Mid-State Health Network

Board of Directors Meeting ~ November 10, 2026 ~ 5:00 p.m.

Board Meeting Agenda

MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

MEMBERS OF THE PUBLIC AND OTHERS UNABLE TO ATTEND IN PERSON CAN PARTICIPATE IN THIS MEETING VIA TELECONFERENCE
Teleconference: (Call) 1. 312.626.6799; Meeting ID: 379 796 5720

1. Call to Order

   Remind members of the Board Member Conduct Policy

   "B. On matters of general comment or comments of a personal nature, after being recognized by the Chairperson, each Board member may speak on items presently before the Board twice, for up to three (3) minutes each time. The Chairperson may extend an additional (3) minute speaking period at the request of the individual board member or if duly authorized by board action. Any member can make a motion to suspend the rule, which motion must be seconded. If the motion passes, the rule shall be suspended for the duration of consideration of the item before the Board.

   C. On matters involving questions about an item presently before the Board, there shall be no limit on board member questions or other inquiry.

   D. On matters of debate involving significant differences in views among board members about an item presently before the Board, the Board Chair may designate a timeframe within which the debate is to occur. The Board, by motion duly seconded and adopted, may extend the period for debate. Any member can motion to close debate, which motion must be seconded and is not debatable. If the motion passes, such debate shall terminate."

2. Roll Call

3. **ACTION ITEM:** Approval of the Agenda

   Motion to Approve the Agenda of the November 10, 2026 Meeting of the MSHN Board of Directors

4. Public Comment (3 minutes per speaker)

5. **ACTION ITEM:** MSHN External Compliance Examination Report Presentation (*Page 4*)

   Motion to receive and file the Report on Compliance of Mid-State Health Network for the year ended September 30, 2025

6. **ACTION ITEM:** Consideration of MSHN Fiscal Year 2027 Budget Amendment (*Page 13*)

   Motion to Approve the MSHN Fiscal Year 2027 Budget Amendment as presented

7. Satisfaction Surveys Presentation (*Page 16*)

MSHN
Mid-State Health Network

Our Mission:

To ensure access to high-quality, locally-delivered, effective and accountable public behavioral health and 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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Board of Directors Meeting Materials:
or visit MSHN's website at:
https://midstatehealthnetwork.org/stakeholders-resources/board-councils/board-of-directors/fy2027-meetings

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Upcoming FY27 Board Meetings
Pending Board Approval

January 5, 2027
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

March 2, 2027
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

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Policies and Procedures
or Visit
https://midstatehealthnetwork.org/provider-network-resources/provider-requirements/policies

8. Chief Executive Officer's Report *(Page 41)*

9. Deputy Director's Report *(Page 54)*

10. Chief Financial Officer's Report

    Financial Statements Review for Period Ended September 30, 2026 *(Page 65)*

    ACTION ITEM: Receive and File the Preliminary Statement of Net Position and Statement of Activities for the Period ended September 30, 2026, as presented

11. **ACTION ITEM:** FY27 Contracts for Consideration/Approval *(Page 74)*

    The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2027 Contracts, as presented on the FY 2027 Contract Listing

12. Chairperson's Report

13. CEO Retirement and Succession

14. **ACTION ITEM:** Consent Agenda

    Motion to Approve the documents on the Consent Agenda

    - 14.1 Approve Board Meeting Minutes 09/01/2026 *(Page 76)*
    - 14.2 Approve Public Hearing Minutes 09/01/2026 (*Page 80*)
    - 14.3 Receive Board Officer Briefing Notes 08/21/2026 *(Page 82)* and 10/16/2026 *(Page 84)*
    - 14.4 Receive Draft Policy Committee Meeting Minutes 09/01/2026 *(Page 85)*
    - 14.5 Receive SUD Oversight Policy Board Meeting Minutes 08/19/2026 *(Page 87)*
    - 14.6 Receive Operations Council Key Decisions 09/21/2026 *(Page 90)* and 10/19/2026 *(Page 94)*
    - 14.7 Approve the following policies:
      - 14.7.1 Compliance and Program Integrity *(Page 96)*
      - 14.7.2 Compliance Reporting and Investigations *(Page 99)*
      - 14.7.3 Critical Incidents Policy *(Page 102)*
      - 14.7.4 Incident Review for Substance Use Disorder Providers *(Page 107)*
      - 14.7.5 Medicaid Event Verification Policy *(Page 112)*
      - 14.7.6 Serious Emotional Disturbance Waiver *(SEDW) (Page 115)*

15. Other Business

16. Public Comment (3 minutes per speaker)

17. Adjourn

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FY27 MSHN Board Roster

Current as of 05/20/2026

Last Name	First Name	Email 1	Email 2	Phone 1	Phone 2	Appointing CMHSP	Term Expiration
Brodeur	Greg	brodeurgreg@gmail.com		989.413.0621		Shia Health & Wellness	2027
Collins	Kevin	kevin.collins@lifewaysmi.org		517.425.2446		LifeWays	2028
Conley	Patrick	conleypat@gmail.com		585.734.6847		BABHA	2028
DeLaat	Ken	kend@nearnorthnow.com		231.414.4173		Newaygo County MH	2029
Garber	Cindy	cgarber@shiawassee.net		989.627.2035		Shia Health & Wellness	2027
Griesing	David	davidgriesing@yahoo.com		989.545.9556	989.823.2687	TBHS	2027
Grimshaw	Dan	midstatetitlesvcs@mstsinc.com		989.823.3391	989.823.2653	TBHS	2029
Hicks	Tina	tmhicks64@gmail.com		989.576.4169		GIHN	2027
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2027
McPeek-McFadden	Deb	deb2mcmail@yahoo.com		616.794.0752	616.343.9096	The Right Door	2027
O'Boyle	Irene	irene.oboyle@cmich.edu		989.763.2880		GIHN	2029
Peasley	Kurt	peasleyhardware@gmail.com		989.560.7402	989.268.5202	MCN	2027
Phillips	Joe	joe44phillips@hotmail.com		989.386.9866	989.329.1928	CMH for Central	2029
Purcey	Linda	dpurcey1995@charter.net		616.443.9650		The Right Door	2028
Raquepaw	Tracey	tl.raquepaw@icloud.com	raquepawt@michigan.gov	989.737.0971		Saginaw County CMH	2028
Scanlon	Kerin	kscanlon@tm.net		502.594.2325		CMH for Central	2028
Schultz	Lori	ljodas63@gmail.com		616.293.8435		Newaygo County MH	2028
Schumacher	Pam	pschumacher82@gmail.com		989.415.9497		BABHA	2029
Smith	Mike	tybacore@gmail.com		989.251.0891		HBH	2029
Stapleton	Jack			989.225.5566		HBH	2029
Washington	Dwight	washindwi@gmail.com		517.974.1658		CEI	2028
White	Jason	jasoncardellwhite@gmail.com		517.648.5638		CEI	2028
Williams	Joanie	joanie.williams1977@gmail.com		989.860.6230		Saginaw County CMH	2029
Woods	Ed	ejw1755@yahoo.com		517.392.8457		LifeWays	2027

Administration:

Sedlock	Joe	joseph.sedlock@midstatehealthnetwork.org	517.657.3036	989.529.9405
Ittner	Amanda	amanda.ittner@midstatehealthnetwork.org	517.253.7551	989.670.8147
Thomas	Leslie	leslie.thomas@midstatehealthnetwork.org	517.253.7546	989.293.8365
Kletke	Sherry	sheryl.kletke@midstatehealthnetwork.org	517.253.8203	517.285.5320

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Background

The Compliance Examination was conducted by Roslund Prestage and Company (RPC) firm for the fiscal year ending September 30, 2025. The intent of the review is for auditors to express an opinion on the PIHP's compliance with the Medicaid Contract. In addition to the tests performed at the PIHP level, the process also includes incorporation of each CMHSP's Compliance Examination results. RPC's auditor presented the report results and allowed questions from board members. MSHN did receive minor findings and implemented corrective action to address issues.

Recommended Motion:

Motion to receive and file the "Report on Compliance" of Mid-State Health Network for the year ended September 30, 2025.

Mid-State Health Network

Report on Compliance
September 30, 2025



RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT ACCOUNTANT'S REPORT ON COMPLIANCE

To the Members of the Board
Mid-State Health Network
Lansing, Michigan

Report On Compliance
We have examined Mid-State Health Network's (the PIHP) compliance with the compliance requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to the Medicaid Contract and/or General Fund (GF) Contract for the year ended September 30, 2025.

Management's Responsibility
Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to the Medicaid Contract and/or GF Contract.

Independent Accountants' Responsibility
Our responsibility is to express an opinion on the PIHP's compliance with the Medicaid Contract and/or GF Contract based on our examination of the compliance requirements referred to above.

Our examination of compliance was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the PIHP complied, in all material respects, with the compliance requirements referred to above.

An examination involves performing procedures to obtain evidence about the PIHP's compliance with the specified compliance requirements referred to above. The nature, timing, and extent of the procedures selected depend on our judgement, including an assessment of the risk of material noncompliance, whether due to fraud or error. The nature, timing and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the compliance requirements described in the *Compliance Examination Guidelines* issued by the Michigan Department of Health and Human Services.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to the engagement.

We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion. However, our examination does not provide a legal determination of the PIHP's compliance.

Opinion on Each Program
In our opinion, the PIHP complied, in all material respects, with the specified compliance requirements referred to above that are applicable to the Medicaid Contract and/or GF Contract for the year ended September 30, 2025.

Other Matters
The results of our examination procedures disclosed instances of noncompliance, which are required to be reported in accordance with Compliance Examination Guidelines, and which are described in the accompanying Comments and Recommendations as item 2025-01. Our opinion is not modified with respect to these matters.

The PIHP's responses to the noncompliance findings identified in our examination are described in the accompanying Comments and Recommendations. The PIHP's responses were not subjected to the examination procedures applied in the examination of compliance and, accordingly, we express no opinion on the responses.

Purpose of this Report
This report is intended solely for the information and use of the Board and management of the PIHP and the Michigan Department of Health and Human Services and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

Roslund, Prestage & Company, P.C.

Roslund, Prestage & Company, P.C.
Certified Public Accountants

June 30, 2026

Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract and/or General Fund Contract:

None

Material noncompliance with the provisions of laws, regulations, or contracts related to the Medicaid Contract and/or General Fund Contract:

None

Known fraud affecting the Medicaid Contract and/or General Fund Contract:

None

During our compliance audit, we may become aware of matters that are opportunities for strengthening internal controls, improving compliance, and increasing operating efficiency. Also, we may identify compliance matters that are expected to have an impact greater than $25,000 but are not individually or cumulatively considered to be material weaknesses in internal control over the Medicaid Contract and/or General Fund Contract. Furthermore, we consider these matters to be immaterial deficiencies, not findings. The following comments and recommendations are in regard to those matters.

2025-01 FSR Examination Adjustments

Criteria or specific requirements:
The Contractor must provide the financial reports to the State as listed in the Medicaid Contract. Forms, instructions and other reporting resources are posted to the MDHHS website. (Contract Schedule E)

Condition:
The PIHP is not in compliance with FSR instructions.

Examination adjustments:
Examination adjustments were made to sections of the FSR. See detailed descriptions of these examination adjustments in the Explanation of Examination Adjustments section of this report.

Context and perspective:
Context and perspective have been included in the description shown on the Explanation of Examination Adjustments page of this report.

Effect:
See detailed descriptions of these examination adjustments in the Explanation of Examination Adjustments section of this report.

Recommendations:
The PIHP should review its current policies and procedures regarding the preparation and review of the Financial Status Report to assure that all amounts are reported in compliance with the reporting instructions. Specifically, a review of the final draft should be performed by a knowledgeable person who is independent from the original preparation of the report(s).

Views of responsible officials:
Management is in agreement with our recommendation.

Planned corrective action:
Mid-State Health Network will continue to review instructions and verify reported information with each individual CMHSP prior to submission of the final Financial Status Report.

Responsible party:
Amy Keinath, Finance Manager

Anticipated completion date:
February 28, 2027

CMHSP Examined Amounts

The following examination adjustments were made to agree MSHN's examined FSR to the examined amounts reported for the CMHSPs:

- Financial Status Report - Medicaid Row A115 Medicaid Managed Care - Affiliate Contracts (Central) was increased from $129,449,640 to $129,449,649; a difference of $9.
- Financial Status Report - Medicaid Row A325 Info only - Affiliate Total Redirected Funds - **I390** (Central) was decreased from ($3) to ($12); a difference of ($9)
- Financial Status Report - Medicaid Row A115 Medicaid Managed Care - Affiliate Contracts (Shiawassee) was decreased from $31,021,009 to $30,958,070; a difference of ($62,939).
- Financial Status Report - Medicaid Row A202 Medicaid Services (Shiawassee) was decreased from $31,021,009 to $30,958,070; a difference of ($62,939).
- Financial Status Report - Healthy Michigan Row AI115 Healthy Michigan Managed Care - Affiliate Contracts (Central) was decreased from $12,900,335 to $12,900,326; a difference of ($9).
- Financial Status Report - Healthy Michigan Row AI325 Info only - Affiliate Total Redirected Funds - **I390** (Central) was increased from $0 to $9; a difference of $9
- Financial Status Report - Healthy Michigan Row AI115 Healthy Michigan Managed Care - Affiliate Contracts (Shiawassee) was increased from $2,961,485 to $2,962,567; a difference of $1,082.
- Financial Status Report - Healthy Michigan Row AI202 Healthy Michigan Plan Services (Shiawassee) was increased from $2,961,485 to $2,962,567; a difference of $1,082.
- Financial Status Report - Health Home Services Row AG202 Expenditure - Health Home Services (Shiawassee) was increased from $180,393 to $180,506; a difference of $113.
- Financial Status Report - Health Home Services Row AG204 Surplus Funding Retained (Shiawassee) was decreased from $31,158 to $31,045; a difference of ($113).

The following examination adjustments were made to reconcile the examined FSR to the trial balance:

- Financial Status Report - Healthy Michigan Row AI310 FROM Medicaid - **A301b** was increased from $14,567,795 to $14,568,868; a difference of $1,073.

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Roslund Prestage & Company
Certified Public Accountants

Communication with Those Charged with Governance at the Conclusion of the Audit

To the Members of the Board
Mid-State Health Network
Lansing, Michigan

We have examined Mid-State Health Network's (the PIHP) compliance with the compliance requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to the Medicaid Contract and/or General Fund (GF) Contract for the year ended September 30, 2025. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you during planning. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Matters

Qualitative Aspects of Compliance Practices
Management is responsible for the selection and use of appropriate accounting and compliance policies. We noted no compliance matters entered into by the PIHP during the year for which there is a lack of authoritative guidance or consensus.

Accounting estimates are prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the compliance requirements, particularly those that may have an impact on the Financial Status Report (FSR). The most sensitive estimates relating to the compliance requirements were as follows:

> Management uses estimates when preparing the PIHP's cost allocation workbook. The cost allocation workbook is used to spread shared costs across the programs and funding sources that benefit from these shared costs. Examples of allocation methodologies used to spread shared costs that use estimates may include full-time equivalent (FTE), square footage of space used, percentage of total salaries and wages, etc. These allocation methodologies should follow the guidance provided by the Michigan Department of Health and Human Services and 2 CFR 200 Subpart E.

Difficulties Encountered in Performing the Audit
We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements
Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. If any of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, they would be reported on Schedule of Findings as shown above. If any of the misstatements detected as a result of audit procedures were expected to have an impact greater than $25,000, but were not material, either individually or in the aggregate, they would be reported on Comments and Recommendations as shown above.

Disagreements with Management
For purposes of this letter, a disagreement with management is an accounting, reporting, compliance, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the PIHP's compliance with the compliance requirements described in the *Compliance Examination Guidelines*. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations
We have requested certain representations from management that are included in the management representation letter.

Management Consultations with Other Independent Accountants
In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves the PIHP's compliance with the compliance requirements or a determination of the type of auditor's opinion that may be expressed, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues
We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the PIHP's auditors. However, these discussions occurred in the normal course of our professional relationship, and our responses were not a condition to our retention.

Other Matters
The PIHP's responses to the noncompliance findings identified in our examination are described in the accompanying Comments and Recommendations. The PIHP's responses were not subjected to the examination procedures applied in the examination of compliance and, accordingly, we express no opinion on the responses.

Restriction on Use
This information is intended solely for the information and use of the Board and management of the PIHP and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

Roslund, Prestage & Company, P.C.

Roslund, Prestage & Company, P.C.
Certified Public Accountants

MSHN
Mid-State Health Network

Background

The draft Amended Budget for Fiscal Year (FY) 27 is being presented off cycle as amendments typically occur during September's board meeting. This presentation is brought forward as MSHN received final rates from MDHHS on September 30, 2026 and the changes are material compared to the original FY 27 budget.

Projected revenues are now $972,086,008 and estimate expenses are $885,114,984. MSHN expects a surplus of $86,971,025 (revenue over expense) which represents an increase of more than $25 M.

MSHN is required to operate under a board approved budget.

