Mid-State Health Network | 530 W. Ionia Street | Lansing, MI 48933 | 517.253.7525| F: 517.253.7552 | www.midstatehealthnetwork.org


## From the Chief Executive Officer's Desk

*Joseph Sedlock*

As people, I think we all strive – sometimes in adaptive and healthy ways and sometimes not – to reduce our fatigue, to relieve our stress, reduce our worries, and to live with renewed purpose and a greater sense of hope.

I am a work in progress and am still working to find more adaptive and healthier ways to do these things. And I have been thinking about the resilience I see in so many others with perhaps even greater stress, worry, and cumulative trauma than me.

Resilience is "the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands[1]."

"Self-care" is a resiliency strategy. It includes taking a walk, spending time in the outdoors, spending time alone, spending time with others, reading, physical exercise, cooking, cleaning, meditating, art, making better sleep a priority, improving one's relationships, practicing gratitude, staying connected, and many other individualized actions. Taken together, self-care is a path to coping with or getting through adversities.

Some of the best role models of resiliency are the people we serve and support. Most of these people have lived with and grown through high doses of trauma and adversity. I am awed by the resiliency they demonstrate! The ingenuity, creativity, strength, character, and resolve they have built in finding strategies to adapt, survive, and thrive is amazing. These are among the strongest people I know.

Please join me in really seeing and then celebrating the resiliency of the people we serve and support, and other role models around us. They have a lot to teach. I have a lot to learn.

[1] American Psychological Association. Resilience. Accessed 11/29/2023.

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

## Organizational Updates

Amanda Ittner, MBA
Deputy Director

### Medicaid Health Plan Rebid

On October 30, the Michigan Department of Health and Human Services (MDHHS) announced the procurement (rebid) for the Comprehensive Health Care Program contract for Michigan's Medicaid Health Plans (MHP). The rebid includes initiatives identified by many stakeholders that informed the five MIHealthyLife strategic pillars:

- Serve the Whole Person, Coordinating Health and Health Related Needs.
- Give All Kids a Healthy Start
- Promote Health Equity and Reduce Racial and Ethnic Disparities.
- Drive Innovation and Operational Excellence.
- Engage Members, Families and Communities.

Responses from bidders are due on January 16, 2024, with expected Medicaid Health Plan contracts effective on October 1, 2024.

#### MHP Coordination with the Public Behavioral Health System

MSHN currently works with eight (8) MHPs, which could change after MDHHS announces the selection next year. The PIHP contract with MDHHS includes many elements to address coordination with the Medicaid Health Plans in the region and includes requirements to:

- Have written functioning Coordination agreements with each Medicaid Health Plan in MSHN's service area

that must address the integration of physical and mental health services.
- Include the participating health plans in the regional consumer handbook.
- Work with the state to develop initiatives to better integrate services and provide incentives to support behavioral health integration.
- Implement practices to encourage all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services.
- Adhere to improvement and benchmarks for joint metrics that account for 30% of the withhold (.75% of revenue).

During FY 2023, MSHN had integrated care plans for 50 individuals in partnership with the 8 Medicaid Health Plans in-region (Blue Cross Complete, Meridian Health Plan, Molina, United Health Care, Aetna, Priority Health, HAP Empowered, and McLaren). ***75% of individuals experienced a reduction in Emergency Department (ED) utilization as compared to the 12-month period prior to being opened for care coordination.***

**Anticipated Changes in the Public Behavioral Health System identified in the Rebid**

While the public behavioral health system responsibility for the specialty behavioral health system is not significantly affected by the rebid, there are some changes as noted below:

- Clarification regarding the MHP obligation to pay for crisis intervention services in Emergency Departments for persons with Severe Mental Illness not associated with the PIHP.
- Continuation of Joint Care Management with PIHPs but additional focus on children in foster care.
- Stronger coordination requirements for children in foster care, including connections between care managers, health liaisons, foster care workers, MDHHS, and PIHP/CMH providers.
- Additional focus on addressing social determinants of health.

