MSHN

Mid-State Health Network

Assessment of Network Adequacy

2014

Mid-State Health Network

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Contents

Definitions

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

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

2. CMHSP Participant and/or Coordinating Agency (CA) /Substance Abuse Sub-Regional Entity (SASRE) Subcontractors: An individual or organization that is directly under contract with a CMHSP and/or CA/SASRE to provide behavioral health services and/or supports.

3. Provider Network: MSHN CMHSP Participants and Substance Abuse CA/SASRE's directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements.

4. Substance Abuse Coordinating Agency (CA): The regional CA as designated by Michigan Department of Community Health. In accordance with Michigan PA 500 and 501 CA functions will be assumed under the scope of PIHP functions effective October 1, 2014.

5. Substance Abuse Sub-Regional Entities (SASRE's): Former Substance Abuse Coordinating Agencies under contract with MSHN to perform managed care functions for substance use disorder treatment programs and services, including management of contracted service providers.

Background

As a Pre-Paid Inpatient Health Plan (PIHP), Mid-State Health Network (MSHN) must assure the adequacy of its network in order to provide access to a defined array of services for specified populations over its targeted geographical area. This document outlines the assessment of such adequacy as performed by Mid-State Health Network.

This assessment of the adequacy of the provider network demonstrates MSHN has the capacity to serve the expected enrollment in its 21 county service area in accordance with Michigan Department of Community Health (MDCH) standards for access to care. The counties in the MSHN service area include:

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

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

- Bay-Arenac Behavioral Health (BABH)
- CMH Authority of Clinton-Eaton-Ingham Counties (CEI)
- CMH for Central Michigan (CMHCM)
- Gratiot County CMH Services (GCCMHA)
- Huron Behavioral Health (HBH)
- Ionia County CMH (ICCMHA)
- LifeWays CMH (LCMHA)
- Montcalm Center for Behavioral Health (MCBH)
- Newaygo County Mental Health Center (NCMHC)
- Saginaw County CMH Authority (SCCMHA)
- Shiawassee County CMH Authority (SHIACMH)
- Tuscola Behavioral Health Systems (TBHS)

In addition to the CMHSP Participants, four Coordinating Agencies for substance abuse (SA) services operate within the counties comprising the MSHN region, specifically:

- Bay-Arenac Behavioral Health (dba Riverhaven Coordinating Agency)
- Saginaw County Health Department
- CMH Authority of Clinton Eaton Ingham Counties
- Northern Michigan Substance Abuse Services

Although Medicaid funds for substance abuse treatment already flow through MSHN, the Coordinating Agencies remained accountable for delivery of substance abuse services funded under Public Act 2, MI-Child and related Block Grants. As a result, responsibility for the management of care for substance abuse treatment and the associated provider networks were retained through the Coordinating Agencies for the duration of FY14. As of 10/1/14 the Coordinating Agency designation is being eliminated by the MDCH and the full responsibility for managing substance abuse services for the three funding streams will be transferred to the PIHP's in Michigan.

MSHN is engaged in planning activities for assumption of these additional managed care obligations, and at this point is planning to delegate functions to a sub-regional entity or entities. The scope of this assessment of provider network adequacy is therefore primarily mental health services for FY14, but will expand in the future to address substance abuse provider networks and services in more detail.

The primary responsibility for assessing local need and establishing the scope of subcontracted and direct operated service providers and programs remains with the CMHSP's (and in the future, the Substance Abuse Sub-Regional Entity(ies), and is overseen by MSHN through a network adequacy assessment. The MSHN assessment of network adequacy is intended to support CMHSP (and SASRE) and MSHN efforts by generating considerations for possible adjustments in the CMHSP Participant direct operated and subcontracted service providers and programs, based upon the network profile generated through the global assessment process. MSHN and the CMHSP's and the SASRE(s) would then act upon these ideas 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 or SASRE regarding the composition and scope of local networks and ensure overall the region is meeting its obligations as a specialty Medicaid Health Plan and providing the services that are needed in each community. In some instances the response to an identified gap in services could result in the implementation of new and creative service delivery models, such as a collaborative initiative among the PIHP and CMHSP Participants to provide a regional level crisis response program, similar to the MDCH statewide model for positive living supports or a regional effort to build therapeutic and non-therapeutic recovery oriented housing.

The scope of this assessment is primarily Medicaid funded specialty behavioral health services, including 1915(b) State Plan and Autism services, the 1915(b)(3) services, as well as services for adults with developmental disabilities enrolled in the Habilitation Support Waiver program, as well as specialty behavioral health (mental health and substance abuse) services under the Healthy Michigan program. Excluded are those services which are exclusively the focus of the CMHSP system, such as services financed with General Funds and the waiver programs for Children with Developmental Disabilities and Serious Emotional Disturbance. Some reference is made, but Mid-State Health Network will more comprehensively incorporate Block Grant, MI-Child and PA2 funded substance use disorder treatment programs in the Provider Network Adequacy Assessment for FY15.

MSHN will perform an initial or prospective assessment of network adequacy and update the assessment on an annual basis. The PIHP must prospectively determine:

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

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

- Whether or not 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

MSHN assumes the process of assessing the adequacy of its provided network is a relatively resource independent process. In other words, an objective assessment of enrollee 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.

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 enrollees in the service area.[1] MSHN assesses the "appropriateness" of the range of services by comparing the service array available with the region, to the array determined to be appropriate by the MDCH for the target population. This array is articulated by MDCH in the Medicaid Managed Specialty Support and Services Concurrent 1915(b)/(c) Waiver Program contract.

MSHN is contractually obligated by MDCH to provide the covered State Plan services under the 1915(b) waiver component of the Michigan 1915(b)/(c) program as described in the Michigan Medicaid Provider Manual, Mental Health-Substance Abuse section. This includes State Plan Services under the iSPA and the 1915(b) Waiver component of the 1915(b)/(c) program for children with autism, as described in MSA Policy Bulletin Number: MSA 13-09 effective April 1, 2013. MSHN is also contractually obligated to provide Medicaid funded substance abuse treatment services and as previously mentioned, after 10/1/14 this will include SUD services funded by MI-Child, Public Act 2 and Block Grants, as well as the expanded benefits available under the Healthy Michigan (HMI) Medicaid expansion program.

Services are to be provided based upon the needs of the population. The following table lists the service array and which services are either directly provided or contracted by each CMHSP participant in the MSHN region, based on local needs.

State Plan Services (1915(b) Waiver) Available in MSHN Provider Network

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Applied Behavioral Analysis	X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	X	X	X		X	X	X	X	X	X	X	X
Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Behavior Treatment Review	X	X	X	X	X	X	X	X	X	X	X	X
Child Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Clubhouse Psychosocial Rehabilitation	X	X	X				X	X		X		
Crisis Interventions	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Residential Services	X	X	X	X	X	X	X	X	X	X	X	X
Family Therapy		X	X	X	X	X	X	X	X	X	X	
Health Services	X	X	X	X	X	X	X	X	X	X	X	X
Home-Based Services	X	X	X	X	X	X	X	X	X	X	X	X

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

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
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		
ICF Facility for Ind. w/ Mental Retardation												
Medication Administration	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
Occupational Therapy	X	X	X	X	X	X	X		X	X	X	
Outpatient Partial Hospitalization Services				X			X	X				
Personal Care in Licensed Spec. Residential	X	X	X	X	X	X	X	X	X	X	X	X
Physical Therapy	X		X	X	X	X		X	X	X		X
Speech, Hearing and Language Therapy	X	X	X	X	X	X	X	X	X	X		X
Substance Abuse Services		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
Transportation		X		X						X	X	
Treatment Planning	X	X	X	X	X	X	X	X	X	X	X	X

MSHN is also responsible for provision of certain enhanced community support services for those beneficiaries in the service areas who are enrolled in Michigan's 1915(c) Home and Community Based Services Waiver (or HSW) for persons with developmental disabilities. These additional services are also offered to consumers based upon need. The MSHN region in aggregate has been assigned 1,637 HSW slots.