Recommended Motion:

Motion to approve the FY 2027 Amended Budget as presented.

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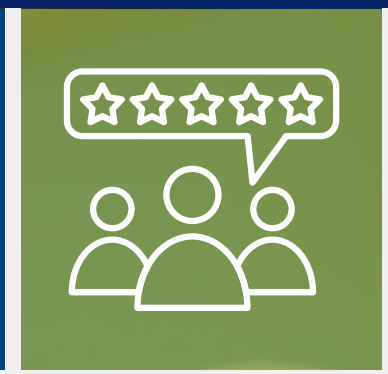
FISCAL YEAR 2027 AMENDED BUDGET

DRAFT

	FY2027 Original Budget	FY2027 Amended Budget	FY2027 Increase (Decrease) from Original Budget	Notes
REVENUES				
Prior Year Savings	$ 40,456,478	$ 40,884,113	$ 427,635	
Medicaid Capitation SP/iSPA MH	470,133,765	459,733,716	(10,400,049)	Budget based on FY2027 final capitation rates dated September 30, 2026
Healthy Michigan Plan Capitation MH	52,869,504	57,608,400	4,738,896	
Medicaid Waivers (HSW, SED, CWP)	152,917,863	160,446,411	7,528,548	
Medicaid Capitation Autism	105,630,447	131,989,471	26,359,023	
Medicaid Capitation SP/iSPA SUD	17,321,937	15,205,551	(2,116,386)	
Healthy Michigan Plan Capitation SUD	27,607,416	28,126,924	519,508	
Health Homes (Behavioral and Substance Use Disorder)	6,436,062	6,436,062	-	Budget based on projected health home enrollment (450 BHH enrollees and 750 SUDHH enrollees)
Community Grant and Other SUD Grants	13,058,194	13,035,737	(22,457)	Budget based on MDHHS allocations
PA2 Liquor Tax SUD	4,544,741	4,544,741	-	Budget based on OPB approved amounts
Hospital Rate Adjustor	43,074,600	43,074,600	-	Budget based on potential inpatient utilization increase
Performance Bonus Incentive Payment	4,676,211	4,875,932	199,721	Budget based on percentage of projected revenues
Medicaid DHS Incentive Payment	2,098,906	2,098,906	-	
Local Match Contribution	1,550,876	1,550,876	-	
Other Grants	374,568	1,374,568	1,000,000	Budget includes Veteran Navigator, Clubhouse Engagement, and Rural Health Transformation Program
Interest Income	1,100,000	1,100,000	-	
TOTAL REVENUE BUDGET	**$ 943,851,570**	**$ 972,086,008**	**$ 28,234,439**	
EXPENDITURES				
ADMINISTRATION:				
Salaries and Wages	$ 7,249,354	$ 7,249,354	$ -	Includes additional staff related to increased PIHP responsibilities; assumes vacant positions are filled; includes cost of living adjustment
Employee Benefits	2,442,394	2,442,394	-	
Other Contractual Agreements	638,910	638,910	-	Includes contract costs such as, but not limited to, IT and access support services
IT Subscriptions and Maintenance	1,225,909	1,225,909	-	Includes software costs such as, but not limited to, care coordination, data analytics, document sharing, managed care, Microsoft Office, parity
Consulting Services	130,000	130,000	-	
Conference and Training Expense	62,500	62,500	-	
Human Resources Fees	68,900	68,900	-	
Mileage Reimbursement	44,800	44,800	-	
Other Expenses	141,200	141,200	-	
Building Rent Amortization	22,875	22,875	-	Includes downsizing lease to one suite
Telephone Expense	175,350	175,350	-	
Office Supplies	129,250	129,250	-	Includes purchasing laptops to replace leased laptops
Printing Expense	39,000	39,000	-	
Meeting Expense	16,000	16,000	-	
Liability Insurance	33,700	33,700	-	
Audit Services	45,000	45,000	-	
OPB and Council Per Diems	19,320	19,320	-	
Dues and Memberships	11,418	11,418	-	
Legal Services	24,000	24,000	-	
Internet Services	6,985	6,985	-	
Subtotal Administration	**$ 12,526,865**	**$ 12,526,865**	**$ -**	
Percent Administration Expenses to Total Expenses	1.42%	1.42%		

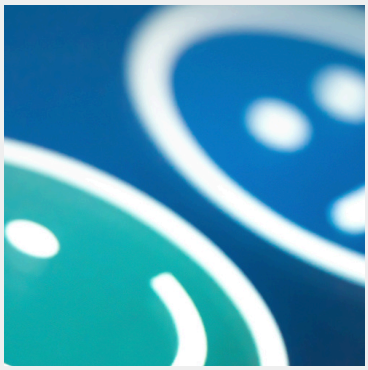
	FY2027 Original Budget	FY2027 Amended Budget	FY2027 Increase (Decrease) from Original Budget	Notes
CMHSP and SUD EXPENSES and TAXES:				
CMHSP Participant All Funding Sources	719,367,758	$ 720,511,080	$ 1,143,322	Budget based on updated CMHSP budgets
CMHSP Participant Other	6,458,562	7,370,946	912,384	Budget includes Performance Bonus Incentive Payments and Clubhouse Engagement and Rural Health Transformation Program grants
SUD Medicaid Contracts	16,200,000	16,480,000	280,000	
SUD Healthy Michigan Plan Contracts	31,000,000	31,700,000	700,000	
Health Homes (Behavioral and Substance Use Disorder)	5,552,046	5,552,046	-	Budget based on projected health home enrollment (450 BHH enrollees and 750 SUDHH enrollees)
Community Grant and Other SUD Grants	11,908,825	11,886,368	(22,457)	Budget based on MDHHS allocations
SUD PA2 Liquor Tax	4,544,741	4,544,741	-	Budget based on OPB approved amounts
Local Match Contribution	1,550,876	1,550,876	-	
Hospital Rate Adjustor	43,074,600	43,074,600	-	Budget based on potential inpatient utilization increase
Insurance Provider Assessment	29,917,461	29,917,461	-	Budget based on annual assessment
Subtotal CMHSP and SUD Expenses and Taxes	**$ 869,574,869**	**$ 872,588,118**	**$ 3,013,249**	
TOTAL EXPENDITURE BUDGET	**$ 882,101,734**	**$ 885,114,984**	**$ 3,013,249**	
Revenue Over/(Under) Expenditures	**$ 61,749,836**	**$ 86,971,025**	**$ 25,221,189**	

2026 Satisfaction Survey Analysis











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Mid-State Health Network

Prepared by Quality Manager on September 14th, 2026
Reviewed/Approved by QIC on
Reviewed by Regional Consumer Action Committee on

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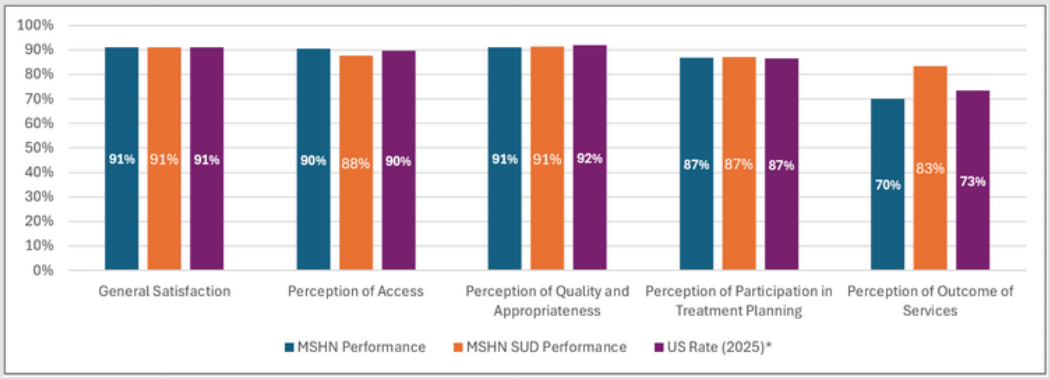


Executive Summary

The Mid-State Health Network (MSHN) Quality Assessment and Performance Improvement Program, as required by the Michigan Department of Health and Human Services (MDHHS), administers a satisfaction survey to a representative group of individuals served on an annual basis. MSHN, in collaboration with the Community Mental Health Services Programs (CMHSPs) and their contracted providers, along with MSHN's Substance Use Disorder Treatment Providers (SUDTP) utilize the Mental Health Statistics Improvement Program (MHSIP) to survey adults experiencing a mental illness and/or intellectual and developmental disability or substance use disorder, and the Youth Satisfaction Survey (YSS) survey tool for children/families. These surveys obtain feedback related to the perception of care for a representative sample of individuals served within the MSHN region to highlight the areas that providers are excelling and to identify improvement opportunities for future growth.

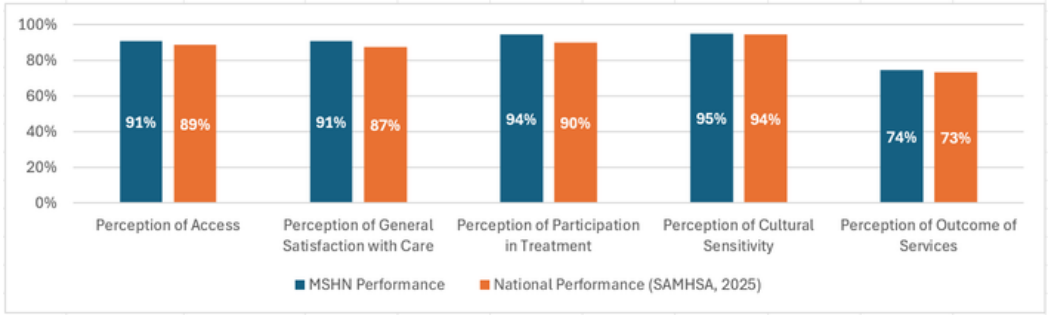
In FY2026, CMHSP participants collected 2,651 MHSIP surveys resulting in an approximate average response rate of 25 percent. CMHSP participants also collected 1,266 YSS surveys resulting in an approximate average response rate of 29 percent. SUD providers collected 1,860 surveys resulting in an average approximate response rate of 49 percent.

Figure 1: MSHN MHSIP Performance Compared to National Average

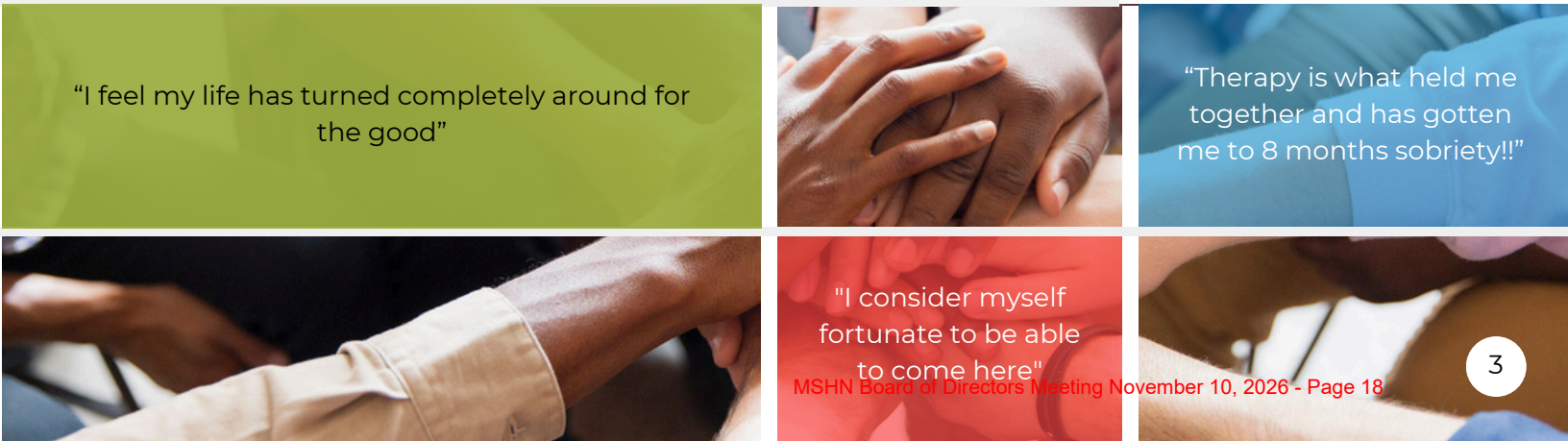


Compared to national averages (SAMHSA, 2025), MSHN CMHSPs and SUD providers performed at or above the rate of satisfaction in the areas of General Satisfaction, Access, and Participation in Treatment Planning. In addition, SUD services scored higher in Outcomes in the MHSIP survey, reflecting consistently strong consumer experiences with service delivery.

Figure 2: MSHN YSS Performance Compared to National Average



Compared to national averages of the YSS survey (SAMHSA, 2025), MSHN outperformed national averages in all areas. These domains include Access, Satisfaction with Care, Participation in Treatment, and Cultural Sensitivity, reflecting strong family engagement and services across the MSHN region.



Methodology

CMHSP providers selected a four week period between June and August to complete satisfaction surveying of adults, youth, and families served. SUD providers completed satisfaction surveying for FY26 for a targeted set of four weeks (June 15th through July 17th).

Survey results are analyzed by domain and subscale items for both the PIHP and the CMHSP for all surveys. In calculating the subscales and domains, the following are excluded from calculation:

- Individuals missing more than 1/3 of the questions in that domain
- Blanks/Not Applicable

Individual mean scores greater than 3.5 (YSS) or less than 2.5 (MHSIP) are classified as being "in agreement." The total number of respondents "in agreement" is divided by the total number of respondents with the result multiplied by 100 to calculate domain agreement. To obtain individual subscale scores, each response is assigned the following numerical values:

	MHSIP-Adult Version	YSS-Child/Family Version
Standard-"In Agreement"	<2.5	>3.5
Strongly Agree	1	5
Agree	2	4
Neutral	3	3
Disagree	4	2
Strongly Disagree	5	1

MSHN has established 80% agreement as the performance standard for all perception-of-care domains. This threshold represents the minimum level of positive consumer response required to demonstrate that services are being delivered effectively and that individuals perceive meaningful benefit. Each survey includes multiple questions which are aggregated into overarching domains. For both the MHSIP and the YSS surveys, there are seven total domains. The first four domains reflect the performance of each provider and the remaining three domains reflect the consumer's status in clinical improvement, daily functioning, and overall well-being:

MHSIP Domains

General Satisfaction
Access to Care
Quality and Appropriateness of Care
Participation in Treatment Planning
Outcomes
Functioning
Social Connectedness

YSS Domains

General Satisfaction
Access to Care
Participation in Treatment
Cultural Sensitivity
Outcome of Services
Social Functioning
Social Connectedness

"Every one is amazing I wouldn't be where I am without them. "

"I absolutely love my current care team and the staff that supports them! Very professional and friendly environment "



2026 Mental Health Statistics Improvement Program (MHSIP) Survey - CMHSP



“Staff is very kind and attentive, I love that they pay attention.”

"I am very happy with my therapist. She took the time to listen and help figure out what I need help with. I feel like she listens and takes the time to clarify if she doesn't understand. I feel like she is as invested in my success as I am."

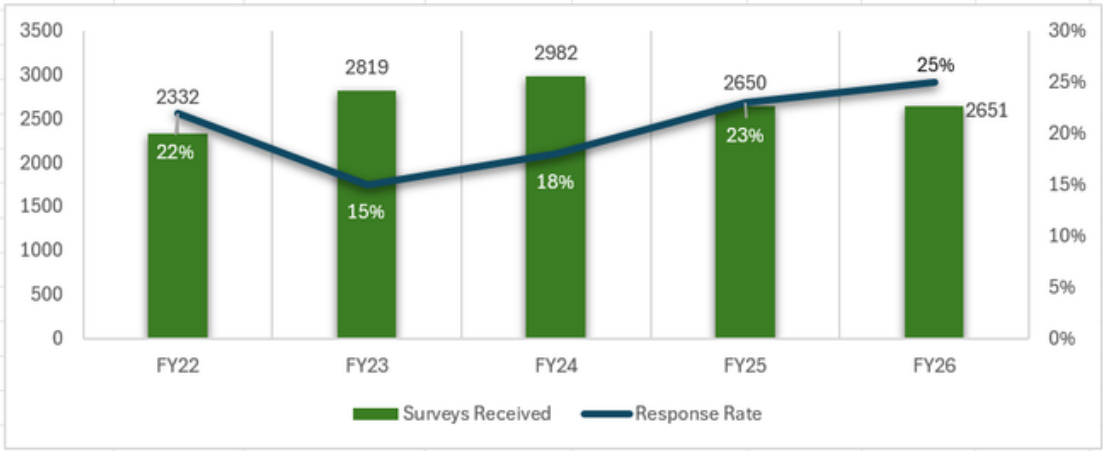
“My support team here are people I can honestly trust and I don't trust too many people so that's a big deal for me, I feel so blessed for all of them.”

