MSHN

Mid-State Health Network

Assessment of Network Adequacy

2017

Approved by MSHN Operations Council:

Approved by MSHN Board of Directors:

Mid-State Health Network

Assessment of Network Adequacy

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Definitions

The following are definitions for key terms used throughout the Mid-State Health Network Assessment of Provider Network Adequacy:

1. CMHSP Participant: One of the twelve-member Community Mental Health Services Program (CMHSP) participants in the MSHN Regional Entity.
2. CMHSP Participant Subcontractors: Individuals and organizations directly under contract with a CMHSP to provide behavioral health services and/or supports.
3. 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.
4. 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 Mid-State Health Network.

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. Like other PIHP's 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.

The counties in the MSHN service area include:

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

Mid-State Health Network 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)
- CMH Authority of Clinton-Eaton-Ingham Counties (CEI)
- CMH for Central Michigan (CMHCM)
- Gratiot Integrated Health Network (GIHN)
- Huron Behavioral Health (HBH)
- Right Door for Hope, Recovery & Wellness (for Ionia Co.)
- Lifeways CMH (LCMHA)
- Montcalm Care Network (MCN)
- Newaygo County Mental Health (NCMH)
- Saginaw County CMH Authority (SCCMHA)
- Shiawassee County CMH Authority (SHIACMH)
- Tuscola Behavioral Health Systems (TBHS)

MSHN also has responsibility for managing substance use disorder (SUD) treatment and prevention services funded under Medicaid, Public Act 2 and related Block Grants was transferred to the PIHP's in Michigan.

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.

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 CMHSP's 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(b)(3) services, services for adults with developmental disabilities enrolled in the Habilitation Support Waiver program, and specialty behavioral health (mental health and substance use disorder)

services under the Healthy Michigan Plan. 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 and the waiver programs for Children with Developmental Disabilities and Serious Emotional Disturbance.

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.

Assessment Updates

MSHN updates its assessment of provider network adequacy on an annual basis. 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
- 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

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.[1] 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).

The service array is articulated by MDHHS in the Medicaid Managed Specialty Support and Services Concurrent 1915(b)/(c) Waiver Program contract. 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 Abuse section:

[1] 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."

- Michigan 1915(b) Waiver State Plan services
- Michigan State Plan SUD services
- Michigan 1915(c) Waiver Habilitation and Support Waiver (HSW) services
- Michigan 1915(b)3 Waiver alternative community based services
- Michigan 1915(i) Waiver Autism Benefit services
- SUD services funded by Public Act 2 and Block Grants
- 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.

MSHN believes its service array to be appropriate and adequate for the needs of Medicaid beneficiaries, with limited exceptions. These exceptions are noted after the tables below which depict the services available for each fund source, and are addressed as recommendations at the end of this assessment.

The array of State Plan mental health services covered under the 1915(b) Waiver are to be provided based upon the needs of the seriously emotionally disturbed children, adults with mental illness and individuals with intellectual/ developmental disability populations in each community but MSHN must assure equity and appropriateness in service availability across the region. Table 1 lists the service array and which services are provided by each CMHSP Participant in the MSHN region, based on local needs.

Table 1: **State Plan Mental Health Services (1915(b) Waiver) Available in the MSHN Provider Network**

	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	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
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
Clubhouse Psychosocial Rehabilitation	X	X	X				X	X		X		
Crisis Interventions	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
Family Therapy	X	X	X	X	X	X	X	X	X	X	X	X
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
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		
ICF Facility for Ind. w/ Mental Retardation												
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
Nursing Facility Mental Health Monitoring	X	X	X	X	X	X	X	X	X	X	X	X

	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Occupational Therapy	X	X	X	X	X	X	X		X	X	X	X
Outpatient Partial Hospitalization Services		X		X	X	X	X	X	X	X		
Personal Care in Licensed Spec. Residential	X	X	X	X	X	X	X	X	X	X	X	X
Physical Therapy	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
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
Transportation		X		X	X		X		X	X	X	
Treatment Planning	X	X	X	X	X	X	X	X	X	X	X	X

PIHP's and CMHSP participants are required by MDHHS to offer a continuum of adult services including case/care management, outpatient therapy, and psychiatric services that can be used in varying intensities and combinations to assist beneficiaries in a recovery-oriented system of care. The beneficiary's level of need and preferences must be considered in the admission process. ACT is the most intensive non-residential service in the continuum of care within the service array of the public behavioral health system. Based upon this requirement and the need for intensive community based service options to preclude avoidable inpatient psychiatric admissions, the MSHN Operations Council determined Assertive Community Treatment (ACT) should be available in all counties in the region. Those CMHSP's in the region lacking ACT services added the service to their provider network over the past year.

Availability of Intensive Crisis Stabilization Services throughout the region is also addressed later in this assessment.

Table 2 shows the array of Medicaid funded services for treatment of substance use disorders and which services are delivered by SUD Providers under the auspices of their contracts with MSHN. MDHHS has begun to enroll providers based upon the intensity of services offered (which is discussed later in this assessment). 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 for outpatient services:

Level 0.5 – Early Intervention
Level 1.0 – Outpatient
Level 2.1 – Intensive Outpatient
Level 2.5 – Expanded Intensive Outpatient

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.

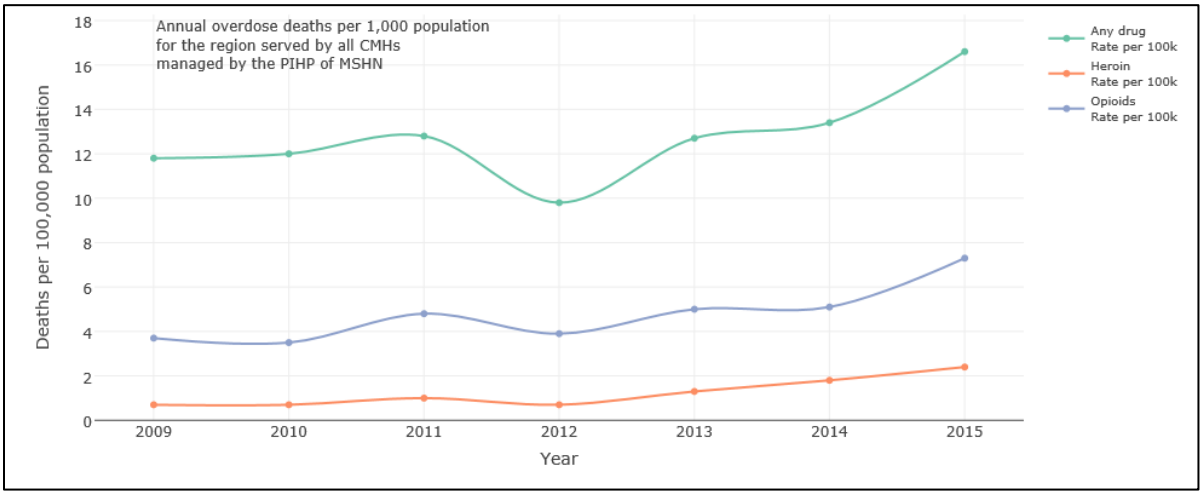
Table 2: **Medicaid Funded Substance Use Disorder Services Available in the MSHN Provider Network**

	0.5 Early Intervention	1.0 Outpatient	2.1 IOP	2.5 Partial Hosp.	3.1 Residential	3.3 Residential	3.5 Residential	3.7 Residential	3.2 WM	3.7 WM	Level 1 OTP
Arenac	X	X									
Bay	X	X	X								
Clare		X									

	0.5 Early Intervention	1.0 Outpatient	2.1 IOP	2.5 Partial Hosp.	3.1 Residential	3.3 Residential	3.5 Residential	3.7 Residential	3.2 WM	3.7 WM	Level 1 OTP
Clinton		X									
Eaton	X	X	X								
Gladwin		X									X
Gratiot	X	X									
Hillsdale		X					X				
Huron	X	X									
Ingham	X	X	X		X	X	X		X	X	X
Ionia		X									
Isabella		X							X		X
Jackson	X	X	X	X			X	X		X	X
Mecosta		X									
Midland		X					X				
Montcalm		X									
Newaygo	X	X	X								
Osceola											
Saginaw	X	X	X		X	X	X		X	X	X
Shiawassee	X	X									
Tuscola	X	X									
Out of Network	X	X	X		X	X	X	X	X	X	X

The opiate addiction and overdose epidemic has accelerated MSHN's attention to regional capacity to provide detox services, Medication Assisted Treatment (MAT), and MAT's associated ancillary outpatient treatment and recovery supports. In some counties, MSHN is looking an increasing capacity for residential as well either because no residential providers exist or to provide consumers with choice per Medicaid requirements. Table 3 shows regional opioid, heroin and all drug overdose deaths, based upon the most recent information available from MDHHS.

Table 3: Trend of Overdose Deaths by Cause in the MSHN Region



Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. 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.

As shown in Figures 1 and 2, most of the MSHN region is covered except for the tip of the thumb, which is being addressed by MSHN. Additionally, the region would like to expand capacity as 60 min/60 miles can be a barrier for consumers in need of services, particularly with daily dosing. As for urban communities, MSHN complies with the 30 min/30 miles requirement (Lansing, Saginaw, Jackson).

Figure 1: **Detox Providers**

Name of Organization	City
Addiction Treatment Services	Traverse City
Allegiance Addiction Recovery Center	Jackson
Community Programs dba Meridian Health	Waterford
DOT Caring Centers, Inc.	Freeland
Harbor Hall, Inc	Petoskey
Holy Cross Counseling Services - Women's Beh. Health	Lansing
Kairos Healthcare - Queen of Angels Facility	Saginaw
Sacred Heart Rehabilitation Center	Richmond
Salvation Army Turning Point	Grand Rapids
Sunrise Centre	Alpena
Ten16 Recovery Network - Detox	Mt. Pleasant
The Recovery Center	Lansing
Healthsource Saginaw	Saginaw

Figure 2: **Medication Assisted Treatment Providers**

Name of Organization	County
Arbor Circle Counseling	**Newaygo**
Cherry Street Services	Kent
DOT Caring Centers, Inc.*	Shiawassee, Saginaw
McCullough Vargas and Associated	**Hillsdale**
Michigan Therapeutic Consultants, PC	Isabella, Ingham
Recovery Pathways, LLC*	Bay, Shiawassee, Isabella, Gladwin, Midland
Red Cedar Clinic	Ingham
The Right Door for Hope Recovery & Wellness	Ionia

Victory Clinical Services	Jackson, Ingham, Saginaw

In addition to the geographic accessibility of services, MSHN is addressing MAT guidelines recently adopted by the MDHHS, which promote the availability of Methadone, Vivotrol, and Suboxone at all MAT locations. Research supports different medications for different stages of disease, and is dependent on the consumer's individualized needs. It's preferable to have a continuum of medication options within the scope of each MAT provider's capacity. This will not be possible at all MAT locations, but MSHN intends to work toward this goal. During FY2017, four (4) existing providers added Suboxone assisted treatment in Newaygo, Gladwin, Midland, Ionia, and Isabella counties; two (2) existing providers added Vivitrol assisted treatment in Ingham and Hillsdale counties.

MSHN has also expanded availability of the overdose reversal medication, naloxone (brand name Narcan). MSHN, in concert with the twelve CMHSPs, established Narcan kit distribution hubs using grant monies. MSHN has also distributed injectable naloxone kits to MAT providers in the region.

Michigan's 1915(c) Habilitation Support Waiver (or HSW) offers community support (mental health) services for those beneficiaries in the MSHN service area who experience intellectual and developmental disabilities, and meet program criteria. Services are offered to consumers based upon need once they are approved by MDHHS for enrollment.

MSHN monitors utilization of HSW enrollments closely to ensure individuals with the commensurate level of need take advantage of this resource. Current enrollment screening strategies include ranking of applicants by Support Intensity Scale standard score and regional review for appropriateness. Table 4 shows the utilization of HSW slots in the region at the time of this assessment.

Table 4: Habilitation and Support Waiver Slots for MSHN Region

	2016		2017	
	Count	**Percent**	**Count**	**Percent**
HSW Slots Filled	1603	98%	1588	97%
HSW Slots Available	34	2%	49	3%
Total Slots	1637		1637	

Table 5 shows the HSW services available in the region:

Table 5: **1915c Habilitation and Support Waiver Services Available in the MSHN Provider Network**

	BABH	CEI	CMHCM	GIHN	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Community Living Supports	X	X	X	X	X	X	X	X	X	X	X	X
Enhanced Medical Equip & Supplies	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request
Enhanced Pharmacy	X	X	X	X	X	X	X		X	X	X	X
Environmental Modifications	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request
Family Training	X	X	X	X		X	X	X	X	X	X	X
Goods & Services	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request	per request
Out-of-Home Non-Voc. Habilitation	X		X	X	X	X	X			X	X	X
Personal Emergency Response Systems			X	per request	per request	per request		Per request		per request		per request
Pre-Vocational Services	X	X	X		X	X	X	X		X		X
Private Duty Nursing	X	X	X	X			X			X	X	X
Respite Care	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

Mid-State Health Network must also assure Medicaid-funded mental health services and supports are available, in addition to Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act. These "B-3" services support community inclusion and participation, independence and productivity and include some of the services listed in the tables above, as well as Table 6:

Table 6: **1915(b)(3) Services Available in the MSHN Provider Network**

	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Assistive Technology	Provided on a per request basis											
Crisis Observation Care		X										
Housing Assistance	Provided on a per request basis											
Peer Specialist 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
Prevention Direct Service Models	X	X	X	X	X	X	X	X	X	X	X	X
• **Child Care Expulsion Prevention**												
• **School Success Program**												
• **Children of Adults w/ MI/ Integ. Serv.**												
• **Infant Mental Health-Prevention**	X	X	X	X				X	X	X	X	X
• **Parent Education**		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
Wraparound Services	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

The Michigan Medicaid Autism Benefit went into effect on April 1, 2013 and provides children ages 18 months to 21 years of age who have a medical diagnosis of Autism Spectrum Disorder (ASD) with Applied Behavioral Analysis services. Services are contracted or directly delivered by the CMHSP Participants as shown in Table 7:

Table 7: **1915(i) Autism Benefit Services Available in the MSHN Provider Network**

	BABH	CEI	CMHCM	GIHN	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	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	**Performed by MDHHS**											
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

The (non-Medicaid) Public Act 2 of 1986 and Block Grant services contracted by MSHN for FY17 are defined in the MSHN SUD Service Provider Manual and shown in Table 8 below. Priority for access to Block Grant funded services are determined at the federal level and include consumers who are pregnant injecting drug users, pregnant users, injecting drug users or parents of children who have been or are at risk of being removed from their home, in that order.