MSHN as well as our CMHSP partners continue our efforts on improving care coordination for individuals served that includes stronger collaboration with the MHP's. We anticipate the results of the rebid will strengthen those partnerships and support efforts included in the MSHN strategic plan, including focus on access, children services, health equity and social determinants of health.

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

## Information Technology

Steve Grulke
Chief Information Officer

The Mid-State Health Network (MSHN) Information Technology (IT) team worked with Zenith Technology Solutions (ZTS) to improve the reporting functionality related to integrated health homes key performance indicators. In order for the reports to pull information related to the integrated health initiatives, the reports need to have a process to identify the individuals participating in the initiative. This sort of parsing out of the participants is completed using what is called an attribution file. This file indicates whether an individual served is enrolled in these areas. The attribution file was recently updated to allow for designation of enrollment in Certified Community Behavioral Health Clinic (CCBHC) and Behavioral Health Home (BHH). These new fields are now populated for everyone in the attribution file.

The IT team also worked on the office space reduction. When Mid-State Health Network (MSHN) decided not to renew the lease for suites B and C, the IT team was tasked with removing all the workstations and other equipment in those areas. Part of this move was to reconfigure the spaces in suites E and F. Once these areas were organized as desired, the IT team had to set up workstations to match the layout. The remaining equipment needed to be evaluated for usefulness. Some items were determined to be worthy of storage for future use as replacement pieces and others were slated for recycling or disposal. One large scale printer was donated to Mid-Michigan Recovery Services. Additional office furnishings were given to other service providers. The items that were put in storage were placed on new shelves that needed to be assembled. An inventory of this equipment is still in progress.

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

## Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

As reported in October 2023, MSHN's Finance Team is continuing Fiscal Year 2023 close-out activities.

Two items reported in October 2023, are highlighted directly below this month for ongoing efforts. Both items assist with financial planning and have demonstrated the importance of managing and reviewing the region's fiscal status at multiple times throughout the fiscal year to monitor fluctuations. The Interim Financial Status Report (FSR) (item 2) is utilized in calculating Interim cost settlement figures (item 1). Although the region's fiscal position was analyzed, reviewed, and discussed at various points in FY 2023, the two items noted below presented a different picture than what was originally anticipated. MSHN does not anticipate FY 2023 Medicaid Savings carryforward. Medicaid Savings is generated when the region's expenses [Community Mental Health Service Providers (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs)] are less than the current fiscal year's revenue. For the first time in nine years, we will begin FY 2024 with an anticipated deficit. Fortunately, the deficit is marginal and can be covered with the Internal Service Fund.

1. MSHN and CMHSPs Interim Cost Settlement-MSHN is obligated to cover allowable CMHSP Medicaid and Healthy Michigan Plan (HMP) expenses. Any dollars in excess of CMHSP expenses must be returned to MSHN. The region typically completes 85% of its preliminary cost settlement transactions in mid-November. If CMHSP expense exceeded revenue provided by MSHN, the PIHP is responsible for sending additional funds to cover the costs.
2. MSHN and Michigan Department of Health and Human Services (MDHHS) Interim Reporting-November is the month MSHN also submits an interim Financial Status Report (FSR) to MDHHS. This report includes a breakdown of Medicaid and HMP expenses by CMHSP and MSHN. It outlines revenue, expenses, potential savings amounts, and Internal Service Fund (ISF) calculations.

In addition to the items above, MSHN's Finance Team is engaged in the following:

1. Direct Care Worker (DCW) Attestations - MSHN is collecting attestations from applicable Substance Use Disorder (SUD) providers to ensure workers rendering qualified services as defined by MDHHS received an extra $2.35 per hour.
2. Staffing Stabilization Reviews - MSHN is reviewing staffing stabilization dollars disbursed to SUD providers to ensure funds were used for the purpose intended. MSHN's board approved $8M regionally to support providers experiencing staffing crisis resulting from the public health emergency (PHE). Providers qualified for funds if they rendered Medicaid services, and the service locations were within MSHN's 21-county region.

