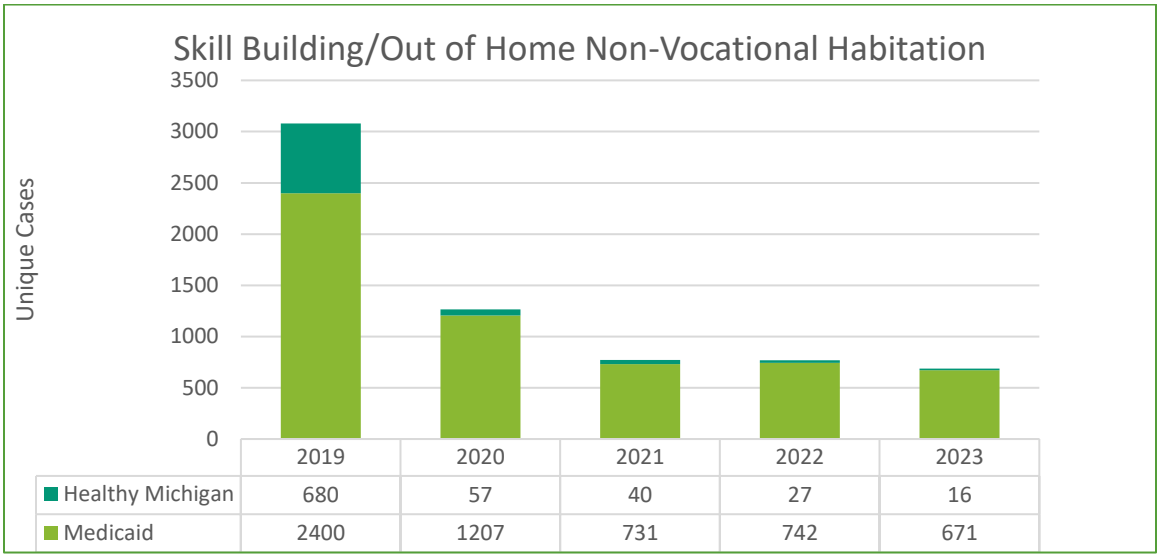
Figure 28: Respite



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

Skill-building assists a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. Since 2019, there has been a dramatic drop in use of skill building/out of home non-vocational habilitation services. This has been due to many different reasons, including HCBS Rule transition, pandemic effects (telehealth and staffing shortages), Medicaid changes relative to skill building being a time-limited service, shifts out of skill building due to medical necessity reviews and advancing to supported/integrated employment, and individual case reviews on whether services were in the community and the type of programming received.

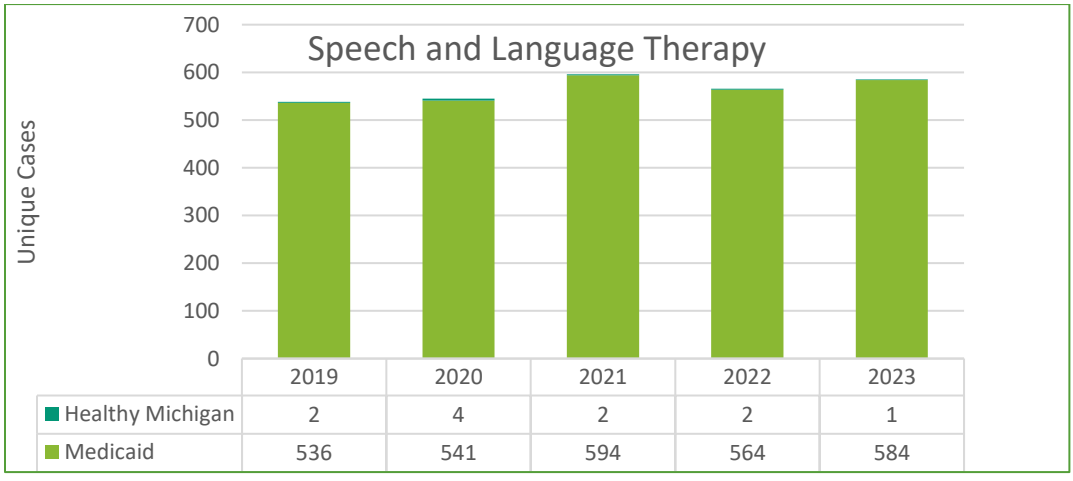
Figure 29: Skill Building/Out of Home Non-Vocational Habilitation



Speech and Language Therapy

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

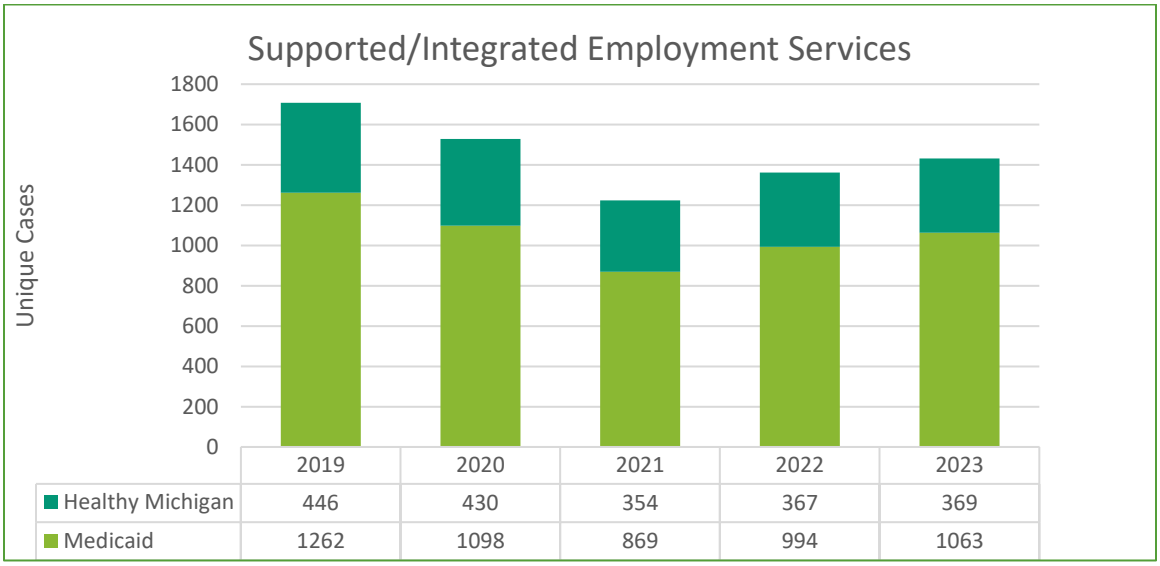
Figure 30: Speech and Language Therapy



Supported Employment Services

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

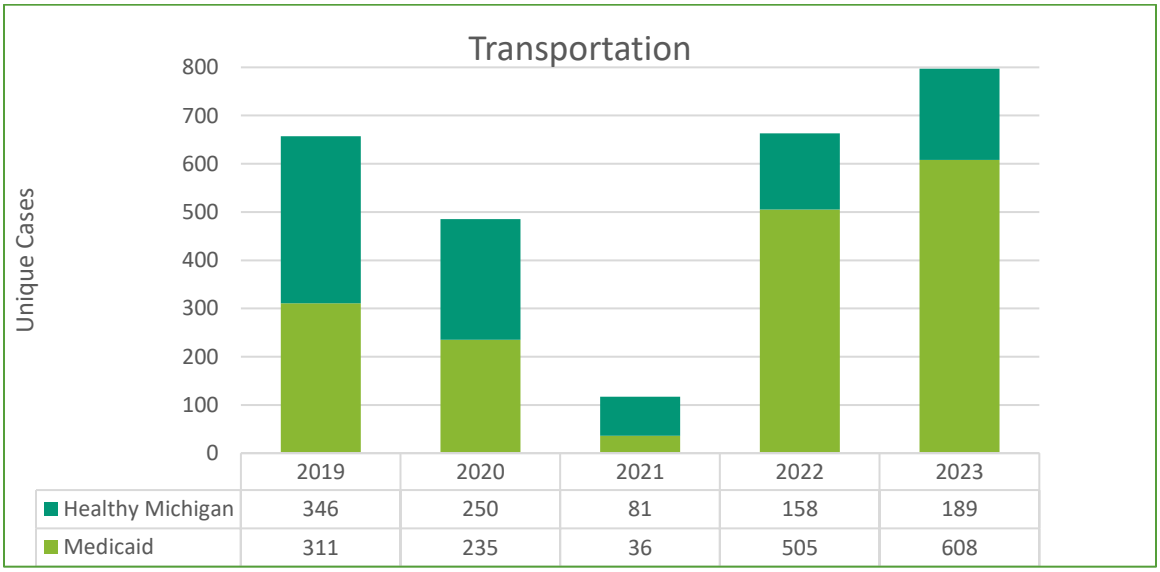
Figure 31: Supported/Integrated Employment Services



Transportation

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

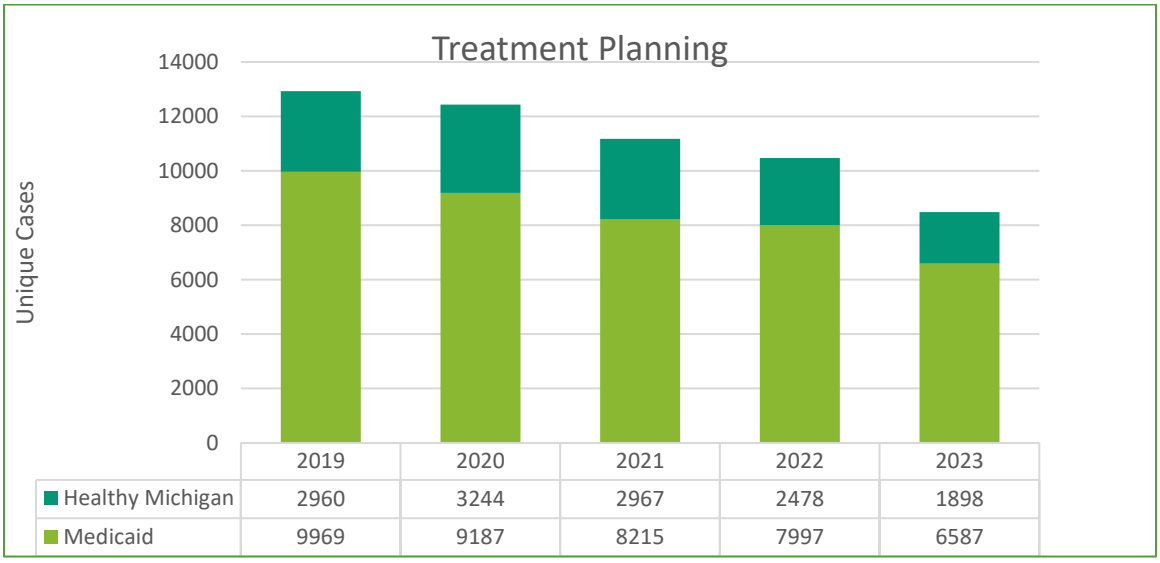
Figure 32: Transportation



Treatment Planning

Activities associated with developing an individual's plan of service. Also included is writing goals and objectives, measurement and monitoring goals and attending person centered planning meetings. There has been a progressive decrease in the use of the treatment planning code. The MDHHS EDIT group has clarified use of this code and how reporting has changed and staff often use other codes as required. This has been connected to the use of other codes, such as the T1017 (case management) or home-based, etc. It appears through this transition of code use, the treatment planning code has experienced a drop as services like case management and home-based have increased.

Figure 33: Treatment Planning



	2019	2020	2021	2022	2023
Healthy Michigan	2960	3244	2967	2478	1898
Medicaid	9969	9187	8215	7997	6587

Single Case Agreements

During FY23, the CMHSPs contracted out via single case agreements approximately 526 services, with the majority of SCA's (71%) for inpatient services. MSHN utilizes the analysis of SCA's to determine adequacy capacity within region. As noted above under crisis services, MSHN is expanding its capacity to address areas of need. There has been a large increase in use of SCAs for inpatient due to hospitals demanding them and refusing to accept the non-contract rate. These are established where there is no existing contract. Another significant contributor to an increase in SCAs includes local hospitals denying admissions requests and the CMHSPs responding by looking to other, further away facilities to ensure proper care availability is covered. There are several meetings scheduled with hospitals to establish contracts where there are currently none. This will likely decrease the use of SCAs for inpatient if the hospitals agree, which has not been shown to be the case for 2023.

Figure 34: Single Case Agreements

Single Case Agreements for FY23		
Inpatient	371	71%
Crisis Resid & Residential	83	16%
Part Hospitalizaton	41	8%
Other	31	6%
Total	526	100%

Evidence Based Practices – Mental Health

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

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

	Pop.	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Alternative for Families CBT	Families in Danger of Physical Violence										X		
Applied Behavioral Analysis	I/DD-Autism	X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Auricular Acupuncture (NADA Protocol)	Dual SUD/MIA				X						X		
Brief Behavior Activation Therapy	Adults w Depression	X		X									
Brief Strategic Family Therapy	Families	X		X	X								
Clubhouse	MIA										X		
Child Parent Psycho Therapy	Young Children	X	X	X				X	X		X		
Cognitive Behavioral Therapy	All	X	X	X	X	X	X	X	X	X	X	X	X
DASH (Dietary Approaches to Stop Hypertension) Diet	MIA		X						X		X		
Dialectical Behavioral Therapy	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Eye Movement Desensitization	PTSD	X	X		X		X	X	X	X	X	X	X
Family Psychoeducation	Families	X	X	X	X	X	X	X	X		X	X	X
Infant Mental Health	Parents	X	X	X	X	X	X	X	X	X	X	X	X
Integrated Dual-Diagnosed Treatment	Dual SUD/MIA	X	X	X		X		X	X	X	X		X
Mobile Urgent Treatment Team	Families	X	X	X	X	X	X		X		X	X	X
Motivational Interviewing	All	X	X	X	X	X	X	x	X	X	X	X	X
Multi-Systemic Therapy	Juvenile offenders			X				X					
Nurturing Parenting Program	Parents			X			X						
Parent-Child Interaction Therapy	Parents			X					X				

	Pop.	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Parent Mgt Training – Oregon Model	Parents	X	X	X	X	X	X			X	X	X	X
Parent Support Partners	Parent		X	X	X		X	X		X	X	X	X
Parenting Through Change	Parents	X	X	X	X		X				X	X	X
Parenting Through Change-R	Parents		X								X		
Parenting Wisely	Parents							X					
Parenting with Love and Limits	Parents	X											
Peer Mentors	I/DD		X									X	
Peer Support Specialists	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Picture Exchange Communication System	I/DD-Autism	X					X				X		
Positive Living Supports	I/DD	X	X		X	X							
Prolonged Exposure Therapy	Adults w PTSD	X		X	X	X			X			X	
Resource Parent Trauma Training	Parents										X	X	
Schema-Focused Therapy	Couples												
Seeking Safety Trauma Group	SUD & PTSD	X	X	X			X		X		X		X
Self-Management and Recovery Training	MIA, SUD	X											
SOGI Safe	All	X									X		
Supported Employment	Adults	X	X	X	X	X	X	X	X	X	X	X	X
Trauma Focused CBT	Children	X	X	X	X	X	X	X	X	X	X	X	X
Trauma Recovery Empowerment Model	Adults			X	X						X		
Whole Health Action Management	Adults		X	X	X				X	X	x		
Wellness Recovery Action Planning	Adults	X	X	X	X			X	X		X		
Wraparound	SED Families	X	X	X	X	X	X	X	X	X	X	X	X
Youth Peer Support			X				X	x		X	X	X	X

Autism Benefit (EPSDT)

The Michigan Medicaid Autism Benefit provides children at birth to 21 years of age who have a medical diagnosis of Autism Spectrum Disorder (ASD) with Applied Behavioral Analysis (ABA) services. Services are contracted or directly delivered by the CMHSP Participants as shown in Table 3.

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

	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Screening Referral	Performed by pediatrician or family physician as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Service											
Comprehensive Diagnostic Evaluation	X	X	X	X	X	X	X	X	X	X	X	X
Determination of Eligibility	X	X	X	X	X	X	X	X	X	X	X	X
Behavioral Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Behavioral Intervention	X	X	X	X	X	X	X	X	X	X	X	X
Behavioral Observation and Direction	X	X	X	X	X	X	X	X	X	X	X	X

MDHHS expanded eligibility for Autism services to age 21 effective January 2016. Since the MSHN region had encountered difficulties previously in meeting the existing demand for services by children aged 18 months through 5 years, there was concern across the region's CMHSP Participants regarding the adequacy of the network's capacity to absorb such a marked increase in demand for these specialized services with limited qualified professionals in local job markets. MSHN and its CMHSP Participants have been successful in increasing BHT/ABA provider capacity. Table 4 shows the growth in volumes for

Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) services as demand has notably risen for these relatively new Medicaid services.

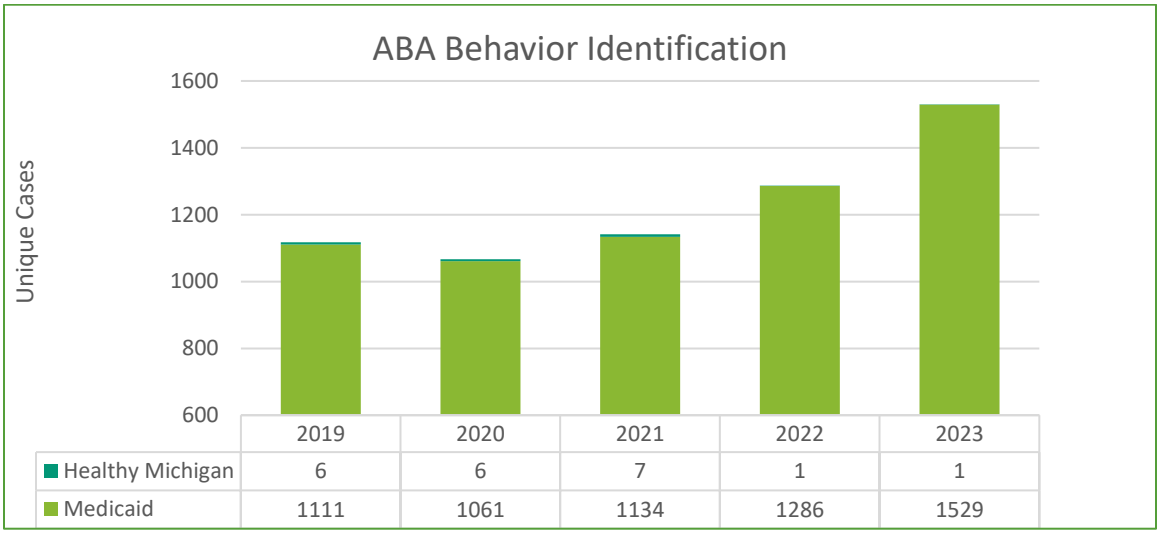
Table 4: Individuals Served by CMHSPs with Autism Spectrum Disorders and ABA Service Utilization

	FY20		FY21		FY22		FY23	
	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit
BABH	248	108	290	135	379	146	444	199
CEI	714	365	862	423	958	444	1,088	471
CMHCM	578	190	685	273	792	336	851	382
GIHN	122	64	131	67	146	64	151	71
HBH	47	8	57	14	88	20	100	14
LCMHA	535	242	604	274	615	252	669	288
MCN	194	79	239	89	308	111	369	151
NCMH	97	14	119	14	137	12	132	19
SCCMHA	566	203	667	239	850	269	862	311
SHW	122	31	158	57	201	66	222	84
TBHS	97	37	118	52	157	33	148	58
TRD	124	30	145	26	170	59	198	37
MSHN	**3,444**	**1371**	**4075**	**1663**	**4801**	**1812**	**5,234**	**2,085**

ABA Behavior Identification

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

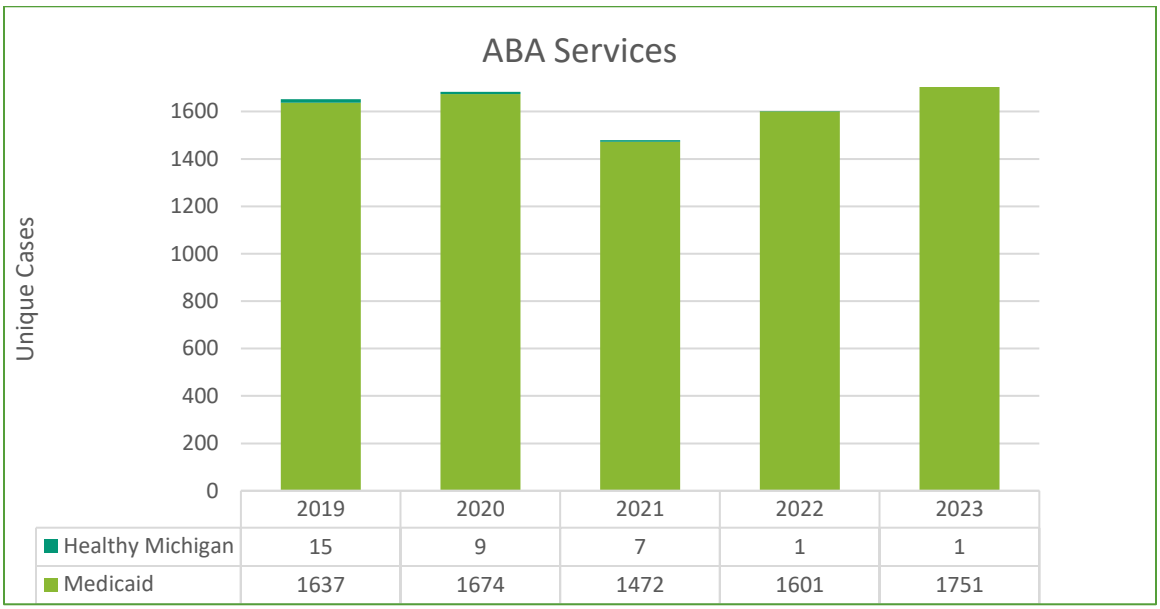
Figure 35: ABA Behavior Identification



ABA Other Services

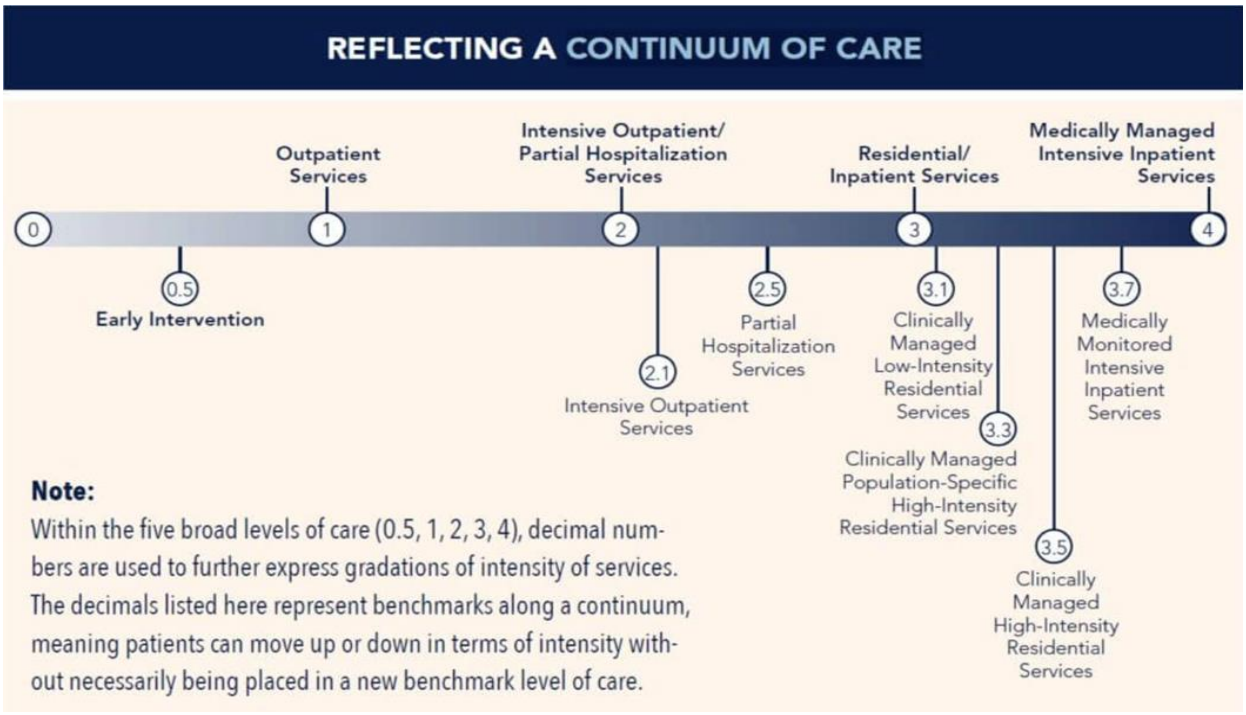
Services include non-medical assessments, psychological testing, and mental health assessments by non-physicians.