MHSIP CMHSP Survey Response Rates

Response rates are calculated by dividing the total number of surveys received by the number of individuals distributed a survey during the surveying period. MHSIP survey response rates have shown notable fluctuations over time. Compared to the past three fiscal years, FY26 had the highest response rate at 25 percent, however, there remains ongoing variability within the CMSHPs based on distribution method utilized which underscores challenges in achieving consistent engagement in survey participation of the MHSIP survey.

Figure 1: Longitudinal MHSIP Response Rates for MSHN Region

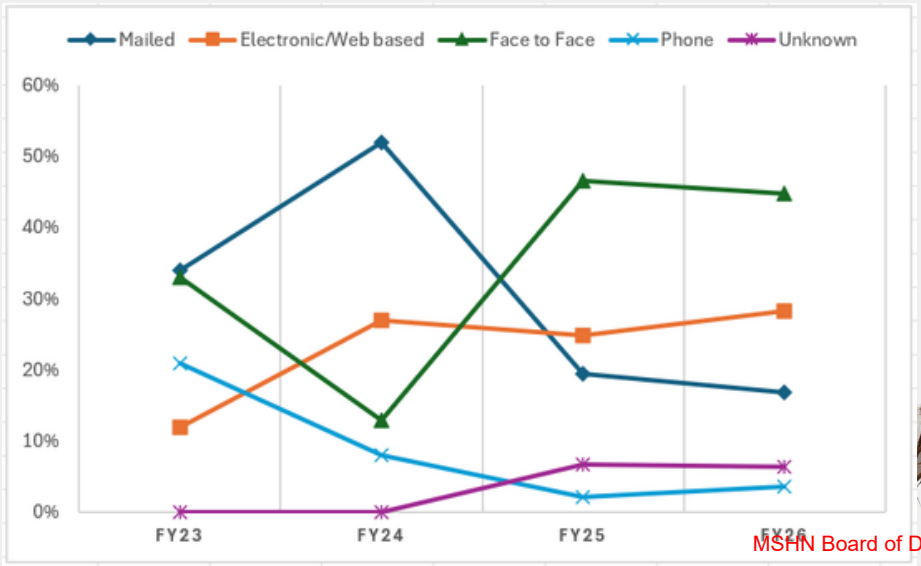
FY22		FY23		FY24		FY25		FY26	
Received	Response Rate	Received	Response Rate	Received	Response Rate	Received	Response Rate	Received	Response Rate
2332	22%	2819	15%	2982	18%	2650	23%	2651	25%



Over the last three fiscal years, distribution methods have moved away from phone and mail surveying, with FY26 marking a 45 percent adoption of face-to-face surveying. This demonstrates a strategic shift by the CMHSPs towards in-person surveying to facilitate increased engagement and collection of surveys.

Figure 2: Longitudinal Distribution Method Percentages

	FY23	FY24	FY25	FY26
Mailed	34%	52%	20%	17%
Electronic/Web based	12%	27%	25%	28%
Face to Face	33%	13%	47%	45%
Phone	21%	8%	2%	4%
Unknown	0%	0%	7%	6%



"I absolutely love my therapist she's very understanding, listens well, she's amazing and all the staff are very sweet and respectful and kind"



MHSIP Survey Analysis

Subscale scoring in FY26 for the MHSIP survey scored above the desired threshold (80 percent) for four out of seven domains as indicated below in Figure 3. MSHN scored the highest in the General Satisfaction and Quality and Appropriateness domains in FY26, which continues the trend of these domains scoring with the highest in consumer agreement. A full question ranking by score for both MSHN overall totals as well as CMHSPs can be found under Appendix A.

Figure 3: Longitudinal Percentages by Domain and Subscale Question

MHSIP Survey Domains and Subscale Questions	FY2022	FY2023	FY2024	FY2025	FY2026	Change FY25 to FY26	Change FY22 to FY26
General Satisfaction	**93%**	**90%**	**88%**	**91%**	**91%**	**0%**	**-2%**
Q1. I like the services that I received.	93%	92%	90%	92%	93%	1%	0%
Q2. If I had other choices, I would still choose to get services from this mental health agency.	89%	86%	85%	88%	87%	-1%	-2%
Q3. I would recommend this agency to a friend or family member.	92%	89%	87%	89%	89%	0%	-3%
Perception of Access	**91%**	**88%**	**87%**	**89%**	**90%**	**1%**	**-1%**
Q4. The location of services was convenient.	89%	89%	88%	89%	91%	2%	2%
Q5. Staff were willing to see me as often as I felt it was necessary.	92%	89%	89%	90%	91%	1%	-1%
Q6. Staff returned my calls within 24 hours.	89%	86%	84%	87%	87%	0%	-2%
Q7. Services were available at times that were good for me.	93%	90%	90%	91%	93%	2%	0%
Q8. I was able to get all the services I thought I needed.	89%	86%	83%	87%	87%	0%	-2%
Q9. I was able to see a psychiatrist when I wanted to.	81%	81%	81%	83%	82%	-1%	1%
Perception of Quality and Appropriateness	**93%**	**89%**	**88%**	**91%**	**91%**	**0%**	**-2%**
Q10. Staff believed that I could grow, change and recover.	91%	88%	87%	90%	90%	0%	-1%
Q12. I felt free to complain.	87%	84%	84%	86%	88%	2%	1%
Q13. I was given information about my rights.	94%	91%	91%	93%	93%	0%	-1%
Q14. Staff encouraged me to take responsibility for how I live my life.	91%	87%	86%	89%	91%	2%	0%
Q15. Staff told me what side effects to watch for.	81%	77%	78%	81%	80%	-1%	-1%
Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	94%	90%	92%	93%	94%	1%	0%
Q18. Staff were sensitive to my cultural/ ethnic background.	90%	87%	88%	88%	89%	1%	-1%
Q19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	90%	86%	85%	89%	88%	-1%	-2%
Q20. I was encouraged to use consumer-run programs.	85%	81%	81%	82%	82%	0%	-3%
Perception of Participation in Treatment Planning	**88%**	**85%**	**83%**	**86%**	**87%**	**1%**	**-1%**
Q11. I felt comfortable asking questions about my treatment, services, and medication.	91%	90%	88%	91%	92%	1%	1%
Q17. I, not staff, decided my treatment goals.	89%	85%	84%	87%	88%	1%	-1%
Perception of Outcome of Services	**70%**	**71%**	**69%**	**69%**	**70%**	**1%**	**0%**
Q21. I deal more effectively with daily problems.	80%	77%	73%	72%	72%	0%	-8%
Q22. I am better able to control my life.	77%	75%	72%	71%	72%	1%	-5%
Q23. I am better able to deal with crisis.	74%	71%	64%	64%	65%	1%	-9%
Q24. I am getting along better with my family.	71%	72%	73%	72%	73%	1%	2%
Q25. I do better in social situations.	65%	66%	69%	71%	73%	2%	8%
Q26. I do better in school and/or work.	61%	62%	68%	69%	66%	-3%	5%
Q27. My housing situation has improved.	64%	71%	72%	72%	73%	1%	9%
Q28. My symptoms are not bothering me as much.	64%	62%	62%	62%	62%	0%	-2%
Perception of Functioning	**69%**	**71%**	**69%**	**65%**	**68%**	**3%**	**-1%**
Q29. I do things that are more meaningful to me.	72%	75%	62%	62%	78%	16%	6%
Q30. I am better able to take care of my needs.	76%	75%	77%	77%	74%	-3%	-2%
Q31. I am better able to handle things when they go wrong.	69%	69%	72%	72%	63%	-9%	-6%
Q32. I am better able to do things that I want to do.	72%	73%	62%	60%	71%	11%	-1%
Perception of Social Connectedness	**71%**	**74%**	**70%**	**71%**	**73%**	**2%**	**2%**
Q33. I am happy with the friendships I have.	75%	78%	72%	73%	76%	3%	1%
Q34. I have people with who I can do enjoyable things.	78%	79%	76%	77%	81%	4%	3%
Q35. I feel I belong in my community.	63%	67%	78%	80%	65%	-15%	2%
Q36. In a crisis, I would have the support I need from family or friends.	78%	79%	66%	65%	79%	14%	1%

MHSIP Survey Analysis (Continued)

The highest rated questions for the MSHN region were the following:

- Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.
- Q1: I like the services that I receive(d).
- Q13. I was given information about my rights.

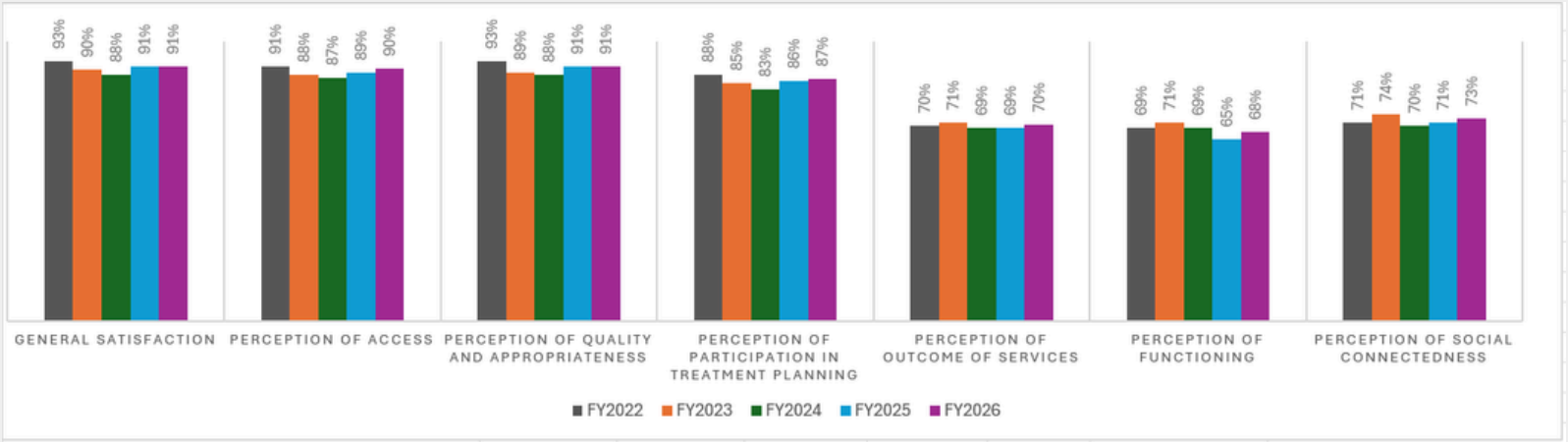
The lowest rated questions for the MSHN region were the following:

- Q23. I am able to deal with crisis.
- Q31. I am able to handle things when they go wrong.
- Q28. My symptoms are not bothering me as much.

Review of longitudinal performance indicates that FY26 demonstrated maintenance and improvement in key perception-of-care domains. Compared to FY25, General Satisfaction remained at 91%, Perception of Access increased to 90% (a 1 percent increase over FY25), Quality and Appropriateness remained stable at 91%, and Participation in Treatment Planning increased to 87% (up from 86% in FY25). All outcome-based domains increased in FY26: Perception of Outcome of Services increased by 1 percent from FY25 to 70%, Perception of Functioning increased from 65% in FY25 to 68% in FY26, and Perception of Social Connectedness increased by 2 percent to 73% when compared to FY25. Overall, consistent with national outcomes as well as historical regional outcomes; the outcome-based domains continue to have lower rates of satisfaction.

Lower satisfactions rates within these outcome domains are attributed to the complex and long-term nature of managing chronic mental health symptoms as compared to immediate service satisfaction. In addition, consumer outcome areas highlight the persistent gaps that exists in external social determinants of health which clinical interventions alone cannot solely impact. While FY26 results reflect improved rates around satisfaction and access measures overall, there remains the ongoing need for targeted interventions which can assist in addressing outcomes, functioning, and connectedness.

Figure 4: Longitudinal Percentages by Domain by FY

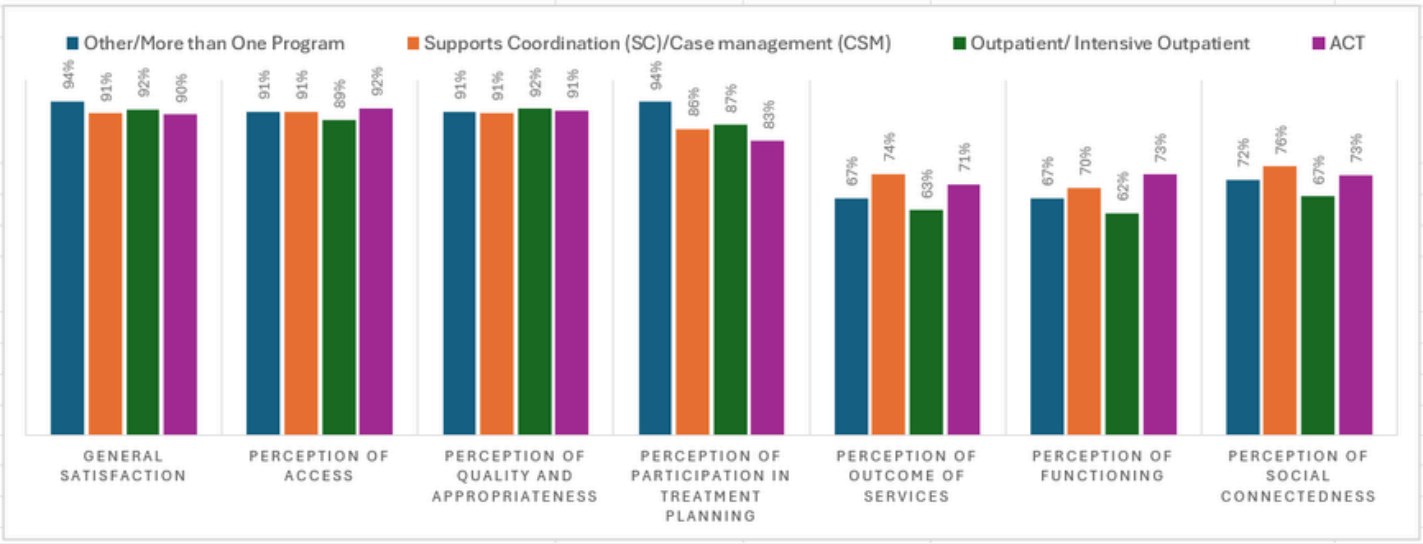


In addition to reviewing overall domain scoring, survey results were also broken down further by four additional subsets:

- Length of Treatment (Less than 6 months, 6 to 12 months, More than 12 months, No longer receiving services, and Blank (where no treatment length was provided))
- Program (Outpatient/Intensive Outpatient/Assertive Community Treatment, Supports Coordination/Case Management, Residential, and Other (which includes multiple programs))
- Supplemental Programs (Long Term Supports and Services (LTSS))
- Race (American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Asian, White, Black or African American, and Other/Not available)

MHSIP Survey Analysis (Continued)

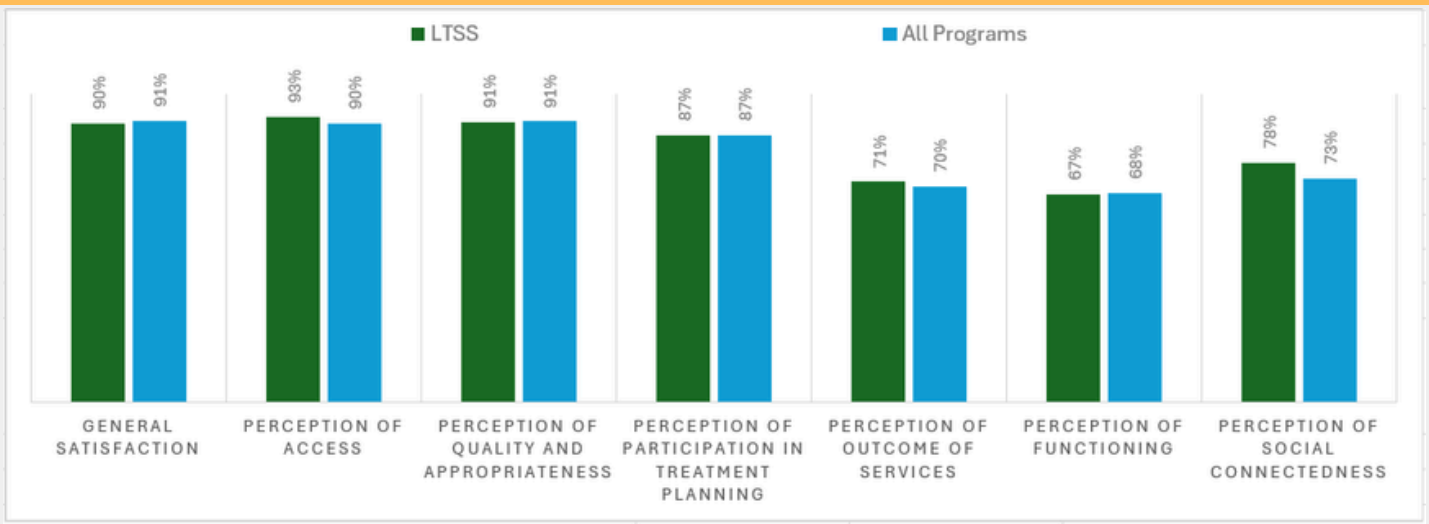
Figure 5: FY26 MHSIP Results by Program and Domain



*Due to less than 30 individuals responding with Residential as their primary program, this program type was not included in analysis.

