MSHN

Mid-State Health Network

Assessment of Network Adequacy

2022

Approved by MSHN Operations Council: June 21, 2022

Reviewed by MSHN Board of Directors: July 5, 2022

Contents

Definitions

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

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

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

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

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

Background

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

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

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

The counties in the MSHN service area include:

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

Scope

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

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

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

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

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

[1]

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

[1] www.michigan.gov/bhdda

[2] www.michigan.gov/bhdda

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

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

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

COVID-19 Assessment

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

Even with adjusted performance and service delivery expectations, the pandemic has impacted the number of services provided to consumers for various reasons. For example, the complexities of treatment while maintaining safety guidelines during the pandemic led to reduced numbers of withdrawal management and residential bed capacity to provide social distancing, adapted individual and group treatment via telehealth while an individual may be quarantining, staff shortages which translated to admissions holds and reduced service delivery, etc. Effective April 1, 2020, MDHHS developed Fiscal Provider Stabilization mandates to ensure provider networks were able to continue as ongoing concerns persisted. Although MDHHS mandated Provider Stability payments, the expectation was for PIHPs to cover the expenditures through existing Per-Eligible Per Month funding. As of December 2020, MSHN disbursed FY 20 stabilization payments totaling $7.5 M for behavioral health and $1.7 M for SUD providers. In addition, Direct Care Workers (DCW) premium payments were required for staff delivering specified in-person services.

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

In relation to COVID-19 impacts specific to Provider Network Adequacy Assessment, MSHN has monitored the use of telehealth (Figure 1-3), count of individuals served (Figure 4-5) and the impact on provider sustainability (Figure 6).

Figure 1: Telehealth Encounters Analysis

Note: Figure 1 utilizes the location code on the encounter lines (02) as the telehealth location, and no longer uses the 'GT' or '95' modifier to calculate telehealth per changes made by MDHHS

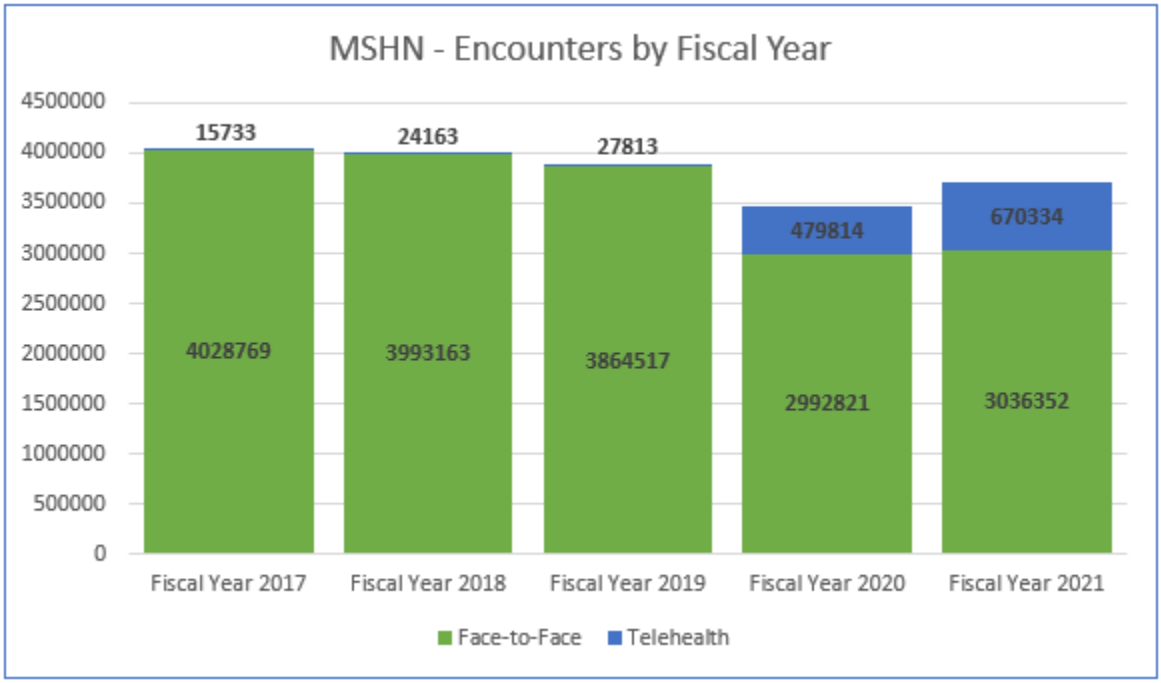


Figure 2: Telehealth Encounters Analysis CMHSP

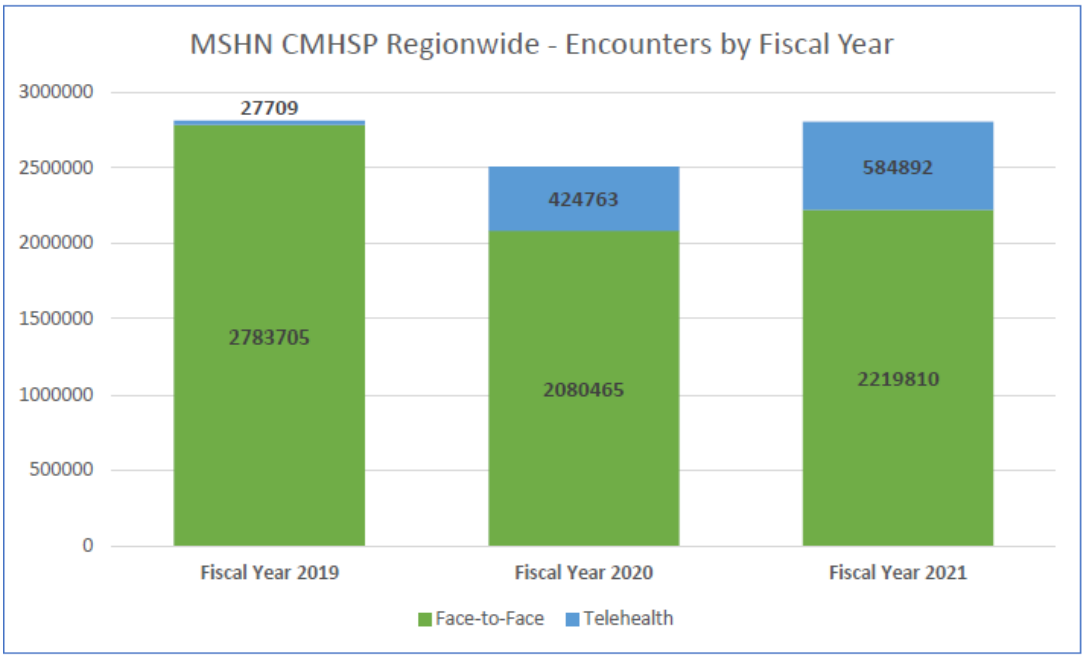


Figure 3: Telehealth Encounters Analysis SUD

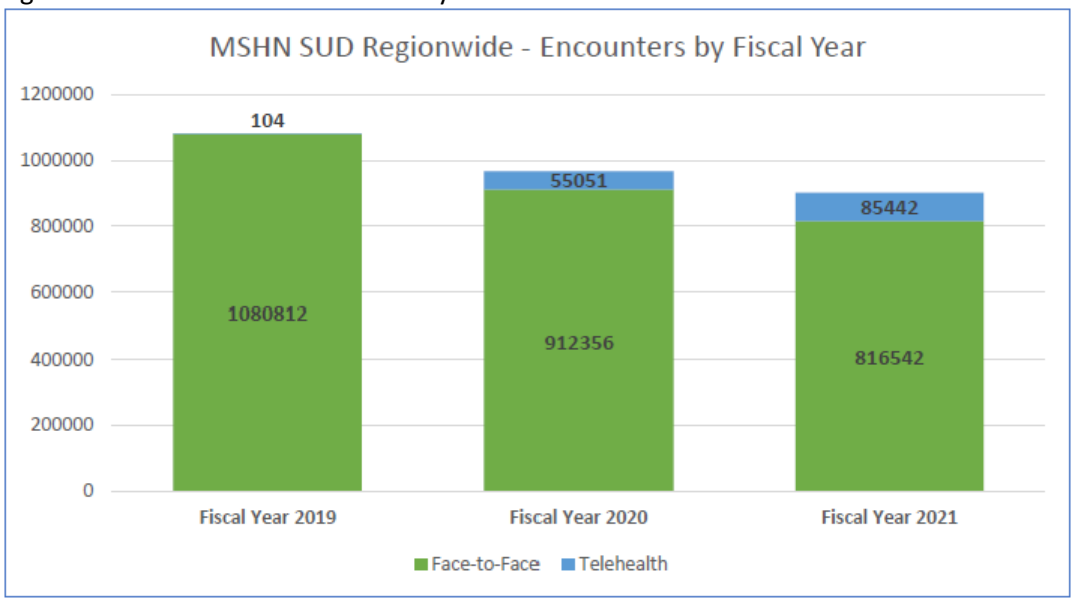


Figure 4: Individuals Served CMHSP

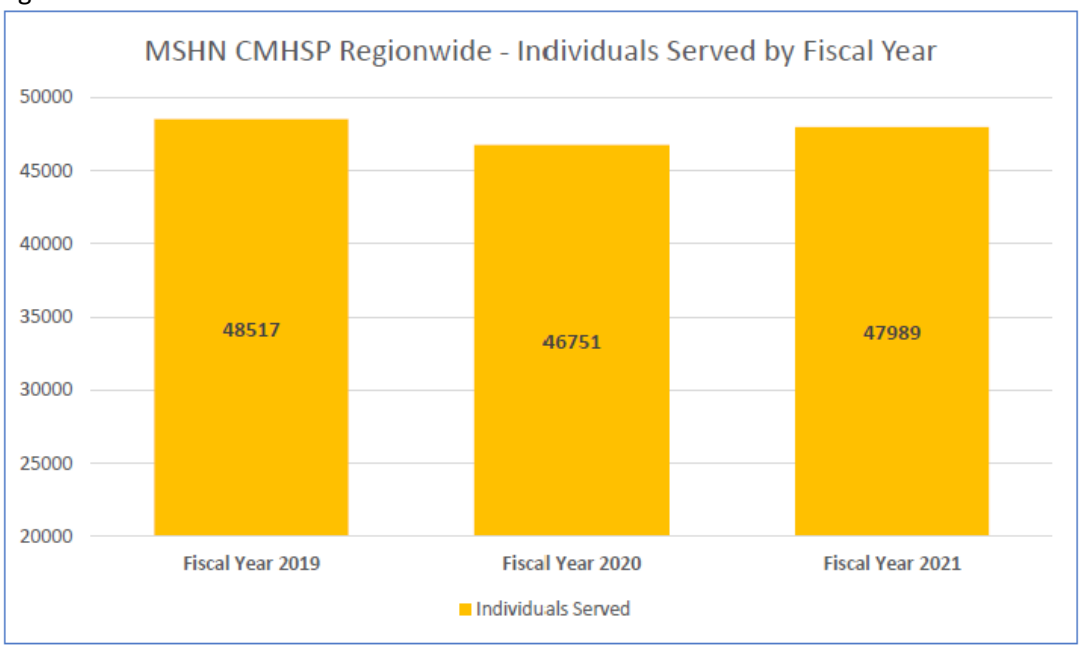


Figure 5: Individuals Served SUD

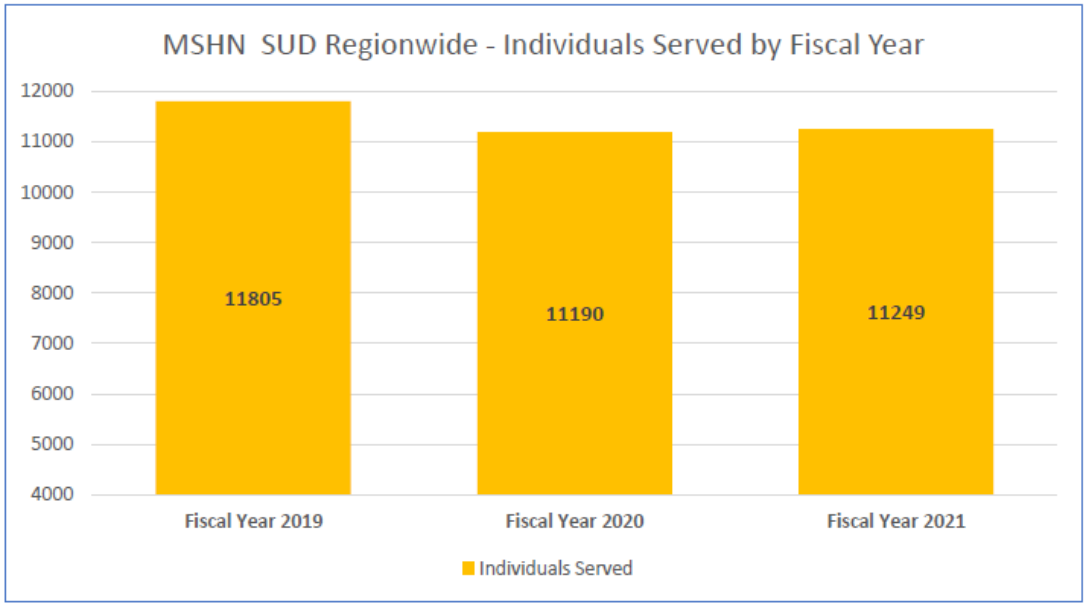


Figure 6: Provider Closures

MSHN PROVIDER STABILIZATION REPORTING THROUGH SEPTEMBER 30, 2021					
Provider Closures Effective After June 1, 2020					
COVID-related	Name of Provider	Date of Closure	Services Provided	Individuals Served	Impact on Network
No	Wedgwood Eaton	06.30.2020	SUD Outpatient	10	No impact
No	Pine Rest	07.12.2020	SUD Residential	0	No impact
Yes	Human Development Commission	12.21.2020	Community Living Supports	1	No impact
No	New Vision	10.12.2020	Community Living Supports	0	No impact
No	AF Services	04.09.2021	Specialized Residential (CLS/PC)	6	Lost 6 beds in the County
No	Bay City Recovery Home	10.20.2021	Recovery Housing	41	Loss of recovery housing
Yes	Hope's Door	07.30.2021	Crisis Residential		Loss of crisis residential

Assessment Updates

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

- How many individuals are expected to be in the target population in its geographic area for the upcoming year
- Of those individuals, how many are likely to meet criteria for the service benefit
- Of those individuals, what are their service needs
- The type and number of service providers necessary to meet the need within the time and distance standards
- How the above can reasonably be anticipated to change over time

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

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

Meeting the needs of enrollees: expected service provisions

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

MSHN is required to serve Medicaid beneficiaries in the region who require the Medicaid services included under the 1115 Demonstration Waiver, 1915(i); who are *eligible* for the 1115 Healthy Michigan Plan, the Flint 1115 Waiver or Community Block Grant; who are *enrolled* in the 1915(c) Habilitation Supports Waiver; 1915(c) Children Waivers (SEDW and CWP) who are *enrolled* in program; or for whom MSHN has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. MSHN must also ensure access to public substance use disorder services funded through Medicaid, Public Act 2, and substance use disorder related Block Grants. Furthermore, MSHN is

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

required to limit Medicaid services to those that are *medically necessary* and appropriate, and that conform to accepted standards of care. Services must be provided (i.e., available) in sufficient amount, duration, and scope to reasonably achieve the purpose of the service.

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

Appropriateness of the range of services

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

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

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

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.

Mental Health Services: The array of State Plan mental health services covered under the 1115 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. 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. Table 1 lists the service provided by each CMHSP Participant in the MSHN region.

[5] 42CFR438.207(b)(1) "Offers an appropriate range of preventative, primary care and specialty services that is adequate for the anticipated number of enrollees in the service area."

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

	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Applied Behavioral Analysis	X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	X	X	X	X	X	X	X	X	X	X	X	X
Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Assistive Technology	Provided on a per request basis											
Behavior Treatment Review	X	X	X	X	X	X	X	X	X	X	X	X
Child Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Clubhouse Psychosocial Rehabilitation	X	X	X				X	X		X		
Community Living Supports	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Interventions	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Observation Care		X										
Crisis Residential Services	X	X	X	X	X	X	X	X	X	X	X	X
Drop-In Centers (Peer Operated)		X	X	X	X	X	X		X	X	X	X
Enhanced Medical Equipment & Supplies	X	X	X	X	X	X	X	X	X	X	X	X
Enhanced Pharmacy	X	X	X	X	X	X	X	X	X	X	X	X
Environmental Modifications	Provided on a per request basis											
Family Support and Training	X	X	X	X		X	X	X	X	X	X	X
Family Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Fiscal Intermediary Services	X	X	X	X	X	X	X	X	X	X	X	X
Goods & Services	Provided on a Per Request Basis											
Health Services	X	X	X	X	X	X	X	X	X	X	X	X
Home-Based Services	X	X	X	X	X	X	X	X	X	X	X	X
Home-Based Serv. – Infant Mental Health	X	X	X	X	X	X	X	X	X	X	X	X
Housing Assistance	Provided on a Per Request Basis											
Individual and Group Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Inpatient Psychiatric Hospital Admission	X	X	X	X	X	X	X	X	X	X	X	X
Intensive Crisis Stabilization Services	X	X	X	X	X	X	X	X	X	X	X	X
ICF Facility for IDD												
Medication Administration	X	X	X	X	X	X	X	X	X	X	X	X
Medication Review	X	X	X	X	X	X	X	X	X	X	X	X
Nursing Facility Mental Health Monitoring	X	X	X	X	X	X	X	X	X	X	X	X
Occupational Therapy	X	X	X	X	X	X	X		X	X	X	X
Out-of-Home Non-Voc Habilitation	X	X	X	X	X	X	X			X	X	X
Outpatient Partial Hospitalization Services	X	X	X	X	X	X	X	X	X	X	X	X
Peer Specialist Services	X	X	X	X	X	X	X	X	X	X	X	X
Personal Care in Licensed Spec. Residential	X	X	X	X	X	X	X	X	X	X	X	X
Personal Emergency Response	Per request	Per request	X	Per request	Per request	Per request		Per request		Per request		Per request
Physical Therapy	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		X									Per request	
• School Success Program												
• Children of Adults w/ MI/ Integ. Serv.												
• Infant Mental Health-Prevention	X	X	X					X	X	X	X	X
• Parent Education		X	X		X		X	X	X	X	X	X
Pre-Vocational Services	X	X	X		X	X	X	X		X		X
Private Duty Nursing	X	X	X	X		Per request	X	X		X	X	X
Respite Care	X	X	X	X	X	X	X	X	X	X	X	X
Skill Building Assistance	X	X	X	X	X	X	X	X	X	X	X	X
Speech, Hearing and Language Therapy	X	X	X	X	X	X	X	X	X	X		X
Supports Coordination	X	X	X	X	X	X	X	X	X	X	X	X
Supported Employment	X	X	X	X	X	X	X	X	X	X	X	X
Targeted Case Management	X	X	X	X	X	X	X	X	X	X	X	X
Telemedicine	X	X	X	X	X	X	X	X	X	X	X	X
Transportation	X	X	X	X	X		X	X	X	X	X	X
Treatment Planning	X	X	X	X	X	X	X	X	X	X	X	X
Wraparound Services	X	X	X	X	X	X	X	X	X	X	X	X

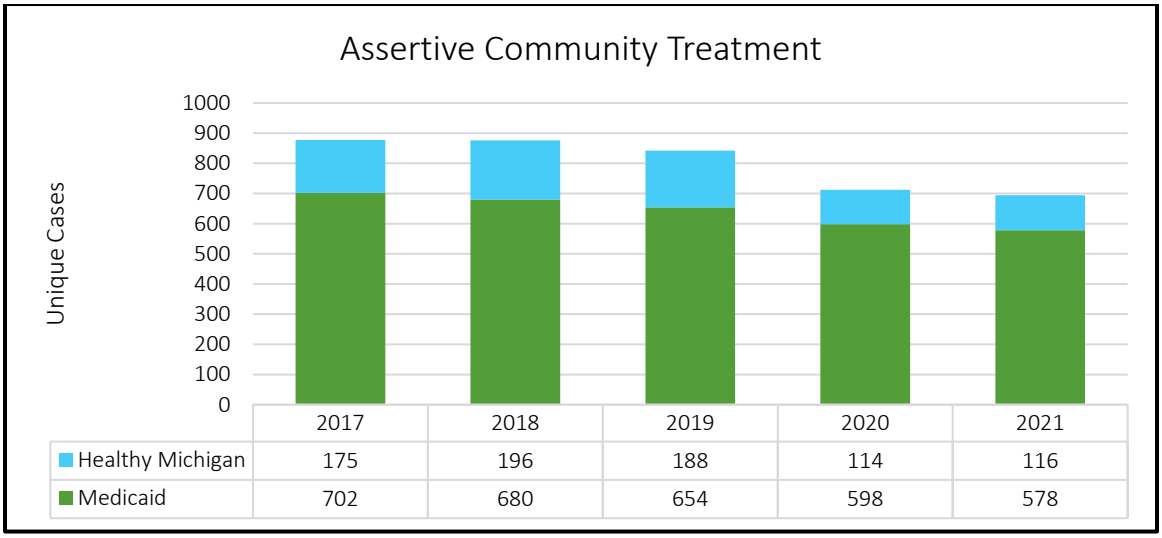
Specialty Services within MSHN

MSHN offers an appropriate array of specialty services provided by the CMHSPs. The following graphs illustrate the number of unique cases served from FY17--FY21 for each specialty service. The information was collected from Medicaid Utilization and Net Cost reports (MUNC). **Programs below include an analysis where MDHHS has required a specific adequacy standard. For all others, the utilization trends will be combined as part of the analysis to determine adequacy.**

Assertive Community Treatment

Assertive Community Treatment (ACT) is a community-based approach to comprehensive assertive team treatment and support for adults with serious mental illness. It provides continuous team-based care 24 hours a day, 7 days a week. ACT is the most intensive non-residential service in the continuum of care within the service array of the public behavioral health system. MDHHS has established an adequacy standard for ACT programs (30,000:1 Medicaid Enrollee to Provider Ratio). Four CMHSPs in the MSHN region do not directly provide ACT services; however, have written agreements in place with other CMHSPs or other subcontractors that provide ACT services to ensure the availability of this evidence-based practice in each of their catchment areas. ACT is but one service that might meet the level of intensity required to address the recipient's care needs. It is often true that individuals who meet the eligibility criteria for ACT often choose other (non-ACT) services or combinations of services more suitable to their individual circumstances. MSHN concluded that as alternatives to ACT, combinations of services and supports that often parallel the services in the ACT service bundle, are available and routinely provided to recipients in the region, including at CMHSPs that do not currently have enrolled ACT Programs and at those that do. MSHN is satisfied that the arrangements in place at the CMHSPs that do not have enrolled ACT programs are adequate to ensure that if/when ACT services are desired by the recipient, they can and will be provided.

Figure 7. Assertive Community Treatment

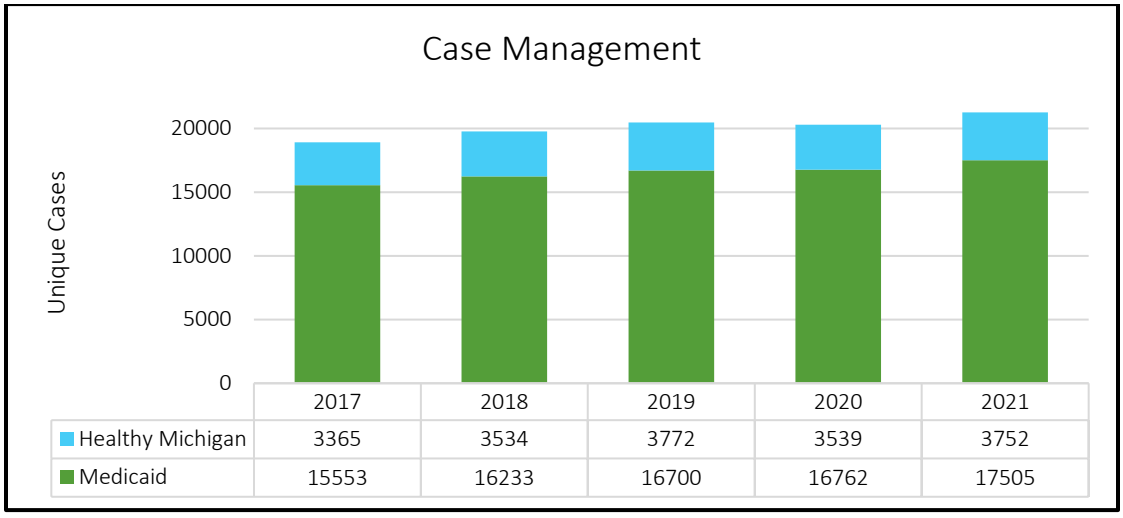


	2017	2018	2019	2020	2021
Healthy Michigan	175	196	188	114	116
Medicaid	702	680	654	598	578

Case Management

For the purpose of the assessment, case management refers to supports coordination and targeted case management. These two services are combined in the following graph. Targeted case management helps with obtaining services and supports. Its focus is goal oriented and individualized. Supports coordination works with waiver beneficiaries in home and community-based settings.

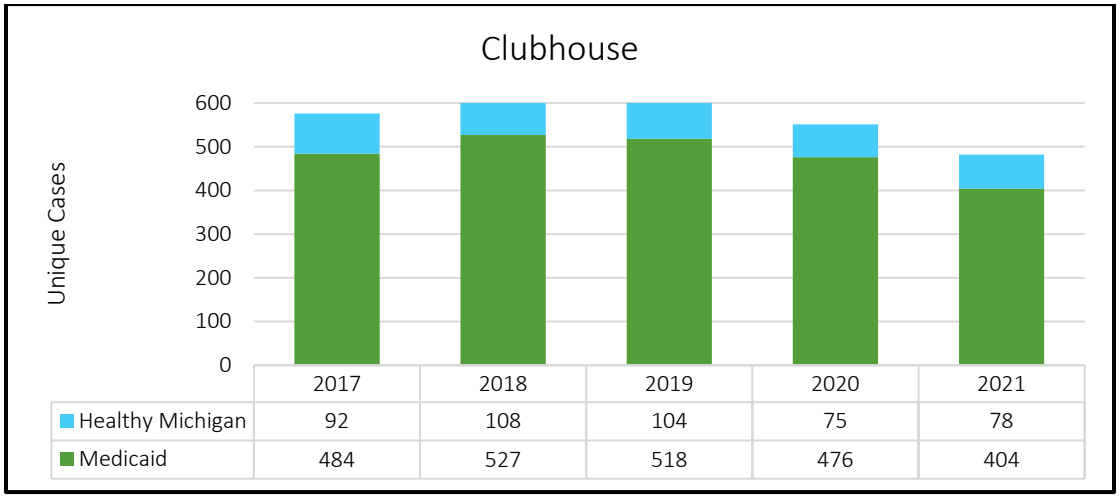
Figure 8. Case Management



Clubhouse Psychosocial Rehabilitation Programs

A Clubhouse is a community-based program designed to support Individuals living with mental illness. Participants work alongside staff to gain skills in employment, education, housing, community inclusion, wellness, community resources, advocacy, and recovery. Clubhouse Psychosocial Rehabilitation Program accreditation by the International Center for Clubhouse Development (ICCD) is required by MDHHS. Additionally, MDHHS has established an adequacy standard for Clubhouse programs (45,000:1 Medicaid Enrollee to Provider Ratio) which requires 6 clubhouse programs in the region, based on the number of adult enrollees. Currently, six CMHSPs have accredited clubhouse programs, meeting the published standard.

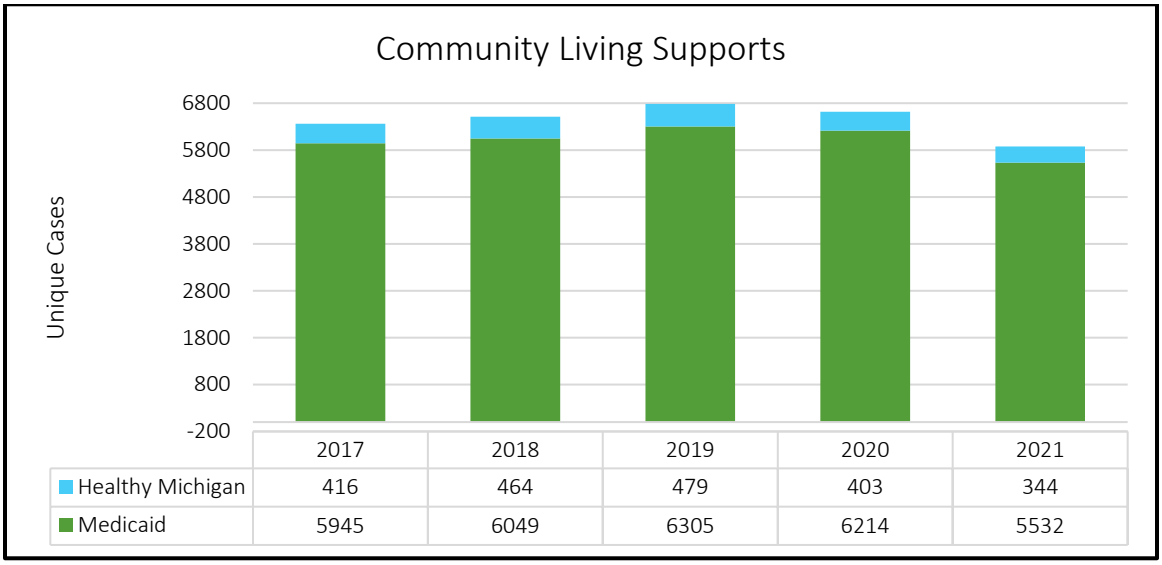
Figure 9. Clubhouse Psychosocial Rehabilitation Programs



Community Living Supports

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

Figure 10. Community Living Supports

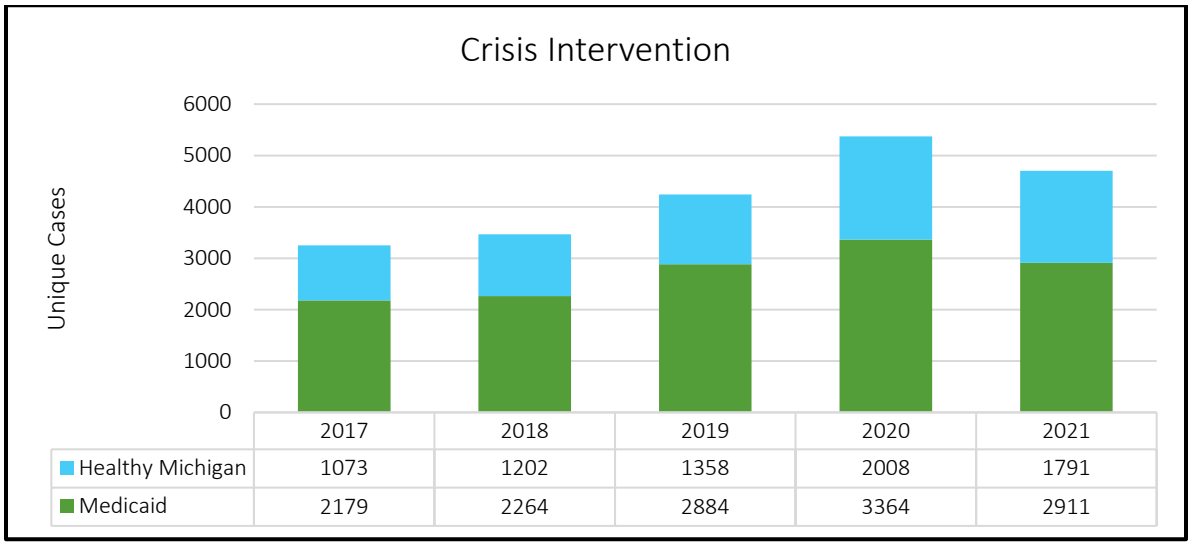


	2017	2018	2019	2020	2021
Healthy Michigan	416	464	479	403	344
Medicaid	5945	6049	6305	6214	5532

Crisis Services: Crisis Intervention

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

Figure 11: Crisis Intervention



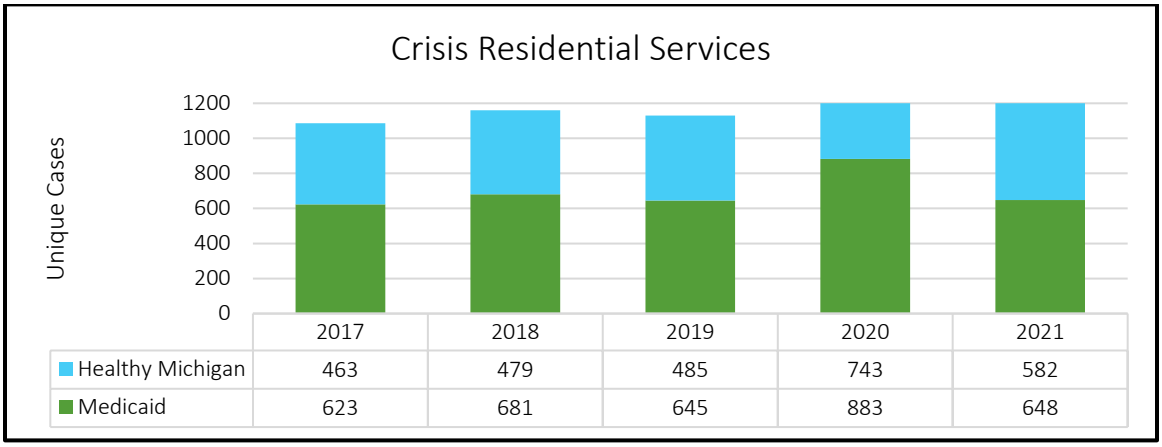
	2017	2018	2019	2020	2021
Healthy Michigan	1073	1202	1358	2008	1791
Medicaid	2179	2264	2884	3364	2911

Crisis Services: Crisis Residential Services

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay. MDHHS has established an adequacy standard (16 adult beds per 500,000 total population and 8-12 pediatric beds per 500,000 total population). MSHN has an inventory of 30 adult crisis residential beds within its region and contracts for approximately 50 additional crisis residential beds located outside of its geographic boundaries (utilization varies). As a result, MSHN considers its capacity to be compliant with the published standard. MSHN is collaborating with other CMHPs and a crisis residential provider to establish an additional adult Crisis Residential Unit (CRU) within the MSHN region, scheduled to be open by September 2022.