Table 8: **Other Substance Use Disorder Services Available in the MSHN Provider Network**

	Outpatient Treatment*	Residential Treatment	Detox Treatment	Treatment and Prevention Programs
Arenac	X	X	X available	X
Bay	X	X	X available	X
Clare	X	X	X available	X
Clinton	X	X	X available	X
Eaton	X	X	X available	X
Gladwin	X	X	X available	X
Gratiot	X	X	X available	X
Hillsdale	X	X	X available	X
Huron	X	X	X available	X
Ingham	X	X	X site located in county	X
Ionia	X		X available	X
Isabella	X	X	X site located in county	X
Jackson	X	X	X site located in county	X
Mecosta	X		X available	X
Midland	X	X	X available	X
Montcalm	X	X	X available	X
Newaygo	X		X available	X
Osceola	X	X	X available	X

	Outpatient Treatment*	Residential Treatment	Detox Treatment	Treatment and Prevention Programs
Saginaw	X	X	X site located in county	X
Shiawassee	X	X	X available	X
Tuscola	X	X	X available	X
Out-of-Network		X	X	

*Outpatient programming includes individual, group, family therapy, medication assisted treatment, recovery support, case management, early intervention, medication reviews, lab fees and medication dosing.

Recovery housing for consumers with SUD was added as a covered service by MDHHS and can be funded using block grant funds in conjunction with treatment services if integral to the treatment process. Several substance use disorder providers have begun to offer recovery housing and supportive services (outpatient, case management and peer recovery) in select counties across the MSHN region. In FY2017, MSHN established contracts with providers in Montcalm, Bay, Mecosta and Ingham counties. MSHN continues to encourage providers to expand recovery housing and continues to work with the State to identify appropriate funding sources for this service.

In 2014 the state of Michigan established a new program, the Healthy Michigan Plan (HMP), for purposes of expansion of Medicaid eligibility to the medically uninsured and underinsured. Mental health services offered through the HMP are similar to those previously offered via the Adult Benefit Waiver program, but the substance use disorder treatment options are expanded from the services previously available through Medicaid. The resulting service array is a comprehensive mix of mental health and substance use disorder services.

MSHN and the CMHSP Participants, as well as the SUD Providers have expanded network capacity to provide HMP services.

- Saginaw CMH added two new case management teams and four enhanced outpatient providers during FY16 for limited services for less impaired persons.
- CEI added new clinical sites to accommodate individuals enrolled in Healthy Michigan.
- Newaygo CMH added an additional office in the county to provide Mental Health and Substance Abuse treatment.

Limited change has been required because many HMP enrollees were previously served by CMHSP Participants through general funds.

The CMHSP Participants and SUD Providers are still determining optimal access pathways for HMP enrollees requiring concurrent mental health and SUD services. To date, MDHHS has not provided clarification regarding the Healthy Michigan service array and required provider qualifications for services which have been traditionally provided only through the mental health treatment system and for which the licensure requirements are different than for SUD services.

The behavioral health services shown in Table 9 are available for HMP enrollees in the region:

Table 9: Healthy Michigan Plan Services Available in the MSHN Provider Network

	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Osceola	Saginaw	Shiawassee	Tuscola
Assertive Community Treatment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessments	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assistive Technology																			X		
Behavior Treatment Review	X		X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	
Clubhouse Psychosocial Rehabilitation	X	X	X	X	X	X		X		X		X	X	X	X	X		X	X		
Community Living Supports	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Enhanced Pharmacy	X						X	X					X						X		
Environmental Modifications	X																		X		
Family Support and Training	X		X			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	X	X		X	X	X	X	X
Hospital Based Psychiatric Services	X		X			X			X			X		X	X		X	X	X	X	
Housing Assistance	X		X			X	X	X	X		X	X	X	X	X		X	X	X	X	
ICF for Individuals w/DD																					
Medication Administration	X	X	X	X	X	X	X	X	X	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	X	X	X	X	X	X	X	X	X
Occupational Therapy	X		X	X	X	X	X	X		X	X	X	X	X	X		X	X	X	X	X
Outpatient Counseling and Therapy	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peer Delivered/Operated Support Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peer Specialist Services (Recovery Coach)	X	X					X	X	X		X		X				X		X	X	
Personal Care in Licensed Spec. Residential	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Physical Therapy	X																X		X		
Prevention – Direct Service Model	X		X			X	X	X	X			X	X	X	X			X	X	X	
Residential SUD Treatment	X	X		X	X			X	X	X			X						X		
Respite Care	X		X	X	X	X	X	X	X	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	X	X	X	X	X	X	X	X	X
Speech, Hearing and Language Therapy	X										X								X		
Sub-Acute Detoxification	X	X		X	X				X	X									X		
Support and Service Coordination	X	X	X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X
Supported/Integrated Employment Services	X	X	X	X	X	X	X	X	X	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	X	X	X	X	X	X
Transportation	X	X	X			X		X	X			X	X	X	X		X	X	X	X	X
Treatment (DPT/CSAT) Approved Pharmacological Supports	X	X		X	X					X									X		
Treatment Planning	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Additional Services																					
Community Psychiatric Inpatient	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Residential	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Home Based	X	X	X			X	X		X		X	X		X	X	X	X	X	X	X	
Health Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Outpatient Partial Hospitalization				X	X		X	X	X	X	X		X				X		X		

In addition to the services for mental health and SUD populations described above, MSHN is required by MDHHS to establish 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. MSHN, CMHSP Participants and SUD Providers have met the following goals and continue to maintain network capacity to:

1) Establish, enhance, or expand relationships between the CMHSP and the SUD provider system within the service area of the CMHSP so that:
   a. 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.
   b. The CMHSP and SUD service providers establish a written after hours protocol for handling referrals during non-business hours.
   c. 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.

2) Engage in community coalitions and other substance use disorder prevention collaboratives by:
   a. Identifying and assigning responsibility for one or more CMHSP-employed individuals to perform this function;
   b. Identify opportunities where existing mental health prevention efforts can be expanded to integrate and/or support primary SUD prevention;
   c. 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).

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 [2] in the MSHN region can be assessed through review of the direct operated and contracted service provider networks established by the CMHSP Participants.

Training and experience

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 CMHSP's are properly licensed (by the Michigan Department of Licensing and Regulatory Affairs (LARA)) and credentialed in accord 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.

[2] 42CFR438.206(b)(iii) "The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services."

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).

CMHSP's also employs or contracts 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 the Michigan Department of Licensing and Regulatory Affairs (LARA). 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 Addiction and Drug Counselor. Regional trainings associated with SUD treatment have included motivational interviewing, auricular acupuncture, trauma-informed care, ASAM, and coordination of care.

Some CMHSP Participants have achieved SUD Licensure through LARA to provide SUD treatment and to support integrated treatment programs as shown in Table 10:

Table 10: CMHSP SUD Licensure

	Prevention (CAIT)	Screening, Assessment, Referral, Follow-Up (SARF)	Outpatient	Case Mgt	Integrated Treatment	Early Intervention	Peer Recovery Support	Outpatient Methadone
BABH	X	X	X	X	X	X		
CEI	X	X	X	X	X	X		
CMHCM			X		X			
GIHN	X	X	X	X	X	X	X	
HBH	X	X	X	X	X			
RDHRW	X	X	X	X			X	
LCHMA			X		X			
MCN			X	X	X	X		
NCMH		X	X	X	X			
SCCMHA	X	X	X	X	X	X	X	
SHIACMH								

	Prevention (CAIT)	Screening, Assessment, Referral, Follow-Up (SARF)	Outpatient	Case Mgt	Integrated Treatment	Early Intervention	Peer Recovery Support	Outpatient Methadone
TBHS			X	X	X			

The credentialing requirements for Autism Benefit Services are highly specific and have triggered provider network capacity concerns across the MSHN region, as well as other areas of the state. Diagnosis of Autism Spectrum Disorders must be performed by a child mental health professional (CMHP) and validated by a physician (preferably a child psychiatrist) and/or a fully licensed psychologist. Oversight of interventions calls for Behavior Analysts and Assistants certified by the Behavior Analyst Certification Board, which requires an extended period to accomplish. This has created shortages of qualified clinicians in the state. The availability in qualified providers in the marketplace is improving but remains a priority for MSHN.

PA 403 of 2016 amended the Public Health Code to require licensure of Behavior Analysts effective April 3, 2017. Rules must be promulgated by April 3, 2019 to establish the minimum standards for licensure as a behavior analyst. MSHN will be monitoring the potential impact on provider network capacity for applied behavior analysis services for children and youth with autism spectrum disorders.

MDHHS requires PIHP's to administrate a clinical assessment/survey for individuals with Intellectual and Developmental Disabilities (IDD), called the Support Intensity Scale or SIS. MSHN delegated completion of the SIS to the CMHSP Participants. MSHN must have an adequate number of trained assessors in the region to provide this service for all IDD consumers aged 18-64 within a 3-year period. MSHN initially determined five full time assessors were needed, but has increased the number to a minimum of six. Six assessors are currently authorized to conduct the surveys; two more are likely to be added within three months. CMHSP Participants are contractually required to have adequate capacity to complete SIS assessments.

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.

All CMHSP Participants and many of the provider agencies in the region are accredited by nationally recognized bodies, including The Joint Commission, CARF and the Council on Accreditation. Achievement of accreditation indicates standards of quality and experience beyond the minimum expectations defined by Medicaid are being met. Table 11 illustrates the accreditation status of the CMHSP Participants:

Table 11: **CMHSP Participant Accrediting Bodies**

	BABH	CEI	CMHCM	GIHN	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
The Joint Commission (TJC)			X									
Commission on Accreditation of Rehabilitation Facilities (CARF)	X	X		X		X	X	X	X	X	X	X
Council on Accreditation (COA)					X							

SUD Providers are required to have their programs accredited as alcohol and/or drug abuse programs. Most providers utilize similar accrediting bodies to the CMHSP Participants and their subcontracted mental health service providers, as shown in Table 12:

Table 12: SUD Providers Accrediting Bodies

The Joint Commission (TJC)
Commission on Accreditation of Rehabilitation Facilities (CARF)
Council on Accreditation of Services for Families and Children (COA)
American Osteopathic Association (AOA)
American Association for Ambulatory Health Care (AAAHC)
National Committee on Quality Assurance (NCQA).

Specialization

In addition to pursuit of accreditation, CMHSP programs and SUD service providers must meet MDHHS program certification requirements for certain specialty programs as outlined in the Michigan Medicaid Manual. The certification process entails meeting additional criteria such as mandatory service components, minimum staff credentials, ongoing training requirements and minimum staffing patterns.

MDHHS Certification is maintained by the CMHSP Participants for the programs indicated in Table 13:

Table 13: **CMHSP Participant Program Certifications through MDHHS**

- Assertive Community Treatment
- Clubhouse Psychosocial Rehabilitation Programs
- Crisis Residential Programs
- Day Program Sites
- Children's Diagnostic and Treatment Services
- Drop-In Programs
- Home Based Services
- Wraparound
- Intensive Crisis Stabilization Services

Clubhouse Psychosocial Rehabilitation Program accreditation by the International Center for Clubhouse Development (ICCD) is now being required by MDHHS and programs must be compliant by September 30, 2018. Table 14 lists the status of Clubhouse accreditation activities in the region.

Table 14: Status of Clubhouse ICCD Accreditation **as of October 2017**

	No Clubhouse	Awarded Accreditation	Accreditation in Process	Accreditation Process Not Initiated
Arenac	(can use Bay Co)			
Bay			X	
Clare	(can use Isabella or Mecosta Co)			
Clinton				
Eaton				
Gladwin	(can use Isabella or Bay Co)			
Gratiot	X			
Hillsdale	(can use Jackson Co)			
Huron	X			
Ingham		X		
Ionia	X			
Isabella			X	
Jackson		X		
Mecosta			X	
Midland	(can use Isabella or Bay)			
Montcalm			X	
Newaygo	X			
Osceola	(can use Isabella or Mecosta Co)			
Saginaw			X	
Shiawassee	X			
Tuscola	X			

Sub-contracted substance use disorder service providers must have a Substance Abuse License from the State of Michigan. MDHHS Certification is maintained by SUD Providers and CMHSP Participants providing SUD services for the following programs, shown in Table 15:

Table 15: **SUD Program Certifications and Licensures**

Licensure Through MI Licensing and Regulatory Affairs (LARA)	Certification Through MDHHS
▪ Substance Abuse Treatment ▪ Substance Abuse Prevention ▪ Residential Sub-Acute Detoxification ▪ Use of Methadone or Other Controlled Substances in the Treatment of Narcotic Addiction	▪ Women's Specialty Services Program

Each CMHSP Participant provides selected specialty services or treatments based upon evidence-based practice models they have adopted in accordance with local needs. Table 16 lists some examples of the many evidence based (or best) practices currently offered by CMHSP participants in the region:

Table 16*:* Examples of Evidence Based Practices Utilized by CMHSP Participants in the MSHN Region

	Pop.	BABH	CEI	CMHCM	GIHN	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Alternative for Families Cognitive Beh Therapy	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
Brief Behavior Activation Therapy	Adults w Depression			X		X							
Brief Strategic Family Therapy	Families	X		X									
Clubhouse	MIA	X	X					X	X		X		
Cognitive Behavioral Therapy	All	X	X	X	X	X	X	X	X	X	X		X
Dialectical Behavioral Therapy	MIA	X	X	X	X	X		X	X	X	X	X	X
Eye Movement Desensitization	PTSD	X					X		X	X	X		
Family Psycho-Education	Families		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	X	X
Mobile Urgent Treatment Team	Families										X		
Motivational Interviewing	All	X	X	X	X	X	X		X	X	X	X	X
Multi-Systemic Therapy	Juvenile offenders			X				X	X				
Nurturing Parenting Program	Parents			X			X						
Parent-Child Interaction Therapy	Parents			X		X			X				
Parent Mgt Training – Oregon Model	Parents	X	X	X	X	X	X		X	X	X	X	X
Parent Support Partners	Parent			X	X	X		X		X	X		
Parenting Through Change	Parents	X		X							X		X
Parenting Wisely	Parents							X			X		
Parenting with Love and Limits	Parents										X		
Peer Mentors	I/DD											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		
Positive Living Supports	I/DD	X	X		X	X					X	X	
Prolonged Exposure Therapy	Adults w PTSD			X		X			X				
Schema-Focused Therapy	Couples												
Seeking Safety Trauma Group	SUD & PTSD	X		X	X	X	X		X		X	X	X
Self-Management and Recovery Training	MIA, SUD	X		X		X							
Seven Challenges	SUD Adolescents										X		
Supported Employment	Adults	X	X	X	X	X	X	X	X	X	X	X	X
Thinking for a Change	SUD Offenders										X		
Trauma Focused Cognitive Beh. Therapy	Children	X		X	X	X	X	X	X	X	X	X	X
Trauma Recovery Empowerment Model	Adults			X	X					X	X		

