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From the Chief Executive Officer's Desk

Joseph Sedlock

Michigan Department of Health and Human Services (MDHHS) officials recently presented detailed information about Certified Community Behavioral Health Clinics (CCBHCs) to the Michigan House sub-Committee on MDHHS Appropriations. This article will highlight several aspects of that presentation.

CCBHCs are non-profit or local government agencies that provide comprehensive and coordinated outpatient behavioral health services for all Michiganders with a mental health and/or substance use disorder regardless of severity, insurance status, or ability to pay. There are currently 30 approved CCBHC sites in Michigan, mostly located in the lower half of the lower peninsula, 13 of which are participating in the federal Medicaid demonstration.

For Fiscal Year (FY) 23 (ended 09/30/23), the 13 federal demonstration sites served 75,006 distinct individuals, of which 8,934 did not have Medicaid. Of the total, 2,171 individuals were served with military service histories; 8,012 individuals presented with a co-occurring mental health and substance use disorder. Notably, over 17,000 Medicaid-covered individuals received CCBHC services in a county different than their primary residence. 15% (or 11,250 persons) of the total served were individuals with mild to moderate behavioral health needs.

There were more than 1 million daily visits and more than 1.2 million CCBHC services delivered in FY 23, 48% of which were outpatient mental health/substance use services and 27% targeted case management.

MDHHS also noted that 82% of Michiganders now live in a county with 24/7 mobile crisis response.

MDHHS is committed to expansion of the CCBHC model because it increases access to a comprehensive array of behavioral health services by serving all individuals in a community. The MDHHS budget includes $191.5 million to expand CCBHCs further across the State with the goal of increasing persons served by 50,000.

There are four CCBHC's in the Mid-State Health Network region: The Right Door for Hope, Recovery and Wellness (Ionia County), Community Mental Health Authority for Clinton-Eaton-Ingham Counties, Saginaw County Community Mental Health Authority, and LifeWays (Jackson/Hillsdale Counties). Additional regional CMHSPs are considering establishing a CCBHC locally.

Please support the request for increased appropriations for the expansion of CCBHCs in Michigan. Improved access to behavioral health services for all people in Michigan is the goal – and the result!

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

Regional Network Adequacy Assessment

Mid-State Health Network (MSHN) along with its regional partners have been working over the last few months to complete the region's Network Adequacy Assessment (NAA). The Code of Federal Regulations (42 CFR Parts 438.68 and 457.1218) charges States holding managed care contracts with the development and implementation of network adequacy standards. Furthermore, it indicates that standards pertinent to behavioral health must be developed for the adult and pediatric populations and must include an analysis that consists of:

- 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;
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Pre-Paid Inpatient Health Plan (PIHP); and
- Offers an appropriate range of preventative, primary care and specialty services that is adequate for the anticipated number of enrollees in the service area.

Michigan Department of Health and Human Services (MDHHS) developed specialty behavioral health requirements that consider time and distance standards to providers and sufficient Medicaid enrollee-to-provider ratios for services congruent with community need and statewide strategic priorities.

- Services for adults include Assertive Community Treatment, Crisis Residential Programs, Inpatient Psychiatric, Opioid Treatment Programs, and Psychosocial Rehabilitation Programs (Clubhouses).
- Services for children include Crisis Residential Programs, Home-Based, Inpatient Psychiatric, and Wraparound Services.
- Time/Distance standards are categorized by urban/rural and frontier status and apply to all services.

In addition, MDHHS required regional specific plans (per 438.68(b)(3)) that requires each PIHP to submit how the standards will be effectuated by region. PIHPs must consider at least the following parameters for their plans:

- Maximum time and distance
- Timely appointments
- Language, Cultural competence, and Physical accessibility

MSHN is in the process of reviewing the region's Network Adequacy Assessment completed using FY2023 data but includes analysis from FY2019-2023. The results are being reviewed with the council/committees to ensure accuracy, identify any gaps in capacity and recommend improvement actions plans. MDHHS requires reporting of the NAA results by April 30, 2024. The MSHN Board of Directors will receive a presentation on the results during the May Board meeting.