Figure 36: ABA Other Services



Substance Use Disorder Services

Table 5 on page 35 shows the array of services for treatment of substance use disorders and which services are delivered by SUD Providers under the auspices of their contracts with MSHN. MDHHS enrolls providers based upon the intensity of services offered. The intensities correspond to the frequency and duration of services established by the American Society of Addiction Medicine (ASAM) levels of care, as shown below.



Level 0.5: Early Intervention. Professional services for early intervention constitutes a service for specific individuals who, for a known reason, are at risk of developing substance-related problems or for those for whom there is not yet sufficient information to document a substance use disorder.

Level I: Outpatient Treatment. Level I encompasses organized, non-residential services, which may be delivered in a wide variety of settings.

Level II: Intensive Outpatient Treatment/Partial Hospitalization. Level II is an organized outpatient service that delivers treatment services during the day, before or after work or school, in the evening or on weekends.

Level III: Residential/Inpatient Treatment. Level III encompasses organized services staffed by designated addiction treatment and mental health personnel who provide a planned regimen of care in a 24hour live- in- setting.

Level IV: Medically Managed Intensive Inpatient Treatment. Level IV programs provide a planned regimen of 24-hour medically directed evaluation, care and treatment of mental and substance-related disorders in an acute care inpatient setting.

ASAM Level of Care Analysis

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

Unduplicated count of adolescents served by ASAM Level

Figure 1: This displays the unduplicated number of adolescents (00-17) that were served at each ASAM level. Note that an individual may be counted in each ASAM level within the same fiscal year. Also note that the ASAM levels displayed are the only ASAM levels that services were provided for in the displayed fiscal year, if another ASAM level service was provided it would be displayed; no ASAM levels were excluded from the report, therefore all levels are reported. The displayed ASAM levels do not mean that other ASAM levels are not available to adolescent population.

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

Figure 1: Data source – MSHN Encounters; REMI backup ASAM tables

Unduplicated Count of adolescents served

Figure 2: This displays the unduplicated number of adolescents (00-17) that were served within each fiscal year. This was calculated by looking at the distinct count of case numbers for individuals under the age of 18 at the time of service that received a service within the respective fiscal year.

Fiscal Year	Unduplicated Individuals
2021	50
2022	34
2023	59

Figure 2: Data source – MSHN Encounters

Findings: There were no Single Case Agreements (SCA) for an individual under the age of 18 for MSHN during the 2021 - 2023 fiscal years (Data source: Provider Network – Contracts). Though MSHN did not receive any SCA requests for adolescent services, we recognize that several of the counties in the region do not have a provider with services designated for the adolescent population. Per the MDHHS NAA response (November 2022), MSHN is in need of adding the adolescent ASAM levels of care for residential 3.1 and 3.7, as well as 3.2 withdrawal management, to be in compliance. At present, these adolescent ASAM levels of care do not exist within the State of Michigan with existing SUD treatment providers. This

is an area that has been discussed with MDHHS-SUGE and the SUD Directors workgroup. A primary challenge to supporting the adolescent services across the State has been the low level of utilization by this population, which does not translate to sustainability for providers who support the programs. MSHN is currently working on developing and implementing an RFP to support the addition and expansion of adolescent SUD services across the region. This includes the ASAM LOC's for residential (3.1 and 3.7), withdrawal management (3.2), and outpatient (0.5, 1.0, 2.1).

As an additional note, the area of SUD early intervention services (ASAM 0.5 LOC) is also supported via the regional SUD prevention provider network with a variety of evidence-based curriculums that are provided to schools and communities across the region. The number of adolescents supported with this type of intervention is harder to discern as the MPDS system is utilized to track this data. In FY23, the MSHN SUD prevention providers supported approximately 2,440 activities in the MSHN region directed toward youth and adolescents ages 0-17 years.

Table 1: Substance Use Disorder Services Available in the MSHN Provider Network - Adolescents

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

*OP Program offer MAT (Suboxone/Vivitrol)

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

Unduplicated count of adults served by ASAM Level

Figure 3: This displays the unduplicated number of adults (18+) that were served at each ASAM level. Note that an individual may be counted in each ASAM level within the same fiscal year. Also note that the ASAM levels displayed are the only ASAM levels that services were provided for in the displayed fiscal year, if another ASAM level service was provided it would be displayed; no ASAM levels were excluded from the report.

ASAM Level	Unduplicated Individuals		
	FY 2021	FY 2022	FY 2023
1.0 Outpatient	4375	3926	3908
1.0 Outpatient: Medication Assisted Treatment	3737	3505	3301
2.1 Intensive Outpatient	434	408	469
2.5 Partial Hospitalization	43	33	50
3.1 Clinically-Managed Low Intensity Residential	573	598	611
3.2 Clinically-Managed Withdrawal Management	51	50	64
3.3 Clinically-Managed Population Specific	7	3	2
3.5 Clinically-Managed High Intensity Residential	2535	2442	2617
3.7 Medically-Monitored Residential	29	24	17
3.7 Medically-Monitored Withdrawal Management	167	149	175

Figure 3: Data source – MSHN Encounters; REMI backup ASAM tables

Adult Single Case Agreements by Fiscal Year

For SUD provider network services, a total of 21 single case agreements (SCA's) were utilized in FY22 and 95 SCA's for FY23.

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

The breakdown by level of care consists of:

FY22

1.0: 21

Findings: Based on the number of SCA's in FY22 for 1.0 Outpatient Services, MSHN continued the efforts to expand outpatient capacity within the region as noted in the FY22 Follow up on Recommendations and Updates - 1a.

FY23

1.0: 89 (Bear River)

3.5: 6 (Ascension Eastwood)

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

Service Location:

The association of provider sites/services with levels of care will provide a framework for MSHN to understand the range of service options available across the region as it continues to expand its network and ensure access to all levels of care. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home. Substance use disorder covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings, and via telehealth.

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

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

County	Outpatient				Residential				Withdrawal Mgt.		OTP	Womens Specialty Services	Recovery Housing	CCBHC - DCO
Shiawassee	X	X*										E		
Tuscola	X	X*										D		
Out of Network	X	X*	X	X	x	X	X	X	X	X	X	D	X	
*OP Program offer MAT (Suboxone/Vivitrol) D = Designated WSS Program E = Enhanced WSS Program														

Medicaid-covered services and supports must be provided, based on medical necessity, to eligible beneficiaries who reside in the region and request services. The Substance Use Disorder services below are authorized through MSHN. Much of the MSHN region is covered relative to the availability of outpatient and medication assisted treatment services; however, the region continues to expand capacity as 60 min/60 miles can be a barrier for consumers in need of services.

The opioid addiction and overdose epidemic continue with MSHN's attention to regional capacity to provide withdrawal management services, Medication for Opioid Use Disorder (MOUD) (formerly Medication Assisted Treatment or MAT) including buprenorphine and naltrexone, and MAT's associated outpatient treatment and recovery supports.

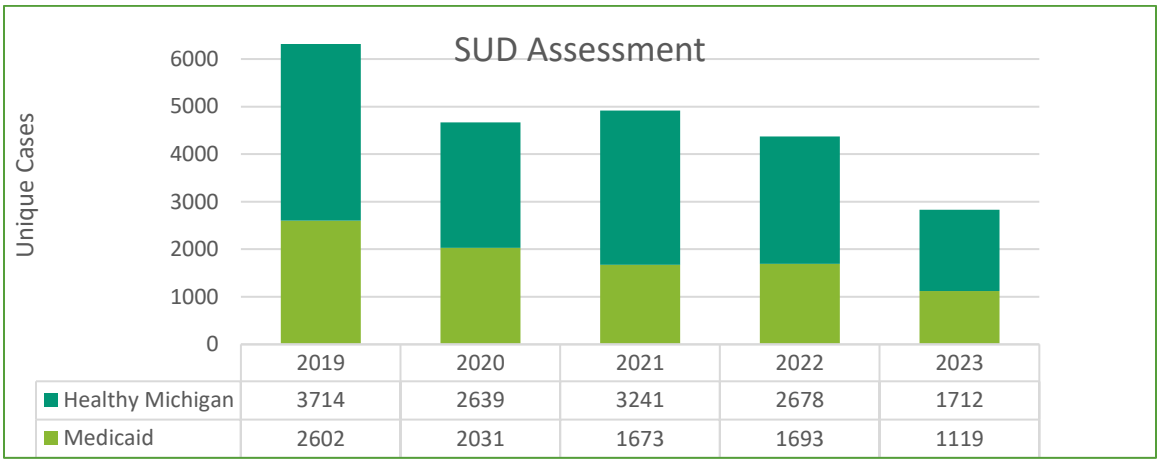
In some categories below, we saw a decline in penetration rates for SUD services across different levels of care. Part of this is likely related to the impact of the pandemic in several ways. First, the pandemic precipitated more closures of SUD treatment sites than at any time in MSHN's history. This was despite financial stabilization and other supports MSHN offered to keep prevention, treatment, and recovery providers afloat. In most cases, these supports sustained our network, but some providers withdrew from our provider network or closed entirely. Second, even those providers who stayed open have established procedures and reduced their capacity to accommodate social distancing which may not have fully returned to pre-pandemic levels. Third, an additional impact with existing providers has been the ongoing struggle to attract, hire, and retain staff at all levels of support. The struggles with staff turnover were a challenge prior to the pandemic and have become a significant concern during and after with providers communicating staff shortages and extended periods of time to find and hire qualified candidates. Lastly, the pandemic disproportionately impacted people of color so populations who already had longstanding mistrust of the medical system may have projected that to SUD treatment especially in the wake of disinformation campaigns about health care, vaccines and so on. Indeed, overdose death rates have risen most steeply in communities of color in recent years, and we've not seen a concomitant association with their engagement in SUD services.

SUD Assessment

Assessment includes an evaluation by a qualified practitioner that investigates clinical status including: presenting problem, history of presenting illness, previous medication history, relevant personal and family history, personal strengths and assets, and mental status examination purposes of determining eligibility for specialty services and supports, and the treatment needs of the beneficiary. The MSHN region saw a decline in assessments in FY23 for a variety of reasons. The first is related to provider staffing. Many providers experienced, and continue to experience, staffing shortages which have limited their existing staff's ability to support the full range of services at pre-pandemic levels. Also, during FY23, the PIHPs were guided by MDHHS that a person in services is only eligible for up to 4 assessments per year. With this guidance, the PIHPs, including MSHN, looked for ways to support individuals with increased provider collaboration with sharing completed assessments from provider to provider, or

utilizing an assessment update instead of a subsequent full biopsychosocial assessment for a person who was engaged with the same provider, or another provider recently when clinically appropriate. This initiative would save the person from having multiple assessments in a short period of time when navigating the SUD provider system on their pathway to recovery. So, while it looks like the number of assessments decreased significantly in the past year, a portion of this decrease was purposeful in how the provider system is approaching collaboration amongst the provider network for assessment sharing with person in services consent. It is also representative of providers updating assessments for people who have left services and returned in short periods of time and updating an assessment versus having a new full assessment. In these instances, the provider has been guided to support the update assessment process with a therapy code (ie. 908XX) versus the H0001 by MDHHS.

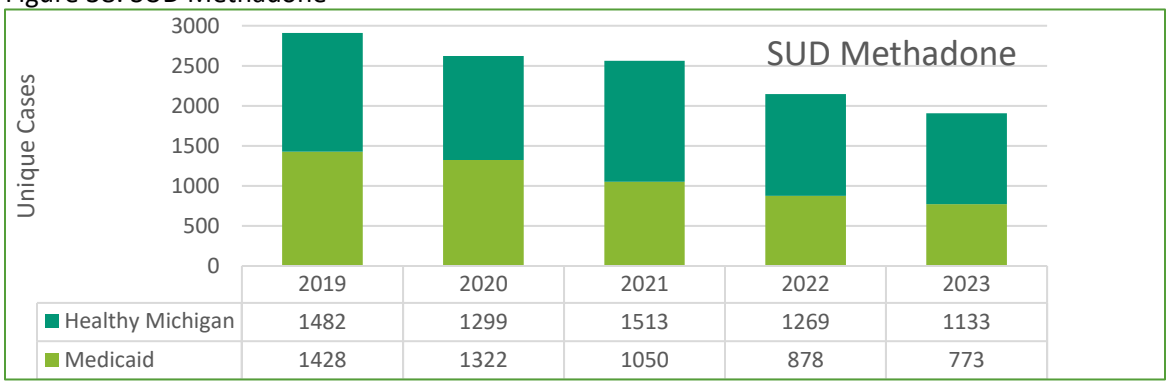
Figure 37: SUD Assessment



SUD Methadone

Methadone is an approved pharmacological support and an adjunct to the treatment of opioid use disorders. Services must be provided under the supervision of a physician licensed to practice medicine in Michigan and licensed to prescribe controlled substances, as well as licensed to work at a methadone program. The MSHN region appears to be experiencing a decline in individuals seeking methadone type services in the 5 years. This can be contributed to a variety of items. While methadone treatment has declined, the MSHN region has expanded its MAT options with OBOT providers over that same period of time. At present, the MSHN region has 25 locations that support MAT with SUD outpatient services. The OBOT providers typically support a variety of MAT options including buprenorphine products and vivitrol. With daily medications or a monthly injectable option, the use of other medications than methadone, may be more optimal to a person's lifestyle and pathway to recovery.

Figure 38: SUD Methadone



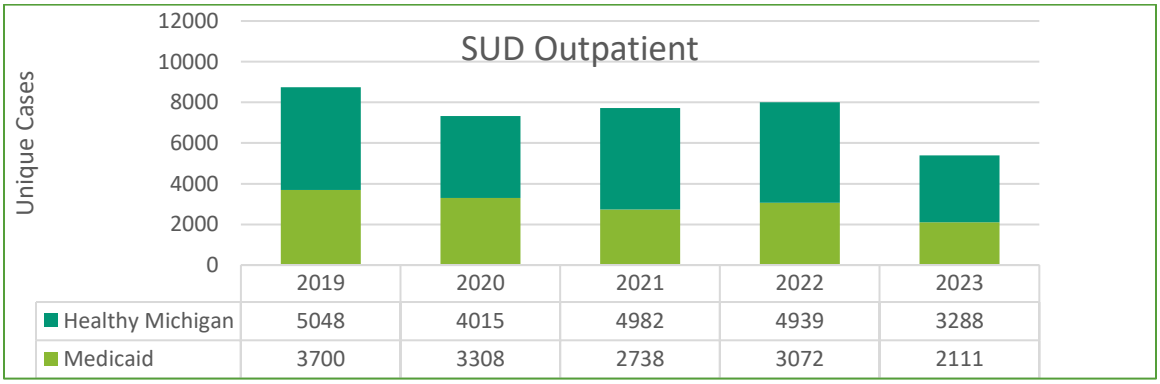
SUD Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT) programs

OTPs are certified by SAMHSA under 42 CFR Part 8.11. MDHHS has an established adequacy standard (35,000:1 Medicaid Enrollee to Provider ratio). MSHN currently contracts with five OTPs in the region that meet this definition. MSHN has significantly expanded the availability of Medication for Opioid Use Disorder (MOUD) providers in the region, and currently contracts with twenty-five (25) MOUD provider locations and as indicated, five (5) SAMHSA certified OTPs. In addition**, MSHN contracts with four (4) MOUD providers out of its geographic region for services to in-region residents. MSHN has an additional 16 contracted OBOT provider locations in region that have physicians who can prescribe naltrexone and/or buprenorphine. MSHN's Ratio: 567,553 Total Medicaid Enrollees to 21 providers, which is over the required 16 providers.**

SUD Outpatient

Outpatient treatment is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment or a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary, can total up to 19 hours in a week. Individual, family, and group therapy, case management, peer supports, and monitoring services may be provided individually or in combination. While the MSHN region shows a decrease in outpatient service engagement for FY23, this was also a time period when CMHSPs expanded to support CCBHC and also had contractual DCO arrangements to support SUD outpatient services in their counties. This was the case for CEI – CMH (supports Clinton, Eaton, and Ingham counties), Lifeways (Jackson and Hillsdale counties), The Right Door (Ionia County), and Saginaw Community Mental Health (Saginaw County). So the occurrence of a decrease could largely be attributed to individuals seeking or obtaining services through another behavioral health option like CCBHC. The ongoing staffing crisis also greatly impacted outpatient providers with being able to recruit, hire, and retain sufficient staffing. Many providers had to limit their admissions to their existing capacity until additional staff could be hired, sometimes with long/extended time periods trying to recruit and hire qualified and competent clinicians.

Figure 39: SUD Outpatient

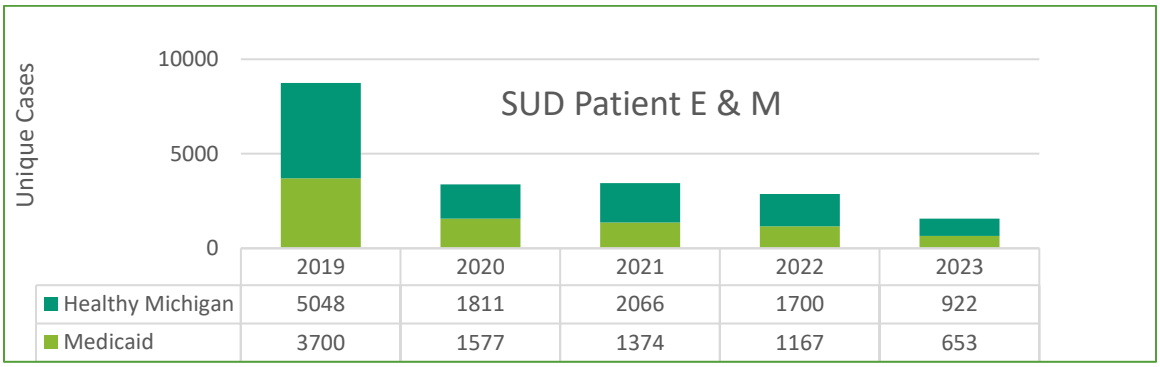


	2019	2020	2021	2022	2023
Healthy Michigan	5048	4015	4982	4939	3288
Medicaid	3700	3308	2738	3072	2111

SUD New and Established Patient Evaluation and Management

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

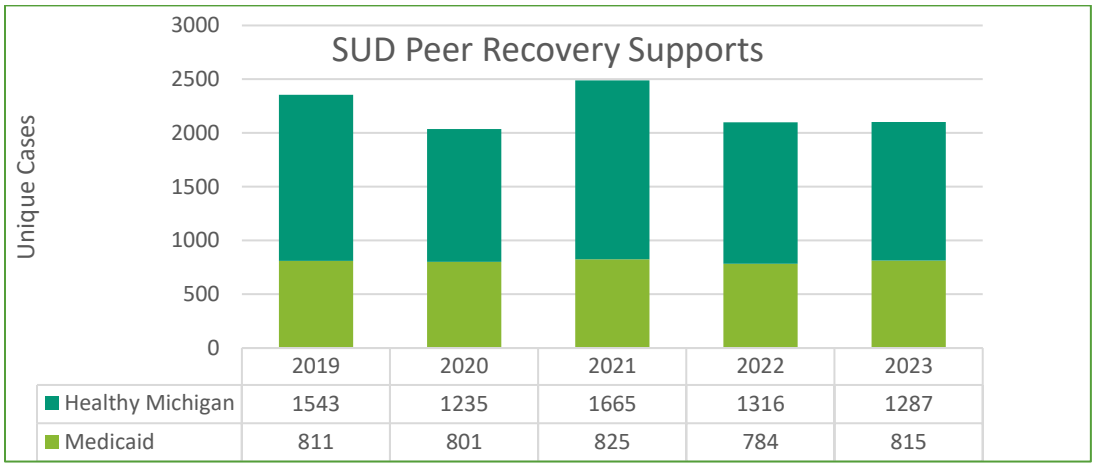
Figure 40: SUD Patient Evaluation and Management



SUD Peer Services/Recovery Supports

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

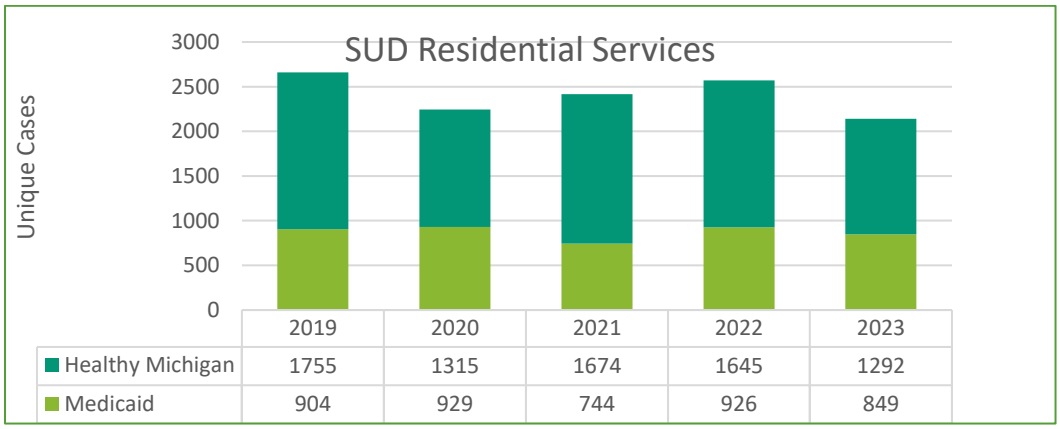
Figure 41: SUD Peer Recovery Supports



SUD Residential Services

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

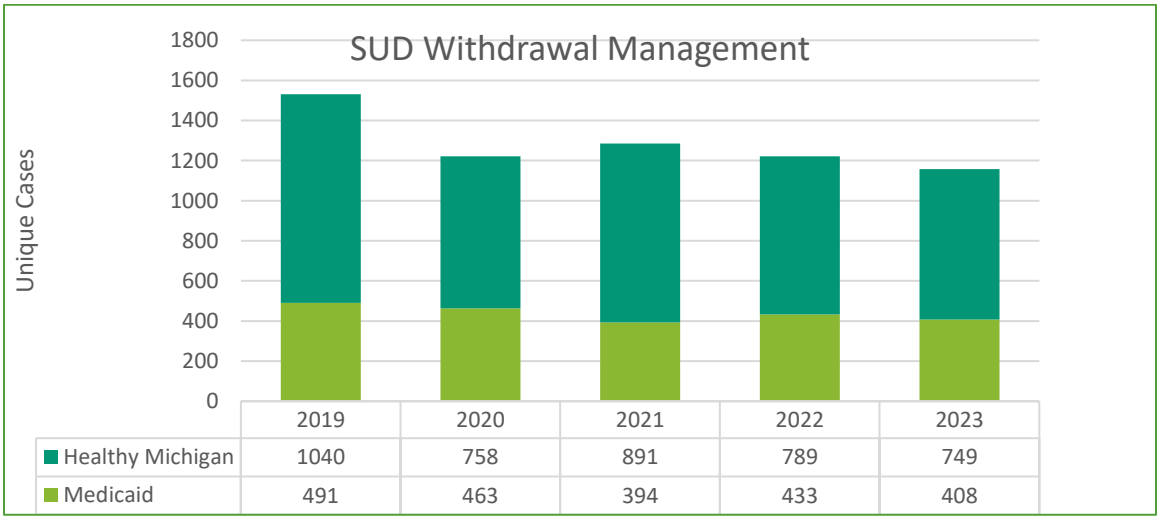
Figure 42: SUD Residential Services



SUD Withdrawal Management

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

Figure 43: SUD Withdrawal Management



Evidenced Based Practices - SUD

SUD Providers also utilize evidence-based practices in the context of prevention, treatment, and recovery models. Recovery focused approaches are prevalent, and some providers employ staff trained in motivational interviewing, integrated dual-diagnosis treatment, trauma-informed and other techniques commonly employed by CMHSP's. Table 6 lists evidence-based practices employed by various SUD Providers in the MSHN region:

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

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

Focus	Evidenced Based Practices	Focus	Evidenced Based Practices
R	24/7 Dads	T	Nurturing Fathers
P	Above The Influence	P	Nurturing Parenting
P	Active Parenting	P	PALS- Peer Assisted Leaders
T	Acupuncture	P	Photo Voice
T	Adolescent Community Reinforcement Approach	P	Positive Action
P	Alcohol and Tobacco Vendor Education	P	Prescription Disposal/Drug Drop Off Boxes
R	Alcoholics Anonymous	P	Prevention PLUS Wellness
T	Alternative Routes	P	Prime for Life
P	An Apple A Day	P	Program to Encourage Active, Rewarding Lives (PEARL)
P/T	Anger Management	T	Progressive Exposure Therapy
T	Art Therapy	P	Project Alert
P	Be A Star	P/T	Project ASSERT
T	Beyond Trauma	P	Project M.A.G.I.C.
P	Big Brothers Big Sisters	P	Project Success
P	Botvin LifeSkills	P	Project Toward No Drug Abuse
P	Breakout	P	QPR Gatekeeper Training for Suicide Prevention
P	Bully Proof	P	Quick Response Team (QRT)
P	Catch My Breath	P	Retailer/Server Education (TIPS)
R	CCAR Peer Recovery Training	P	Safer Smarter Teens
P	Choices	P	Sanford Harmony SEL
T	Cognitive Behavioral Therapy (CBT)	R/T	Screening, Brief Intervention, Referral to Treatment
R	Community-Based Support Group	P	Second Step
T/R	Contingency Management (CM)	T/R	Seeking Safety
T	Correctional Therapeutic Community for SUD	R/T	Self-Management and Recovery Training (SMART)
P	Cross Age Mentoring Programming	P	SMART Leaders/SMART Moves
T	Dialectical Behavior Therapy (DBT)	R	SMART Recovery
P	Do Your Part-State Social Norm Campaign	T	Solution Focused Brief Therapy (SFBT)
T	Eye Movement Desensitization and Re-Processing (EMDR)	P	SPORTPLUS Wellness
P	Families and Schools Together (FAST)	P	Step Bullying Prevention
T	Family Psychoeducation	P	STEP-Teen
T	Functional Family Therapy	P	Strengthening Families Home
T	Helping Women Recover/Helping Men Recover	P/T	Strengthening Families
P/T	Incredible Years	P	Student Assistance Programs
P	INDEPTH	P	SURF
P	In-School Probation: Early Intervention	P	Synar Compliance Checks
P	It's All About Being A Teena	P	Systematic Training for Effective Parenting (STEP)
P	JUMP	P	Teen Court

P	Letting Go of Anger	P	Teen Intervene
T	Living in Balance	T	Thinking for a Change
P	Making Good Choices	P	This Is Not About Drugs
T	MATRIX Model	P	This Is Not About Drugs
T	Medication Assisted Treatment (MAT)	P	TIPS Training
P	Michigan Model for Health	T	Tobacco Cessation
T	Mindfulness	P	Too Good for Drugs
T/R	Modified Therapeutic Community (MTC)	P	Too Good for Violence
T/R	Moral Recognition Therapy	P	Total Trek Quest
P	MOST Social Norming Campaign	T	Trauma Informed CBT
T	Motivational Enhancement Therapy (MET)	T	Trauma-Focused Yoga
T/R	Motivational Interviewing	T	TREM
T	M-TREM	P	Wellness Initiative for Senior Education (WISE)
R	Narcotics Anonymous	P	Wise Owl
T	Narrative Therapy	P	Youth Empowerment Program
P	NOT on Tobacco		

Numbers and types of providers (training, experience, and specialization)

The adequacy of the numbers and types of providers (in terms of training, experience, and specialization) required to furnish the contracted Medicaid services [7] in the MSHN region can be assessed through review of the direct operated and contracted service provider networks established by the CMHSP Participants. MSHN and its CMHSP Participants have developed regional training requirements, which establish minimum training standards to ensure a base level of competency across the provider network.