	Pop.	BABH	CEI	CMHCM	GIHN	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Whole Health Action Management	**Adults**		X	X	X	X	X		X	X	X		
Wellness Recovery Action Planning	**Adults**	X	X	X	X		X		X	X	X		
Wraparound	**SED Families**	X	X	X	X	X	X	X	X	X	X	X	X

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 17 lists evidence-based practices employed by various SUD Providers in the MSHN region:

Table 17: **Examples of Evidence Based Practices Utilized by SUD Providers in the MSHN Region**

Focal Area*	EBP Practices	Focal Area*	EBP Practices
P	A Second Look	T	Motivational Enhancement Therapy
P	Active Parenting Now	T	Motivational Interviewing
T	Acupuncture	T/P	Nurturing Parents
P	Alcohol and Tobacco Vendor Education	P	OJJDP: Strategies for Success
P	All Stars	P	Peer Assisted Leaders (PALs)
T/P	Alternative Routes	P	Parenting Now
T/P	Anger Management	T	Partners for Change Outcome Measurement System
P	Children of Addicted Parents	P	Party Patrols
P	Choices	P	Permanent Drug Disposal Box Initiatives
P	CMCA – Communities Mobilizing for Change on Alcohol	P	Positive Action
T	Cognitive Behavioral Therapy (CBT)	P	Prescription Take Back Programs
P	Communities that Care	P	Project Alert
P	Community Intervention: Helping Teens Overcome Problems with Alcohol, Marijuana and Other Drugs	P	Project EX
P	Community Trials	P	Prime for Life
P	Conflict Resolution	P	Promoting Alternative Thinking Strategies
T	Correctional Therapeutic Community for Substance Abuse	P	Protecting You/Protecting Me
T	Dialectical Behavior Therapy (DBT)	T	Screening, Brief Intervention, Referral to Treatment (SBIRT)
P	Diversionary Programs	P	Second Step
P	Early STEP	T	Seeking Safety
T	Eye Movement Desensitization and Re-Processing	P	SMART Leaders/SMART Moves
P	Families and Schools Together (FAST)	P	Social Norming/Marketing and Media Campaigns
T	Family Psycho-Education	P	Start Taking Alcohol Risk Seriously (STARS)
T	Functional Family Therapy	P	Step Bullying Prevention
P	Guiding Good Choices	P	Steps to Respect
T	Helping Women Recover/Helping Men Recover	T/P	Strengthening Families
P	Mentoring	P	Student Assistance Program
P	Law Enforcement and Civilian Compliance Checks	P	Systematic Training for Effective Parenting (STEP)

Focal Area*	EBP Practices	Focal Area*	EBP Practices
P	Life Skills Training	T	Tobacco Cessation
P	Lions Quest Skills for Adolescents	P	Teen Intervene
P	Mapping-Enhanced Counseling	T	Thinking for a Change
P	Michigan Model for Health	P	TIPS Training
T	Mindfulness	P	Too Good for Drugs (TGFD)
P	Minor in Possession Program	P	Too Good for Violence (TGFV)
T	Moral Recognition Therapy	T	Trauma Informed Care

*T=Treatment; P=Prevention

The MDHHS Trauma Policy requires PIHP's 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. To assure compliance with MDHHS requirements, MSHN added a TIC section to its CMHSP site review tool to assess competency and compliance in this area. In FY17, MSHN treatment providers were also asked to conduct a self-assessment regarding trauma-informed competence. For those who need improvement, trainings and/or technical assistance will be provided.

In addition to specialized organizational certifications and deployment of research-based service delivery models, individual clinicians often obtain specialized credentials, some of which are required by MDHHS for the delivery of specialty services. As an example, many clinical staff in the region providing services within CMHSP participant direct operated programs and contracted service provider agencies hold substance abuse treatment credentials including Certified Advanced Alcohol and Drug Counselor (CAADC) and Certified Alcohol and Drug Counselor (CADC). Substance use disorder service provider staffs offering prevention services are required to hold certifications as Certified Prevention Specialists (CPS).

MSHN has drafted a plan and report on action and progress toward Recovery-Oriented System of Care (ROSC/Recovery Implementation and Enhancement 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 strength based practices.

Project Assert is one vehicle by which MSHN is empowering its SUD provider panel to pursue Screening, Brief Intervention and Referral to Treatment (SBIRT). Communities using Project Assert report increased connections between behavioral health and primary health care integration. Currently Project Assert programs exist in Clare, Gladwin, Midland, Gratiot, Mecosta and Osceola counties. Project Assert is being implemented this year (FY18) in the additional counties of Saginaw, Isabella, and Ingham counties with development also being discussed in the counties of Hillsdale, Jackson, Montcalm and Ionia. It is the intent of MSHN in using OROSC Opioid funds and Strategic Targeted Response (STR) funds to incorporate the use of Project Assert (SBIRT) throughout the entire MSHN region over the next two years.

MSHN seeks to increase the number of qualified recovery coaches throughout the region, particularly peers, and is funding Connecticut Community of Addiction Recovery (CCAR) training through the MI Office of ROSC Opioid and STR funds which qualifies individuals with a minimum of two years' sobriety to earn the state required credentials to be offered employment by MSHN SUD providers seeking to add recovery supports to their service array. One component of this funding is to increase the number of recovery coaches within treatment drug courts and MSHN hopes to offer to this opportunity to other interested MSHN counties in the next two programming years based upon multiple requests from other counties and initial success.

MSHN has supported the increased network of Families Against Narcotics (FAN) programs that have been implemented within the past year as well as a variety of other 12 step and non-traditional supports. Throughout the region, Smart Recovery, Life Ring, Celebrate Recovery and others are promoted within and among a network of peers supported by MSHN SUD programs in addition to traditional programs such as AA, NA and Al-Anon. In addition, MSHN has increased recovery housing options for people in recovery – thereby increasing opportunities for long-term success in 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.[3] Medicaid enrollment, service penetration rates and community demand are key factors to consider.

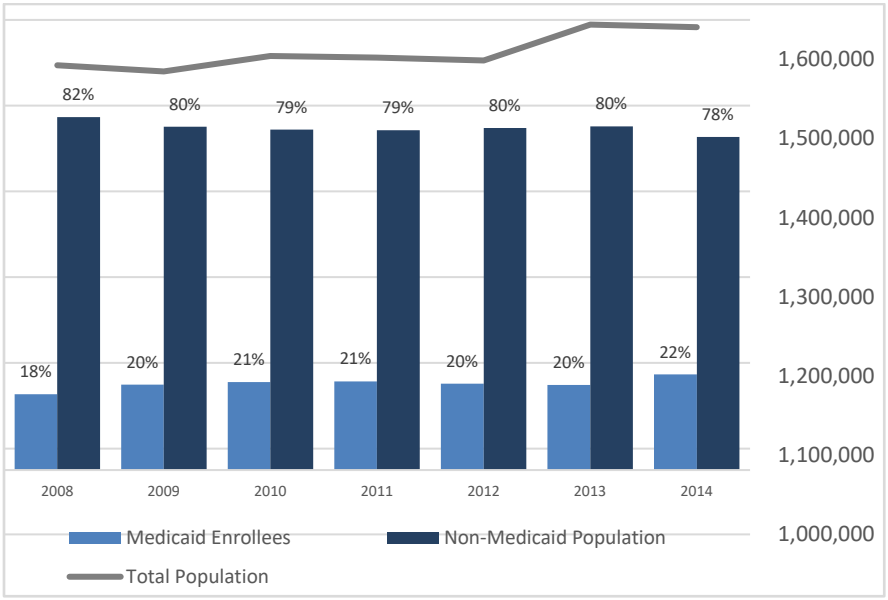
Medicaid enrollment

Medicaid enrollment in Michigan has been climbing in the past decade, most likely due to a general deterioration in the state's economy. The past couple of year's enrollment has shown signs of plateauing. Medicaid enrollments in the counties comprising the MSHN region remain relatively high with MSHN Medicaid remaining over 20% of the total population, based upon CMHSP Participant Community Needs Assessment data as illustrated in Figure 3)[4]. Higher Medicaid enrollment is associated with a relatively greater number of potential consumers of specialty behavioral health services. This suggests the size of the MSHN provider network should remain at least at the existing level for the upcoming year, but begin to expand. As described elsewhere in this assessment, some CMHSP's have been expanding their outpatient clinic offerings in response to Healthy Michigan enrollments.

[3] 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."

[4] Population census data and Medicaid enrollments taken from Community Needs Assessment Community Data Sets worksheets provided by each CMHSP.

Figure 3: Proportions of Medicaid/Non-Medicaid Populations and Total Regional Population



Service population penetration rates

The number of Medicaid enrollees residing in the region who received specialty behavioral health services meets or exceeds the state average for most of the counties in the region. This suggests service capacity should remain at or above existing levels and should not be reduced.

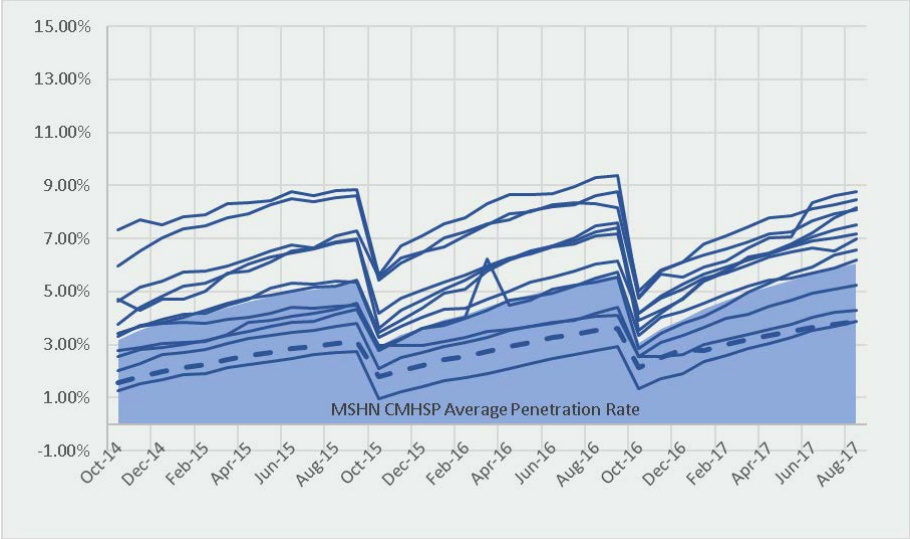
Figure 4 shows the mental health service penetration rate per CMHSP (solid lines), the regional SUD service penetration rate (dashed line) and the regional average (shaded area) of traditional Medicaid by month for over the past few fiscal years.

Figure 4: Traditional Medicaid Service Penetration Rates

Variability does exist among the CMHSP Participants in the region relative to population penetration rates, which is being 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.

MSHN identified greater variance in service penetration rates for HMP Medicaid beneficiaries across the MSHN region during the early years of the Medicaid expansion program. Figure 5 shows the Healthy Michigan service penetration rate per CMHSP (solid lines), the regional SUD service penetration rate (dashed line) and the regional average (shaded area). The variance was addressed by the MSHN Operations Council. Variance in HMP service penetration rates decreased in 2017 and the regional average has increased as the program has matured.

Figure 5: Health Michigan Plan Service Penetration Rates



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 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 18.

Table 18: Community Needs Assessment Priorities FY16[5]

Based on the Top Five Priorities per CMHSP Only

Community Needs	Composite Regional Priority	BABH	CEI	CMHCM	GIHN	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Services for Individuals with SUD/ Co-Occurring Disorders	1	1	3	3	3	1	1		2	3	5	2	1
Integrated healthcare and health outcomes	2		4	1					3	5	1	1	2
Services for children	3	2		2	2	3	3	4			4		3
Access to Psychiatric Services	4				1	2							
Community education/ prevention activities/ community outreach	5	5			5		5			5	3		5

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

Community Needs	Composite Regional Priority	BABH	CEI	CMHCM	GIHN	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Ease of access to MH care	6							5	1	4		4	
Services to individuals with mild/ moderate mental health needs; the underinsured	7	3	1					1	4			5	
Affordable and appropriate housing; Homelessness	8		5			4		3			2		
Alternatives to inpatient psychiatric services	9								5			3	4
Effect of Trauma	10-11	4								2	5		
Transportation to MH services	10-11				4			2					
Jail Diversion and Post Incarceration Treatment	12		2				5						
Services for the elderly	13-14												
Veteran's Outreach	13-14						4						
Poverty	15					5							

Across the region, services for individuals with substance use disorders or co-occurring mental health and SUD disorders was 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. The second highest priority across the region was integration of healthcare and improving health outcomes, and third, services for children, with an emphasis on community stakeholder collaboration and coordination of services.