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

Information Technology

Steve Grulke
Chief Information Officer

The Mid-State Health Network (MSHN) Information Technology (IT) team worked with the Michigan Department of Health and Human Services (MDHHS) and their contracted software vendor HHAeXchange (HHAX) on Electronic Visit Verification (EVV). The Center for Medicare & Medicaid Services (CMS) requires Michigan Medicaid begin EVV in 2024. The EVV process is expected to ensure that the service takes place with the consumer present and in the location identified. Much of the work by MDHHS and HHAX, at this point, has been learning through data gathering, trainings, surveys, etc.

To date, most of the discussions have been regarding the data elements in the consumer file and the authorization file. Additional data files, including the 837 billing file, will be discussed at a future training. HHAX has requested a list of all sub-contracted providers of Community Living Supports, Respite Services and Fiscal Intermediaries, so they can contact them for training purposes. These providers will be required to use an electronic device (cell phone, tablet, laptop) to verify the start and stop time and location of these services. There is an allowance for non-connected areas to enter data manually following the service.

Implementation:
The latest implementation plan from MDHHS has seven (7) program areas using a phased in approach. The schedule is as follows:

- Phase 1 - Medicaid FFS Home Health is slated to go live April 1, 2024
- Phase 2 - Home Help is slated to go live July 1, 2024
- Phase 3 - **Behavioral Health**, MI Health Link, MI Choice, Medicaid Managed Care Home Health and

Community Transitions Services are slated to go live **September 3, 2024.**

Exemptions:
MDHHS has decided to support live-in caregiver exemptions to EVV, as allowable by CMS and pre-approved by MDHHS, with the exception of Home Help services. There will be an identified process for live-in caregiver exemption requests and approvals within Behavioral Health, details for which will be provided once those are finalized.

Provider Requirements:
For those providers still needing to enroll in Community Health Automated Medicaid Processing System (CHAMPS) and/or obtain a National Provider Identifier (NPI) for EVV purposes, as outlined in the Michigan Medicaid Policy (MMP) 23-76 bulletin, it is imperative to do so as soon as possible to avoid any negative impacts and/or delays related to EVV system use and reporting requirements. Community Mental Health Service Programs (CMHSPs) should be in the process of getting their providers all enrolled as needed.

CMHSPs have the option to use the State selected system or implement one of their own. CMHSPs are still deciding which option will be utilized, but most seem to be leaning toward using the State system. A couple reasons for using the state system have been discussed at the Information Technology Council.

1. The information being received related to the State system is not very complete so it is uncertain what it will entail;
2. The information about what will be required of another system is not very clear to know if that might be less labor intensive or not; and
3. The purchase plus implementation cost of a separate system seems unlikely to be acceptable when there is a "free" alternative (even if the work involved costs more).

Currently the expectation is that all data will flow directly between the CMHSPs and HHAX. The Pre-Paid Inpatient Health Plan (PIHP) will not be part of the data flow process.

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

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN's Finance Team is currently engaged with Roslund Prestage & Company (RPC) to complete work on MSHN's Fiscal Year (FY) 2023 Compliance Examination and Single Audit.

Compliance Examination - Compliance Examination Guidelines require that an independent Auditor examine compliance issues related to contracts between Pre-Paid Inpatient Health Plans (PIHPs) and Michigan Department of Health and Human Services (MDHHS) to manage the Concurrent 1915(i)/(c) Medicaid, Healthy Michigan, and the Flint 1115 waiver. These Compliance Examination Guidelines, however, DO NOT replace or remove any other Audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. The main PIHP responsibilities associated with this exam are:

1. Maintain internal control over the Medicaid Contract that provides reasonable assurance that the PIHP is managing the contract in compliance with laws, regulations, and the contract provisions that could have a material effect on the contract.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not be limited to: the Medicaid Contract, the Mental Health Code (Michigan Compiled Laws 330.1001-330.3106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 Code of Federal Regulations (CFR) 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.

In addition, MSHN's Compliance Examination completion is contingent on final Community Mental Health Service Program (CMHSP) Compliance Examinations as any changes or updates from the region impact the PIHP's final report. Lastly, any adjustments/changes noted must have a plan in place to address moving forward.