Each of the CMHSP participant agencies in the region have extensive experience in the behavioral health care industry, as have many of their contracted service providers. Practitioners and staff employed or contracted by the CMHSPs are properly licensed (by the Michigan Department of Licensing and Regulatory Affairs (LARA) and credentialed in accordance with MDHHS requirements for provider qualifications as defined in the Michigan Medicaid Manual. Disciplines include Licensed/Board Certified Psychiatrists, Licensed Nurse Practitioners, Registered Nurses, Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Full and Limited License Psychologists, Board Certified Behavioral Analysts and Licensed Professional Counselors, among others. Credentialing and re-credentialing procedures, as well as privileging procedures for psychiatrists, are utilized by each CMHSP with their provider networks. Agencies under contract are overseen by CMHSP staff and residential settings are licensed in accordance with MDHHS requirements.

In Michigan, staff providing certain Medicaid mental health services to specific clinical populations must meet education and work experience criteria for designation as a Child Mental Health Professional (CMHP), a Qualified Intellectual Disability Professional (QIDP), Qualified Behavioral Health Professional (QBHP) or a Qualified Mental Health Professional (QMHP).

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

CMHSPs also employ or contract with individuals who are on their own course of recovery as Peer Specialists, working particularly with people recovering from mental illnesses. Peer Specialists are certified by the state.

Similar credentialing procedures are in place for SUD Providers. Provider agencies must be licensed as Substance Use Disorder Programs by LARA, unless provided by a CMHSP which isn't required to have a LARA license. Individual clinicians, specifically treatment supervisors, specialists, and practitioners, as well as prevention supervisors and professionals, are required to hold certification through the Michigan Certification Board of Addiction Professionals, such as a Certified Advanced Addiction and Drug Counselor (CAADC) and Certified Alcohol and Drug Counselor (CADC). Substance use disorder service provider staff offering prevention services are required to hold certifications as Certified Prevention Specialists (CPS). In addition, MSHN also encourages all SUD Recovery Coaches to seek certification through the state's newly designed 'Peer Recovery Coach program' if the Coach qualifies under State requirements. This state-offered certification program allows recovery coaches the opportunity upon graduation to pursue other funding sources for reimbursement (ex: Medicaid system). Peer Recovery Coach (PRC) are also able to become certified through the Connecticut Community for Addiction Recovery (CCAR) curriculum to provide supportive PRC services in the MSHN region.

Trauma Informed Care

The MDHHS Trauma Policy requires PIHPs to ensure their provider networks have the capability to provide trauma informed care (TIC) and sensitive treatment for individuals with mental health and substance use disorders who have experienced or are experiencing trauma. In addition to requiring the use of trauma screening and assessment tools, the policy mandates the completion of organizational or environmental assessments of service sites for trauma sensitivity. MSHN assesses competency and compliance through annual audits. MSHNs CMHSPs and SUD treatment providers conduct a self-assessment regarding trauma-informed competence and develop goals for their organizations to become more trauma informed in the supports they provide.

Recovery Oriented Systems of Care (SUD)

MSHN maintains a plan for the implementation of Recovery-Oriented Systems of Care (ROSC) which focuses on holistic and integrated services beyond symptom reduction, that is person-driven, trauma informed and culturally responsive, ensures continuity of care, and incorporates evidence and strengths-based practices. Across the 21-county region, MSHN supports three regional ROSC groups known as East, West, and South ROSC. Regional ROSC initiatives have focused on reducing the stigma of substance use disorders, sober family events, and working with community partners to assist people on their path to recovery.

Adequacy of Services for Anticipated Enrollees

In addition to ensuring the appropriateness of the range of specialty behavioral health services, MSHN must also determine that services are adequate for the anticipated number of Medicaid Beneficiaries in the service area.[8] Medicaid enrollment, service penetration rates and community demand are key factors to consider.

[8] 42CFR438.207(b)(1) "Offers an appropriate range of preventative, primary care and specialty services that is adequate for the anticipated number of enrollees in the service area."

Medicaid/Healthy Michigan enrollment

Over the past couple of years, enrollment in Medicaid and Healthy Michigan has shown signs of plateauing, with an increase in enrollees in FY22 & FY23 from Medicaid continuous enrollment. Figures 44 and 45 show the Medicaid and Health Michigan enrollment trends for the mental health and SUD populations.

Figure 44: Total Enrollees vs. Served – MH and Total Enrollees vs. Served - SUD

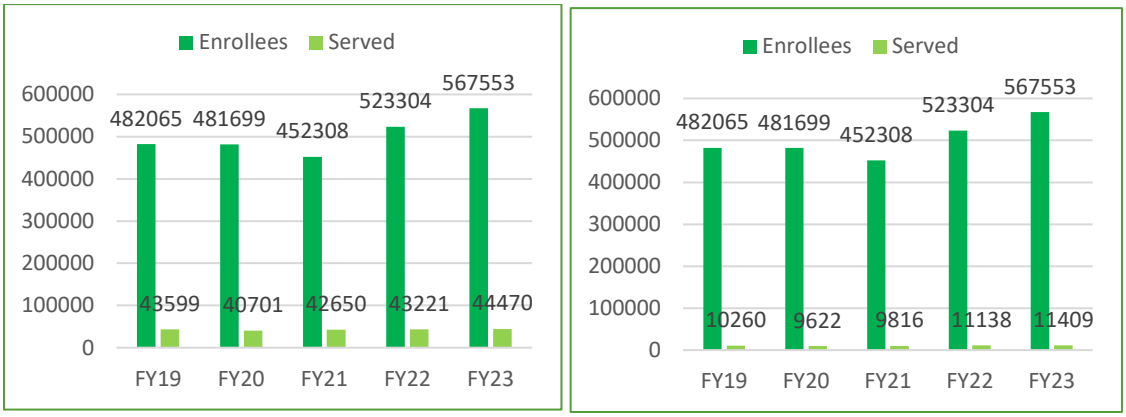


Figure 44a: Average Enrollees and Individual Served, FY22-FY23

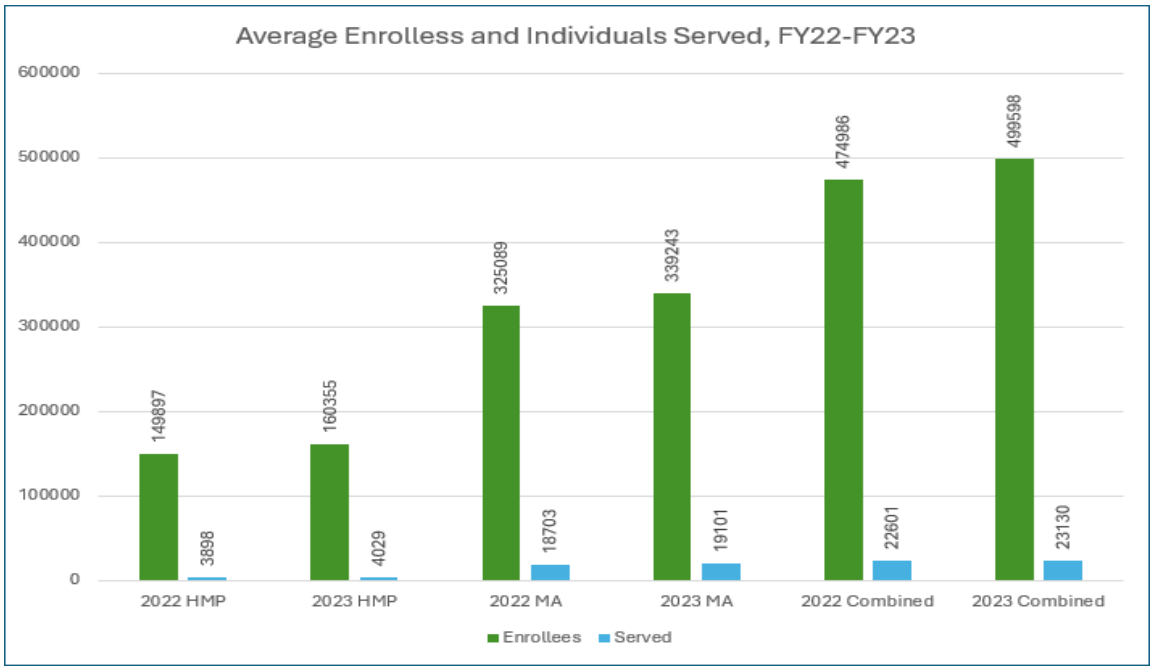
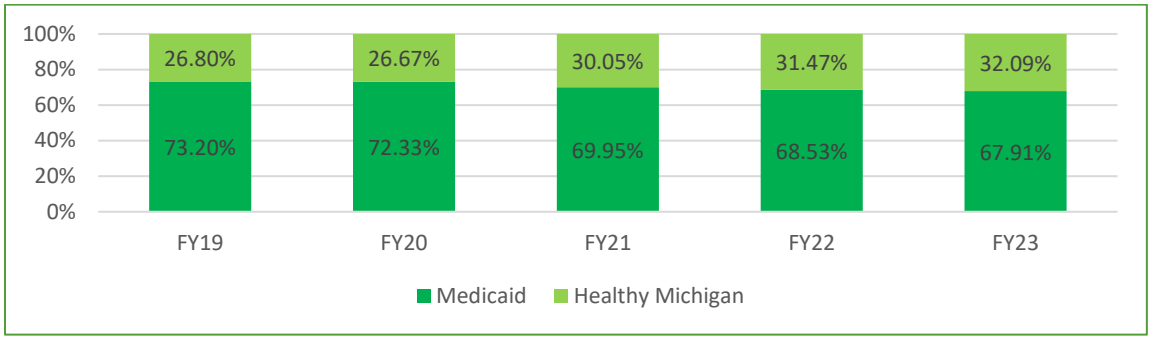


Figure 45: Proportions of Medicaid/HMP Populations



Disenrollments

Effective June 2023, MDHHS began the Medicaid and Health Michigan renewals as part of the Public Health Emergency end of continuous enrollment. MSHN has been monitoring the disenrollments to ensure and assist individuals with maintaining coverage where appropriate. Disenrollments may also affect those eligible for services. As of March 2024, MSHN has seen a decline in Medicaid and Health Michigan, with 81,894 individuals losing coverage.

Figure 46: Disenrollments

Mid-State Health Network

CMH	Assets	Income	Admin	Other	Total	Enrollees	March % disenrolled	February % disenrolled	CORRECTED January % disenrolled	December % disenrolled	November % disenrolled	October % disenrolled	September % disenrolled	August % disenrolled	July % disenrolled
BABH	3	69	737	32	841	32029	2.6%	2.2%	2.4%	2.1%	2.1%	2.4%	2.5%	1.4%	2.3%
CEI	5	182	2665	98	2950	108481	2.7%	2.4%	2.4%	2.6%	2.5%	2.3%	2.6%	1.7%	2.4%
CMCMH	1	143	1622	82	1848	69589	2.7%	2.3%	2.4%	2.2%	2.3%	2.4%	2.7%	1.6%	2.3%
GIHN	0	23	256	11	290	10793	2.7%	2.3%	2.3%	2.2%	2.1%	1.7%	2.6%	1.9%	2.5%
Huron	2	15	152	11	180	7222	2.5%	2.5%	2.1%	2.2%	1.9%	2.3%	2.2%	1.7%	2.5%
Lifeways	3	66	1288	49	1406	54805	2.6%	2.2%	2.3%	2.1%	2.4%	2.5%	3.0%	1.8%	2.4%
MCN	2	36	408	23	469	17677	2.7%	2.0%	2.2%	2.2%	2.3%	2.2%	2.6%	1.8%	2.1%
Newaygo	0	38	357	21	416	15087	2.8%	2.2%	2.2%	1.9%	2.0%	2.2%	2.9%	1.8%	2.7%
SCCMH	0	46	1381	67	1494	61124	2.4%	2.1%	2.2%	2.0%	2.1%	2.1%	2.2%	1.5%	1.8%
Shiawassee	0	52	369	19	440	17586	2.5%	2.4%	2.4%	2.8%	2.6%	2.7%	2.7%	1.7%	2.6%
TBH	3	28	369	23	423	14599	2.9%	2.3%	2.3%	2.0%	1.9%	2.1%	2.6%	1.5%	2.5%
TRD	0	31	336	15	382	13981	2.7%	2.6%	2.3%	2.4%	2.3%	2.8%	2.5%	1.8%	2.5%
Not in region	0	0	17	0	17										
Total March	**19**	**729**	**9957**	**451**	**11156**	**422,973**	**2.6%**								
Total February	**13**	**631**	**8743**	**432**	**9819**	**429,694**		**2.3%**							
Total January	**11**	**322**	**5450**	**227**	**6010**	**438,214**			**2.4%**						
Total December	**20**	**522**	**9222**	**294**	**10058**	**445,661**				**2.3%**					
Total November	**15**	**686**	**9699**	**288**	**10688**	**455,840**					**2.3%**				
Total October	**14**	**715**	**10072**	**374**	**11175**	**472,737**						**2.4%**			
Total September	**13**	**816**	**11249**	**522**	**12600**	**477,567**							**2.6%**		
Total August	**20**	**549**	**7208**	**476**	**8253**	**494,113**								**1.7%**	
Total July	**89**	**1251**	**9872**	**539**	**11751**	**504,867**									**2.3%**
Reduction since July						**81,894**	**0.0%**	**16.2%**							
Reduction since October (FY24)						**49,764**	**0.0%**	**9.9%**							

Note:
Includes both Medicaid and HMP

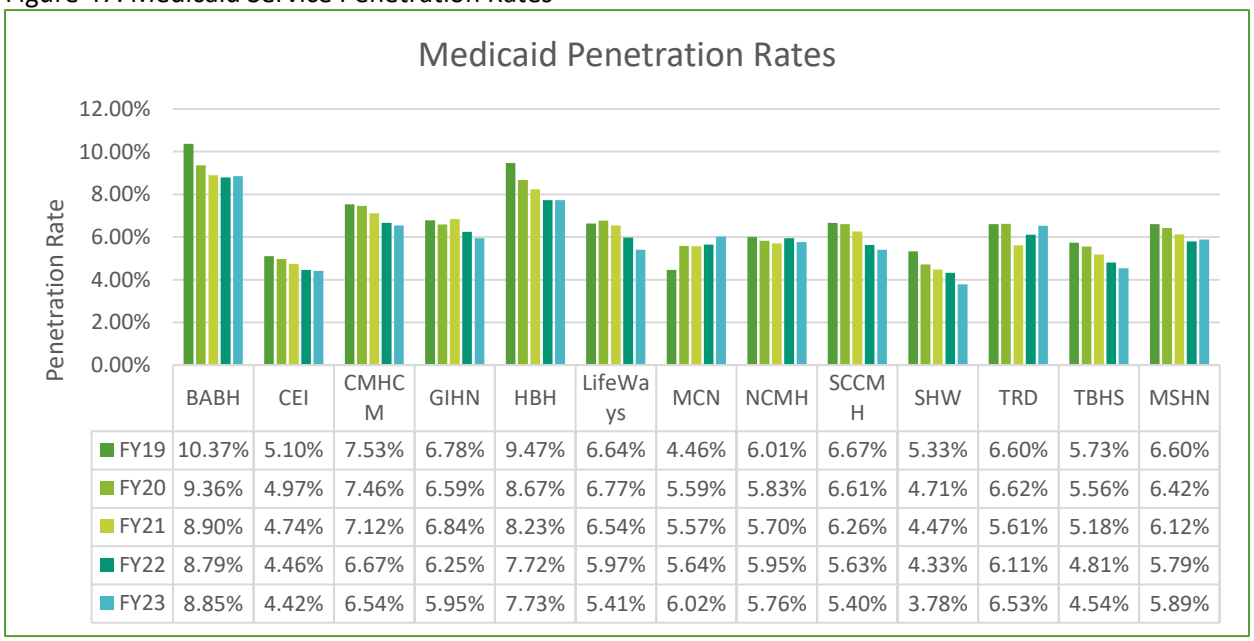
Service Population Penetration Rates

Medicaid enrollees since FY21 have steadily been increasing from the intentional hold on any eligibility loss due to COVID-19. Eligibility reviews began at the end of FY23. The impact for the future will be a decrease in Medicaid enrollment for FY24. Variability does exist among the CMHSP Participants in the

region relative to population penetration rates, which is reviewed at the executive level by the MSHN Operations Council and is addressed on an ongoing basis by the MSHN Utilization Management Committee. The goal is to determine if the variance is commensurate with community need or if action by the Operations Council is warranted relative to network capacities. Figure 47 and 48 show the Medicaid and Healthy Michigan penetration rate per CMHSP by fiscal year. Figure 49 shows the number of consumers serviced.

Compared to FY19 (prior COVID-19) 1 CMHSPs increased their Medicaid penetration rate in FY23 (MCN), with 11 CMHSPs experiencing a decrease. As of the end of FY23, (MDHHS, July 1, 2022 - September 30, 2022)[9] MSHN had the third highest penetration rate at 7.20% out of the 10 PIHPs.

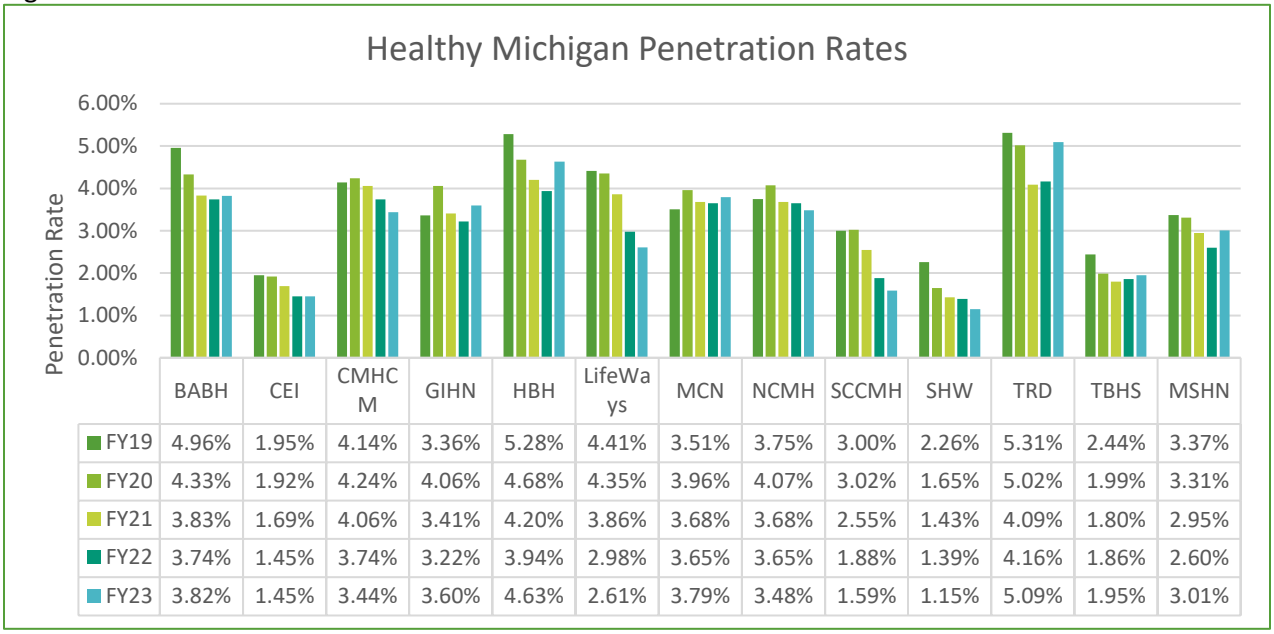
Figure 47: Medicaid Service Penetration Rates[10]



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS	MSHN
FY19	10.37%	5.10%	7.53%	6.78%	9.47%	6.64%	4.46%	6.01%	6.67%	5.33%	6.60%	5.73%	6.60%
FY20	9.36%	4.97%	7.46%	6.59%	8.67%	6.77%	5.59%	5.83%	6.61%	4.71%	6.62%	5.56%	6.42%
FY21	8.90%	4.74%	7.12%	6.84%	8.23%	6.54%	5.57%	5.70%	6.26%	4.47%	5.61%	5.18%	6.12%
FY22	8.79%	4.46%	6.67%	6.25%	7.72%	5.97%	5.64%	5.95%	5.63%	4.33%	6.11%	4.81%	5.79%
FY23	8.85%	4.42%	6.54%	5.95%	7.73%	5.41%	6.02%	5.76%	5.40%	3.78%	6.53%	4.54%	5.89%