The following table shows which CMHSP participant either directly provides or contracts for a particular service. Services which may be provided on a one-time basis, such as Enhanced Medical Equipment and Supplies, would not be addressed via a program or contract and are therefore not delineated per CMHSP.

1915c Home and Community Based Services Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Community Living Supports	X	X	X	X	X	X	X	X	X	X	X	X
Enhanced Medical Equip & Supplies	----	----	----	----	----	----	----	----	----	----	----	----
Enhanced Pharmacy		X		X			X		X	X	X	X
Environmental Modifications	----	----	----	----	----	----	----	----	----	----	----	----
Family Training	X	X	X	X		X	X	X	X	X	X	
Goods & Services	----	----	----	----	----	----	----	----	----	----	----	----
Out-of-Home Non-Voc. Habilitation			X			X	X			X		X
Personal Emerg. Response Systems			X	X	X					X		
Pre-Vocational Services	X	X	X	X	X	X	X			X		
Private Duty Nursing	X	X					X			X	X	
Respite Care	X	X	X	X	X	X	X	X	X	X	X	X
Supports Coordination	X	X	X	X	X	X	X	X	X	X	X	X
Supported Employment	X	X	X	X	X	X	X	X	X	X	X	X

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

1915(b)(3) Services Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Assistive Technology	----	----	----	----	----	----	----	----	----	----	----	----
Crisis Observation Care		X										
Housing Assistance	----	----	----	----	----	----	----	----	----	----	----	----
Peer Specialist Services	X	X	X	X	X	X	X	X	X	X	X	X
Drop-In Centers (Peer Operated)	X	X	X	X	X	X	X		X	X	X	X
Prevention Direct Service Models			X			X	X			X		X
• **Child Care Expulsion Prevention**												
• **School Success Program**												
• **Children of Adults w/ MI/ Integ. Serv.**										X		
• **Infant Mental Health**	X	X	X	X	X	X	X		X	X	X	
• **Parent Education**		X	X	X			X			X	X	
Skill Building Assistance	X	X	X	X	X	X	X	X	X	X	X	X
Wraparound Services		X	X	X		X	X	X	X	X	X	X
Fiscal Intermediary Services	X	X	X	X	X	X	X	X	X	X	X	X

The services for treatment of substance use disorders for which MSHN receives Medicaid funding include the following:

Medicaid Funded Substance Abuse Service Array for the MSHN Provider Network

Service
Individual Assessment
Individual Treatment Planning
Individual Therapy
Group Therapy
Family Therapy
Crisis Intervention
Referral/Linking/Coordinating/Management of Services
Peer Recovery and Recovery Support
Compliance Monitoring
Early Intervention
Detoxification/Withdrawal Monitoring
Pharmacological Supports
SA Treatment Services

The specific services contracted by each CA for FY14 are defined in their action plans and service manuals. The Public Act 2, Block Grant and MI-Child programs offer additional services. More information will be incorporated into this assessment when it is updated for FY15.

In 2014 MDCH expanded Medicaid eligibility to previously unserved populations, which will be discussed in detail in another section of this document. The service array for the expansion program includes a comprehensive array of mental and substance abuse services. MSHN and the CMHSP Participants, as well as the Coordinating Agencies (future SASRE's) are still establishing provider networks and obtaining clarification from the MDCH regarding their service obligations under this new program.

Since MSHN is in its first year of operation, the service array tables above represent the region's baseline provider network offerings. Review of these baseline tables by the CMHSP Participants, CA/SASRE's and MSHN leadership are occurring in FY14 and will continue into FY15, and will be helpful for purposes of comparing local services, verifying the availability of priority services throughout the region, and evaluating if there is service capacity that could be made available across geographic boundaries to fill an unmet service need.

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

The adequacy of the numbers and types of providers (in terms of training, experience and specialization) required to furnish the contracted Medicaid services [2] in the MSHN region can be assessed through review of the direct operated and contracted service provider networks established by the CMHSP Participants.

Training and experience

Each of the CMHSP participant agencies in the region have been in operation in the behavioral health care industry for decades, as have many of their contracted service providers. Practitioners and staff employed or contracted by the CMHSP's are properly licensed and credentialed in accord with MDCH requirements as defined in the Michigan Medicaid Manual. Disciplines include licensed/board certified Psychiatrists, licensed Nurse Practitioners, Registered Nurses, Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Full and Limited License Psychologists, 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 MDCH requirements.

Coordinating Agencies (and in the future, the SASRE's) have similar credentialing procedures for their sub-contracted service providers. Clinical staff, specifically treatment supervisors, specialists and practitioners, as well as prevention supervisors and professionals are required to

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

hold certification through the Michigan Certification Board of Addiction Professionals, such as a Certified Addiction and Drug Counselor.

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

CMHSP Participant Accrediting Bodies

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Joint Commission			X									
Commission on Accreditation of Rehabilitation Facilities	X	X		X		X	X	X	X	X	X	X
Council on Accreditation					X							

Substance Abuse Coordinating Agencies (and probably the SASRE's in the future) are not required to be accredited as entity, but their sub-contracted service providers are required to have their programs accredited as alcohol or drug abuse programs. Most providers utilize similar accrediting bodies to the CMHSP Participants and their subcontracted mental health service providers.

Specialization

In addition to pursuit of accreditation, CMHSP programs must meet MDCH program certification requirements for certain specialty programs as outlined in the Michigan Medicaid Manual. The certification process entails meeting additional criteria such as mandatory service components, minimum staff credentials, ongoing training requirements and minimum staffing patterns. MDCH Certification is maintained by the CMHSP Participants for the following programs:

CMHSP Participant Program Certifications Through MDCH

- Assertive Community Treatment
- Clubhouse Psychosocial Rehabilitation Programs
- Crisis Residential Programs
- Day Program Sites
- Drop-In Programs
- Home Based Services
- Wraparound

Sub-contracted substance abuse service providers of the CA/SASRE's must be licensed by the State of Michigan as Substance Abuse Programs. Each CMHSP participant provides selected specialty services or treatments based upon evidence-based practice models they have

adopted in accordance with local needs. The following are some examples of the many evidence based (or best) practices currently offered by CMHSP participants in the region:

Examples of Evidence Based Practices Deployed by CMHSP Participants in the MSHN Region

	Pop.	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Alternative for Families Cognitive Beh Therapy	Families in Danger of Physical Violence										X		
Applied Behavioral Analysis	I/DD-Autism	X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	MIA	X	X	X		X	X	X	X	X	X	X	X
Brief Behavior Activation Therapy	Adults w Depression			X									
Brief Strategic Family Therapy	Families	X		X	X								
Clubhouse	MIA	X						X	X		X		
Cognitive Behavioral Therapy	All	X	X	X	X	X	X	X	X	X	X		
Communities That Care	All										X		
Dialectical Behavioral Therapy	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Family Psycho-Education	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	
Integrated Dual-Diagnosed Treatment	Dual SUD/MIA	X	X	X	X	X		X	X	X	X	X	X
Mobile Urgent Treatment Team	Families										X		
Motivational Interviewing	All	X	X	X	X	X			X	X	X		
Multi-Systemic Therapy	Juvenile offenders			X	X			X					
Nurturing Parenting Program	Parents			X			X						
Parent-Child Interaction Therapy	Parents			X					X				
Parent Mgt Training – Oregon Model	Parents	X	X	X	X		X			X	X	X	X
Parenting Through Change	Parents			X									
Parenting Wisely	Parents							X			X		
Peer Mentors	I/DD										X		
Peer Support Specialists	MIA	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				
Schema-Focused Therapy	Couples			X									
Seeking Safety Trauma Group	SUD & PTSD	X		X		X	X				X		
Self Management and Recovery Training	MIA, SUD	X		X									
Seven Challenges	SUD Adolescents										X		
Supported Employment-Dartmouth Model	Adults	X	X	X	X	X	X	X	X	X	X	X	X
Thinking for a Change	SUD Offenders										X		
Trauma Focused Cognitive Beh. Therapy	Children	X		X			X	X		X	X		
Trauma Recovery Empowerment Model	Adults			X							X		
Whole Health Action Management	Adults			X					X				
Wellness Recovery Action Planning	Adults	X		X					X				
Wraparound	SED Families		X	X	X		X	X	X	X	X	X	