Analysis of MHSIP results by program reveals consistent strengths across core satisfaction and access domains, with all program types reporting results above 85% except for the Assertive Community Treatment (ACT) program participants scoring the Perception of Participation in Treatment Planning at 83%. Variation becomes more pronounced in the outcome-related domains. The Perception of Outcomes domain presented the widest disparity: Supports Coordination/Case Management reported the strongest score (74%), while Outpatient/Intensive Outpatient scored the lowest (63%). Perception of Functioning revealed similar challenges, with Supports Coordination/Case Management highest at 70% and the Outpatient/Intensive Outpatient being the lowest at 62%. Social Connectedness, while relatively stable compared to the other Outcome measures, showed a range from 67% (Outpatient/Intensive Outpatient) to 76% (Supports Coordination/Case Management).

Figure 6: FY26 MHSIP Results by Supplemental Program and Domain

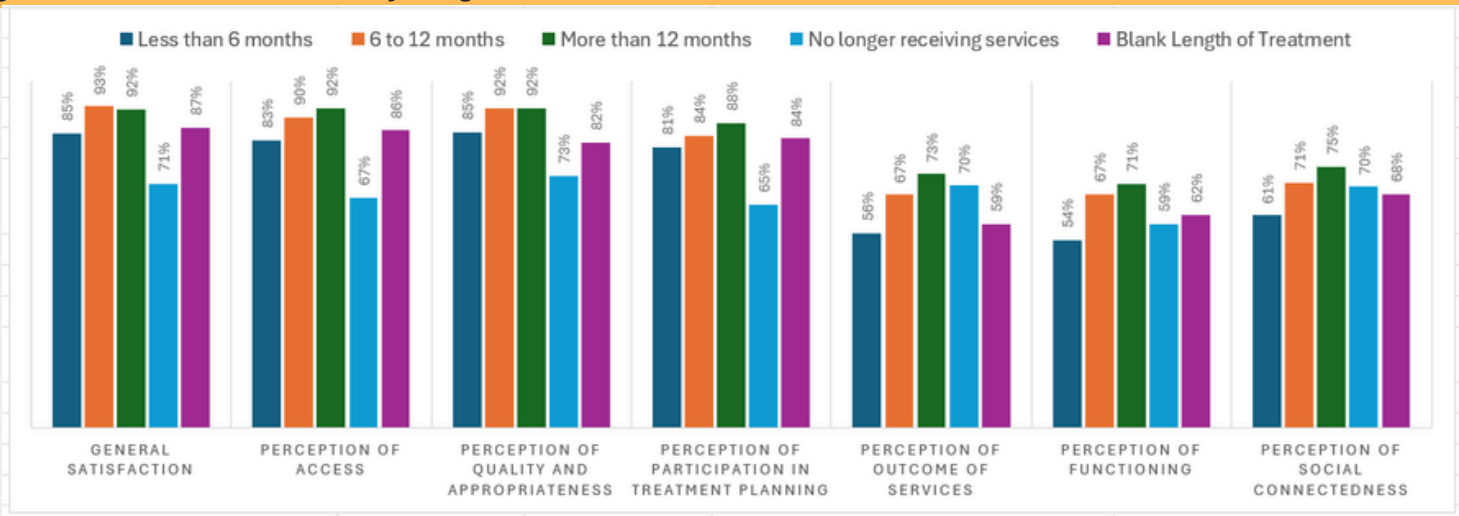


In addition to analyzing primary programming, MSHN also conducts regional analysis on Long Term Supports and Services (LTSS). Analysis across the LTSS population shows overall consistency in Satisfaction and Access domains, with all categories scoring at or above 87%; in addition, the Perception of Access for those receiving LTSS services was 3% higher when compared to all programs. These results demonstrate that core processes are being met reliably within LTSS settings.

Variations in satisfaction emerge when looking at outcome-related domains between LTSS services and all programs. Perception of Functioning scored the lowest across all programs, particularly LTSS (67%). Social Connectedness displayed one of the more positive results for the LTSS program (78%) and demonstrated a 5% higher rate of satisfaction than all programs overall. Scoring in this area suggests that individuals engaged in LTSS program supports may experience broader social support networks and community engagement.

MHSIP Survey Analysis (Continued)

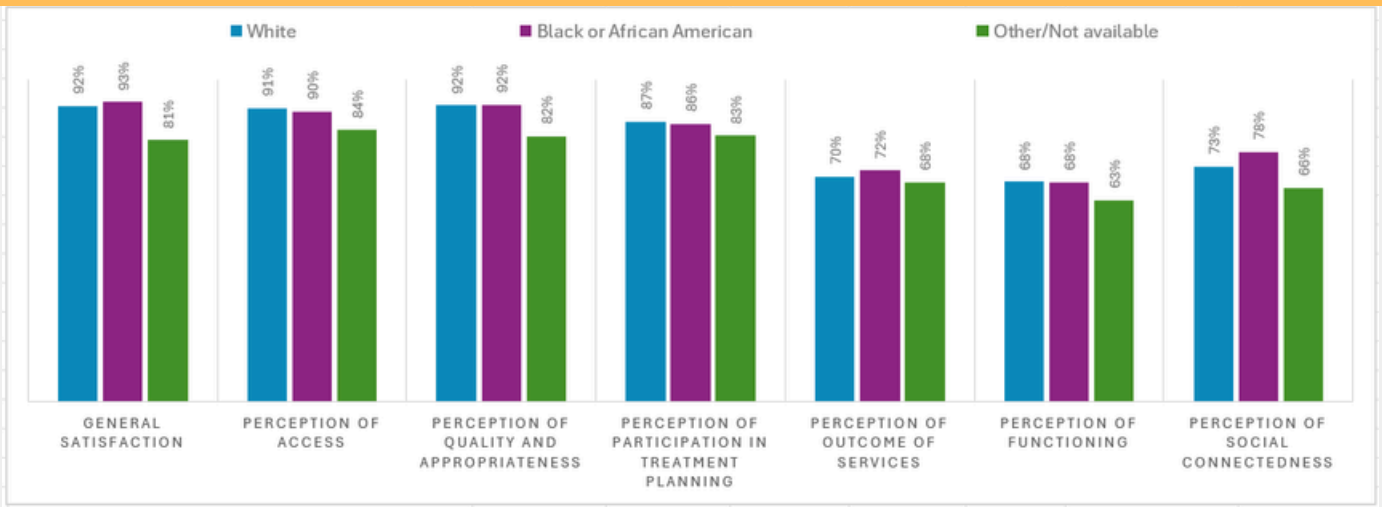
Figure 7: FY26 MHSIP Results by Length of Treatment and Domain



Review of FY26 satisfaction data stratified by length of treatment reveals a clear relationship between a consumer's duration of treatment and reported satisfaction across domains. Individuals that were engaged in services for more than 12 months consistently reported the highest agreement across nearly all domains, particularly in the domains of Outcomes (73%), Functioning (71%), and Social Connectedness (75%). These results suggest that sustained involvement in services contributes to stronger perceptions of recovery progress/outcomes, functioning, and social connection.

Conversely, the lowest scores were observed amongst individuals no longer receiving services and those with limited treatment exposure (<6 months). For example, Outcomes (56%), Functioning (54%), and Social Connectedness (61%) were significantly lower in the early treatment period for those in services less than 6 months, and dropped even further amongst those no longer in care.

Figure 8: FY26 MHSIP Results by Race and Domain



***Due to less than 30 individuals responding with American Indian or Alaska Native, Native Hawaiian/Other Pacific Islander, or Asian as their primary race, these were not included in analysis.**

Analysis by race demonstrates consistently high performance in satisfaction, access, and quality across the White and Black/African American groups with decreased satisfaction noted primarily for those that did not report their race or selected "Other Race". General Satisfaction ranged from 93% (Black/African American) to 81% for Other/Not Available, and 92% for the White population. Perception of Access remained stable between 90-91% for the White and Black/African American population, with the lowest rate for the Other Race/Not Available category at 84%. Similarly, Quality and Appropriateness scored variably, and ranged from 82–92% across all three groups. More notable variation emerges in outcome-related domains. Participation in Treatment Planning was strongest amongst White respondents at 87%, with Black/African American respondents scoring 86%, and the Other/Not Available group at 83%. Perception of Outcomes showed similar differences, with the White population at 70%, Black/African American at 72%, and the Other/Not Available group at 68%. Functioning reflected a similar pattern, with the White and Black/African American population scoring 68% and the Other/Not Available category scoring 63%. Social Connectedness showed greater differences with the Black/African American respondents reporting stronger connections at 78% compared to White at 73% and Other at 66%.

2026 Youth Services Survey (YSS)



"My child can now enjoy going out in public and he has been doing amazing"

"My daughter's therapist [staff name] has gone above and beyond for my daughter, including checking in on her at school when she was struggling. She made appointments easy to schedule and became someone my daughter and I feel comfortable with fully."

"Me and my family are very satisfied and grateful for [staff name] getting us through all of this. He's been a huge help and support at every stressful time in our life."

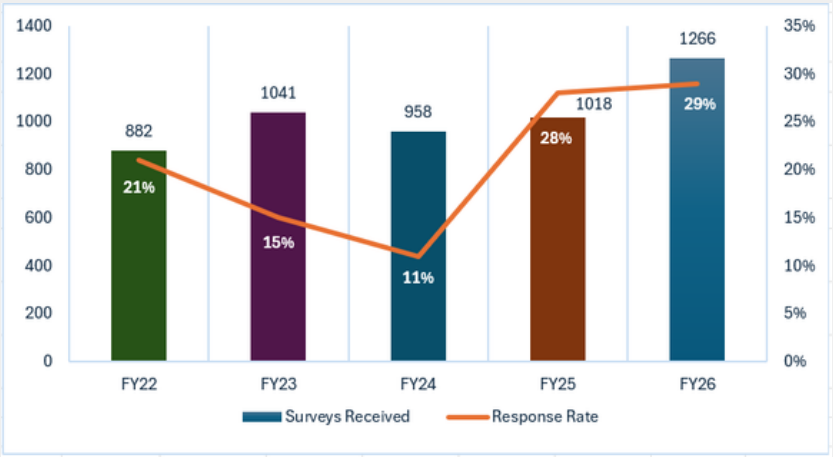


YSS CMHSP Survey Response Rates

Response rates are calculated by dividing the total number of surveys received by the number of individuals distributed a survey during the surveying period. YSS survey response rates have shown notable fluctuations over the past five fiscal years with FY24 having the lowest response rate of 11 percent and FY26 having the highest response rate at 29 percent.

Figure 1: Longitudinal YSS Response Rates for MSHN Region

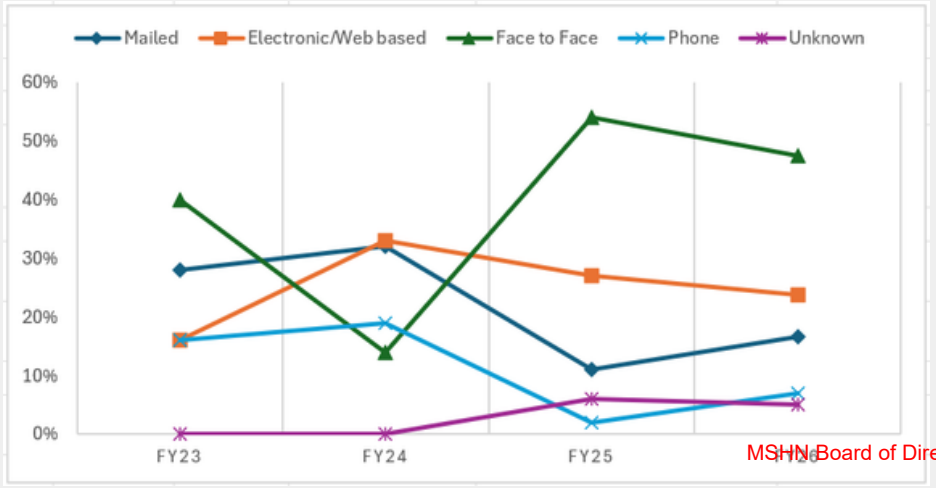
FY22		FY23		FY24		FY25		FY26	
Received	Response Rate	Received	Response Rate	Received	Response Rate	Received	Response Rate	Received	Response Rate
882	21%	1,041	15%	958	11%	1,018	28%	1,266	29%



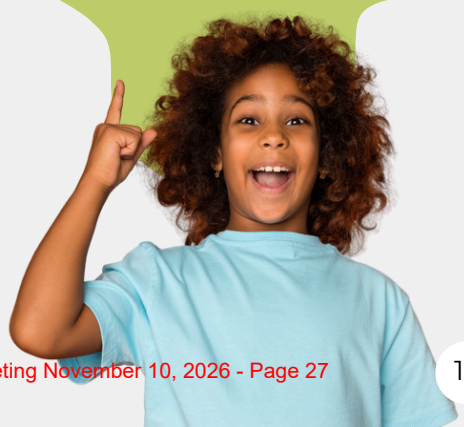
Similar to the MHSIP survey, distribution methods have varied over the past three fiscal years with methods moving away from phone and mailed surveying, with FY25 marking the highest adoption of face-to-face surveying and FY26 continuing this progression. This changeover to increased adoption of face-to-face surveys has increased engagement and response rates for the YSS and MHSIP surveys overall.

Figure 2: Longitudinal Distribution Method Percentages

	FY23	FY24	FY25	FY26
Mailed	28%	32%	11%	17%
Electronic/Web based	16%	33%	27%	24%
Face to Face	40%	14%	54%	47%
Phone	16%	19%	2%	7%
Unknown	0%	0%	6%	5%



"[Staff name] has been able to help both of my children in ways I couldn't have imagined. She has been amazing in so many ways and I couldn't have asked for a better experience ."



YSS Survey Analysis

MSHN's percentage of agreement for each subscale for FY26 scored above the desired threshold (80 percent) for five out of seven domains as indicated below in Figure 3. MSHN scored the highest in the Cultural Sensitivity (95%) and Participation in Treatment (94%) domains for FY26. A full question ranking by score for both MSHN overall totals as well as CMHSPs can be found under Appendix B.

Figure 3: Longitudinal Percentages by Domain and Subscale Question

YSS Domains and Questions	FY22	FY23	FY24	FY25	FY26	Change FY25 to FY26	Change FY22 to FY26
Perception of Access	**96%**	**90%**	**90%**	**93%**	**91%**	**-2%**	**-5%**
Q8. The location of services was convenient for us.	95%	93%	94%	96%	95%	-1%	0%
Q9. Services were available at times that were convenient for us.	93%	90%	90%	93%	91%	-1%	-2%
Perception of Participation in Treatment	**94%**	**92%**	**92%**	**95%**	**94%**	**0%**	**0%**
Q2. I helped to choose my child's services.	91%	89%	89%	93%	93%	0%	2%
Q3. I helped to choose my child's treatment goals.	94%	92%	92%	95%	95%	0%	1%
Q6. I participated in my child's treatment.	95%	93%	96%	95%	96%	0%	1%
Perception of Cultural Sensitivity	**98%**	**95%**	**95%**	**96%**	**95%**	**-1%**	**-3%**
Q12. Staff treated me with respect.	97%	95%	95%	96%	95%	-1%	-2%
Q13. Staff respected my family's religious/spiritual beliefs.	93%	91%	92%	94%	95%	1%	2%
Q14. Staff spoke with me in a way that I understand.	98%	96%	97%	97%	97%	0%	-1%
Q15. Staff were sensitive to my cultural/ethnic background.	93%	92%	93%	94%	94%	0%	1%
Appropriateness	**92%**	**84%**	**83%**	**87%**	**89%**	**2%**	**-3%**
Q1. Overall, I am satisfied with the services my child received.	92%	89%	87%	91%	92%	1%	0%
Q4. The people helping my child stuck with us no matter what.	88%	86%	86%	89%	89%	0%	1%
Q5. I felt my child had someone to talk to when she/he was troubled.	90%	85%	84%	86%	89%	2%	-1%
Q7. The services my child and/or family received were right for us.	89%	86%	84%	89%	90%	2%	1%
Q10. My family got the help we wanted for my child.	85%	82%	81%	85%	86%	1%	1%
Q11. My family got as much help as we needed for my child.	80%	79%	76%	79%	83%	4%	3%
Perception of Outcome of Services	**68%**	**66%**	**67%**	**71%**	**74%**	**3%**	**6%**
Q16. My child is better at handling daily life.	69%	66%	69%	75%	77%	3%	8%
Q17. My child gets along better with family.	70%	66%	73%	76%	76%	1%	6%
Q18. My child gets along better with friends and other people.	69%	64%	71%	76%	76%	0%	7%
Q19. My child is doing better in school and/or work.	62%	60%	63%	64%	67%	3%	5%
Q20. My child is better able to cope when things go wrong.	59%	60%	51%	49%	53%	4%	-6%
Q21. I am satisfied with our family life right now.	70%	66%	67%	69%	72%	3%	2%
Q22. My child is better able to do things he or she wants to do.	71%	70%	65%	74%	78%	3%	7%
Perception of Social Connectedness	**92%**	**92%**	**85%**	**87%**	**90%**	**3%**	**-2%**
Q23. I know people who will listen and understand me when I need to talk.	91%	89%	87%	90%	92%	2%	1%
Q24. I have people that I am comfortable talking with about my child's problems.	93%	90%	88%	92%	92%	0%	-1%
Q25. In a crisis, I would have the support I need from family or friends.	86%	86%	83%	83%	85%	3%	-1%
Q26. I have people with whom I can do enjoyable things.	89%	88%	87%	90%	90%	1%	1%
Perception of Social Functioning	**71%**	**68%**	**64%**	**66%**	**72%**	**6%**	**1%**
Q16. My child is better at handling daily life.	69%	66%	69%	75%	77%	3%	8%
Q17. My child gets along better with family.	70%	66%	73%	76%	76%	1%	6%
Q18. My child gets along better with friends and other people.	69%	64%	71%	76%	76%	0%	7%
Q19. My child is doing better in school and/or work.	62%	60%	63%	64%	67%	3%	5%
Q20. My child is better able to cope when things go wrong.	59%	60%	51%	49%	53%	4%	-6%
Q22. My child is better able to do things he or she wants to do.	71%	70%	65%	74%	78%	3%	7%

YSS Survey Analysis (Continued)

The highest rated questions for the MSHN region were the following:

- Q12. Staff treated me with respect.
- Q13. Staff respected my family's religious/spiritual beliefs.
- Q14. Staff spoke with me in a way that I understand.