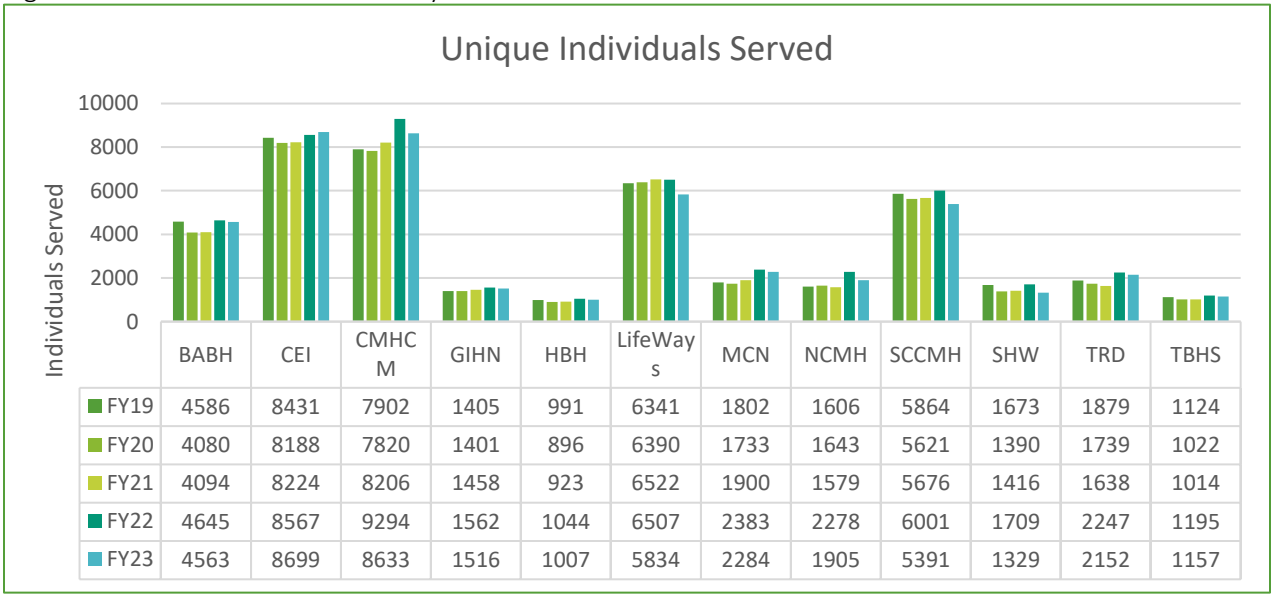
[9] Source: MDHHS, MMBPIS September 2022
[10] Source: MSHN REMI Penetration Report

Figure 48: HMP Service Penetration Rates[11]



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS	MSHN
FY19	4.96%	1.95%	4.14%	3.36%	5.28%	4.41%	3.51%	3.75%	3.00%	2.26%	5.31%	2.44%	3.37%
FY20	4.33%	1.92%	4.24%	4.06%	4.68%	4.35%	3.96%	4.07%	3.02%	1.65%	5.02%	1.99%	3.31%
FY21	3.83%	1.69%	4.06%	3.41%	4.20%	3.86%	3.68%	3.68%	2.55%	1.43%	4.09%	1.80%	2.95%
FY22	3.74%	1.45%	3.74%	3.22%	3.94%	2.98%	3.65%	3.65%	1.88%	1.39%	4.16%	1.86%	2.60%
FY23	3.82%	1.45%	3.44%	3.60%	4.63%	2.61%	3.79%	3.48%	1.59%	1.15%	5.09%	1.95%	3.01%

Figure 49: Total Individuals Served by CMHSP[12]



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS
FY19	4586	8431	7902	1405	991	6341	1802	1606	5864	1673	1879	1124
FY20	4080	8188	7820	1401	896	6390	1733	1643	5621	1390	1739	1022
FY21	4094	8224	8206	1458	923	6522	1900	1579	5676	1416	1638	1014
FY22	4645	8567	9294	1562	1044	6507	2383	2278	6001	1709	2247	1195
FY23	4563	8699	8633	1516	1007	5834	2284	1905	5391	1329	2152	1157

Community Needs Assessments: Priority Needs and Planned Actions

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

[11] Source: MSHN REMI Penetration Report

[12] Source: MSHN REMI Penetration Report

community needs this year or provided an update of their last assessment. A regional composite of CMHSP Needs Assessment Priority Needs is shown in Table 7.

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

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

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

Of these top five regional unmet community needs, all are already addressed in this assessment in various ways, with the exception of children's services. Appendix A summarizes CMHSP Participant efforts to expand service capacity for families and children and increase the number accessing services, as described in their community needs assessment updates.

Consumer Satisfaction

Consumer satisfaction with services is an important consideration when evaluating the adequacy of a provider network. MSHN assesses consumer perception of care annually for individuals receiving services funded by the PIHP. A standardized survey or assessment tool is used in accordance with the service population. The assessment/survey addresses quality, availability, and accessibility of care for adults and children receiving long term supports and services who experience a mental illness, developmental disability, and/or a substance use disorder. The results are analyzed regionally and locally by service programs. Service programs include but are not limited to Assertive Community Treatment, Outpatient Therapy, and Targeted Case management/Supports Coordination Services, Home Based Services, Residential, and Withdrawal Management. Distribution methods include mailed surveys, phone surveys, electronic surveys, and face to face.

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

The responses to the Perception of Access (to services) subscale indicated a favorable response of 90% for youth and 88% for adults. Respondents indicated a favorable response of 84% for youth and 89% for adults that services received were appropriate in addressing treatment needs. Individuals receiving services for a substance use disorder indicated a favorable response of 90% for the treatment received. Despite meeting the standard (80%) for satisfaction, it remains a goal for the MSHN region to increase these rates.

Consumer satisfaction results are reviewed by the MSHN Quality Improvement Council, MSHN Clinical Leadership Committee, and the Regional Consumer Advisory Council to determine if any trends are evident and if any regional improvement efforts would be recommended. Areas of improvement are targeted toward percentage rate of <80% or any area that has demonstrated s significant decrease from previous assessment. Priority areas as identified through review of the regional councils and committees.

Anticipated changes in Medicaid eligibility or benefits

Consideration of anticipated changes in Medicaid eligibility or benefits in the near term and an assessment of their anticipated impact on enrollment in the region is an important consideration relative to the adequacy of provider network capacity.

Home and Community Based Services

The Centers for Medicare and Medicaid Services (CMS) released new rules in 2014 for Home and Community-Based Services (HCBS) waivers. In the final rule, CMS has defined home and community-based settings by the presence of opportunities the individual has to make his or her own choices, come and go as they choose, interact in their community, and move freely and access public areas of their home. The changes related to clarification of home and community-based settings will maximize opportunities for participants in HCBS programs to have access to the benefits of community living, receive services in the most integrated setting, and effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.

In FY17, MDHHS delegated increased responsibility for completion of the surveys to PIHPs. A combination of onsite and desk reviews continues to be completed to ensure ongoing HCBS compliance region wide. As of March 17, 2023, all settings were required to be fully HCBS compliant. MSHN and its CMHSP Participants are actively participating in MDHHS system assessments, provider surveys, heightened scrutiny work, provisional application processing, and corrective action plans.

The system assessments have grown in volume and complexity and now include surveys of newer provisional approvals, as well as providers who were on heightened scrutiny status who were de-escalated to out of compliance status. An important aspect of the reviews has been to ensure that restrictive or intrusive interventions, the exercising of personal freedoms and choice, and community inclusion are all appropriately accounted for in the HCBS reviews. This has led to an increased review of BTPRC processes to ensure that the individual's recipient rights are not being violated.

Sufficiency of Network in Number, Mix and Geographic Distribution

MSHN must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area[14]. The effectiveness of the number of providers in the network may be evaluated by past performance.

Sufficiency of Number of Providers: Access Timeliness and Inpatient Follow-up

In addition to the services for mental health and SUD populations described within this assessment, MSHN is required by MDHHS to maintain a 24-hour access system for all target populations. The region has established a multi-portal access system – a 'no wrong door' approach, with 24/7/365 access for individuals with a primary SUD concern. CMHSP Participants operate a 24-hour access system, either directly or through a contractual arrangement with other CMHSPs. MSHN, CMHSP Participants and SUD Providers have met the following goals and continue to maintain network capacity to:

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

- SUD service provider phone systems either link directly to the CMHSP access system during non-business hours or their automated response systems instruct callers to contact the CMHSP access system during non-business hours.
- The CMHSP and SUD service providers establish a written after-hours protocol for handling referrals during non-business hours.
- Local first responder systems (i.e., police, sheriff, jail, emergency medical, etc.), hospitals and other potential referral sources are informed of the availability of after-hours availability of access services for individuals in need of substance use-related supports and services.

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

- Identifying and assigning responsibility for one or more CMHSP-employed individuals to perform the function.
- Identify opportunities where existing mental health prevention efforts can be expanded to integrate and/or support primary SUD prevention.
- With MSHN support general community education and awareness related to behavioral health prevention, access and treatment including outreach (note that a regional goal is to increase the number of persons served, with emphasis on SUD and persons with HMP).

Timely Appointments

MDHHS requires PIHPs to report indicators of access timeliness and outcomes related to inpatient follow-up. MDHHS, in coordination with the PIHPs and CMHSP participants, developed and implemented two new indicators to be reported for FY20Q3. The new indicators do not exclude any individuals and measure the percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service, and the percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. The indicators that measure persons being seen for a follow up within 7 days of a discharge from inpatient or detox do not exclude those who chose an appointment outside of the required timeframe or chose not to engage in treatment following a

[14] Source: 42CFR438.207(b)(2) "Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."

request. MSHN should continue to monitor access to timeliness to treatment. Table 8 shows the recent year-to-year performance of the 21-county region. The indicators highlighted below with the lower percentages is due to not having appointments available due to workforce capacity issues and opposed to lack of providers.

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

	Population	MSHN Performance Rate FY21	MSHN Performance Rate FY22	MSHN Performance Rate FY23
The percentage of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (Standard: 95%)	MI-Children	99.58%	97.69%	98.49%
	MI-Adults	99.22%	98.96%	99.55%
The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergent request for service. (Standard: NA)	MI-Children	69.31%	64.26%	59.81%
	MI-Adults	63.69%	61.42%	62.82%
	DD-Children	65.30%	57.77%	44.27%
	DD-Adults	72.74%	67.77%	56.47%
	Total	67.39%	62.29%	60.70%
The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment (Standard: NA).	MI-Children	68.29%	59.24%	58.83%
	MI-Adults	72.62%	64.01%	62.26%
	DD-Children	78.33%	73.26%	81.09%
	DD-Adults	68.01%	65.58%	62.50%
	Total	71.34%	63.08%	62.54%
The percentage of new persons during quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergent request for services. (SUD Only) (Standard: NA)	Medicaid SUD	83.34%	75.49%	*73.82%
The percentage of discharges from psychiatric inpatient unit/substance use disorder detox unit seen for follow-up care within 7 days. (Standard: ≥95%)	Children	98.90%	97.44%	97.83%
	Adults	97.02%	96.17%	95.76%
	Medicaid SUD	96.68%	97.18%	97.48%
The percentage of readmissions to an inpatient psychiatric unit within 30 days of discharge. (Standard: <15%)	Children	7.97%	5.50%	8.81%
	Adults	12.62%	10.08%	12.31%

*FY23 through Q3

Maximum Time and Distance Standards

Understanding the locations of behavioral health providers in relation to the people needing services is the first step in addressing distance challenges associated with network adequacy. We employ the following methodology to understand network adequacy.

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

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

Figure 50: Time and Distance Standards for Inpatient Psychiatric Services

Time and Distance Standards for Inpatient Psychiatric Services

Adults

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

Pediatrics

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

Figure 51: Overview of Time and Distance Standards

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

Based on the key findings in Figure 51, MSHN should focus efforts related to recruitment of providers for SUD residential, psychiatric inpatient for children, and crisis residential. In FY22, MSHN conducted an RFP for a Crisis Residential Unit (CRU) with anticipated opening in March 2024. In FY23, MSHN supported an RFP for SUD residential and withdrawal management services, as well as outpatient SUD services (with option of MAT). MSHN identified a provider in FY23 to support the SUD residential and withdrawal management services with focus in Isabella County and has been working on implementation into FY24. At present, the SUD residential facility will be open with capacity up to 75 beds in July of 2024. The SUD withdrawal management program will be implemented after the SUD residential program, with an anticipated implementation in fall of 2024. MSHN also identified providers to support SUD outpatient services during FY23. This included a provider in Montcalm County to support SUD outpatient and MAT services, as well as another to support SUD outpatient in Isabella County where needs were identified outside of the time and distance standards.

For further details, including locations and racial/ethnic breakouts see Appendix B: MSHN Drive Time Analysis.

Sufficiency of Number of Providers: HCBS/Independent Assessment

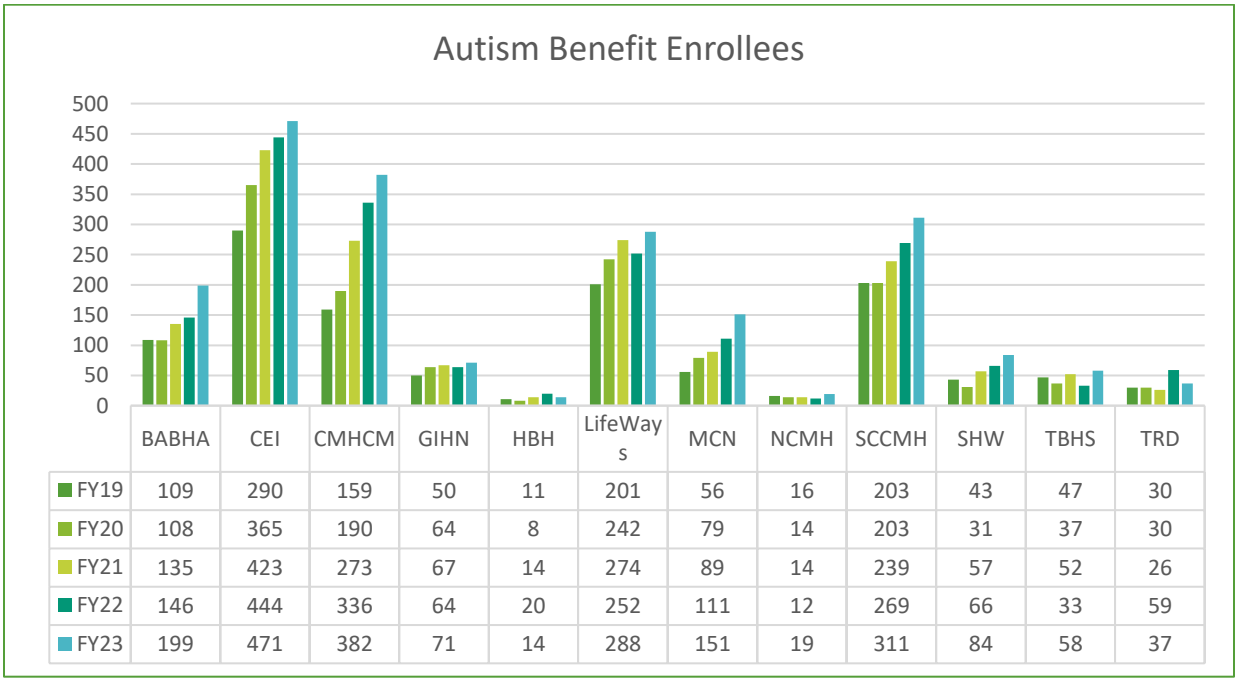
In November 2017, MDHHS released a new Medicaid Provider Manual Home and Community Based Services chapter to address the implementation of the CMS HCBS Final Rule. In its new HCBS guidance, MDHHS instructs that the HCBS Final Rule "provides requirements for independent assessment. This is a face-to-face assessment, conducted by a conflict-free individual or agency. The assessment is based on

the individual's needs and strengths and is part of the person-centered planning process." This language appears to highlight the necessity of conflict-free case management and of clinical assessment and person-centered planning free of conflicts of interest. The CMS Federal Rule provides that "the assessor must be independent; that is, free from conflict of interest with regard to providers, to the individual and related parties, and to budgetary concerns." The degree to which this expectation impacts network adequacy will depend on its implementation, and it anticipated that CMHSPs will need to take steps to insure the clinical assessment process against problematic conflicts and opposing interests moving forward. MDHHS has indicated that its implementation plan requirements will not be shared with PIHPs and CMHSPs until mid-February 2024, thus, the impact on network adequacy is unknown at this time but will be address fully in the PIHP conflict free access and planning implementation plan.

Sufficiency of Number of Providers: Autism Spectrum Disorder Capacity

Previous year's assessments found that CMHSP Participants were finding it difficult to secure adequate providers to provide Behavioral Health Treatment/Applied Behavioral Analysis services for individuals with autism, due to the extensive training requirements for providers and the relative newness of the required credentials in the behavioral health industry and Michigan. As discussed previously in this assessment, however, MSHN and its CMHSP Participants have worked diligently to address the issue of BHT supervisor capacity over the course of the previous year. With the current total of 63 ABA provider contracts (22 shared providers and 41 single CMHSP contracts), the region continues to establish contracts with additional ABA providers since the rate of enrollees has climbed precipitously in many CMHSPs over the past year. Figure 52 shows that most CMHSPs have experienced significant increases in Autism Benefit service enrollment in the past few years.

Figure 52: Autism Benefit Enrollees[15]



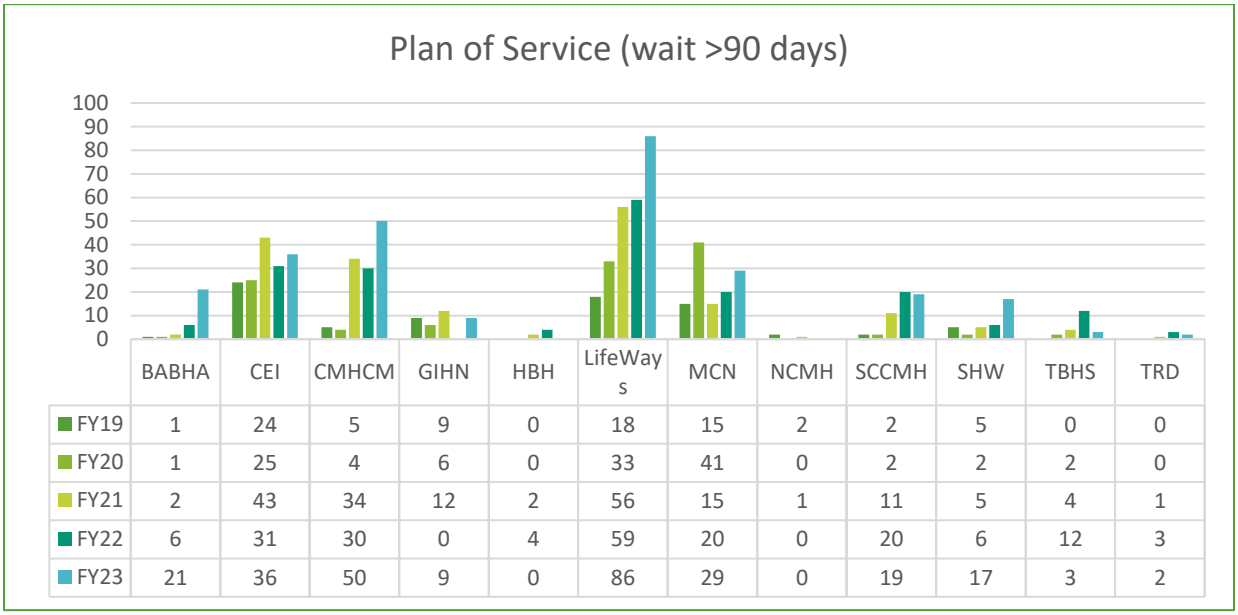
	BABHA	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TBHS	TRD
FY19	109	290	159	50	11	201	56	16	203	43	47	30
FY20	108	365	190	64	8	242	79	14	203	31	37	30
FY21	135	423	273	67	14	274	89	14	239	57	52	26
FY22	146	444	336	64	20	252	111	12	269	66	33	59
FY23	199	471	382	71	14	288	151	19	311	84	58	37

The issue of the region having an adequate number of ABA contract providers continues to be monitored and addressed. This year, with the elimination of the WSA for autism tracking and monitoring, MSHN has

[15] Source: MSHN Autism Report

worked with our CMHSPs to develop a new system for oversight outside of the WSA. Within this new system, ABA quality and compliance issues continue to be highlighted in regular monthly reporting and shared with the CMHSPs. MSHN provides monthly notification to each CMHSP with data linked to referral date (date family requested services) to the current number of days pending completion of an initial comprehensive evaluation. MSHN also sends notification monthly to each CMHSP with data referencing all individuals with an Overdue Service Start Date. This measures the time from eligibility determination to start date of ABA services within the new tracking system. For instance, the number of individuals who have been found eligible for Autism Benefit services and are still waiting for a plan of service after 90 days has increased over the past year (see Figure 53), but the number of enrollees in the autism benefit has also risen 11% in FY23. Nonetheless, several new cases each month continue to surpass the 90-day threshold for the start of services. This demonstrates the need for continued efforts to work with ABA providers to get assessments completed and individuals into services more quickly. The COVID-19 pandemic also affected the provision of services across our region, including delivery of services via telehealth and an increase in staffing shortages across all service providers. Additionally, families have indicated a desire to wait to start ABA services until a specific provider was available. Some of the identified reasons for a families' request to wait for services with a particular provider have been access to specialty services like SLP/OT, provider location, provider reputation, availability of services outside of school hours, and available transportation. MSHN has provided monthly information to the Autism Workgroup and to the Operations Council quarterly about 90-day benchmarks, with the intention of facilitating internal tracking systems to ensure that individuals are getting into services in a timely fashion. MSHN has worked to streamline and manage compliance issues through the Autism Operations Workgroup, the Regional Standardized ABA contract, and through shared provider performance reviews. CMHSP participants will continue to work within their purviews to address gaps in provider network capacity for autism benefit services.

Figure 53: Individuals Enrolled with an Overdue Service Start Date (Greater than 90 Days from Eligibility)[16]



	BABHA	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TBHS	TRD
FY19	1	24	5	9	0	18	15	2	2	5	0	0
FY20	1	25	4	6	0	33	41	0	2	2	2	0
FY21	2	43	34	12	2	56	15	1	11	5	4	1
FY22	6	31	30	0	4	59	20	0	20	6	12	3
FY23	21	36	50	9	0	86	29	0	19	17	3	2

[16] Source: MSHN Autism Report

Sufficiency of Mix of Providers: Cultural Competence

MSHN requires cultural competence training for staff and its provider network. Out of 1,393 provider listings in the region's Provider Directory, 90.9% indicated Cultural Competency training and MSHN is working to bring this to full compliance. MSHN providers are empaneled in areas with concentrations of ethnic or cultural groups, such as the Latino counseling services available through the CEI provider network. The MSHN Provider Directory indicates where providers specialize in distinct ethnic or cultural groups. MSHN recognizes that we do not have sufficient providers with diverse clinical staff that mirror the diversity of communities like Saginaw, Lansing, Jackson and Mt. Pleasant. This is likely a contributing factor in low penetration rates for Black, Hispanic and Native American communities. MSHN collects and provides public information via MSHN's website related to the persons served by Race (Figure below). CMHSPs and SUD Providers collect information from individuals served related to specific cultural awareness/needs as identified during person centered planning.