Single Audit – PIHPs that expend $750,000 or more in Federal awards during the fiscal year must obtain a Single Audit in accordance with 2 CFR 200, Subpart F. This Audit must be performed by an independent auditor, and in accordance with Generally Accepted Government Auditing Standards (GAGAS). Federal funds referenced for Single Audit are associated with MSHN's Block Grant dollars. In recent fiscal years, various expanded Block Grant categories have been introduced (some specifically related to the Public Health Emergency). Please
Note: Medicaid and Healthy Michigan reviews are handled within MSHN's financial audit.

We anticipate completion of both reviews by June 30, 2024.

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

Behavioral Health

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

What is a Crisis Continuum and Why is it Important?

A crisis reaction can occur when an individual encounters an abrupt, traumatic, and often unexpected precipitating

event that leads to negative changes in mental status or presentation. A crisis continuum is needed to ensure that an individual receives timely and impactful care, ensuring safety and stability can be addressed. A precipitating or triggering event can turn an underlying condition into an active form of an individual's behavioral health problem. Even though this precipitating event can cascade into a full-blown crisis, the crisis response itself may start with warning signs that can be missed because it is not an obvious and intense crisis reaction. If possible, it is always critical to respond as early in the crisis-cycle to help interrupt the potential for a worsening condition and the potential that there would need to be a service of higher intensity. If the individual's decompensation continues unaddressed, it often leads to use of more intensive and invasive services and experiences for the individual involved, such as police/jail, emergency department utilization, or inpatient psychiatric admission. Each of these higher-intensity levels of service often entails loss of personal control and familiar environment for the individual, potentially leading to more trauma.

A behavioral health continuum of care conceptualizes the care as a range of services going from least intense (e.g., outpatient counseling) to the most intense (e.g., inpatient psychiatric care). Specifically, the crisis continuum of care focuses on services meant to address acute mental health issues which are comprehensive and coordinated to ensure an effective and timely response. The crisis continuum minimally involves the presence of a crisis call center, mobile crisis teams, crisis centers, and post-crisis care (i.e., discharge planning). Balfour et al. (2020) noted that 80% of crises are resolved in the initial call to a crisis line and that 70% of crises are resolved using mobile crisis response teams that consist of mental health professionals who travel to the crisis and provide assessment, intervention, and support. Mobile crisis teams have begun to partner with local law enforcement who have been trained to identify mental health crises and to respond using crisis intervention techniques. If the crisis line or mobile crisis services are not adequate, the crisis residential facility can be used. The crisis residential setting often results in 65% of individuals being discharged back to their community from the facility. It is likely the remaining 35% needed a higher level of care, such as a psychiatric inpatient unit. Individuals who have used a crisis residential facility remain stable 85% of the time, which also means that post-crisis wraparound of services (discharge planning) becomes very important to maintaining stability.

Increased use of crisis residential services leads to a decrease in the use of the higher restrictive and more costly services. Mid-State Health Network (MSHN) is involved in establishing a brand-new crisis residential facility. The provider, Healthy Transitions (located in Alma), is undergoing renovations and moving toward completing licensure and special program approval from the Michigan Department of Health and Human Services (MDHHS). This expansion of crisis continuum service availability will be for all adult Community Mental Health (CMH) beneficiaries (with a mental illness) in the MSHN region. This service addition will provide a warm, welcoming, and safe space for individuals in crisis to re-attain stability and return to their community as soon as possible. Healthy Transitions is targeted to open in late April 2024.

References:

Balfour, M.E., Hahn Stephenson, A, Winsky, J., & Goldman, M.L. (2020). Cops, Clinicians, or Both? Collaborative approaches to responding to behavioral health emergencies. Alexandria, VA. National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

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

Utilization Management & Care Coordination

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

Statewide Psychiatric Bed Registry

As Board Members may recall, Public Act 658 (8) of 2018 established a requirement for the State of Michigan to implement a statewide psychiatric bed registry. The Michigan Departments of Licensing and Regulatory Affairs (LARA) and Health and Human Services (MDHHS) partnered to launch the Michigan Care Access Referral Exchange (MiCARE), with full statewide implementation occurring by the end of 2022.