Pediatric Crisis Residential Beds: The most significant deficit in the MSHN region is the absence of any in-region crisis residential beds for children and adolescents. Based on information provided through the Crisis Residential Network, this appears to be a statewide issue as there are only approximately six child crisis residential facilities in Michigan out of 20 total crisis residential facilities. In FY21, MSHN contracted with Beacon Crisis Residential Treatment Program at Sandhurst to provide services to children and adolescents aged 5-17 SED primary and/or cooccurring. Beacon at Sandhurst services are designed for children and youth with mental illness, or children with both a mental illness and another concomitant disorder. However, the primary reason for services must be mental illness.

Figure 12: Crisis Residential Services



	2017	2018	2019	2020	2021
Healthy Michigan	463	479	485	743	582
Medicaid	623	681	645	883	648

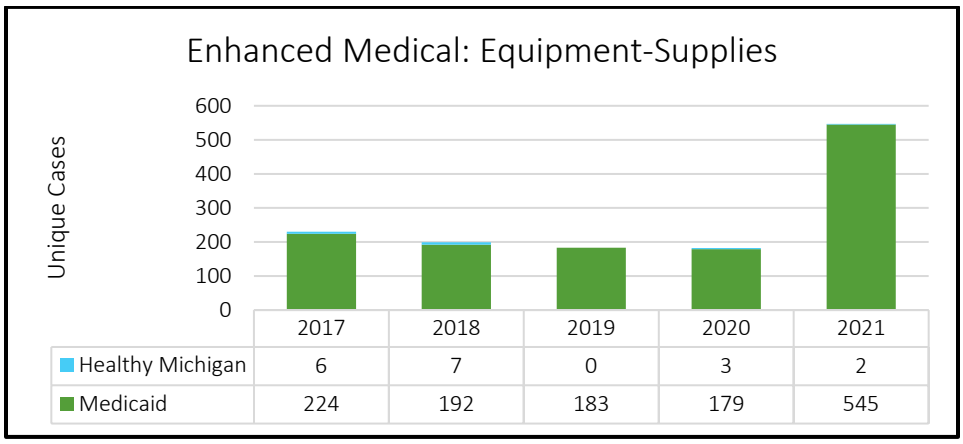
Crisis Services: Intensive Crisis Stabilization Services (ICSS)

Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated. Children's ICSS are provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement. These services must be available to children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD). Encounter data is not available (H2011 TJ, HB, HC and previously S9484). This warrants investigation to ensure accurate reporting.

Enhanced Medical Equipment Supplies

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

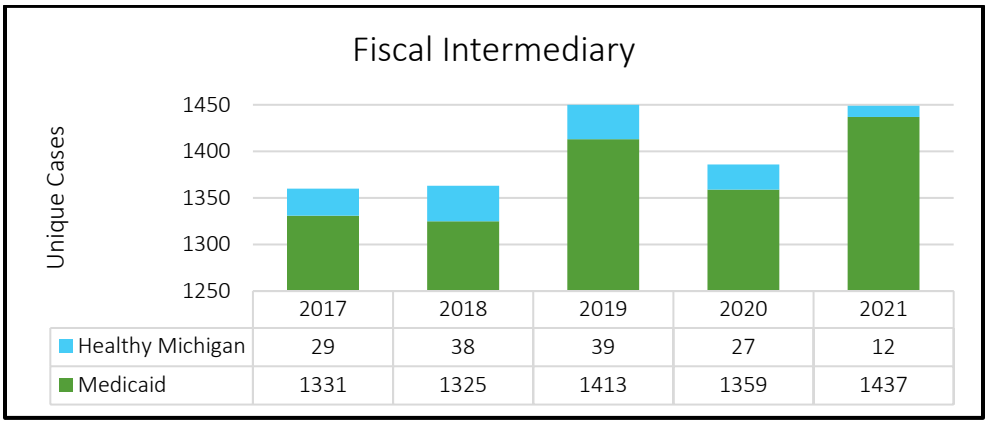
Figure 13: Enhanced Medical Equipment-Supplies



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

A financial management service/fiscal intermediary is an independent legal entity – organization or individual - that acts as the fiscal agent of the CMHSP for the purpose of assuring fiduciary accountability for the funds authorized to purchase specific services identified in the consumer's individual plan of service (IPOS) under a self-determination arrangement. The self-direction technical requirement and implementation guideline published October 2020 states that *each PIHP must ensure there are at least two FMS providers within the region and ensure access to all impaneled FMS providers*[6]. MSHN meets this requirement.

Figure 14: Fiscal Intermediary

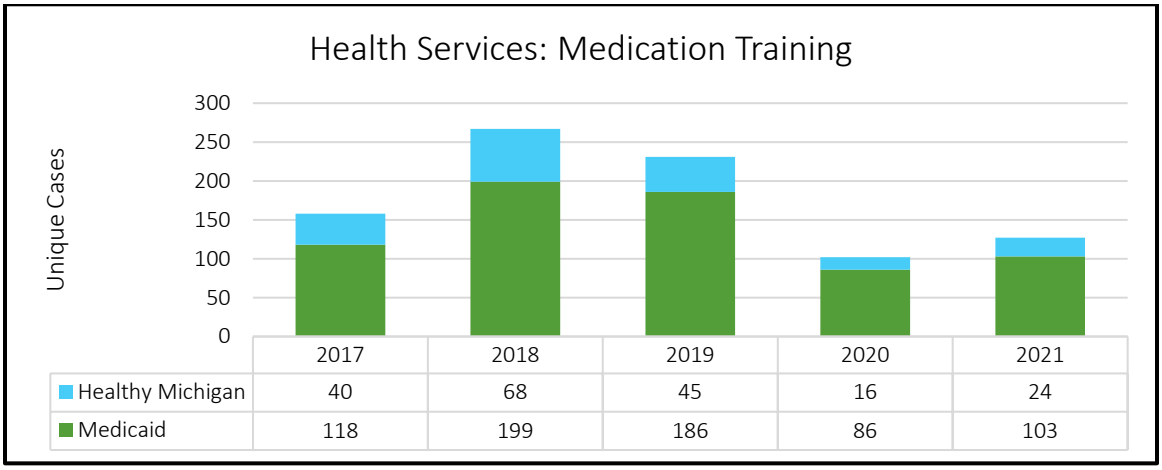


[6] Source: MDHHS Self-Direction Technical Requirement Implementation Guide

Health Services: Medication Training

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

Figure 15: Health Services: Medication Training

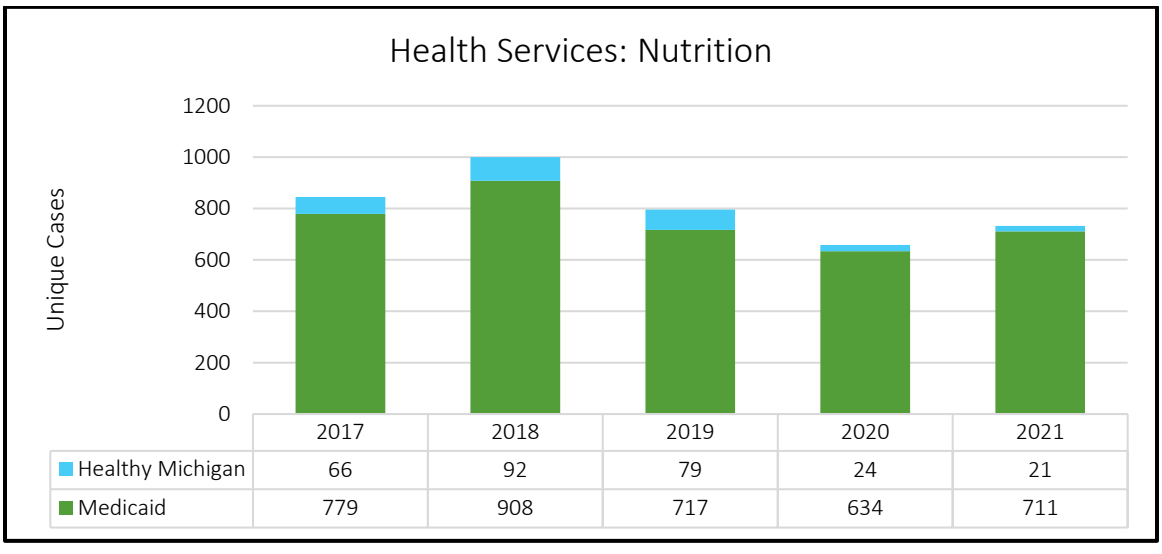


	2017	2018	2019	2020	2021
Healthy Michigan	40	68	45	16	24
Medicaid	118	199	186	86	103

Health Services: Nutrition

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

Figure 16: Health Services: Nutrition

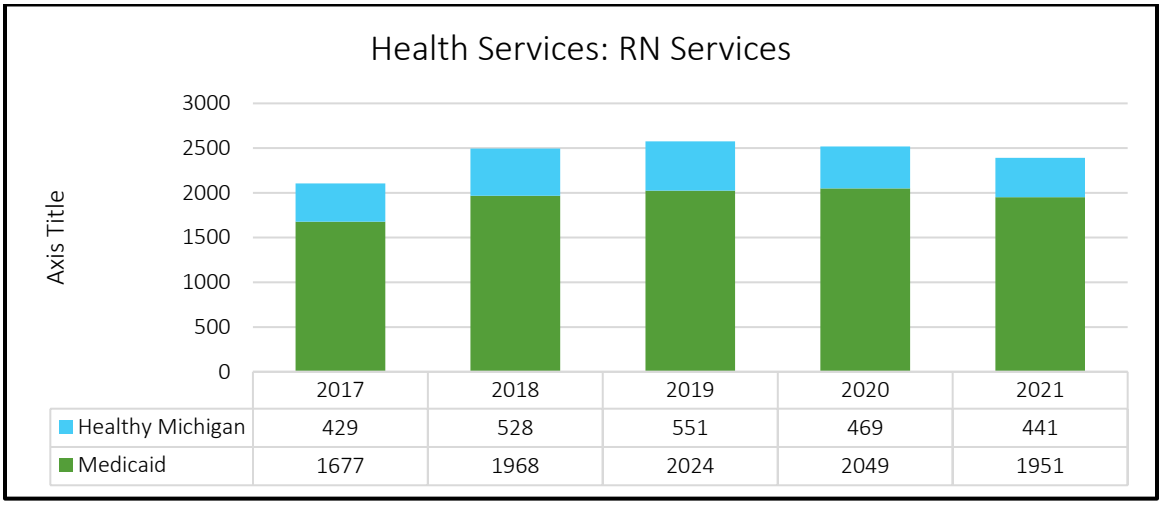


	2017	2018	2019	2020	2021
Healthy Michigan	66	92	79	24	21
Medicaid	779	908	717	634	711

Health Services: RN Services

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

Figure 17: Health Services: RN Services

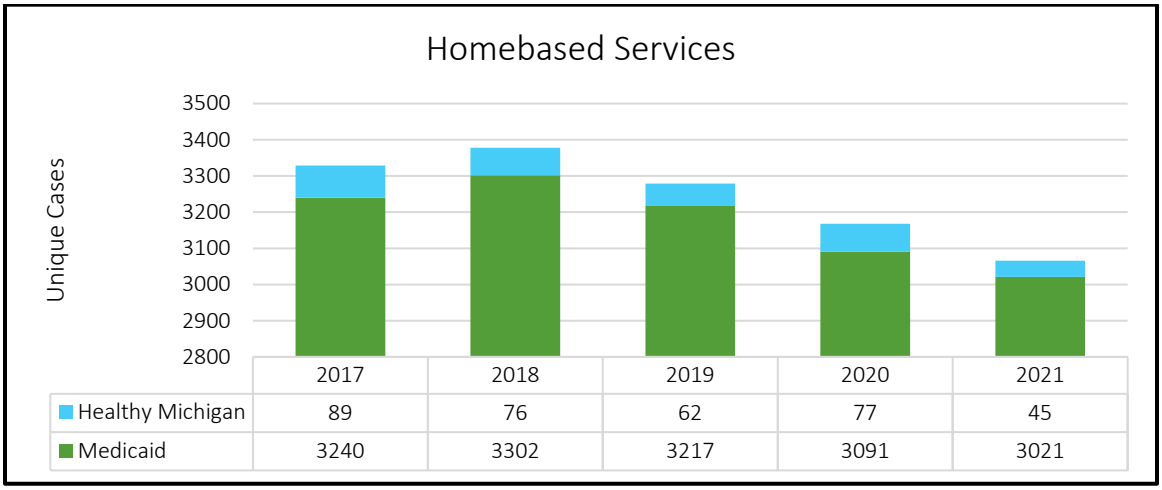


	2017	2018	2019	2020	2021
Healthy Michigan	429	528	551	469	441
Medicaid	1677	1968	2024	2049	1951

Homebased Services

Homebased services provide assistance to children and their families with multiple service needs. The goals are to meet children's developmental needs, support families, reunite families and prevent out of home placement. MDHHS has an established adequacy standard (2,000:1 Medicaid Enrollee to Provider Ratio). Home-Based services were verified through provider enrollment information to ensure compliance with educational standards of licensure and FTE designations. MSHN meets published standard with 144 FTEs.

Figure 18: Homebased Services

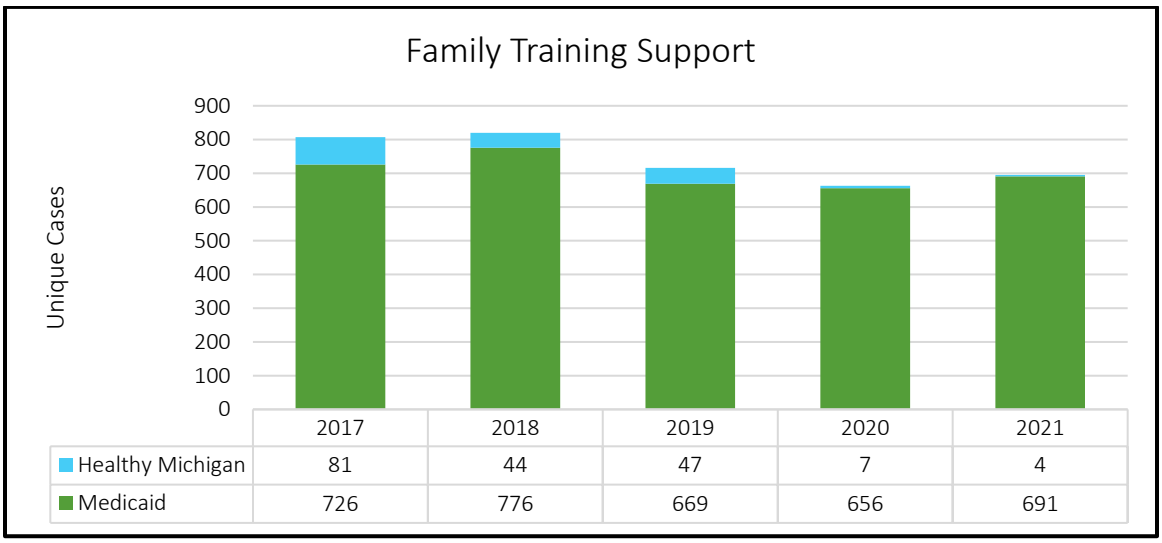


	2017	2018	2019	2020	2021
Healthy Michigan	89	76	62	77	45
Medicaid	3240	3302	3217	3091	3021

Homebased Services: Family Training Support

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

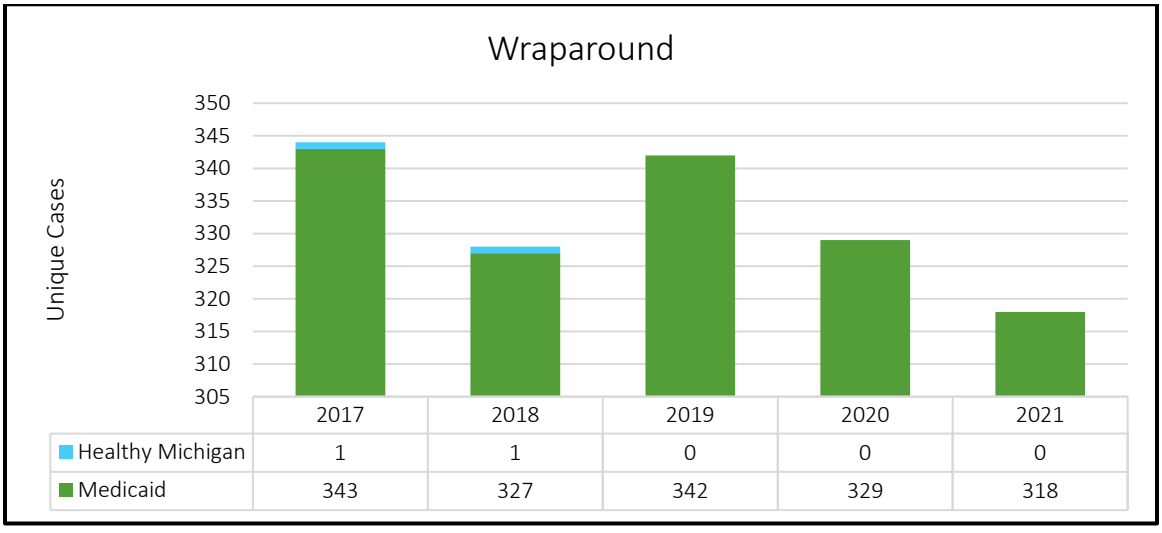
Figure 19: Family Training Support



Homebased Services: Wraparound

Wraparound services for children and adolescents are highly individualized planning processes facilitated by specialized supports coordinators. MDHHS has an established adequacy standard (5,000:1 Enrollee to Provider Ratio). Wraparound services are verified through provider enrollment information to ensure compliance with educational standards of licensure and FTE designations. MSHN region meets published standards with 58 FTEs.

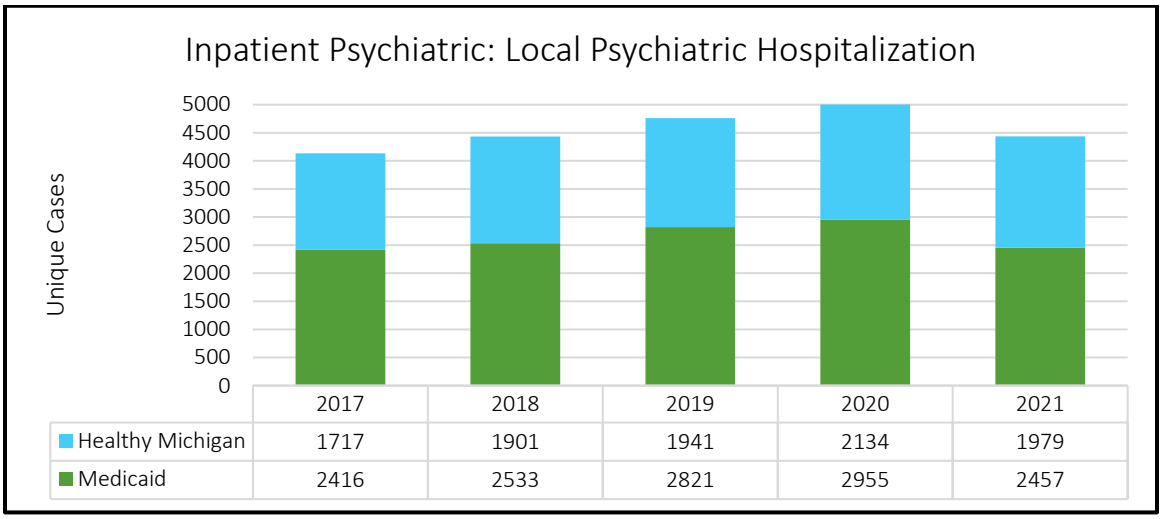
Figure 20: Wraparound



Inpatient Psychiatric - Local Psychiatric Hospital

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

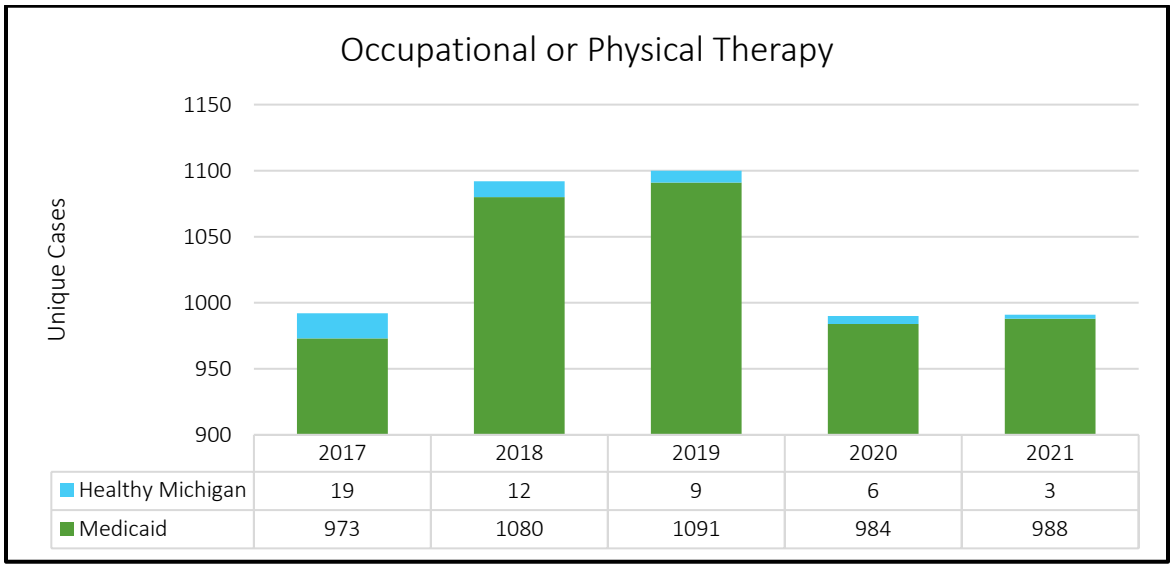
Figure 21: Inpatient Psychiatric: Local Psychiatric Hospitalization



Occupational or Physical Therapy

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

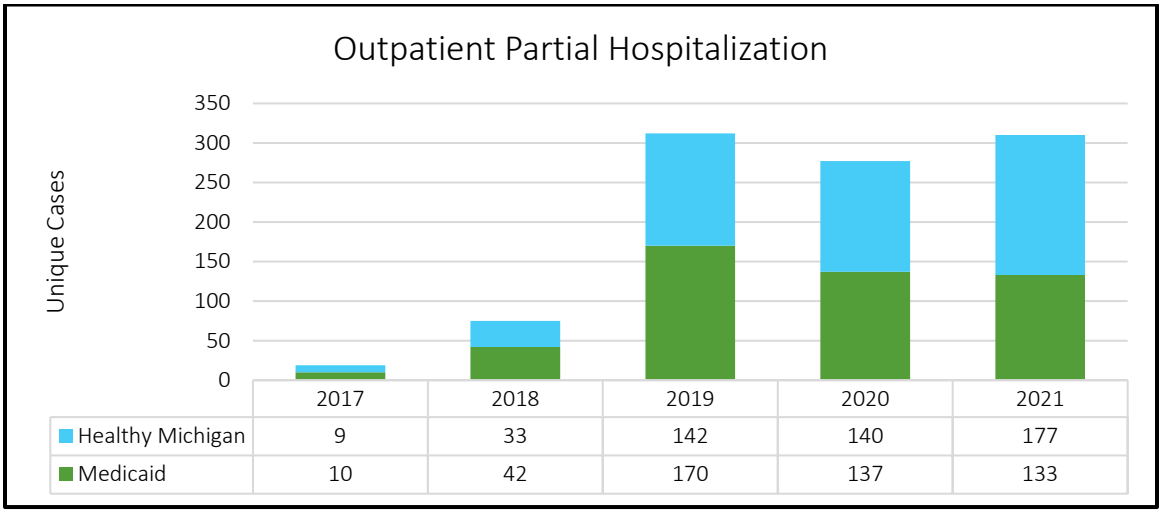
Figure 22: Occupational or Physical Therapy



Outpatient Partial Hospitalization

Partial hospitalization is used when an individual does not meet the need for inpatient hospitalization but requires more than traditional outpatient mental health services. Partial hospitalization services may be used to treat an individual with a mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Services are provided more than six hours per day, five days per week. Partial hospitalization utilization went markedly up in 2019 due to the service becoming available to a number of MSHN CMHSPs; however, the increase was primarily attributed to two CMHSP participants utilizing this service.

Figure 23: Outpatient Partial Hospitalization

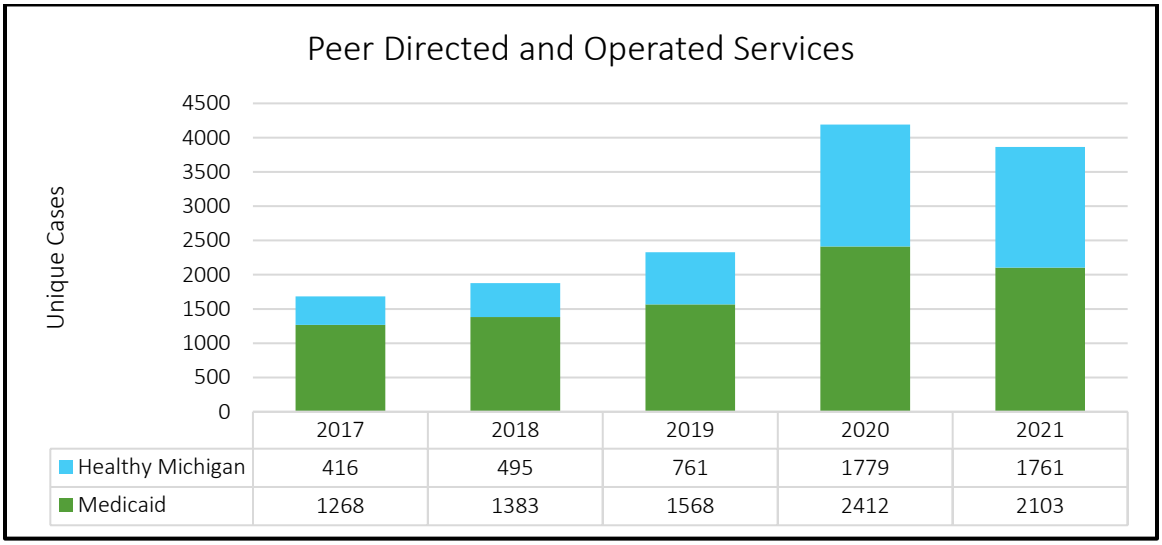


	2017	2018	2019	2020	2021
Healthy Michigan	9	33	142	140	177
Medicaid	10	42	170	137	133

Peer Directed and Operated Support Services

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

Figure 24: Peer Directed and Operated Support Services

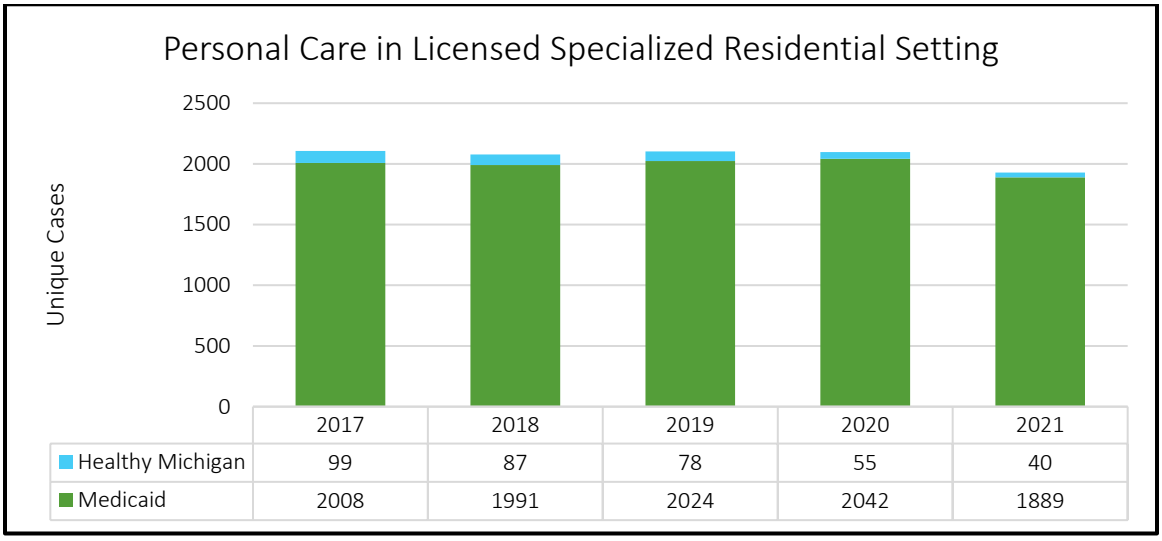


	2017	2018	2019	2020	2021
Healthy Michigan	416	495	761	1779	1761
Medicaid	1268	1383	1568	2412	2103

Personal Care in Licensed Specialized Residential Setting

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

Figure 25: Personal Care in Licensed Specialized Residential Setting

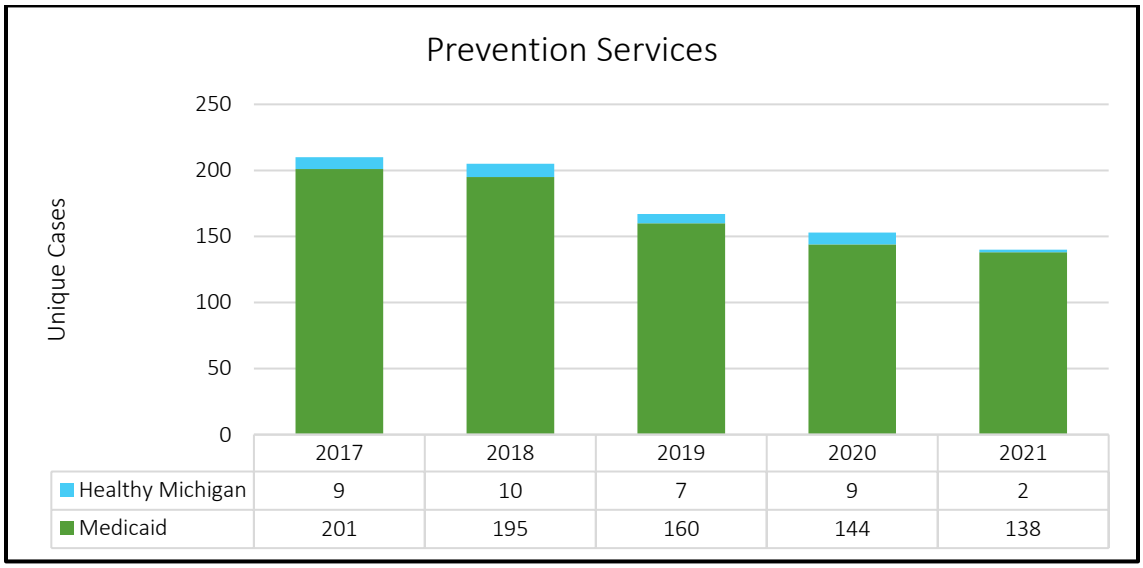


	2017	2018	2019	2020	2021
Healthy Michigan	99	87	78	55	40
Medicaid	2008	1991	2024	2042	1889

Prevention Services

Services include school success, avoiding childcare expulsion, infant mental health, and parent education.