Of the top three regional unmet community needs, both are already addressed in this assessment, with the exception of children's services. The following list 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:

- BABH
  - Operate an autism clinic and expanded the service provider network specific to autism services
  - Exploring options with the Health Department for a shared clinic based in the school system.
  - 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 and partnering with DHHS to address trauma screening for children
- CEI
  - Participating in the Breakthrough Collaborative with MDHHS and the Children's Trauma Assessment Center; added screening tools to be used by intake staff; using tool to screen DHS kids and meeting with DHS to make referrals; leadership are meeting to problem solve.
  - Increasing the number of screenings done with Ingham County DHS; meeting with Eaton and Clinton County DHS representatives as well
  - Working on contracting with additional providers to meet the increased demand for ABA and evaluative services
  - Contracting with the Michigan State University Laboratory pre-school to provide an Applied Behavioral Analysis clinic in the pre-school setting

- Developing a set of services designed specifically for families with adolescents or young adults who are experiencing a behavioral crisis:
  - Enhanced crisis services through the addition of urgent care program. This service provides immediate follow up by a Mental Health Therapist after an initial Crisis services contact. Contact is intense through a 2-3-week stabilization period. Service include safety planning, referrals, as well as mental health counseling.
  - Currently, exploring mobile crisis services for children.
- Added 40 hours of Telepsychiatry.
- Added trauma screening instruments in each clinical program and planning to launch an organizational self-assessment on trauma-informed care.
- Developed Care Coordination projects in clinical programs addressing asthma, hypertension, diabetes, and high Emergency Department Utilization.
- Formed the Information Integration Committee 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 3 rounds of 40 - hour training sessions for Officers. 140 Law Enforcement Officers from across Clinton, Eaton, and Ingham Counties were trained in 2017.
- 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 addition of several positions with navigator responsibilities such as the Veterans Navigator, Youth Prevention Therapist, Peer Recovery Coaches and Central Access Staff Outreach.
- Added Youth Mobile Crisis Response capabilities.
- Expanded 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 with assistance from the PIHP.
- Work with county jails for Naloxone to be in inmate property for those released to outpatient programs or no SUD programming.
- Arranged to bring Medically Assisted Detox protocols to The Recovery Center, the sub-acute detox center in Lansing.
- Partnering with Ingham Health Plan's Community of Care Committee who is working with local hospital Emergency Departments on locating persons with SUD and working with the access to treatment services.
- Provided Signs of Suicide follow up with schools and students in collaboration with Eaton Regional Education Service Agency.
- Started the "Tri-County Lifesavers" coalition to address Suicide awareness in tri-county area.
- Worked with Lansing School District to do School Summit Presentation on Mental Health/Suicide risk assessment training.
- Trained 140 community members in Mental Health First Aid.
- Collaborating with Lansing Landlords for 4-5 Outreach Case Management Services clients as a community project for housing MI clients.
- Created 6 additional beds in licensed homes designed to serve persons who have high behavioral needs.
- Added additional Applied Behavioral Analysis provider contracts to increase capacity to meet demand.

- CMHCM
  - Identified focusing on increasing services to children as part of the strategic plan
  - Will co-locate staff in local schools
  - Have significantly increased the number of children on an SED Waiver
  - Continuing to promote additionally staff trained on TF-CBT, PMTO, PCIT
  - Working with TBD Solutions to determine feasibility of a children's therapeutic foster care
  - Added an additional Wraparound staff (total 7 agency-wide)

  - Supporting staff training on SUD to increase the number of staff with CAADC or CADC credentials
  - Charged a work team with studying the areas of training needs for individuals with a COD
  - Participating in education with community partners on Naloxone
  - Co-location of MAT services in 3 offices with plans to expand to the remaining 3
  - Met with the local Methadone provider for increased collaboration
  - Lean Process with MDHHS in 4 counties with plans to add the other 2 counties
  - Michigan Collaborative Care Program
  - Transforming Research into Action to improves the lives of students
  - Increasing Multi-Systemic Therapy
  - Increased Baby Court
  - Continuing to promote ongoing training with the core EBPs (PMTO, BSFT, PCIT, TF-CBT, adolescent DBT, Nurturing Parenting Program, Parenting Through Change, Seeking Safety)
  - Increased training on SUD, Opioid addiction, distribution of Naloxone kits, and met with the local Methadone Provider to increase collaboration and coordination of care
- GIHN
  - Co-located a clinician in area schools
  - Positions were added or capacity increased at the following sites:
    - Health Department
    - Child Advocacy Center
    - Physician's office
    - Court systems
  - Expansion of Autism Services
  - Trained local schools and RESD in Mental Health First Aid- Youth
  - Staff trained in TF-CBT
  - Member of the Great Start Collaborative
- HBH
  - 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
  - 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;
  - Added trauma screening in each clinical program and have completed an organizational self-assessment on trauma-informed care capabilities;
  - Working 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, and FPE
  - Developing a Children's Intensive Mobile Crisis Team
  - Ongoing meetings with DHS, court staff, ISD, attorneys and Prosecutor staff to improve cross-agency collaboration on shared children/ family cases.
  - Staff and community partners trained on Trauma Informed Care and screening
  - Working with community partners to enhance and expand the Wraparound Collaborative
  - Open 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
- RDHRW
  - Have a full-time School Outreach Worker to increase the collaboration and referral rate from schools

  - Partnered with Ionia Schools and have two Masters level staff providing social work services to Ionia High School and Ionia Middle School.
  - Actively enhancing capacity to provide Mental Health First Aid for Youth in schools
  - Participate in Great Start Collaborative in Ionia County.
  - Expanding our Wraparound Program to include another Wraparound provider.
  - Participate in School Readiness Advisory Council.
  - Presented at 2017 "opening day," a personal development day for all public-school teachers – 320 teachers
  - Held an educational event on the autism benefit to educators.
  - Assisting a current ABA Aid employee in obtaining their BCBA to expand capacity of ABA services. This staff received her BCBA in November of 2016 and we are currently aiding another staff to obtain her BCBA.
  - Providing screening at the court house to juvenile offenders.
  - Child psychiatrist provides consultation to primary care providers and provides his person cell phone.
  - Are a licensed child placing agency.
  - Provide treatment foster care.
  - Opened State of the Art ABA Center in June 2017.
  - We have staff trained in TFCBT.
  - We have a Home-Based therapist staffed one day a week in a local elementary.
  - 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.
- LCHMA
  - 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
- 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.
  - Increased collaboration with DHHS in relation to reunification for children in placement or foster care and Family Team Meeting participation for children and youth with active Children's Protective Services cases.
  - Continued implementation of Children's Mental Health Block Grant for a multi-county MST program in partnership with Gratiot and Isabella Counties.
- NCMH
  - Participating in community collaborations, such as NC3, wraparound, Families First
  - 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, 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
  - Working on contracting with and hiring additional providers to meet the increased demand for ABA benefit and evaluative services (interviewing and will be hiring for additional autism aides, one case manager and an additional BCBA)
  - In discussion with NCRESA staff to utilize CMH office space to house one of their Parents as Teachers Workers at NCMH.
- SCCMHA
  - Awarded PA2 funds for the expansion of prevention funding with the Parents as Teachers home visiting model
  - Specific marketing with 'Many Challenges. One Call' brochure and disseminated widely in community to partners (3,900 copies) and available on the website as well.
  - Added a Youth Transition Program
  - Added additional Case Management team for Adults with Mental Illness
  - Added additional Supports Coordination team for individuals with Intellectual and Developmental Disabilities
  - Added full time mental health clinicians in 10 Saginaw City School Elementary and Middle School sites
  - Added mental health services for integrated care at CMH CMU Medical School Family Practice Clinic
  - Initiated a community Saginaw Hoarding Task Force with treatment beginning FY 2017
  - Facilitating Open Table and Mentoring services through the Children's System of Care Expansion grant
  - Revision of SCCMHA website
  - Mental Health First Aid/Youth First Aid Training
  - Central Access & Intake/Crisis Intervention Services remodel and living room model
  - Provision of same day/next day service
  - Expansion of autism services
  - SCCMHA co-location in CMU Health Pediatric site
  - Mobile Urgent Treatment Team expansion for both children/families and adults
  - SOGI (Sexual Orientation and Gender Identity) Training and Champions
  - Creation of Access, Assessment & Stabilization (AASC) project and improved front door response for children and families
  - Neonatal Abstinence Project Leadership by SCCMHA funded by MHEF via MPHI
  - Cancer Control Community of Practice Site selection by National Council and NBHN
- SHIACMH
  - 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
  - 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
  - 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.
- 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.
  - Added screening tools to the intake process for all children.
  - 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 three staff trained in Mental Health First Aid Youth.
  - 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.

MSHN is required to prepare a three-year Strategic Plan for Substance Use Disorder Prevention, Treatment and Recovery Services, which analyzes community needs. The MSHN SUD Strategic Plan for FY2015-2017 needs assessment analyzes trends in the primary substance in use at time of admission, rates of alcohol use, and mortality rates due to poisoning.

Through the MSHN SUD Strategic Plan needs assessment, it was determined an increased provider network capacity for opiate and medication assisted treatment was needed in the region. The region issued a request for proposals in 2015. The proposals received did not result in new providers joining the network. MSHN continues to work with existing providers to enhance regional capacity to meet consumer needs.

Waiting Lists

CMHSP Participants may establish waiting lists for certain services but are not permitted to use waiting lists for Medicaid services.

For SUD services, a hold may be placed on admission referrals to a program if that provider exceeds capacity. MSHN has developed a simple daily reporting mechanism for detox and residential providers to indicate the number of available beds each morning. This helps MSHN

assist with placing consumers by reaching out to providers who report immediate availability. Consumers can generally gain entrance into a detox facility within 48 hours if they are willing and able to go to the first available provider in the region. This is the same for residential providers, however, men generally have a longer wait time since there are few beds for men. This is an ongoing area of attention for MSHN. Providers are required to report monthly on priority population waiting list deficiencies. Since October 1, 2016, reports indicate consumers can access services timely and are not placed on waiting lists.

MSHN and the CMHSP Participants may elect to seek or add providers to regional provider networks to meet existing or new needs of consumers.

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.

Autism Spectrum Disorder Services

MDHHS expanded eligibility for Autism services to age 21 effective January 2016. Table 19 shows the growth in volumes for Applied Behavioral Analysis (ABA) services as demand has risen for these relatively new Medicaid services.

Table 19: Children Served by CMHSP's with Autism Spectrum Disorders and ABA Service Utilization

CMSHP	FY15		FY16		FY17	
	Number of Children-Adolescents w/ Autism Spectrum Disorder	Total on Autism Benefit 18 mos.-5 yrs.	Number of Children-Adolescents w/ Autism Spectrum Disorder	Total on Autism Benefit 0-21 yrs.	Number of Children-Adolescents w/ Autism Spectrum Disorder	Total on Autism Benefit 0-21 yrs.
BABH	102		234	49	290	95
CEI	200		600	122	610	208
CMHCM	261		377	57	462	126
GIHN	51		80	25	100	37
HBH	32		35	2	32	10
RDHRW	59		340	13	433	23
LCHMA	150		117	100	152	155
MCN	49		90	13	116	37
NCMH	83		454	14	550	16
SCCMHA	149		143	112	156	167
SHIACMH	66		123	17	155	24
TBHS	61		78	12	103	34

CMSHP	FY15		FY16		FY17	
	Number of Children-Adolescents w/ Autism Spectrum Disorder	Total on Autism Benefit 18 mos.-5 yrs.	Number of Children-Adolescents w/ Autism Spectrum Disorder	Total on Autism Benefit 0-21 yrs.	Number of Children-Adolescents w/ Autism Spectrum Disorder	Total on Autism Benefit 0-21 yrs.
MSHN	1,605	150	2,671	536	3,159	932

Since the MSHN region had encountered difficulties 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. See the section on sufficiency of number of providers for further analysis of provider network capacity to deliver Autism Benefit services.

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 is moving toward defining home and community-based settings by the nature of quality of individuals' experiences. The changes related to clarification of home and community-based settings and 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.

MSHN and its CMHSP Participants are actively participating in MDHHS system assessments, individual consumer surveys, residential, and non-residential service setting surveys. In FY17 MDHHS delegated increased responsibility for completion of the surveys to PIHP's. From these surveys, compliance with the HCBS rules is being assessed. In FY17 providers began receiving notice of the results of the surveys. Surveying has been completed for sites serving Habilitation Waiver beneficiaries and B-3 services.

It is still early in the process, but at the time of this Plan, 35 out of 486 non-residential sites and 0 out of 871 residential sites in the region have been assessed by the state as compliant. Full compliance with the requirements and the state's transition plan is required no later than March 2019.

In September 2017 MDHHS issued a directive effective October 1, 2017 that new home and community based service providers must be in immediate compliance with the HCBS rules to render services to Medicaid beneficiaries. New providers are permitted to sign an attestation of intent to comply with the rules and will be reviewed within 90 days of opening, which is not necessarily a barrier to network growth where needed. However, MDHHS has also indicated existing providers who have been determined to be under 'Heightened Scrutiny' are not permitted to expand their services until they achieve compliance. This latter requirement is creating some concern regarding regional capacity to add services or sites within the

established provider network when enrollee demand warrants expansion. This issue will be addressed by MSHN and the CMHSP Participants. Table 20 shows the volume of sites determined to require heightened scrutiny of their compliance with HCBS rules based upon the results of the surveys that have been completed at this point.

Table 20: HCBS Compliance Status for Sites Serving Habilitation Waiver Beneficiaries

	Heightened Scrutiny
Bay-Arenac Behavioral Health	92
CMH for Central MI	94
CMHA CEI	243
Gratiot Integrated Health Network	22
Huron Behavioral Health	15
The Right Door for Hope, Recovery, and Wellness	7
Lifeways	45
Montcalm Care Network	19
Newaygo CMH	15
Saginaw CMH	56
Shiawassee CMH	21
Tuscola CMH	19
MSHN TOTAL	**648**

Michigan Public Act 200 (Kevin's Law)

In June of 2014, Michigan Public Act 200 amended Chapter 2A (Substance Abuse Disorder Services) of the Mental Health Code to allow a court to order involuntary treatment for an adult who had a substance use disorder, under certain circumstances. The person would be guaranteed an independent expert evaluation and legal counsel. A judge could order treatment for up to 72 hours or until a hearing could be held.

Effective February 14, 2017, 320 Public Act 2016 amended the Mental Health Code to clarify procedure and expand criteria for ordering individuals to receive assisted outpatient treatment (Kevin's Law) as one of several options of involuntary mental health treatment. Among other changes, PA 320 of 2016 expanded the length of time permitted to initiate treatment and added flexibility regarding present versus historical risk factors.

CMHSP Participants and SUD Providers have not reported a strong impact on service demand for services because of PA 200 (and consequently, provider network capacity).

Veteran's Access, Choice and Accountability Act of 2014

Improved access to behavioral health care for veterans is a priority for the State of Michigan and MSHN added a similar strategic priority to its action plan in 2015. In addition, the federal Veteran's Access, Choice and Accountability Act of 2014 allows those veterans who are unable to schedule an appointment within 30 days or if their place of residence is more than 40 miles

from the closest Veteran's Administration health care facility, to elect to receive care from eligible non-VA health care entities or providers.