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

## Behavioral Health

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

### Introducing the Psychiatric Residential Treatment Facility

The Psychiatric Residential Treatment Facility (PRTF) is new to the state of Michigan. This is a residential treatment service for youth under the age of 21 years who are experiencing mental illness, substance abuse, or severe emotional disturbance. The PRTF is designed to provide short-term, intense, focused mental health treatment with an eventual successful return of the youth to the community. The length of stay for a youth could be up to 90 to 180 days as appropriate to the individualized plan of service (IPOS) that identifies the needs and goals of the youth and the ongoing medical necessity, amount, duration, and scope of the supports and services planned to be provided. The youth and the family are the integral focus of active, culturally competent, and strengths-based services. PRTF is not a residential service, but rather it is a non-hospital facility that provides intensive inpatient level care in a residential setting while under the direction of a physician. Due to the youth's prevailing behavioral health needs, as documented in the youth's Individual Plan of Service (IPOS), is still in need of an inpatient level of treatment without the requirement for related intensive safety, security, and monitoring that is characteristic of an inpatient psychiatric hospital.

The PRTF is a structured, therapeutic environment providing individualized and intensive treatment 24 hours a day, 7 days a week. Often, youth in behavioral health care have experienced the destructive effects of trauma. Treatment in the PRTF setting focuses on strength and resiliency-based factors as a response to the presence of trauma and the role it has played as a disruptive force in the life of the youth. Youth in foster care experience multiple traumas, due to being in different placements, a lack of connectedness to primary caregivers, and a sense of ongoing marginalization, and loss. Trauma is a major contributor to youth behavioral and mental health issues. The PRTF system of care focuses on resiliency factors designed to address the negative effects of trauma. This comprehensive care will include skill building, family engagement, individual and therapeutic interventions, crisis response and de-escalation training as well as work with multiple credentialed and trained staff.

Additionally, the PRTF will work with the Michigan Department of Health and Human Services (MDHHS), the Pre-Paid Inpatient Health Plan (PIHP) and the Community Mental Health Services Program (CMHSP) to develop a successful transitional process that involves discharge to a less restrictive or family-based setting. This process includes identifying plans for aftercare and referrals for continuity of care. Depending on the needs of the youth and family, the IPOS is adjusted to reflect targeting referrals to school, ongoing treatment, and inclusion of other community-based providers. Appropriate discharge planning is a critical feature to the PRTF process and will begin at the onset of treatment. This can be adjusted and refined as treatment progresses.

A request for PRTF admission is submitted by the PIHP/CMHSP or state inpatient facility to MDHHS. MDHHS will make the authorization and approval decision for PRTF services. They are the payer for PRTF services and the PIHP/CMHSP will work with them to address all admission and continuing stay responsibilities to ensure that proper care is driven by medical necessity and need criteria as reflected in the youth's IPOS. The PRTF is an important residential treatment service fitting on the behavioral healthcare care continuum at the inpatient level. The MDHHS PRTF policy went into effect as of December 1, 2023, and Mid-State Health Network looks forward to working with its partner CMHSPs and MDHHS in making the PRTF a practical and positive inpatient treatment alternative.

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

## Utilization Management & Care Coordination

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

## Supporting Veterans and Military Families

In recognition of Veteran's Day (11/10/2023), I asked MSHN's regional veteran navigator, Tammy Foster, if she would be willing to co-author this article and take a deeper dive into the complex challenges faced by veterans and the unique role that veteran navigators (VN's) play in helping them to address those challenges. VN's assist veterans and military families with accessing behavioral health and substance use services, as well as community resources for other needs like food insecurity and homelessness. Perhaps most importantly, though, veteran navigators understand the unique challenges and experiences of veterans since they are also veterans themselves.