The goal of MiCARE was to create a statewide, comprehensive network of all behavioral health treatment providers, referrers, and social support resources with the capability to link those in need of treatment to appropriate, available care. One of the anticipated outcomes of MiCARE was that it would streamline the process for Community Mental Health staff to quickly identify which psychiatric hospitals have availability and facilitate faster admissions for individuals in need of hospitalization. Unfortunately, LARA found that less than 10% of the 1,000+ licensed behavioral health providers and facilities completed the onboarding and training process to begin using MiCARE. In October 2023, MDHHS announced a decision to discontinue the MiCARE bed registry due to lack of utilization.

In March 2024, MDHHS announced that it selected a new vendor, EMResource, to begin developing an improved psychiatric bed registry platform. Many emergency departments and inpatient psychiatric facilities are already familiar with and using EMResource, as it is currently utilized by MDHHS in another capacity related to public health emergencies.

MDHHS intends to partner with the Michigan Health and Hospital Association and the Community Mental Health Association of Michigan along with representatives from people with lived experience, psychiatric hospitals, emergency departments, Pre-paid Inpatient Health Plans (PIHPs), and Community Mental Health Service Programs (CMHSPs) to modify EMResources to fulfill the legislative requirement for tracking psychiatric bed availability. An advisory group will be instrumental in the development and implementation of the new bed registry platform.

In summary, a statewide bed registry could greatly improve efficiency for Community Mental Health staff and lead to more timely admissions for individuals in need of psychiatric hospitalization if designed and implemented correctly with appropriate oversight to ensure that hospitals and referring agencies are using the registry consistently as intended. MSHN will continue to provide updates to its regional partners as this project progresses.

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

Substance Use Disorder Policy, Strategy and Equity

Dr. Dani Meier, PhD, LMSW, MA
Chief Clinical Officer

Redefining Sobriety

The pairing of sobriety with "abstinence" dominated the substance use disorder (SUD) field through most of the 20th century. The most radical expression of an abstinence approach, of course, was Prohibition which in 1919 banned alcohol sales in the U.S. Prohibition's failure to curb drinking combined with unintended negative consequences precipitated its repeal in 1933. Two years later, however, the abstinence movement gave rise to Alcoholics Anonymous, a 12-Step model that became integrated into SUD treatment programs in the 1940s and 1950s as part of the emerging Minnesota Model of SUD treatment. This model accelerated the spread of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) and established the abstinence-focused 12-Step program as central to mainstream SUD treatment. Today the abstinence model persists in some treatment settings (Volkow, 2020), but treatment practices have been evolving for decades in new and positive directions.

1. Use of methadone for heroin addiction began in the mid-1960s and as the devastating overdose epidemic exploded starting in the 1990s, a broader array of Medication for Opioid Use Disorder (MOUD)—methadone, buprenorphine and/or naltrexone—became the standard of care for those with an Opioid Use Disorder. Resistance persists to MOUD from some in the medical community and the general public, but there's growing and steady acceptance of MOUD as a best practice.
2. A more inclusive and expansive view of recovery was also catalyzed by the Acquired Immunodeficiency Syndrome (AIDS) epidemic in the 1980s and 1990s when drug use was identified as having a role in disease transmission. That prompted the adoption of a public health approach to treating SUD (Sobell & Sobell, 1995). The realization that human immunodeficiency virus (HIV) had been spreading among people who injected drugs led to the first syringe services programs (SSPs), an early expression of harm reduction in the mid-1980s. Harm reduction has gained increasing traction in recent years at the federal and state level.
3. The use of cannabis and psychedelics has also expanded as state laws and attitudes have grown more permissive. Fueled by lobbying efforts from combat veterans and others, use of psychedelics to offset or even *treat* addictions to alcohol, opioids and/or stimulants continues to gain momentum within the medical establishment.

Since 2003, Dr. Nora Volkow has been the director of the National Institute on Drug Abuse. She acknowledges that she was trained to think that "the only way out of an addiction is total and full [abstinence]." Over the years she came to realize that defining recovery as abstinences was unrealistic for some patients. Reduced use and replacing highly addictive drugs like opioids or alcohol with cannabis, can help some patients establish a positive and sustained recovery pathway, Volkow acknowledged.

For more information on expanding the continuum of SUD treatment to include non-abstinence approaches, please see this article in *Clinical Psychology Review*.