The sub-contracted service providers of the CA/SASRE's also utilize evidence based practices, particularly prevention 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. The following are evidence-based practices deployed by various sub-contracted service providers in the MSHN region:

Focal Area	EBP Practice
TREATMENT	Cognitive Behavioral Therapy (CBT)
	Correctional Therapeutic Community for Substance Abuse
	Dialectical Behavior Therapy (DBT)
	Drug Court
	Eye Movement Desensitization
	Functional Family Therapy
	Mindfulness
	Motivational Enhancement Therapy
	Motivational Interviewing
	Methadone Treatment (Includes Opioid Maintenance)
	Partners for Change Outcome Measurement System
	Recovery Coaches
	Recovery Focused Treatment Practices
	Relapse Prevention
	Substance Abuse Treatment for Persons with Co-occurring Disorders
	Thinking for a Change
	Trauma Focused Treatment Practices
PREVENTION	All Stars
	Active Parenting Now
	A Second Look
	Life Skills Training
	Mapping-Enhanced Counseling
	Positive Action
	Project Alert
	Project EX
	Parenting Now
	Second Step
	Start Taking Alcohol Risk Seriously (STARS)
	Teen Intervene
	Too Good For Drugs (TGFD)
	Too Good For Violence (TGFV)
	Too Good for Domestic Violence (TGDV)

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

Counselor (CADC). Substance abuse service provider staffs offering prevention services are required to hold certifications as Certified Prevention Specialists.

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 enrollees in the service area.[3] Medicaid enrollment, service penetration rates and community demand are key factors to consider.

Medicaid enrollment

Medicaid enrollment in Michigan has been climbing in the past decade, most likely due to a general deterioration in the state's economy. In the past couple of years enrollment has shown signs of plateauing. Medicaid enrollments in the counties comprising the MSHN region still remain relatively high, with 15 out of 21 counties at or above the statewide average enrollment in June of 2013, and 14 out of 21 in December of that year (see table below). Higher Medicaid enrollment is associated with a relatively greater number of potential consumers of specialty behavioral health services. This suggests the size of the MSHN provider network should remain at least at the existing level for the upcoming year.

Medicaid Enrollments for Counties in the MSHN Region

County	2010 Population	June 2013 Medicaid Eligibles	Medicaid Eligible % of Population	December 2013 Medicaid Eligibles	Medicaid Eligible % of Population
Arenac	15,899	3,011	***19%***	2,975	***19%***
Bay	107,771	17,224	***16%***	17,138	***16%***
Clare	30,926	6,845	***22%***	6,821	***22%***
Clinton	75,382	6,383	8%	6,261	8%
Eaton	107,759	12,195	11%	12,086	11%
Gladwin	25,692	4,766	***19%***	4,613	***18%***
Gratiot	42,476	7,120	***17%***	7,136	***17%***
Hillsdale	46,688	8,118	***17%***	8,038	***17%***
Huron	33,118	4,757	14%	4,740	14%
Ingham	280,895	43,916	***16%***	43,281	15%
Ionia	63,905	9,539	15%	9,322	15%
Isabella	70,311	8,192	12%	7,969	11%
Jackson	160,248	26,691	***17%***	26,294	***16%***
Mecosta	42,798	7,057	***16%***	6,792	***16%***
Midland	83,629	10,307	12%	10,252	12%
Montcalm	63,342	11,242	***18%***	11,220	***18%***
Newaygo	48,460	9,871	***20%***	9,798	***20%***

[3] 42CFR438.207(b)(1) "Offers an appropriate range of preventative, primary care and specialty services that is adequate for the anticipated number of enrollees in the service area."

County	2010 Population	June 2013 Medicaid Eligibles	Medicaid Eligible % of Population	December 2013 Medicaid Eligibles	Medicaid Eligible % of Population
Osceola	23,528	4,701	***20%***	4,630	***20%***
Saginaw	200,169	39,723	***20%***	39,444	***20%***
Shiawassee	70,648	11,522	***16%***	11,425	***16%***
Tuscola	55,729	9,492	***17%***	9,602	***17%***
Total Region 5	**1,649,373**	**262,672**	**16%**	**259,837**	**16%**
Total state	9,883,640	1,600,870	16%	1,591,240	**16%**

An analysis of historical and current Medicaid enrollment for the counties in the MSHN region that is specific to the eligibility groups relevant to 1915(b) (i.e., State Plan) services; 1915(b)(3) services; 1915(c) (i.e., HSW) services, Adult Benefits Waiver and other PIHP related benefits as determined by MDCH, such DHS Incentive Payment, Autism Waiver or a new I-waiver may be of value to the region for predicting future enrollment trends.

Service population penetration rates

The number of Medicaid enrollees residing in the region who received specialty behavioral health services meets or exceeds the state average for most of the counties in the region. Again, this suggests service capacity should remain at or above existing levels and should not be reduced. The following was derived from FY2012 Section 404 Legislative Boilerplate data[4]:

Population Service Penetration Rate

	State Average	MSHN Average	Difference
Adults with Mental Illness	2.42%	2.49%	+.07%
Children with Emotional Disturbance	2.54%	2.75%	+.21%
Persons with Intellectual and Developmental Disabilities	0.46%	0.59%	+.13%

Similar statistics are not currently available to MSHN for substance abuse treatment services but will be added to this report in future updates.

Community demand

Each CMHSP is required by the MDCH 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. Similarly the CA/SASRE's are required to prepare a tri-annual action plan addressing community needs. Community Needs Assessments and Action Plans completed during 2014 will be incorporated into the MSHN Assessment of Provider Network Adequacy for 2015 as appropriate.

[4] Source: FY2012 Section 404 Boilerplate Data (MSHN FY2012 Benchmark Utilization Analysis)

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.

Medicaid expansion

The state of Michigan has established a new program, the Healthy Michigan Plan (HMP), for purposes of expansion of Medicaid eligibility to the medically uninsured and underinsured. The population groups that became eligible for Medicaid through the Healthy Michigan program are Michigan residents earning up to 133 percent of the federal poverty level who are otherwise not eligible for Medicaid at the time of enrollment and are:

- Aged 19 through 64 (there is already a mandatory Medicaid group for individuals under age 19 up to 160% of FPL, and those aged 65 and older can receive Medicaid up to 100% of FPL).
- Not currently eligible and receiving coverage under a mandatory Medicaid group (spend-down is not a mandatory group, nor is an unmet spend-down considered "coverage").
- Not a Medicare recipient. (Medicare is considered minimum essential coverage, so none of the healthcare law was intended to address Medicare supplementation).
- Not pregnant at the time they apply.