*Tammy Foster, Regional Veteran Navigator:*
*"My two short years at MSHN have been spent learning and understanding the complexities of substance use disorders (SUD), behavioral health and co-occurring disorders, suicide, and how to help veterans in those spaces. The word 'help' is defined differently depending on a person's situation.*

*Sometimes a veteran is in crisis and doing things FOR them like making calls on their behalf or together with them on the phone is 'help.'*

*Sometimes a veteran just needs minimal 'help' like a list of resources and contact names and they are off and running on their own.*

*Sometimes 'help' is an understanding voice and a listening ear with no time stamp attached to it. It is veteran to veteran talk. No advice, no resources, just an opportunity to reflect and process one's current situation and what led them down this path. Sometimes it means the caller goes back to a specific incident that happened to them in the military and works their way forward to the present day and reason for the call.*

*I often get calls from veterans who are reluctant to enroll in Veteran's Affairs (VA) healthcare. They might not know if they are eligible, or they do not enroll because they think it would take that benefit away from another veteran who needs it more, or they do not enroll due to a negative experience with the VA or with the military in general. It is important to take the time to really talk about that and to go over potential benefits they earned and programs they may be eligible for by enrolling in VA healthcare. Enrolling in VA healthcare makes other programs available to the veteran such as housing/homeless services, geriatric services, community care, caregiver support, and many more, but enrolling in VA healthcare should not become a barrier to obtaining SUD or mental health services.*

*I continually work to collaborate with the 3 VA hospitals and the numerous VA community-based outpatient clinics that serve veterans in the MSHN region. I have requested that if a veteran cannot get services at the VA for any reason that the VA will connect the veteran directly to me or another veteran navigator to see if they are eligible for services through the public mental health system. I found that making these connections, having problem solving meetings and sharing what we can do as a PIHP for eligible Medicaid, Healthy Michigan or Block Grant recipients can be life changing. If veteran service providers know about each other, we can often find a solution for any person who wants treatment and make it as barrier-free as possible. My goal is that any veteran who wants help, gets help, and does not have to wait.*

*For example, recently a veteran was suffering from alcohol use disorder and his spouse took him to the VA hospital, unaware that the VA hospital does not provide detox services. The VA sent him to a local community hospital which kept him for 24 hours until he was stable then sent him home with medication and told him to contact the VA for an evaluation for SUD residential treatment. When he called the VA, they did not have a bed for him. He hung up and considered drinking again but decided to try calling me since my number was on the list of resources that he was given by a patient advocate at the VA. He and his wife called and told the story of what they had been through and that he desperately wanted help to stop drinking. He was hopeful to get a bed at the VA, only to find out one was not available. Since he was already enrolled in Medicaid and he was not able to get the needed services at the VA, I connected him with a MSHN SUD provider where he was able to get help and start services the very same day."*

Please join MSHN in showing our appreciation for the excellent work being done by veteran navigators and veteran peer supports in our region to ensure that veterans and military families are able to get the help they need, when they need it.

Regional Veteran Navigator:
Tammy Foster, Region 5, MSHN

County Veteran Navigators:
Matthew Clark, Saginaw, Bay, Midland, Saginaw County Community Mental Health
Randy Evans, Hillsdale and Jackson, LifeWays
Jonathan Ferguson, Clinton, Eaton, Ingham Community Mental Health

Veteran Peer support:
Brandon Hetherton, Clinton, Eaton, Ingham Community Mental Health

For more information and resources for veterans and military families, please contact Tammy.Foster@midstatehealthnetwork.org or 517-483-2742.

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

## Substance Use Disorder Policy, Strategy and Equity

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

### From Trauma-Informed to Inter-Generational Trauma

On November 30, 2023, I joined a panel of national experts in Lansing's Union Missionary Baptist Church to talk about communities healing from trauma. The keynote was delivered by Dr. Robert Anda, chief architect of the Adverse Childhood Experiences (ACE) study conducted by Kaiser-Permanente in the mid-1990s. The ACEs study was transformative to how behavioral health professionals and the health care industry more broadly defined trauma and for how it identified a direct correlation between childhood trauma and negative health outcomes later in life.

Following Dr. Anda's keynote, I discussed how powerful research like the ACEs study which expanded our field's understanding of trauma in the late 20th century coincided with on-the-ground historical events that highlighted trauma, from the Vietnam War and Post-Traumatic Stress Disorder (PTSD) to trauma following domestic violence and sexual assault (which was not new but was taboo to discuss until the Women's Movement opened that door), the War on Drugs which led to mass incarceration and urban violence which traumatized communities of color disproportionately, and international conflicts from Northern Ireland to Iraq to Somalia.