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

Substance Use Disorder Providers and Operations

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

Reduced Drug Use is a Meaningful Treatment Outcome for People with Stimulant Use Disorder

Historically, total abstinence has been the standard goal of treatment for substance use disorders, however, study findings support the growing recognition that a more nuanced perspective on measuring treatment success may be beneficial. According to a study published in Addiction, reducing stimulant use was associated with significant improvement in measures of health and recovery among people with stimulant use disorder, even if they did not achieve total abstinence. This finding is according to an analysis of data from 13 randomized clinical trials of treatments for stimulant use disorders involving methamphetamine and cocaine.

Researchers found that transitioning from high use (five or more days a month) to lower use (one to four days a month) was associated with lower levels of drug craving, depression, and other drug-related challenges compared to no change in use. These results suggest that reduction in use of methamphetamine or cocaine, in addition to abstinence, is a meaningful surrogate or intermediate clinical outcome in medication development for stimulant addiction. Unlike other substance use disorders, such as opioid use disorder or alcohol use disorder, there are currently no U.S. Food and Drug Administration-approved pharmacological treatments for stimulant use disorders.

“These findings align with an evolving understanding in the field of addiction, affirming that abstinence should be neither the sole aim nor only valid outcome of treatment,” said National Institute on Drug Abuse (NIDA) Director Nora Volkow, M.D. “Embracing measures of success in addiction treatment beyond abstinence supports more individualized approaches to recovery, and may lead to the approval of a wider range of medications that can improve the lives of people with substance use disorders.”

Temporary returns to use after periods of abstinence are part of many recovery journeys, and relying exclusively on abstinence as an outcome in previous clinical trials may have masked beneficial effects of treatment. To help address this research gap, investigators analyzed data from previous clinical trials to study the effects of transitioning to reduced drug use or abstinence on a broad range of health measures. Researchers analyzed data from 13 randomized clinical trials evaluating the impact of potential pharmacological medications for stimulant use disorders, which included more than 2,000 individuals seeking treatment for cocaine or methamphetamine use disorders at facilities across the United States. The trials were of varying duration and were undertaken from 2001 to 2017.

Researchers compared “no reduced use,” “reduced use,” and “abstinence” in association with multiple health outcomes, such as severity of drug-related symptoms, craving, and depression. The study found that more participants reduced the frequency of primary drug use (18%) than achieved abstinence (14%). While abstinence was associated with the greatest clinical improvement, reduced use was significantly associated with multiple measures of improvements in psychosocial functioning at the end of the trials, such as a 60% decrease in craving for the primary drug, 41% decrease in drug-seeking behaviors, and a 40% decrease in depression severity, compared to the beginning of the trial.

These findings suggest that improvements in health and functioning can occur with reduced use and should be considered in the development and approval of treatments for substance use disorders. Research on alcohol use disorder has shown similar results, with studies finding that transitioning from high-risk to low-risk drinking is associated with functional improvement and fewer mental and general health consequences caused by alcohol. As a result, a reduced number of heavy drinking days is already recognized as a meaningful clinical outcome in medication development for alcohol use disorder.

“With addiction, the field has historically acknowledged only the benefits of abstinence, missing opportunities to celebrate and measure the positive impacts of reduced substance use,” said Mehdi Farokhina, M.D., M.P.H., a staff scientist in the NIDA Intramural Research Program, and author on the paper. “This study provides evidence that reducing the overall use of drugs is important and clinically meaningful. This shift may open opportunities for medication development that can help individuals achieve these improved outcomes, even if complete abstinence is not immediately achievable or wanted.”

To help support individuals with Stimulant Use Disorders to reduce their daily use and engage in treatment, MSHN supports providers with the evidence-based practice of Contingency Management. MSHN recently applied with Michigan Department of Health and Human Services (MDHHS) to participate in a statewide demonstration for Contingency Management called the Recovery Incentive Pilot. MDHHS has notified MSHN that we are approved to participate and will be working to develop and implement the program by October 1, 2024 in the region.