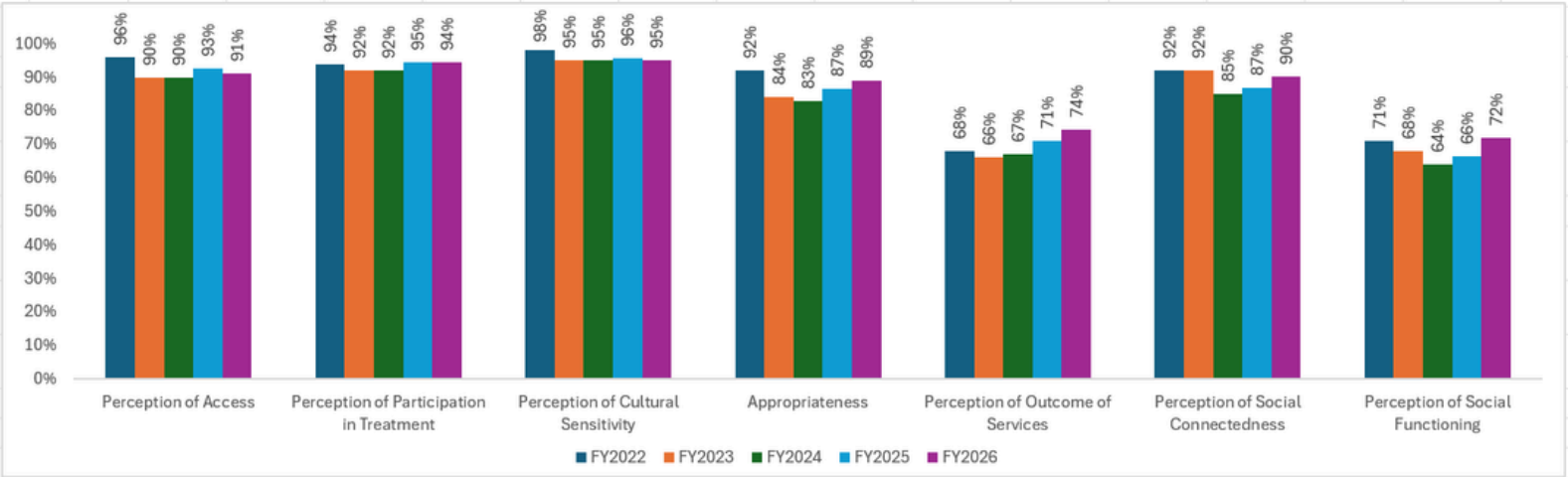
The lowest rated questions for the MSHN region were the following:

- Q19. My child is doing better in school and/or work.
- Q20. My child is better able to cope when things go wrong.
- Q21. I am satisfied with our family life right now.

Results across the past five fiscal years show that FY26 demonstrated an increase in several outcome domains with slight reductions in satisfaction in provider satisfaction domains. Perception of Outcome of Services improved to 74% in FY26 (71% in FY25), and Perception of Social Connectedness rose to 90% (87% in FY25). In addition, Perception of Social Functioning increased to 72%, up from 66% in FY26. Cultural Sensitivity continues to be the strongest domain, at 95% in FY26, consistent with sustained performance above 95% across all fiscal years.

Similar to the MHSIP survey, there continues to be challenges in meeting the 80% threshold for most outcome-focused domains with the YSS surveys. Perception of Outcomes increased to 74% in FY26 (a 3% increase when compared to FY25 (71%)). Social Functioning, which is historically the weakest domain, improved by 6% in FY26 (72%) when compared to 66% in FY25. Overall, FY26 YSS results indicate that while satisfaction, access, and treatment participation remain consistently strong, ongoing gaps remain in Outcomes and Social Functioning.

Figure 4: Longitudinal Percentages by Domain by FY

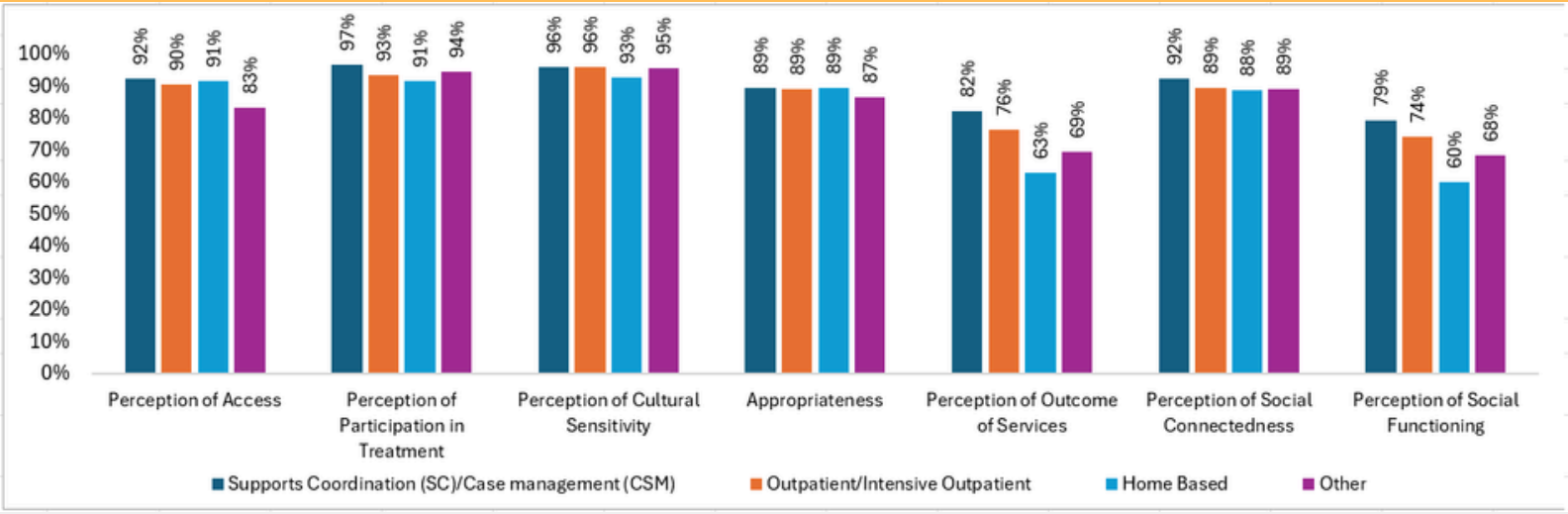


In addition to reviewing overall domain scoring, survey results were also broken down further by four additional subsets:

- Length of Treatment (Less than 6 months, 6 to 12 months, More than 12 months, No longer receiving services, and Blank (where no treatment length was provided))
- Program (Outpatient/Intensive Outpatient, Supports Coordination/Case Management, Residential, Home Based, and Other (which includes multiple programs))
- Supplemental Programs (Long Term Supports and Services (LTSS))
- Race (American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Asian, White, Black or African American, and Other/Not available)

YSS Survey Analysis (Continued)

Figure 5: FY26 YSS Results by Program and Domain

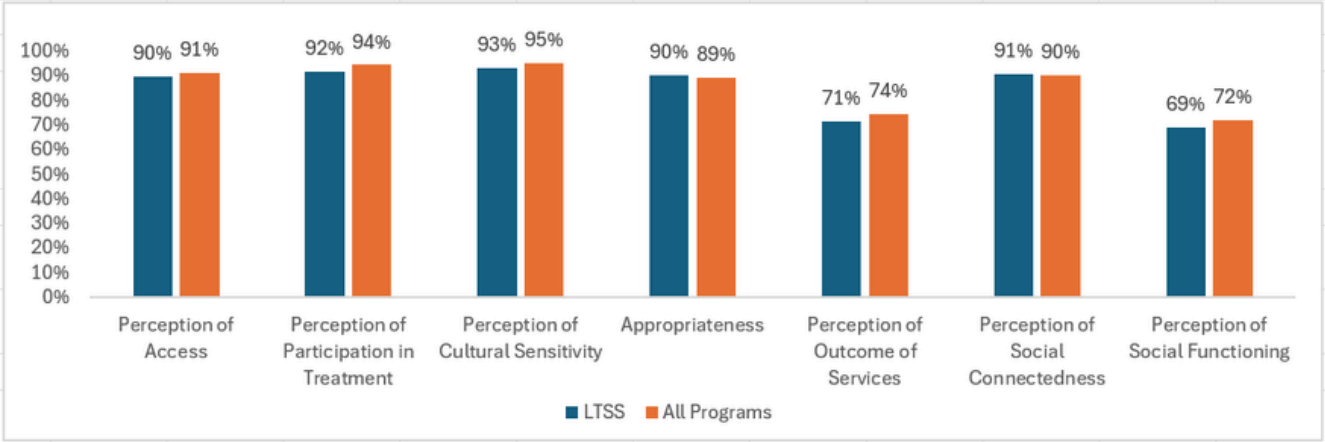


*Due to less than 30 individuals responding with Residential as their primary program, this program type was not included in analysis.

Supports Coordination/Case Management (SC/CSM) services consistently outperformed other program types, reporting the highest agreement across all YSS domains. These results suggest that case management and coordination models provide strong engagement, effective communication, and greater impacts on functioning and connectedness when compared to other primary programs.

While SC/CSM demonstrated the highest levels of satisfaction across domains, Outpatient/Intensive Outpatient and Home-Based services demonstrated strong satisfaction and access scores across the majority of domains as well; however, outcome-related domains fell short of the 80 percent threshold (Perception of Outcomes of Services and Social Functioning). This indicates that while service delivery processes are highly valued and deemed satisfactory, families/youth perceive less improvements in daily life, outcomes, and recovery as these domains measure long term outcomes rather than point-in-time satisfaction questions.

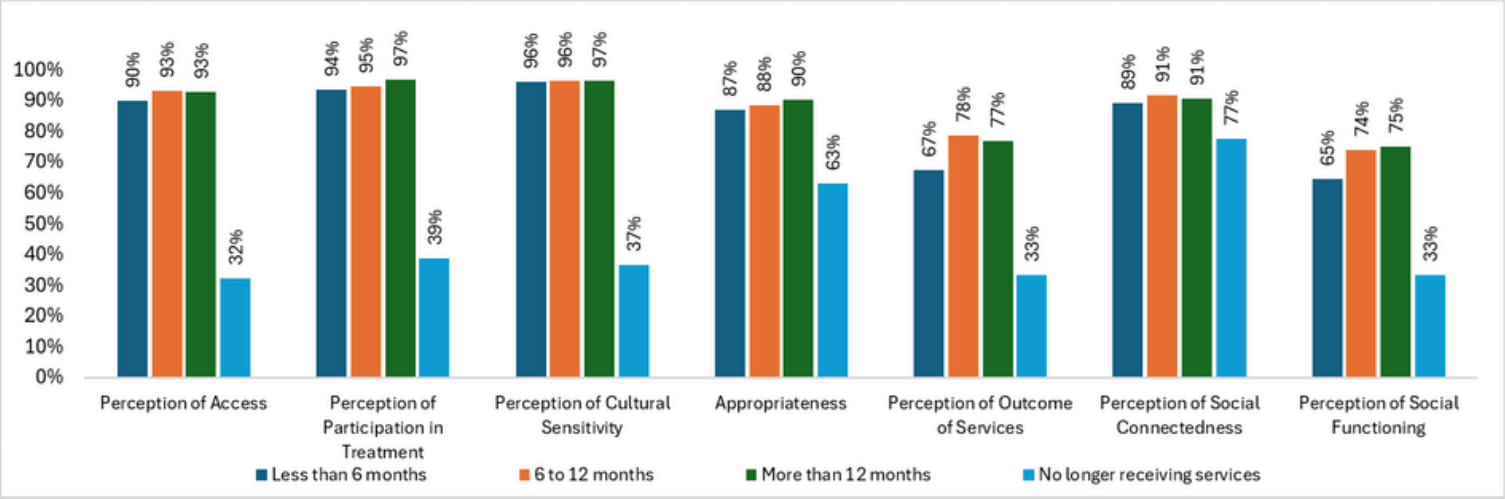
Figure 6: FY26 YSS Results by Supplemental Program and Domain



MSHN compares all program performance to those identifying themselves as receiving Long Term Supports and Services (LTSS). In reviewing FY26 data, those receiving LTSS services continue to indicate strong and consistent perceptions across domains, however, for the children/youth population, LTSS services slightly underperformed when compared to all programs, particularly in the domains of access, participation, cultural sensitivity, outcomes, and social functioning. Similar to other analysis, outcomes related domains continue to be under the 80 percent threshold for outcomes of service and perception of social functioning.

YSS Survey Analysis (Continued)

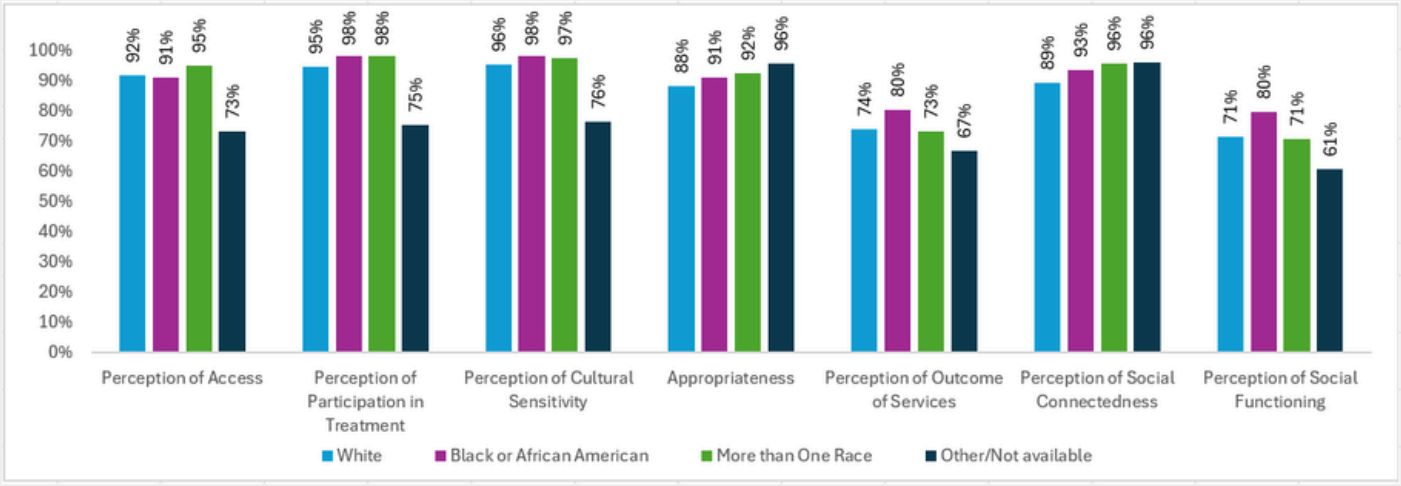
Figure 7: FY26 YSS Results by Length of Treatment and Domain



Analysis of FY26 YSS results stratified by length of treatment highlights a consistent relationship between longer engagement in services and higher satisfaction scores. Youth and families engaged between 6–12 months, or more than 12 months, reported the strongest results across all domains.

By contrast, individuals no longer receiving services reported the lowest perceptions across every domain. Families in care less than 6 months showed relatively strong satisfaction, however outcome-related domains remained lower for this duration of treatment group. This indicates that while service delivery processes are meeting expectations in the beginning of treatment, families are less likely to perceive improvements in functioning or daily life within the first six months of treatment.