These traumatizing historical events combined with powerful research like the ACE studies, drove the behavioral health field to become what we now call trauma-informed. As a therapist and school social worker, my clinical work was informed by ACEs research as is true for 100s of behavioral health professionals across our region every day.

Developing a trauma-informed system of care, however, until recently primarily applied that trauma lens to behavioral health protocols at the *individual* or *household* level. It rarely incorporated an understanding of historical trauma that affects entire communities, demographic groups and/or nations, often for generations.

Intergenerational trauma was first identified in children and grandchildren of Holocaust survivors[1], but many populations before and since in Africa, Asia, Australia, Europe and the Americas have seen collective traumas passed down through the generations,[2] from both epigenetic effects—i.e., how trauma and stress impact gene expression—and in how survivor communities create meaning from collective traumas that informs their group identity.[3]

Recent 21st century events—from the 9/11 attacks to mass shootings in the U.S. and today's Israeli-Palestinian war—precipitated spikes in Islamophobic and/or antisemitic violence[4]. But communities of color have been living with both historical trauma and *ongoing current trauma* that's revisited daily which compounds health impacts in those communities.

Any good clinician knows that sweeping trauma under the rug makes people sicker. Denial manifests in substance use disorders, severe mental health disorders and negative physical health outcomes. As individuals start to open up about their past trauma, they begin to heal.
Similarly, ignoring trauma makes societies sick. In places like South Africa after apartheid or Peru and Guatemala following state violence towards indigenous populations, Truth & Reconciliation Commissions helped societies begin to heal as they opened up about their collective trauma.

To support healing in our communities, our region and our nation, it's critical therefore that we resist efforts to strip our schools, universities and libraries from teaching factual history. Whether that's the traumas of slavery and Jim Crow or destruction of Native American communities, the Holocaust and other historical injustices, these historical realities have traumatized generations of our friends, family, and neighbors with ongoing health impacts to this day.

Sitting next to me on the panel on November 30th was Representative Felicia Brabec; Chair of the Michigan House Health Policy subcommittee on Behavioral Health, who's been an important ally of the public behavioral health system in Michigan. She and the other panelists concurred that to truly address the impacts of trauma at both the individual *and* the community level, it must be tackled not only clinically and through truth-telling in our educational institutions, but with legislation, policies and institutional changes that break down barriers, provide resources and allow communities the space to heal.

For additional reading, see here.

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

## Substance Use Disorder Providers and Operations

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

### Combination Drug Use Increases Overdoses

According to the National Institute for Health Care Management (NIHCM), the overdose crisis is evolving rapidly, with the current emphasis placed on the impact of multiple drugs commonly found in combination. Per available data, the primary substances being found in combination include xylazine, cocaine, methamphetamine, and other opioids (i.e. heroin).

Fentanyl overdose deaths involving xylazine have increased 276% from 2019 (3%) to 2022 (10.9%) (Figure 1). States with the highest percentage of fentanyl deaths involving xylazine include Maryland (28%), Connecticut (26%), and Pennsylvania (23%). Xylazine, also known as “tranq,” is a non-opioid sedative. Xylazine can cause sedation, dangerously low blood pressure, slowed heart rate, difficulty breathing, severe withdrawal symptoms, wounds that can become infected, and death (NIHCM, 2023

Figure 1


While synthetic opioids continue to be the leading contributor to overdoses, the presence of stimulants like cocaine and methamphetamine have increased as well (Figure 2). The latest data on substance combinations indicates that 74% of cocaine deaths and 58% of methamphetamine deaths involved a synthetic opioid (Figure 3). Overdose death rates rose amongst all ethnic groups, but Native Americans and Alaska Natives had the highest amount from opioids and meth, while African Americans had the highest from cocaine (Figure 4). Drug overdose death rates are highest for adults ages 35-44 in the United States with 25–34-year-olds the second highest, and 45–54-year-olds the third highest (Figure 5). Drug overdose deaths also vary geographically in the United States for opioids, cocaine, and methamphetamine (Figure 6).