Figure 54: Persons Open by Race

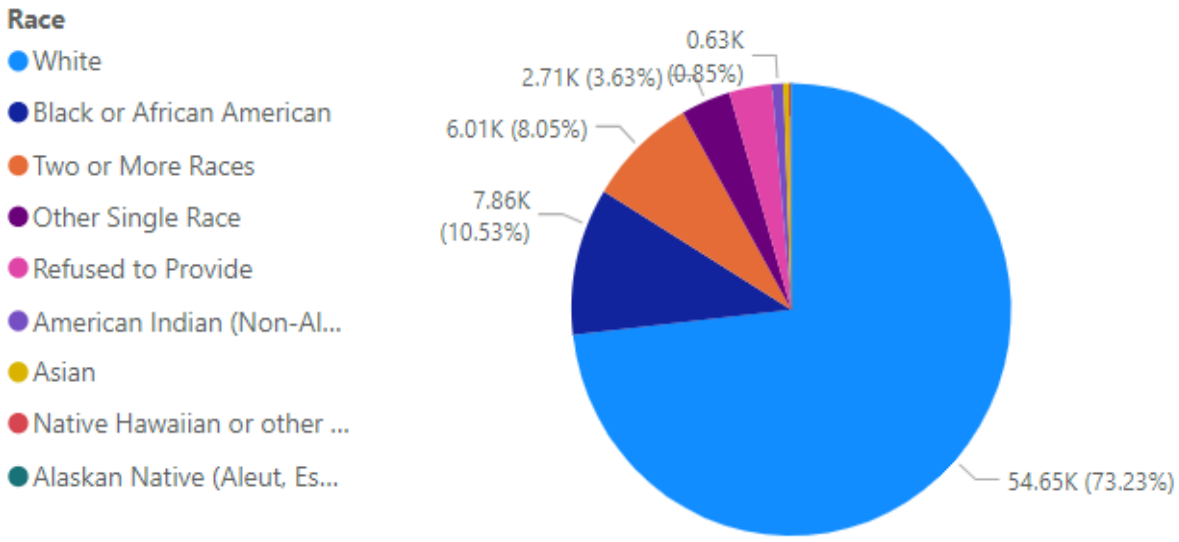


Figure 55: MSHN Regional Penetration Rate by Race/Ethnicity FY2022 and FY2023

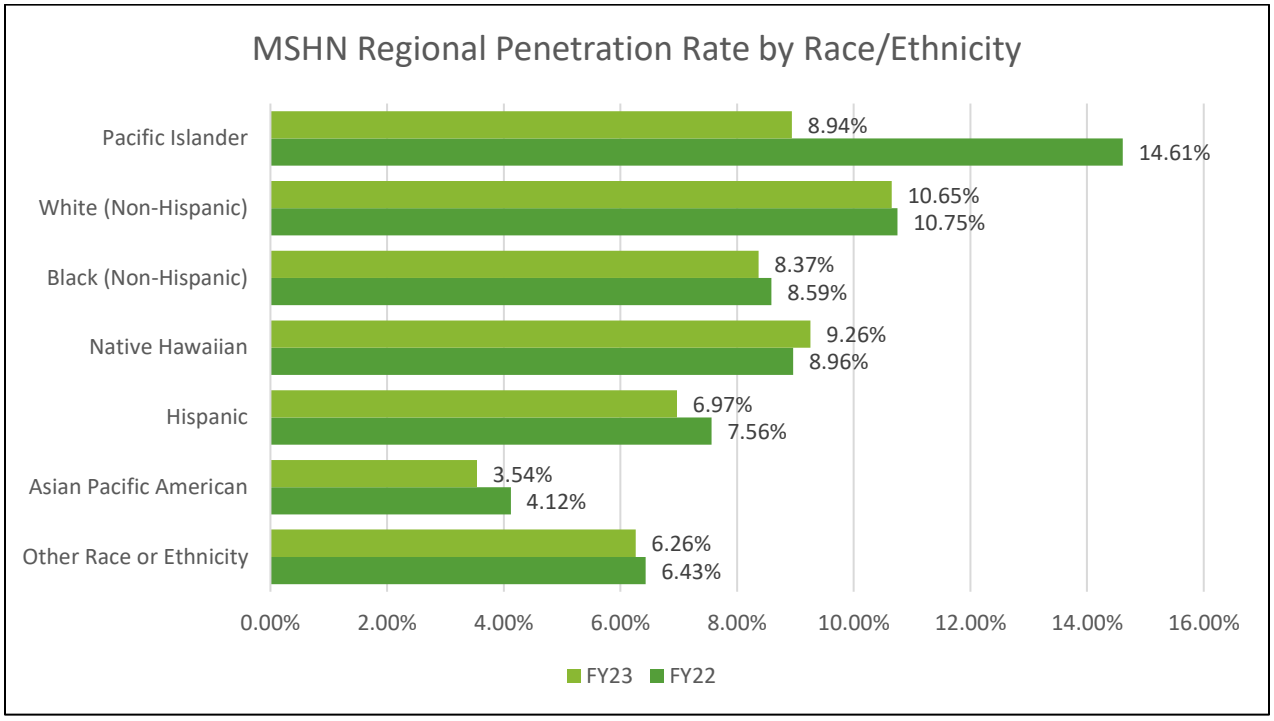
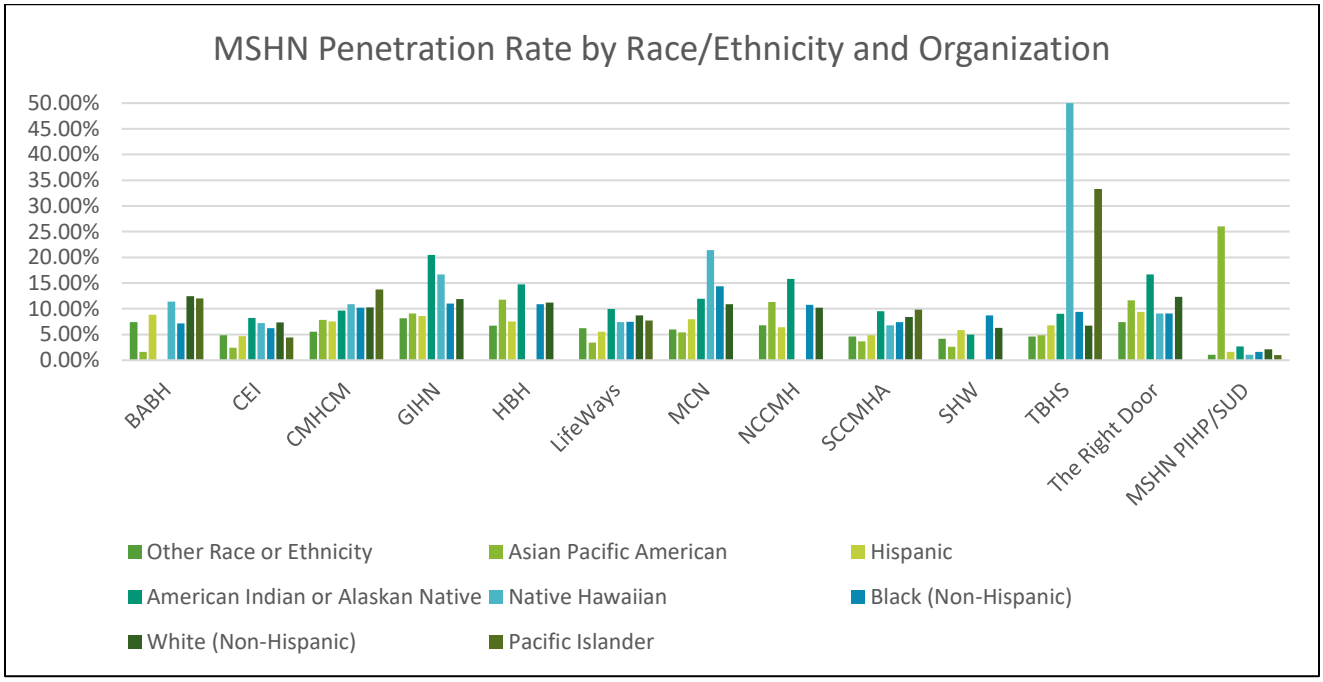


Figure 56: Penetration Rate by Race/Ethnicity FY2023



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

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

MSHN along with its CMHSP partners have developed diversity, equity and inclusion plans and policies to address local community specific areas of need. Areas of focus depend on improvement efforts identified locally but themes emerged regional that include the below:

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

MSHN is in the process of developing a developing a Diversity, Equity and Inclusion plan. The plan will identify regional efforts to reduce health disparities, increase diversity with the network and ensure equitable service delivery throughout the region.

Sufficiency of Mix of Providers: Consumer Choice

Consumers are offered a choice of provider whenever possible within the constraints of the local health care provider marketplace. Rural areas may not have adequate numbers of qualified provider agencies or independent practitioners available to permit CMHSP participants to offer a choice. Some locations in the region are designated by the State of Michigan as medically underserved areas, thereby qualifying for supplemental physician recruitment and training efforts.

Transportation is a greater challenge for CMHSP Participants given the rural and small/medium city composition of the region. Public transit is limited to city centers and surrounding suburbs in most instances. Delivery of services in non-clinic settings and use of targeted transportation programs helps address any gaps in accessibility for consumers of services.

Substance use disorder providers also continue to add specialized transportation services to meet the needs of MSHN region. One example is added home based services for women with children, which is an enhanced women's specialty service, to address geographic limitations/ transportation problems individuals were having in trying to access clinic-based services. MSHN also supports transportation to and from SUD levels of care for withdrawal management and residential in an attempt to eliminate this as a barrier to treatment for individuals.

In accordance with revisions to the managed care rules, the availability of triage lines or screening systems must also be considered in state provider network adequacy standards. Most of the CMHSPs in the region have used or would use telehealth services for key services which are in short supply, such as psychiatric care. Additionally, the impact of the pandemic has resulted in the temporary expansion of allowable telehealth services. MSHN will continue to monitor telehealth expansion.

All the CMHSPs use emergency services hotlines to receive and triage calls from Medicaid beneficiaries and other members of the community. Some CMHSPs also use telephone based pre-screening programs for determination of medical necessity for psychiatric inpatient care and/or for preliminary eligibility screenings for specialty behavioral health and SUD services.

Accommodations

All CMHSP Participants offer services in locations with physical access for Medicaid beneficiaries with disabilities[17]. Out of 1,383 provider listings in the region's Provider Directory, 94.07% indicated accommodations in accordance with the American Disabilities Act. Delivery of services in home settings as well as telemedicine can offset barriers to physical access where present.

The majority of the CMHSPs and SUD providers in the region are CARF accredited, which requires specific accommodations and accessibility evaluations or plans to ensure services are readily available to individuals with special needs.

Each CMHSP Participant and SUD provider endeavors to maintain a welcoming environment that is sensitive to the trauma experienced by individuals with serious mental illness and that is operated in a manner consistent with recovery-oriented systems of care.

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

Interpreter services, although available across the region in accord with MDHHS standards, are less than adequate for crisis intervention services, where a timely clinical response is critical and wait times for access to an interpreter may delay treatment. The region will monitor the impact of this issue on crisis response capacity.

MSHN requested that CMHSPs and SUD Providers ensure accommodations are available as required for individuals accessing services who experience hearing or vision impairments and that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services. This has been addressed during site reviews by the MSHN audit team. Based on MSHN audits, providers are following these requirements.

As of the date of this assessment, Ingham County has 13.1% non-English speaking individuals.

[17] Source: 42CFR438.206(b)(vi) ". . . considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities."

Table 9: Limited English Proficiency

County	LEP Combined	English Only	Spanish	Other Indo-European language	Asian and Pacific Islander Languages	Other languages
Arenac	1.6%	98.4%	0.9%	0.4%	0.1%	0.2%
Bay	2.0%	98.0%	1.1%	0.6%	0.3%	0.0%
Clare	5.0%	95.0%	0.5%	4.2%	0.1%	0.2%
Clinton	4.1%	95.9%	1.7%	1.1%	0.9%	0.3%
Eaton	6.5%	93.5%	2.0%	2.3%	1.3%	0.9%
Gladwin	3.8%	96.2%	0.7%	2.9%	0.1%	0.0%
Gratiot	4.0%	96.0%	2.3%	1.0%	0.5%	0.2%
Hillsdale	4.2%	95.8%	0.8%	2.9%	0.3%	0.2%
Huron	3.7%	96.3%	1.6%	1.5%	0.6%	0.1%
Ingham	13.1%	86.9%	3.4%	3.5%	4.4%	1.8%
Ionia	2.5%	97.5%	1.7%	0.5%	0.2%	0.1%
Isabella	5.7%	94.3%	1.8%	2.4%	0.9%	0.6%
Jackson	3.2%	96.8%	1.5%	0.9%	0.4%	0.3%
Mecosta	4.6%	95.4%	1.2%	2.8%	0.5%	0.0%
Midland	3.6%	96.4%	1.0%	1.3%	1.2%	0.1%
Montcalm	3.6%	96.4%	1.7%	1.3%	0.4%	0.2%
Newaygo	4.9%	95.1%	3.3%	1.2%	0.3%	0.1%
Osceola	4.1%	95.9%	0.9%	2.8%	0.2%	0.1%
Saginaw	4.3%	95.7%	2.2%	1.3%	0.5%	0.3%
Shiawassee	2.2%	97.8%	1.1%	0.6%	0.2%	0.4%
Tuscola	2.8%	97.2%	1.6%	0.9%	0.2%	0.1%

FY23 Health Home Expansion

Certified Community Behavioral Health Clinics

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

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

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

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

As of September 30, 2023, MSHN enrollment in CCBHCs totaled 13,577 beneficiaries.

The CCBHC model eligibility criteria includes:

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

As the demand and services expand across the region, MSHN along with the CCBHCs will continue to monitor sufficient provider capacity.

Opioid Health Home

MSHN successfully implemented the first Opioid Health Home in the region during FY23 in partnership with Victory Clinical Services in Saginaw County. An Opioid Health Home (OHH) is a model of care that provides comprehensive care management and coordination services to Medicaid beneficiaries with an Opioid Use Disorder (OUD). The OHH functions as the central point of contact for directing patient-centered care across the broader health care system. OHH services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. Beneficiaries work with an interdisciplinary team of providers that includes a Health Home Director, Behavioral Health Specialist, Peer Recovery Coach/Community Health Worker/Medical Assistant, Medical Consultant, and Psychiatric Consultant. The OHH model is designed to increase access to health care, reduce unnecessary emergency room visits and unnecessary hospital admissions, increase hospital post-discharge follow up, elevate the role of peer recovery coaches and community health workers in particular to foster empathy, and improve overall health and wellness. Participation is voluntary, and enrolled beneficiaries may opt out at any time.

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

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

As of September 30, 2023, MSHN enrollment in OHH totaled 179 beneficiaries.

MSHN is currently working with 4 providers toward implementation of 5 new OHH locations during FY24. The proposed new OHH locations will expand availability of OHH services to Jackson, Ingham, Isabella, Bay, Clare and surrounding counties.

Behavioral Health Home

MSHN successfully implemented the first Behavioral Health Homes in the region during FY23in partnership with CMH for Central MI, Saginaw CMH Authority, Montcalm Care Network, Newaygo CMH, and Shiawassee Health & Wellness. The Behavioral Health Home (BHH) provides comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. For enrolled beneficiaries, the BHH functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model also elevates the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time.

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

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

As of September 30, 2023, MSHN enrollment in BHH totaled 566 beneficiaries.

MSHN is currently working with Gratiot Integrated Health Network toward implementation of BHH in FY24. Other regional partners have indicated potential interest in implementing a BHH. MSHN will continue to offer support and technical assistance to other regional partners who have indicated potential interest in implementing a BHH during FY24.

Appendix A – CMHSP Delegated Efforts to Expand Service Capacity

BABH

- Continued partnership with the Juvenile Detention Center mental health services for youth and families via Juvenile Liaison position embedded in the local Juvenile Center.
- Expansion of service provider network specific to autism services
- Expansion of ancillary services, Occupation Therapy, Physical Therapy, Speech Language Pathology to meet the needs of toddlers and children receiving ABA services
- Engaging in community outreach with schools, courts, community corrections, and DHS
- Screening children in the Juvenile Court to determine if mental illness exists, to prevent children with mental illness from being involved in the juvenile system.
- Providing school-based outpatient services in Arenac County school district to improve service access for youths and families.
- Collaborating partnership with local DHHS to address t needs of children/families who may be at risk of home removal and/or lack of natural supports due to significant mental health issues.
- Enhancing collaborative partnership with courts, law enforcement, prosecutor, jail, and juvenile center to increase jail diversion activities.
- Conducting EBP survey to focus efforts on increasing availability of multiple EBP's within the BABH provider network.
- Recruitment and retention planning to increase availability of outpatient therapy services and direct care workers.
- Continued collaboration with Arenac County community stakeholders to increase the availability of adequate substance use disorder services in the county.
- Program planning to expand peer support services to include implementation of Parent Support Partner and Youth Peer Mentor.
- Increasing availability of crisis residential services, expected in FY24.

CEI

- Added more therapists certified in trauma.
- Added prevention therapist.
- Added additional hours in the evening to serve youth and families.
- Created a Clinton Truancy Intervention Program.
- Piloting the Therapeutic Foster Care Oregon (TFCO) program, with four homes in operation
- Developed a mobile crisis team and became certified. It includes mobile Parent Support Partners. Added additional teams and days/hours.
- Added additional Telepsychiatry for youth.
- Added additional Evidenced Based Clinicians in TFCBT, PMTO and DBT.
- Provided Signs of Suicide follow up with schools and students in collaboration with Eaton Regional Education Service Agency.
- Continuing to work on the "Tri-County Lifesavers" coalition to address Suicide awareness in tri-county area including development of videos designed for parents who need access to emergency psychiatric care or other mental health services for their child.
- Offered Various Youth Mental Health First Aid courses.
- Introducing QPR training opportunities to the community.
- Convened a community group in a local community to address increased suicide rates of your adults from their community.
- Offering Transitional Youth Services.
- Hosted another Children's Mental Health Awareness Event.

- Trained additional staff on Critical Incident Stress Management, expanded the CISM Team and responded to multiple organization and community events.
- Implemented Care Coordination projects in clinical programs addressing asthma, hypertension, hepatitis, diabetes, and high Emergency Department Utilization.
- The Information Integration Committee developed and refined a Care Coordination Document for improved coordination with primary care physicians and continued to increase the knowledge, understanding, and use of health-related data for care coordination across the organization.
- Worked with Tri-County Crisis Intervention Team Steering Committee to implement additional rounds of 40 - hour training sessions for Officers. Over 200 Law Enforcement Officers from across Clinton, Eaton, and Ingham Counties were trained as of 2019.
- Continued to provide and expand various points of entry into services through Primary Care Physicians; Crisis Services and Crisis Response Team and Urgent Care/Emergency Rooms as well as the maintenance of several positions with navigator responsibilities such as the Veterans Navigator, Youth Prevention Therapist, Peer Recovery Coaches and Central Access Staff Outreach.
- Continued expansion of Access Department outreach for assisting consumers with SUD to locate appropriate level of treatment; addition of Recovery Coaches for Admission, Transfer and assisting individuals in their effort to get to treatment programs, working with the local Provider Network on admissions and transfers.
- Continue providing Naloxone Kits at three CMHA-CEI SUD programs and to law enforcement agencies in each county with assistance from the PIHP.
- Participation on the MAT Team with Ingham County Health Department and Ingham County Sheriff Department on bringing MAT services to the jail.
- Partnering with Ingham County Sheriff on the Rapid Response Team to provide immediate access to treatment services to individuals who have experience a recent drug overdose.
- Provide ongoing follow up to the Sequential Intercept Mapping project held in 2017 resulting in the development of reentry services for each county jail targeting special needs populations.
- Continued collaboration and expansion of work with Lansing Landlords to house consumers with mental illness
- Added additional Applied Behavioral Analysis provider contracts to increase capacity to meet demand.
- Secured a Certified Community Behavioral Health Clinic Expansion Grant to expand care coordination and healthcare integration efforts.
- Continue working with Sparrow Hospital emergency department (ED) to assist in reducing beneficiary time spent in the ED.
- Increased psychiatry staffing for children and adults
- Increased staffing in homebased staff
- Increased staffing in children's crisis services
- Increased staffing and streamlined intake process across all clinical programs
- Added daycare expulsion program
- Added additional providers for CLS/respite services
- Increased nursing staff
- Added an after-hours clinic for mild/moderate population
- Expanded adolescent services
- Summary of gaps in services or need:
- *Feedback from Community Services for Developmentally Disabled (CSDD):*
- Remain unable to keep up with requests for Autism screening due to lack of qualified assessors in the region (positions are funded, unable to hire).
- Despite delays in assessing individuals, we've been able to connect more individuals to Autism services and have adequate provider capacity. But we in turn need more clinicians and support staff

to appropriately coordinate and monitor those increased services and compliance with MSHN standards.
- Recognize a need for an increased number of case managers within the Family Support unit (to facilitate the growing demand for intakes and, in part, as tied to the coordination of Autism services).
- Increased capacities (i.e. funding in place) for enhanced children's crisis support, family training, directly supported CLS, etc., but unable able to hire anyone to fill these positions, and in fact are losing staff.
- Recognize a need for more highly specialized, behaviorally oriented, residential care providers in the region. We lack providers who can address acuity needs appropriately, as well as overall demand for this support type in the region.
- *Feedback from Adult Mental Health Services (AMHS):*
- Need to build out adult crisis mobile and secure staffing/therapists. CMHA-CEI is working on a CSU.
- *Feedback from Quality, Customer Service, and Recipient Rights (QCSRR):*
- Need to focus on timeliness from inquiry to assessment and from assessment to start of service (PIs 2a and 3).
- *Feedback from Families Forward:*
- Need for Mental Health Therapist to provide Evidence Based Treatments, CLS/Respite providers and Psychiatry.

CMHCM

Services for Individuals with SUD/COD

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

Direct Care Worker Recruitment/Retention

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

Alternatives to inpatient psychiatric services

- We have strengthened our crisis intervention team to maintain our good outcomes with a high diversion rate

- We have contracted with more children and adult CRUs
- We used a consulting firm to do a feasibility study on bringing a CRU to our catchment area and did outreach with neighboring CMHSPs for potential partnerships
- We are working with local hospital system on potential arrangements for individuals who need care for symptoms related to SUD

Integrated healthcare and health outcomes

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

Ease of access to MH care

- We are looking at potential ways to improve our access system to be more consumer-friendly
- We have defined which individuals that will be opened using GF when Medicaid is not available
- We have done outreach to local providers, including universities, law enforcement, hospitals, EDs, community colleges to educate them about CMH services
- We have identified space in the community where we can see consumers afterhours to reduce unnecessary ED visits and for pre-booking jail diversion
- We are exploring other technology options to improve access to crisis services for individuals who do not have a telephone
- Piloting the early launch of the Michigan Child and Adolescent Needs and Strengths Tool ahead of full implementation.
- We offer up to 4 therapy appointments for anyone in the community regardless of eligibility through GF – and it often results in it turning out they do meet eligibility so we can refer them through
- We have increased our marketing efforts
- We are establishing a workgroup to develop more group therapy to be able to offer more group only treatment for individuals and expanding our service array.
- We have partnerships with several schools where we screen kids and can refer them for treatment ongoing if it appears needed.

GIHN

- Co-Located Clinician in local Schools
- Co-Located Clinician providing Therapy at Child Advocacy
- Nurse Practitioner located at St. Louis satellite office providing physical health care services
- Co-located clinician in the court system and jail
- Partnered with law enforcement to implement use of ipad screening capability for officers

- Co-located clinician in the Emergency Department (expanded to 2FTE)
- Member of the Great Start Collaborative
- Health Department co-located in the St. Louis medical clinic providing WIC and immunizations.
- Contract with local Dial A Ride to provide transportation for services
- Trained community members in Adult and Youth Mental Health First Aid.
- Participates in back-to-school events.
- Addition of FASD Screening at Access
- Critical Incident Stress Debriefing Team
- Member of School Safety Alliance
- Contract with ACMH for a Youth Peer Support 20 hours per week
- Increase use of Mobile Children's Crisis through community education
- Collaborate with Gratiot/Isabella RESD and FQHC to utilize 31n funding to increase behavioral health in schools
- Promote and increase consumers served for MAT, and provide Narcan to community
- Support staff SUD training and increase the number of staff with CADC and CAADC
- GIHN Service Committee continue reviewing high crisis and hospitalization service
- Collaborate with Court, Jail etc. for treatment of juvenile and adults in legal system
- Enhance the GIHN Integrated Health Committee activities
- Increased utilization of Wrap Around services through targeted community partner education
- GIHN became a Behavioral Health Home

HBH

- Participate in the Great Starts Collaborative; composed of many providers in the community that work with families and children to provide support and education to parents
- Active in community events where outreach to families can occur to assist with education and linkages to needed services or supports to strengthen parenting skills
- Have an active Wraparound program
- Expansion of Autism services and working with contractual provider to increase the timeliness and meet the increased demand for ABA and evaluative services.
- We screen for trauma in each clinical program and have completed an organizational self-assessment on trauma-informed care capabilities.
- Continuing work with MSHN on care coordination for high utilization cases, and have developed clinical tracking projects for persons with diabetes and cardiac issues
- Continuing promotion of staff training in TF-CBT, PMTO, DBT and FPE
- Have a Children's Intensive Mobile Crisis Team available for families
- Participate in on-going meetings with DHHS, court staff, ISD, attorneys and Prosecutor staff to improve cross-agency collaboration on shared children/ family cases.
- Staff and community partners have been trained on Trauma Informed Care and screening
- Have an active Wrap-around collaborative
- On-going training for community members on the use/application of Naloxone and distribution of rescue kits
- Trained community partners, and community-at-large members in Youth Mental Health First Aid
- Federally Qualified Health Center co-located at HBH for one-half day per week
- Provision of same day/next day service

LCMHA

- Increased the availability of BHT services to meet the needs of the Autism expansion
- Has a Prevention & Wellness Program including participation on the Jackson Substance Abuse Prevention Coalition, which includes the Most Teens Don't effort
- Partner in the Intermediate School District Project AWARE, bringing Youth Mental Health First Aid to school staff and establishing mental health supports in into pilot schools; includes a Teen Advisory Team, committed to breaking down the stigma of seeking mental health supports
- Facilitating Youth Mental Health First Aid for the Community-at-large
- Participated in the iChallengeU by South Central Michigan Works where students were tasked with providing strategies to help teens engage in services when needed
- Children's ICSS is operational; adult mobile crisis available in place of ICSS

MCN

- Initiative to provide community training in Mental Health First Aide Training for Youth
- Implementation of SAMHSA Drug Free Communities Grant with focus on prevention of underage substance use
- Expansion of Medicaid Autism services benefit
- Implementation of integrated health services for children with serious emotional disturbances
- Expansion of TF-CBT services including training addition clinicians and partnering with DHHS on the parenting group to target children in foster care.
- Participating in Trauma-Informed Community initiative to raise awareness about the impact of ACEs and identify children and families in need of support.
- Expand number of children's clinicians trained in EMDR.
- Partner with local ISD under 31 N funding to bring additional mental health services into the school districts.
- Expand 31 N funded mental health services in the local school districts
- Initiate an IDDT program including a medication assisted treatment component
- Implement HIV and Hep C testing for at risk persons
- Continue to refine implementation of Patient Activation Measure and Coaching for Activation to improve outcomes in integrated health services
- Implement CE-CERT with clinical and support staff
- Expand trauma-informed community initiatives specifically targeting the legal community and faith-based community
- Expand community prevention efforts including Mental Health First Aid and Narcan distribution
- MCN became a Behavioral Health Home
- MCN's focus this past year has been on expanding capacity to provide services by leveraging the workforce that is available in our community.
- We have introduced new models that incorporate bachelor and paraprofessional staff into departments.
- In Home-Based, we expanded caseloads of master level clinicians but partnered them with Bachelor level staff to manage the case management and skills training functions
- In Case Management we also expanded caseloads and added support coordinator assistants at the parapro level.
- In our Access department, we have shifted billing to General Fund and employed bachelor level staff with oversight of a Master Clinicians.