Mental health services offered through the HMP are similar to those previously offered via the Adult Benefit Waiver program, but the substance use disorder treatment options are expanded from the services previously available through Medicaid. The following list comprises the Healthy Michigan Plan Alternative Benefit Package for behavioral health. According to MDCH, "this list is reflective of the services that are currently described in the Medicaid Provider Manual; however, it does not delineate them as being B waiver services, state plan services or B 3 services. An individual qualifies for these services based on medical necessity and the individual eligibility for each service (such as diagnosis)." [5]

Healthy Michigan Plan Behavioral Health Services

- Crisis interventions
- Assessments – including psychiatric, diagnostic evaluation, referral, patient placement and other health services (OT, PT and speech hearing and language)
- Treatment planning
- Inpatient hospital psychiatric care and partial hospitalization
- Outpatient care including psychotherapy or counseling (individual, family, group)
- Intensive outpatient
- Medication administration and review
- Sub-acute detoxification
- Intensive Crisis Stabilization
- Intermediate care facility
- Personal care
- Transportation
- Assistive technology
- Community living supports
- Enhanced pharmacy
- Environmental modifications
- Family support and training
- Housing assistance
- Peer delivered or peer operated services (peer

[5] Communication from Elizabeth Knisely of MDCH on 5/12/14 Titled: HMP Behavioral Health Benefit message; SUD Services for HMP-Final.pdf

- Approved Pharmacological Supports (Methadone)
- Targeted case management
- Assertive Community Treatment
- Behavior Treatment Review
- Clubhouse Psychosocial Rehabilitation
- Crisis residential
- Residential treatment
- specialists and drop-in centers)
- Prevention direct service models
- Respite care
- Skill building assistance
- Support and service coordination
- Supported/integrated employment services
- Fiscal intermediary

MSHN will be working closely its provider network, MDCH and substance use disorder licensing to address which SUD services must be offered by a licensed provider versus a MDCH certified or MSHN credentialed behavioral health provider. Given the newness of the HMP, MSHN will need to monitor closely the availability of licensed substance abuse treatment providers to meet the potentially increased demand.

MDCH indicated in its press releases for the HMP that 322,000 low income residents in Michigan were expected to qualify. In December of 2013 the MSHN region had 16% of the state's Medicaid enrollees living within its borders, which a rough calculation suggests 51,520 people in the MSHN region may ultimately qualify. The Michigan Primary Care Association published estimates of the number of uninsured people who may be eligible for HMP benefits. The following table shows the counties in the MSHN region, which represents a total of 74,519 potential new enrollees: [6]

Uninsured Estimated Eligibles for Healthy Michigan Plan Benefits

County	Estimate		County	Estimate		County	Estimate
Arenac	839		Hillsdale	2,435		Midland	3,276
Bay	4,174		Huron	1,446		Montcalm	3,178
Clare	1,874		Ingham	14,407		Newaygo	2,450
Clinton	2,476		Ionia	2,483		Osceola	1,234
Eaton	3,617		Isabella	4,941		Saginaw	8,463
Gladwin	1,338		Jackson	6,479		Shiawassee	2,968
Gratiot	1,557		Mecosta	2,459		Tuscola	2,425

At this point in time MSHN is unable to project utilization for Healthy Michigan. Enrollment data has been made available but MSHN believes enrollments may be over-stated due to challenges MDCH has experienced with the transition from prior programs such as the Adult Benefits Waiver (ABW) and errors that have been identified with Medicaid enrollment classifications of individuals. Enrollments have also been lagging, so the data should not be considered generalizable until more months of enrollment have passed. The SUD benefit in particular is concerning relative to network capacity and the risk reserve is not currently established for this program.

[6] Figures obtained from Michigan Primary Care Association: HMP Enrollment Report by County 5-5-14; based upon Uninsured estimated HMP eligible provided by Census Bureau SAHIE, Ages 18-64, <=138% FPL, All Races, Both Sexes; http://www.census.gov/did/www/sahie/data/interactive

CMHSP Participants and MSHN leadership have raised concerns with MDCH regarding the structuring of the Healthy Michigan program and a concurrent reduction in the General Funds which are typically used to provide Mental Health Code mandated priority services and care for the indigent. Healthy Michigan was anticipated by some to be an adequate replacement for General Fund supported services and other Medicaid programs such as ABW, but the populations eligible for the services are not fully inclusive of all individuals who previously received General Fund supported services. The result in some communities has been the tightening of service eligibility criteria, reduction in service arrays, and in some instances, an inability to offer any behavioral health treatment to some populations.

Although General Fund services are not directly under the scope of authority of MSHN, the funding reduction is impacting MSHN CMHSP Participant's ability to function as a community safety net provider and ensure an adequate provider network for core services required by the Mental Health Code. The greatest gaps in coverage are for individuals with behavioral health related disabilities who have spend-down thresholds to meet each month in order to achieve Medicaid eligibility.

For those individuals with non-specialty behavioral health service needs (i.e. mild to moderate mental health needs), the Medicaid or Medical Health Plans contracted by the MDCH are expected to provide the mental health benefit. In some counties in the MSHN region, the availability of such services are limited or non-existent due to service capacity issues, low reimbursements or other barriers. A recent informal survey by MSHN of the CMHSP Participants in the region yielded the following results:

Mid-State Health Network: CMHSP – MHP Service Access and Coordination Survey 3/13/14

1. Do consumers in your county/counties have difficulty accessing Medicaid Health Plan outpatient services for mild/moderate mental health needs?
   Yes, Always: 3
   Yes, sometimes: 6
   I am not sure: 1

2. If yes, which county/counties?	3. If yes, are access difficulties because?
Arenac, Huron, and Gratiot	The MHP has no mental health outpatient providers in our county/counties (other than CMHSP if contracts are established).
Shiawassee, Mecosta, Osceola, Clare, Gladwin, Clinton, Eaton, Ingham, and Hillsdale	The MHP(s) have a limited mental health outpatient providers and there are long waits.
Montcalm	No MHP Psychiatric providers after 6.1.2014
Newaygo	Services and limited out of Grand Rapids. The CMHSP is the only provider.

Note: The survey results are inclusive of feedback form 10 or 12 CMHPS.

Meeting the needs of enrollees: expected utilization of services

MSHN must maintain a network of providers that is sufficient to meet the needs of the anticipated number of enrollees in the service area[7]. A determination of whether the network of providers is sufficient would typically be made at through analysis of the characteristics and health care needs of the populations represented in the region[8]. 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 enrollees.

MSHN is required to serve Medicaid beneficiaries in the region who *require* the Medicaid services included under the 1915(b) Specialty Services Waiver; who are *enrolled* in the 1915(c) Habilitation Supports Waiver; or for whom MSHN has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. Furthermore, MSHN is required to limit Medicaid services to those that are *medically necessary* and appropriate, that conform to accepted standards of care, and in sufficient amount, duration and scope to reasonably achieve the purpose of the service.

Specific definitions of the target populations for specialty behavioral health services go beyond the International Classification of Diseases definitions and Diagnostic and Statistical Manual of Mental Disorders criteria, requiring specific degrees of impairment in functioning, as follows:

- Developmental Disability: A developmental disability means either of the following:
    - If applied to an individual older than five years, a severe, chronic condition that meets all of the following requirements: Is attributable to a mental or physical impairment or a combination of mental and physical impairments; is manifested before the individual is 22 years old; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activities: self-care; receptive and expressive language; learning, mobility; self-direction; capacity for independent living; and economic self-sufficiency; and reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
    - If applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined above if services are not provided.
- Serious Emotional Disturbance: A diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic And Statistical Manual Of Mental Disorders published by the American Psychiatric Association and approved by the MDCH, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities.
- Serious Mental Illness: A diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic And Statistical Manual Of Mental Disorders published by the American Psychiatric Association and approved by the MDCH and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities.

[7] 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."
[8] 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."

The PIHP must also ensure access to public substance abuse services in accordance with the MDCH/PIHP and MDCH/Substance Abuse Coordinating Agency (CA) contract. Effective October 1, 2014 MSHN will assume responsibility for the full range of services for persons with primary SUD including the following funding sources Medicaid, Block Grant, and PA 2 funds. In preparation for this transition MSHN is working with existing CAs to develop the required three-year strategic plan due to MDCH August 1, 2014. MSHN has issued an RFP to assure continuity of the required service array and administrative capacity. Contracts for sub-regional SUD administrative activities will be in place no later than September 2014. Contracts with the existing SUD sub-contractors are required to continue through December 31, 2014. MSHN and its sub-regional SUD administrative provider(s) will assure assessment of ongoing service array and network adequacy prior January 1, 2015.