Figure 26: Prevention Services

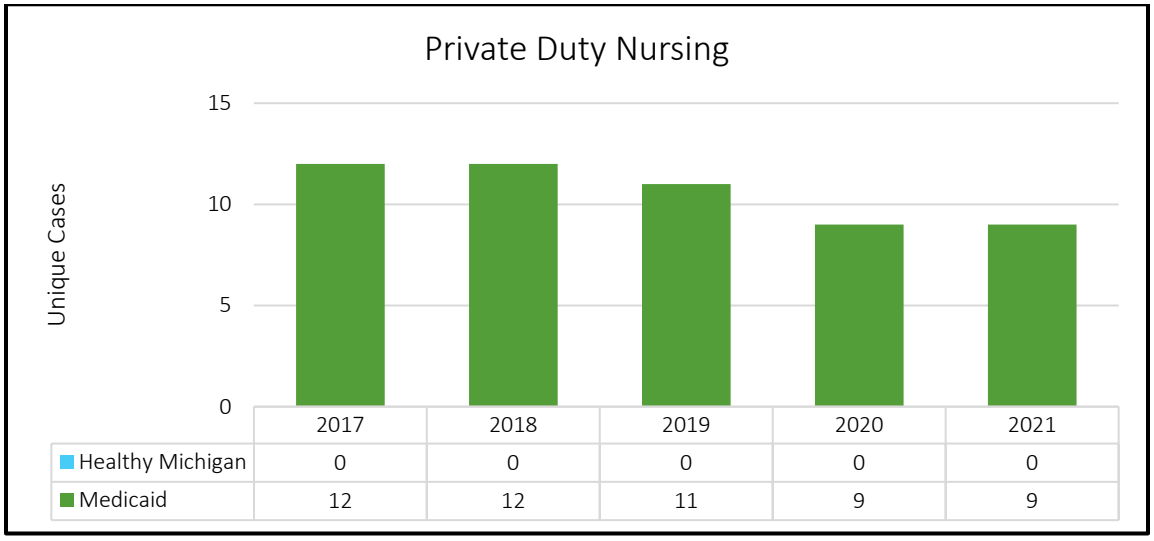


	2017	2018	2019	2020	2021
Healthy Michigan	9	10	7	9	2
Medicaid	201	195	160	144	138

Private Duty Nursing

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

Figure 27: Private Duty Nursing

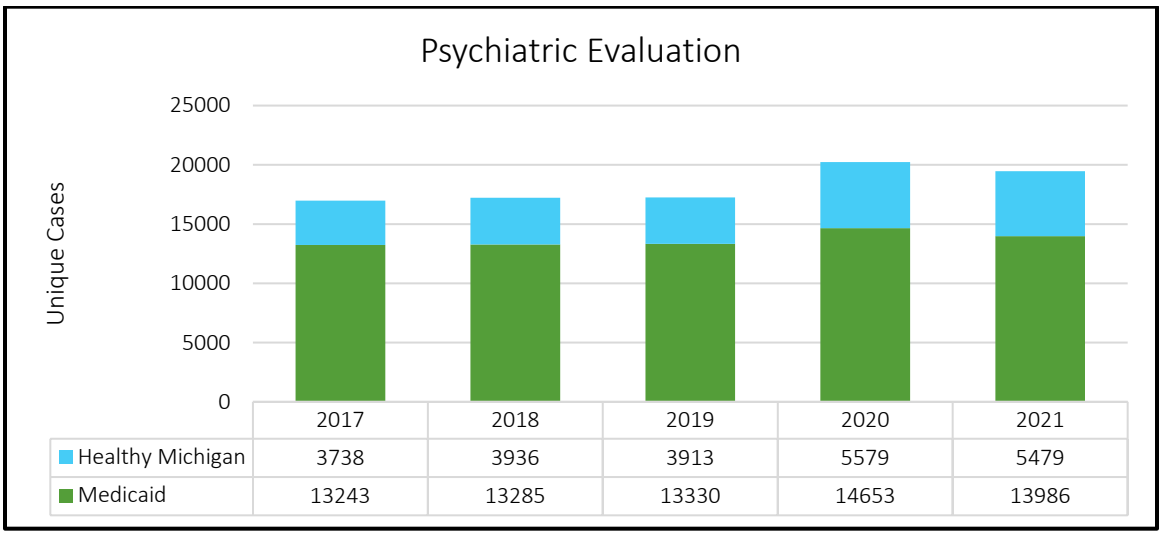


	2017	2018	2019	2020	2021
Healthy Michigan	0	0	0	0	0
Medicaid	12	12	11	9	9

Psychiatric Evaluation and Medication

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

Figure 28: Psychiatric Evaluation

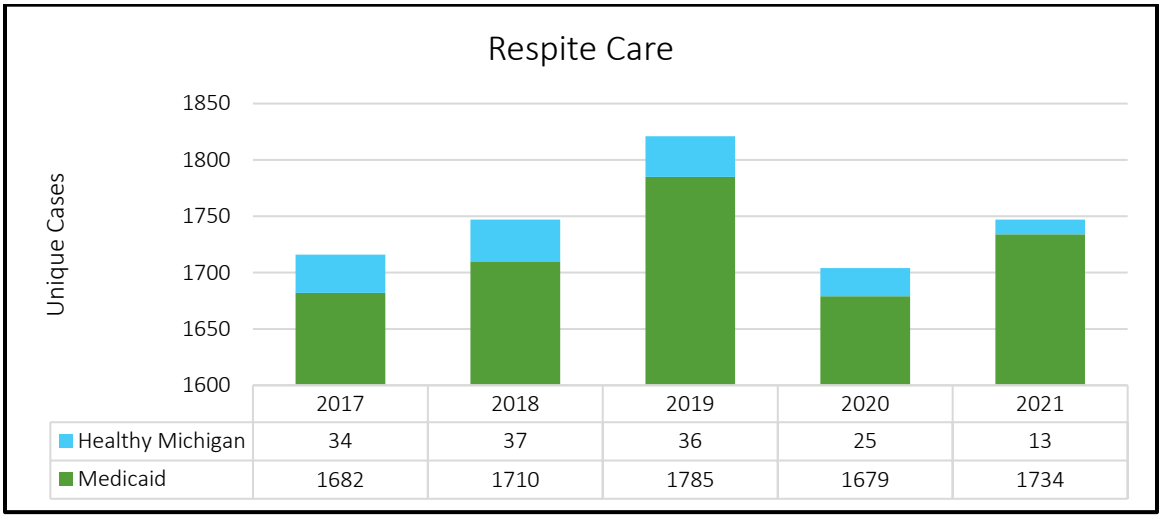


	2017	2018	2019	2020	2021
Healthy Michigan	3738	3936	3913	5579	5479
Medicaid	13243	13285	13330	14653	13986

Respite

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

Figure 29: Respite

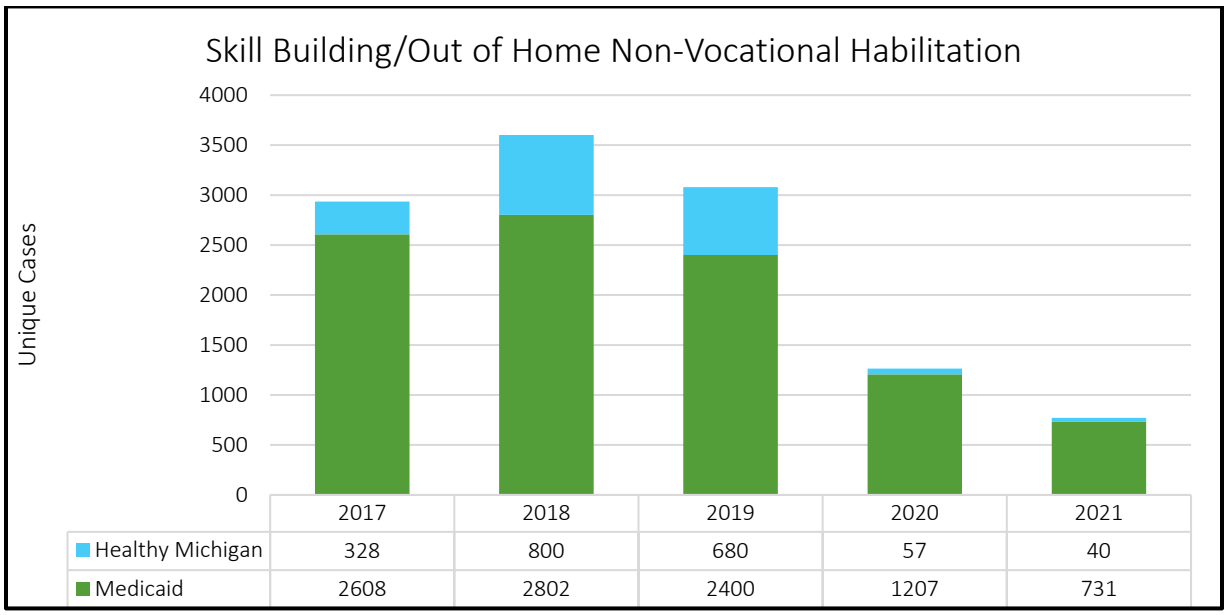


	2017	2018	2019	2020	2021
Healthy Michigan	34	37	36	25	13
Medicaid	1682	1710	1785	1679	1734

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

Skill-building assists a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. HCBS transition has had an impact on availability of services, but it is expected to stabilize or increase moderately as providers come into compliance.

Figure 30: Skill Building/Out of Home Non-Vocational Habilitation

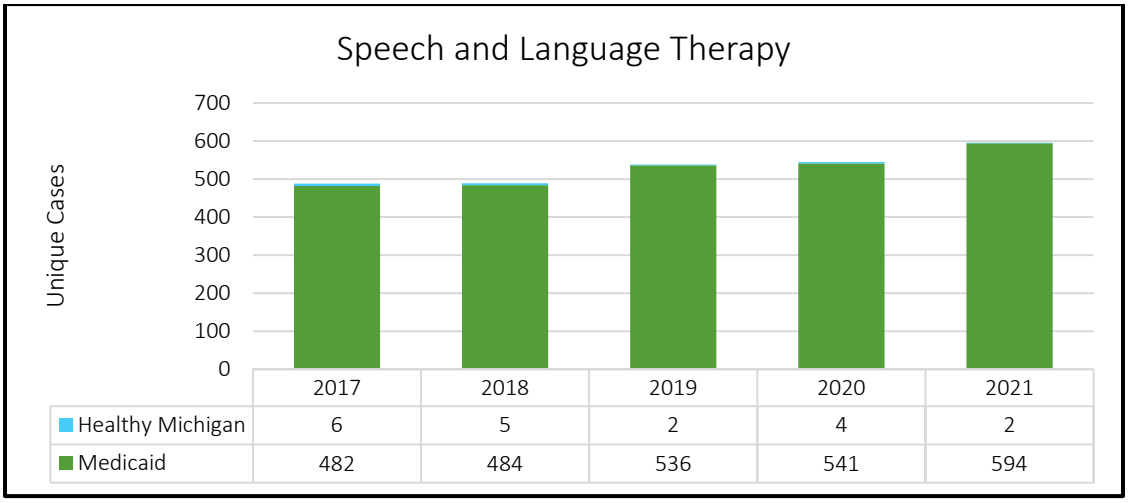


	2017	2018	2019	2020	2021
Healthy Michigan	328	800	680	57	40
Medicaid	2608	2802	2400	1207	731

Speech and Language Therapy

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

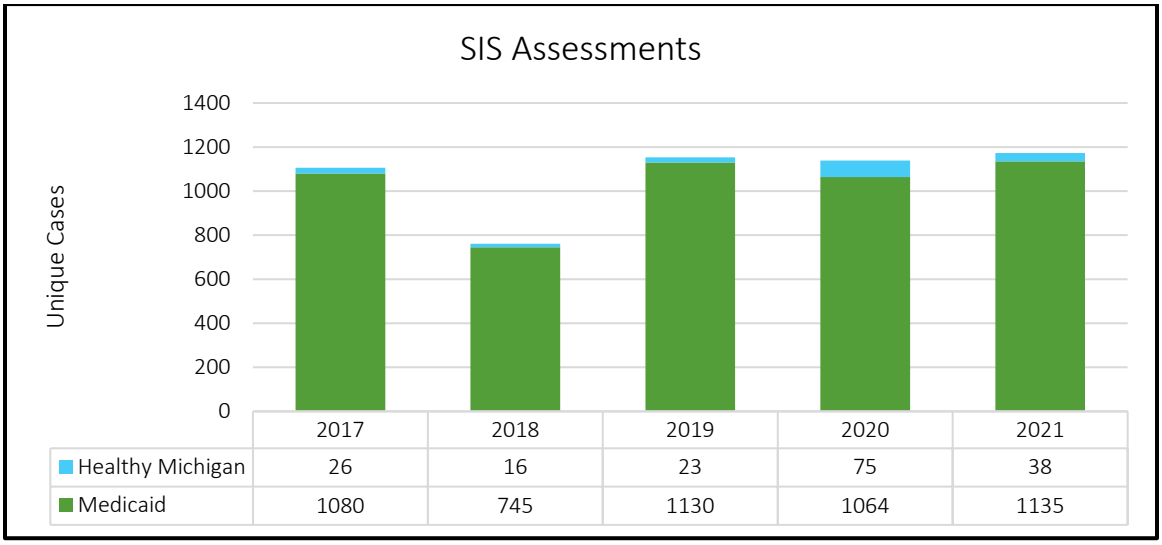
Figure 31: Speech and Language Therapy



Supports Intensity Scale Assessments

MDHHS requires PIHPs to administer a clinical assessment for individuals aged 16 and up with intellectual and developmental disabilities (IDD) called the Supports Intensity Scale (SIS). MSHN has delegated completion of the SIS to the CMHSP participants. The SIS assessors are a group of staff certified to complete SIS assessments for all Medicaid eligible adults with an intellectual or developmental disability (IDD). MSHN must ensure an adequate cadre of assessors are in place to ensure that each eligible individual receives a SIS assessment at least once every three years. These qualified SIS assessors exist across the region to ensure that all individuals are assessed in the required timeframe.

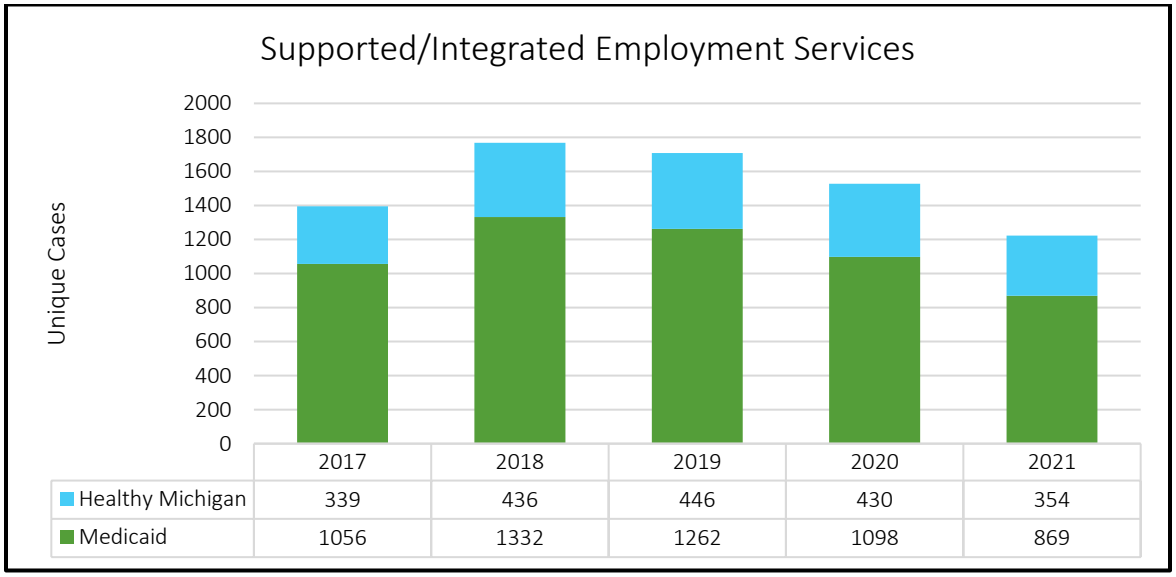
Figure 32: Supports Intensity Scale Assessments



Supported Employment Services

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

Figure 33: Supported/Integrated Employment Services

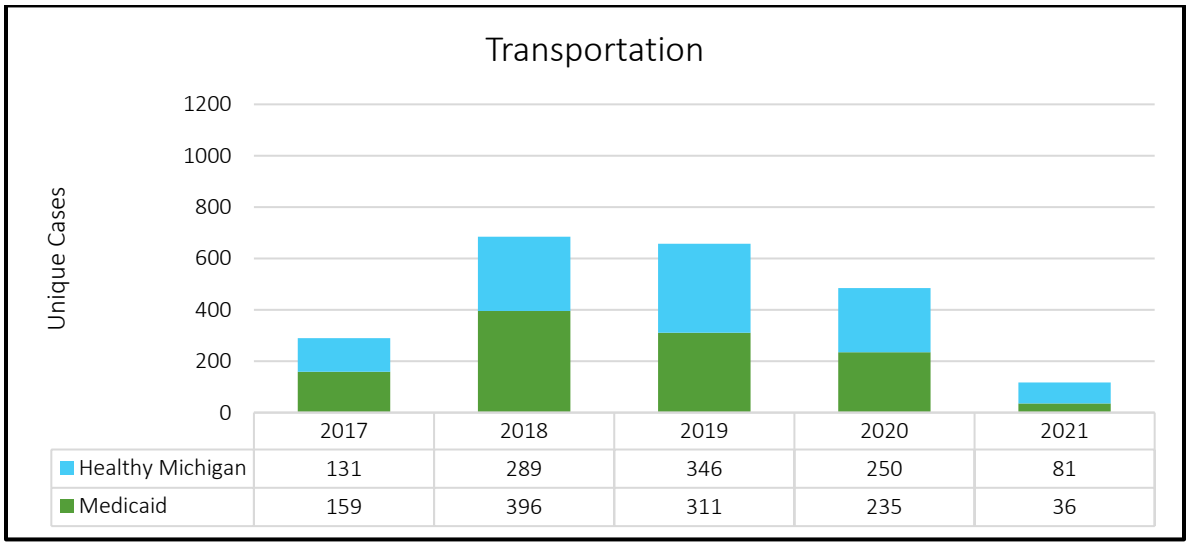


	2017	2018	2019	2020	2021
Healthy Michigan	339	436	446	430	354
Medicaid	1056	1332	1262	1098	869

Transportation

Transportation is used to transport individuals to/from services other than daytime activity, skill building, clubhouse, supported employment, or community living activities.

Figure 34: Transportation

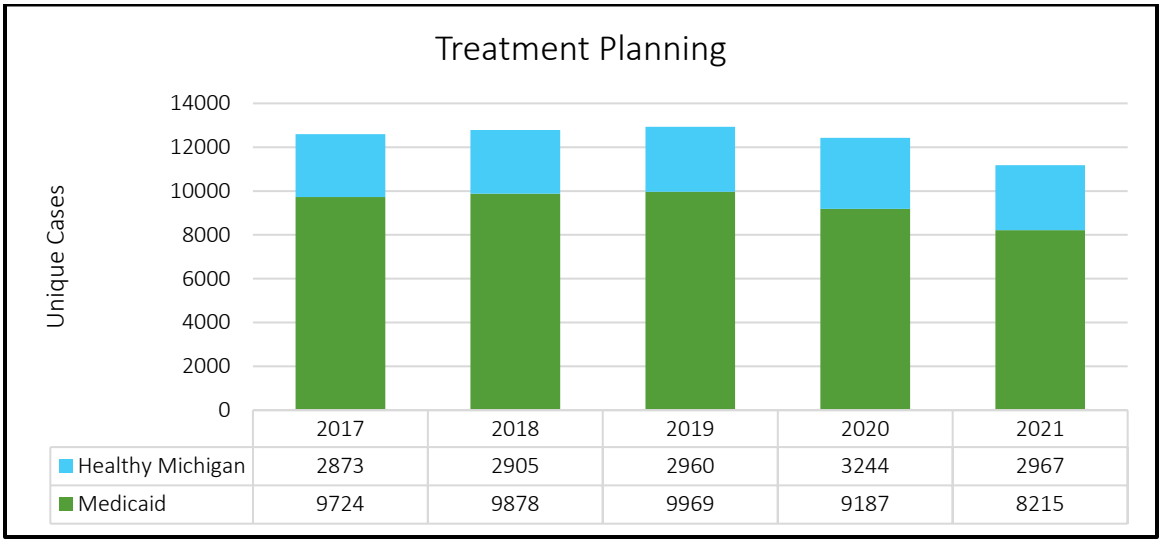


	2017	2018	2019	2020	2021
Healthy Michigan	131	289	346	250	81
Medicaid	159	396	311	235	36

Treatment Planning

Activities associated with developing an individual's plan of service. Also included is writing goals and objectives, measurement and monitoring goals and attending person centered planning meetings.

Figure 35: Treatment Planning



Evidence Based Practices – Mental Health

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

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

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

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

Autism Benefit (EPSDT)

The Michigan Medicaid Autism Benefit provides children ages 18 months to 21 years of age who have a medical diagnosis of Autism Spectrum Disorder (ASD) with Applied Behavioral Analysis (ABA) services. Services are contracted or directly delivered by the CMHSP Participants as shown in Table 3.

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

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

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

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

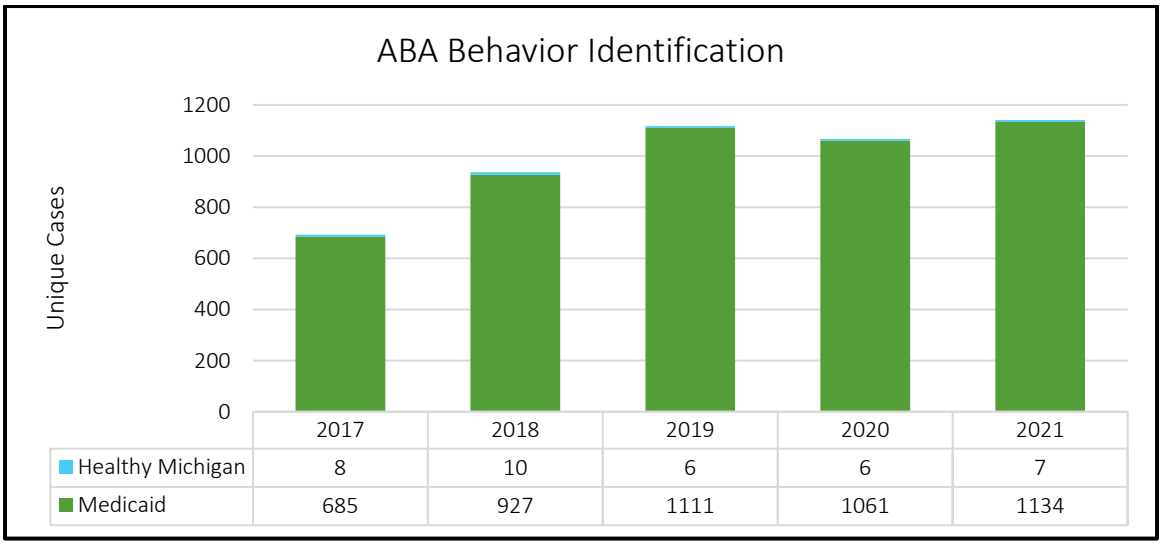
Table 4: Individuals Served by CMHSPs with Autism Spectrum Disorders and ABA Service Utilization

	FY18		FY19		FY20		FY21	
	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit	Individuals with an ASD diagnosis	Individuals Enrolled in the BHT Benefit
BABH	212	99	231	110	248	108	290	135
CEI	504	267	589	312	714	365	862	423
CMHCM	407	161	531	167	578	190	685	273
GIHN	88	50	114	63	122	64	131	67
HBH	48	15	50	11	47	8	57	14
LCMHA	316	215	462	192	535	242	604	274
MCN	102	46	177	67	194	79	239	89
NCMH	82	16	92	14	97	14	119	14
SCCMHA	432	205	525	209	566	203	667	239
SHW	89	38	115	32	122	31	158	57
TBHS	85	37	99	39	97	37	118	52
TRD	118	28	126	31	124	30	145	26
MSHN	**2,483**	**1,178**	**3111**	**1,247**	**3,444**	**1371**	**4075**	**1663**

ABA Behavior Identification

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

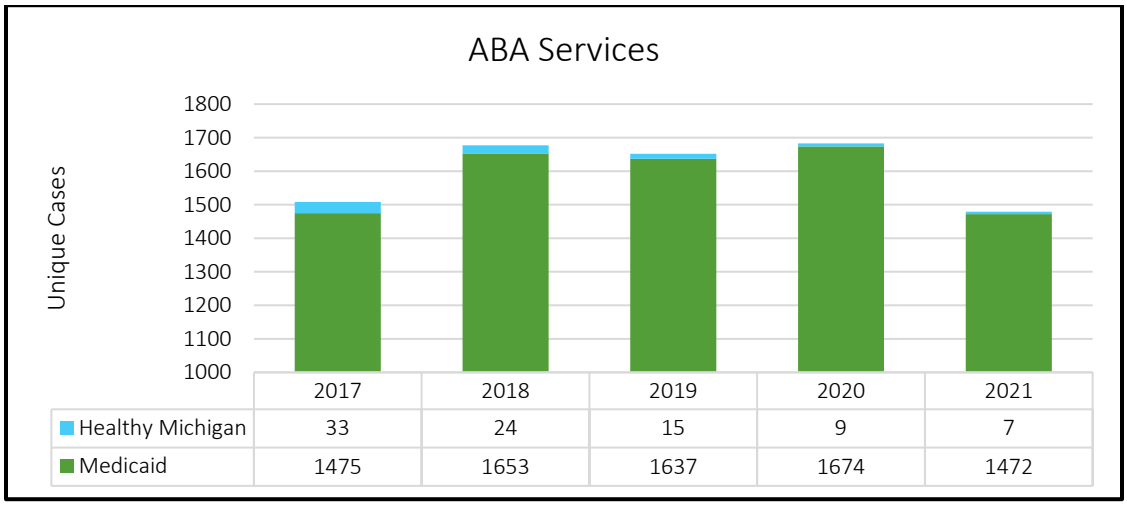
Figure 36: ABA Behavior Identification



ABA Other Services

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

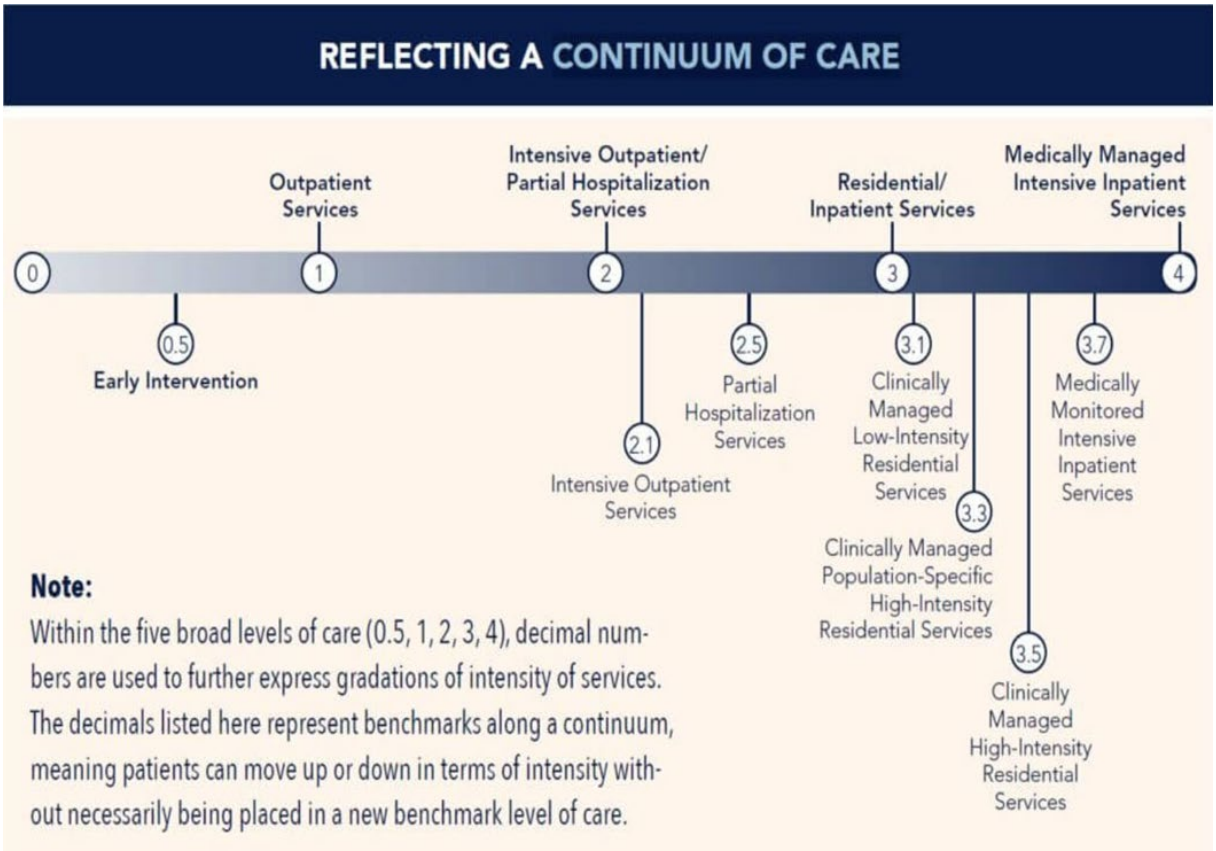
Figure 37: ABA Other Services



	2017	2018	2019	2020	2021
Healthy Michigan	33	24	15	9	7
Medicaid	1475	1653	1637	1674	1472

Substance Use Disorder Services

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



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

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

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

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

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

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

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

	Outpatient				Residential				Withdrawal Mgt.		OTP	Recovery Housing
County	**0.5**	**1.0**	**2.1**	**2.5**	**3.1**	**3.3**	**3.5**	**3.7**	**3.2**	**3.7**	**Level 1**	**III or IV**
Arenac	X - MCU	X - MCU										
Bay	X	X*	X									
Clare		X										
Clinton		X										
Eaton	X	X*	X									
Gladwin		X*										
Gratiot	X*	X										
Hillsdale		X			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					X
Montcalm		X*	X									X
Newaygo	X	X*	X									X
Osceola		cb	cb									
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	X
cb (Community Based Services)		*OP Program offer MAT (Suboxone/Vivitrol)					MCU – Mobile Care Unit					

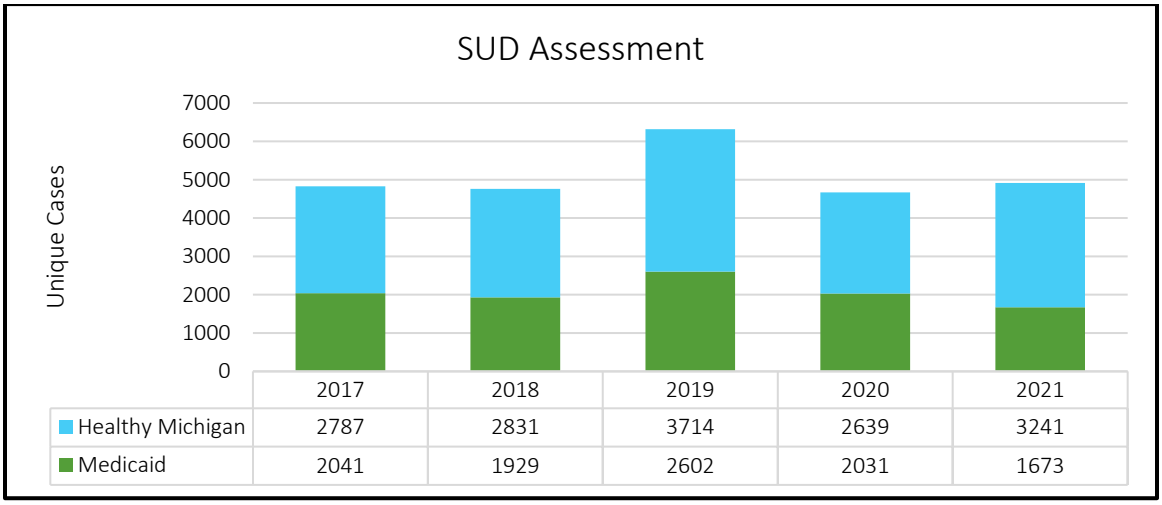
Medicaid-covered services and supports must be provided, based on medical necessity, to eligible beneficiaries who reside in the region and request services. The Substance Use Disorder services below are authorized through MSHN. Much of the MSHN region is covered relative to the availability of outpatient and medication assisted treatment services; however, the region continues to expand capacity as 60 min/60 miles can be a barrier for consumers in need of services. MSHN owns a mobile care unit, a retrofitted RV that brings counseling, therapeutic, and physical health services to SUD patients. The mobile unit has an area for intake and scheduling, a restroom to incorporate urine screening, a one private room for counseling. Harm reduction activities including syringe services, overdose education, and naloxone distribution will also be provided. The unit has telehealth capabilities to incorporate Medication Assisted Treatment (MAT) supports as needed. Locations of access for the mobile care unit is evaluated by MSHN based on community need.