- In Mobile Crisis, we added bachelor staff
- We have sought out grant funding to grow staff including MHBG to create and hire an IDDT team and MI Kids Now MC funds for bachelor positions
- We have added multiple contracts to expand access to care in areas that include Specialized Residential, Inpatient, and Autism services

NCMH

- Participating in community collaborations, such as NC3, wraparound, Families Together, and Headway for Substance Abuse (NCMH staff chairs Headway committee).
- Part of the Great Starts Collaborative; composed of many providers in the community that work with families and children to provide support and education to parents.
- Active in community events where outreach to families can occur to assist with education and linkages to needed services or supports to strengthen parenting skills—including annual participation in Tools for School Event, Family Expo, Health & Wellness Expo, Training provided to all area Head Starts in the county (includes parents and Head Start staff).
- Have a youth team staff designated as a liaison between CMH and DHHS specific youth services. CMH staff attends monthly staff meetings for foster care and protective services staffs at the local DHHS office and educates on CMH services, the referral process, assists with the SED waiver enrollment.
- Have a contract with juvenile court to provide home based services to adjudicated children in the court system who do not have Medicaid and would not typically qualify for CMH services.
- Facilitating Youth Mental Health First Aid for the Community-at-large.
- Have an active Wraparound program and have hired an additional (full time) wraparound facilitator to meet the increased demand of referrals to this process.
- Developed a pilot program to offer “Breaking the Silence” curriculum in the upper elementary, middle, and high schools (taught in gym and health classes) within Newaygo County to education community youth about mental health issues and help to reduce stigma.
- CMH staff is a member of the Teen Pregnancy Prevention Initiative recently started in the county.
- NCMH participates in local Families Against Narcotics (FAN) chapter.
- Newaygo CMH became a Behavioral Health Home.

SCCMHA

- Implementation of Mental Health First Aid throughout the community and continued promotion for participation of all community members in the identification of persons who may require mental health services.
- Currently offering Mental Health First Aid trainings monthly both Youth and Adult. Offer Mental Health First Aid training to Law Enforcement and Fire and Rescue personnel.
- Continue to participate in collaborative projects such as the MiHIA regional Opioid Taskforce, the regional Neonatal Abstinence Syndrome project and PA2 prevention project for distribution of Naloxone.
- Working with local resources to improve admission referral acceptance and to diversify crisis response options.
- Expand current Mobile Response and Stabilization Services to extend hours of service.
- Working with the Saginaw Police Department to roll out our crisis connect program.
- SCCMHA continues to educate and review behavioral assessments and intervention process through the new QI workgroup.
- Working with consumer stakeholders in focused access assessment and quality improvement projects.

- SCCMHA provides transportation to and from mental health appointments. However public transportation for all other daily life activities remains limited in this county. We will work with Alignment Saginaw the Saginaw Human Services Collaborative body to explore ways to improve access to transportation.
- Initiated a work group to impact the boarding of consumers in hospitals by working with two area hospitals to improve consumer wait time for hospital admissions.
- Data from our newly created Access and Stabilization for Children team (ASC), revealed significant increase in family engagement in services.
- Movement to value-based purchasing for supported employment.
- We continue to provide respite services to support families.
- Participation in Child Parent Psychotherapy (CPP) training cohort. This is an intervention model for children ages 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including PTSD.
- We added Eye Movement Desensitization as an evidence-based practice.
- Improve our presence in Saginaw Community Schools to assist youth with mental health concerns with Co-located therapists.
- Participated in CCBHC expansion grant.
- Currently participating in CCBHC demonstration grant with MSHN.
- Continue to have a co located primary healthcare clinic.
- Have co located laboratory services to accommodate transportation barriers for persons served.
- Have hired a Veterans Navigator.
- We have a Hispanic Outreach Worker to bridge the gap to services.
- Saginaw CMH became a Behavioral Health Home.

SHW

- Engaging in community outreach with schools, courts, community corrections, and DHS
- Participating in the Great Start collaborative and health and human services coalition
- Board representative for Child Advocacy Center
- Partnership with Shiawassee Community Health Center (Patient-Centered Medical Home) providing integrated health care in both the primary care setting and behavioral health setting
- Same-day Access
- Added Telehealth services
- Added ABA contract provider
- Partnership with DHS in providing continuing education for foster parents
- Partnership with the ISD and other community agencies in providing trauma-focused care
- Co-located early childhood staff with ISD, DHS, public health, early on
- Added Mobile crisis teams for adults and youth
- CISM team available to primary and secondary schools if needed
- Increased the availability of BHT services to meet the needs of the Autism expansion
- Robust respite program for children
- Participating in TF-CBT
- Efforts to expand service capacity for families and children to increase the number accessing services, as identified in the community needs assessment
- SHW became a Behavioral Health Home

TRD

- Have 2 full-time School Outreach Workers to increase the collaboration and referral rate from schools
- Partnered with Ionia Schools and have one master's level staff providing social work services to three Ionia elementary schools and Ionia Middle School.
- Participate in Great Start Collaborative in Ionia County in the executive meeting and on the full board meeting.
- Participate in School Readiness Advisory Council.
- We are providing ABA services to Montcalm Care Network.
- The Right Door has three homegrown BCBAs and have two BCBAs that came to us with their credentials. We have one person in BCBA in training.
- Providing screening at the courthouse to juvenile offenders.
- Child psychiatrist provides consultation to primary care providers and provides his personal cell phone number.
- Are a licensed child-placing agency.
- Provide treatment foster care.
- We have staff trained in and providing TF-CBT, Nurturing Parenting, Parenting Through Change and Love and Logic. PMTO and TRAILS provided in schools through School Outreach and School-based social workers. Child-Parent psychotherapy cohort certification.
- We are an active participant in the Children's Advocacy Center for Montcalm/Ionia Counties.
- Extensive collaboration with DHHS to provide coordination of care for children aging out of the Foster Care system.
- Directly providing Children's Mobile Crisis for Ionia County.
- Participate in ICAN (Ionia County Council for the Prevention of Child Abuse). Parent partner available to families being served.
- Provide outreach at numerous housing complexes in Ionia County.
- Participate with the Ionia County Substance Abuse Coalition.
- Executive committee member of the Ionia County Community Collaborative – the social services collaborative expanding service understanding and referrals.
- Became a provisionally certified CCBHC and expanded service providers in outpatient therapy, access, added care coordinators, nursing staff and peers.
- Hold monthly meetings with local DHHS Partners
- Hold monthly meetings with Ionia ISD and Local school administrators.
- Participate in school safety committee
- Hosted a booth for kid's day at Ionia County Fair – Kids yoga and coping mechanism card handout
- Participate in Family Support and Wellness Committee
- Participate in local interagency coordinating council
- Added Youth Peer Services
- Expanded number of intake clinicians to prepare for CCBHC expansion
- Expanded number of outpatient clinicians to prepare for CCBHC expansion
- Mental Health First Aid- two staff providing this training.
- Parent support partner providing services.
- Outreach at community events to families.

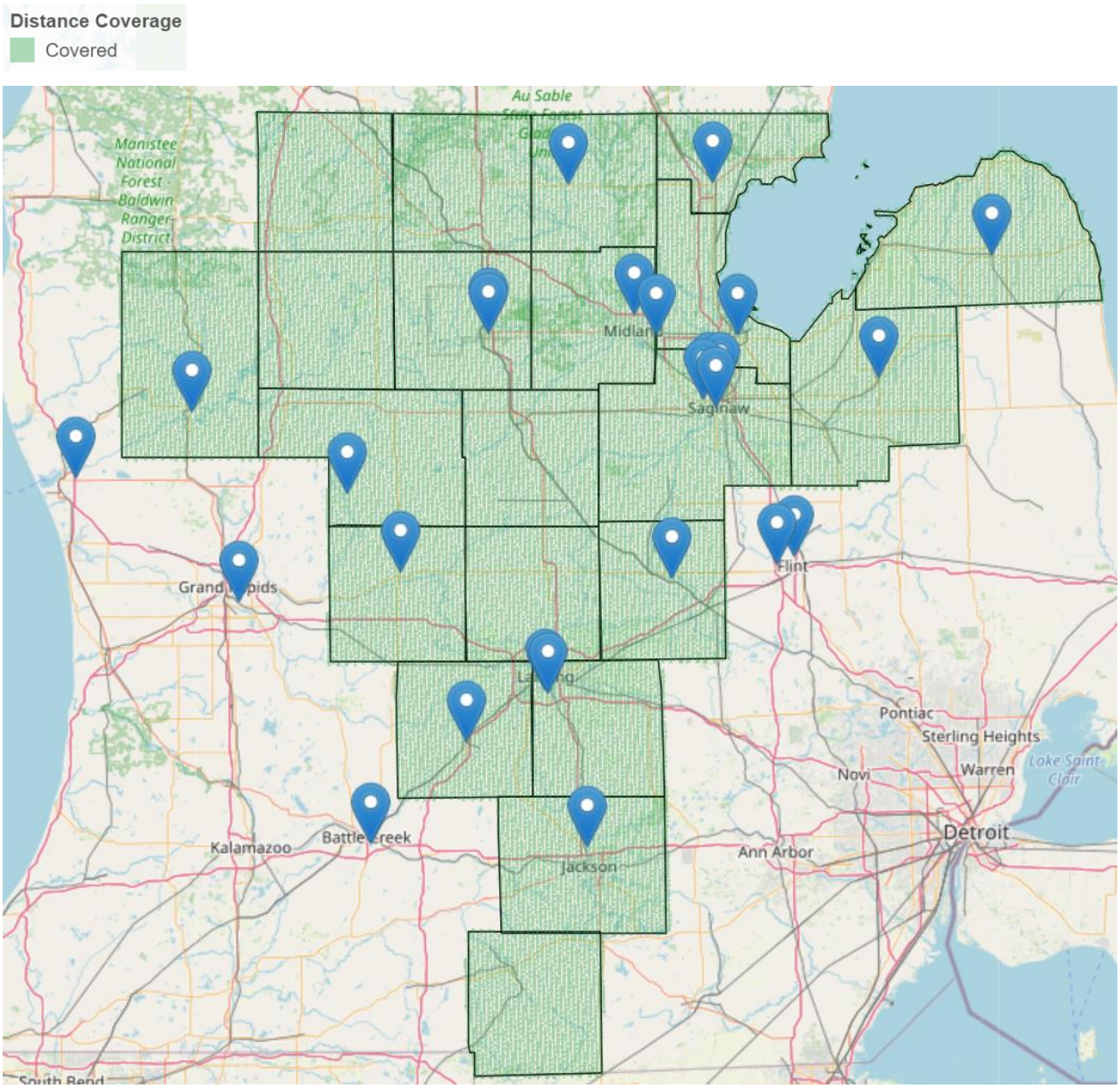
TBHS

- Participate in Great Start Collaborative as well as subcommittees providing education, support and services to children and families.
- Participate in a court collaboration process which primarily focuses on multi-agency involvement in providing services to children and families.

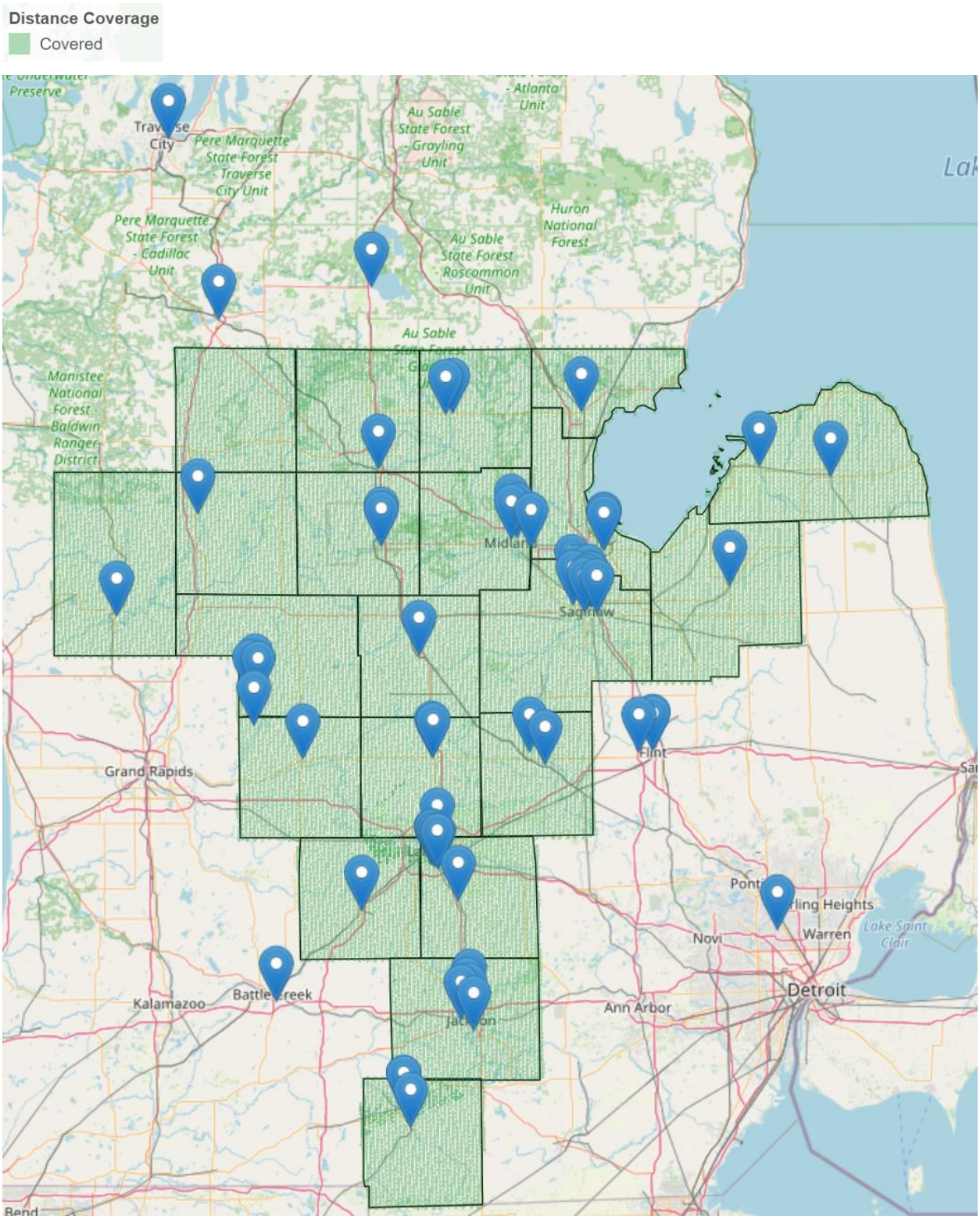
- Participating in multiple EBPs such as PMTO, PTC, TF-CBT, TF-CBT Caregiver Education (which has also been offered externally as a part of prevention services).
- Active in community events where outreach to families occurs.
- Provide ongoing presentations and education as requested by community agencies (local hospitals, DHHS, courts, etc.).
- Active in Child Death Review Board to evaluate service delivery as well as services offered, gaps, etc. to assist in preventing county wide child deaths.
- Have two staff trained in Mental Health First Aid Youth with one more scheduled for training.
- Participating in a prevention group called Start Now which primarily focuses on providing services to children and families despite eligibility criteria, as well as looking at a trauma informed work force.
- Continued services with the Parent Support Partner to work with parents.
- Continued Intensive Crisis Stabilization Services for Children.
- Additional staff have been trained in various Evidence-Based Practices for children.
- TBHS participates in case consultation meetings with Tuscola Probation every six weeks as it relates to coordinating treatment and care for children.
- TBHS continues with the contracts with the four ABA providers, with two clinic-based and two home/community-based providers.
- Added two additional ABA providers in 2023.

Appendix B – MSHN Drive Time Analysis

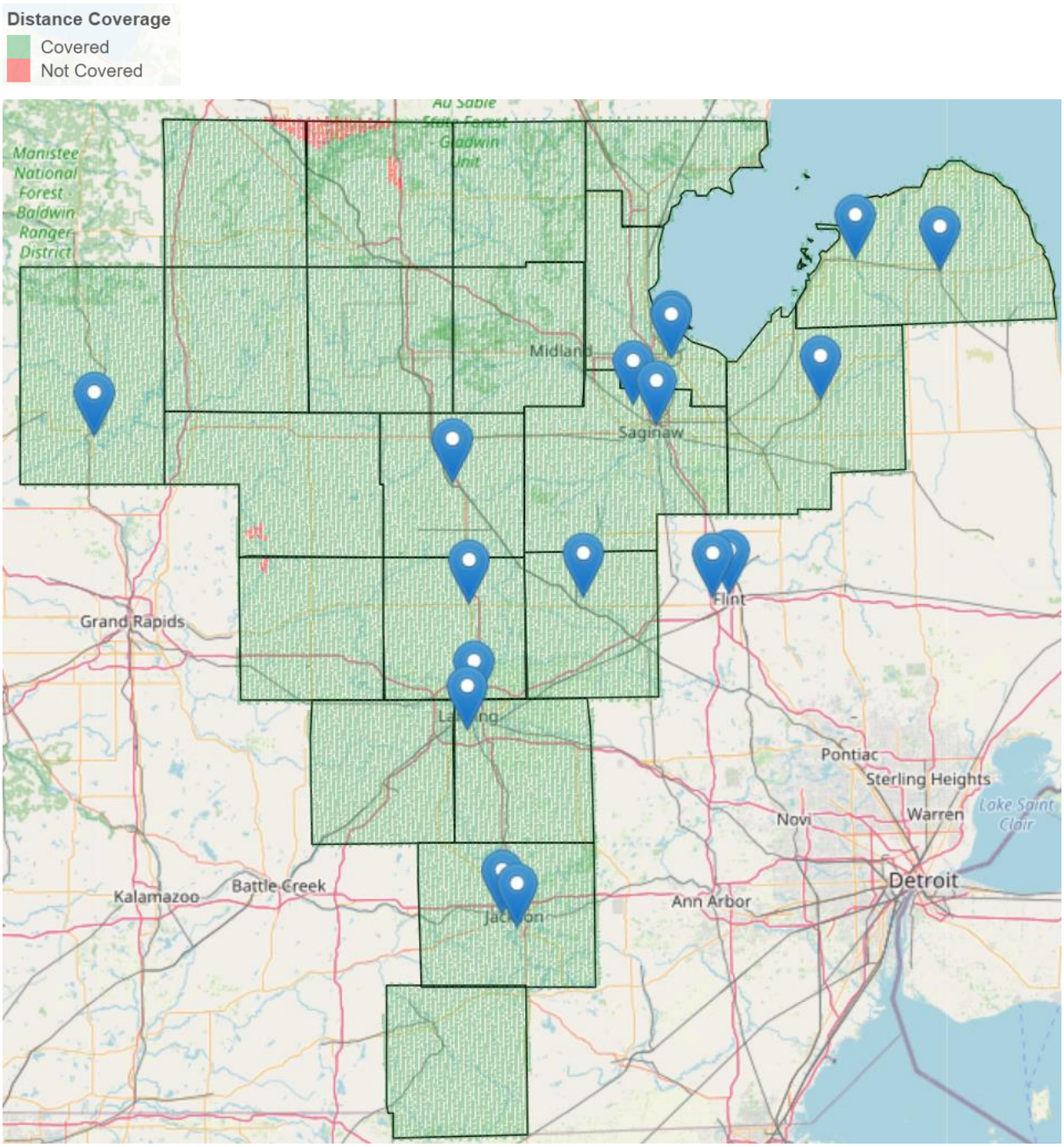
Medication Assisted Therapy – 100% of Population Covered



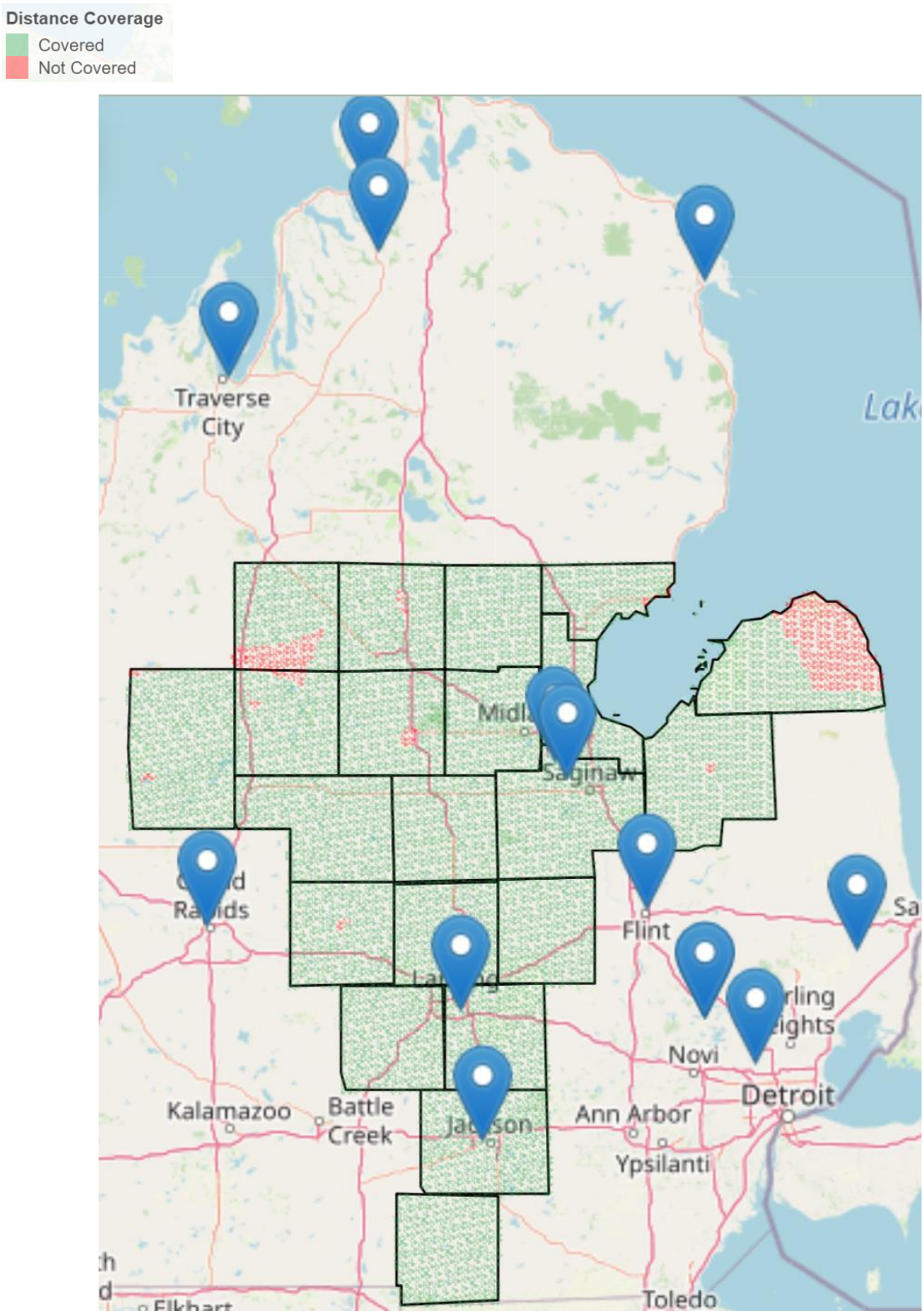
Outpatient Therapy – 100% of Population Covered