Medical necessity and clinical eligibility determination criteria for substance abuse service are as follows:

- Medical Necessity" means determination that a specific service is medically (clinically) appropriate, necessary to meet a Consumer's treatment needs, consistent with the Consumer's diagnosis, symptoms and functional impairments and stage of change and consistent with clinical Standards of Care.
    - Individuals with the most severe forms of addiction, meaning specifically those who have a 'dependency' diagnosis and are at a minimum in the 'preparation' stage of change, shall be authorized for admission.
    - Individuals who have less severe forms of addiction, specifically those with an 'abuse' diagnosis and who are in the 'preparation' stage of change or higher, may be admitted to formal services.
- Clinical Eligibility Determination – Clinical eligibility determination includes triage (assessment of risk), determination of medical necessity (the presence or a likelihood of a substance use disorder), a determination of the initial level of care (LOC) (based on the American Society of Addiction Medicine Patient Placement Criteria 2R (ASAM), and a provisional diagnostic impression that must include appropriate referral(s) for services.
- The service is based on a level of care determination using the six assessment dimensions of the current ASAM Patient Placement Criteria:
    - Withdrawal potential
    - Medical conditions and complications
    - Emotional, behavioral or cognitive conditions and complications
    - Readiness to change
    - Relapse, continued use or continued problem potential
    - Recovery/living environment.

Since eligibility and medical necessity for service involves factors beyond the determination of a diagnosis, prevalence may not be best predictor of future demand. Service utilization will be monitored as a proxy for consumer demand. Future iterations of this assessment will include analysis of service encounter history for the MSHN region.

Consumer satisfaction with services is an important consideration when evaluating the adequacy of a provider network. MSHN will be completing its first assessments of consumer perception of care during 2014-2015 and will utilize the results in future assessments of its network.

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 enrollees in the service area[9]. The effectiveness of the baseline number of providers in the network may be evaluated to a great extent by past performance.

Sufficiency of number of providers

MDCH requires PIHP's to report indicators of access timeliness and inpatient follow-up. Below is a table showing the performance of the 21 county region, as calculated for purposes of this assessment, based upon the numerators and denominators reported by the PIHP's which were in operation prior to the formation of MSHN[10]. Past performance should be indicative of future performance, as the entities who achieved this performance to a large extent remain in place, in the form of the CMHSP Participants in the MSHN region. In most instances, MDCH expectations for service access are being met. The following table is a snapshot of recent regional performance.

State Performance Indicators for Access Timeliness and Inpatient Follow-Up

Time Period: 4/1/13-6/30/13	Population	State Average	MSHN Region Composite Score	Difference
New persons receiving face to face assessment w/in 14 days of non-emergency assessment (Standard: ≥95%)	MI-Children	98.23%	98.49%	+0.26%
	MI-Adults	98.43%	99.34%	+0.91%
	DD-Children	98.39%	100.00%	+1.61%
	DD-Adults	97.81%	100.00%	+2.19%
	Medicaid SA	98.79%	99.47%	+0.68%
New persons starting on-going service w/in 14 calendar days of a non-emergent assessment (Standard: ≥95%)	MI-Children	97.29%	96.54%	-0.75%
	MI-Adults	98.02%	99.15%	+1.13%
	DD-Children	96.05%	91.89%	-4.16%
	DD-Adults	97.40%	94.64%	-2.75%
	Medicaid SA	98.40%	100.00%	+1.60%
Persons discharged from psychiatric inpatient unit/ substance abuse detox unit seen for follow-up care w/in 7 days (Standard: ≥95%)	Children	98.55%	100.00%	+1.45%
	Adults	97.05%	97.58%	+0.53%

[9] 42CFR438.207(b)(2) "Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."
[10] MDCH State Fiscal Year 2013 Validation of Performance Measures; September 2013; prepared by Health Services Advisory Group

Time Period: 4/1/13-6/30/13	Population	State Average	MSHN Region Composite Score	Difference
	Medicaid SA	98.35%	100.00%	+1.65%
Persons readmitted to an inpatient psychiatric unit w/in 30 days of discharge	Children	11.92%	4.82%	-7.10%
	Adults	15.58%	9.63%	-5.95%

Since MSHN is in its first year of operation, it is deploying a multi-disciplinary approach to assess the adequacy of the availability of services as evidenced through the timeliness of service access. The MSHN Quality Improvement Council, Utilization Management Committee and CMHSP Participant clinical representatives will be reviewing provider network performance against access timeliness standards. Any findings will be addressed in the next update of this assessment.

All CMHSP Participants are required via their contract with MSHN, and indirectly by MSHN's contract with MDCH to accept new Medicaid patients[11].