Figure 2

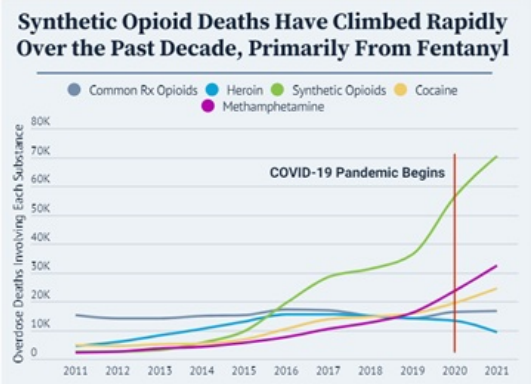



Figure 3

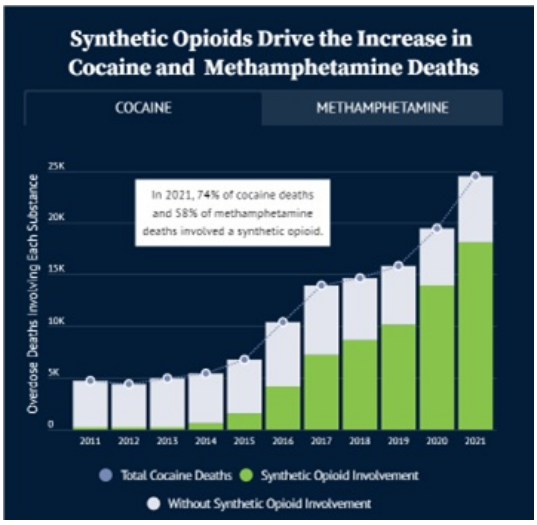



Figure 4

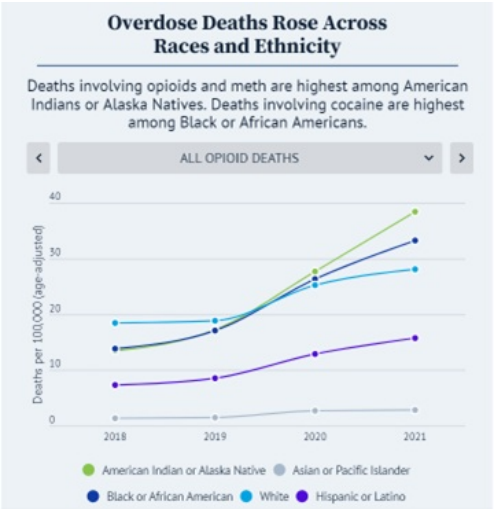



Figure 5

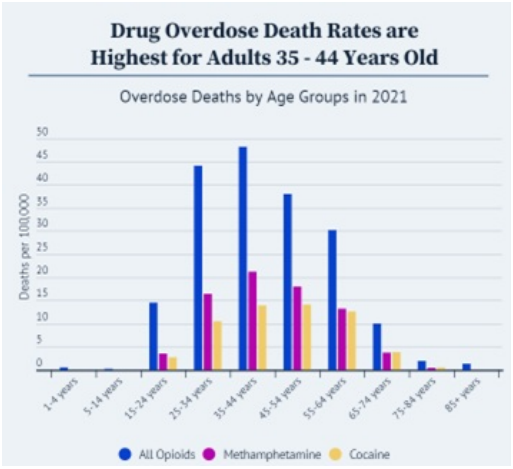
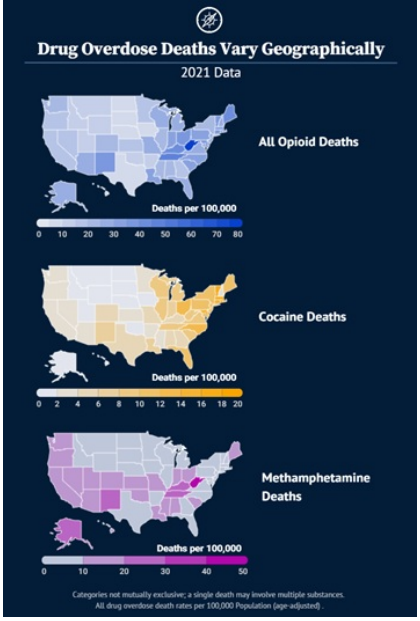



Figure 6

The Substance Use Disorder (SUD) Clinical Team has implemented several evidence-based strategies to assist with impacting and reducing the occurrence of drug overdoses in the MSHN region in the areas of prevention, treatment, recovery, and harm reduction. This has included implementing strategies




such as increasing the availability of fentanyl and xylazine test strips, expanding naloxone access and training, supporting syringe services and harm reduction programs, increasing access and availability of Medication Assisted Treatment (MAT) programs, working to expand and diversify the SUD provider network workforce, offering evidence-based practice trainings to strengthen the clinical workforce, and working to reduce stigma for those seeking SUD services and supports.