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

SUD Assessment

Assessment includes an evaluation by a qualified practitioner that investigates clinical status including: presenting problem, history of present illness, previous medication history, relevant personal and family history, personal strengths and assets, and mental status examination purposes of determining eligibility for specialty services and supports, and the treatment needs of the beneficiary.

Figure 38: SUD Assessment

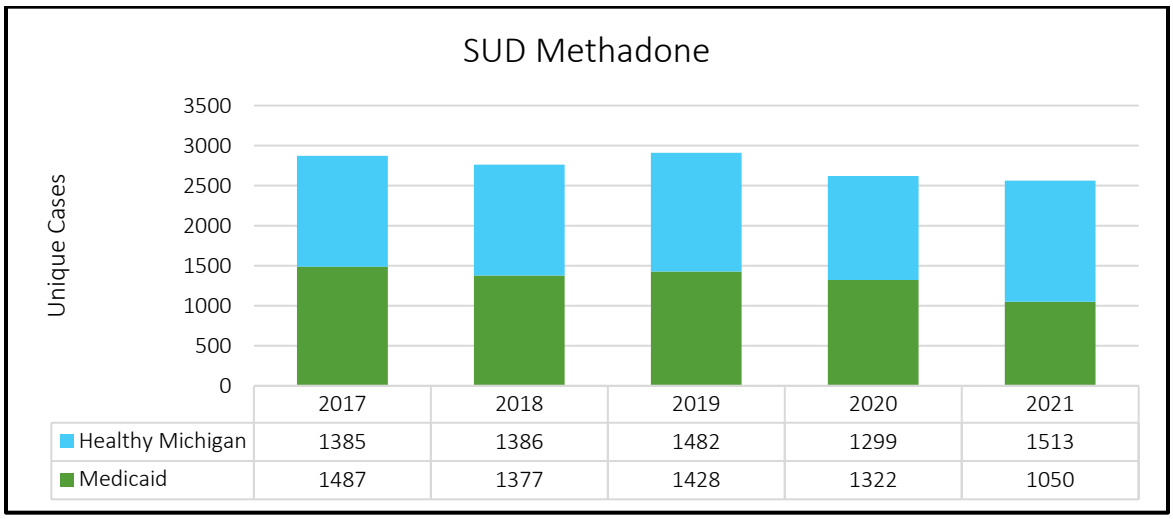


	2017	2018	2019	2020	2021
Healthy Michigan	2787	2831	3714	2639	3241
Medicaid	2041	1929	2602	2031	1673

SUD Methadone

Methadone is an approved pharmacological support and an adjunct to the treatment of opioid use disorders. Services must be provided under the supervision of a physician licensed to practice medicine in Michigan and licensed to prescribe controlled substances, as well as licensed to work at a methadone program.

Figure 39: SUD Methadone



	2017	2018	2019	2020	2021
Healthy Michigan	1385	1386	1482	1299	1513
Medicaid	1487	1377	1428	1322	1050

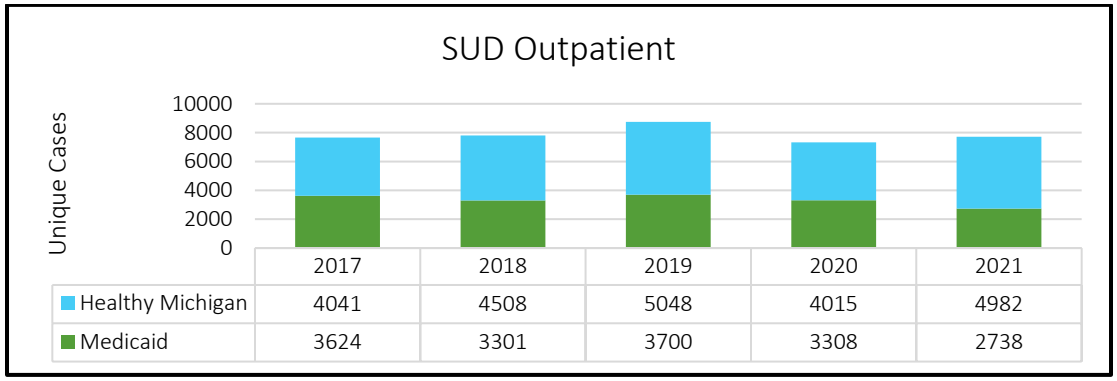
SUD Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT) programs

OTPs are certified by SAMHSA under 42 CFR Part 8.11. MDHHS has an established adequacy standard (35,000:1 Medicaid Enrollee to Provider ratio). MSHN currently contracts with five OTPs in the region that meet this definition. MSHN has significantly expanded the availability of Medication for Opioid Use Disorder (MOUD) providers in the region, and currently contracts with eighteen (18) MOUD provider locations and as indicated, five (5) SAMHSA certified OTPs. In addition, MSHN contracts with four (4) MOUD providers out of its geographic region for services to in-region residents. MSHN has an additional 13 contracted OBOT provider locations in region that have physicians who can prescribe naltrexone and/or buprenorphines.

SUD Outpatient

Outpatient treatment is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment or a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary, can total over 20 hours in a week. Individual, family, and group therapy, peer supports, and monitoring services may be provided individually or in combination.

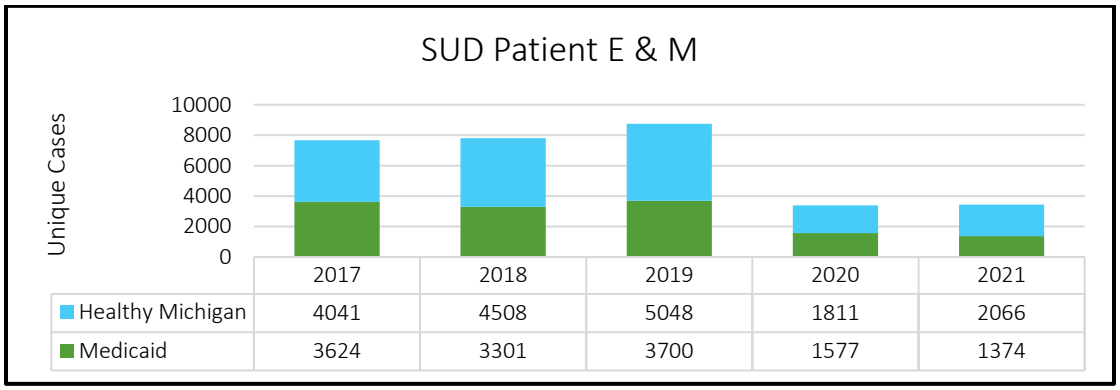
Figure 40: SUD Outpatient



SUD New and Established Patient Evaluation and Management

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

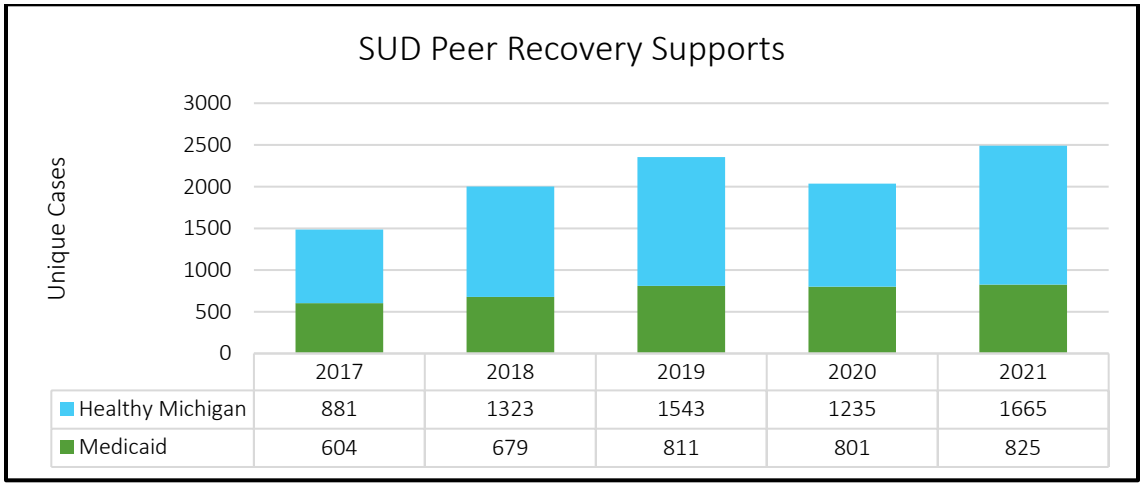
Figure 41: SUD Patient Evaluation and Management



SUD Peer Services/Recovery Supports

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

Figure 42: SUD Peer Recovery Supports

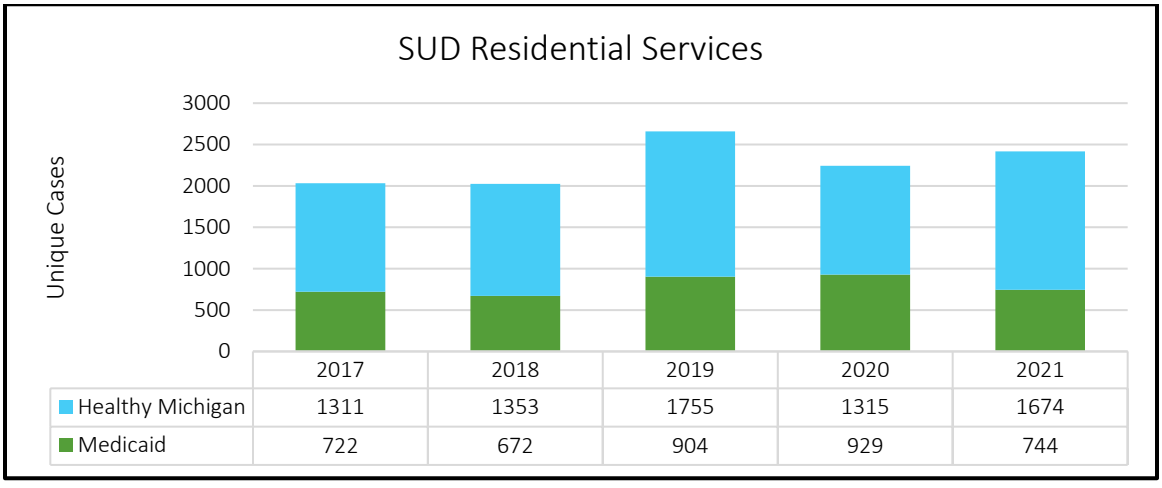


	2017	2018	2019	2020	2021
Healthy Michigan	881	1323	1543	1235	1665
Medicaid	604	679	811	801	825

SUD Residential Services

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

Figure 43: SUD Residential Services

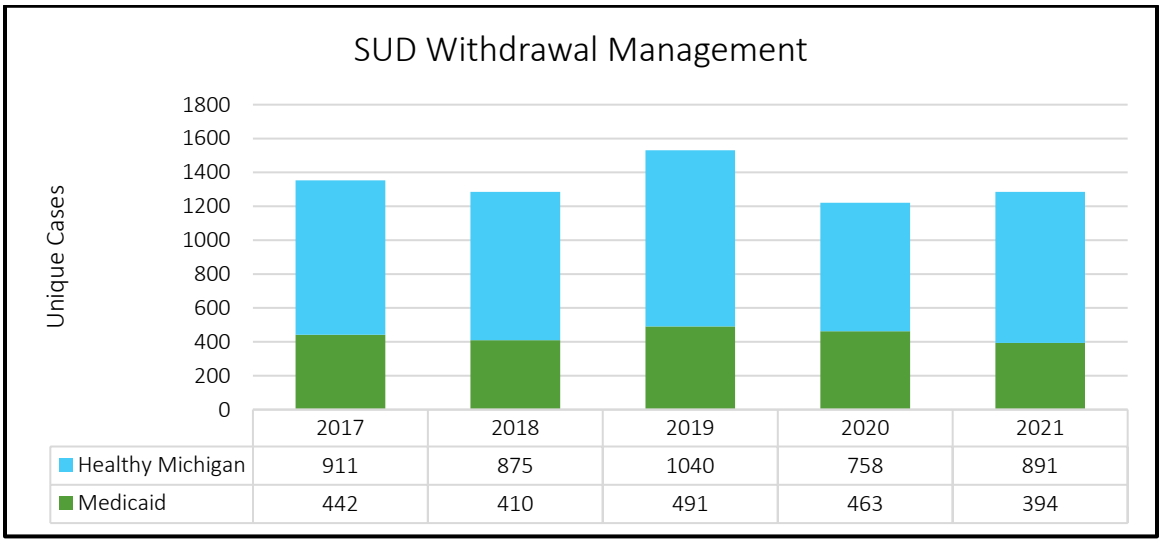


	2017	2018	2019	2020	2021
Healthy Michigan	1311	1353	1755	1315	1674
Medicaid	722	672	904	929	744

SUD Withdrawal Management

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

Figure 44: SUD Withdrawal Management



Evidenced Based Practices - SUD

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

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

*T=Treatment; P=Prevention

Focus	Evidenced Based Practices	Focus	Evidenced Based Practices
P	A Second Look	P	PhotoVoice
P	Above The Influence	P	Not on Tobacco
P	Active Parenting Now	P	Permanent Drug Disposal Box Initiatives
T	Acupuncture	P	Prescription Disposal/Drug Drop Off Boxes
T	Adolescent Community Reinforcement Approach	P	Prime for Life 420
P	Alcohol and Tobacco Vendor Education	P	Program to Encourage Active, Rewarding Lives (PEARL)
T	Alternative Routes	P	Prevention PLUS Wellness
P	An Apple A Day	P	Project Alert
P/T	Anger Management	P	Total Trek Quest
P	Be A Star	P	Project M.A.G.I.C.
P	Big Brothers Big Sisters	P	Project Success
P	Botvins Life Skills	P	This Is Not About Drugs
P	Breakout	P	Project Toward No Drug Use
P	Choices	P	Protecting You/Protecting Me
T	Cognitive Behavioral Therapy (CBT)	P	Promoting Alternative Thinking Strategies
P	Communities Mobilizing for Change on Alcohol	P	QPR Gatekeeper Training for Suicide Prevention

Focus	Evidenced Based Practices	Focus	Evidenced Based Practices
P	Communities that Care	P	Retailer/Server Education (TIPS)
P	Community Intervention: Helping Teens Overcome Problems with Alcohol, Marijuana and Other Drugs	P	Safe Prom and Graduation Initiatives
P	Community Trials to Reduce High Risk Drinking	P	SAMSHA - 8 Dimensions of Wellness
T	Contingency Management (CM)	P	SAMSHA - Prevention Messages at Schools
T	Correctional Therapeutic Community for SUD	T	Screening, Brief Intervention, Referral to Treatment
P	Cross Age Mentoring Programming	P	Second Step
T	Dialectical Behavior Therapy (DBT)	P/T	Seeking Safety
P	Do Your Part-State Social Norm Campaign	T	Self-Management and Recovery Training (SMART)
P	Drug Take Back Events	P	Signs of Suicide
P	Early Childhood STEP	P	SMART Leaders/SMART Moves
P	Eight Dimensions of Wellness	P	Social Norming/Marketing and Media Campaigns
T	Eye Movement Desensitization and Re-Processing	P	SPEC Signs of Suicide
P	Families and Schools Together (FAST)	P	SPORTPLUS Wellness
T	Family Psychoeducation	P	Stay It Straight
T	Functional Family Therapy	P	Step Bullying Prevention
T	Helping Women Recover/Helping Men Recover	P	STEP-Early Childhood
P/T	Incredible Years	P	STEP-Teen
P	In-School Probation: Early Intervention		
P	It's All About Being A Team		
P	JUMP	P/T	Strengthening Families
P	Life Skills Training	P	Strengthening Families Home
T	Living in Balance	P	Student Assistance Programs
T	Medication Assisted Treatment (MAT)	P	SURF
P	Mentoring	P	Synar Compliance Checks
P	Mentoring Programs	P	Systematic Training for Effective Parenting (STEP)
P	Michigan Model for Health	P	TCU Mapping - Enhanced Counseling
T	Mindfulness	P	Teen Intervene
P	Minor in Possession Program	T	Thinking for a Change
T	Moral Reconation Therapy	P	TIPS Training
P	MOST Social Norming Campaign	T	Tobacco Cessation
T	Motivational Enhancement Therapy (MET)		

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

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

Each of the CMHSP participant agencies in the region have extensive experience in the behavioral health care industry, as have many of their contracted service providers. Practitioners and staff employed or contracted by the CMHSPs are properly licensed (by the Michigan Department of Licensing and Regulatory Affairs (LARA)) and credentialed in accord with MDHHS requirements for provider qualifications as defined in the Michigan Medicaid Manual. Disciplines include Licensed/Board Certified

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

Psychiatrists, Licensed Nurse Practitioners, Registered Nurses, Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Full and Limited License Psychologists, Board Certified Behavioral Analysts and Licensed Professional Counselors, among others. Credentialing and re-credentialing procedures, as well as privileging procedures for psychiatrists, are utilized by each CMHSP with their provider networks. Agencies under contract are overseen by CMHSP staff and residential settings are licensed in accordance with MDHHS requirements.

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

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

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

Trauma Informed Care

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

Recovery Oriented Systems of Care (SUD)

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

Standard Assessment (SUD)

The pursuit of a single statewide substance use disorder assessment that is based on ASAM levels of care as defined under the CMS-approved 1115 waiver was resolved. Through advocacy of the PIHP CEOs, PIHP SUD Directors, and Provider Alliance, the ASAM CONTINUUM was recommended and subsequently approved by BHDDA for statewide implementation by October 1, 2021. The ASAM CONTINUUM was approved for adults, but the GAIN I-Core was chosen as the approved assessment for adolescents as the ASAM CONTINUUM was not standardized to meet the assessment needs of this population. MDHHS-BHDDA in collaboration with CMHAM offered 3 months of training opportunities for ASAM CONTINUUM certification for the SUD treatment provider network during July, August, and September of 2021. The trainings were 4 hours of self-paced virtual coursework, and then an additional 4 hours of in-person virtual training with an ASAM trainer. While the 21 training sessions offered were supportive of getting the majority of clinicians trained statewide, there was still a need for training of newly hired staff. After October 1, 2021, ASAM was able to offer an 8-hour self-paced virtual option to SUD Treatment Providers to meet this need. MSHN continues to offer GAIN I-Core certification training for regional clinicians through a contracted local trainer to meet the needs of the SUD provider network.

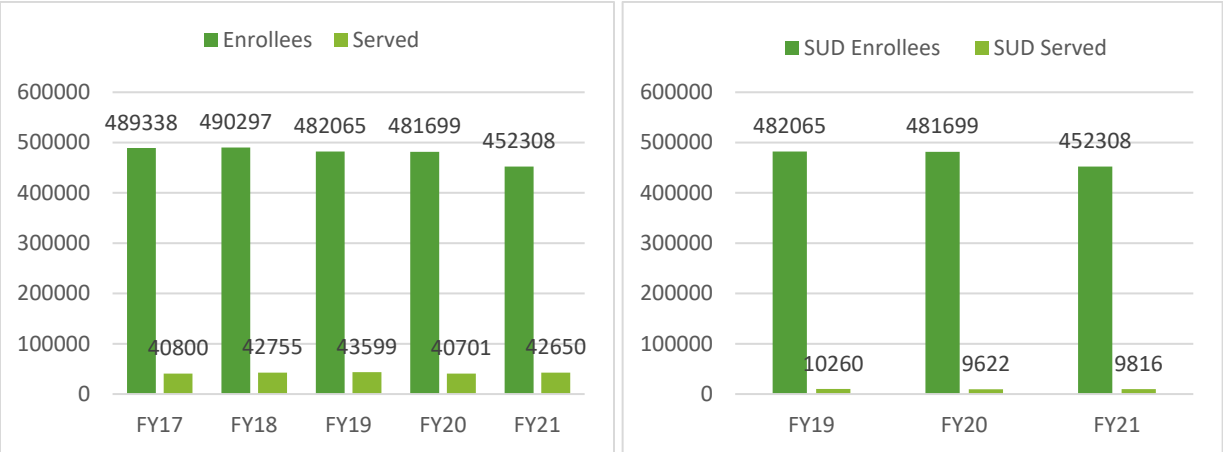
Adequacy of Services for Anticipated Enrollees

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

Medicaid/Healthy Michigan enrollment

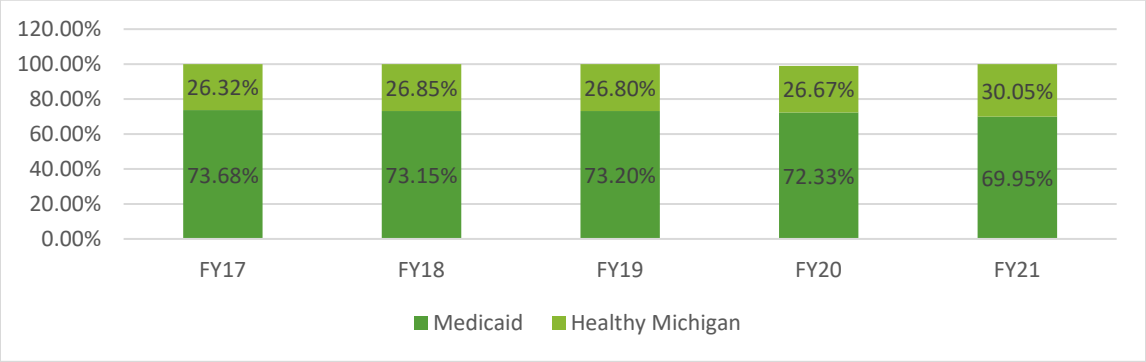
Over the past couple of years, enrollment in Medicaid and Healthy Michigan has shown signs of plateauing. Based on enrollment alone, this suggests that MSHN does not need to expand its provider network system. Figures 45 and 46 show the Medicaid and Health Michigan enrollment trends for the mental health and SUD populations.

Figure 45: Total Enrollees vs. Served – MH and Total Enrollees vs. Served - SUD



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

Figure 46: Proportions of Medicaid/HMP Populations

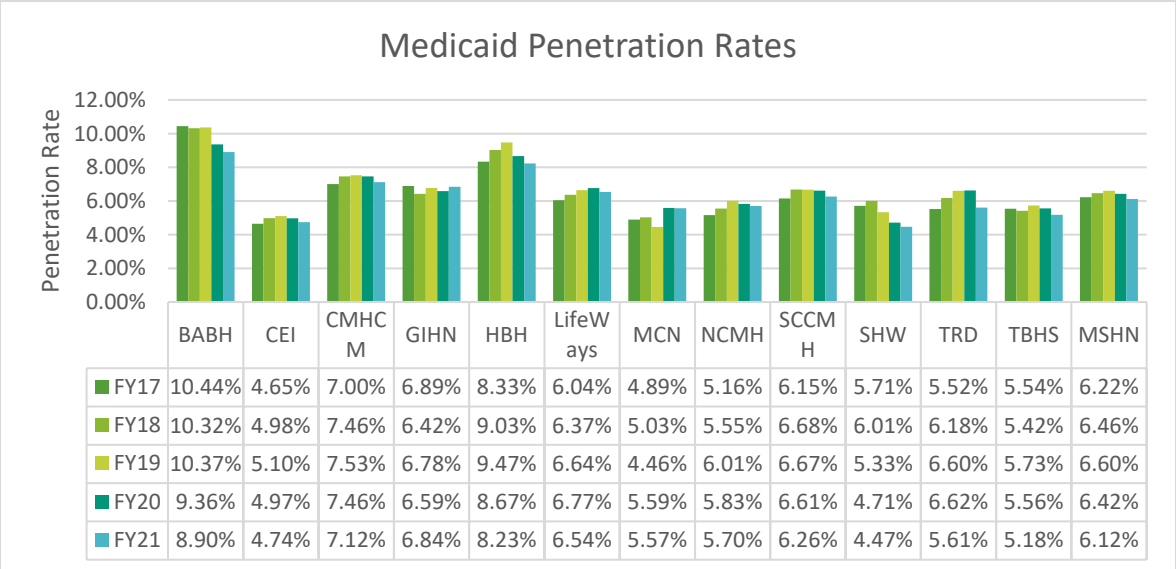


Service Population Penetration Rates

Medicaid enrollees since March 2020 have steadily been increasing from the intentional hold on any eligibility loss due to COVID-19. The future outlook indicates eligibility reviews will begin in FY22 after the end of the Federal Public Health Emergency, which may result in reduced enrollees. Variability does exist among the CMHSP Participants in the region relative to population penetration rates, which is reviewed at the executive level by the MSHN Operations Council and is addressed on an ongoing basis by the MSHN Utilization Management Committee. The goal is to determine if the variance is commensurate with community need or if action by the Operations Council is warranted relative to network capacities. Figure 47 and 48 shows the Medicaid and Healthy Michigan penetration rate per CMHSP by fiscal year. Figure 49 shows the number of consumers serviced.

Compared to FY19 (prior COVID-19) 2 CMHSPs increased their Medicaid penetration rate in FY21 (GIHN and MCN), with 10 CMHSPs experiencing a decrease. As of the end of FY21, (MDHHS, July 1, 2021 - September 30, 2021)[9] MSHN had the highest penetration rate at 7.74% out of the 10 PIHPs.

Figure 47: Medicaid Service Penetration Rates[10]

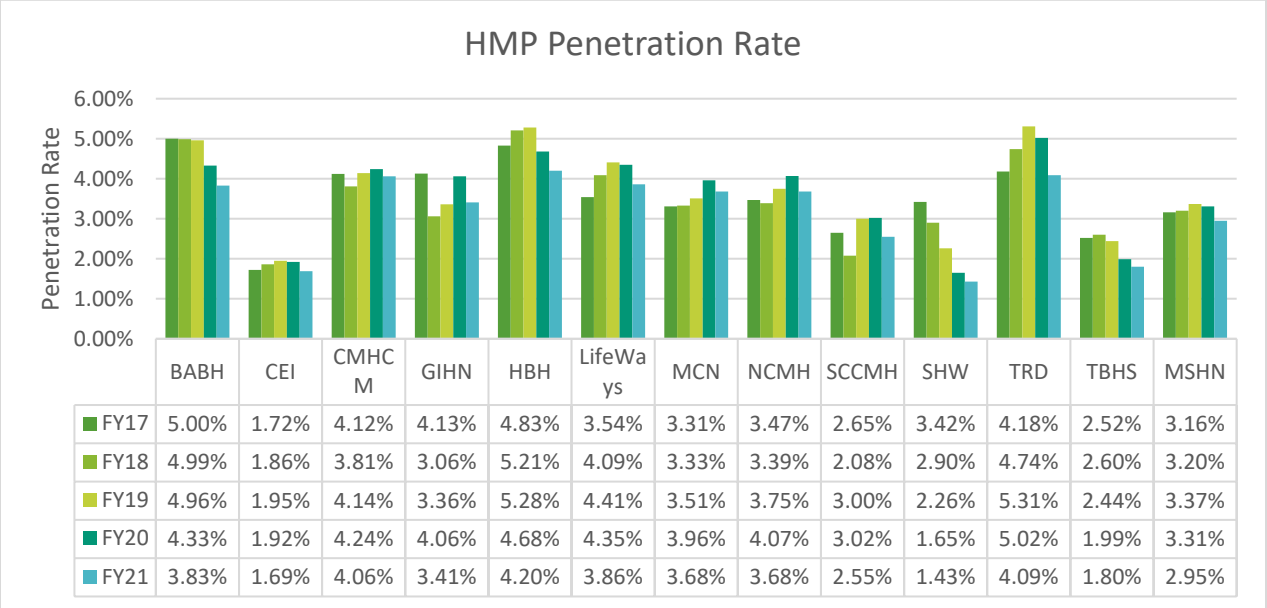


	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS	MSHN
FY17	10.44%	4.65%	7.00%	6.89%	8.33%	6.04%	4.89%	5.16%	6.15%	5.71%	5.52%	5.54%	6.22%
FY18	10.32%	4.98%	7.46%	6.42%	9.03%	6.37%	5.03%	5.55%	6.68%	6.01%	6.18%	5.42%	6.46%
FY19	10.37%	5.10%	7.53%	6.78%	9.47%	6.64%	4.46%	6.01%	6.67%	5.33%	6.60%	5.73%	6.60%
FY20	9.36%	4.97%	7.46%	6.59%	8.67%	6.77%	5.59%	5.83%	6.61%	4.71%	6.62%	5.56%	6.42%
FY21	8.90%	4.74%	7.12%	6.84%	8.23%	6.54%	5.57%	5.70%	6.26%	4.47%	5.61%	5.18%	6.12%

[9] Source: MDHHS, MMBPIS September 2021

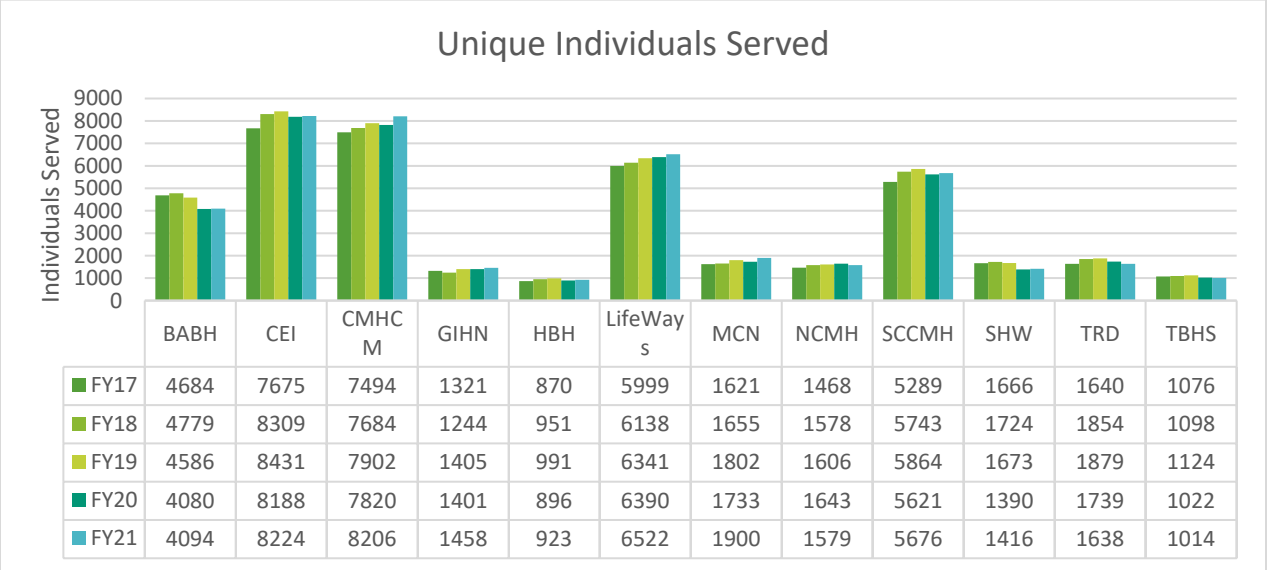
[10] Source: MSHN REMI Penetration Report

Figure 48: HMP Service Penetration Rates[11]



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS	MSHN
FY17	5.00%	1.72%	4.12%	4.13%	4.83%	3.54%	3.31%	3.47%	2.65%	3.42%	4.18%	2.52%	3.16%
FY18	4.99%	1.86%	3.81%	3.06%	5.21%	4.09%	3.33%	3.39%	2.08%	2.90%	4.74%	2.60%	3.20%
FY19	4.96%	1.95%	4.14%	3.36%	5.28%	4.41%	3.51%	3.75%	3.00%	2.26%	5.31%	2.44%	3.37%
FY20	4.33%	1.92%	4.24%	4.06%	4.68%	4.35%	3.96%	4.07%	3.02%	1.65%	5.02%	1.99%	3.31%
FY21	3.83%	1.69%	4.06%	3.41%	4.20%	3.86%	3.68%	3.68%	2.55%	1.43%	4.09%	1.80%	2.95%

Figure 49: Total Individuals Served by CMHSP[12]



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS
FY17	4684	7675	7494	1321	870	5999	1621	1468	5289	1666	1640	1076
FY18	4779	8309	7684	1244	951	6138	1655	1578	5743	1724	1854	1098
FY19	4586	8431	7902	1405	991	6341	1802	1606	5864	1673	1879	1124
FY20	4080	8188	7820	1401	896	6390	1733	1643	5621	1390	1739	1022
FY21	4094	8224	8206	1458	923	6522	1900	1579	5676	1416	1638	1014

Community Needs Assessments: Priority Needs and Planned Actions

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

[11] Source: MSHN REMI Penetration Report

[12] Source: MSHN REMI Penetration Report

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

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

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

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

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

Consumer Satisfaction

Consumer satisfaction with services is an important consideration when evaluating the adequacy of a provider network. MSHN assesses consumer perception of care for adults who are experiencing a mental illness utilizing Assertive Community Treatment, Outpatient Therapy, and Targeted Case management/Supports Coordination services and children with serious emotional disturbance receiving Home Based Services, Outpatient Therapy, and Case management/Supports Coordination. In an attempt to increase response rates during the pandemic and emergency orders, accommodations were made in the distribution methods by allowing mailed survey, phone surveys, electronic surveys, and face to face when available in an attempt to increase response rates.