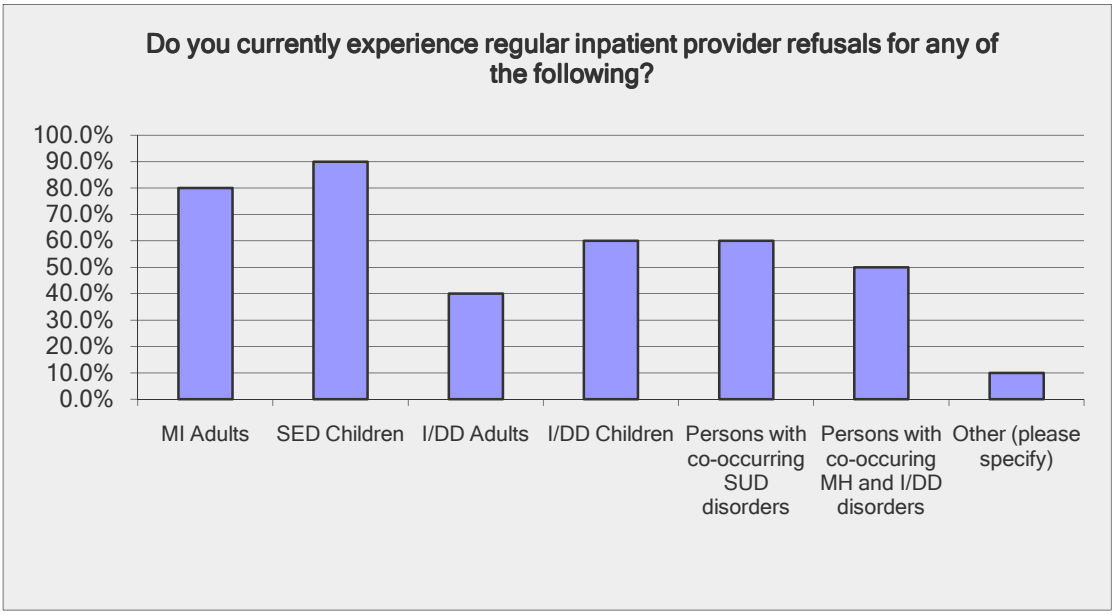
Sufficiency of mix of providers

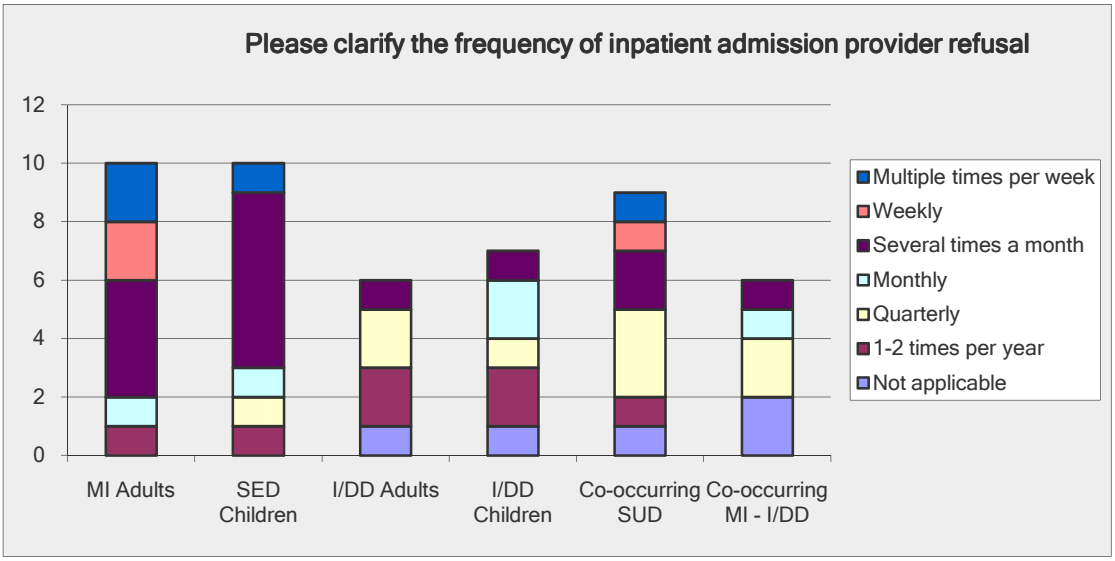
MSHN is required to give priority to individuals with serious mental illness, serious emotional disturbance and developmental disabilities with the most serious forms of illness and those in urgent and emergent situations.

Key services for individuals with urgent and emergent needs include inpatient psychiatric care and 24/7 emergency response capacity. Both services are available in all 21 counties in the MSHN region. However, MSHN has noted psychiatric inpatient capacity in the region may not be adequate to meet the needs of all consumers (at any given time) for whom a pre-screening has been completed and admission determined to be warranted. Initial concerns include the possible refusal of consumers with behavioral challenges or certain diagnoses. MSHN conducted a survey to identify specific barriers to inpatient admissions and gaps in bed capacity.

MSHN - Reported Experience Inpatient Hospital Refusal/Denial of Admission 2014 5/29/2014

[11] 42CFR438.206(b)(iv) "The numbers of network providers who are not accepting new Medicaid patients."

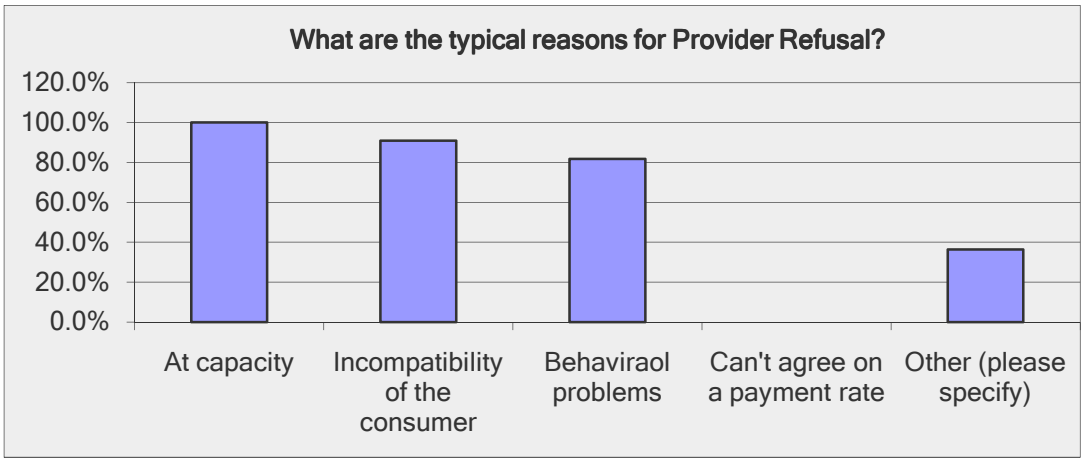




Please specify the hospitals you experience the highest rate of provider refusals with:

HOSPITAL	# of Respondents		HOSPITAL	# of Respondents
Pine Rest	6		Mid-Michigan Medical Center - Gratiot	
U of M			Coldwater	
White Pines	3		Owosso Memorial	2
Hillsdale			Havenwyck	2
Lapeer Regional Medical Hospital			Forest View*	6
McLaren Bay Medical Center	2		Mid-Michigan Medical Center	2
Port Huron			Healthsource	3
Memorial Healthcare			Allegiance	
St. Mary's Med Psych			Sparrow/St. Lawrence	
Oaklawn	2		Hadley	

*MSHN UM Committee members report that Forest View has applied for a certificate of need for 30 child inpatient beds and has been approved to flex adult beds for children and adolescents.



MSHN leadership in conjunction with its Provider Network Management Committee is working to address issues with access to inpatient care.

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

Historically, CMHSP Participants been challenged with recruiting and maintaining ancillary health services such as occupational, speech language pathology and physical therapists, especially in rural counties. Relatively recent transitions from social work registration to licensure has increased requirements for clinicians and lengthen the time required to secure full licensure, however, it is not evident this has created significant issues with network capacity.

In the past year or two, some CMHSP Participants and their direct operated and subcontracted service programs have found it difficult to secure adequate providers to provide applied behavioral analysis services for children with autism, due to the extensive training requirements for providers and the relative newness of the required credentials in the behavioral health industry and Michigan in particular.

In February 2014, MDCH completed a survey of the Medicaid and MI-Child funded public mental health system's capacity to serve children with Autism Spectrum Disorders; results for the CMHSP Participants in the MSHN region are shown in the table below.

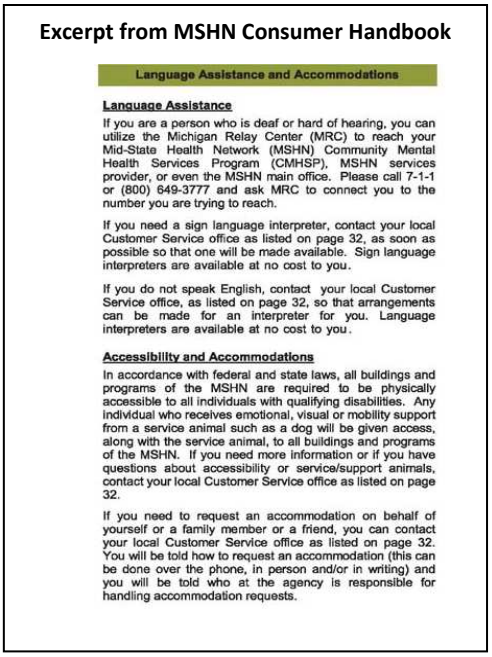
Capacity to Serve Children with Autism Spectrum Disorders

	BABH	CEI	CMHCM	GCCMHA	HBH	ICCMHA	LCMHA	MCBH	NCMHC	SCCMHA	SHIACMH	TBHS
Do you have adequate capacity for diagnostic services of ASD to serve your caseload?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Do you have the capacity to assist additional children w/ diagnostic services of ASD?	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No
Can you provide applied behavioral analysis to additional children in addition to your current caseload?	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes
Do you need assistance acquiring Board Certified Behavior Analyst's?	No	No	No	No	Yes	No	No	No	No	Yes	No	No
What is the average length of time for an individual to start ABA services after referral for services?	8 weeks	4 weeks	3 weeks	4 weeks	-	13 weeks	10 weeks	0 weeks	8 weeks	15 weeks	6 weeks	Unable to deter

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

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

Excerpt from MSHN Consumer Handbook



Language Assistance and Accommodations

Language Assistance

If you are a person who is deaf or hard of hearing, you can utilize the Michigan Relay Center (MRC) to reach your Mid-State Health Network (MSHN) Community Mental Health Services Program (CMHSP), MSHN services provider, or even the MSHN main office. Please call 7-1-1 or (800) 649-3777 and ask MRC to connect you to the number you are trying to reach.

If you need a sign language interpreter, contact your local Customer Service office as listed on page 32, as soon as possible so that one will be made available. Sign language interpreters are available at no cost to you.