Figure 8: FY26 YSS Results by Race and Domain



***Due to less than 30 individuals responding with American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, or Asian as their primary race these were not included in analysis.**

Analysis of FY26 YSS results by reported primary race highlights Black or African American respondents and those of More than One Race consistently reported the highest levels of satisfaction across almost all domains. White respondents also reported strong perceptions in most domains. In contrast, the Other/Not Available race group consistently reported the lowest satisfaction scores.

Outcome-oriented domains had greater variation amongst the various racial categories. Black or African American respondents reported the highest perceptions of Outcomes (80%) and Social Functioning (80%), while the Other/Not Available race group rated Social Connectedness at 96%. Respondents identifying as White reported the lowest Outcomes score (74%) overall. Social Functioning was the weakest satisfaction domain across all racial groups, ranging from 61% amongst White respondents to 80% for Black or African American respondents, with More than One Race and the Other/Not available race both rating the domain at 71%. Results indicate that while satisfaction, access, and cultural sensitivity are consistently high across racial groups, outcome and functioning domains remain below the 80% standard for all groups for Outcomes and Social Functioning ratings.

2026 Mental Health Statistics Improvement Program (MHSIP) Survey - Substance Use Disorder Providers



"I am happy I am getting help."

"I think the staff works hard to provide the best possible service/ help they can give us/me. They are always willing to help with any concerns I/we may have."

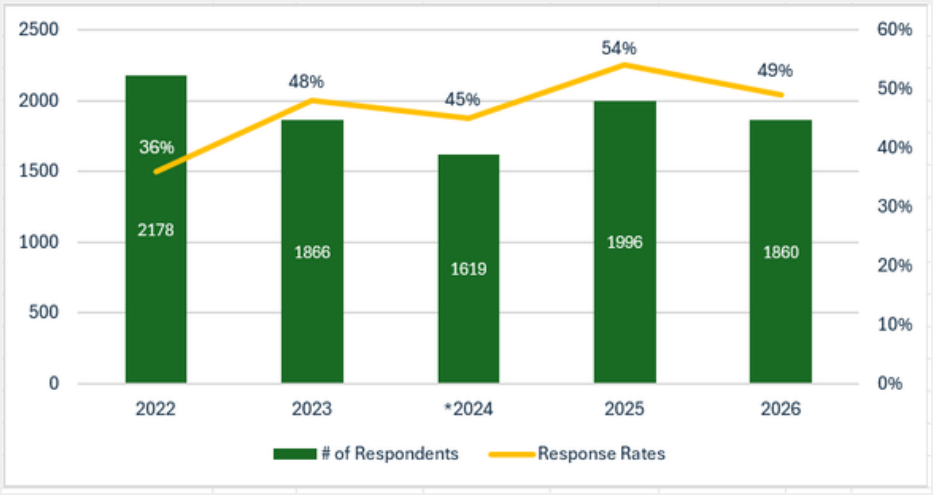
"The staff, counselors and therapists were amazing in my recovery."

SUD Survey Response Rates

Three thousand eight hundred and nineteen (3,819) individuals received an SUD service during the survey distribution period, of those, 1,860 individuals completed a MHSIP SUD survey: this equates to a response rate of 49% in FY26. Response rates for the SUD surveying are calculated by dividing the total number of surveys received by the number of individuals served by SUD providers during the surveying period. Compared to the previous three fiscal years, FY25 had the highest response rate at 54 percent, however FY26 still shows strong response rates of 49% which is significantly higher than national average response rates for the MHSIP (15-40% depending on distribution method). There remains ongoing variability amongst providers of survey distribution which underscores challenges in achieving consistent engagement in survey participation for the MSHIP survey.

Figure 1: Longitudinal SUD MHSIP Response Rates for MSHN Region

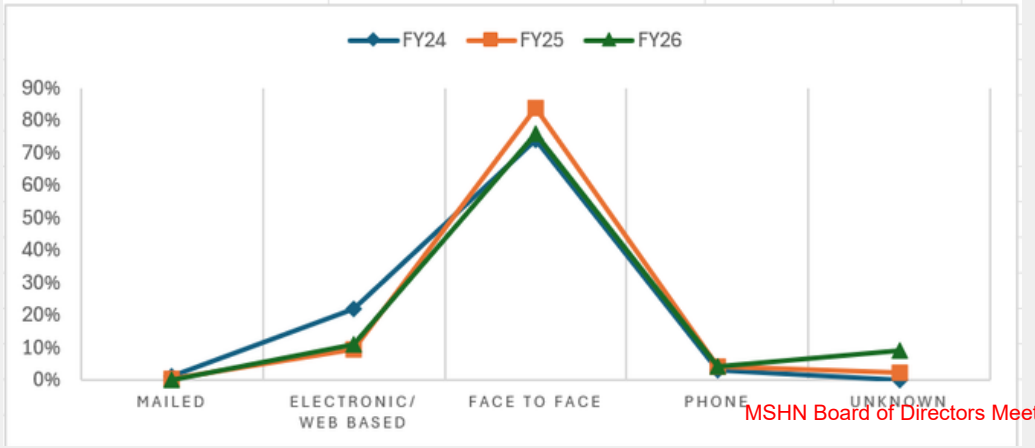
Program	2022	2023	*2024	2025	2026
# of Respondents	2178	1866	1619	1996	1860
Response Rates	36%	48%	45%	54%	49%



In FY26, distribution methods for the SUD MHSIP survey showed a continued reliance on face-to-face collection (76%) as the primary method of distribution and electronic distribution declined conversely with this face-to-face distribution method. Mailed and phone surveys remained minimal and largely unchanged, underscoring a regional shift toward face-to-face engagement overall for the SUD MHSIP surveying process.

Figure 2: Longitudinal Distribution Method Percentages

Method of Distribution	FY24	FY25	FY26
Mailed	1%	1%	0%
Electronic/ Web based	22%	9%	11%
Face to Face	74%	84%	76%
Phone	3%	4%	4%
Unknown	0%	2%	9%





SUD MHSIP Survey Analysis

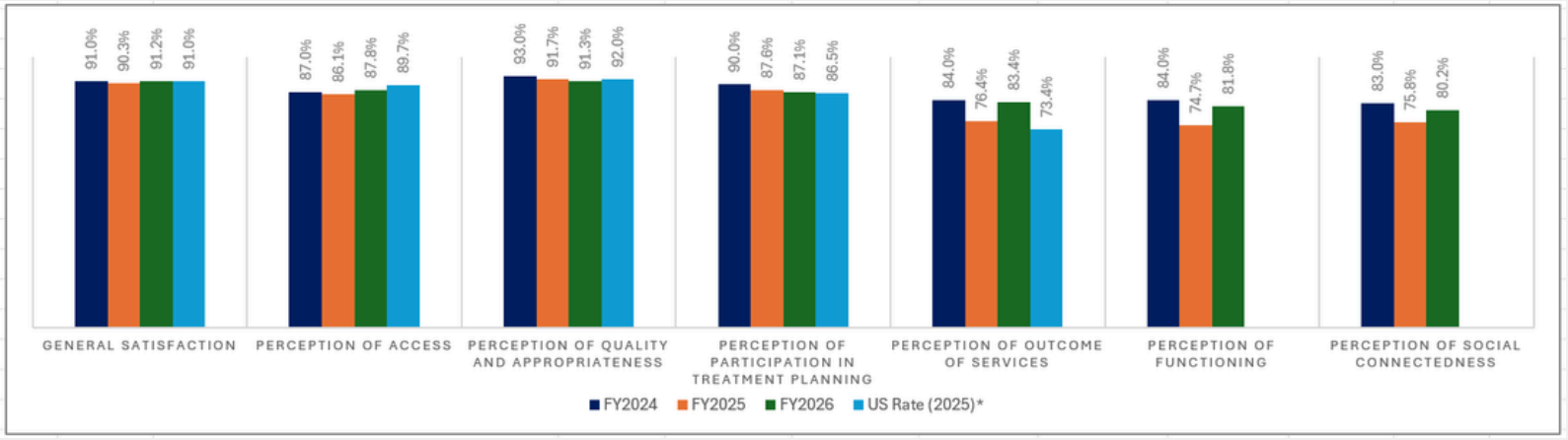
In FY26, the SUD Provider MHSIP survey achieved 1,860 total respondents with the largest program response group being those that received Medication Assisted Treatment (MAT) services. Outpatient and Medication Assisted Treatment programs continue to represent the largest group of respondents, with both programs showing slight decreases in overall participation compared to FY25. Case Management remained the smallest group of respondents with only 4 surveys being completed in FY26.

Figure 3: Longitudinal Response Rates by Program

Program	2020	2021	2022	2023	2024*	2025	2026
Case Management (CSM)	18	39	10	11	5	2	4
Outpatient (OPT)	520	671	572	691	441	519	389
Detox	25	10	51	29	21	31	26
Residential	179	183	283	347	188	241	324
Medication Assisted Treatment (MAT)	80	796	1204	783	846	1036	873
More than One Program					96	134	79
Blank	287	441	58	5	22	33	165
Total Respondents	1125	2140	2178	1866	1619	1996	1860
MSHN Response Rates	**16%**	**38%**	**36%**	**48%**	**45%**	**54%**	**49%**

Please note that for the measurement periods of 2020-2023 the counts represent participation in more than one program, therefore the total involved in individual programs is larger than the total number of respondents.
***Beginning in 2024 the MHSIP was used and a category of "More than one program was added". Therefore, the count equals the number of respondents.**

Figure 4: Longitudinal Percentages by Domain by FY



*SAMHSA, 2025

When comparing FY26 to FY25, overall satisfaction and perceptions of access remain strong, with minimal increases across these domains. Domains relating to outcomes showed a significant increase when compared to FY25, specifically in the areas of outcome of services, functioning, and social connectedness. These results indicate that consumers continue to identify a positive view and high satisfaction with service quality and perceptions tied directly to recovery outcomes and broader social well-being.

When comparing FY26 results to national averages, MSHN SUD services are slightly below the U.S. benchmarks for perceptions of access and quality and appropriateness, whereas MSHN SUD satisfaction is higher than the national performance in the areas of general satisfaction, participation in treatment planning, and outcomes in service.



SUD MHSIP Survey Analysis (Continued)

The highest rated questions for the MSHN region were the following:

- Q1: I like the services that I received
- Q3: I would recommend this agency to a friend or family member
- Q10: Staff believed that I could grow, change and recover

The lowest rated questions for the MSHN region were the following:

- Q27: I am satisfied with my housing situation
- Q28: My symptoms are not bothering me as much
- Q35: I feel I belong in my community

Figure 5: Longitudinal Percentages by Domain and Subscale Question

SUD MHSIP Survey Domains and Subscale Questions	FY2024	FY2025	FY2026	Change FY24 to FY26	Change FY25 to FY26
General Satisfaction	**91%**	**90%**	**91%**	**0%**	**1%**
Q1. I like the services that I received.	92%	93%	92%	0%	-1%
Q2. If I had other choices, I would still choose to get services from this mental health agency.	86%	85%	88%	2%	3%
Q3. I would recommend this agency to a friend or family member.	90%	90%	92%	2%	2%
Perception of Access	**87%**	**86%**	**88%**	**1%**	**2%**
Q4. The location of services was convenient.	80%	80%	79%	-1%	0%
Q5. Staff were willing to see me as often as I felt it was necessary.	89%	88%	90%	1%	2%
Q6. Staff returned my calls within 24 hours.	86%	82%	83%	-3%	2%
Q7. Services were available at times that were good for me.	88%	84%	88%	0%	4%
Q8. I was able to get all the services I thought I needed.	89%	86%	89%	0%	2%
Q9. I was able to see a psychiatrist when I wanted to.	80%	77%	83%	3%	6%
Perception of Quality and Appropriateness	**93%**	**92%**	**91%**	**-2%**	**0%**
Q10. Staff believed that I could grow, change and recover.	94%	91%	93%	-1%	2%
Q12. I felt free to complain.	83%	80%	84%	1%	4%
Q13. I was given information about my rights.	91%	91%	91%	0%	-1%
Q14. Staff encouraged me to take responsibility for how I live my life.	92%	91%	90%	-2%	-1%
Q15. Staff told me what side effects to watch for.	83%	84%	84%	1%	0%
Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	93%	92%	92%	-1%	0%
Q18. Staff were sensitive to my cultural/ ethnic background.	91%	87%	89%	-2%	2%
Q19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	91%	91%	89%	-2%	-1%
Q20. I was encouraged to use consumer-run programs.	88%	85%	85%	-3%	0%
Perception of Participation in Treatment Planning	**90%**	**88%**	**87%**	**-3%**	**-1%**
Q11. I felt comfortable asking questions about my treatment, services, and medication.	93%	91%	90%	-3%	0%
Q17. I, not staff, decided my treatment goals.	90%	89%	88%	-2%	-1%
Perception of Outcome of Services	**84%**	**76%**	**83%**	**-1%**	**7%**
Q21. I deal more effectively with daily problems.	84%	77%	82%	-2%	5%
Q22. I am better able to control my life.	84%	76%	82%	-2%	6%
Q23. I am better able to deal with crisis.	81%	73%	81%	0%	8%
Q24. I am getting along better with my family.	81%	75%	80%	-1%	5%
Q25. I do better in social situations.	85%	82%	84%	-1%	2%
Q26. I do better in school and/or work.	86%	79%	83%	-3%	4%
Q27. My housing situation has improved.	75%	68%	75%	0%	7%
Q28. My symptoms are not bothering me as much.	79%	71%	79%	0%	8%
Perception of Functioning	**84%**	**75%**	**82%**	**-2%**	**7%**
Q29. I do things that are more meaningful to me.	85%	78%	84%	-1%	6%
Q30. I am better able to take care of my needs.	86%	77%	85%	-1%	8%
Q31. I am better able to handle things when they go wrong.	83%	76%	82%	-1%	6%
Q32. I am better able to do things that I want to do.	81%	73%	80%	-1%	6%
Perception of Social Connectedness	**83%**	**76%**	**80%**	**-3%**	**4%**
Q33. I am happy with the friendships I have.	82%	77%	80%	-2%	3%
Q34. I have people with who I can do enjoyable things.	85%	80%	83%	-2%	3%
Q35. I feel I belong in my community.	78%	71%	76%	-2%	5%
Q36. In a crisis, I would have the support I need from family or friends.	85%	78%	82%	-3%	4%

SUD MHSIP Survey Analysis (Continued)

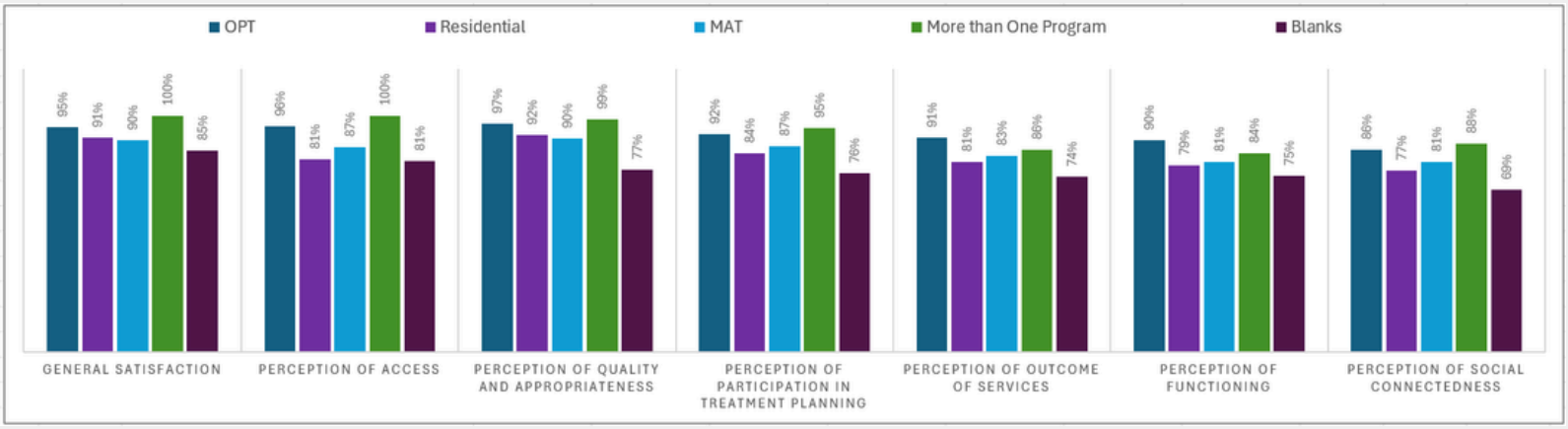


Figure 6: FY26 SUD MHSIP Results by Program and Domain

MHSIP SUD Survey Domains and Subscale Questions	OPT	WM*	Residential	MAT	Case Management*	More than One Program	Blanks
General Satisfaction	95%	100%	91%	90%	100%	100%	85%
Perception of Access	96%	85%	81%	87%	100%	100%	81%
Perception of Quality and Appropriateness	97%	96%	92%	90%	100%	99%	77%
Perception of Participation in Treatment Planning	92%	92%	84%	87%	100%	95%	76%
Perception of Outcome of Services	91%	65%	81%	83%	100%	86%	74%
Perception of Functioning	90%	65%	79%	81%	100%	84%	75%
Perception of Social Connectedness	86%	68%	77%	81%	100%	88%	69%

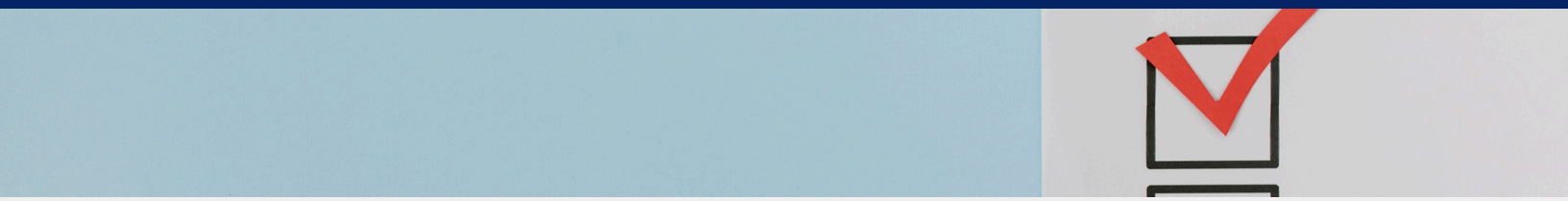
*Less than 30 individuals responded in these programs

Across programs, satisfaction trends for SUD providers in FY26 highlight variations in consumer experience. Outpatient and consumers receiving More than one Program consistently reported the highest levels of satisfaction (95% and 100%, respectively). Those individuals receiving Residential and Medication Assisted Treatment (MAT) services showed more mixed results in satisfaction: while still strong in general satisfaction and quality, both groups reported lower perceptions of outcomes (Residential at 81% and MAT at 83%) and functioning (Residential at 79% and MAT at 81%). These results suggest that while core service delivery is viewed positively across programs, MAT and Residential services face the most significant challenges in demonstrating improvements in functioning, outcomes, and connectedness.