CMHSP Participants and SUD Providers may be the closest available behavioral health service provider in some areas of the region, since CMHSP's are located in each county in the region. Depending upon the level of demand, portions of Huron County to the east, Osceola, Clare, Mecosta and Isabella Counties to the northwest, and Newaygo and Montcalm Counties to the west, could see increases in demand for services.

Figure 6 shows the location of Veteran's Administration (VA) Medical Centers and Clinics relative to the MSHN region.

Figure 6: Location of VA Medical Centers and Clinics in MSHN Region

MSHN has begun preliminary analysis of baseline levels of service penetration among the veterans' population in the region. In FY17 less than 2% of the individuals receiving behavioral treatment in the region were identified as veterans, as shown in Figure 7.

Figure 7: Veteran Status in MSHN Region in FY17

	Count	Percentage
Not a Veteran	22191	95%
Not Collected	707	3%
Veteran	464	2%
MSHN TOTAL	**23362**	**100%**

CMHSP's responding to a need for VA services are required to meet the same qualifications as required by Medicare and the service array is primarily psychiatric services and outpatient therapies. Lifeways Community Mental Health operates a clinic in Jackson County which provides behavioral health services to veterans. LifeWays is currently in the process of contracting with TriWest Healthcare Alliance which is part of the Community Care Network in collaboration with Magellan Healthcare to serve veterans in our area. This is to take place in early 2018. There is also a clinic in the Lansing area. Saginaw CMH met with the state

Veteran's Liaison and the regional navigator, have promoted their information system wide, and added a Veteran's section to their website. Saginaw CMH is also attempting to finalize a memorandum of understanding the Veteran's Administration hospital located in Saginaw.

In 2017 MSHN added a Veteran Navigator (VN), a grant-funded position that is charged by MDHHS with identifying resources for Veteran and Military Families (V/MFs) in the region. The Navigator assists CMHSP's with making appropriate referrals, coordinating care, and providing follow up. Coordination is also provided for volunteer peer supports for veterans such as Buddy-To-Buddy, Vet-to-Vet, and other peer programs that may exist in the community. The VN has begun to network with regional Community Based Outpatient Clinics (CBOCs), Veteran Community Action Teams (VCATs), MSHN's CMHSP's, and will be reaching out to the SUD provider network.

The region will continue to monitor the demand for and adequacy of its capacity to serve veterans.

Intensive Crisis Stabilization Services

In September 2017 MDHHS modified Medicaid standards to require Intensive Crisis Stabilization Services be available for children (i.e., birth to 21 years of age) effective 10/1/17. This includes 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).

Intensive crisis stabilization programs are available to people in Clare, Gladwin, Hillsdale, Isabella, Jackson, Mecosta, Midland, Osceola and Saginaw counties. Programs in these geographic areas will be broadened to include the target population.

Some CMHSPs in the region do not anticipate sufficient volume to sustain (single CMHSP) local programming. In those cases, neighboring CMHSPs will collaborate on the development of intensive crisis stabilization services multi-laterally through shared service arrangements or contracting with vendors who can provide the services in the catchment area. MSHN and the CMHSP's may collaborate for regional/sub-regional procurement for these services.

Healthy Michigan Plan 1115 Demonstration Waiver

The Marketplace Option amendment of the Healthy Michigan program provides that Medicaid beneficiaries with incomes greater than 100% of the federal poverty level who have been enrolled in an HMP health plan for 12 consecutive months may be required to receive their health benefits through a Marketplace Option if they have not completed the healthy behavior requirements of the Healthy Behaviors Incentive Program. As required by state law, individuals who are determined medically frail in accordance with 42 CFR 440.315 are not excluded from the Marketplace Option. Additionally, individuals exempt from premiums and cost-sharing pursuant to 42 CFR 447.56 are exempt from the Marketplace Option.

The transition of the HMP beneficiaries who qualify for the Marketplace Option will begin on April 1, 2018. Beneficiaries who do not qualify for the Marketplace Option will continue to receive their health benefits through HMP managed care.

MDHHS has indicated that HMP eligible individuals receiving specialty behavioral health services automatically meet the medically frail definition. However, the process for excluding this population will be complex and some people may be misclassified. The PIHP and CMHSP's will be monitoring this transition closely and have been advised to notify MDHHS should an HMP eligible individual receiving specialty behavioral health services receive a notification letter that they must engage in a healthy behavior or migrate to the marketplace.

MDHHS initiated an enrollment process for SUD providers in preparation for the 1115 combined waiver. This process includes review of the level of care for outpatient, withdrawal management, and residential programs. Results of the review are shown in Table 21.

Table 21: Level of Care for Outpatient, Residential and Withdrawal Management Programs

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

Meeting the needs of enrollees: expected utilization of services

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[6]. 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[7]. 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 1915(b) Specialty Services Waiver; who are *enrolled* in the 1915(c) Habilitation Supports Waiver; who are enrolled in the Autism Benefit; or for whom MSHN has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. The PIHP 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.

Since eligibility and medical necessity for service involves factors beyond the determination of a diagnosis, prevalence may not be best predictor of future demand. Service utilization may serve as a better proxy for consumer demand.

Table 22 shows the number of consumers serviced, units provided, and count of services during FY16 and FY17. The number of people served has increased and the count of services is relatively stable.

Table 22: Service Utilization by CMHSP

	FY16			FY17		
CMHSP	Number Served	Units Provided	Count of Services	Number Served	Units Provided	Count of Services
Bay-Arenac Behavioral Health	4,912	2,732,332	306,200	4,779	2,320,011	288,194
CMHA CEI	7,189	5,174,614	573,454	7,453	4,892,630	808,643
CMH for Central Michigan[8]	7,518	10,726,502	995,368	7,605	6,138,441	692,524

[6] 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."

[7] 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."

[8] CMHCM shifted more toward a CLS per diem model resulting in a significant reduction in units of service.

CMHSP	FY16 Number Served	FY16 Units Provided	FY16 Count of Services	FY17 Number Served	FY17 Units Provided	FY17 Count of Services
Gratiot Integrated Health Network	1,375	383,239	74,196	1,361	296,562	49,370
Huron Behavioral Health	879	470,204	51,979	894	460,616	50,068
Lifeways	5,686	2,258,982	291,402	5,882	2,040,972	284,702
Montcalm Care Network	1,497	570,928	54,064	1,644	484,708	52,250
Newaygo CMH	1,361	309,379	67,754	1,471	267,391	60,986
Saginaw CMH	4,696	3,754,356	340,035	5,416	3,687,382	361,544
Shiawassee CMH	1,519	1,296,394	108,290	1,712	1,459,440	118,204
The Right Door for Hope Recovery & Wellness	1,479	403,615	62,452	1,602	253,462	55,788
Tuscola CMH	1,102	437,349	65,923	1,113	399,866	70,729
MSHN TOTAL	**39,213**	**28,517,894**	**2,991,117**	**40,932**	**22,701,481**	**2,893,002**

Table 23 shows the number of consumers served for Home-Based Services (HBS), Targeted Case Management (TCM), and Habilitation Supports Waiver (HSW) for the same time periods. Demand has likewise been largely stable.

Table 23: HBS, TCM, and HSW Service Utilization

CMHSP	HBS Number Served FY16	HBS Number Served FY17	TCM Number Served FY16	TCM Number Served FY17	HSW Number Served FY16	HSW Number Served FY17
BABH	178	173	1289	1300	166	178
CEI	1064	1013	3154	3194	245	239
CMHCM	417	471	1662	1451	515	495
GIHN	133	117	478	414	62	57
HBH	71	76	250	236	49	46
LCHMA	575	597	1856	1991	254	254
MCN	262	311	472	508	35	32
NCMH	122	130	743	647	25	24
SCCMHA	36	9	2018	2317	129	145
SHIACMH	94	101	258	227	72	74
RDHRW	226	222	549	395	47	46
TBHS	133	137	52	45	66	71
MSHN Total	**3311**	**3357**	**12781**	**12725**	**1665**	**1661**

Consumer satisfaction with services is an important consideration when evaluating the adequacy of a provider network. MSHN assesses consumer perception of care for adults with mental illness utilizing Assertive Community Treatment services and children with serious emotional disturbance receiving Home Based Services. Although not necessarily representative of all consumer populations, these high need groups have been repeatedly identified by MDHHS as key stakeholders for solicitation of feedback and therefore are used here as proxies for the satisfaction of MSHN recipients of service.

Results of the regional Perception of Care Surveys conducted over the past few years are shown in in Figures 8 and 9. Generalization of survey results has been difficult due to historically low survey response rates, which results in a lower than desired confidence level in the findings. Keeping that limitation in mind, the responses to the Access (to services) subscale for Home-Based and ACT services are relatively favorable, with less than 10% of youth and 15% of adults

expressing concern about access to services. An even higher level of satisfaction remains a goal for the MSHN region.

Figure 8: **Percent Agree by Subscale, Home-Based Services**

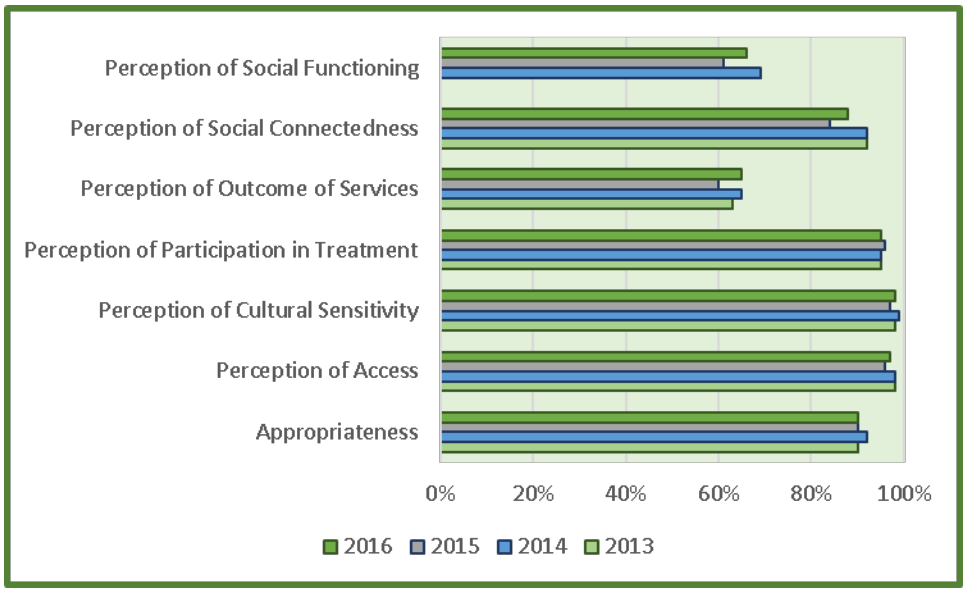
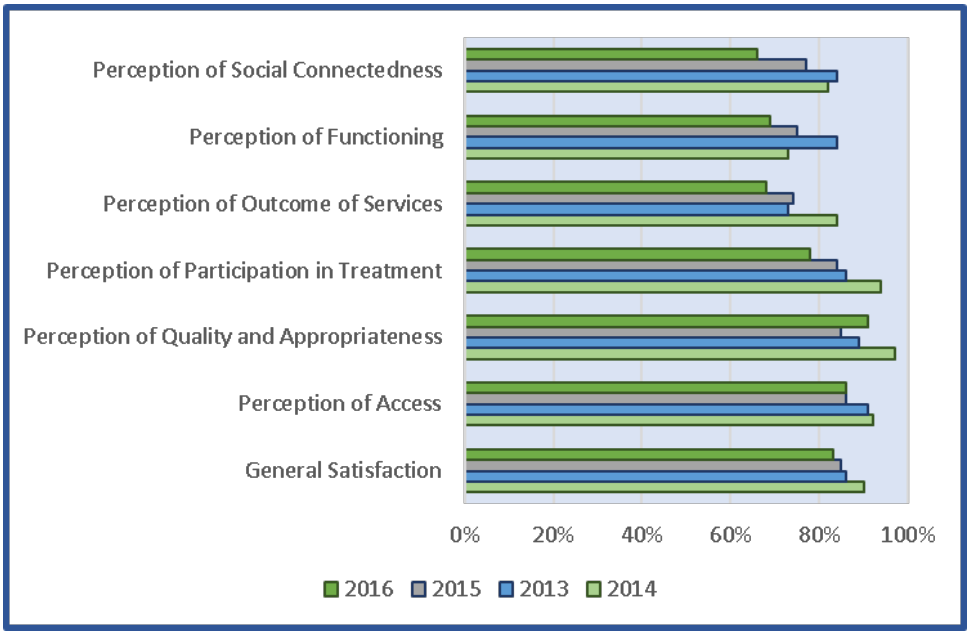


Figure 9: **Percent Agree by Subscale, Assertive Community Treatment**



The results are reviewed by the MSHN Quality Improvement Council and the Regional Consumer Advisory Council to determine possible region wide improvement efforts as well as identification of any trends that have occurred from year to year. The results are compared to

national averages as available. The areas of improvement will be targeted towards the domains with the lower average scores (based on the regional average of all scores) and those domains that have shown a decrease from the previous years. Each CMHSP will also review their local results for areas of improvement at the local level.

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[9]. 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

MDHHS requires PIHP's to report indicators of access timeliness and inpatient follow-up. Table 24 shows the recent year-to-year performance of the 21-county region. MSHN's performance is above state thresholds, indicating beneficiaries are generally accessing services in a timely fashion.

Table 24: **State Performance Indicators for Access Timeliness and Inpatient Follow-Up**

	Population	MSHN Score FY16 Q3	MSHN Score FY17 Q3
New persons receiving face to face assessment w/in 14 days of non-emergency assessment (Standard: ≥95%)	MI-Children	98.72%	98.51%
	MI-Adults	99.29%	99.26%
	DD-Children	100.00%	97.30%
	DD-Adults	98.82%	100.00%
	Medicaid SA	98.96%	98.39%
New persons starting on-going service w/in 14 calendar days of a non-emergent assessment (Standard: ≥95%)	MI-Children	96.83%	96.98%
	MI-Adults	97.55%	98.25%
	DD-Children	96.36%	100.00%
	DD-Adults	96.36%	98.48%
	Medicaid SA	100.00%	100.00%
Persons discharged from psychiatric inpatient unit/ substance abuse detox unit seen for follow-up care w/in 7 days (Standard: ≥95%)	Children	99.14%	99.22%
	Adults	97.03%	96.97%
	Medicaid SA	100.00%	97.51%
Persons readmitted to an inpatient psychiatric unit w/in 30 days of discharge	Children	6.31%	11.88%

[9] 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."