If you do not speak English, contact your local Customer Service office, as listed on page 32, so that arrangements can be made for an interpreter for you. Language interpreters are available at no cost to you.

Accessibility and Accommodations

In accordance with federal and state laws, all buildings and programs of the MSHN are required to be physically accessible to all individuals with qualifying disabilities. Any individual who receives emotional, visual or mobility support from a service animal such as a dog will be given access, along with the service animal, to all buildings and programs of the MSHN. If you need more information or if you have questions about accessibility or service/support animals, contact your local Customer Service office as listed on page 32.

If you need to request an accommodation on behalf of yourself or a family member or a friend, you can contact your local Customer Service office as listed on page 32. You will be told how to request an accommodation (this can be done over the phone, in person and/or in writing) and you will be told who at the agency is responsible for handling accommodation requests.

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

Geographic accessibility

The MSHN region, although rural in some areas, is able to meet MDCH standards for geographic accessibility, as follows:

- For office or site-based mental health services, the individual's primary service providers (e.g., case manager, psychiatrist, primary therapist, etc.) must be within 30 miles or 30 minutes of the recipient's residence in urban areas, and within 60 miles or 60 minutes in rural areas.
- For office or site-based substance abuse services, the individual's primary service provider (e.g., therapist) must be within 30 miles or 30 minutes of the recipient's residence in urban areas and within 60 miles or 60 minutes in rural areas.[12]

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.

Accommodations

All CMHSP Participants offer services in locations with physical access for Medicaid enrollees with disabilities[13]. Delivery of services in home settings as well as telemedicine (now available in selected counties) can offset barriers to physical access where present.

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

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

Public Policy Priorities

In its 2013 Application for Participation for PIHP's, MDCH identified a series of public policy initiatives which reflected the state's priorities relative to maintaining an adequate provider network capacity for Medicaid beneficiaries.

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

[13] 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."

Regional Crisis Response Capacity

It is expected by MDCH that MSHN will have a crisis response capacity fully available by January 1, 2015 that includes clinical expertise that can be immediately accessed for mental health or behavioral crises. As stated in the MDCH AFP guidance for AFP item 5.1 Regional Crisis Response Capacity:

> *That expertise may be a team or teams of clinicians who are available for telephonic consultation and on-site observation and consultation, and have the training and experience to address the needs of children and adults with serious mental illness (SMI/SED) and children and adults with intellectual/developmental disabilities (I/DD), and children and adults with co-occurring SMI/SED and I/DD. This crisis response capacity must also have a residential or inpatient component to which an individual can be transported, reside for a short period, and receive treatment or intervention until his/her crisis stabilizes.*
>
> *This capacity could be intensive crisis stabilization or crisis residential services in a free-standing licensed adult foster care facility and a free-standing licensed children's foster care facility, staffed with clinicians and workers who are specially trained to respond effectively to behavioral crises exhibited by adults or children with SMI/SED or adults with I/DD. This capacity could alternatively be an agreement with a regional inpatient psychiatric unit that is willing and able to receive any individual (SMI, SED or I/DD, adult or child) who is exhibiting a behavioral crisis. This capacity must include emergency admission.*

MSHN provided data regarding individuals considered at-risk of crisis placement, as presented in the following table:

Individuals at Risk of Crisis Placement

	911 Calls	Temporary placements in crisis home	On-site visit by CPLS mobile team	ER visit	Admission to psych inpatient unit	Request for inpatient admission to state facility
Child with SED	8	0	0	22	228	14
Adult with SMI 18-64	59	249	0	128	1567	69
Adult with SMI 65+	0	2	0	4	25	3
Child with I/DD*	4	1	1	3	5	5
Adult with I/DD* 18-64	25	11	3	24	58	11
Adult with I/DD* 65+	0	0	0	2	1	0

*People on the Autism Spectrum Disorder or people with co-occurring SMI/SED and I/DD in included this category

The MSHN Utilization Management Committee has initiated a focused review of inpatient utilization. The Utilization Management Committee will review the report during the next quarter and determine a process to ensure oversight and monitoring of inpatient utilization and need for improved access.

MSHN has established a policy requiring critical incident reporting. In addition, MSHN's Quality Assessment Performance Improvement Program (QAPIP) includes the reporting and follow up process required by the CMHSP's in the region regarding critical incidents. MSHN also requires through policy that the provider network (CMHSP's) either adopts the regional QAPIP or has a local QAPIP that is in compliance with the regional plan. As required, MSHN submitted critical incident reports for the month of January and February for our region. The QIC will review the data during their April meeting to determine further analysis and any recommendations for improvement.

Health and Welfare

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

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

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

Olmstead Compliance

Community Living

Title II's integration mandate of the Americans with Disabilities Act requires that the "services, programs, and activities" of a public entity be provided "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR 35.130(d). Such a setting is one that "enables individuals with disabilities to interact with nondisabled persons to

the fullest extent possible." 28 CFR 35, App. B at 673. MDCH expects MHSN to ensure compliance with the Olmstead decision related to successful community living, appropriateness of placement and choice of housing.

The following tables' list data from MSHN regarding the housing arrangements/ current placements for selected individuals in the region, as reported in the 2013 AFP.

Individuals Living In Any Licensed Setting

	In Licensed Setting <6 Beds	# In Licensed Setting – 6 Beds	# In Licensed Setting 7-12 Beds	# In Licensed Setting 13+ Beds	# In Skilled Nursing Facilities	Total # Per Population	Percent Of Total Served
Children w/ SED	156	3	1	1	0	161	2.00%
Adults SMI 18-64	162	273	170	121	89	815	2.92%
Adults SMI 65+	53	60	44	20	167	344	16.9%
Children w/ I/DD	18	1	2	1	0	22	1.91%
Adults I/DD 18-64	378	810	221	111	37	1557	30.28%
Adults I/DD 65+	94	141	60	30	11	336	60.32%
Total	861	1288	498	284	304	3235	7.21%

Individuals Living In A Licensed Setting Outside of the PIHP Region As Of Dec. 31, 2012

	# in licensed setting <6 beds	# in licensed setting – 6 beds	# in licensed setting 7-12 beds	# in licensed setting 13+ beds	Total # Per Population	% of Total Served
Children w/ SED	14	0	2	3	19	0.24%
Adults SMI 18-64	13	17	14	19	63	0.23%
Adults SMI 65+	1	2	0	2	5	0.23%
Children w/ I/DD	3	0	1	0	4	0.34%
Adults I/DD 18-64	23	15	8	7	53	1.00%
Adults I/DD 65+	2	0	0	0	2	0.34%
Total	56	34	25	31	146	0.32%

Individuals Living Independently

	Independent w/o Supports	Independent w/ Supports	Independent w/ House/ Roommates	Independent w/o House/ Roommates
Adults SMI 18-64	**9594**	**1004**	**5376**	**4890**

	Independent w/o Supports	Independent w/ Supports	Independent w/ House/ Roommates	Independent w/o House/ Roommates
Adults SMI 65+	**477**	**102**	**226**	**337**
Adults I/DD 18-64	**789**	**464**	**738**	**348**
Adults I/DD 65+	**76**	**70**	**104**	**26**

In the AFP MSHN committed to conducting an annual analysis of current capacity for offering alternatives to licensed settings. MSHN is in the process of gathering updated data from the CMHSP Participants for the above tables. The MSHN UM and Provider Network Management Committees will evaluate utilization patterns and consumer requests and satisfaction to determine the adequacy of current regional capacity. This exploration will include determining gaps within the MSHN continuum of care and areas where new living and support opportunities need to be developed. A workgroup with representation from sub-regional groups or all CMHSPs will be convened as necessary to assist with barrier identification and removal, local service/support development, and other network development activities.