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

The responses to the Perception of Access (to services) subscale for these services were relatively favorable, with 96% of youth and 92% of adults expressing satisfaction. Despite the high levels of satisfaction, it remains a goal for the MSHN region to increase these rates.

The SUD treatment provider network administers a satisfaction survey to adults and adolescent consumers who received a service. Consumers were asked to rate satisfaction on a 5-point scale with 5 being "strongly agree" and high level of satisfaction. With a comprehensive score of 4.61, this indicates an overall agreement with the statements in the survey and represents a continuous increase in satisfaction from year to year,

MSHN also conducts the Recovery Self-Assessment (RSA) to assist the provider network and other stakeholders develop a better understanding of the strengths and weaknesses in MSHN's recovery-oriented care. This report was developed utilizing voluntary self-reflective surveys completed by providers and administrators who provide treatment to individuals who experience mental illness and/or a substance use disorder. The assessments consisted of six (6) separate subcategories that included Inviting, Choice, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment. MSHN received a score of 3.50 or greater for each domain indicating satisfaction with the recovery environment. MSHN also met the expectation of improvement each year by demonstrating a comprehensive score of 4.27.
Consumer satisfaction results are reviewed by the MSHN Quality Improvement Council, MSHN Clinical Leadership Committee, and the Regional Consumer Advisory Council to determine if any trends are evident and if any regional improvement efforts would be recommended. Areas of improvement are targeted toward below average scores (>3.50) and/or priority areas as identified through review of the regional councils and committees.

Anticipated changes in Medicaid eligibility or benefits

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

Home and Community Based Services

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

In FY17, MDHHS delegated increased responsibility for completion of the surveys to PIHPs. A combination of onsite and desk reviews continues to be completed to ensure ongoing HCBS compliance region wide. Sites found to be non-compliant with the HCBS rule must submit a corrective action plan to the PIHP to achieve full compliance by the March 2023 deadline; however, the state intends to stick to the March 2022 plan as identified in the State Transition Plan. MSHN and its CMHSP Participants are actively participating in MDHHS system assessments, individual participant surveys, provider surveys, heightened scrutiny work, provisional application processing, and corrective action plans.

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

Sufficiency of Network in Number, Mix and Geographic Distribution

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

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

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

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

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

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

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

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

Timely Appointments

MDHHS requires PIHPs to report indicators of access timeliness and outcomes related to inpatient follow-up. MDHHS, in coordination with the PIHPs and CMHSP participants, developed and implemented two new indicators to be reported for FY20Q3. The new indicators measure the percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service, and the percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. MSHN's performance rate for FY20 represents the new indicators for quarter 3 and quarter 4. The pandemic has impacted individual's ability to access services. MSHN should continue to monitor access to timeliness to treatment. Table 8 shows the recent year-to-year performance of the 21-county region.

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

	Population	MSHN Performance Rate FY20	MSHN Performance Rate FY21
The percentage of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (Standard: 95%)	MI-Children	99.53%	99.58%
	MI-Adults	99.12%	99.22%
The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergent request for service. (Standard: NA)	MI-Children	78.33%	69.31%
	MI-Adults	71.70%	63.69%
	DD-Children	68.81%	65.30%
	DD-Adults	76.41%	72.74%
	Total	73.61%	67.39%
The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment (Standard: NA).	MI-Children	71.37%	68.29%
	MI-Adults	77.21%	72.62%
	DD-Children	75.12%	78.33%
	DD-Adults	75.39%	68.01%
	Total	75.45%	71.34%
The percentage of new persons during quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergent request for services. (SUD Only) (Standard: NA)	Medicaid SUD	92.39%	*80.98%
The percentage of discharges from psychiatric inpatient unit/substance use disorder detox unit seen for follow-up care within 7 days. (Standard: ≥95%)	Children	98.10%	98.90%
	Adults	96.59%	97.02%
	Medicaid SUD	97.29%	96.68%
The percentage of readmissions to an inpatient psychiatric unit within 30 days of discharge. (Standard: >15%)	Children	8.46%	7.97%
	Adults	12.48%	12.62%

*Unconfirmed

Maximum Time and Distance Standards

A drive-time analysis was performed to assess the geographic accessibility of MSHN service providers as required by MDHHS Network Adequacy Standards procedure: Time and Distance Standards for Inpatient Psychiatric Services[15].

For this report, the Google Distance API was used to calculate the number of minutes it takes to drive from pre-defined geographical regions containing consumer residences to the nearest service providers.

Drive-time metrics were calculated for FY21 MSHN consumers across eleven service categories. The drive-time metrics gathered were benchmarked against time and distance standards derived from MDHHS-defined requirements for inpatient psychiatric services. Standards for time and distance vary

[15] MDHHS Network Adequacy Standards – Medicaid Specialty Behavioral Health Services

based on urban and rural geography. Rural and urban areas were defined using the U.S. Census Bureau method, which defines rural as everything not included within an Urban Area or Urban Cluster.

Figure 50: Time and Distance Standards for Inpatient Psychiatric Services

Time and Distance Standards for Inpatient Psychiatric Services

Adults

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

Pediatrics

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

Figure 51:

Key Findings: Percent of FY21 MSHN Consumers for Whom Drive Time Standard Was Met

	SUD Outpatient	Outpatient	Homebased	ACT	Clubhouse	Wraparound	Psych Inpatient Children	Psych Inpatient Adults	SUD Residential	SUD Withdrawal Management	Crisis Residential
Rural Standard	60 min	60 min	60 min	60 min	60 min	60 min	120 min	90 min	90 min	90 min	60 min
Urban Standard	30 min	30 min	30 min	30 min	30 min	30 min	60 min	30 min	30 min	30 min	30 min
Consumers with Standard Met	16150 (100.0%)	10176 (100.0%)	3309 (100.0%)	759 (100.0%)	494 (99.0%)	517 (98.7%)	581 (98.0%)	4271 (92.9%)	2752 (89.8%)	1331 (88.5%)	1192 (87.8%)

Based on the key findings in Figure 51, MSHN should focus efforts related to recruitment of providers for SUD residential, SUD withdrawal management and crisis residential. In FY22, MSHN conducted an RFP for a Crisis Residential Unit (CRU) and once a location is secured, the analysis related to the need for additional CRUs will be completed.

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

Sufficiency of Number of Providers: HCBS/Independent Assessment

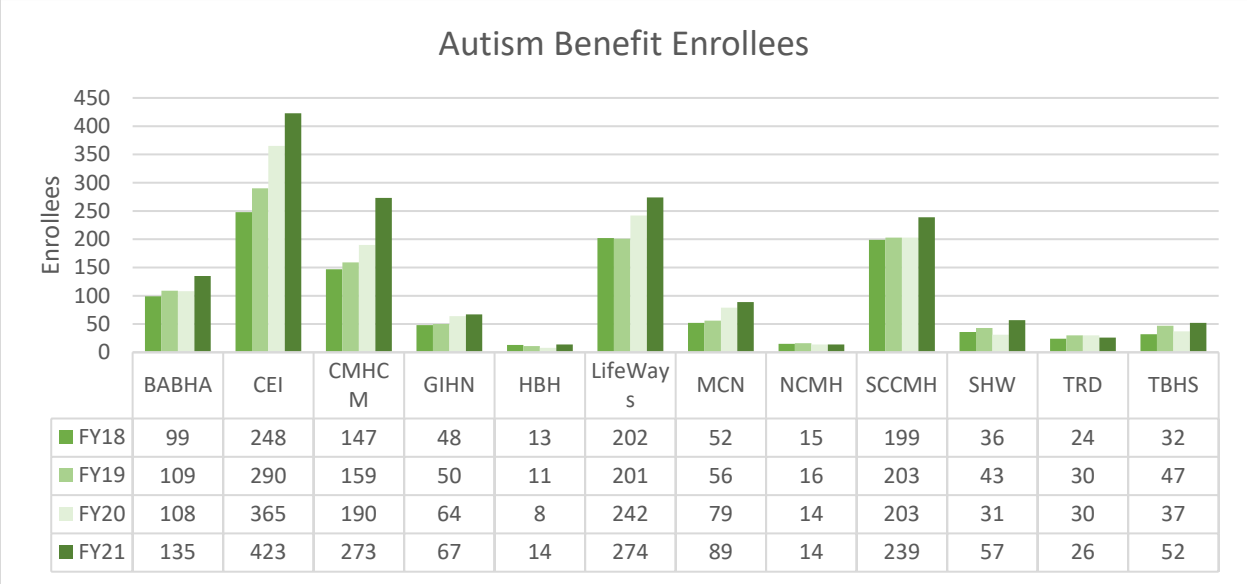
In November 2017, MDHHS released a new Medicaid Provider Manual Home and Community Based Services chapter to address the implementation of the CMS HCBS Final Rule. In its new HCBS guidance, MDHHS instructs that the HCBS Final Rule "provides requirements for independent assessment. This is a face-to-face assessment, conducted by a conflict-free individual or agency. The assessment is based on the individual's needs and strengths and is part of the person-centered planning process." This guidance has prompted inquiries among the CMHSP Participants regarding the nature of the independent assessment requirement and its potential impact on network adequacy. MSHN is currently in the process of seeking clarification on this guidance from the state, but the language does appear at very least to highlight the necessity of conflict-free case management and of clinical assessment and person-centered planning free of conflicts of interest. The CMS Federal Rule provides that "the assessor must be independent; that is, free from conflict of interest with regard to providers, to the individual and related parties, and to budgetary concerns." The degree to which this expectation impacts network adequacy

will depend on its implementation, but it is certainly plausible that CMHSPs will need to take steps to insure the clinical assessment process against problematic conflicts and opposing interests moving forward.

Sufficiency of Number of Providers: Autism Spectrum Disorder Capacity

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

Figure 52: Autism Benefit Enrollees[16]



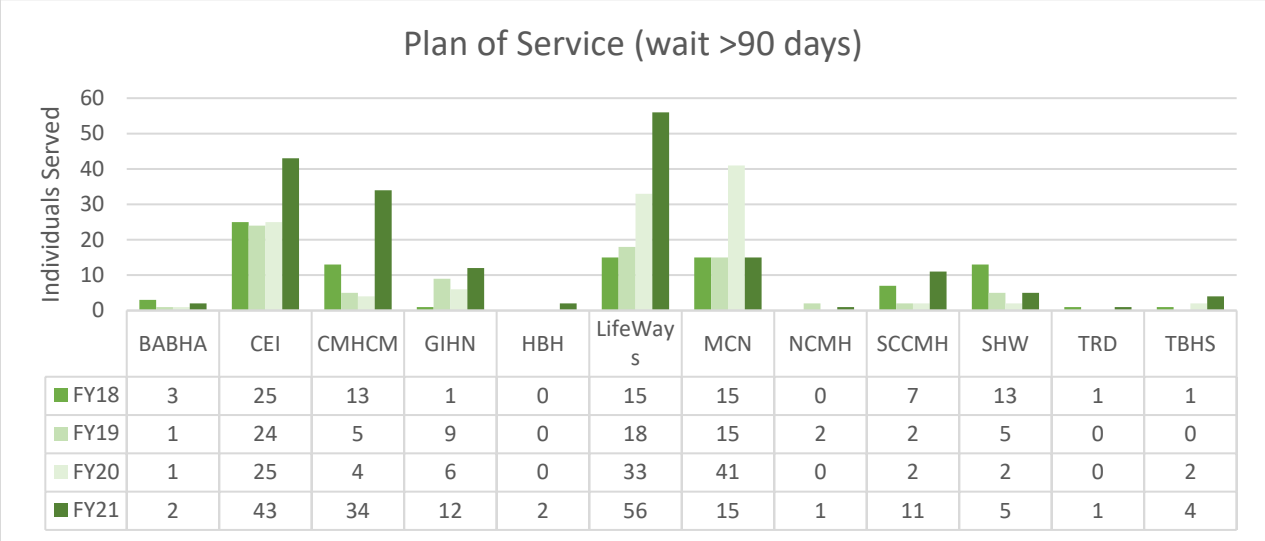
	BABHA	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS
FY18	99	248	147	48	13	202	52	15	199	36	24	32
FY19	109	290	159	50	11	201	56	16	203	43	30	47
FY20	108	365	190	64	8	242	79	14	203	31	30	37
FY21	135	423	273	67	14	274	89	14	239	57	26	52

The issue of the region having an adequate number of ABA contract providers continues to be monitored addressed. ABA quality and compliance issues are highlighted in regular monthly reporting and shared with the CMHSPs. MSHN intervenes with the CMHSP when it has taken longer than 90 days to complete an assessment and suggests considering provider capacity be addressed. For instance, the number of individuals who have been found eligible for Autism Benefit services and are still waiting for a plan of service after 90 days has decreased notably over the past year (see Figure 53), but the number of enrollees in the autism benefit has risen 19% in FY21. Nonetheless, several new cases each month continue to surpass the 90-day threshold for start of services. This demonstrates the need for continued efforts to work with ABA providers to get assessments completed and individuals into services more quickly. The COVID-19 pandemic has also affected the provision of services. CMHSPs are performing face to face services and using safety measures where appropriate but have also encountered families that have indicated a desire to wait until the danger of the pandemic has decreased, and non-related but

[16] Source: MSHN Autism Report

relevant is that some families had indicated a desire to wait until a specific provider was available. MSHN has provided monthly information to the Autism Workgroup and to the Operations Council quarterly about 90-day benchmarks, with the intention of facilitating internal tracking systems to ensure that individuals are getting into services in a timely fashion. MSHN will work further to streamline and manage compliance and performance issues through workgroup activities. There is also a need to address issues such as frequent provider changes and how to access and utilize current providers more effectively. CMHSP participants will continue to work within their purviews to address gaps in provider network capacity for autism benefit services.

Figure 53: Individuals with Autism Waiting Longer than 90 Days for a Plan of Service[17]



	BABHA	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS
FY18	3	25	13	1	0	15	15	0	7	13	1	1
FY19	1	24	5	9	0	18	15	2	2	5	0	0
FY20	1	25	4	6	0	33	41	0	2	2	0	2
FY21	2	43	34	12	2	56	15	1	11	5	1	4

Sufficiency of Mix of Providers: Cultural Competence

MSHN requires cultural competence training for staff and its provider network. Out of 1,267 provider listings in the region's Provider Directory, 90.4% indicated Cultural Competency training and MSHN is working to bring this to full compliance. While providers are empaneled in areas with concentrations of ethnic or cultural groups, such as the Latino counseling services available through the CEI provider network, MSHN recognizes that we do not have sufficient providers with diverse clinical staff that mirror the diversity of communities like Saginaw, Lansing, Jackson and Mt. Pleasant. This is likely a contributing factor in low penetration rates for Black, Hispanic and Native American communities. MSHN collects and provides public information via MSHN website related to the persons served by Race (Figure below). CMHSPs and SUD Providers collect information from individuals served related to specific cultural awareness/needs. Though this data is not collected at the PIHP level, under MSHN's goal of Better Equity, MSHN is working to increase data collection and analysis to improve our understanding of health disparities, gaps in cultural competence and areas for improvement.

[17] Source: MSHN Autism Report

Figure 54: Persons Open by Race

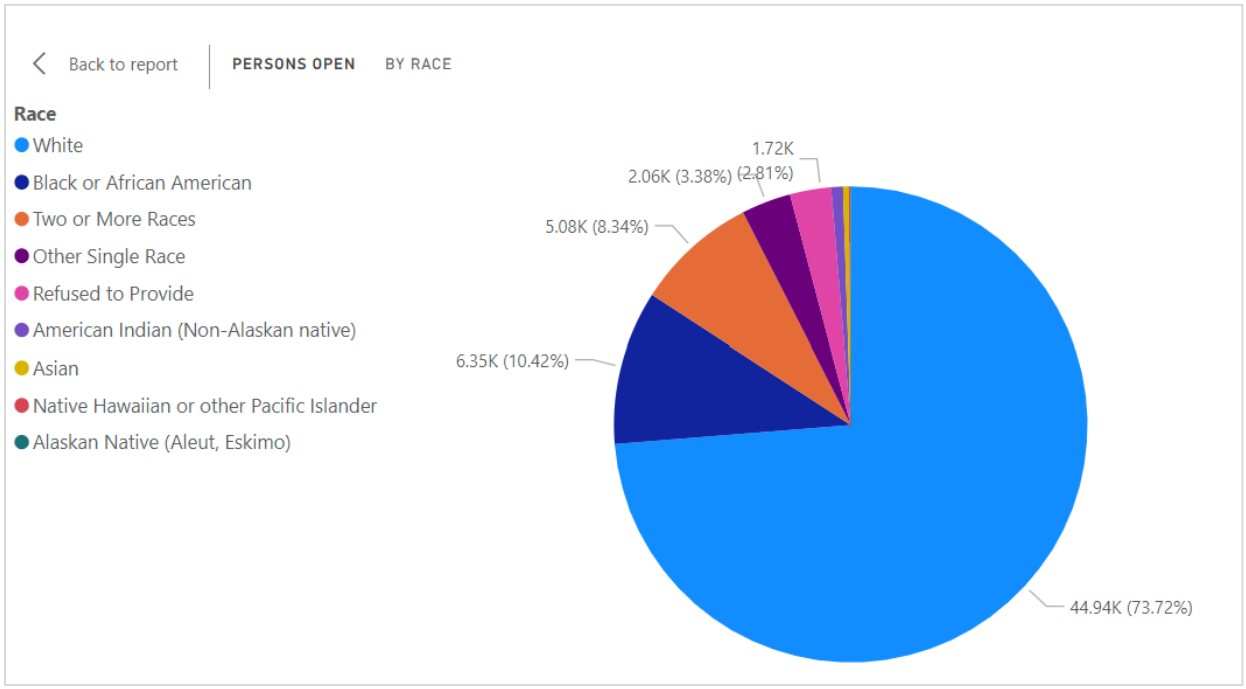


Figure 55: MSHN Regional Penetration Rate by Race/Ethnicity FY2021

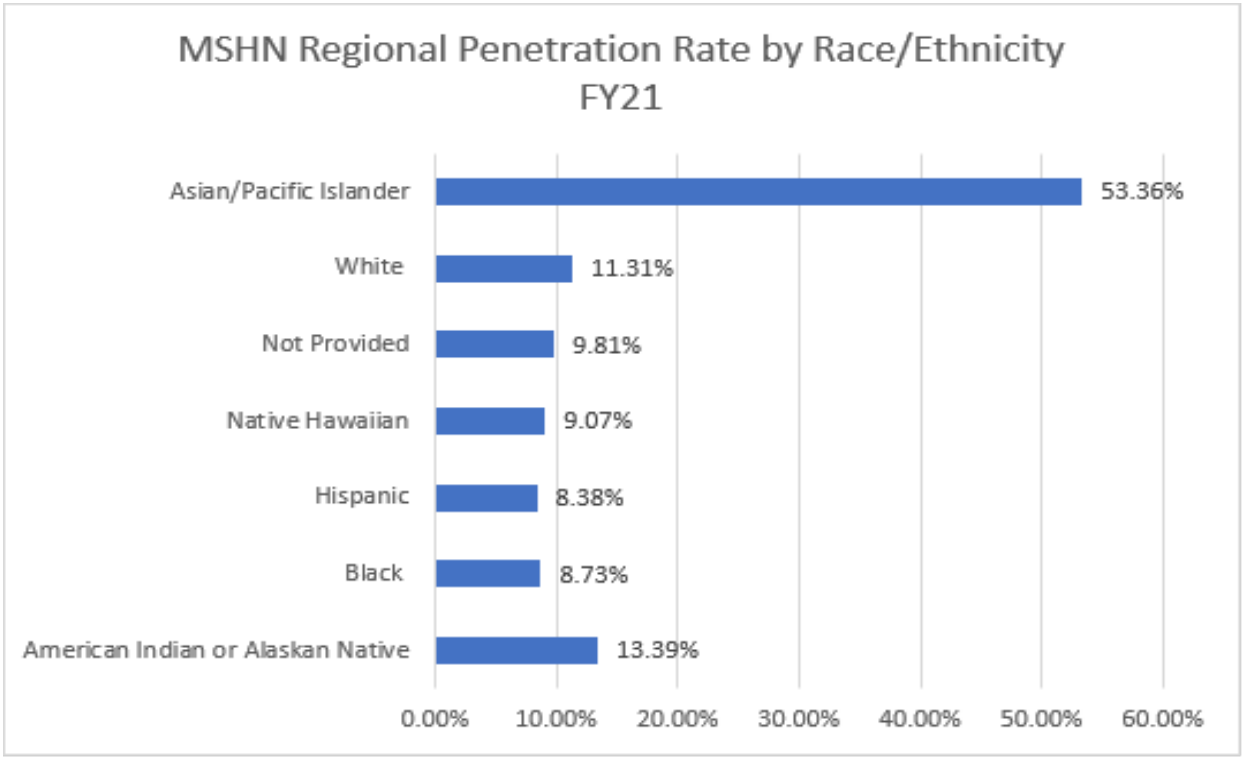
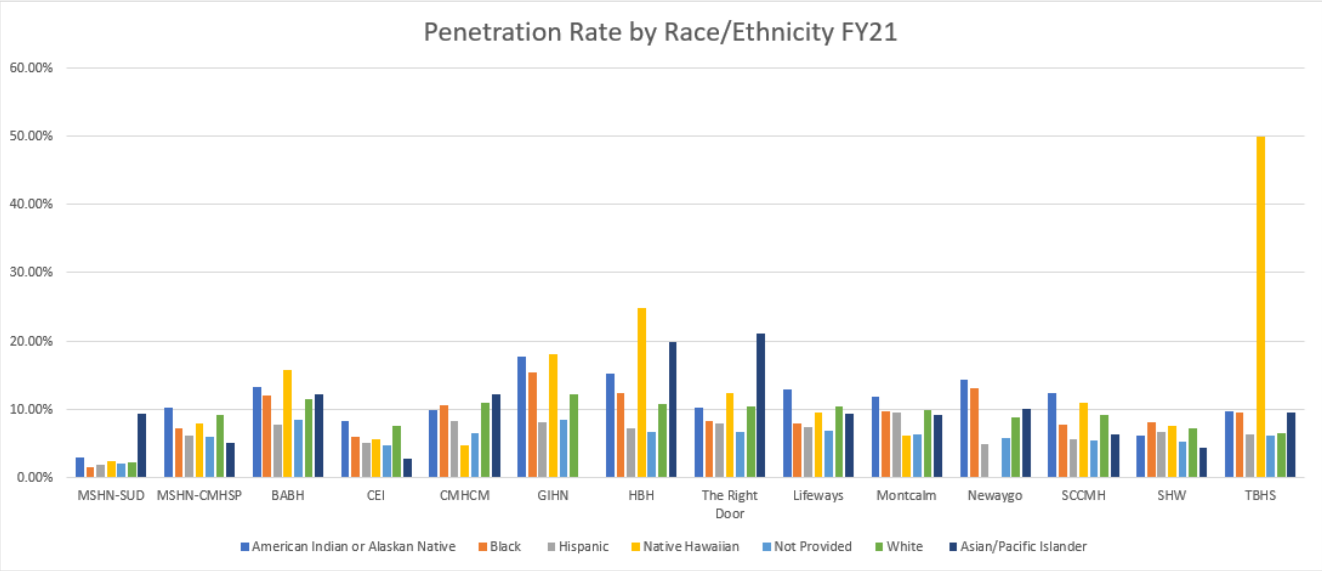


Figure 56: Penetration Rate by Race/Ethnicity FY2021



Sufficiency of Mix of Providers: Consumer Choice

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

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

Substance use disorder providers also continue to add specialized transportation services to meet the needs of MSHN region. One example is added home based services for women with children, which is an enhanced women's specialty service, to address geographic limitations/ transportation problems individuals were having in trying to access clinic-based services.

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

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

Accommodations

All CMHSP Participants offer services in locations with physical access for Medicaid beneficiaries with disabilities[18]. Out of 1,267 provider listings in the region's Provider Directory, 92.9% indicated accommodations in accordance with the American Disabilities Act. Delivery of services in home settings as well as telemedicine can offset barriers to physical access where present.

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

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

As of the date of this assessment, Ingham County has 13% non-English speaking individuals. Interpreters and translators are available at each CMHSP for persons with Limited English Proficiency (individuals who cannot speak, write, read, or understand the English language at a level that permits them to interact effectively with health care providers) as required by Executive Order 13166 "Improving Access to Services for Persons with Limited English Proficiency"). This includes the use of sign interpreters for persons with hearing impairments and audio alternatives for people with vision limitations.

County	LEP Combined	English Only	Spanish	Other Indo-European language	Asian and Pacific Islander Languages	Other languages
Arenac	1.6%	98.4%	0.9%	0.3%	0.2%	0.2%
Bay	2.1%	97.9%	0.9%	0.8%	0.2%	0.3%
Clare	5.6%	94.4%	0.3%	5.1%	0.1%	0.1%
Clinton	4.0%	96.0%	1.7%	1.0%	1.0%	0.3%
Eaton	6.7%	93.3%	2.6%	2.5%	1.1%	0.5%
Gladwin	3.5%	96.5%	0.5%	3.0%	0.1%	0.0%
Gratiot	3.5%	96.5%	1.9%	1.0%	0.4%	0.1%
Hillsdale	3.8%	96.2%	1.1%	2.1%	0.3%	0.3%
Huron	3.8%	96.2%	1.6%	1.7%	0.4%	0.1%
Ingham	12.9%	87.1%	3.2%	3.1%	4.6%	2.0%
Ionia	3.0%	97.0%	2.0%	0.6%	0.3%	0.2%
Isabella	5.2%	94.8%	1.5%	1.9%	1.0%	0.8%
Jackson	3.2%	96.8%	1.3%	0.9%	0.6%	0.3%
Mecosta	3.7%	96.3%	1.1%	2.0%	0.6%	0.1%
Midland	4.1%	95.9%	0.9%	1.7%	1.4%	0.1%
Montcalm	3.4%	96.6%	1.8%	1.3%	0.2%	0.1%
Newaygo	5.6%	94.4%	3.7%	1.5%	0.2%	0.2%
Osceola	4.2%	95.8%	0.7%	3.2%	0.3%	0.0%
Saginaw	4.3%	95.7%	2.0%	1.4%	0.6%	0.4%
Shiawassee	1.7%	98.3%	0.8%	0.6%	0.3%	0.1%
Tuscola	2.1%	97.9%	0.9%	0.9%	0.2%	0.0%

[19]

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

[19] Source: LEP.GOV and Unites States Census – Languages Spoken 2016-2020

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

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

Future Provider Network Outlook

Certified Community Behavioral Health Clinics

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

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

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

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

In addition, Substance Abuse Mental Health Services Administration (SAMHSA) has awarded CCCBHC funding directly to organization in Michigan referred to as Expansion Grants. In the MSHN region, LifeWays Community Mental Health (Jackson & Hillsdale Counties) was awarded funding from SAMHSA.

The CCBHC model eligibility criteria includes:

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

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

Opioid Health Home

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

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

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

Behavioral Health Home

MSHN will be implementing a Behavioral Health Home beginning in FY24. The Behavioral Health Home (BHH) will provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. For enrolled beneficiaries, the BHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model will also elevate the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time.

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

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

FY 20 Follow Up on Recommendations and Updates:

1. Continue to advocate for and participate in statewide planning relative to inpatient access; assess for and develop alternative inpatient/crisis response options, particularly for individuals with intellectual and developmental disabilities (such as Autism) exhibiting behavioral challenges.
    a. Status Update: MSHN issued a Request for Proposals (RFP) to establish a new Crisis Residential Unit (CRU) within the region. A bidder was selected through the MSHN procurement process and a board-approved contract was executed. Currently, MSHN is working with the new provider to locate and secure a suitable building location for rent or purchase. The new CRU will be located in the central portion of the MSHN region (target counties are Isabella or Midland) and operate 6-8 beds. All CMHSPs in the MSHN region will be able to utilize the CRU through a regional contract.
2. Continue to assess and address the integration of mental health, substance use disorder and physical health care.
    a. Status Update: MSHN continues to assess integration and supports coordination of care as presented in the Population Health Plan, including joint efforts with Medicaid Health plans through joint metrics and joint care plans and other key performance indicators that support care coordination.
3. Continue to monitor and address changes to provider network capacity brought on by the implementation of the HCBS Final Rule and the State Transition Plan.
    a. Status Update: MSHN HCBS staff continue to monitor provider compliance with the HCBS Final Rule throughout the region. This has involved a series of reviews including residential, non-residential, and provisional approval of new providers. Since each out of compliance review is per individual, reviews are completed fully for a provider until all resident's situations are HCBS compliant. Similar processes occur for non-residential providers. Provisional approvals, when involving a provider who may be on heightened scrutiny, need to also involve MDHHS to ensure that the placement can address the unique needs of the individual and achieve compliance. Lastly, providers on heightened scrutiny are the closest to not complying with HCBS. MSHN keeps a list of all individuals and the status of their providers and determines where there may be the potential for provider loss due to HCBS non-compliance. MSHN staff work with each provider and the CMHSP HCBS staff to ensure that all attempts are made to achieve compliance and if not, to communicate clearly the potential for provider closures. MSHN staff also keep track of provisional providers as this group represents new services to a CMHSP
4. Continue to monitor SUD residential and withdrawal management needs in the region, more specifically Level of Care capacity.
    a. Status Update: MSHN continues to monitor and assess the regional needs around SUD residential and withdrawal management. During the course of the pandemic the need to provide social distancing in residential and withdrawal management programs reduced the capacity within contracted providers and, at times, created larger than normal wait times before admission was available. In response to this occurrence, MSHN contracted with an additional provider out of region, Flint Odyssey Village, to support withdrawal management and residential services to meet the region's needs. This provider was also a resource for individuals who had tested positive for COVID and needed a safe place to quarantine, if the person needed a place to stay and did not want to leave the treatment environment.
5. Continue to discuss opportunities for regional action to address CMHSP identified issues with services for children.
    a. Status Update: MSHN continues to address CMHSP identification of issues with services for children through the Clinical Leadership Committee. MSHN staff have also used conversations with its CMHSP clinical directors related to service referral issues, systems and communication issues with other agencies, as well as community resource issues affecting

services to children. Conversations have begun with MDHHS to address systemic and operational problems and additional meetings will be had. This effort seeks to comprehensively address this issue as well as track the requirements of the Mi Kids Now/KB Lawsuit requirements so as to ensure that compliance with new requirements and improvements to children's service access can be achieved. Also reviewing the effect of intensive crisis stabilization policy relative to staffing, safety, and community collaboration with law enforcement. Additionally, MDHHS has been asked to address this as well as safety-related guidance when staff are deployed into the community during afterhours. There are counties that have one officer patrolling the whole county overnight which makes it very difficult to implement a partnership with law enforcement. Staffing shortages have also made it difficult in ICSS as well as attracting new staff who perceive the workload of ICSS to be unsafe.