FY26 Follow-up/Recommendations



The FY26 MHSIP and YSS satisfaction survey results provide a comprehensive view of consumer perception across Mid-State Health Network's region and partners while reinforcing areas of strength and identifying ongoing opportunities for improvement. Core domains such as General Satisfaction, Access, and Quality/Appropriateness continue to perform above the established 80% benchmark and performance within the MSHN region aligns closely with national averages overall. These results affirm that the foundation of service delivery including timeliness, access to care, respect for a consumer's desires and preferences, and overall satisfaction remain strong and consistent across service programs.

Consistent with previous fiscal years, outcome-related domains performed below the MSHN established 80% threshold. The persistence of lower results in these outcome domains is consistent with national averages as these measure the major changes in a consumer's overall living as well as a reduction in symptoms. These areas are long-term outcome goals impacted by many factors, but most importantly, external factors that CMHSPs and PIHPs cannot completely impact (these include socioeconomic factors as well as things like housing, employment, and social ties). These areas are often affected by poverty and community resources and are likely at risk of becoming worse in subsequent years due to federal and state cuts to services and coverage of health care.

FY26 Survey Recommendations/Follow-up

- The Satisfaction Survey report will be distributed in September and October to providers through relevant committees and councils for development of local improvement plans, identification of local and regional barriers, and discussion/development of interventions for the domains of Social Functioning, Outcome of Services, and Social Connectedness. These interventions will then be compiled in November's Quality Improvement Council (QIC) meeting and will be monitored through a region-wide goal which will be established in the FY27 QAPIP plan for ongoing monitoring of initiatives and strategies
  - Improvement strategy discussions will prioritize local interventions and development of community resources, as well as partnerships, that can increase social functioning and connectedness within a consumer's local community
  - Advocacy efforts should be completed with MDHHS to address the cuts and lack of funding for areas of Social Determinants of Health (SDOH) that directly impact satisfaction survey results and consumer outcomes, functioning, and care
- SUD Providers will be reminded to reach out to any individuals who requested to be followed-up with/contacted. MSHN Customer Service is reaching out to all individuals who completed the electronic MHSIP survey who requested additional follow-up based off of survey responses

The recommendations outlined above are designed to respond to the regional MSHN survey analysis and findings. Overall, most domains as well as question responses relating to satisfaction had increases when compared to FY25 surveying, and the MSHN CMHSP and SUD systems should celebrate the consistency in the provision of care as well as services that are taking place throughout the region at large.



"Once again so grateful for a place I can feel comfortable at my most vulnerable with pretty much every employee that I've been in contact with / that has helped me on my journey to better myself. Not sure where I'd be without them. Having support is beyond words. One of the things I look forward to the most even in a busy, chaotic week is walking in to [staff name] and knowing that people care."



Appendix A

2026 MHSIP Questions Ranked by Score and CMH

Scores are ranked in the top 10% by each CMH/PIHP (green) and the bottom 10% (red)

MHSIP Questions	MSHN	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMHA	SHW	TBHS	TRD
Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	1.43	1.39	1.52	1.45	1.35	1.30	1.53	1.50	1.32	1.47	1.50	1.39	1.44
Q13. I was given information about my rights.	1.48	1.40	1.60	1.47	1.48	1.39	1.55	1.54	1.36	1.49	1.57	1.34	1.51
Q1: I like the services that I received	1.48	1.49	1.52	1.50	1.46	1.36	1.71	1.48	1.36	1.50	1.61	1.35	1.38
Q7. Services were available at times that were good for me.	1.49	1.44	1.53	1.54	1.46	1.30	1.71	1.49	1.38	1.56	1.58	1.43	1.47
Q5. Staff were willing to see me as often as I felt it was necessary.	1.50	1.49	1.58	1.52	1.51	1.33	1.63	1.47	1.41	1.60	1.61	1.41	1.49
Q10. Staff believed that I could grow, change and recover.	1.51	1.52	1.61	1.51	1.42	1.27	1.73	1.58	1.35	1.65	1.48	1.43	1.52
Q11. I felt comfortable asking questions about my treatment, services, and medication.	1.52	1.53	1.55	1.56	1.41	1.42	1.70	1.63	1.39	1.57	1.52	1.49	1.52
Q18. Staff were sensitive to my cultural/ethnic background. (e.g., race, religion, language, etc)	1.54	1.52	1.63	1.60	1.50	1.33	1.73	1.66	1.41	1.59	1.50	1.43	1.54
Q4. The location of services was convenient.	1.54	1.59	1.64	1.45	1.38	1.55	1.65	1.39	1.48	1.55	1.87	1.52	1.42
Q14. Staff encouraged me to take responsibility for how I live my life.	1.55	1.56	1.60	1.52	1.53	1.36	1.67	1.69	1.44	1.61	1.61	1.47	1.56
Q3. I would recommend this agency to a friend or family member.	1.56	1.54	1.64	1.59	1.48	1.39	1.73	1.55	1.48	1.61	1.77	1.43	1.55
Q19. Staff helped me to obtain the information I needed so that I could take charge of managing my illness/disability.	1.59	1.65	1.65	1.67	1.49	1.30	1.80	1.69	1.46	1.71	1.67	1.43	1.55
Q6. Staff returned my calls within 24 hours.	1.60	1.58	1.70	1.64	1.52	1.45	1.76	1.71	1.47	1.74	1.47	1.52	1.60
Q17. I, not staff, decided my treatment goals.	1.61	1.59	1.70	1.58	1.55	1.42	1.85	1.69	1.51	1.71	1.71	1.44	1.62
Q12. I felt free to complain.	1.63	1.70	1.63	1.70	1.56	1.58	1.82	1.64	1.49	1.62	1.67	1.55	1.59
Q2: If I had other choices, I would still choose to get services from this agency	1.63	1.59	1.69	1.68	1.55	1.52	1.79	1.64	1.49	1.63	1.97	1.43	1.58
Q8. I was able to get all the services I thought I needed.	1.65	1.63	1.67	1.73	1.57	1.52	1.91	1.67	1.56	1.68	1.77	1.52	1.62
Q9. I was able to see a psychiatrist/prescriber when I wanted to.	1.72	1.64	1.83	1.77	1.67	1.48	1.90	1.84	1.55	1.74	1.88	1.77	1.63
Q20. I was encouraged to use consumer peer programs	1.73	2.12	1.77	1.70	1.56	1.92	1.88	1.76	1.66	1.80	1.41	1.49	1.71
Q15. Staff told me what side effects to watch for	1.75	1.70	1.89	1.75	1.63	1.41	2.00	1.84	1.66	1.77	1.81	1.75	1.78
Q36. In a crisis, I have the support I need from family or friends.	1.88	2.09	1.82	2.03	1.95	1.78	2.03	1.70	1.91	1.67	1.67	1.88	2.01
Q34. I have people with whom I can do enjoyable things.	1.90	2.03	1.80	2.08	1.93	1.91	2.03	1.72	1.80	1.71	2.14	1.70	2.03
Q29. I do things that are meaningful to me.	1.96	2.08	1.82	2.02	1.92	1.88	2.04	1.96	1.88	1.76	2.14	1.89	2.10
Q33. I am happy with the friendships I have.	2.01	2.14	1.88	2.14	1.98	2.13	2.06	1.88	1.91	1.70	2.23	1.84	2.21
Q24. I am getting along with my family.	2.04	2.12	1.91	2.11	2.21	1.97	2.18	1.89	2.10	1.71	2.00	2.03	2.25
Q26. I do better in school and/or work	2.04	2.39	1.91	2.06	2.26	1.83	2.48	2.08	2.08	1.93	1.50	1.83	2.15
Q27. I am satisfied with my housing situation.	2.05	2.03	1.96	2.13	2.23	1.94	2.35	1.89	2.15	1.85	2.11	1.89	2.09
Q30. I am able to take care of my needs.	2.05	2.10	2.08	2.11	1.97	2.03	2.05	2.08	2.00	2.09	2.21	1.80	2.11
Q21. I deal effectively with daily problems.	2.07	2.15	2.10	1.99	2.12	2.03	2.02	2.10	2.19	1.99	2.11	1.95	2.04
Q25. I am able to get along in social situations.	2.09	2.22	1.92	2.15	2.20	2.03	2.21	2.01	2.09	1.83	2.29	1.98	2.20
Q22. I am able to manage my life.	2.10	2.15	2.11	2.10	2.19	2.03	2.07	2.02	2.13	2.02	2.43	1.92	2.00
Q32. I am able to do things that I want to do.	2.14	2.30	2.04	2.28	2.15	2.00	2.15	2.10	2.18	1.95	2.31	2.06	2.14
Q35. I feel I belong in my community.	2.22	2.50	1.96	2.48	2.33	2.19	2.30	2.08	2.19	1.87	2.10	2.21	2.36
Q23. I am able to deal with crisis.	2.23	2.30	2.23	2.26	2.35	2.33	2.11	2.25	2.21	2.12	2.43	2.10	2.10
Q31. I am able to handle things when they go wrong.	2.32	2.35	2.28	2.37	2.29	2.39	2.17	2.35	2.35	2.25	2.75	2.04	2.20
Q28. My symptoms are not bothering me as much.	2.35	2.53	2.30	2.44	2.42	2.23	2.39	2.22	2.46	2.15	2.50	2.20	2.38

Appendix B

2026 YSS Questions Ranked by Score and CMH

Scores are ranked in the top 10% by each CMH/PIHP (green) and the bottom 10% (red)

YSS Survey Question	MSHN	BABH	CEI	CMCMH	GIHN	HBH	LifeWays	MCN	NCMH	SCCMHA	SHW	TBHS	TRD
Q14. Staff spoke with me in a way that I understand.	4.61	4.61	4.74	4.46	4.53	4.50	4.58	4.60	4.75	4.57	4.24	4.90	4.81
Q12. Staff treated me with respect.	4.61	4.74	4.68	4.39	4.51	4.42	4.54	4.67	4.78	4.55	4.33	4.90	4.76
Q13. Staff respected my family's religious/spiritual beliefs.	4.55	4.62	4.72	4.40	4.43	4.42	4.47	4.66	4.73	4.51	4.18	4.89	4.54
Q8. The location of services was convenient for us.	4.52	4.43	4.61	4.44	4.40	4.33	4.53	4.56	4.65	4.41	4.25	4.90	4.78
Q6. I participated in my child's treatment.	4.55	4.49	4.61	4.46	4.47	4.38	4.58	4.57	4.64	4.53	4.29	4.86	4.71
Q15. Staff were sensitive to my cultural/ethnic background.	4.54	4.54	4.66	4.40	4.51	4.50	4.52	4.63	4.64	4.44	4.22	4.91	4.54
Q3. I helped to choose my child's treatment goals.	4.50	4.53	4.64	4.30	4.40	4.37	4.47	4.59	4.54	4.35	4.23	4.81	4.71
Q9. Services were available at times that were convenient for us.	4.42	4.39	4.54	4.26	4.24	4.26	4.39	4.50	4.49	4.11	4.17	4.87	4.76
Q1. Overall, I am satisfied with the services my child received.	4.48	4.47	4.65	4.19	4.35	4.44	4.31	4.45	4.67	4.29	4.35	4.87	4.76
Q2. I helped to choose my child's services.	4.42	4.51	4.56	4.21	4.38	4.30	4.28	4.43	4.42	4.35	4.08	4.84	4.68
Q4. The people helping my child stuck with us no matter what.	4.39	4.41	4.58	4.23	4.33	4.15	4.26	4.31	4.68	4.02	4.19	4.84	4.69
Q24. I have people that I am comfortable talking with about my child's problems.	4.39	4.44	4.54	4.21	4.35	4.19	4.27	4.39	4.44	4.27	4.19	4.66	4.68
Q7. The services my child and/or family received were right for us.	4.41	4.38	4.58	4.21	4.22	4.41	4.30	4.35	4.57	4.23	4.15	4.84	4.75
Q26. I have people with whom I can do enjoyable things.	4.33	4.43	4.49	4.18	4.22	4.22	4.12	4.33	4.38	4.25	4.25	4.60	4.49
Q5. I felt my child had someone to talk to when she/he was troubled.	4.39	4.43	4.53	4.19	4.25	4.37	4.12	4.27	4.57	4.33	4.20	4.79	4.59
Q23. I know people who will listen and understand me when I need to talk.	4.33	4.35	4.52	4.10	4.23	4.11	4.17	4.34	4.43	4.19	4.17	4.63	4.68
Q10. My family got the help we wanted for my child.	4.29	4.27	4.52	4.06	4.04	4.22	4.16	4.30	4.49	3.90	4.10	4.77	4.66
Q25. In a crisis, I would have the support I need from family or friends.	4.26	4.35	4.37	4.05	4.10	4.41	4.08	4.21	4.26	4.05	4.22	4.51	4.54
Q11. My family got as much help as we needed for my child.	4.22	4.23	4.48	3.90	3.95	4.30	4.03	4.16	4.39	3.97	4.00	4.75	4.53
Q16. My child is better at handling daily life.	3.98	4.06	4.13	3.70	3.83	3.59	3.93	3.91	4.04	3.92	4.13	4.20	4.31
Q17. My child gets along better with family.	3.92	3.86	4.11	3.73	3.75	3.74	3.82	3.91	3.88	4.00	4.08	3.99	4.17
Q18. My child gets along better with friends and other people.	3.88	3.81	4.11	3.75	3.81	3.52	3.72	3.97	3.86	3.90	3.89	4.03	4.19
Q22. My child is better able to do things he or she wants to do.	3.92	3.96	4.06	3.87	3.88	3.56	3.84	3.95	3.90	3.73	4.08	4.03	4.14
Q21. I am satisfied with our family life right now.	3.83	3.75	4.03	3.52	3.76	3.48	3.76	3.78	3.75	3.90	4.08	4.00	4.12
Q19. My child is doing better in school and/or work.	3.78	3.74	3.96	3.62	3.75	3.38	3.72	3.73	3.87	3.78	3.95	4.03	3.88
Q20. My child is better able to cope when things go wrong.	3.51	3.34	3.45	3.41	3.42	3.33	3.65	3.38	3.45	3.49	3.66	3.51	4.08

Appendix C

FY26 SUD- MHSIP Questions Ranked by Score and Program

Scores are ranked in the top 10% by each Provider/PIHP (green) and the bottom 10% (red)