In January 2014 the Centers for Medicare and Medicaid Services (CMS) published a final rule about Home and Community Based Services (HCBS) that ensures individuals receiving services through HCBS programs, which include MDCH's 1915c and 1915i programs, have full access to the benefits of community living. MSHN anticipates the ruling will impact residential services, as well as other community based programs. MSHN will work collaboratively with MDCH, other regional entities and CMHSP's to develop an implementation plan due to the CMS in 2015. Full implementation of the rules and related capacity development is required by 2019.

Employment and Community Activities

CMS underscores that the competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is the optimal outcome of Pre-Vocational/Skill-building services. MDCH expects that MSHN will embrace the above tenets and encourage its provider network to provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

The following table list data from MSHN regarding the employment and community activities for adults in the region, as reported in the 2013 AFP:

Adults In Employment And Community Activities

	Sheltered Workshop	Supported Employment*	Integrated Employment*	Volunteer job	No volunteer or paid work activity, includes retired	Total served
Adults SMI 18-64	157	164	3776	72	16093	27813
Adults SMI 65+	8	3	57	6	1326	2196

	Sheltered Workshop	Supported Employment*	Integrated Employment*	Volunteer job	No volunteer or paid work activity, includes retired	Total served
Adults I/DD 18-64	910	338	580	125	2456	5288
Adults I/DD 65+	86	8	17	4	318	585

MDCH requires PIHP's to report data from which an employment rate can be calculated. Below is a table showing the performance of the 21 county region, as calculated for purposes of this assessment, based upon the information reported by the PIHP's which were in operation prior to the formation of MSHN14.

State Performance Indicators for Competitive Employment

Time Period: 2012	Population	State Average	MSHN Region Composite Score	Difference
Percentage of adults competitively employed	MI-Adults	Not available	9.10%	n/a
	DD-Adults	Not available	8.74%	n/a
	MI/DD Adults	Not available	6.71%	n/a

In the AFP MSHN committed to establishing a Provider Network workgroup with representatives from each CMHSP Participant to evaluate utilization patterns and consumer requests and satisfaction to determine current regional capacity. The MSHN Quality Improvement Council, the MSHN Utilization Management Committee and the MSHN Provider Network Management Committees will be addressing various aspects of this issue and determining gaps within our continuum of care and areas where new opportunities need to be developed. The new CMS ruling on home and community based services will also impact employment related services, so MSHN will be concentrating its efforts on 2015, when greater clarity regarding new federal and state expectations is expected.

Substance Use Disorder Prevention and Treatment

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

- Prevent the development of new substance use disorders.
- Reduce the harm caused by addiction.

[14] MDCH State Fiscal Year 2013 Validation of Performance Measures; September 2013; prepared by Health Services Advisory Group

- Help individuals make the transition from brief experiments in recovery initiation to sustained recovery maintenance via diverse holistic services.
- Promote good quality of life and improve community health and wellness.

In the 2013 AFP, MSHN committed to implementing a ROSC, and MSHN is adopting the MDCH ROSC Guiding Principles.

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

Economies of scale in purchasing or rate setting

MSHN will explore economies of scale in purchasing, rate setting, regional capacity development and other efficiencies across the provider network. Two initiatives are already in process; specifically an analysis of inpatient rates for purposes of identifying opportunities for better value through collaborative rate setting; and a review of rates for Community Living Supports. The following tables show the results of initial survey activity conducted this year by MSHN and the CMHSP Participants:

Mid-State Health Network Inpatient Rate Assessment

HOSPITAL	CMHSP	Adult Per Diem	Child Per Diem	Notes
Allegiance Health	LifeWays	$675.00		
Alpena General	BABH	$750.00		
Bay Regional Med. Center (McLaren Bay Region)	TBHS/BABH	$650.00		
	Huron	$631.11		
	Saginaw	$631.00		
Behavioral Centers of America (BCA-Stone Crest)	TBHS	$700.00		
	CEI	$645.00		
	LifeWays	$650.00		
	Saginaw	$600.00	$625.00	
	Gratiot	$735.00		
Chelsea	LifeWays	$759.00		
Community Health/Branch Co.	LifeWays	$710.00		
Forest View	TBHS/CEI/Montcalm/Gratiot	$783.00	$814.00	
	Huron	$735.00		
	BABH	$790.00		
	Huron	$708.00	$737.00	

HOSPITAL	CMHSP	Adult Per Diem	Child Per Diem	Notes
Harbor Oaks	LifeWays	$600.00		
	TBHS	$635.00		
Havenwyck	CEI	$572.00		
	BABH/LifeWays	$600.00		
	Saginaw	$550.00		
	Gratiot	$705.00		
Healthsource-Saginaw	TBHS	$702.27		
	BABH	$675.00		
	Montcalm	$820.00		Day 0ne
	Montcalm	$760.00		Day Two +
	Saginaw	$675.00		
	Gratiot	$688.50		
Henry Ford Kingswood	TBHS	$650.00		
Herrick	LifeWays	$600.00		
Hillsdale Community Health	LifeWays	$660.00		
McLaren Lapeer Region	TBHS	$720.00		
Memorial Healthcare	TBHS	$775.00		FY 15 - $790.00
	Montcalm	$875.00		
	Saginaw	$775.00		
Memorial of Owosso	CEI	$805.00		
Mid-Michigan Midland/Saginaw	TBHS/BABH/Saginaw	$875.00		
	Gratiot	$838.00		
	Central	$875.00		
Oaklawn	CEI	$766.00		
	LifeWays	$800.00		
Pine Rest / St. Mary's	TBHS/ Lifeways/ CEI/ Montcalm/ Gratiot	$876.75	$909.75	
	Huron/Saginaw	$879.00		
Samaritan Hospital	CEI	$680.00		
	Saginaw	$630.00		
Sparrow / St. Lawrence	CEI	$771.00		Yr. 2: $789
Trinity Health / St Mary's HC	Saginaw	$847.50		
UM Health Systems	??	$900.00		
	Mean	$723.83	$771.44	
	Min	$550.00	$625.00	
	Max	$900.00	$909.75	

Community Living Services Rates

Mid State Health Network CLS Rates		
BABH	$3.35	Unit
CEI	$3.92	Unit
CMHCM	$4.03	Unit
GCCMHA	$3.87	Unit
HBH	$3.86	Unit
ICCMHA	$4.06	Unit
LCMHA	$4.30	Unit
MCBH	$3.16	Unit
NCMHA	$4.57	Unit
SCCMHA	$3.80	Unit
ShiaCMH	$3.51	Unit
TBHS	$2.68	Unit
Average Rate	**$3.68**	Unit
Other CMH CLS Rates		
Lenawee	2.50	Unit
Northern Lakes	4.50	Unit
North Country	3.59	Unit
Network 180	4.95	Unit
Livingston	3.85	Unit
Average Rate	**$3.88**	Unit

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

Recommendations/Conclusions

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

1. Prepare the regional provider network for assumption of responsibility for substance abuse services, including the addition of MI-Child, PA 2 and Block Grant programs.
2. Continue to gain clarification regarding expected utilization and required provider qualifications, such as alcohol and drug program licensure, for Medicaid Expansion program.

3. Continue to advocate for adequate coverage and funding for uninsured behavioral health populations.
4. Continue to support provider network capacity to offer key evidence based programs, such as recovery and trauma informed programming.
5. Determine next steps relative to inpatient admission refusals and additional regional crisis response/ inpatient alternative capacity options.
6. Monitor regional autism service capacity and utilization to ensure sufficient network capacity to meet consumer demand.
7. Continue to develop provider network competency and access to integrated health care information.
8. Once the system changes expected as a consequence of the HCBS Final Rule are more understood, develop a plan of action to alter provider capacity for residential, employment and other community living related services.
9. Monitor out-of-region placements for return to in-region services where feasible and appropriate.
10. Continue to address reciprocity between CMHSP Participants relative to requirements applied to sub-contracted service providers.