	Population	MSHN Score FY16 Q3	MSHN Score FY17 Q3
	Adults	9.35%	11.10%

MSHN has already identified network crisis response capacity and community psychiatric inpatient availability as areas of concern for the region's provider network, although MSHN performs better than state averages relative to inpatient recidivism. Both areas are being addressed by MSHN, which will be expected to help with inpatient recidivism as well.

Sufficiency of number of providers – autism spectrum disorder capacity

CMHSP Participants have found it difficult to secure adequate providers to provide Applied Behavioral Analysis services for children 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. Insufficiencies in the quantity of providers who are qualified to provide Autism benefit services, particularly Board Certified Applied Behavioral Analysts (BCBA's) to provide Applied Behavioral Analysis (ABA) services is a challenge in some areas of the provider network, although progress has been made. Table 25 shows current system capacity.

Table 25: MDHHS Medicaid Autism Spectrum Disorder (ASD) Capacity as of 3/31/17

	BABH	CEI	CMHCM	GIHN	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Adequate capacity for diagnostic services of ASD?	2015 –Yes 2016- Yes 2017 -Yes	2015-Yes 2016-No 2017 -No	2015-Yes 2016-No 2017 -Yes	2015-Yes 2016-Yes 2017 -Yes	2015-Yes 2016-Yes 2017 -Yes	2015-Yes 2016-Yes 2017 -Yes	2015-Yes 2016-Yes 2017 -Yes	2015-Yes 2016-Yes 2017 -	2015-Yes 2016-Yes 2017 -	2015-Yes 2016-Yes 2017 -No	2015-Yes 2016-No 2017 -No	2015-Yes 2016-Yes 2017 -
Capacity to assist additional children with diagnostic services for ASD?	2015-No 2016-No 2017 -No	2015-Yes 2016-No 2017 -No	2015-No 2016-No 2017 -No	2015-Yes 2016-No 2017 -No	2015-No 2016-No 2017 -No	2015-Yes 2016-Yes 2017 -Yes	2015-Yes 2016-Yes 2017 -Yes	2015-No 2016-Yes 2017 -	2015-Yes 2016-Yes 2017 -	2015-No 2016-No 2017 -No	2015-Yes 2016-No 2017 -No	2015-Yes 2016-No 2017 -
Capacity to provide ABA for additional children in addition to your community?	2015-No 2016-No 2017 -No	2015–Yes 2016-Yes 2017 -No	2015-No 2016-No 2017 -No	2015-No 2016-No 2017 -No	2015-No 2016-No 2017 -No	2015-Yes 2016-Yes 2017 -Yes	2015-Yes 2016-Yes 2017 -No	2015-Yes 2016-No 2017 -	2015-Yes 2016-No 2017 -	2015-No 2016-No 2017 -No	2015-No 2016-No 2017 -No	2015-No 2016-No 2017 -
As of Mar 31, # of children eligible for the benefit	2015 – 17 2016 – 49 2017 -67	2015 - 65 2016 – 105 2017 -140	2015 – 29 2016 – 40 2017 -109	2015 – 13 2016 – 21 2017 -33	2015 – 0 2016 – 2 2017 -11	2015 – 5 2016 – 13 2017 -15	2015 – 31 2016 – 53 2017 -126	2015 – 2 2016 – 25 2017 -	2015 – 5 2016 – 9 2017 -	2015 – 51 2016 -145 2017 -155	2015 – 10 2016 – 15 2017 -155	2015 – 7 2016 – 5 2017 -
Of those eligible, number receiving ABA services	2015 – 15 2016 – 35 2017 -44	2015 - 60 2016 – 92 2017 -128	2015 – 24 2016 – 33 2017 -65	2015 – 10 2016 – 14 2017 -21	2015 - 0 2016 – 2 2017 -8	2015 – 4 2016 – 5 2017 -15	2015 – 23 2016 – 53 2017 -106	2015 – 2 2016 - 8 2017 -	2015 – 5 2016 – 6 2017 -	2015 – 38 2016 – 110 2017 -96	2015 – 8 2016 - 14 2017 -96	2015 – 5 2016 - 3 2017 -
Do you need assistance acquiring BCBA(s)?	2015 – Yes 2016 – No 2017 -No	2015 – Yes 2016 – Yes 2017 –No	2015 – Yes 2016 - Yes 2017 -Yes	2015 – No 2016 – No 2017 -No	2015 – No 2016 - No 2017 -No	2015 – No 2016 – No 2017 -No	2015 – No 2016 – Yes 2017 -Yes	2015 – No 2016 – No 2017 -	2015– No 2016– No 2017 -	2015 – Yes 2016 – No 2017 -No	2015 – Yes 2016 – Yes 2017 -No	2015 – No 2016 – Yes 2017 -
Average length of time to start ABA services after referral (after initial contact w/ CMH for ASD services)	2015 - 12 weeks 2016 – 10 weeks 2017 -47 weeks	2015 - 30 Days 2016 – 131 days 2017 -162 days	2015 - 8 weeks 2016 – 2-4 months 2017 - 3-6 months	2015 - 3 weeks 2016 – 7.5 weeks 2017 -90+ days	2015 – Unknown 2016 – 30-45 days 2017 -90 days	2015 - 10 weeks 2016 – 59 days 2017 -45 days	2015 - 8 weeks 2016 - 30-60 days 2017 -98 days	2015 – 90 2016 – 30 days (testing) 2017 -	2015 - 11 weeks 2016 – 75 days 2017 -	2015 - 45 days 2016 – 45 days 2017 -90+ days	2015 - 6 weeks 2016 – 60-65 days 2017 -90+ days	2015 - 20 weeks 2016 – 90 days 2017 -

The average age of the individuals utilizing Autism benefits in the MSHN region is 8.83 years of age. There are individuals who have been waiting more than 90 days for a plan of service,

which in October of 2017 totaled 192, and in November,145, as shown in Table 26. CMHSP Participants continue to address gaps in provider network capacity for autism benefit services.

Table 26: Individuals with Autism Waiting Longer Than 90 Days for a Plan of Service

	As of 10/1/2017	As of 11/1/2017
Bay-Arenac Behavioral Health	28	17
CMH for Central MI		29
CMHA CEI	31	30
Gratiot Integrated Health Network	9	2
Huron Behavioral Health	2	2
The Right Door for Hope, Recovery, and Wellness	4	0
Lifeways	43	30
Montcalm Care Network	6	10
Newaygo CMH	6	1
Saginaw CMH	15	19
Shiawassee CMH	5	3
Tuscola CMH	9	2
MSHN Total	**192**	**145**

MSHN identified some weaknesses in network capacity for substance use disorder services, as specified in the multi-year strategic plan. Additional detox beds were established in Saginaw county due to lack of capacity to meet current demand and a methadone provider for Suboxone was replaced to maintain current provider volumes.

All CMHSP Participants are required via their contract with MSHN, and indirectly by MSHN's contract with MDHHS, to accept new Medicaid patients[10]. The same requirement applies to SUD Medicaid services.

Sufficiency of mix of providers – IDD, SED

MSHN is required to give priority to individuals with serious mental illness, serious emotional disturbance and developmental disabilities with the most serious forms of illness and those in urgent and emergent situations. Key services for individuals with urgent and emergent needs include inpatient psychiatric care and 24/7 emergency response capacity. Both services are available in all 21 counties in the MSHN region. However, MSHN has noted access to psychiatric inpatient in the region may not be adequate to meet the needs of all consumers (at any given time) for whom a pre-screening has been completed and admission determined to be warranted.

[10] 42CFR438.206(b)(iv) "The numbers of network providers who are not accepting new Medicaid patients."

The issues causing this network capacity concern appearance to be the result of a convergence of several factors. Some hospitals are reporting a lack of capacity, but anecdotal evidence suggests capacity is only a barrier in limited geographic areas or for certain specialty populations. The slackening economy in Michigan in the past several years appears to have triggered restricted staffing in some hospitals, thereby limiting their capacities.

Anecdotal evidence suggests the needs of the patient population have increased due to the growth in opiate and other addictions, married with expanding populations of individuals who were discharged to their home communities during the most recent phase of state center closures and census reductions. The needs of the patient populations are growing ever more complex. Some psychiatric inpatient hospitals have reacted by refusing to admit individuals with significant behavioral challenges or other more intensive/complex symptomatic presentations.

The region has acted by advocating for regional need at state Certificate of Need (CON) Commission meetings and approaching the MDHHS for assistance. In February 2016, MSHN entered an agreement with the Certificate of Need Commission (CON) and the Behavioral Health and Developmental Disabilities Administration (BHDDA) to pilot the collection of psychiatric inpatient denial data in MSHN's 21 county region. The goal of the pilot was to address issues surrounding appropriate and immediate access to inpatient psychiatric care not only with MSHN's region, but around the state, for the state to investigate and resolve patterns of inpatient admission difficulties, and to reduce denials, which should lead to better access for individuals experiencing acute psychiatric distress.

Between 3/1/16 and 7/9/17, CMHSP's in the MSHN region reported 11,108 instances of psychiatric inpatient admission denials impacting 1,676 consumers. This was an average of 19 denials per consumer. Of the total number of consumer denied admission, 13% were children/minors and 87% were adults. The most common reason for denial reported was 'at capacity' (81%).

Given a large majority of calls resulted in a denial due to capacity, MSHN, along with other parties, advocated with the CON commission to consider investigating patters of denial that were inconsistent with existing CON commission rules. Trends in psychiatric admission difficulties for certain sub-populations were also noted. Census data, and the CON commissions own records showing bed availability and need showed there were enough beds; however, they may not be available for specific populations. To address the needs of these specific sub-populations, the CON commission approved a statewide pool of 370 additional psychiatric beds to meet the needs of special population groups – adult IDD, child/adolescent IDD, geriatric psychiatric, adult SMI, and child/adolescent SMI. These beds were designated to address inpatient access barriers by people in these sub-populations only and did not address the needs of persons in the severe mental illness category that do not experience these complications.

As a companion activity, MSHN commissioned Health Management Associates (HMA) to conduct national research around public psychiatric inpatient bed registry (PBR) systems.

Several states have implemented either mandatory or voluntary systems for the purposes of maintaining real time bed availability. The final report was shared with BHDDA and the CON commission and in June 2017 was presented publicly to a stakeholder group to gauge interest and support for developing a PBR system in Michigan. With support for moving forward, BHDDA established a workgroup to define system requirements in addition to several other stakeholder groups to address key issues related to inpatient access barriers.

Community-based psychiatric treatment and behavioral intervention may be considered the next highest priority relative to stabilization of acute clinical symptoms for consumers in urgent and emergent situations. Both services are likewise available in all counties in the region. However, it is challenging to sustain adequate psychiatric capacity, particularly physicians with specialized certifications such as board certification in the treatment of adolescents and children.

Sufficiency of mix of providers - SUD

With the recent implementation of the Healthy Michigan Plan, MSHN will need to monitor closely the availability of licensed substance abuse treatment providers to meet the potentially increased demand. MSHN will be working with its provider network, MDHHS, and substance use disorder licensing to address which SUD services must be offered by a licensed provider versus a MDHHS certified or MSHN credentialed behavioral health provider.

Similarly, MSHN must assure that the twelve CMHSP participants, in addition to network SUD service providers, have adequate capacity and competence to participate in an integrated service access process for individuals seeking treatment for both mental health and substance use disorders. Cross credentialing is an area of focus for the region.

Sufficiency of mix of providers – cultural competence

Each CMHSP participant includes training for staff regarding cultural competence. Providers are empaneled in areas with concentrations of ethnic or cultural groups, such as the Latino counseling services available through the CEI provider network. Each CMH is responsible for understanding the ethnic composition of their communities and adhering to requirements for publication of materials in different languages.

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.

Geographic accessibility

The MDHHS is working with the PIHP's in the state 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.

The MSHN region, although rural in some areas, can meet existing MDHHS standards for geographic accessibility, as follows:

- For office or site-based mental health services, the individual's primary service providers (e.g., case manager, psychiatrist, primary therapist, etc.) must be within 30 miles or 30 minutes of the recipient's residence in urban areas, and within 60 miles or 60 minutes in rural areas.

- For office or site-based substance abuse services, the individual's primary service provider (e.g., therapist) must be within 30 miles or 30 minutes of the recipient's residence in urban areas and within 60 miles or 60 minutes in rural areas.[11]

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.

In accordance with revisions to the managed care rules, the availability of triage lines or screening systems, as well as also be considered in state provider network adequacy standards. Most of the CMHSP's in the region have used or would use tele-medicine services for key services which are in short supply, such as psychiatric care. All the CMHSP's use emergency services hotlines to receive and triage calls from Medicaid beneficiaries and other members of the community. Some CMHSP's 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[12]. Delivery of services in home settings as well as telemedicine (now available in selected counties) can offset barriers to physical access where present.

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[11] Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY13 Contract; 3.1 Access Standards

[12] 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."

The majority of the CMHSP's 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 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.

As of the date of this assessment, none of the populations in the counties in the MSHN region have more than 1% of non-English speaking individuals. However, interpreters/ 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 CMHSP's 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 is being addressed during site reviews by the MSHN audit team.

Public Policy Priorities

In its 2013 Application for Participation for PIHP's, MDHHS identified a series of public policy initiatives which reflected the state's priorities relative to maintaining an adequate provider network capacity for Medicaid beneficiaries. A number of the priorities are addressed here. The following are areas of focus for MSHN dashboard and quality reporting and have been removed from this assessment:

- Olmstead Compliance – Community Living
    - Individuals Living in Any Licensed Setting
    - Individuals Living in a Licensed Setting Outside of the PIHP Region
    - Individuals Living Independently
- Employment and Community Activities
    - Adults in Employment and Community Activities
    - Competitive Employment

Regional Crisis Response Capacity

MDHHS requires PIHP's to have a crisis response capacity fully available that includes clinical expertise that can be immediately accessed for mental health or behavioral crises. MSHN, along with other PIHP's, has encountered challenges in meeting this requirement. CMHSP's in the region have telephonic response capacity, typically including some type of active monitoring program and the ability to engage in face-to-face crisis contacts if needed. Options for effectively and defensibly expending Medicaid funds to develop and maintain an ongoing residential crisis response capacity is still being addressed by MSHN and the CMHSP Participants.