6. Continue to support enhanced requirements for trauma informed and sensitive treatment, including any changes that may be needed in provider network specializations; Continue to promote trauma informed care relative to SUD treatment and offer SUD providers opportunities for trauma competence training.
    a. Status Update: MSHN requires its SUD providers to engage in a Trauma Informed Organizational survey every 3 years, and from its outcome, set annual goals to improve or strengthen the agency's ability to be trauma informed and capable. In FY21, the majority of SUD treatment providers were due for this assessment and subsequently completed them and identified goals for improvement. The MSHN Treatment Team then reviews progress during annual planning.
7. Continue to monitor network adequacy as it relates to the standardized SUD assessment; ensure an adequate training plan is established to ensure the provider network is qualified to administer the assessment.
    a. Status Update: The ASAM Continuum and GAIN-I Core assessments were successfully implemented as of 10-1-2021 in the MSHN region. MDHHS provided 21 training sessions for statewide implementation of the SUD provider network for ASAM Continuum in the summer of 2021. After 10-1-2021, a virtual self-paced training was made available to assist with onboarding of new staff or staff that were unable to attend previous training sessions for ASAM Continuum. GAIN-I Core capacity was previous established in the region when the GAIN was the assessment being implemented, so only a few clinicians requested training for capacity by 10-1-2021. The MSHN region continues to have GAIN-I Core certification training available through a regional trainer, as needed. Evaluate results from the Provider Wellness Profile to develop regional priorities which will inform the strategic action planning relative to Better Provider Systems.
    b. Status Update: The Provider Wellness Profile results were reviewed and incorporated into the FY22-FY23 Strategic Plan. SUD Provider and CMH Provider feedback included additional funding to conduct compensation analysis, in support or recommendation for increased pay/benefits.
8. Ensure accurate reporting of intensive crisis stabilization services to better assess capacity.
    a. Status Update: MSHN has shared the updated data template with CMHSP staff for the gathering of CMHSP ICSS activity, which included timeframe for reporting. Current data suggests that there is very little use of ICSS during afterhours and overnight hours, leading to concerns that it is poor fiscal strategy to staff this program overnight when there have been no or very few calls. MDHHS has been asked to address this and safety concerns, which is underway.

9. Monitor the impact of telehealth expansion.
    a. Status Update: Over FY21, MSHN has been monitoring telehealth use via trends in encounters and service utilization, including financial support to implement telehealth strategies at the provider level.
10. Continue to monitor access to timeliness to treatment; ensure processes are established to accurately report data for new performance indicators.
    a. Status Update: MSHN contracted with TBD Solutions in January 2022 to utilize our FY21 service data and recipients served to conduct a time and distance analysis, with the results included in the FY2021 NAA.

FY 2022 Recommendations:

MSHN recommends the following priorities and initiatives to address the adequacy concerns delineated in this assessment:

1. Conduct provider expansion feasibility analysis for SUD residential and withdrawal management services.
2. Determine if tracking consumer choice for service provider had an impact on the time and distance analysis related to provider capacity in SUD residential and withdrawal management.
3. Determine if tracking denials related to COVID-19 social distancing requirements had an impact on the time and distance analysis related to provider capacity in SUD residential and withdrawal management.
4. Continue to monitor HCBS Heightened Scrutiny for possible provider closures.
5. Continue to monitor provider capacity impact as it relates to new initiatives (CCBHC, OHH, BHH).
6. Conduct feasibility study to collect information from CMHSPs and SUD Providers regarding specific cultural competency requests.
7. Analyze the collection efforts related to ADA and ensure network adequacy related to specified accommodations.
8. Analyze timeliness indicators specific to priority populations (pregnant, injecting drug users, etc.).
9. Analyze the counties with non-English language prevalence to ensure compliance with LEP requirements.
10. Continue monitoring of regional provider staffing crisis stabilization and impact on providers ability to continue to maintain and sustain service delivery.
11. Continue to support opportunities to offer evidence-based practice trainings to the provider network.

Appendix A – CMHSP Delegated Efforts to Expand Service Capacity

BABH

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

CEI

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

- Trained additional staff on Critical Incident Stress Management, expanded the CISM Team and responded to multiple organization and community events.
- Implemented Care Coordination projects in clinical programs addressing asthma, hypertension, hepatitis, diabetes, and high Emergency Department Utilization.
- The Information Integration Committee developed and refined a Care Coordination Document for improved coordination with primary care physicians and continued to increase the knowledge, understanding, and use of health-related data for care coordination across the organization.
- Worked with Tri-County Crisis Intervention Team Steering Committee to implement additional rounds of 40 - hour training sessions for Officers. Over 200 Law Enforcement Officers from across Clinton, Eaton, and Ingham Counties were trained as of 2019.
- Continued to provide and expand various points of entry into services through Primary Care Physicians; Crisis Services and Crisis Response Team and Urgent Care/Emergency Rooms as well as the maintenance of several positions with navigator responsibilities such as the Veterans Navigator, Youth Prevention Therapist, Peer Recovery Coaches and Central Access Staff Outreach.
- Continued expansion of Access Department outreach for assisting consumers with SUD to locate appropriate level of treatment; addition of Recovery Coaches for Admission, Transfer and assisting individuals in their effort to get to treatment programs, working with the local Provider Network on admissions and transfers.
- Continue providing Naloxone Kits at three CMHA-CEI SUD programs and to law enforcement agencies in each county with assistance from the PIHP.
- Participation on the MAT Team with Ingham County Health Department and Ingham County Sheriff Department on bringing MAT services to the jail.
- Partnering with Ingham County Sheriff on the Rapid Response Team to provide immediate access to treatment services to individuals who have experience a recent drug overdose.
- Provide ongoing follow up to the Sequential Intercept Mapping project held in 2017 resulting in the development of reentry services for each county jail targeting special needs populations.
- Continued collaboration and expansion of work with Lansing Landlords to house consumers with mental illness
- Added additional Applied Behavioral Analysis provider contracts to increase capacity to meet demand.
- Secured a Certified Community Behavioral Health Clinic Expansion Grant to expand care coordination and healthcare integration efforts.
- Summary of gaps in services or need:
- *Feedback from Community Services for Developmentally Disabled (CSDD):*
- Remain unable to keep up with requests for Autism screening due to lack of qualified assessors in the region (positions are funded, unable to hire).
- Despite delays in assessing individuals, we've been able to connect more individuals to Autism services and have adequate provider capacity. But we in turn need more clinicians and support staff to appropriately coordinate and monitor those increased services and compliance with MSHN standards.
- Recognize a need for an increased number of case managers within the Family Support unit (to facilitate the growing demand for intakes and, in part, as tied to the coordination of Autism services).
- Increased capacities (i.e. funding in place) for enhanced children's crisis support, family training, directly supported CLS, etc., but unable able to hire anyone to fill these positions, and in fact are losing staff.
- Recognize a need for more highly specialized, behaviorally oriented, residential care providers in the region. We lack providers who can address acuity needs appropriately, as well as overall demand for this support type in the region.

- *Feedback from Adult Mental Health Services (AMHS):*
- Need to build out adult crisis mobile and secure staffing/therapists. CMHA-CEI is working on a CSU.
- *Feedback from Quality, Customer Service, and Recipient Rights (QCSRR):*
- Need to focus on timeliness from inquiry to assessment and from assessment to start of service (PIs 2a and 3).
- *Feedback from Families Forward:*
- Need for Mental Health Therapist to provide Evidence Based Treatments, CLS/Respite providers and Psychiatry.

CMHCM

Services for Individuals with SUD/COD

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

Direct Care Worker Recruitment/Retention

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

Alternatives to inpatient psychiatric services

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

Integrated healthcare and health outcomes

- We have an adult block grant for an integrated health dashboard that shows outcomes and monitors health indicators over time for consumers
- We have provided extensive training for our nurse care managers and case holders on integrated health practices, including case to care management

- We have implemented team huddles and will be working toward caseload alignment within our teams for improved team-based care
- We have utilized health data available from multiple platforms to address consumer needs
- We use ADT data and track it daily for follow up
- We have done outreach to our primary care practices to strengthen partnerships
- We have a co-located therapist in a local primary care office
- We have strong partnerships with care management with FQHCs in our area
- We have implemented healthy living opportunities in our local clubhouses

Ease of access to MH care

- We are looking at potential ways to improve our access system to be more consumer-friendly
- We have defined which individuals that will be opened using GF when Medicaid is not available
- We have done outreach to local providers, including universities, law enforcement, hospitals, EDs, community colleges to educate them about CMH services
- We have identified space in the community where we can see consumers afterhours to reduce unnecessary ED visits and for pre-booking jail diversion
- We are exploring other technology options to improve access to crisis services for individuals who do not have a telephone

GIHN

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

HBH

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

LCMHA

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

MCN

- Initiative to provide community training in Mental Health First Aide Training for Youth
- Implementation of SAMHSA Drug Free Communities Grant with focus on prevention of underage substance use
- Expansion of Medicaid Autism services benefit
- Implementation of integrated health services for children with serious emotional disturbances
- Expansion of TF-CBT services including training addition clinicians and partnering with DHHS on the parenting group to target children in foster care.
- Participating in Trauma-Informed Community initiative to raise awareness about the impact of ACEs and identify children and families in need of support.
- Expand number of children's clinicians trained in EDMR.

- Partner with local ISD under 31 N funding to bring additional mental health services into the school districts.
- Expand 31 N funded mental health services in the local school districts
- Initiate an IDDT program including a medication assisted treatment component
- Implement HIV and Hep C testing for at risk persons
- Continue to refine implementation of Patient Activation Measure and Coaching for Activation to improve outcomes in integrated health services
- Implement CE-CERT with clinical and support staff
- Expand trauma-informed community initiatives specifically targeting the legal community and faith-based community
- Expand community prevention efforts including Mental Health First Aid and Narcan distribution

NCMH

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

SCCMHA

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

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

SHW

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

TRD

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

TBHS

- Participate in Great Start Collaborative as well as subcommittees providing education, support and services to children and families.
- Participate in a court collaboration process which primarily focuses on multi-agency involvement in providing services to children and families.
- Participating in multiple EBPs such as PMTO, PTC, TF-CBT, TF-CBT Caregiver Education (which has also been offered externally as a part of prevention services).
- Active in community events where outreach to families occurs.

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

Appendix B – MSHN Drive Time Analysis

Drive Times Between MSHN Consumers and Providers

Overview

A drive-time analysis was performed to assess the geographic accessibility of MSHN service providers. For this report, the Google Distance API was used to calculate the number of minutes it takes to drive from pre-defined geographical regions containing consumer residences to the nearest service providers.

Drive-time metrics were calculated for FY21 MSHN consumers[1] across eleven service categories. The drive-time metrics gathered were benchmarked against time and distance standards derived from MDHHS-defined requirements for inpatient psychiatric services.[2] Standards for time and distance vary based on urban and rural geography. Rural and urban areas were defined using the U.S. Census Bureau method, which defines rural as everything not included within an Urban Area or Urban Cluster.[3]

Data Considerations

The results of this report should be interpreted with the following considerations:

- Consumers' addresses are grouped if they fall into the same square-mile hexagon. The center of the hexagon is used to calculate drive times.
- Only consumers with valid addresses are used in the analysis. This removed roughly 12% of consumers from the dataset.
- Consumers with multiple residences during FY21 are counted at each residence they received a service.
- Only individuals who received a given service are included in this report. This does not consider individuals who would have received a service had a provider been located closer to their residence.
- For each service, around 3% of drive-times were significantly miscalculated by the Google Distance API. These geographic areas and their corresponding consumers were subsequently removed from the analysis.
- Maps display the distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

Key Findings: Percent of FY21 MSHN Consumers for Whom Drive Time Standard Was Met

	SUD Outpatient	Outpatient	Homebased	SUD Women's Specialty Services	Assertive Community Treatment	Clubhouse	Wraparound	Psych Inpatient Children	Psych Inpatient Adults	SUD Residential	SUD Withdrawal Management	Crisis Residential
Rural Standard	60 min	60 min	60 min	60 min	60 min	60 min	60 min	120 min	90 min	90 min	90 min	60 min
Urban Standard	30 min	30 min	30 min	30 min	30 min	30 min	30 min	60 min	30 min	30 min	30 min	30 min
Consumers with Standard Met	16150 (100.0%)	10176 (100.0%)	3309 (100.0%)	1325 (100.0%)	759 (100.0%)	494 (99.0%)	517 (98.7%)	581 (98.0%)	4271 (92.9%)	2752 (89.8%)	1331 (88.5%)	1192 (87.8%)

See Appendix for results broken out by consumers' race.

[1] Individuals who received at least one service during FY21 and lived within MSHN's 21-county region

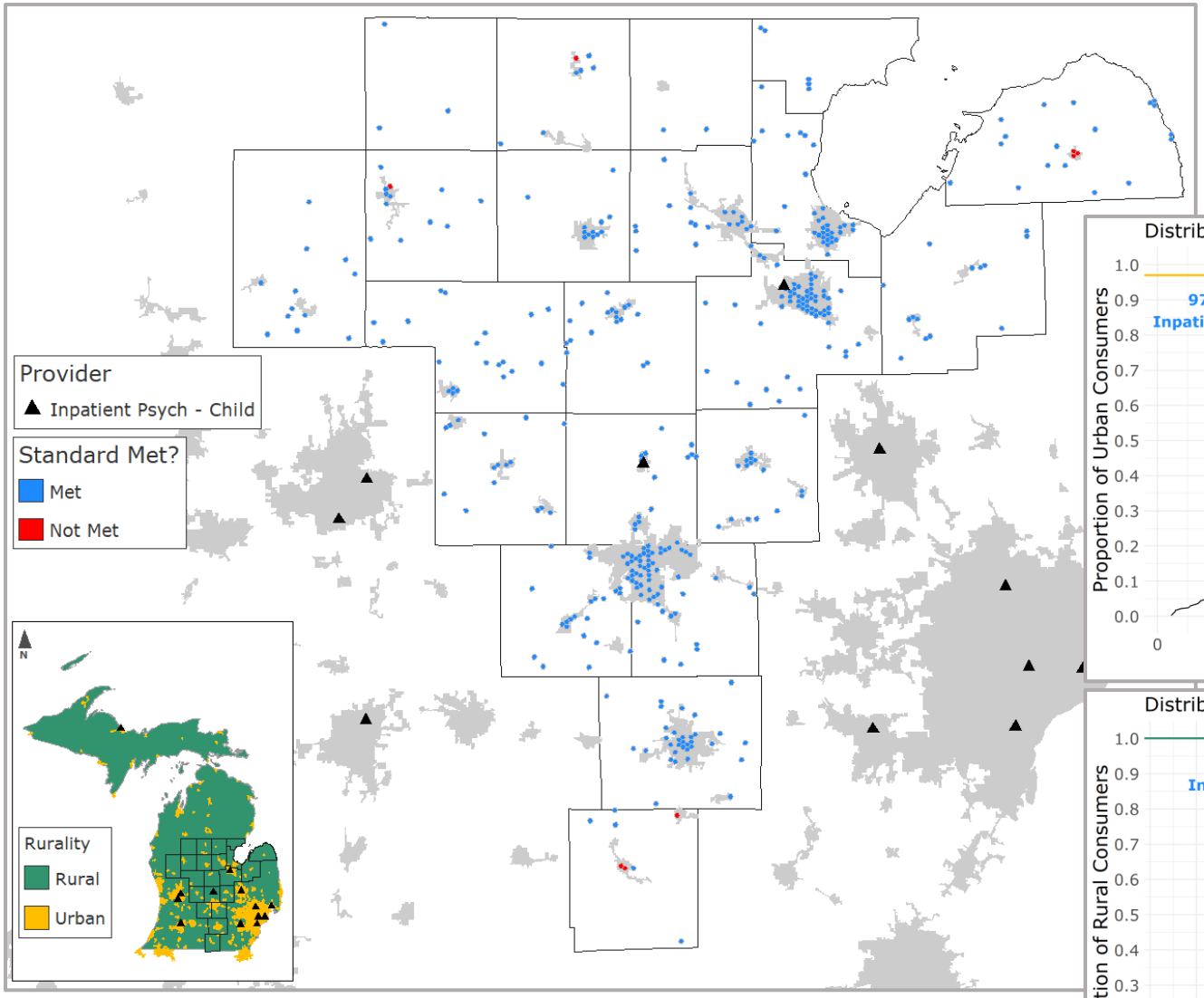
[2] BHDDA (2020, July 8). *Procedure: MDHHS Network Adequacy Standards—Medicaid Specialty Behavioral Health Services*. https://www.michigan.gov/documents/mdhhs/Procedure_MDHHS_Network_Adequacy_Standards_--_Medicaid_Speciality_Behavioral_Health_Services_10-29-2018_644426_7.pdf

[3] United States Census Bureau. (2021, October 8). *2010 Census Urban and Rural Classification and Urban Area Criteria*. https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural/2010-urban-rural.html

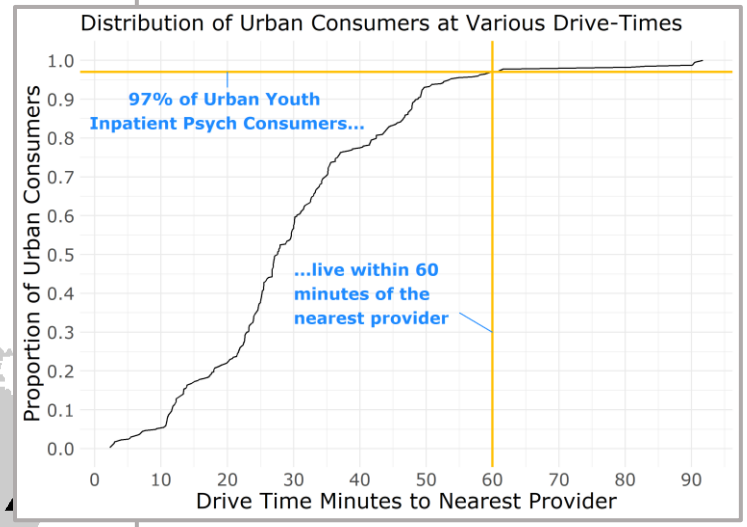
Inpatient Psych - Children FY21

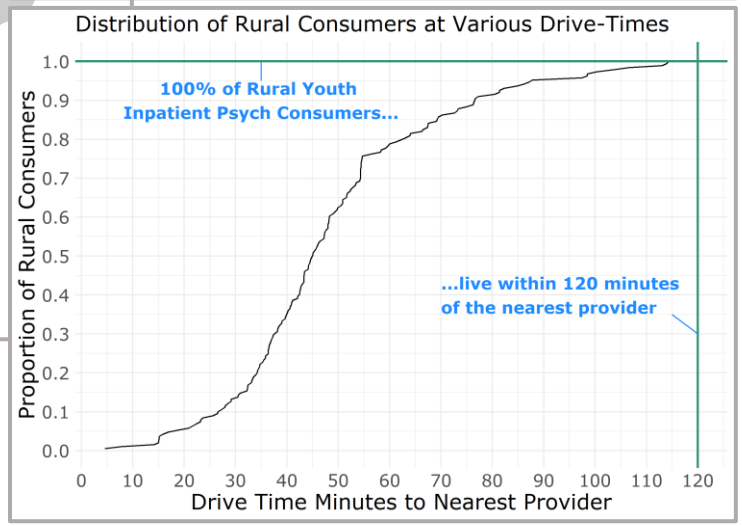
Drive Times Between Youth MSHN Consumers and Child Inpatient Psych Providers

Service Codes: 0100, 0114, 0124, 0134, 0154



Inpatient Psych - Child Drive Time Standard		
	Urban Consumers: 60 minutes	Rural Consumers: 120 minutes
Met	392 (97.0%)	189 (100.0%)
Not Met	12 (3.0%)	0 (0%)
Total	404	189



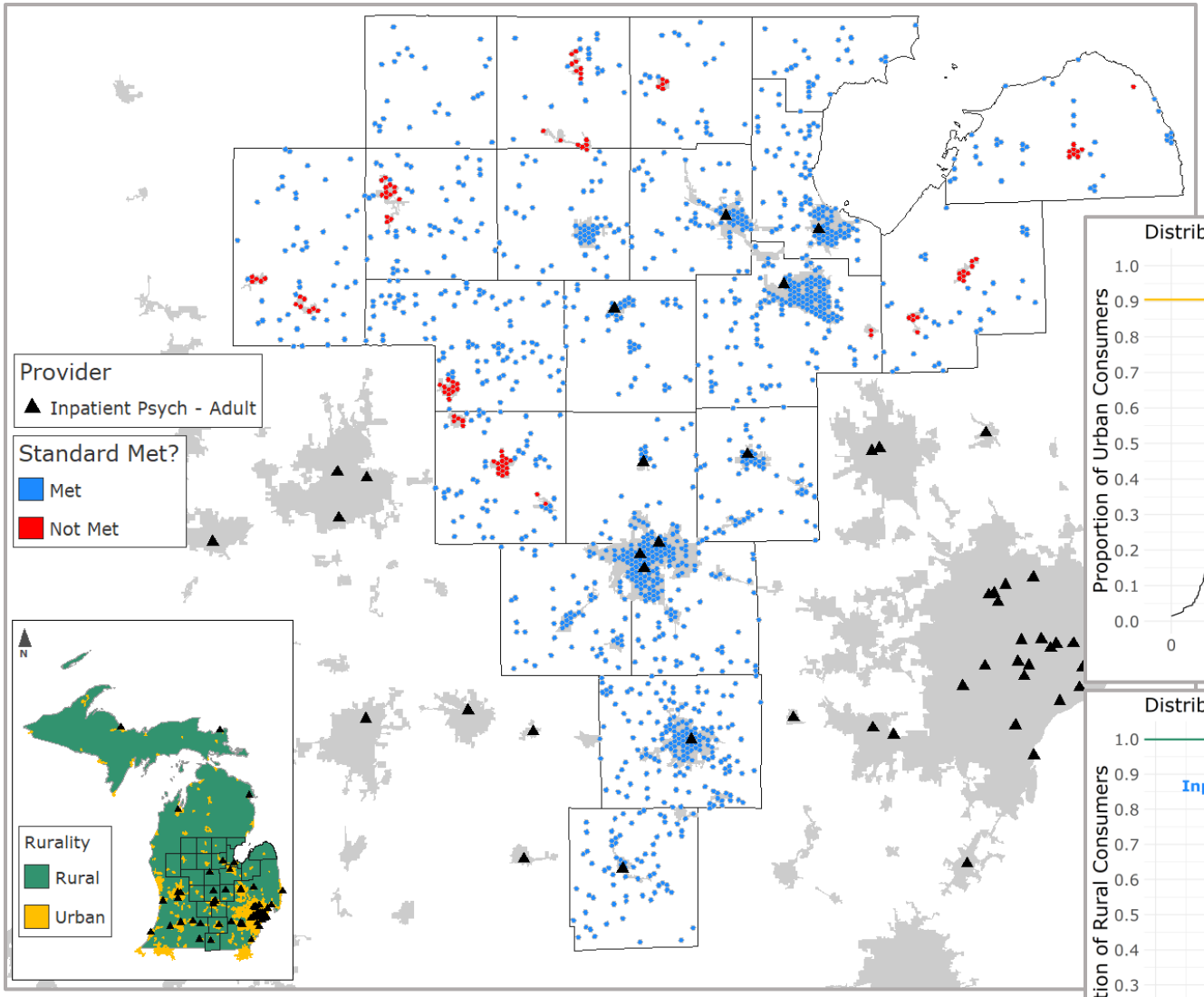


Youth MSHN consumers who received an Inpatient Psych service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

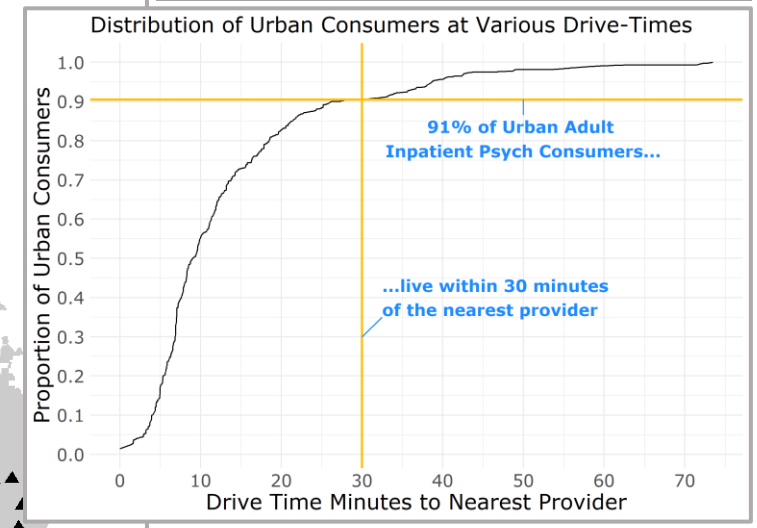
Inpatient Psych - Adults FY21

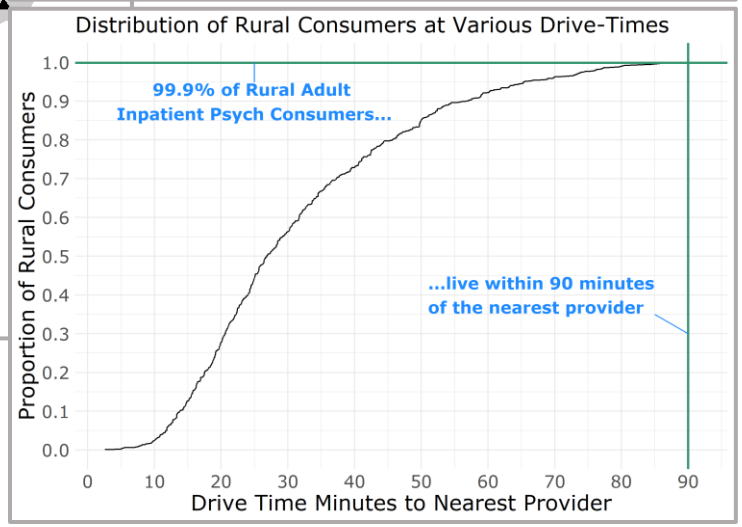
Drive Times Between Adult MSHN Consumers and Adult Inpatient Psych Providers

Service Codes: 0100, 0114, 0124, 0134, 0154



Inpatient Psych - Adult Drive Time Standard		
	Urban Consumers: 30 minutes	Rural Consumers: 90 minutes
Met	3119 (90.5%)	1152 (99.9%)
Not Met	327 (9.5%)	1 (0.1%)
Total	3446	1153



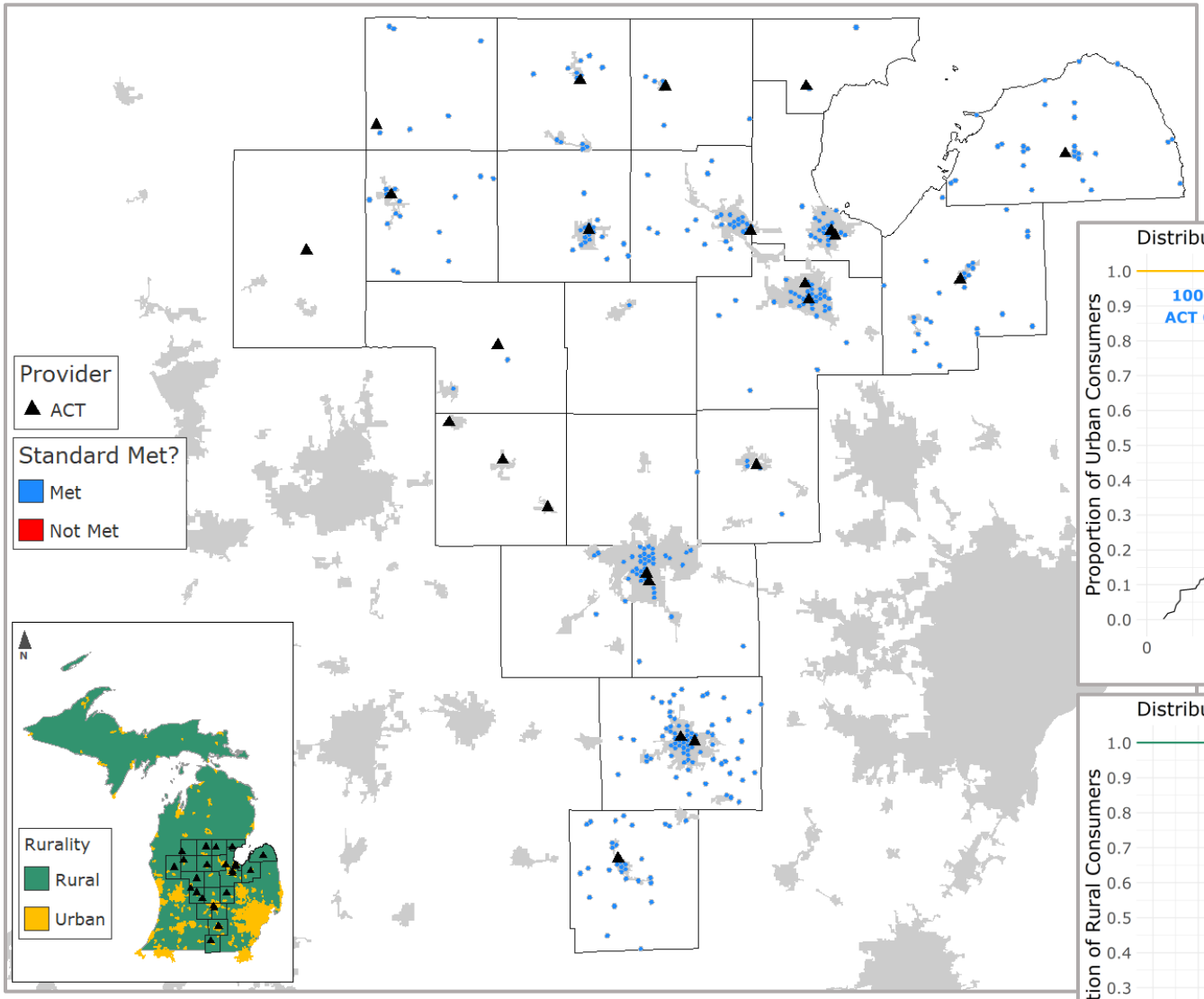


Adult MSHN consumers who received an Inpatient Psych service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

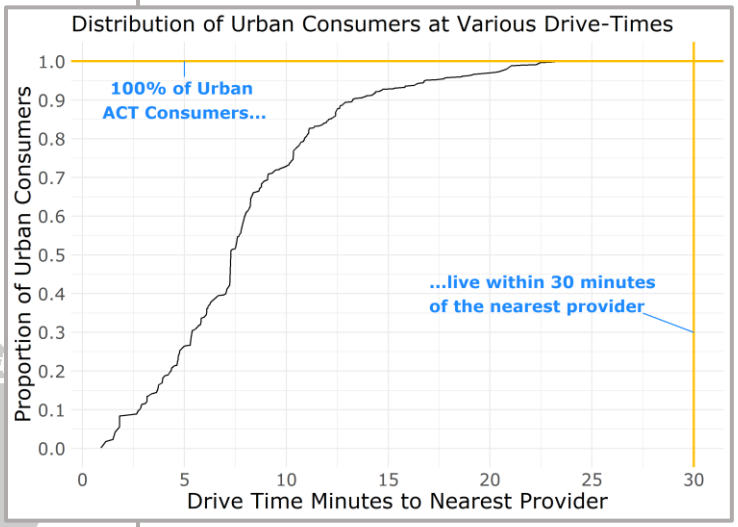
Assertive Community Treatment (ACT) FY21