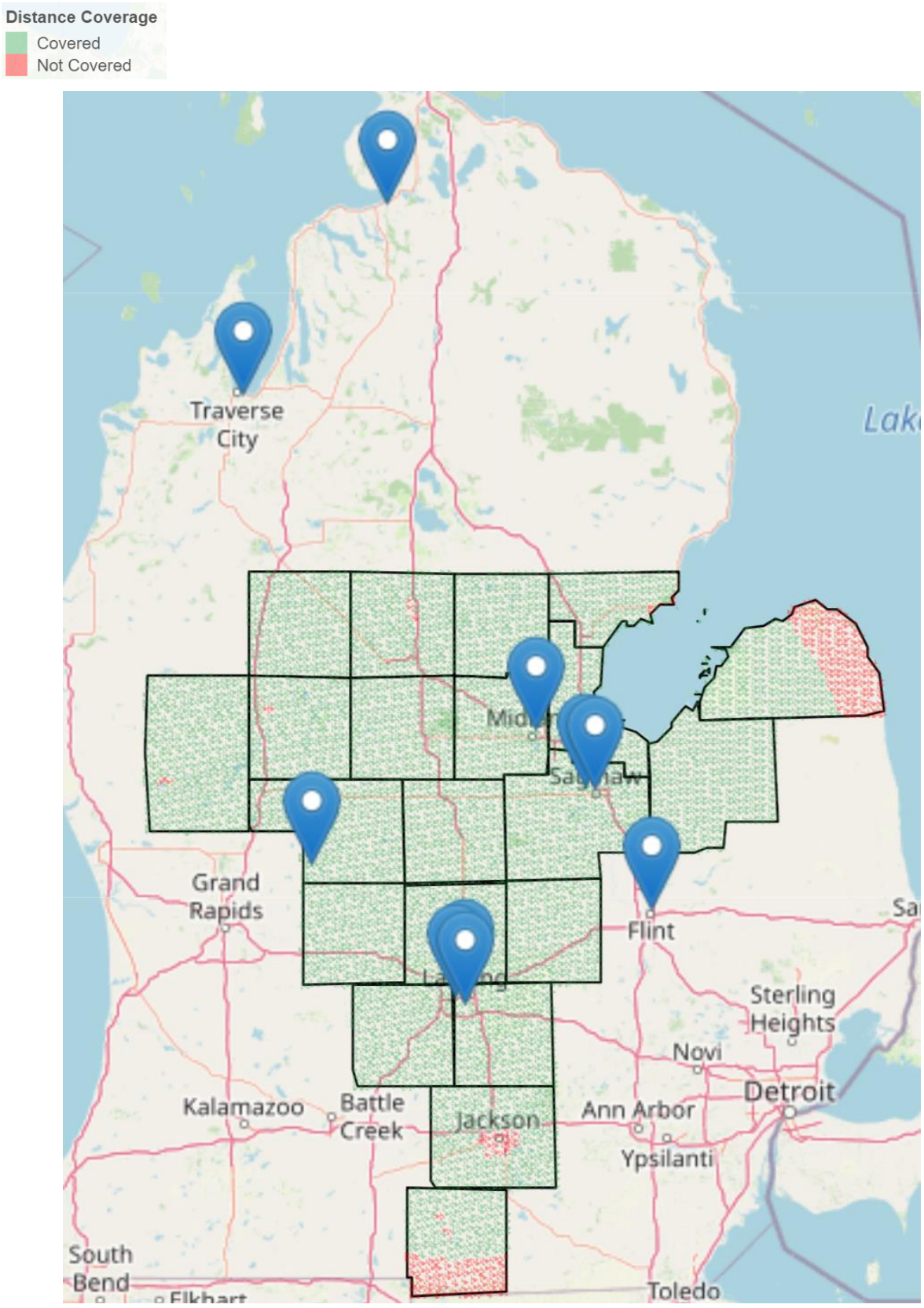
Early Intervention – 99.3% of Population Covered



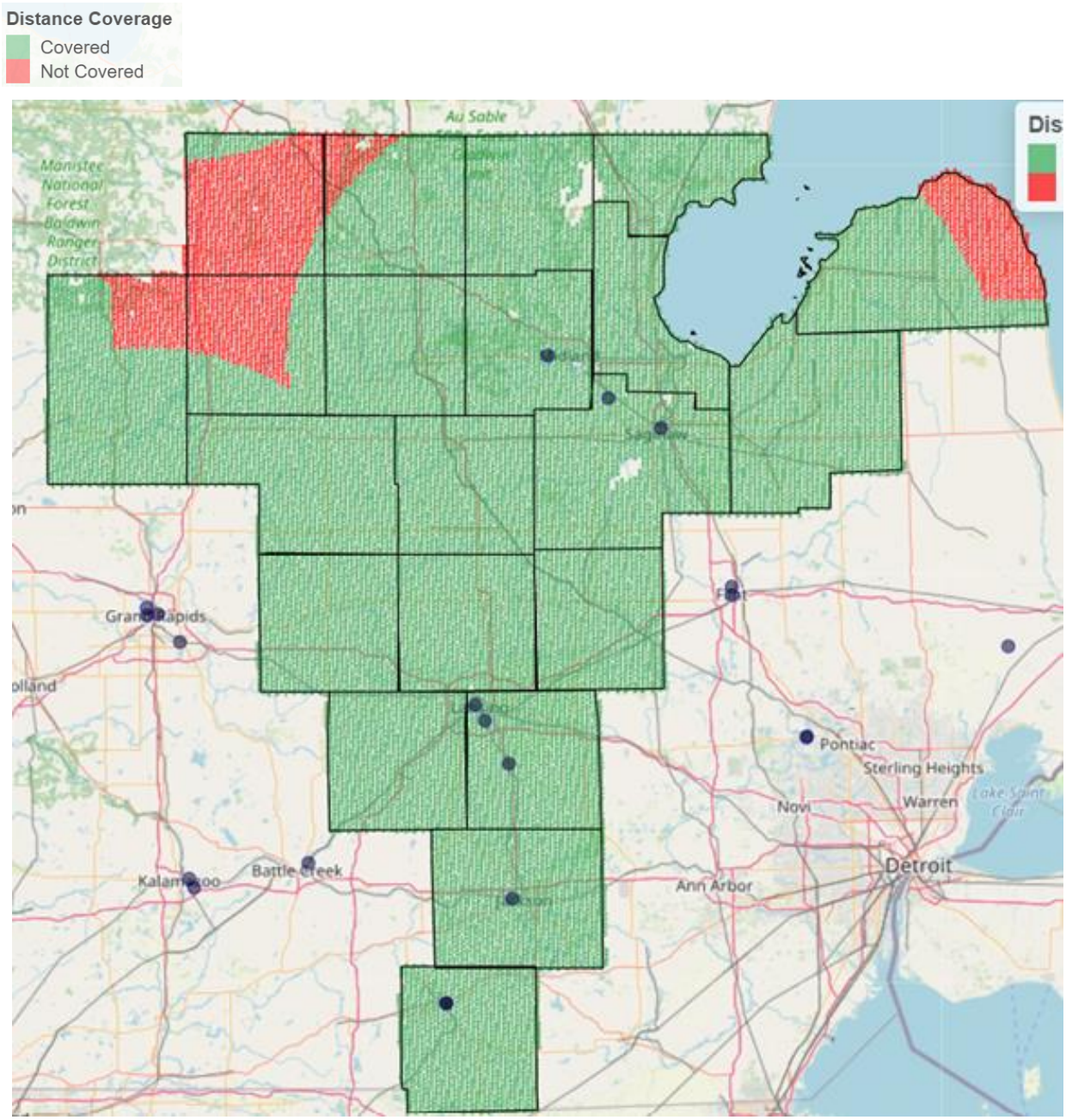
Withdrawal Management – 99.7% of Population Covered



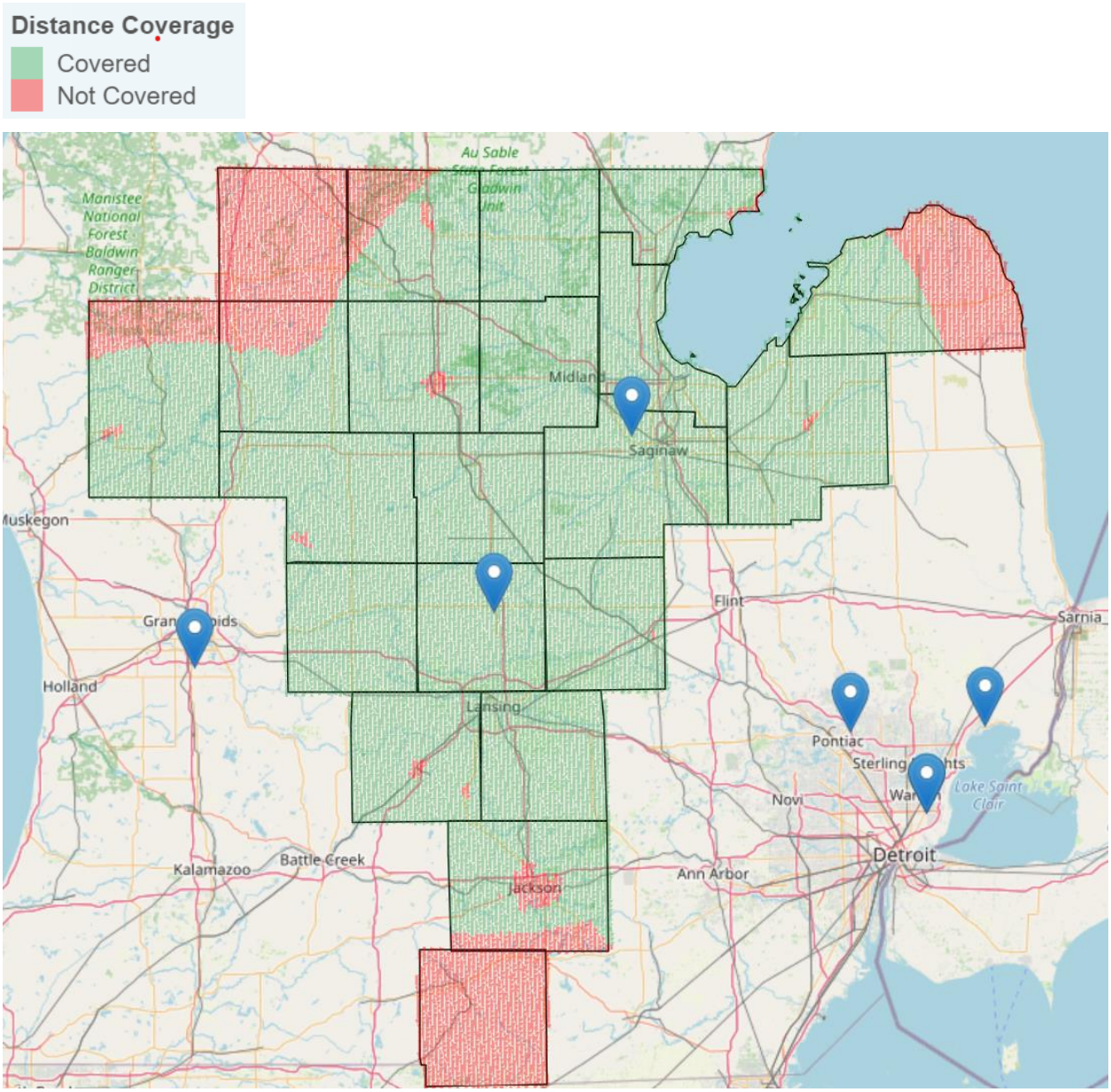
Recovery Residence (Residential) – 94.9% of Population Covered



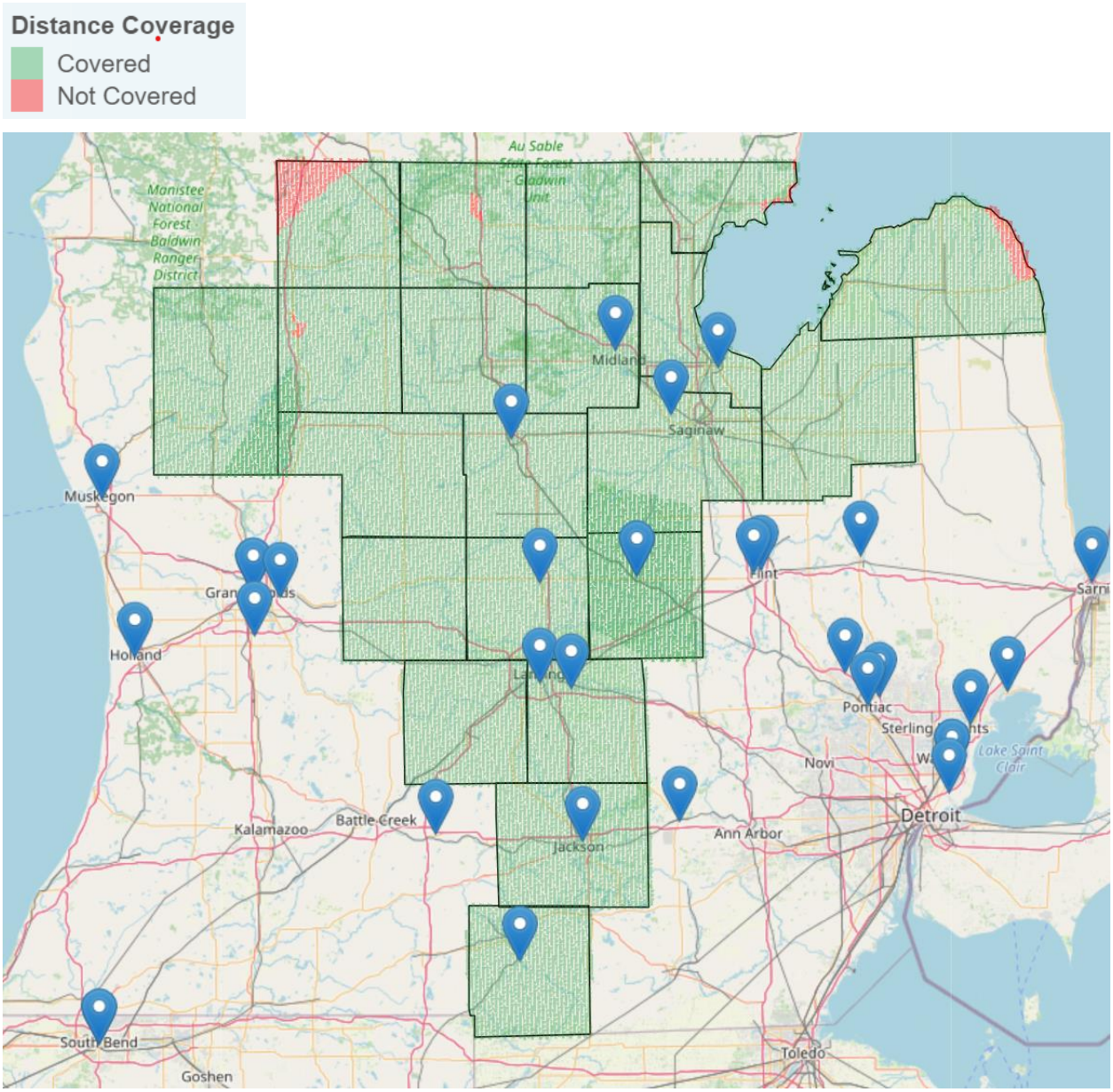
Residential Treatment – 95.5% of Population Covered



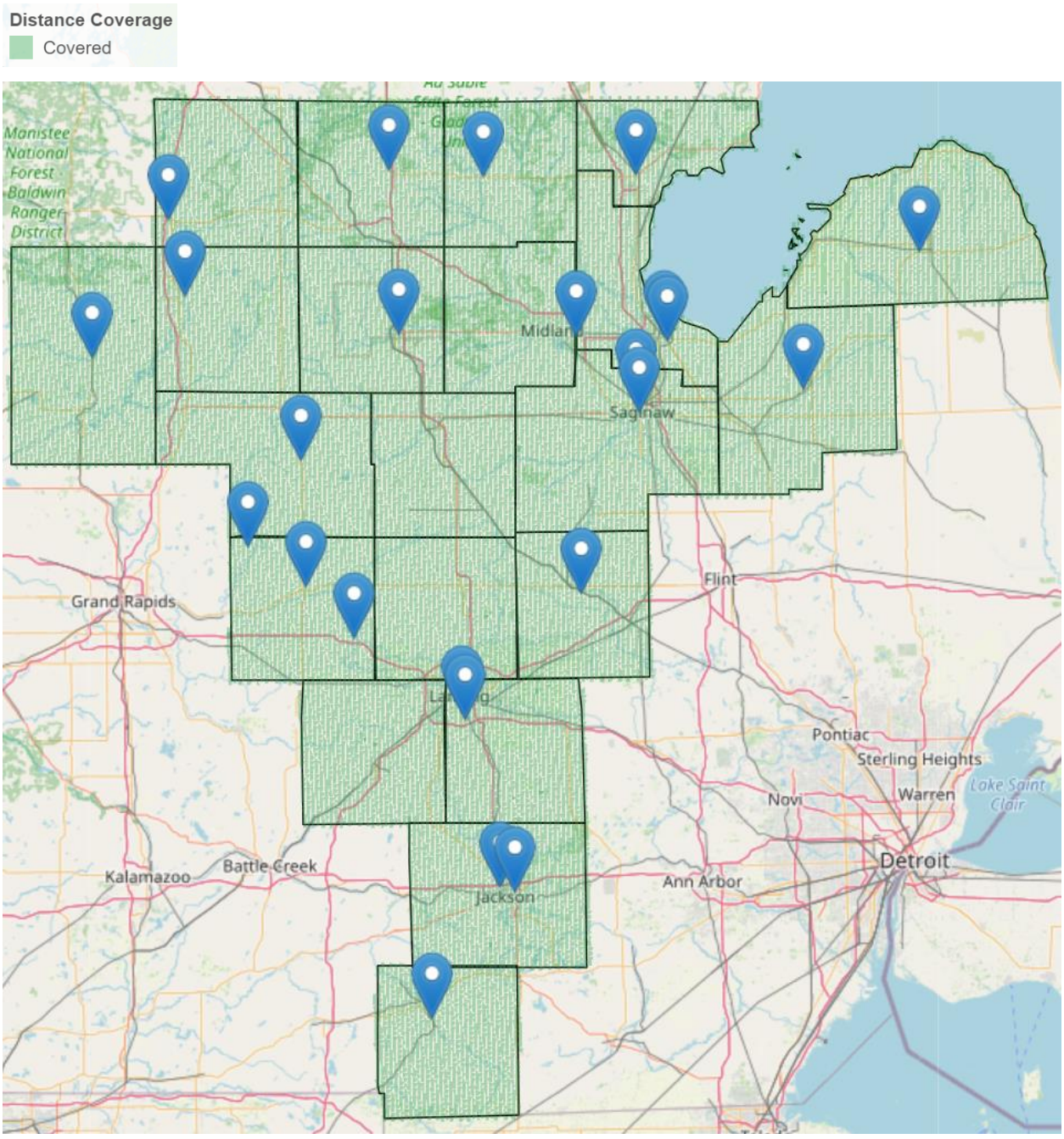
Child Psychiatric Inpatient – 86% of the population covered.



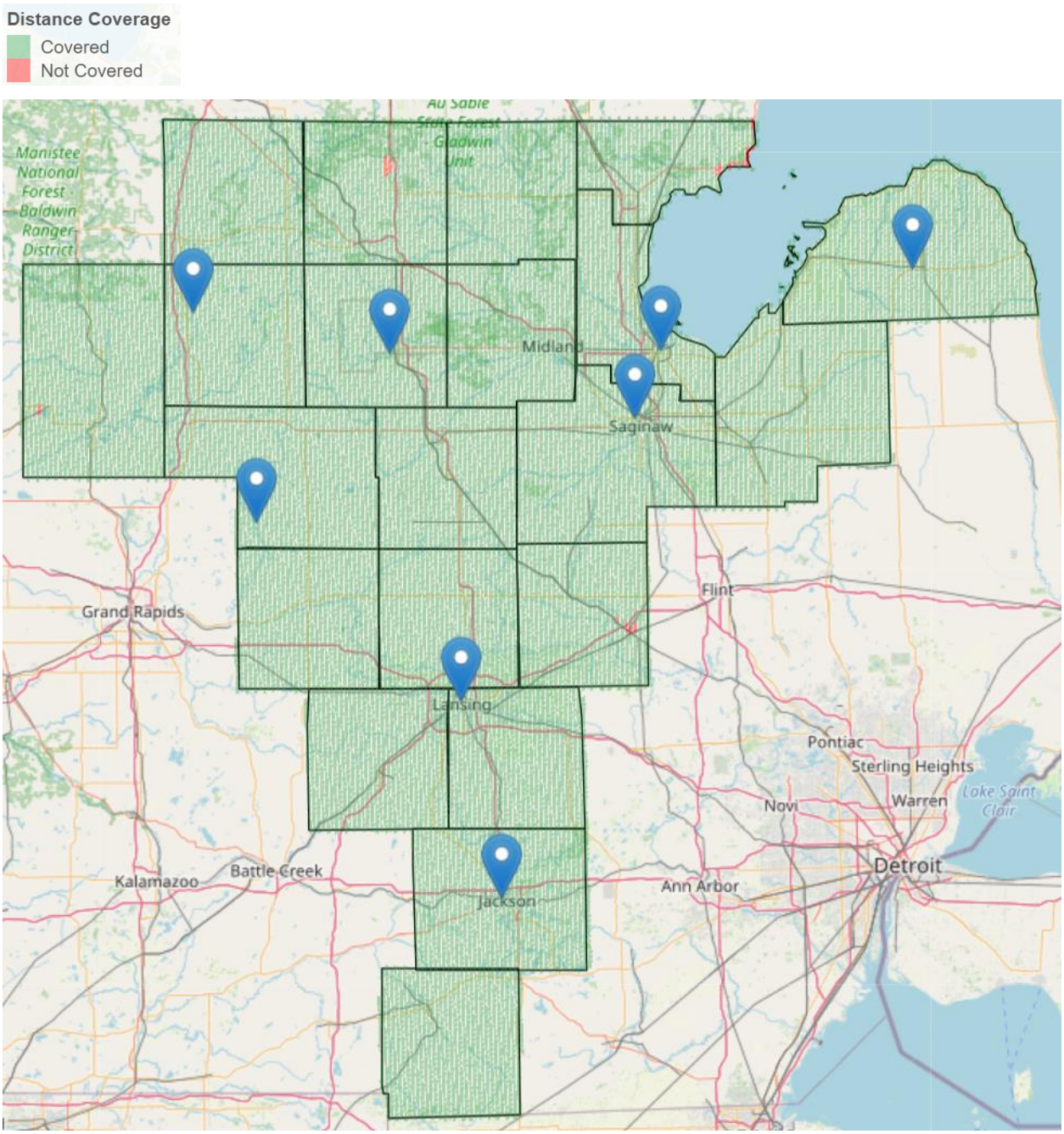
Adult Psychiatric Inpatient – 99% of the population covered.