Previously in this document current barriers to access to inpatient psychiatric care are addressed, which has weakened the region's crisis response capacity. Crisis response remains a priority for the region.

Health and Welfare

MDHHS is seeking greater integration of systems of care to promote healthy behaviors and management of chronic conditions and all aspects of health: physical health, behavioral health, and habilitation. MDHHS expects that MSHN will assure that individuals being served receive appropriate, culturally-relevant and timely healthcare; that medical care providers are knowledgeable in how to approach and treat individuals with mental illness and/or intellectual/developmental disabilities; and that the PIHPs' provider networks are partners on the health care team for health care planning and monitoring purposes.

MSHN is focusing its health efforts on expanded competency and access to integrated health care information. Additionally, MSHN recently completed a Mental Health Federal Block Grant to expand/enhance the availability of peer health coaches and to address regional infrastructure development for Trauma Informed Care.

MSHN staff is working with DCH to obtain access to Care Connect 360 and the Data Analytics. In addition, MSHN QIC and Information Technology Council are coordinating efforts to determine what data will be extracted and utilized to ensure compliance with the state Performance Indicator Project and provide performance improvements opportunities that will create positive outcomes for individuals served in the region.

Substance Use Disorder Prevention, Treatment and Recovery

MDHHS is committed to a transformational change that promotes and sustains wellness and recovery for individuals, families, and communities. This change to a recovery-oriented system of care (ROSC) employs strategies to:

- Prevent the development of new substance use disorders.
- Reduce the harm caused by addiction.
- Help individuals make the transition from brief experiments in recovery initiation to sustained recovery maintenance via diverse holistic services.

- Promote good quality of life and improve community health and wellness.

Per MDHHS's Recovery Policy and Practice Advisory, Version 10.15.15, MSHN and the other PIHPs are charged with assessing regional ROSC capacity and developing a growth plan to close any gap in capacity by February 2018.

MSHN is also tending to the needs of individuals with co-occurring substance use and mental health conditions by selecting a region-wide behavioral health recovery survey tool for implementation later this year. CMHSP Participants and MSHN have adopted recovery oriented language for inclusion in job descriptions. Recovery principles are being incorporated in the MSHN mission, vision and values. MSHN will be continuing to develop regional capacity to support consumer recovery over the next year.

Integration of mental health, substance use disorder and physical health care

MSHN and its CMHSP Participants are currently evaluating the state of integration of mental health, substance use disorder and physical health care publicly funded systems of care. MSHN through their FY15 Strategic Plan and the CMHSP Participants identified integration of health care as one of their top priorities. The region adopted a performance improvement project which addresses diabetes screening for individuals prescribed certain medications which are associated with exacerbation of metabolic disorders or predispositions.

MSHN has obtained access to Medicaid claims data for the region and in 2014 entered a joint agreement with three other PIHP's for the purchase services from a data analytics vendor. Key measures have been identified for monitoring of the health status and wellness efforts of the region's Medicaid population.

In FY16, MDHHS included contractual requirements regarding PIHP and Medicaid Health Plan Coordination with specific measurements and expectations related to obtaining a performance bonus. MSHN has eight (8) Medicaid Health Plans in the region and has provided health information data regarding our shared population. MSHN along with United Health Care is facilitating state-wide meetings to define a risk stratification process the will prioritize and identify individuals that will receive care coordination. In addition, in FY16 MSHN has developed a data exchange with hospitals in our region to receive admit, discharge and transfer information.

While the PIHP and MHPs work together on the care coordination at the plan level, the CMHSP Participants and the SUD Provider system will see an increase in care management demands at the consumer level. MSHN expects this will increase utilization of CMHPS resources and provider network service.

The following list summarizes CMHSP Participant efforts to increase healthcare integration, as described in their community needs assessment updates:

- BABH
  - Implemented a revised nursing model to expand access to healthcare; embedded questions in social work assessments focused on typical chronic co-morbid conditions to identify consumers for referral to nursing staff for health assessment and enhanced coordination of care with primary care providers; embedding questions in person centered planning process regarding health risk profile
  - Participating in a performance improvement project involving diabetes screening and coordination with primary care physicians
  - Providing funding for the Community Health Assessment
  - Key partner for Saginaw Valley State University and Bay County Health Department HRSA grant to add a behavioral health team to a nurse practitioner primary care clinic
  - Pilot site for MDHHS, MiHIN and PCE for development of embedding of CC 360 in EHR
  - Working with Zenith for potential embedding of the Integrated Health Care Platform in EHR, including risk analysis for poor health outcomes
  - Providing wellness classes run by nursing staff
  - Implemented electronic lab ordering and receipt of test results with multiple labs
  - Contracted with Great Lakes Health Connect for information exchange with regional health center and primary physician clinics
  - Collaborative effort to implement a Vivitrol program in the jail with Bay County Jail leadership, Sheriff's Dep't, Courts (judges), Public Health Dep't and SUD providers
- CEI
  - Have Behavioral Health Consultants (BHC) placed in two Sparrow Hospital Primary Care Practices and one McLaren Primary Care Practice to review screenings based on the Bright Futures Screening Protocol, and consult with patients and provide brief treatment at the clinic. Additionally, BHCs continue to provide onsite behavioral health interventions, including both brief intervention as well as ongoing treatment.
  - In partnership with Michigan Child Collaborative Care (MC3) offering pediatricians and OB/GYNs psychiatric consultation with University of Michigan psychiatry staff. Currently 75 local providers have been enrolled into MC3, with dozens already utilizing psychiatric consultation.
  - CMHA-CEI's Families Forward Program continues to convene the Action Learning Network (ALN) a consortium of five CMH Children's Services including CEI, Detroit-Wayne, Kalamazoo, Kent and Saginaw. The ALN has completed 4 additional Practice Briefs this year; 2 of which have been disseminated, and 2 more that will be disseminated prior to September 30, 2016. Practice Briefs have focused on the value of integration between the Community Mental Health System and pediatric primary care practices.
  - Have CMHA-CEI Supervised Behavioral Health Consultants embedded in 4 Ingham County Federally Qualified Health Center locations, with Volunteers of America Homeless Shelter Medical Clinic site to be added in 2018. Working towards connecting ICHD and CMHA-CEI Electronic Health Records. SUD specialist will be added to support SBIRT and consultation in the FQHCs in FY18.
  - The Ingham County Health Department operates the Birch Health Center (FQHC) located inside our CMHA-CEI Jolly Rd. Building with both CMHA-CEI Behavioral Health Consultant and CMHA-CEI Psychiatric Nurse Case Manager embedded in the clinic.
  - Have CMHA-CEI Crisis Services Mental Health Therapists embedded into the McLaren-Greater Lansing Hospital Emergency Department daily 2pm to 2am.
  - In partnership with Michigan Child Collaborative Care (MC3) offering pediatricians and OB/GYNs psychiatric consultation with University of Michigan psychiatry staff. Currently 75 local providers have been enrolled into MC3, with dozens already utilizing psychiatric consultation.
  - CMHA-CEI Wellness Center provides Adult Outpatient Treatment co-located in the Ingham County Health Department Forest Community Health Center.
  - CMHA-CEI Wellness Center Mental Health Services provide services within the Cristo Rey Community Center Medical Clinic.

  - Working on care coordination pilot projects within CMHA-CEI clinical departments that address chronic illness or emergency department usage to be implemented in FY18.
- CMHCM
  - Co-locating five therapists
  - Participating in the Michigan Health Improvement Alliance collaborating with other agencies to achieve a community of health excellence
  - Meeting with Great Lakes Health Information Exchange about integrating lab and available physical health data into the EMR
  - Accessing State of Michigan web portal, Care Connect 360 that provides population health and data analytics information was pursued. Work will continue this year on these initiatives.
  - Meeting with all hospitals in the area and collaborating on several fronts
  - Medical Director is now adjunct prof at CMU and is teaching with their med students.
  - Having CMU's 3rd and 4th year psych residents with us as a placement site
  - Full-time staff located on site at the new Emergency Department that Mid-Michigan Health is building here in Mt. Pleasant
  - Meeting with the Mid-Michigan Regional Medical Center and sharing the CC360 data
  - Strategizing on how to approach the highest ED users
  - Continued development of the MDHHS Integrated Health grant
  - Established an Outpatient Orientation session to help educate consumers about the relationship between mind/body
  - Promoting use of MI skills for integrated health changes
  - Applying for Michigan Health Endowment grants
  - Medical Director continues to meet with local Health Plans to explore services to shared consumers.
- GIHN
  - Adding P.A. to our service array at our satellite office in St. Louis.
  - Care Manager analyzing ICDP data, and networking with primary staff on care alerts
  - New EMR that adds health and wellness tracking
  - Participate in Live Well Gratiot – county wide health and wellness committee
  - Peer led smoking cessation classes
- HBH
  - Have a co-located FQHC provider at the CMH site
  - CMH staff are co-located in the emergency department
  - Psychiatric consultation is provided to primary care sites
  - Providing healthy lifestyle education
  - Integrating wellness and recovery principles into services
  - Participating in a performance improvement projects involving diabetes and cardiovascular screening
  - Nursing staff providing health & wellness classes for consumers focusing on healthy lifestyle changes
  - Initiated access into the State of Michigan web portal, Care Connect 260, that provides population health and data analytics information.
  - Hosting students working on their advanced nursing degrees (pursuing nurse practitioner certification)
  - Taking steps toward implementing a tobacco-free campus (all locations) and providing necessary support to consumers through the transition
  - Assisting consumers who do not have a primary care provider connect to a physician by connecting them to either the local FQHC clinic or a private primary care provider of their choice
  - Medical Director provides consultation to community primary care physicians as requested.
- RDHRW
  - The Board of Directors established consumer based outcomes related to wellness: 85% of Medicaid Population (Healthy Michigan, Medicare/Medicaid, Medicaid) served are seen annually by a primary care

physician OR receive an annual health screen with a nurse from The Right Door for Hope, Recovery and Wellness.
  - Strategically providing "physician outreach" whereby the psychiatrist, nurses and clinical leaders meet with local primary care providers to educate, provide consultation and address high utilizing patients.
  - Have formal coordination of care agreements with most all Rural Health Clinics in Ionia County; including Sparrow Medical Group Clinic in Ionia and various physician practices.
  - Providing lunches for primary care providers in Ionia County with our Medical Director at least annually
  - Providing the Medical Director's personal cell phone number to community primary care providers for direct consultation
  - In addition to sending medication reviews and evaluation notes, also share lab values with primary care providers
  - Publishing a quarterly newsletter on best practices and coordination of care for primary care providers
  - Consumers seen by the Medication Services team has their BMI, waist circumference, AIMS testing, and lab orders completed
  - Tracking ER visits with our consumers through Zenith and contacting consumer to provide guidance and make sure primary care follow up happens.
  - Visiting primary care offices twice monthly with education in form of material, lunch discussions or speakers.
  - All primary care referrals receive a health screen to bring both medical and mental health together.
  - Primary care offices working with us by providing topics from groups for their consumers.
  - One time consults by our providers at the request of the primary care provider.
  - Medical Review summaries sent to primary care offices.
  - Nurses attend doctor appts with consumer when consumer struggles with knowledge of their medical condition.
  - Helping consumers who do not have a primary care provider connect to a new primary care provider by calling their office and setting up first appt.
- LCHMA
  - Providing Care Management services to consumers enrolled in PBHCI SAMHSA Grant – coordinating care with primary care physicians and specialists
  - Co-Location of the Federally Qualified Health Center on site at the LifeWays building
  - Participation in our Health Improvement Organization aimed at conducting a community health assessment and developing a community action plan to improve overall health of our community.
  - Providing Wellness Wednesday, Learning about Healthy Living – Tobacco and You, Nutrition Exercise Wellness and Recovery (NEW-R) classes, and Stress less events aimed at improving overall health of our consumers.
- MCN
  - Opened Wellness Works in partnership with Dartmouth University, a combination community fitness facility, program location for In-SHAPE and transitional employment work site; Dartmouth is reporting and benchmarking outcomes; MSU Extension provides nutrition classes
  - Operating an embedded primary care practice in partnership with the Mid Michigan Health Dept.; staffed by a physician's assistant
  - Offering outreach screening and eligibility access services at host physical health care providers, including Spectrum Hospital System, Cherry Health Services (an FQHC), and the Mid-MI Health Department
  - Adding a Pediatric Nurse and Children's Case Manager to increase integrated healthcare for children
  - Training Children's staff in health and wellness protocols; targeting obesity and reducing emergency room overuse
  - Co-sponsoring health prevention classes at the Wellness Center with community hospital partners (United Lifestyles) on topics such as Diabetes Education

  - Offering consultation and training to mid-level practitioners on psychiatric conditions and prescribing to increase the Primary Care Community's comfort level in treating persons with mild/moderate mental health conditions; sponsoring education on prescription drug abuse
- NCMH
  - Co-locating clinicians into physical health settings
  - Co-locating a clinician into an OBGYN clinic
  - Participating in a Process Improvement Project to identify individuals who may need a diabetic screening and linking them back to their PCP.
  - Collaborating with a local health care provider and non-profit organization to develop a care model to meet the needs of those with complex mental and/or physical health concerns who are seeking heat/energy assistance.
  - Providing education on MATP to local health providers.
  - Providing multidisciplinary team care as medically necessary to patients with high behavioral and physical health needs
- SCCMHA
  - Co-located primary health services; renovating building in fall of FY 2016 to offer pharmacy, lab and primary care; relocated psychiatry, nursing and enhanced health services a new Wellness Center to optimize provider networking
  - In year 3 of the PBHCI grant, with implementation of tobacco cessation program Implemented a Children's Health Access Program (CHAP) through a grant from the Michigan Health Endowment Fund; provides community health workers in pediatric practices using the Pathways to Better Health model; when grant ended, brought the attributes into the Community Care HUB
  - Awarded a SAMHSA expansion grant for behavioral health consultation in primary care
  - Actively utilizing the MSHN Zenith Data Analytics program as well as CC360 to identify at risk groups as well as at risk individuals
  - Added behavioral health services to CMU Medical School's Medical Services Family Practice Clinic
  - All adults are screened at the front door for chronic health conditions
  - Added a mental health consultant to a co-located primary care site
  - EMR dashboard now also includes biometrics
  - Selected as national site participant in the Cancer Control Community of Practice with National Council and National Behavioral Health Network for Tobacco Use Reduction
- SHIACMH
  - Using Care Connect 360 data to demonstrate improvement in both outcome and process measures for one chronic disease identified as a HEDIS measure
  - Continuing to work with the PIHP on the HSAG developed PIP r/t monitoring of A1C for individuals prescribed anti-psychotic medications
  - Collaborating with local hospital and EMR vendor to support HL7 electronic transfer/upload capabilities for all laboratory and test results; functionality is currently in place with Quest Labs
  - Nurse or Medical Assistant performs a brief assessment (including vitals) for all newly enrolled consumers and those coming in for medication reviews
  - Nursing supervisor/medical staff provide "brown bag" trainings to case holders related to physical health and integration
  - Strong partnership with Shiawassee Community Health Center (patient-centered medical home), who is co-located in the CMHSP, and provides primary care on site to just under one-hundred shared consumers
  - Participating in workgroup through Great Start, which is looking at partnering with OB/GYNs and pediatricians to do maternal screening
  - CMHSP Medical Director provides ongoing psychiatric consultation with Shiawassee Community Health Center (patient-centered medical home)
  - Nursing staff is partnering with Drop-in Center staff and doing wellness classes