Source: Latest Data: Combination Drug Use Increases Overdoses (nihcm.org)

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

## Quality, Compliance & Customer Service

Kim Zimmerman, MBA-HC, LBSW, CHC
Chief Compliance and Quality Officer

### New Program Integrity Contract Requirements

The requirements for a compliance program are identified in the 42 Code of Federal Regulations (CFR) 438.608 and state that the Pre-Paid Inpatient Health Plan (PIHP) must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.

The Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the Contractor and all Subcontracted Entities/Network Providers consistent with the Contract and the requirements under 42 CFR 438.608.

The 42 Code of Federal Regulations (CFR) 438.608 states that a compliance program must include, at a minimum, the following elements:

- Written policies, procedures and standards of conduct that articulate the organizations commitment to comply with all applicable requirements and standards under the contract.
- The designation of a Compliance Officer responsible for developing and implementing policies, procedures and practices designed to ensure compliance with requirements.
- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.
- A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract.
- Effective lines of communication between the compliance officer and the organization's employees.
- Enforcement of standards through well-publicized disciplinary guidelines.
- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

The MDHHS-OIG has included additional requirements in the Fiscal Year 2024 MDHHS/PIHP Contract that the PIHP compliance program must adhere to. The following are the substantial additions but are not inclusive of all the new requirements that are defined within the contract.

- Policies and procedures the PIHP must have as well as the content of the policies and procedures.
- Duties and responsibilities of the Compliance Officer.
- Composition and responsibilities of the Compliance Committee.
- Training requirements and who must be trained, how often and the content.
- Disciplinary guidelines for non-compliance and failure to detect non-compliance during routine observation and/or due diligence.
- Guidelines for internal auditing.
- Regular, periodic reviews of the compliance program to determine overall effectiveness to be completed a minimum of annually.
- Staff questionnaire regarding observed violations of the compliance program and code of conduct.

- Verification process that services have been represented as delivered by network providers and were received by enrollees.
- The operation of a distinct Fraud, Waste, and Abuse Unit, Special Investigations Unit (SIU).
- Data mining activities using statistical models, complex algorithms, and pattern recognition programs to detect possible fraudulent or abusive practices.
- Risk-based auditing and monitoring activities of provider transactions, including, but not limited to, claim payments, vendor contracts, credentialing activities and Quality of Care/Quality of Service concerns that indicate potential Fraud, Waste, or Abuse.
- Presentation of all suspected fraud referrals to the OIG and the Attorney General – Health Care Fraud Division (AG-HCFD).
- Submission of an annual Program Integrity Report containing improper payments, overpayments recovered, and costs avoided for the program integrity activities for the current and upcoming year.
- Submit to MDHHS-OIG a Quarterly Provider Prepayment Review Placement Log for providers placed on prepayment review as a result of a program integrity activity.
- Issue Provider Manual and Bulletins or other means of Provider communication to the providers of medical, behavioral, dental and any other services covered under contract. The manual and bulletins must serve as a source of information to providers regarding Medicaid covered services, policies and procedures, statutes, regulations, and special requirements to ensure all contract requirements are being met.
- Review its Provider Manual, Bulletins and all Provider policies and procedures at least annually to ensure that current practices and requirements are reflected in the written policies and procedures.
- Employ or contract with a Special Investigations Unit (SIU) Manager/Liaison.

The addition of these new requirements will require both additional time and resources and MSHN is reviewing to determine our capacity and ability to provide the required information and perform the new functions.

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

## Our Mission:

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

## Our Vision:

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

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