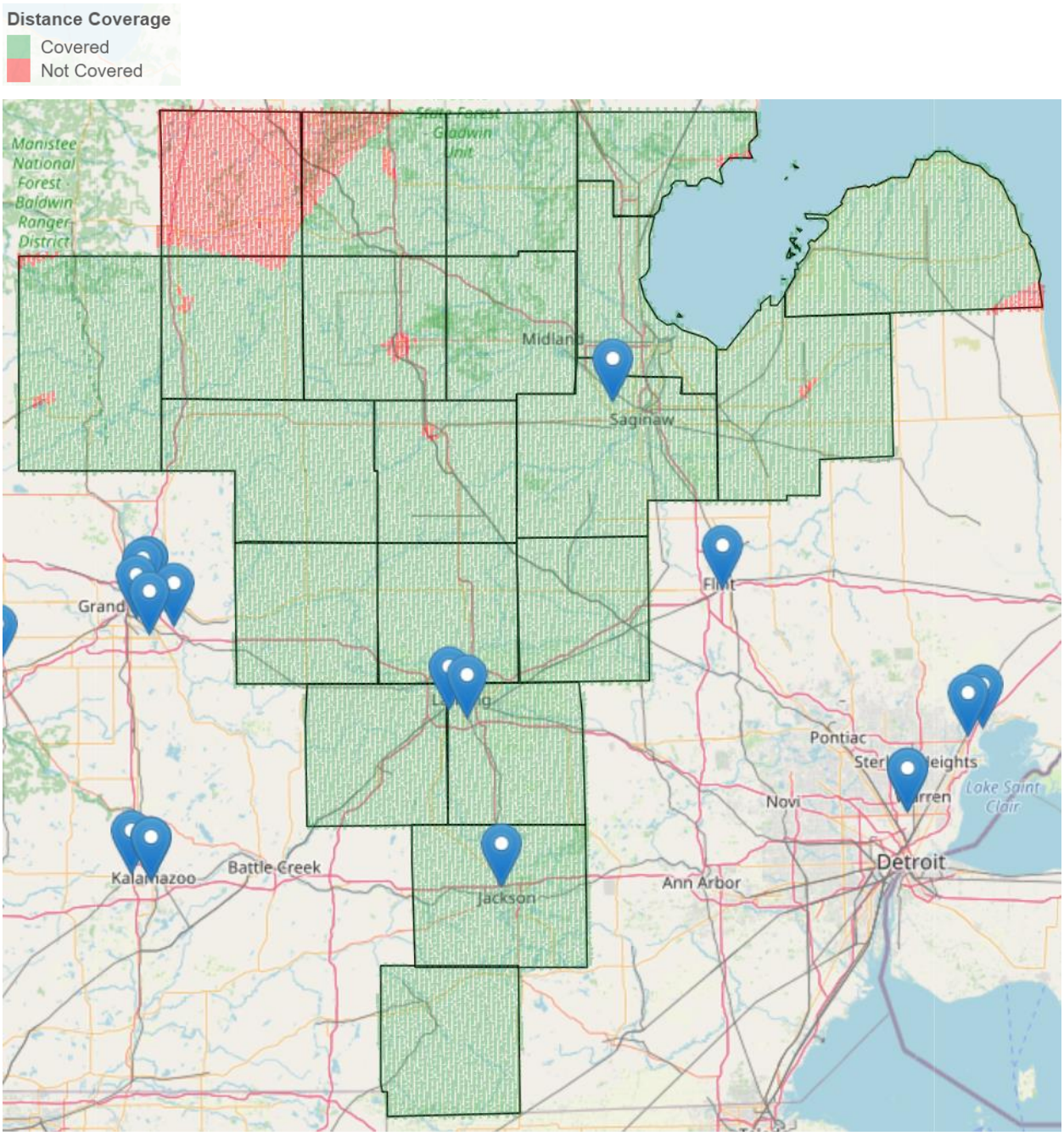
Assertive Community Treatment – 100% of Population Covered



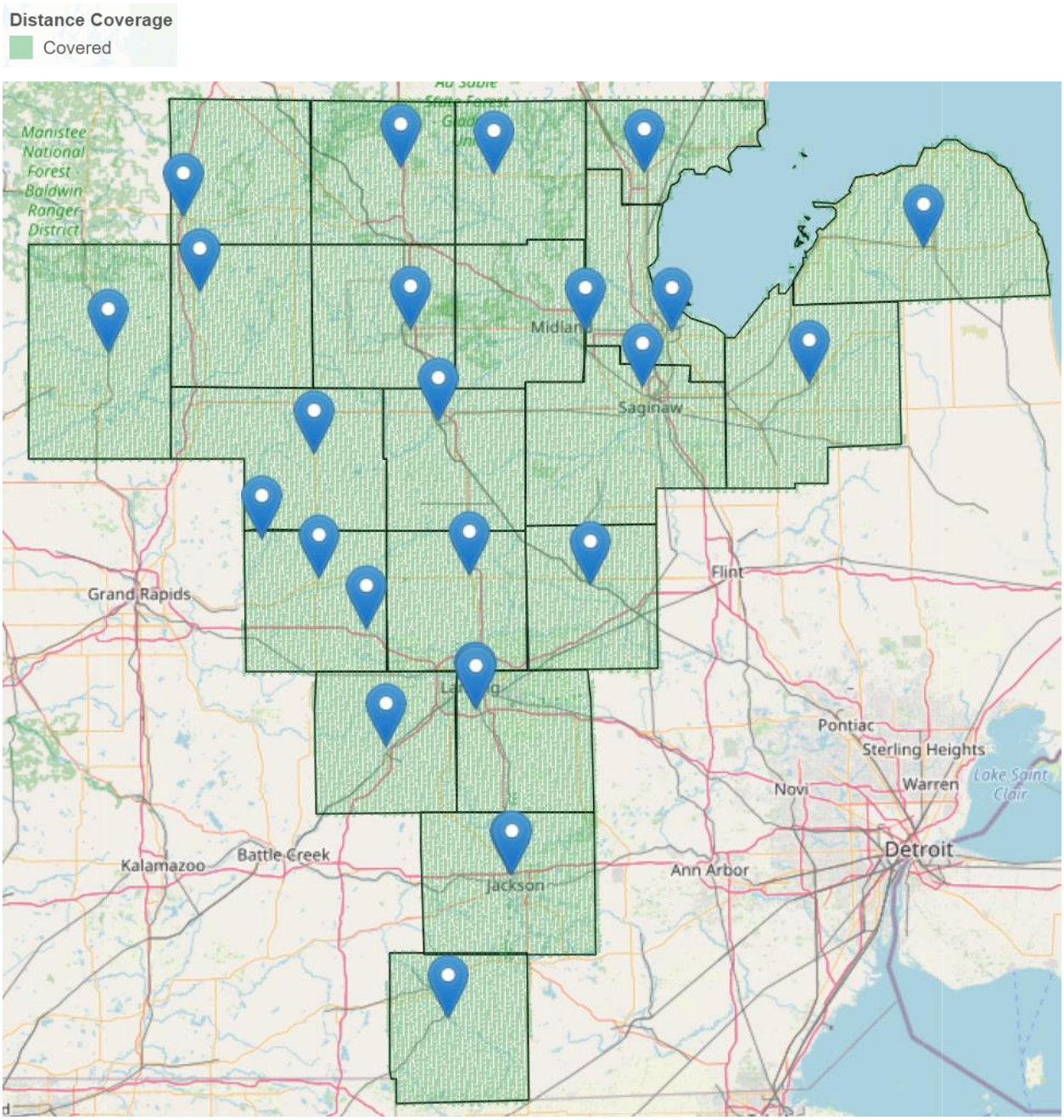
Clubhouse – 99.63% of Population Covered



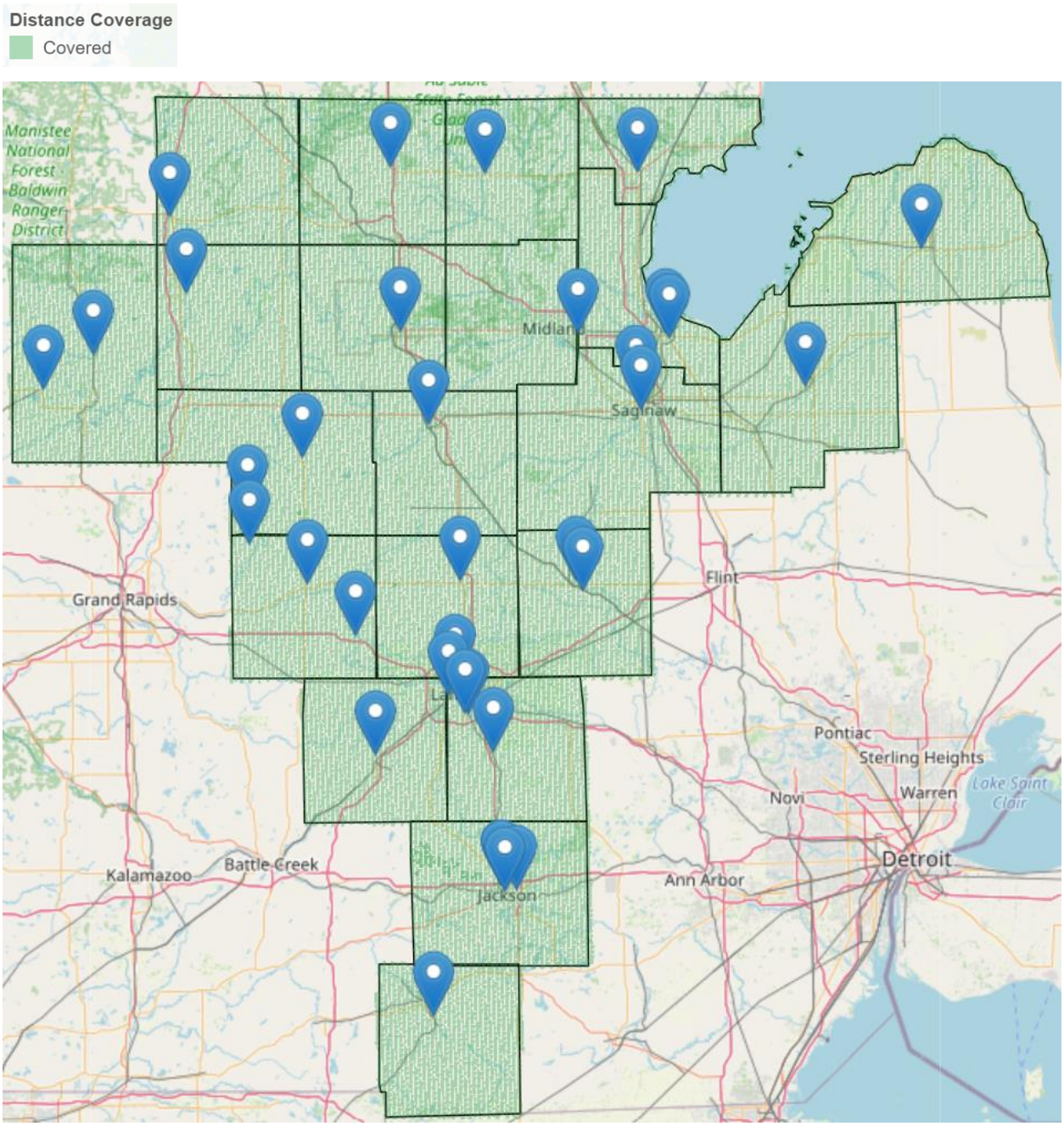
Crisis Residential – 95.19% of Population Covered



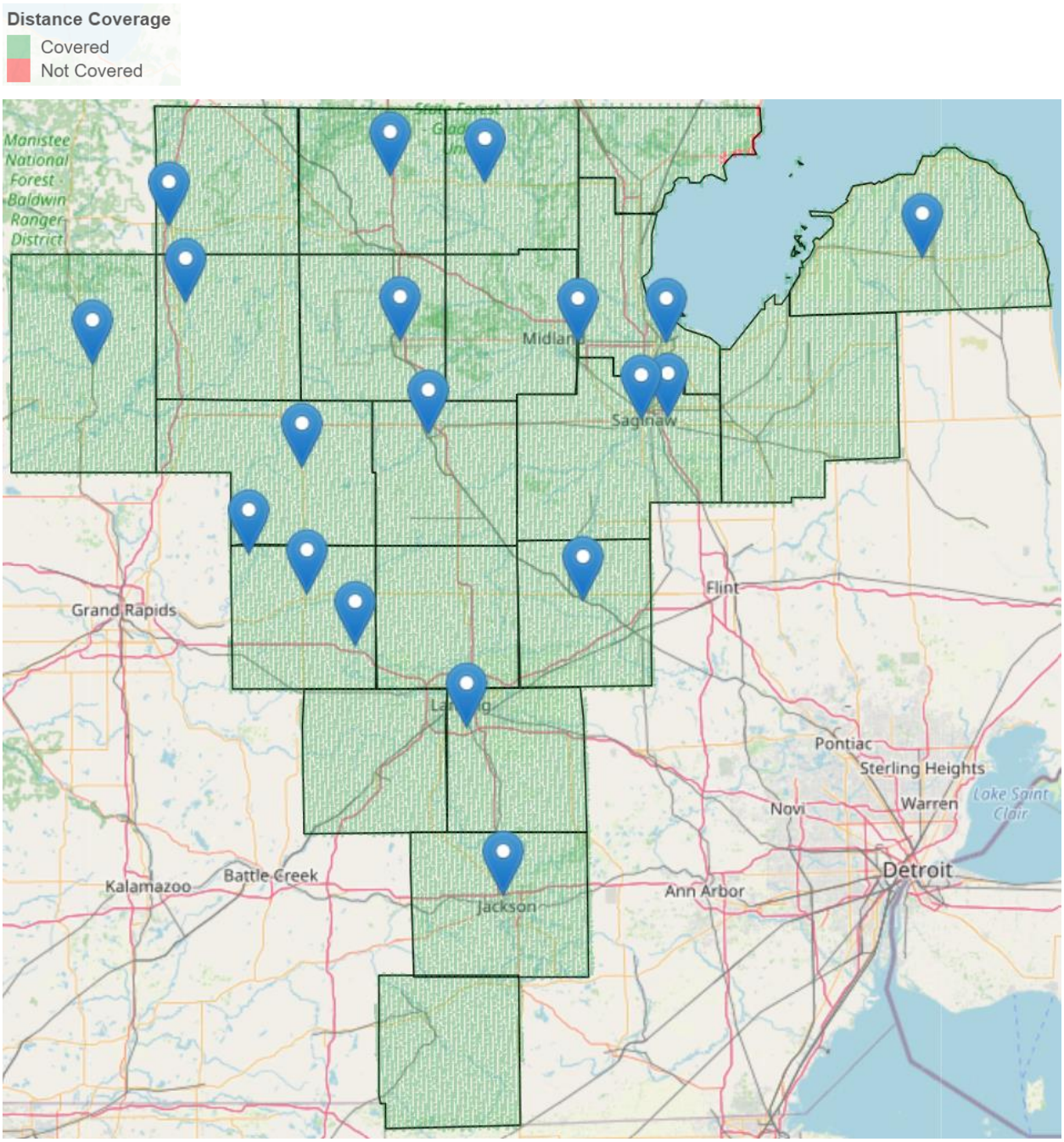
Homebased – 100% 0f Population Covered



Outpatient Therapy (CMHSP) – 100% 0f Population Covered



Wraparound – 99.90% of Population Covered



FY22 Follow Up on Recommendations and Updates

During FY23, MSHN did not complete a full network adequacy assessment as MDHHS indicated a Network Adequacy Certification Template would be required for submission. However, MSHN has continued to implement actions related to the FY22 recommendations as noted below.

1. Determine if tracking consumer choice for service provider had an impact on the time and distance analysis related to provider capacity in SUD residential and withdrawal management.
    a. **Status Update:** After a review of the level of resources required and lack of tracking consumer choice, MSHN doesn't have the ability to review prior years. MSHN is in the process of developing a tracking mechanism for consumer choice.
2. Continue to monitor HCBS Heightened Scrutiny for possible provider closures.
    a. **Status Update:** The HCBS heightened scrutiny (HS) list is monitored closely for its implication to losing very needed providers. MSHN works with each of its CMHSPs when a where there is the possibility of there being an HS outcome based on the HCBS survey or site review. MSHN is monitoring the list of service providers who potentially could potentially be affected by an adverse HS outcome. The adverse outcome typically will not close a provider, but it will invalidate that provider from providing Medicaid-reimbursed services to the specific individual. However, there could also be traits about the provider's services that broadly apply HS to all individuals. These circumstances would result in HS applying to *all* individuals. After the HS submission to CMS, MSHN was notified by MDHHS that six settings in the region were selected for further review. MSHN has notified the providers and conducted reviews of each setting to ensure adequate responses to CMS if required. MSHN is confident that these six providers are in compliance with the final rule and are not considered HS. MDHHS will share updates once available, but they have stated they do not anticipate any provider removals.
3. Continue to monitor provider capacity impact as it relates to new initiatives (CCBHC, OHH, BHH).
    a. **Status Update:** In FY22, MSHN had three (3) CMHSPs participate in CCBHC demonstration. The impact on provider capacity at this time is the increased demand related to serving the uninsured and mild to moderate population as required by CCBHC. OHH and BHH will impact FY23 and forward, with both initiatives anticipating increased staffing demand and provider capacity.

4. Conduct feasibility study to collect information from CMHSPs and SUD Providers regarding specific cultural competency requests.
    a. **Status Update:** During FY23, MSHN explored the development of a process to add data points that capture culturally competency service requests but it was determined that the current practices in place that ensure staff are required to be properly trained, that requests are included within the planning process/documents, and cultural competency is identified on the provider directory and provider applications was sufficient to account for specific cultural competency request fulfillment.
5. Analyze the collection efforts related to ADA and ensure network adequacy related to specified accommodations.
    a. **Status Update:** MSHN's online provider network application has been updated to include specific detailed ADA accommodations available at each provider site. The Directory is updated monthly with new ADA data.
6. Analyze timeliness indicators specific to priority populations (pregnant, injecting drug users, etc.).
    a. **Status Update**: MSHN's information system management software has been updated to report and track priority populations timeliness indicators percentages. Beginning with FY23Q2, the report will include the new tracking along with follow-up to improve low performance, if needed.
7. Analyze the counties with non-English language prevalence to ensure compliance with LEP requirements.
    a. **Status Update**: MSHN's current policy indicates a region wide 5% threshold for non-English language prevalence. The MSHN Customer Service Committee reviewed the MDHHS PIHP Contract Cultural Competence requirements to ensure current LEP policies and procedures meet the requirements. Ongoing analysis will be completed in the FY24 NAA to ensure each provider has an effective methodology to assess any prevalent non-English language(s) spoken by individuals likely to be served in their county/CMHSP service area.
8. Continue monitoring of regional provider staffing crisis stabilization and impact on providers ability to continue to maintain and sustain service delivery.
    a. **Status Update:** Throughout FY20-FY23 MSHN has monitoring the provider stabilization and related staffing crisis by providing funding to cover both stabilization (due to underutilization and lack of staff) along with funding to provide staffing retention, incentives and recruitment strategies. Both programs have allowed the continuation of the provider network stability.
9. Continue to support opportunities to offer evidence-based practice trainings to the provider network.
    a. **Status Update**: During FY22, MSHN provided trainings to the Provider Network for EMDR and FASD. During FY23, MSHN has supported a variety of EBP trainings including Grief &

Loss, Trauma Informed Yoga, Solution Focused Brief Intervention (SFBT), and Cognitive Behavioral Therapy (CBT). MSHN has also utilized grant funds to support provider participation at the MDHHS annual SUD & Co-occurring conference, the National Stimulant Summit, and the MCBAP CCS Supervisor Development Training. The MSHN SUD Clinical Team also shares available EBP training information that is provided by MDHHS and CMHAM with the provider network on a regular basis. This most recently included an ASAM Criteria training.

FY23 Follow up on Recommendations

1) CMHSP Network Capacity will continue to be monitored and updated based on the FY23 projected increase in inpatient, crisis and residential services.

   Status Update: During FY23, MSHN continued development of a crisis residential setting placed centrally within its regional borders. This specifically is intended to benefit all MSHN CMHSPs as any of the partners will be able to make referrals. This is a MSHN direct-contracted service available to the region and is starting initially with six beds, targeted for open in March 2024 and a plan to expand to twelve. MSHN has worked with the provider to ensure licensing and safety inspections are met as well as successful recruiting of staff, development of policies and procedures, and completion of all MDHHS-required paperwork for the approval of a special program. This crisis residential setting was developed completely new, with only a structure and the need to completely renovate, so the building and setting will meet up to date code standards as well as crisis residential treatment trends. Additionally, a MSHN CMHSP partner will be establishing another crisis residential setting in Bay City, MI. This service will become available most likely in the second half of FY24 but will add at least six more crisis beds to the MSHN region. CMH for Clinton, Eaton, and Ingham Counites is also establishing a crisis stabilization unit.

2) MSHN will conduct geomapping and time/distance standards analysis effective October 2023 to ensure inclusion in the FY23 Network Adequacy Assessment.

   Status Update: During FY24 geomapping and time/distance standards were completed for FY23 and incorporated into the FY23 NAA.

3) MSHN will continue to support and expand CCBHC, OHH and BHH in-region.

   Status Update: During FY23, MSHN implemented (1) OHH program and (5) BHH programs in the region. MSHN also hosted monthly meetings with regional CCBHC, OHH, and BHH partners which will continue in FY24. The monthly regional provider partner meetings provide opportunities for technical assistance and development of consistent regional processes to support these initiatives. Expansion plans for FY24 include the addition of (1) new CCBHC, (5) new OHH programs, and (2) new BHH programs. Additional OHH and BHH programs may be added in FY24 based on provider interest, with priority given to communities where a health home program does not already exist.

4) MSHN will continue efforts to develop adolescent services for ASAM levels of care for outpatient 1.0 and 2.1, residential 3.1 and 3.7, as well as 3.2 and 3.7 withdrawal management.

   Status Update: MSHN is supporting an RFP for adolescent services in FY24 with implementation focus by 10-1-2024 for FY25.

5) MSHN will evaluate cultural competency request and support development in provider capacity as needed.

   Status Update: This was reviewed by the Regional Customer Service Committee and Quality Improvement Council. Recommendations were sent to the Operations Council for consideration. The CMHSPs are providing copies of their current Diversity, Equity and Inclusion plans, cultural competency plans/workplans, etc. Additional elements will be added to the Network Adequacy Assessment related to information received from the CMHSPs.

6) MSHN will evaluate priority populations (pregnant, injecting drug users, etc.) tracking reports to determine sufficient capacity to be in compliance with timeliness indicators.

Status Update: MSHN's information system management software produces a report to monitor the timeliness of the priority population (pregnant, injecting drug users, etc.) in obtaining treatment. Modifications were made to the report to include the ASAM levels of care to more accurately monitor the timelines for specific population groups. Access training was provided to the provider network in May 2023 and a recording of the session has been made available to the provider network on MSHN's website for continued review by the provider network. Continued work will be completed through treatment specific workgroups to identify reasons for individuals not receiving treatment within the required timeframes and implement improvement strategies to improve access.

FY24 Recommendations

1) MSHN's Home Based Services FY23 Ratio: 567,553 Total MH Medicaid Enrollees to 151.85, which is under the required ratio of 283.78 FTEs. Conduct additional analysis to determine appropriate home-based service demand and deficit areas in the region. (MSHN Lead: Chief Behavioral Health Officer)

2) MSHN's Wraparound FY23 Ratio: 567,553 Total MH Medicaid Enrollees to 34.3 FTEs, which DOES NOT meet the required 113.51. Conduct additional analysis to determine appropriate wraparound demand and deficit areas in the region. (MSHN Lead: Chief Behavioral Health Officer)

3) MSHN will continue to work with our CMHSPs on building appropriate network capacity to serve all individuals eligible for autism specific services within a timely manner (focus on LifeWays and CMHCM regions). (MSHN Lead: Chief Behavioral Health Officer)

4) MSHN will continue to work with MDHHS to increase pediatric bed availability statewide. (MSHN Lead: Chief Behavioral Health Officer)

5) MSHN will continue to work with in-region and participate in state-wide efforts to address the workforce shortage and increase timelines to services. (MSHN Lead: Chief Behavioral Health Officer)

6) MSHN will continue to evaluate, coordinate, and implement changes specific to the new ASAM Criteria 4th edition and ensure training opportunities for the network. (MSHN Lead: Director of SUD Operations)

7) MSHN will continue to look for opportunities to increase provider capacity to serve adolescents in need of SUD services. (MSHN Lead: Director of SUD Operations)

8) Continue to expand the number of Certified Community Behavioral Health Clinics (CCBHCs), Behavioral Health Homes (BHH), and Opioid Health Homes (OHH) in the region. (MSHN Lead: Chief Population & Health Officer)

9) MSHN will continue to work with MDHHS to increase children psychiatric capacity as well as conduct feasibility for out of state psychiatric services. (MSHN Lead: Chief Population & Health Officer and Chief Behavioral Health Officer)