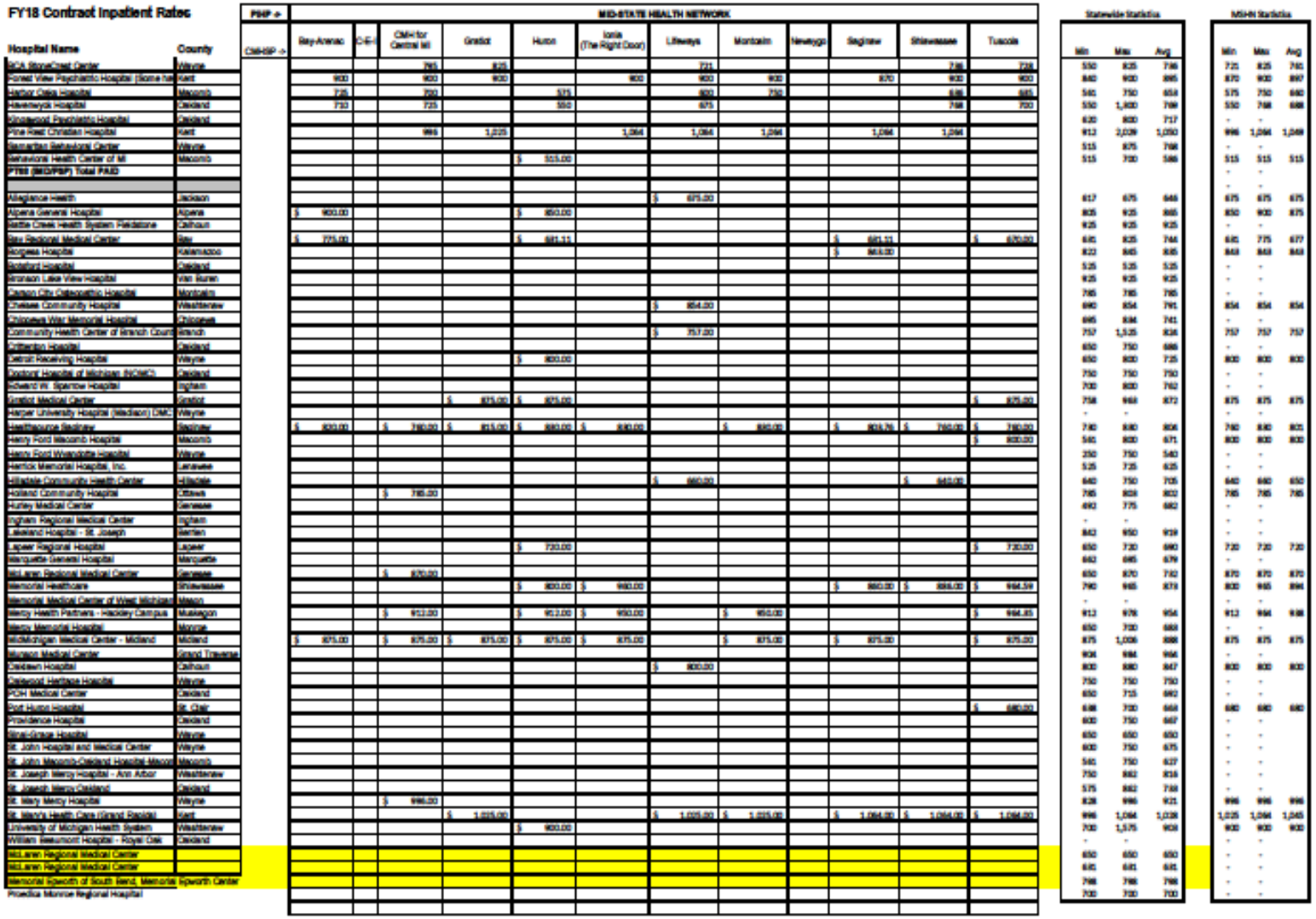
  - Social worker co-located at Shiawassee Community Health Center, and becoming trained in smoking cessation and will ultimately offer groups at both the FQHC and CMHSP
- TBHS
  - Have an integrated primary health and behavioral care clinic on site
  - Have staff trained as a behavioral health consultant
  - Sponsored wellness initiatives for service recipients aimed at improving overall health via grant funding
  - Plan to include additional healthcare providers onsite, behavioral healthcare consultation services at primary healthcare locations, and expanded health related initiatives

Economies of scale in purchasing or rate setting

MSHN will explore economies of scale in purchasing, rate setting, regional capacity development and other efficiencies across the provider network. One initiative is already in process; specifically, an analysis of inpatient rates for purposes of identifying opportunities for better value through collaborative rate setting.

Figure 10 shows the results of an inpatient rate survey initially conducted in 2014 and repeated in 2015 by MSHN and the CMHSP Participants:

Figure 10: FY 16 MSHN Inpatient Rate Assessment



FY18 Contract Inpatient Rates

Hospital Name	County	PIHP →	MID-STATE HEALTH NETWORK												Statewide Statistics			MSHN Statistics		
		CMH-ISF ->	Bay-Arenac	D-F-I	CMH for Central MI	Gratiot	Huron	Ionia (The Right Door)	Lifeways	Montcalm	Newaygo	Saginaw	Shiawassee	Tuscola	Min	Max	Avg	Min	Max	Avg
BCA StoneCrest Center	Wayne				785	825			725				736	725	550	825	746	725	825	765
Forest View Psychiatric Hospital (Stone Hat	Kent		900		900	900		900	900	900		870	900	900	840	900	895	870	900	897
Harbor Oaks Hospital	Macomb		725		700		575		800	750			695	685	541	750	654	575	750	660
Havenwyck Hospital	Oakland		710		725		550		675				748	700	550	1,400	799	550	748	688
Kingswood Psychiatric Hospital	Oakland														630	800	717	-	-	
Pine Rest Christian Hospital	Kent				969	1,225		1,094	1,094	1,094		1,094	1,094		913	2,039	1,050	996	1,094	1,049
Samaritan Behavioral Center	Wayne														515	875	798	-	-	
Behavioral Health Center of MI	Macomb						$ 555.00								515	700	586	515	515	515
PTMI (BHO/PIHP) Total PAID																		-	-	
																		-	-	
Allegiance Health	Jackson								$ 675.00						617	675	646	675	675	675
Alpena General Hospital	Alpena		$ 900.00				$ 850.00								825	925	865	850	900	875
Battle Creek Health System Fieldstone	Calhoun														925	925	925	-	-	
Bay Regional Medical Center	Bay		$ 775.00				$ 681.11					$ 681.11		$ 670.00	645	835	744	645	775	677
Borgess Hospital	Kalamazoo											$ 869.00			822	845	835	849	849	849
Botsford Hospital	Oakland														525	525	525	-	-	
Brighton Lake View Hospital	Van Buren														925	925	925	-	-	
Carson City Osteopathic Hospital	Montcalm														785	785	785	-	-	
Chelsea Community Hospital	Washtenaw								$ 854.00						690	854	791	854	854	854
Chippewa War Memorial Hospital	Chippewa														695	884	741	-	-	
Community Health Center of Branch County	Branch								$ 757.00						757	1,535	826	757	757	757
Cottage Hospital	Oakland														650	750	686	-	-	
Detroit Receiving Hospital	Wayne						$ 800.00								650	800	725	800	800	800
Oakland Hospital of Michigan (NOMC)	Oakland														750	750	750	-	-	
Edward W. Sparrow Hospital	Ingham														700	800	762	-	-	
Grattot Medical Center	Grattot					$ 875.00	$ 875.00							$ 875.00	758	968	872	875	875	875
Harper University Hospital (Madison) DMC	Wayne														-	-		-	-	
Healthsource Saginaw	Saginaw		$ 800.00		$ 780.00	$ 815.00	$ 880.00	$ 880.00		$ 885.00		$ 809.76	$ 765.00	$ 780.00	740	880	806	740	880	805
Henry Ford Macomb Hospital	Macomb													$ 800.00	541	800	671	800	800	800
Henry Ford Wyandotte Hospital	Wayne														250	750	540	-	-	
Herrick Memorial Hospital, Inc.	Lenawee														525	725	625	-	-	
Hillsdale Community Health Center	Hillsdale								$ 660.00				$ 640.00		640	750	705	640	660	650
Holland Community Hospital	Ottawa			$ 785.00											795	809	802	795	795	795
Hurley Medical Center	Genesee														490	775	682	-	-	
Ingham Regional Medical Center	Ingham														-	-		-	-	
Lakeland Hospital - St. Joseph	Berrien														842	950	919	-	-	
Lapeer Regional Hospital	Lapeer						$ 720.00							$ 720.00	650	720	690	720	720	720
Marquette General Hospital	Marquette														662	695	679	-	-	
McLaren Regional Medical Center	Genesee			$ 870.00											650	870	710	870	870	870
Memorial Healthcare	Shiawassee						$ 800.00	$ 980.00				$ 860.00	$ 884.00	$ 984.59	790	985	879	800	985	894
Memorial Medical Center of West Michigan	Mason														-	-		-	-	
Mercy Health Partners - Hackley Campus	Muskegon			$ 912.00			$ 912.00	$ 980.00		$ 950.00				$ 984.85	912	978	954	912	984	938
Mercy Memorial Hospital	Monroe														650	700	668	-	-	
MidMichigan Medical Center - Midland	Midland		$ 875.00	$ 875.00	$ 875.00	$ 875.00	$ 875.00	$ 875.00		$ 875.00		$ 875.00		$ 875.00	875	1,006	886	875	875	875
Munson Medical Center	Grand Traverse														904	984	966	-	-	
Oaklawn Hospital	Calhoun								$ 800.00						800	880	847	800	800	800
Oakwood Heritage Hospital	Wayne														750	750	750	-	-	
POH Medical Center	Oakland														650	715	682	-	-	
Port Huron Hospital	St. Clair													$ 680.00	688	700	668	680	680	680
Providence Hospital	Oakland														600	750	667	-	-	
Sinai-Grace Hospital	Wayne														650	650	650	-	-	
St. John Hospital and Medical Center	Wayne														600	750	675	-	-	
St. John Macomb-Oakland Hospital-Macomb	Macomb														541	750	627	-	-	
St. Joseph Mercy Hospital - Ann Arbor	Washtenaw														750	882	816	-	-	
St. Joseph Mercy Oakland	Oakland														575	882	749	-	-	
St. Mary Mercy Hospital	Wayne			$ 986.00											828	986	921	986	986	986
St. Mary's Health Care (Grand Rapids)	Kent					$ 1,025.00			$ 1,025.00	$ 1,025.00		$ 1,064.00	$ 1,064.00	$ 1,064.00	996	1,064	1,028	1,025	1,064	1,045
University of Michigan Health System	Washtenaw						$ 900.00								700	1,575	909	900	900	900
William Beaumont Hospital - Royal Oak	Oakland														-	-		-	-	
McLaren Regional Medical Center															650	650	650	-	-	
McLaren Regional Medical Center															695	695	695	-	-	
Memorial Ispworth of South Bend, Memorial	Ispworth Center														798	798	798	-	-	
Promedica Monroe Regional Hospital															700	700	700	-	-	

Through assessment of regional rates MSHN has determined significant variance exists from CMHSP to CMHSP when negotiating with certain provider types. MSHN and its CMHSP Participants have agreed, where possible, to engage in regional rate negotiations. Joint planning and negotiation is intended to assure best value and to enhance/expand capacity of required services.

Recommendations/Conclusions

MSHN intends to use the Assessment of Network Adequacy as a dynamic plan, with data collection initiatives, plans, external requirements and other information incorporated throughout the year. Current priorities include Application for Participation focal points, opportunities to gain efficiency through regional collaboration and other areas warranting strengthening to optimize the provider network, as follows:

1. Continue to seek guidance from MDHHS regarding provider qualifications for Medicaid Expansion program (HMP) services for beneficiaries with SUD who need services which are not provided by SUD licensed programs.
2. Continue to support provider network capacity to offer key evidence based programs, such as recovery and trauma informed programming, including ROSC.
3. Determine next steps relative to inpatient admission refusals and additional regional crisis response/ inpatient alternative capacity options, particularly for individuals with intellectual and developmental disabilities (such as Autism) exhibiting behavioral challenges.
4. Continue to monitor and expand regional autism service capacity and utilization to ensure sufficient network capacity to meet consumer demand.
5. Continue to assess and address the integration of mental health, substance use disorder and physical health care.
6. Once the system changes expected as a consequence of the HCBS Final Rule are more understood, develop a regional plan of action if necessary to alter provider capacity for residential, employment and other community living related services, at the network level.
7. Continue to address reciprocity between CMHSP Participants relative to requirements applied to sub-contracted service providers.
8. Continue to address network capacity for detox services and medication assisted treatment, including availability of Methadone, Vivotrol, and Suboxone at all MAT locations; Continue to support CMHSPs and SUD providers as Narcan kit distribution sites.
9. Continue to discuss opportunities if any for regional action to address CMHSP identified issues with services for children.
10. Continue to monitor the demand for and adequacy of its capacity to serve veterans.
11. Continue to monitor legislative change and financial resources for the implementation of PA 200 for those with substance use disorders.
12. Evaluation the status of compliance with the enhanced requirements for trauma informed and sensitive treatment, including any changes that may be needed in provider network specializations.

13. Continue to monitor capacity to complete Support Intensity Scale (SIS) assessments for individuals with developmental disabilities.