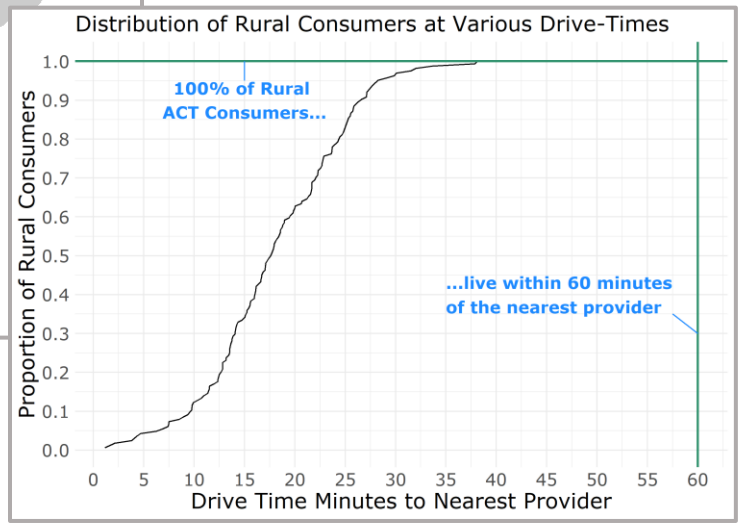
Drive Times Between MSHN Consumers and ACT Providers

Service Codes: H0039



ACT Drive Time Standard		
	Urban Consumers: 30 minutes	Rural Consumers: 60 minutes
Met	595 (100.0%)	164 (100.0%)
Not Met	0 (0%)	0 (0%)
Total	595	164



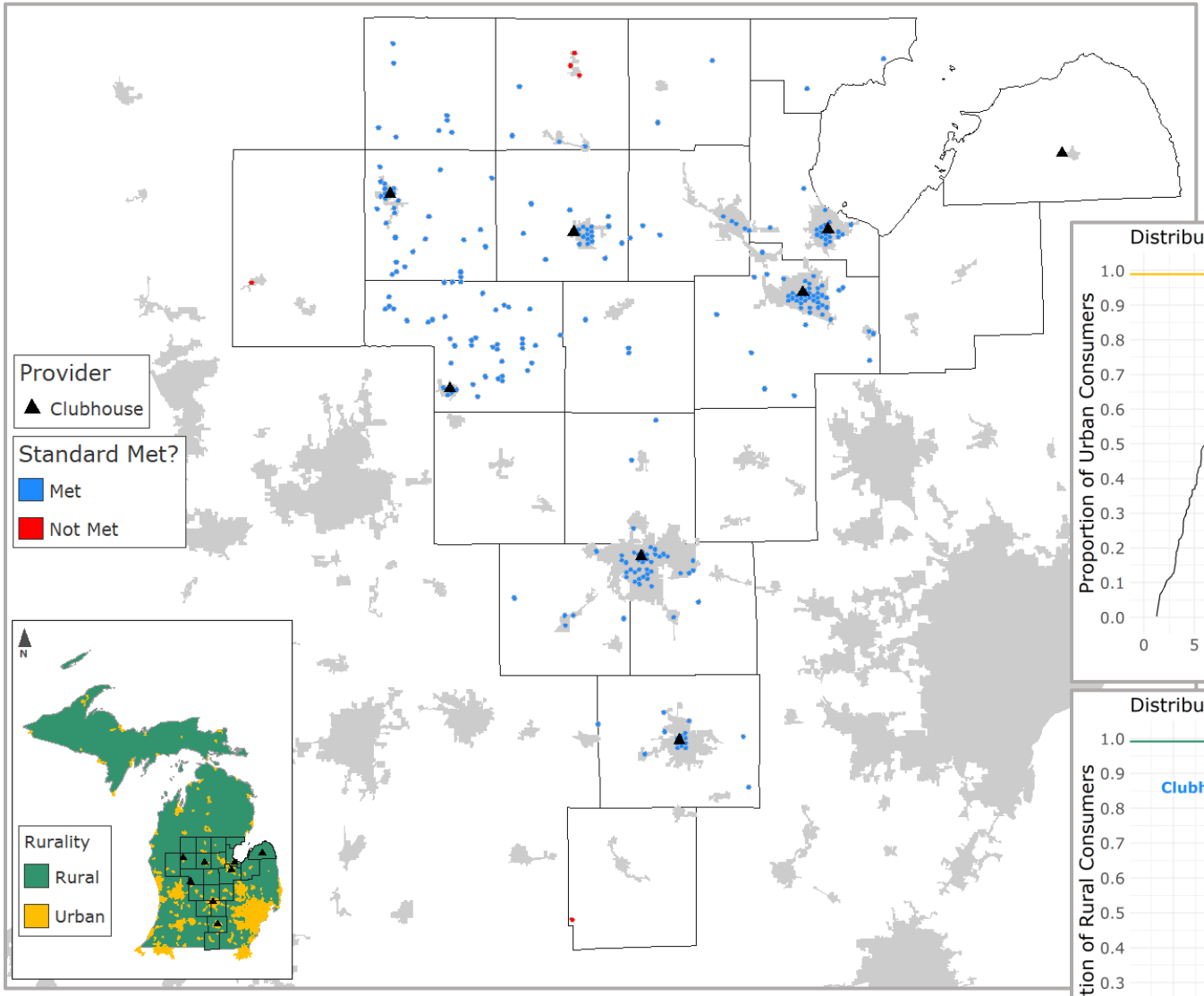


MSHN consumers who received an ACT service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

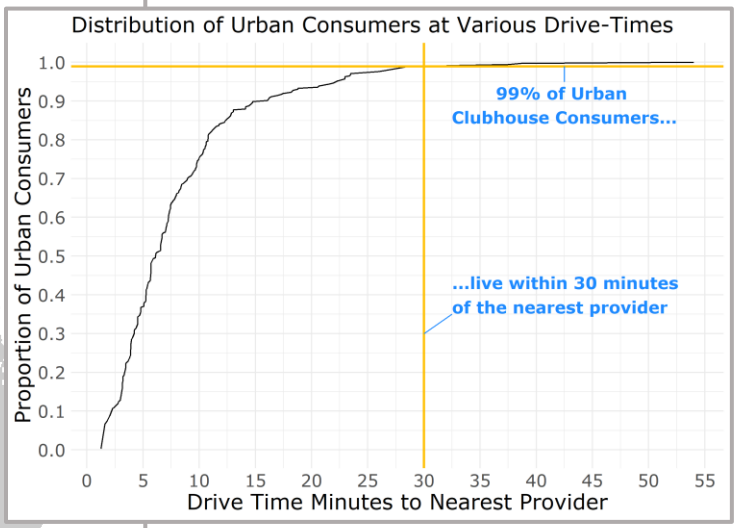
Clubhouse FY21

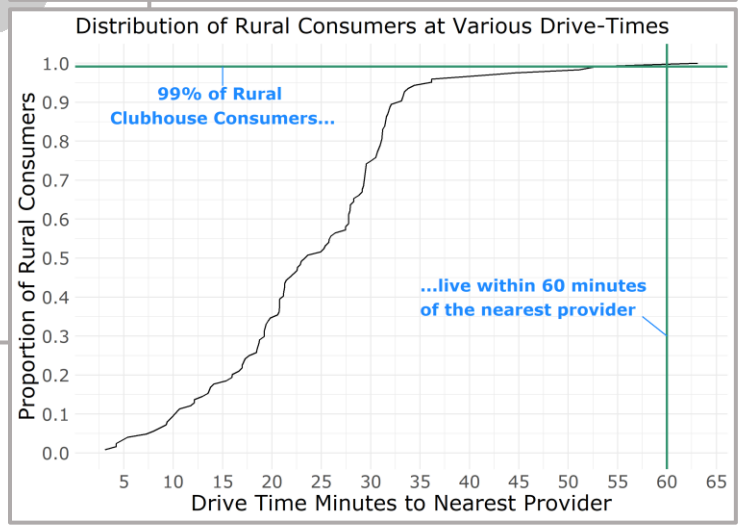
Drive Times Between MSHN Consumers and Clubhouse Providers

Service Codes: H2030



Clubhouse Drive Time Standard		
	Urban Consumers: 30 minutes	Rural Consumers: 60 minutes
Met	371 (98.9%)	123 (99.2%)
Not Met	4 (1.1%)	1 (0.8%)
Total	375	124



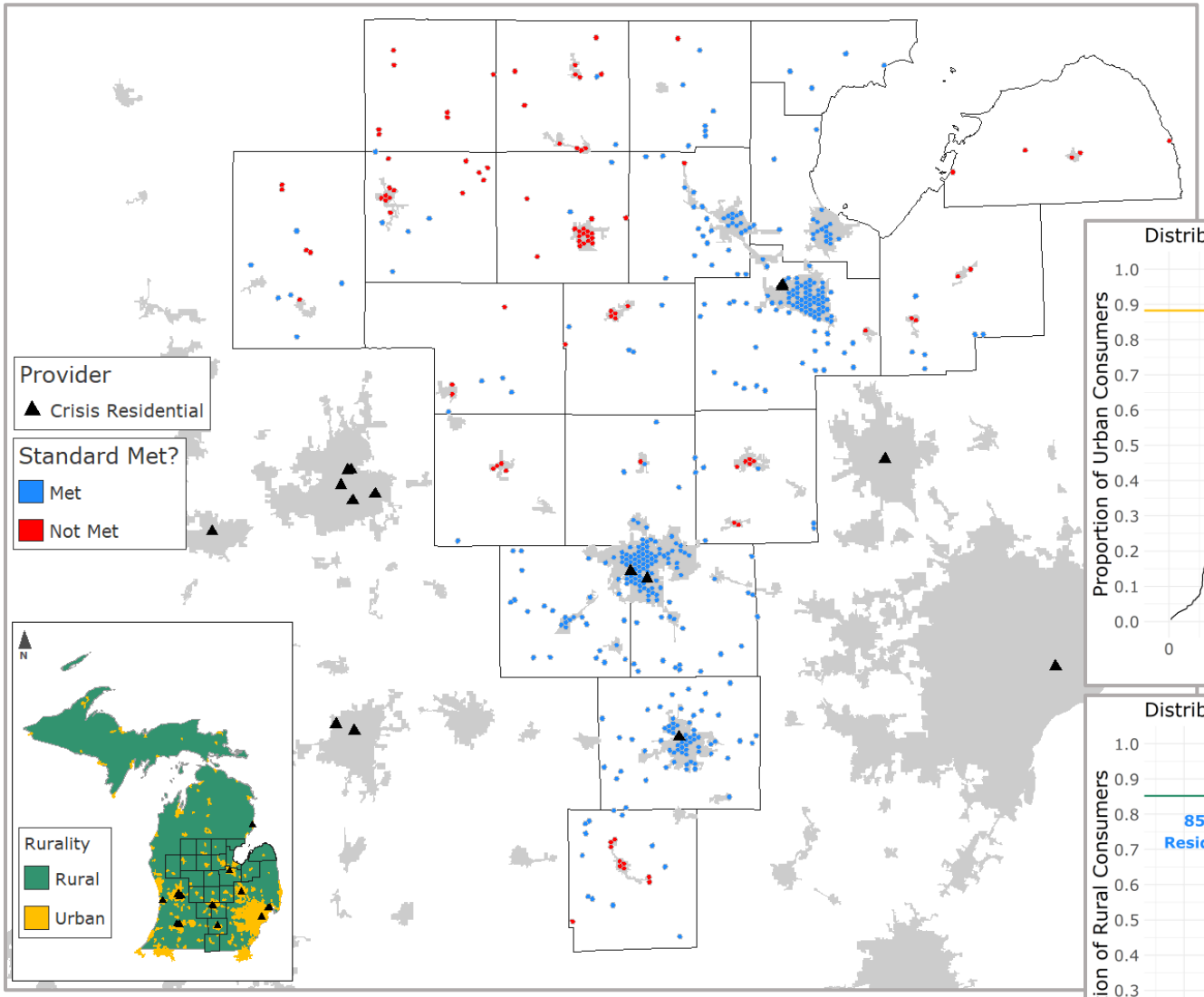


MSHN consumers who received a Clubhouse service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

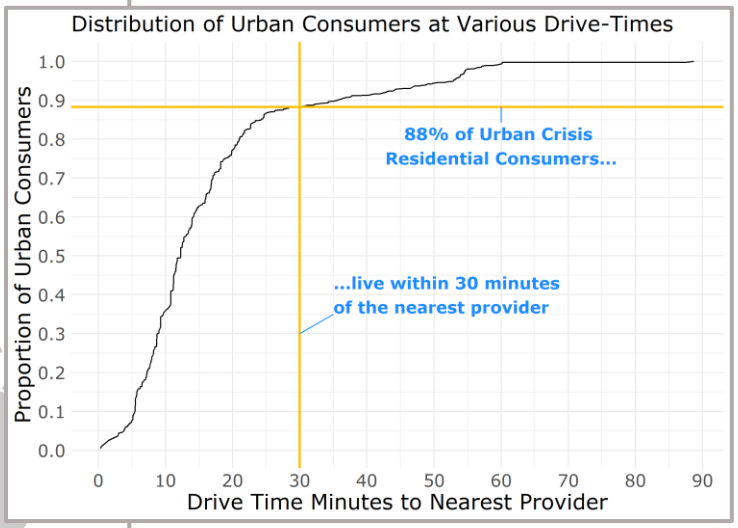
Crisis Residential FY21

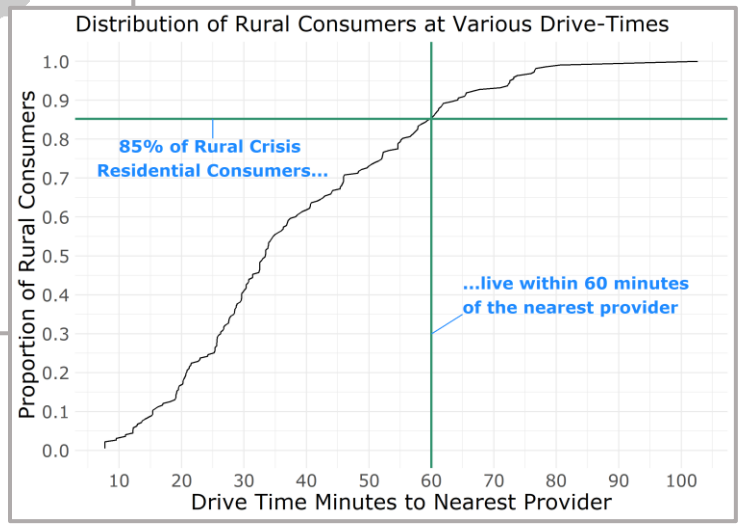
Drive Times Between MSHN Consumers and Crisis Residential Providers

Service Codes: H2018



Crisis Residential Drive Time Standard		
	Urban Consumers: 30 minutes	Rural Consumers: 60 minutes
Met	1002 (88.3%)	190 (85.2%)
Not Met	133 (11.7%)	33 (14.8%)
Total	1135	223



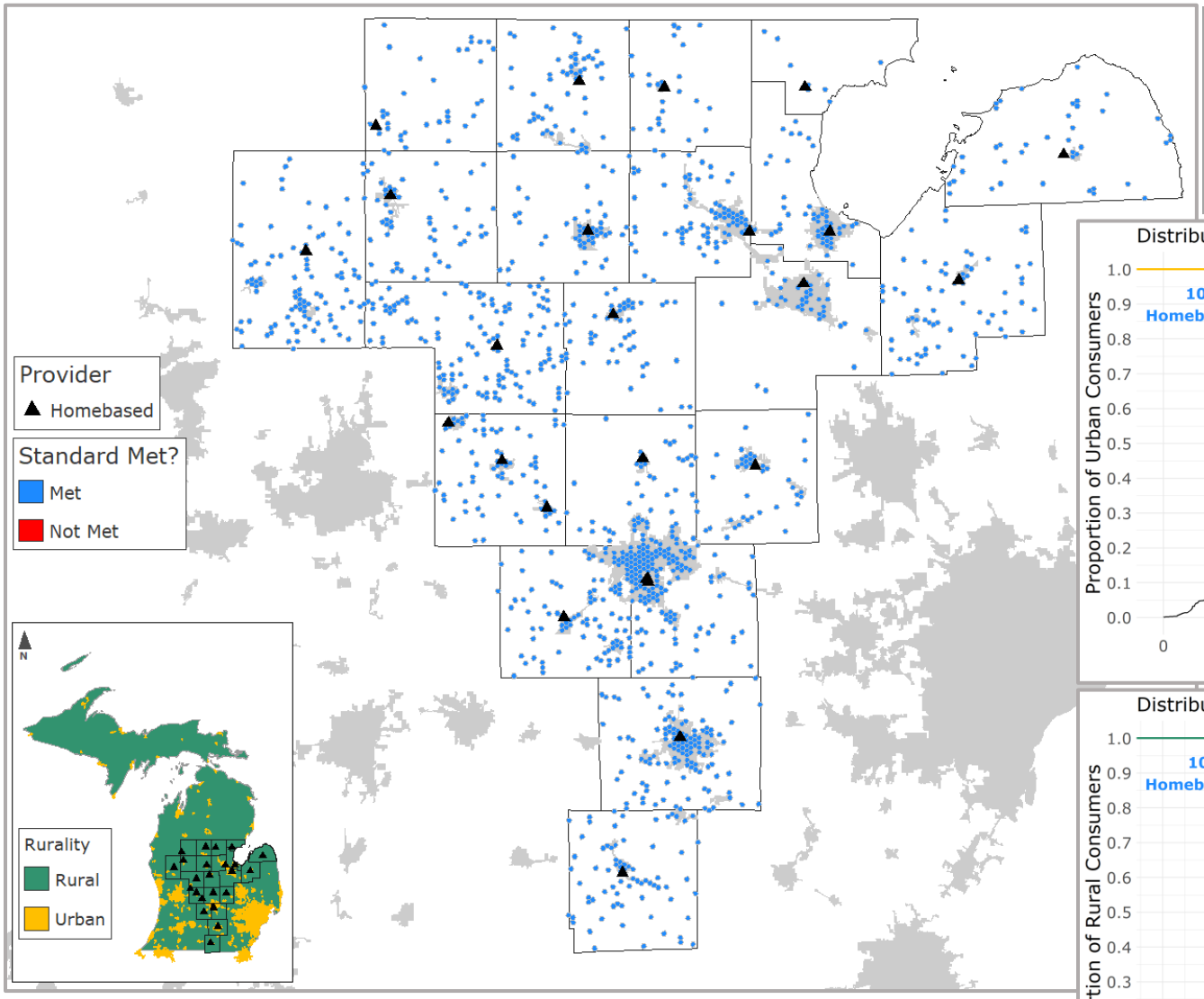


MSHN consumers who received a Crisis Residential service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

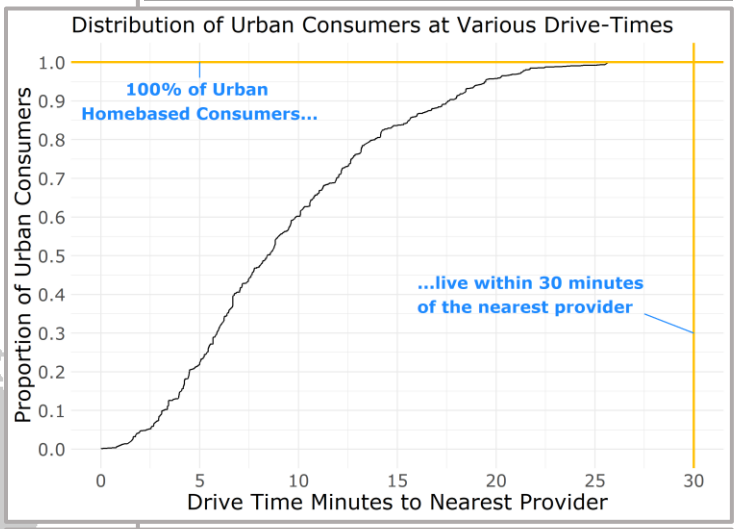
Homebased FY21

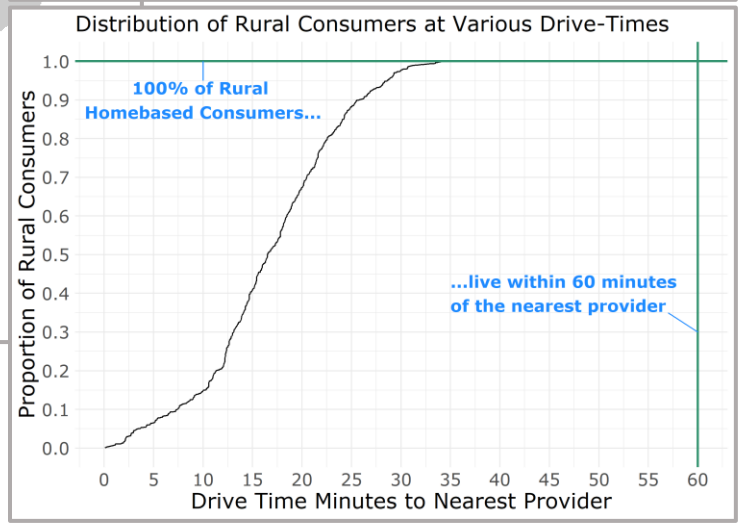
Drive Times Between MSHN Consumers and Homebased Providers

Service Codes: H0036, H2033



Homebased Drive Time Standard		
	Urban Consumers: 30 minutes	Rural Consumers: 60 minutes
Met	2014 (100.0%)	1295 (100.0%)
Not Met	0 (0%)	0 (0%)
Total	2014	1295



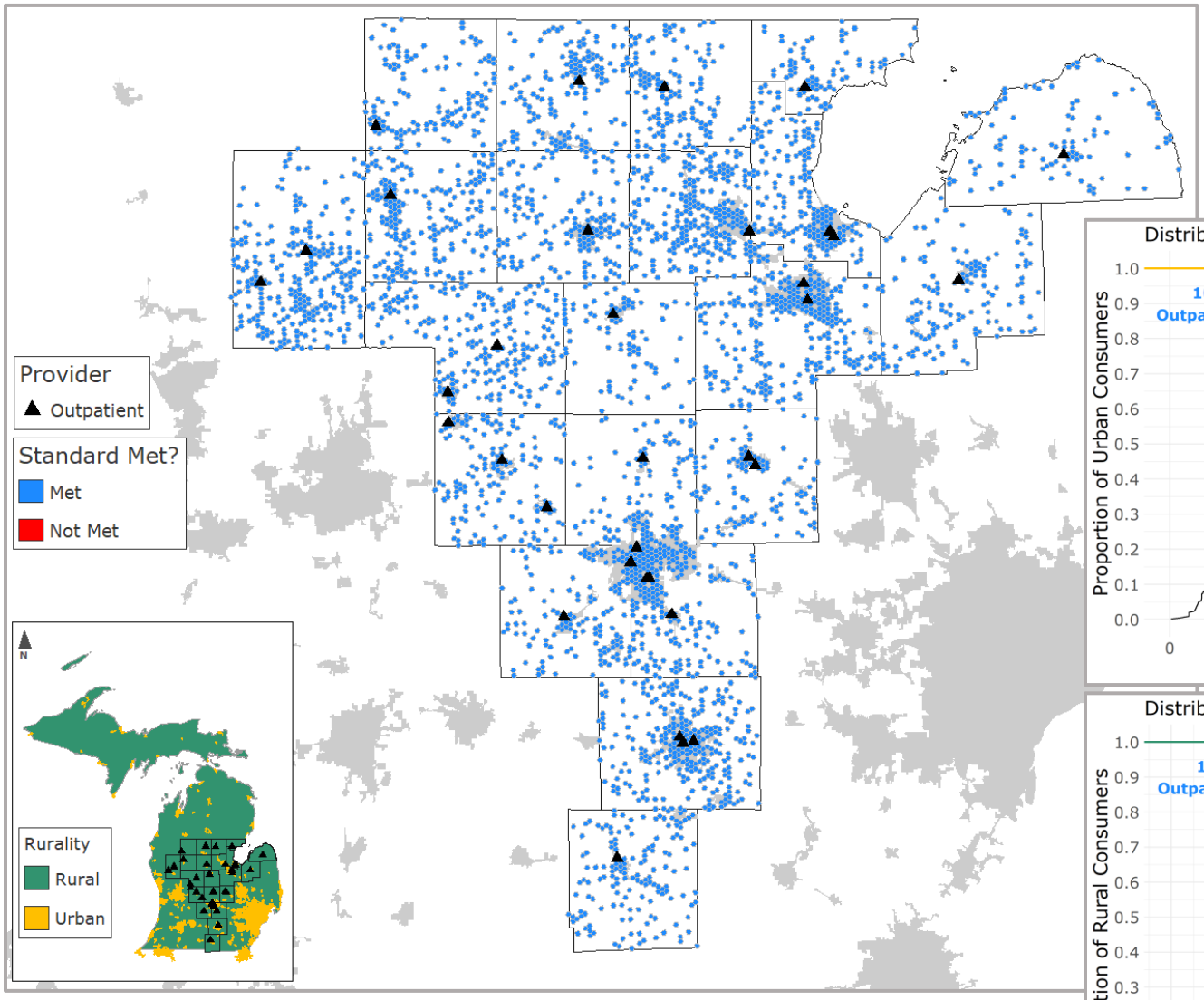


MSHN consumers who received a Homebased service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

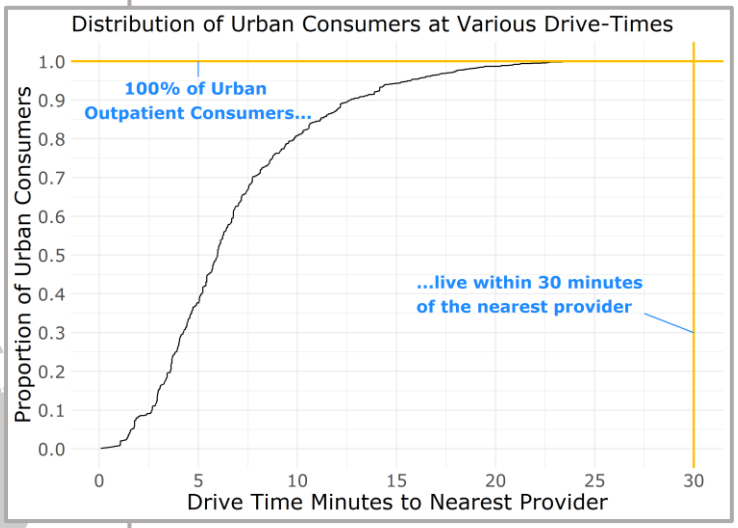
Outpatient FY21

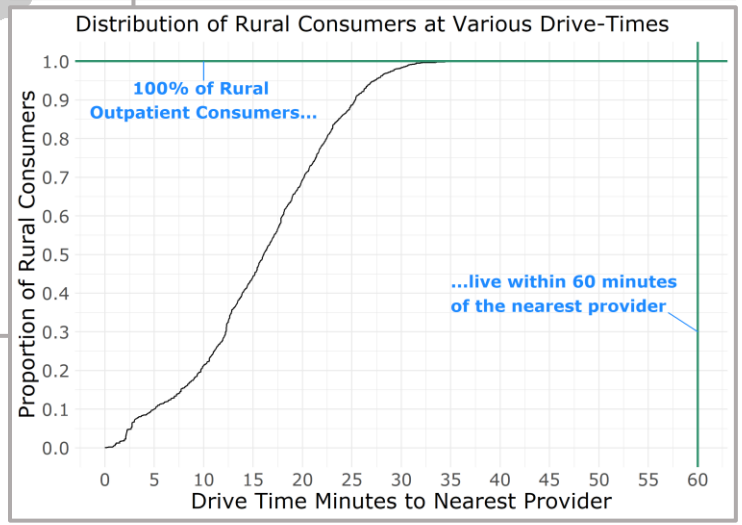
Drive Times Between MSHN Consumers and Outpatient Providers

Service Codes: 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90840, 90846, 90847, 90849, 90853, H2019



Outpatient Drive Time Standard		
	Urban Consumers: 30 minutes	Rural Consumers: 60 minutes
Met	10714 (100.0%)	5436 (100.0%)
Not Met	0 (0%)	0 (0%)
Total	10714	5436



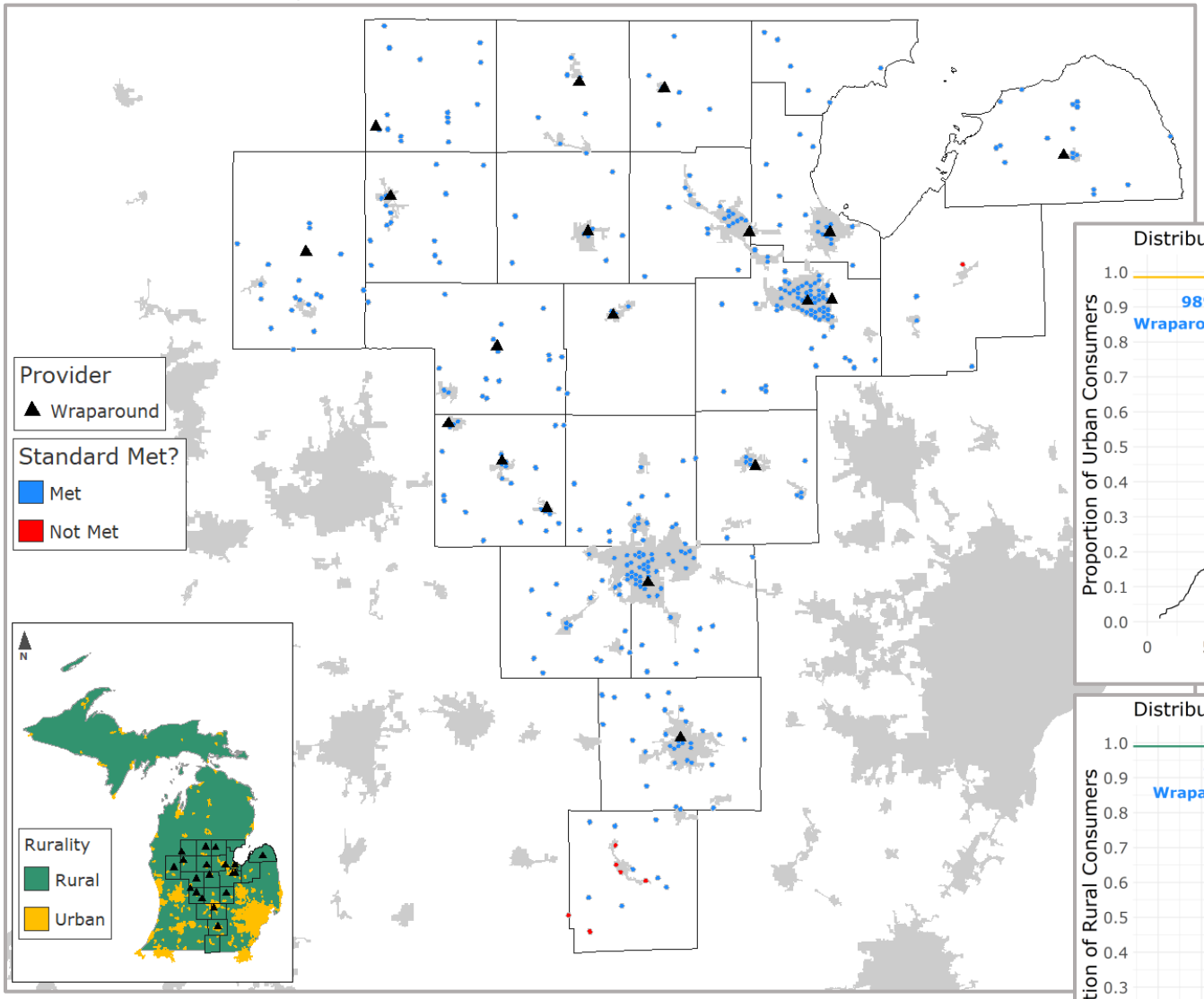


MSHN consumers who received an Outpatient service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