Source: Reduced drug use is a meaningful treatment outcome for people with stimulant use disorders | National Institute on Drug Abuse (NIDA) (nih.gov)

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

Quality, Compliance & Customer Service

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Fiscal Year 2024 Monitoring and Oversight Updates

The Michigan Department of Health and Human Services (MDHHS) provides monitoring and oversight to the Pre-Paid Inpatient Health Plans (PIHPs) through the completion of several reviews each year. Included are the external quality reviews completed by the Health Services Advisory Council and the MDHHS waiver reviews that include the Habilitation Supports Waiver (HSW), the Waiver for Children with Serious Emotional Disturbance (SEDW) and the Children’s Waiver Program (CWP). These reviews look at compliance with activities required by the Balanced Budget Act of 1997 (BBA), Code of Federal Regulations (CFR) and contract requirements. In addition to the external reviews, Mid-State Health Network (MSHN) completes delegated managed care reviews to ensure compliance with contractual functions that have been delegated to the Community Mental Health Services Participants (CMHSPs) and the Substance Use Disorder (SUD) Providers.

MSHN CMHSP Review Process Change
With the support of the Operations Council and our CMHSP partners, MSHN has made several changes to our Delegated Managed Care (DMC) review process. The changes will eliminate duplication, increase efficiencies, and narrow the scope of each review to allow for more focus on quality improvement and technical assistance. The most significant changes include:

- Aligning MSHN DMC reviews with any external reviews involving CMHSP documentation.
- Modified the two-year review cycle into a three-year review cycle allowing for more targeted and effective

reviews.
MSHN has implemented the process for FY25 and looks forward to working with our region to ensure the success of the new process.

MDHHS Waiver Reviews
MDHHS, from March through August, will be conducting a full review of the Habilitation Supports Waiver for Persons with Developmental Disabilities (HSW), the Children's Home and Community-Based Waiver (CWP), the Children's Serious Emotional Disturbance Home and Community Based Waiver (SEDW), and the 1915(i) State Plan Amendment (iSPA). MSHN and CMHSPs have started preparing for the review based on the information that MDHHS has shared to date. Timeframes for the review are estimated and include regional preparation time, MDHHS review timeframe, and final report and corrective action planning.

Health Services Advisory Group (HSAG) Encounter Data Validation (EDV)
The EDV is a new addition to the oversight efforts for FY24. This is being referred to as a study, versus a review, and is scheduled to take place over several months (April through June) and will require several different documentation submissions. The goal of the study is to evaluate MDHHS encounter data completeness and accuracy through a review of medical records. Each PIHP can expect a random sample of 411 member files that received services from 10/1/22 – 9/30/23 and were continuously enrolled in the same PIHP and had at least one visit covered by Medicaid in the study period.

HSAG Network Adequacy Validation (NAV)
The NAV is a new addition to the oversight efforts of MDHHS for FY24 and will be tentatively completed from May through August. The NAV review is conducted to ensure that each managed care organization has adequate provider networks in coverage areas to deliver services to its Medicaid eligible members. The NAV activities involve a retrospective and comparative data analysis to assess multiple dimensions of access including network capacity, geographic distribution, and availability of services. The results will include provider-to-member ratios (i.e., network capacity), and results of time/distance analyses (i.e., geographic distribution) according to the state requirements. In the past, HSAG has conducted provider telephone surveys to verify the accuracy of the provider databases and assess the availability of appointments. HSAG uses both direct call and secret shopper-type survey approaches to meet specific provider network review or validation needs.

HSAG Performance Measure Validation (PMV)
The PMV review will be tentatively completed from May through August with the purpose being to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow the state and federal specifications and reporting requirements. The review includes completion and review of the Information Systems Capabilities Assessment Tool (ISCAT), MSHN source code, and CMHSP source code (programming language) for performance indicators, performance indicator report analysis, source documentation, and supporting documentation to validate reports including policies, procedures, file layouts, system flow diagrams, system log files and data collection processes.

HSAG Compliance Review
The Compliance review will be tentatively completed between May through September and includes a review of thirteen (13) different program areas including Member Rights and Member Information, Emergency and Post-Stabilization Services, Availability of Services, Assurance of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, Sub contractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program. HSAG reviews half of the standards in Year 1, the other half in Year 2, and completes a review to ensure all corrective action and recommendations from Year 1 and Year 2 were implemented in the Year 3 review.

MSHN utilizes the results of all the identified reviews to enhance our processes, improve quality of services, and ensure compliance with state and federal standards.

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

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

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

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