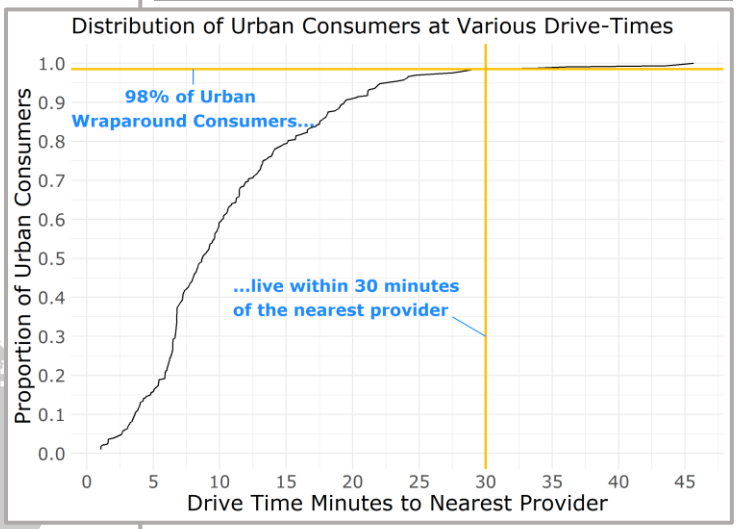
Wraparound FY21

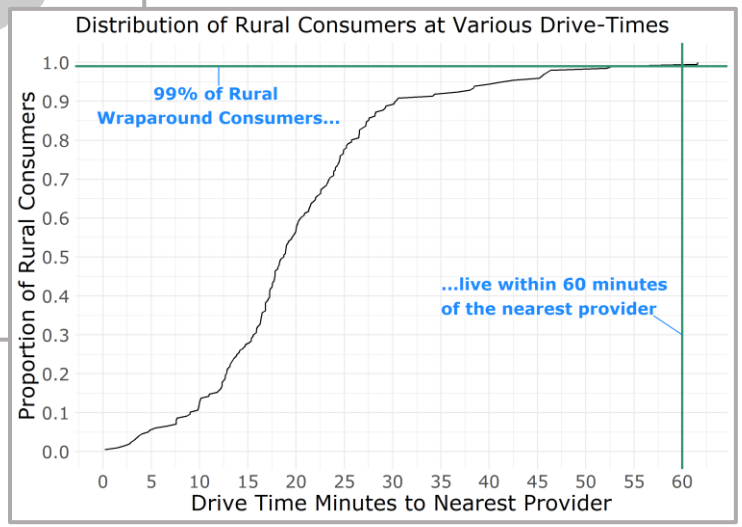
Drive Times Between MSHN Consumers and Wraparound Providers

Service Codes: H2021, H2022



Wraparound Drive Time Standard		
	Urban Consumers: 30 minutes	Rural Consumers: 60 minutes
Met	323 (98.5%)	194 (99.0%)
Not Met	5 (1.5%)	2 (1.0%)
Total	328	196



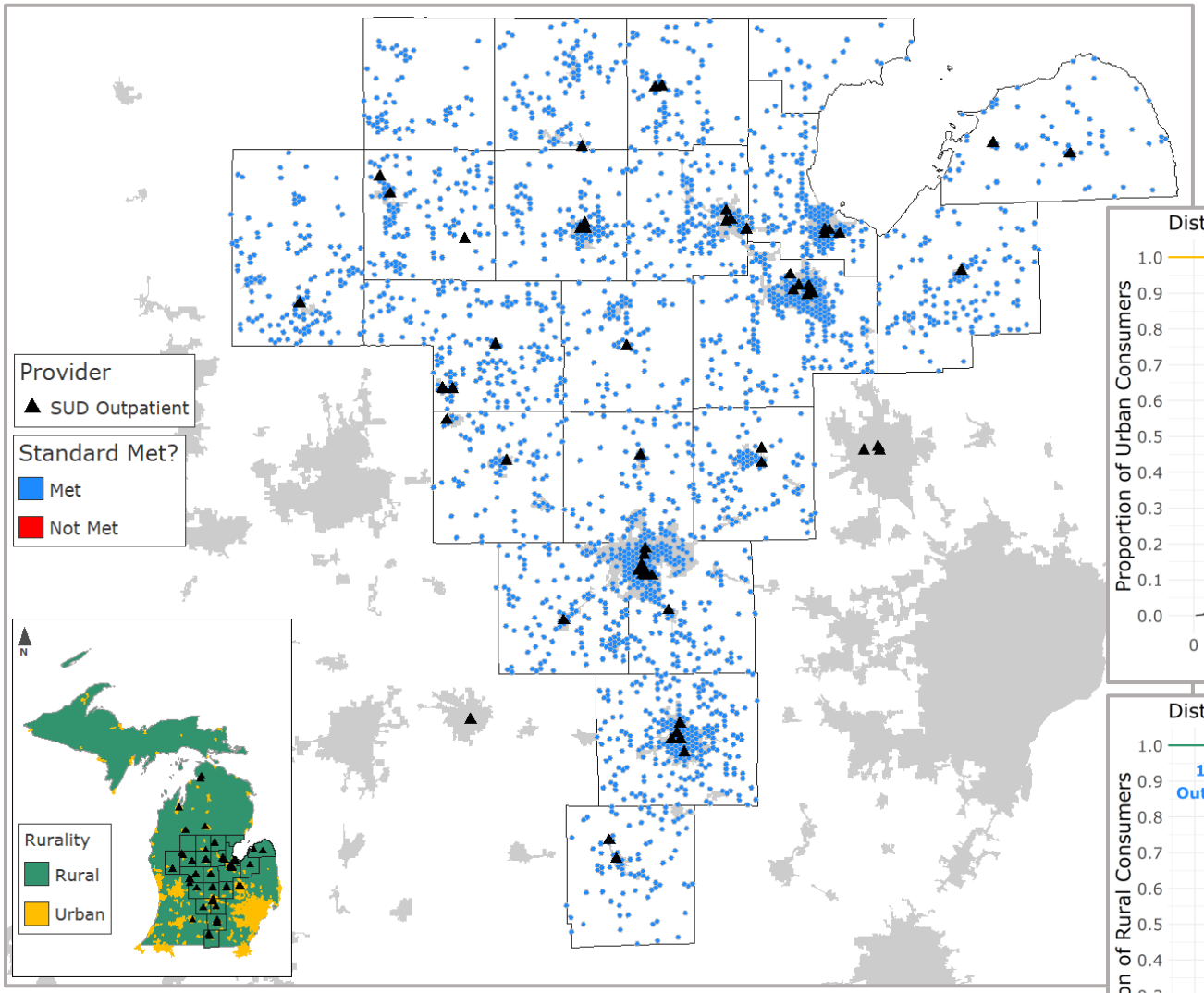


MSHN consumers who received a Wraparound service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

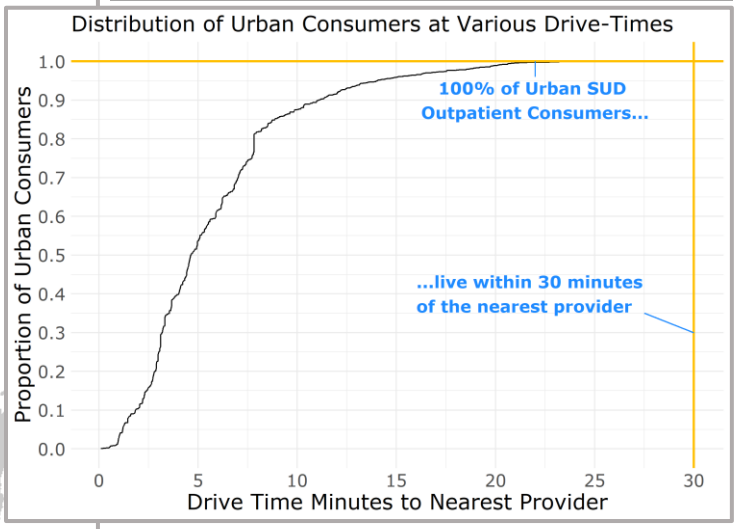
SUD Outpatient FY21

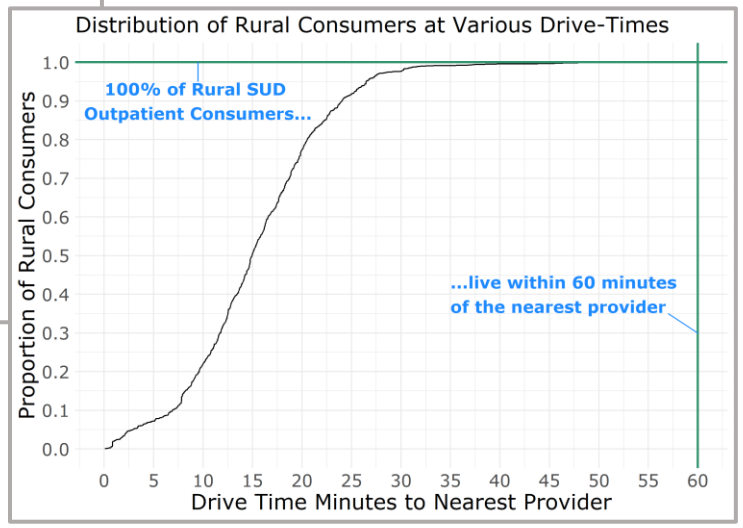
Drive Times Between MSHN Consumers and SUD Outpatient Providers

Service Codes: 90791, 90832, 90834, 90837, 90846, 90847, 90853, 97810, 97811, 99202, 99213, A0110, H0001, H0003, H0004, H0005, H0022, H0048, H0050, H2011, H2027, H2035, S0215, T1009, T1012, T2003



SUD Outpatient Drive Time Standard		
	Urban Consumers: 30 minutes	Rural Consumers: 60 minutes
Met	7645 (100.0%)	2531 (100.0%)
Not Met	0 (0%)	0 (0%)
Total	7645	2531



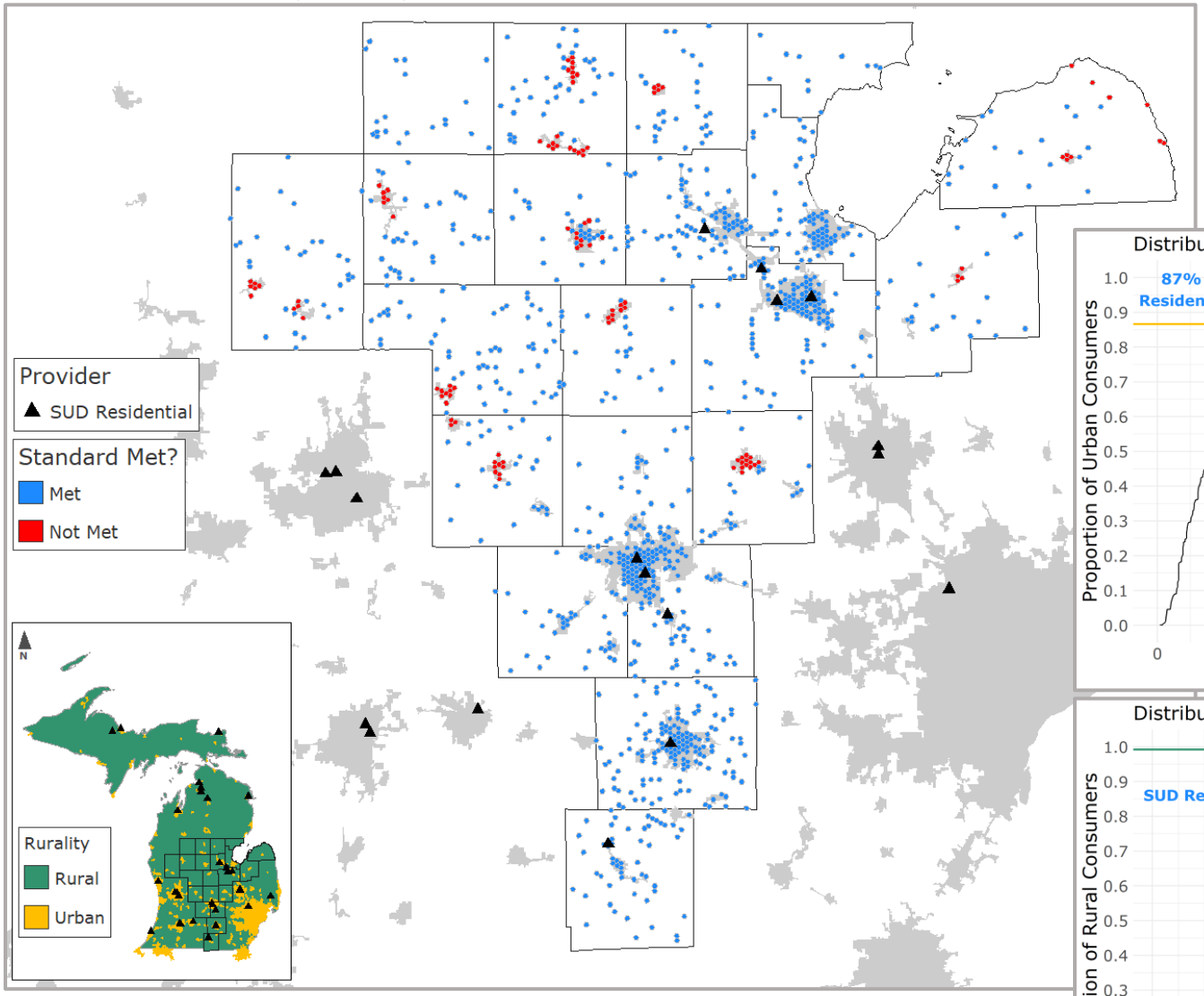


MSHN consumers who received an SUD Outpatient service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

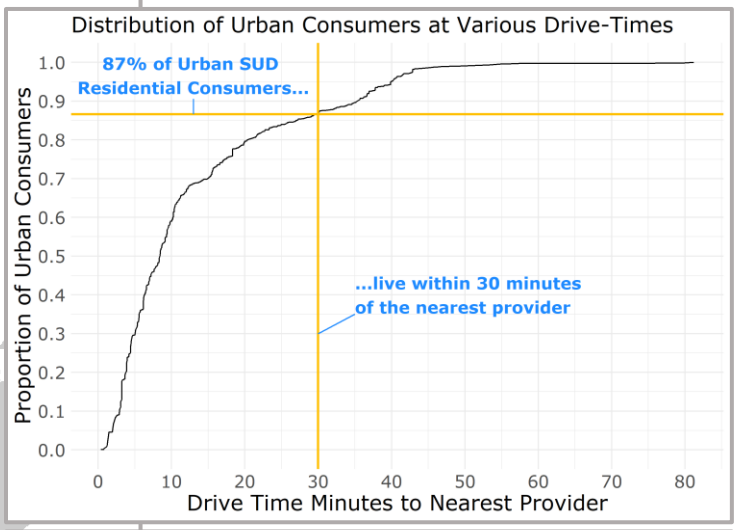
SUD Residential FY21

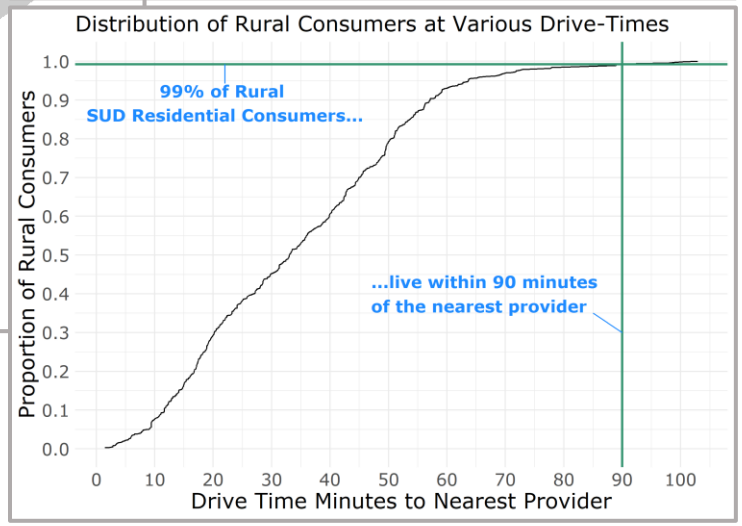
Drive Times Between MSHN Consumers and SUD Residential Providers

Service Codes: H0018, H0019, S9976



SUD Residential Drive Time Standard		
	Urban Consumers: 30 minutes	Rural Consumers: 90 minutes
Met	1991 (86.6%)	761 (99.2%)
Not Met	308 (13.4%)	6 (0.8%)
Total	2299	767



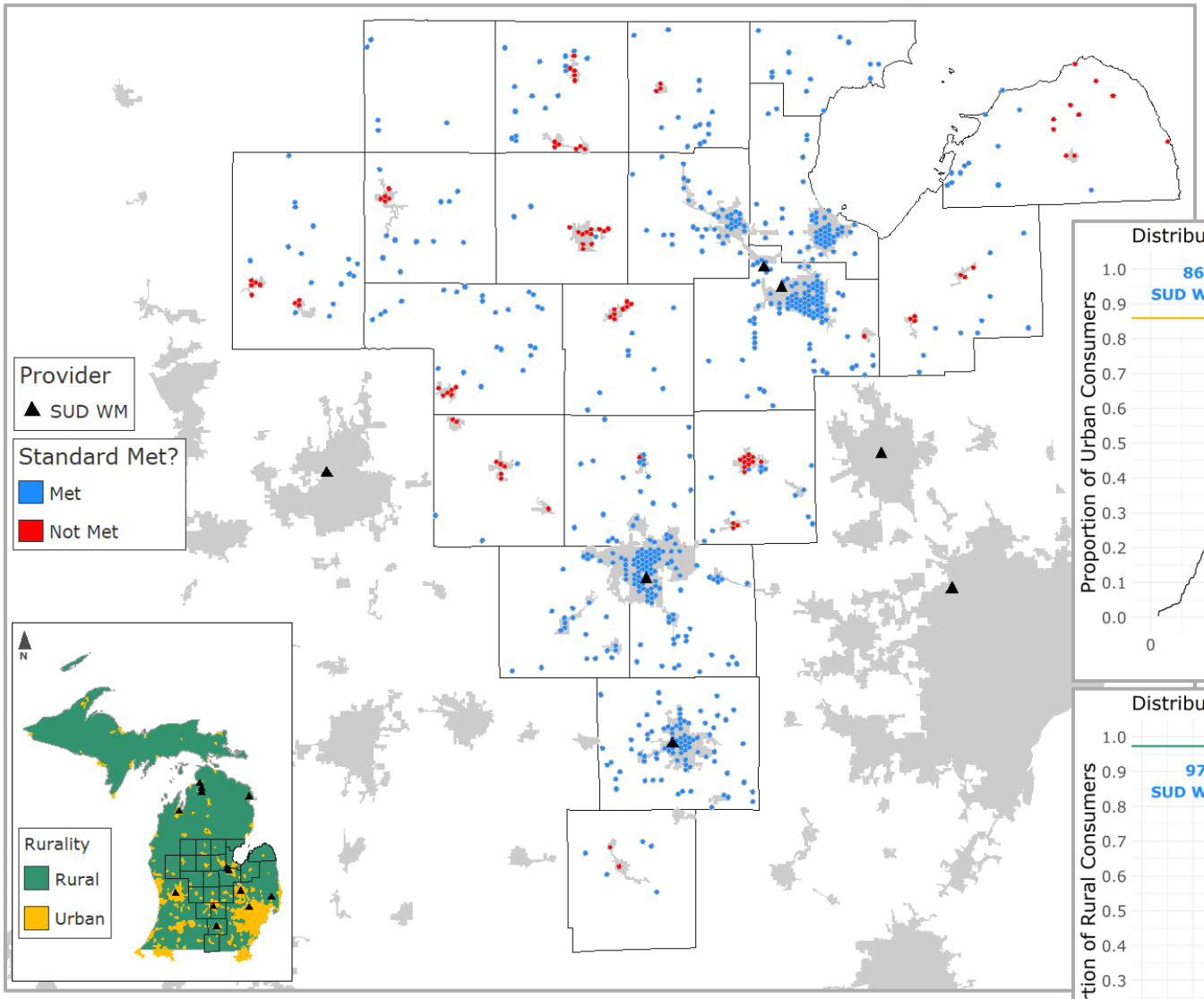


MSHN consumers who received an SUD Residential service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

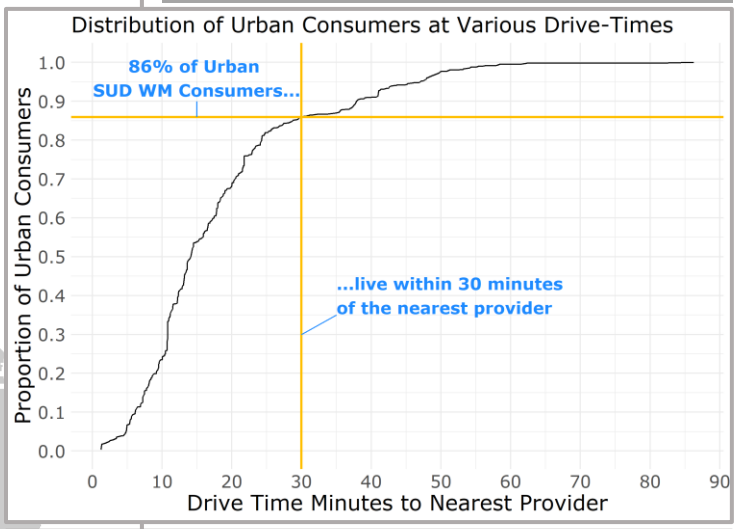
SUD Withdrawal Management (WM) FY21

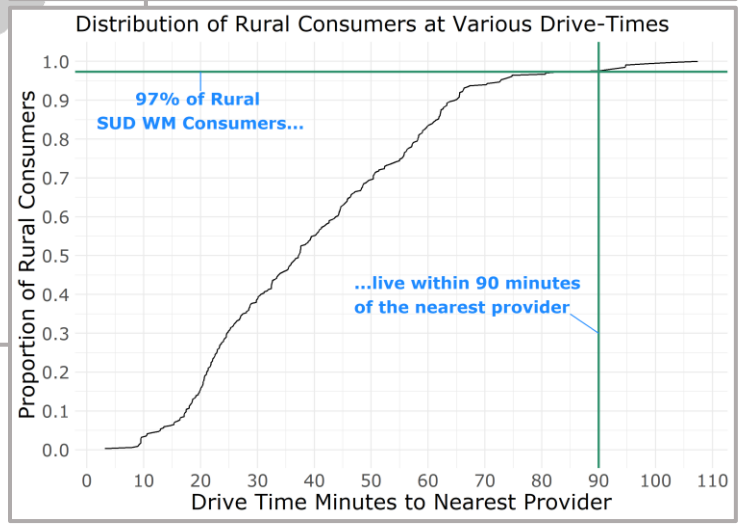
Drive Times Between MSHN Consumers and SUD WM Providers

Service Codes: H0010, H0012



SUD WM Drive Time Standard		
	Urban Consumers: 30 minutes	Rural Consumers: 90 minutes
Met	1003 (85.9%)	328 (97.3%)
Not Met	164 (14.1%)	9 (2.7%)
Total	1167	337



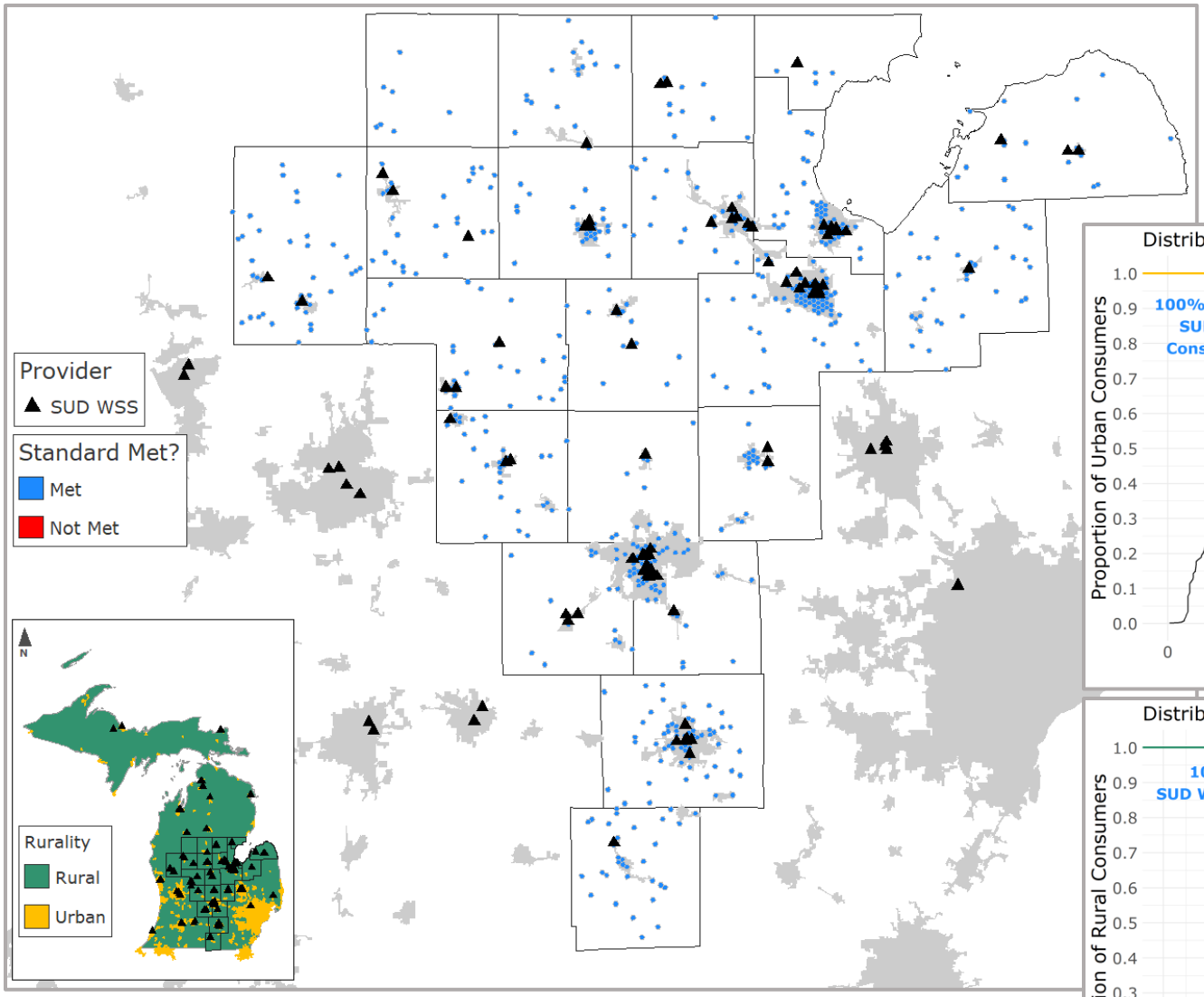


MSHN consumers who received an SUD WM service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

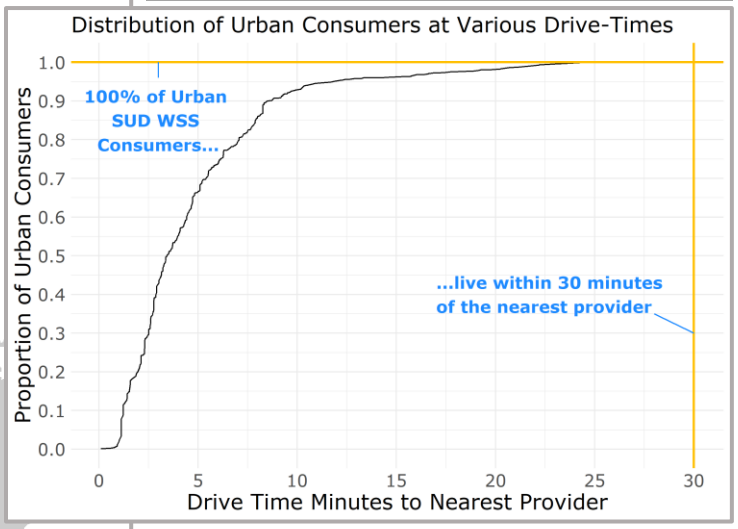
SUD Women's Specialty Services (WSS) FY21

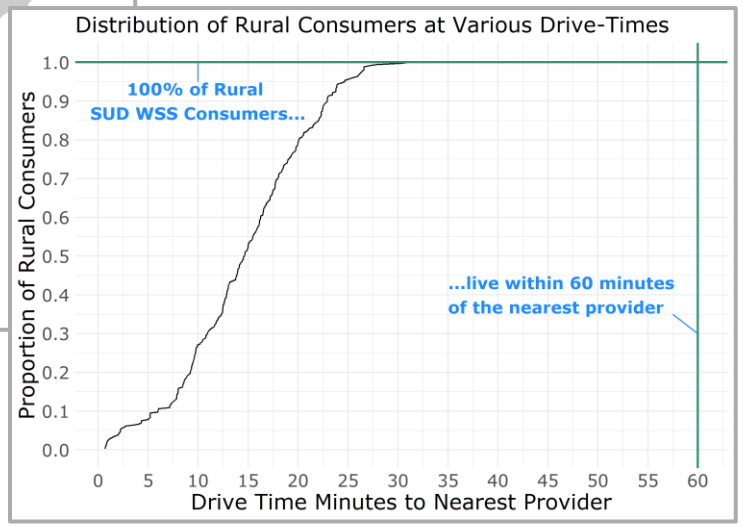
Drive Times Between MSHN Consumers and SUD WSS Providers

Service Codes: All SUD encounters with and HD modifier



SUD WSS Drive Time Standard		
	Urban Consumers: 30 minutes	Rural Consumers: 60 minutes
Met	967 (100.0%)	358 (100.0%)
Not Met	0 (0.0%)	0 (0.0%)
Total	967	358





MSHN consumers who received an SUD WSS service in FY21 are organized in square-mile hexagons based on place of residence. Hexagons are colored based on the time in minutes from their centroid to the nearest provider. Rural is defined as everything not within an Urban Area or Urban Cluster. Only consumers with valid addresses within MSHN's 21-county region during FY21 were included. Hexagons and consumers with miscalculated drive-times were removed from the dataset. This map displays distribution of served consumers at a detail level that may constitute Protected Health Information under HIPAA standards.

Appendix A

Percent of FY21 MSHN Consumers for Whom Drive Time Standard Was Met, Overall and By Race

	Psych Inpatient Children	Psych Inpatient Adults	ACT	Clubhouse	Crisis Residential	Homebased	Outpatient	Wraparound	SUD Outpatient	SUD Residential	SUD Withdrawal Management	SUD Women's Specialty Services
Rural Standard	120 min	90 min	60 min	60 min	60 min	60 min	60 min	60 min	60 min	90 min	90 min	90 min
Urban Standard	60 min	30 min	30 min	30 min	30 min	30 min	30 min	30 min	30 min	30 min	30 min	30 min
Consumers: Standard Met	581 (98.0%)	4271 (92.9%)	759 (100.0%)	494 (99.0%)	1192 (87.8%)	3309 (100.0%)	16150 (100.0%)	517 (98.7%)	10176 (100.0%)	2752 (89.8%)	1331 (88.5%)	1325 (100.0%)

By Race:	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Alaskan Native	1	100.0%	1	100.0%	0		0		0		1	100.0%	5	100.0%	0		2	100.0%	0		0		1	100.0%
American Indian	11	100.0%	31	93.9%	7	100.0%	4	100.0%	13	100.0%	28	100.0%	106	100.0%	1	100.0%	77	100.0%	22	84.6%	14	66.7%	7	100.0%
Asian	2	100.0%	20	90.9%	6	100.0%	0		12	92.3%	7	100.0%	44	100.0%	1	100.0%	16	100.0%	5	100.0%	5	100.0%	3	100.0%
Black or African American	58	98.3%	619	99.4%	98	100.0%	62	100.0%	244	96.4%	202	100.0%	1385	100.0%	72	98.6%	1069	100.0%	326	97.0%	152	99.3%	94	100.0%
Native Hawaiian or Other Pacific Islander	0		2	100.0%	0		0		1	100.0%	0		12	100.0%	0		9	100.0%	4	80.0%	1	50.0%	2	100.0%
White	409	97.8%	3040	91.6%	561	100.0%	387	98.7%	795	84.8%	2576	100.0%	12762	100.0%	365	98.4%	7787	100.0%	2025	88.9%	1007	87.3%	1067	100.0%
Other Single Race	15	100.0%	138	95.8%	10	100.0%	8	100.0%	30	90.9%	42	100.0%	315	100.0%	6	100.0%	307	100.0%	69	89.6%	48	87.3%	29	100.0%
Two or More Races	60	98.4%	272	92.8%	77	100.0%	29	100.0%	82	90.1%	397	100.0%	1222	100.0%	67	100.0%	597	100.0%	284	88.8%	97	90.7%	75	100.0%
Refused to Provide	11	100.0%	75	94.9%	0		3	100.0%	8	100.0%	31	100.0%	125	100.0%	3	100.0%	57	100.0%	17	89.5%	4	80.0%	12	100.0%
Missing	14	93.3%	73	89.0%	0		1	100.0%	7	77.8%	25	100.0%	174	100.0%	2	100.0%	255	100.00%	0		3	100.0%	35	100.0%

Consumer race data was sourced from the latest BH-TEDS record on file for FY21.