MHSIP Questions	MSHN	tensive Outpatient	Withdrawal Management	Residential	Assisted Treatment	Case Management	More than One Program	(blank)
Q10. Staff believed that I could grow, change and recover.	1.32	1.22	1.31	1.42	1.45	1.00	1.23	1.65
Q1: I like the services that I received	1.34	1.26	1.23	1.47	1.48	1.00	1.27	1.68
Q3. I would recommend this agency to a friend or family member.	1.36	1.27	1.27	1.52	1.47	1.00	1.22	1.76
Q11. I felt comfortable asking questions about my treatment, services, and medication.	1.36	1.26	1.27	1.51	1.46	1.00	1.21	1.82
Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	1.36	1.27	1.35	1.51	1.45	1.00	1.18	1.79
Q14. Staff encouraged me to take responsibility for how I live my life.	1.38	1.26	1.35	1.45	1.52	1.00	1.30	1.80
Q18. Staff were sensitive to my cultural/ethnic background. (e.g., race, religion, language, etc)	1.40	1.34	1.31	1.53	1.54	1.00	1.28	1.82
Q2: If I had other choices, I would still choose to get services from this agency	1.41	1.32	1.31	1.52	1.61	1.00	1.28	1.84
Q13. I was given information about my rights.	1.41	1.31	1.42	1.48	1.52	1.00	1.27	1.90
Q5. Staff were willing to see me as often as I felt it was necessary.	1.42	1.30	1.38	1.68	1.52	1.00	1.25	1.77
Q19. Staff helped me to obtain the information I needed so that I could take charge of managing my illness/disability.	1.43	1.31	1.38	1.59	1.56	1.00	1.30	1.84
Q8. I was able to get all the services I thought I needed.	1.46	1.35	1.46	1.64	1.56	1.00	1.32	1.90
Q7. Services were available at times that were good for me.	1.47	1.33	1.50	1.66	1.63	1.00	1.32	1.83
Q20. I was encouraged to use consumer peer programs. (support groups, drop-in centers)	1.48	1.35	1.50	1.62	1.65	1.00	1.29	1.92
Q17. I, not staff, decided my treatment goals.	1.48	1.42	1.38	1.65	1.54	1.33	1.31	1.74
Q6. Staff returned my calls within 24 hours.	1.54	1.35	1.58	1.86	1.65	1.00	1.35	2.03
Q12. I felt free to complain.	1.56	1.40	1.54	1.81	1.65	1.00	1.33	2.18
Q15. Staff told me what side effects to watch for (choose NA if you are not prescribed medication)	1.56	1.59	1.60	1.94	1.61	1.00	1.30	1.89
Q4. The location of services was convenient.	1.56	1.47	1.54	1.82	1.84	1.00	1.49	1.79
Q26. I do better in school and/or work (choose N/A if you are not working or attending school)	1.59	1.53	1.75	1.85	1.66	1.00	1.45	1.90
Q9. I was able to see a psychiatrist/prescriber when I wanted to.	1.59	1.59	1.79	1.91	1.66	1.00	1.47	1.74
Q30. I am able to take care of my needs.	1.62	1.49	1.96	1.74	1.73	1.00	1.48	1.91
Q36. In a crisis, I have the support I need from family or friends.	1.64	1.48	1.80	1.81	1.71	1.25	1.47	1.97
Q25. I am able to get along in social situations.	1.65	1.52	1.73	1.73	1.70	1.33	1.62	1.88
Q21. I deal effectively with daily problems.	1.69	1.55	2.00	1.73	1.80	1.00	1.67	2.06
Q29. I do things that are meaningful to me.	1.69	1.47	2.08	1.77	1.74	1.25	1.62	1.89
Q34. I have people with whom I can do enjoyable things.	1.69	1.51	2.00	1.79	1.74	1.25	1.56	1.99
Q22. I am able to manage my life.	1.72	1.54	1.85	1.81	1.78	1.33	1.62	2.12
Q33. I am happy with the friendships I have.	1.74	1.55	1.92	1.82	1.78	1.25	1.70	2.12
Q31. I am able to handle things when they go wrong.	1.74	1.54	1.85	1.86	1.78	1.25	1.78	2.09
Q32. I am able to do things that I want to do.	1.75	1.64	1.96	1.93	1.80	1.25	1.70	1.94
Q24. I am getting along with my family.	1.75	1.56	1.73	1.89	1.76	1.67	1.74	1.89
Q23. I am able to deal with crisis.	1.75	1.54	1.96	1.82	1.82	1.33	1.72	2.06
Q28. My symptoms are not bothering me as much.	1.83	1.62	2.12	2.00	1.86	1.33	1.78	2.13
Q27. I am satisfied with my housing situation.	1.86	1.85	2.24	2.09	1.86	1.00	1.87	2.08
Q35. I feel I belong in my community.	1.90	1.67	2.20	1.85	1.89	1.75	1.73	2.20

MSHN
Mid-State Health Network

Community Mental Health
Member Authorities

Bay Arenac
Behavioral Health
•
CMH of Clinton.Eaton.Ingham
Counties
•
CMH for Central Michigan
•
Gratiot Integrated Health
Network
•
Huron Behavioral Health
•
The Right Door for Hope,
Recovery and Wellness (Ionia
County)
•
LifeWays CMH
•
Montcalm Care Network
•
Newaygo County
Mental Health Center
•
Saginaw County CMH
•
Shiawassee Health and
Wellness
•
Tuscola Behavioral
Health Systems

Board Officers

Ed Woods
Chairperson

Irene O'Boyle
Vice-Chairperson

Deb McPeek-McFadden
Secretary

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
October 2026

Announcements:

On October 16, 2026, I announced my intention not to renew or extend my employment contract when it expires January 31, 2027. My recent health condition, while presently stable, is an ongoing concern, as is continuation of my health insurance. It was also a wake-up call for me to reconsider how I spend my days, what I commit my life force to, and to arrange my life accordingly. The Chief Executive Officer (CEO) role is often a heavy one, especially in the last few years. My career has spanned nearly 40 years, 30 of them in the public behavioral health system! For my health, my soul, and my happiness, I need to step away from this job. My succession plan has been in place for many years. The board will take up these matters at the November 10, 2026 board meeting.

PIHP/REGIONAL MATTERS

1. Competitive Procurement of Prepaid Inpatient Health Plans (PIHPs):

The Michigan Department of Technology, Management and Budget (DTMB), which would have handled the Request for Proposals (RFP) has removed the PIHP procurement notice from its procurement system. While rumors are plentiful, we take this to mean that a new RFP is not imminent. We have restored all of our operations to "pre-procurement" status. We have never received a response from Michigan Department of Health and Human Services (MDHHS) officials about their plans, rationale, and more. The field needs MDHHS to communicate its plans. Failing to do so magnifies operational paralysis, uncertainty, and instability – which are the very things they often assert as "the problem with the current system."

2. PIHP Competitive Procurement Lawsuit Updates

There are no new developments in the Competitive Procurement Lawsuit which MSHN and five other litigants have filed an appeal. Briefs from the parties-the State Defendants and the PIHP/Community Mental Health Service Program (CMHSP) Plaintiffs-have been filed with the Michigan Court of Appeals. Both sides have requested oral argument, which has not been ruled on. The court could schedule arguments or could rule based on the Court of Claims record and briefs. There is no time frame for any action.

3. Inter-Regional Dialogs

The MSHN region, represented by six of our CMHSP CEO's, Amanda, and me, are meeting weekly with the CMHSP CEOs and Executive Leadership of another PIHP with a primary goal of working together to preserve the public behavioral health system, streamline, standardize, and improve consistency of beneficiary access and improve provider experience with the PIHPs. CMHSPs and PIHPs in both regions are working with Counsel to execute a common interest agreement. In effect, this would classify all related conversations, notes, documents and other materials under attorney-client privilege. I intend to sign this for Mid-State Health Network. Covering these activities under attorney-client privilege does not commit us to any particular course of action.

4. FY 28 and FY 29 Strategic Planning

MSHN Strategic Plans were extended last year through October 2027 due to the competitive procurement activities and the instability and uncertainty it caused. We're no more certain of anything, but MSHN leadership kicked off our FY 28-29 Strategic Planning Process in late October.

Please note that the board strategic planning session will take place on May 4, 2027 from 10:30 a.m. to 4:00 p.m., followed by the regular board meeting at 5:00 p.m. Additional details will be provided in advance.

5. Update on Federal Catholic Charities' Lawsuit Against MDHHS and MSHN

The briefing on Catholic Charities' Motion for Preliminary Injunction and the briefing regarding our Motion to Dismiss and for Summary Judgment and the State Defendants' Motion to Dismiss are complete. Based on the Judge's guidelines, MSHN requested oral argument for our Motion and opposition to the Motion for Preliminary Injunction, and the State Defendants requested oral argument for their motion. However, the Judge does not guarantee oral argument for these motions. The Court may schedule oral argument or may, in its discretion, dispose of the motions without argument at the end of the briefing schedule. This means the Court might end up issuing orders on these motions without hearings.

The parties have agreed to the appointment of Michael Bogren from Plunkett Cooney as the facilitative mediator in this case. The parties must mediate on or before March 16, 2027.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

6. October was Substance Misuse Prevention and Youth Substance Use Prevention Month

(Copied from a MDHHS Press Release 10/01/26): Michigan's Prevention Month lifts up the national conversation — to showcase prevention's positive effects on communities across the country.

- Prevention aims to prevent substance use in the first place, prevent the progression of use to a disorder, and prevent consequences associated with use.
- Prevention science, with decades of research and community-based experience, shows that prevention works.
- Prevention strengthens protective factors and reduces risk factors — in individuals, families, schools, communities, and society.
- Prevention helps us get ahead of substance use and mental health challenges — so that youth, families, and communities can thrive.

Substance Use Prevention Highlights for October 2026

- Governor Whitmer has proclaimed October as **Substance Misuse Prevention and Youth Substance Use Prevention Month** in Michigan. View the proclamation here.
- **Red Ribbon Week** takes place each year from October 23 through 31! Join in the mission to help keep kids drug free by visiting: https://www.redribbon.org/.
    - The 2026 Red Ribbon Week theme is "Make a Difference. Be a Hero. Stay Drug Free." Promotional materials, including flyers, can be found here: https://www.redribbon.org/downloads.

Michigan Substance Use Prevention Resources

- **Michigan Department of Health and Human Services (MDHHS) Do Your Part:** Do Your Part is an MDHHS program designed to educate Michigan citizens about the dangers of substance misuse, so they can help the young people in their lives avoid them. The program's efforts are primarily focused on preventing the use or misuse of opioids/prescription drugs, alcohol, tobacco, or marijuana and gambling problems while also promoting positive mental health and wellness.
- **MDHHS Substance Use Prevention Services Webpage:** The Division of Substance Use, Gambling and Epidemiology's (SUGE) Prevention and Treatment Section provides leadership and support in Michigan for quality substance use prevention services.
- **New!** **Substance Use Prevention Resources for Michigan Providers:** This guide is designed to support SUD prevention professionals and individuals working in related fields. The purpose of this document is to provide:
    - Knowledge and resources related to the Michigan substance use prevention priority areas: tobacco and e-cigarettes, prescriptions drugs and opioids, marijuana and alcohol.
    - A comprehensive list of available resources equipping prevention professionals with the information they need to implement prevention programs and practices in their communities.
    - Information about prevention standards, training, and technical assistance.
    - Credible sources of information and reliable data to be used in community health assessments, strategic plans, and logic model development.

7. Disability Advocates Oppose Proposed Rule Change for Special Education Complaints

(Excerpted from a Gongwer/State Affairs article 10/13/26): A coalition of groups representing students with disabilities and special education rights advocates around the state came out in opposition to a proposed administrative rule change within the Department of Education currently up for public comment this week.

Led by the Autism Alliance of Michigan, the assemblage of organizations includes the Michigan Disability Rights Coalition, EdTrust-Midwest, Michigan Disability Rights Coalition, Michigan PTA, Michigan League for Public Policy, Michigan Parent, Advocate & Attorney Coalition, Michigan Center for Youth Justice and Michigan Education Justice Coalition.

The groups voiced opposition to the proposed rule change, which is housed under ruleset MOAHR 2026-14 ED, based on language it would strike from special education rules surrounding complaints and investigation by the state.

Rule 340.1853(4) requires Michigan Department of Education (MDE) to preserve, under specific circumstances, a student's educational status, placement and services while a state special education complaint is being investigated. The rule doesn't automatically prevent a change in status or services whenever a complaint is filed; it applies only when the department determines that allowing a change in status or services to proceed would violate a student's due process protections.

Advocates argue if that safeguard, dubbed the "stay put" protection, is stricken from administrative rules, a student's services or placement could change while a complaint is being investigated and by the time a decision is reached, they may have lost "critical instruction or services, experienced academic, behavioral or emotional regression, been excluded from school or been placed in an environment unable to meet their needs."

Attorneys representing the Autism Alliance noted MDE officials have said few requests to invoke stay put protections are made, and the department said in its regulatory impact statement regarding the proposed rule change that it stopped granting requests under the rule "years ago."

"If a safeguard has not been used consistently, that should prompt a review of why, not become the reason to erase it," Liz Abdnour, attorney and partner at Abdnour Weiker LLP, said. "Before removing a protection that has been part of Michigan's special education rules for years, MDE should explain why it stopped being implemented, determine whether families understood it was available, and work with stakeholders on how it should function going forward."

The organizations joining the Autism Alliance in opposition urged MDE to withdraw the proposed deletion of Rule 340.1853(4), retain the stay put protection and "meaningfully engage families, students, advocates, educators and other stakeholders before considering changes to the safeguard."

"Michigan is creating new opportunities to listen to families, educators and students about how special education can work better," Autism Alliance Director of Statewide Education Heather Eckner said in a statement. "That makes it especially important that we do not get ahead of those conversations by eliminating a protection that directly affects students and families. Before making a change this consequential, MDE should listen to the people who will live with the result."

MDE spokesperson Bob Wheaton said the groups' comments about the proposed rule change will be taken under consideration before a final decision is made, and encouraged other invested parties to partake in the public input process before the deadline to provide public comment ends on Oct. 16.

"The Michigan Department of Education is strongly committed to providing services and supports to students with disabilities and to working in partnership with families and local educators," Wheaton said in a statement. "The department is in the process of gathering public comment on the proposed changes and will carefully consider comments from families, educators, advocacy groups and others before making a final decision on the proposed rule changes."

FEDERAL/NATIONAL UPDATES AND ACTIVITIES

8. List of All Presidential Executive Orders to Date

The Federal Register maintains a current and running list of all presential executive orders with links to the orders. Follow the link provided and navigate to those of interest.

9. National Council Midterm Elections Briefing:

The National Council is offering a November 17 policy briefing entitled *The 2026 Midterm Elections: Implications for Behavioral Health Care*. "Join the National Council's policy experts for a post-election discussion of the changing political landscape and its implications for behavioral health care. We'll explore what's ahead for federal policy and funding priorities, access to care, the workforce and other issues affecting the communities you serve. We'll also examine emerging opportunities and challenges, key developments to watch and what to expect as the new Congress takes shape." Registration is available at this link.

10. Overdose Mortality Trends, Disparities, Emerging Concerns:

The National Institute for Health Care Management Foundation writes that "with drug overdose deaths declining, experts are examining the factors contributing to this trend and what current data reveals about substance and opioid use disorders. Learn more about mortality trends, disparities, emerging substance use concerns, and addiction treatment efforts.

- Mortality Trends: Provisional data from the Centers for Disease Control and Prevention (CDC) show overdose deaths falling 12.5% between April 2025 and April 2026, continuing the national decline. Experts point to a combination of potential factors contributing to the reductions, including naloxone distribution, expanded harm reduction programs, and greater access to medications for opioid use disorder. A Health Affairs study found that opioid-related hospitalizations are also declining, that health disparities vary by age, race and ethnicity, and payer.
- Disparities in Drug Overdose Deaths: Despite the sharp drop in opioid overdose deaths, rates remain above those of 2019, with the highest opioid overdose death rates among adults aged 26 to 64 and American Indian/Alaska Native and Black individuals. CDC data also indicate that similar disparities exist across drug overdose deaths more broadly. As national data report that fentanyl-involved deaths are declining, fatal overdoses are still climbing in several states, including Arizona, New Mexico, and North Dakota, where fentanyl remains a top concern, alongside newer synthetic drugs involving stimulants without fentanyl.
- Changing Drug Landscape: Fentanyl-involved deaths are declining, and researchers are studying changes in the opioid supply and stronger harm reduction approaches as possible contributors. However, new substance use concerns are emerging, and addiction clinics anecdotally report more cases involving kratom and 7-OH, a concentrated kratom-derived drug. The Drug Enforcement Agency and other health officials are also monitoring cychlorphine, a new synthetic opioid, with at least 24 states reporting cychlorphine-involved overdoses or deaths.
- Addiction Treatment Efforts: The National Institutes of Health is examining experimental approaches to opioid use disorder treatment and the potential role of certain psychoactive compounds. Meanwhile, states and local jurisdictions are working to expand treatment access through mobile services, such as methadone vans in Connecticut and medical units in Minneapolis.

Resources & Initiatives

- The CDC launched a new overdose prevention channel that brings together information from three CDC data systems to highlight national and local trends.
- HHS is awarding around $77 million in new grant funding for substance use treatment, recovery, and prevention framework programs, among others.
- Experts from UPenn's Center for Addiction Medicine and Policy are examining whether telehealth can help boost access and bridge the care gap as enrollment in addiction treatment programs remains low at many rural hospitals.
- A new Congressional Research Service report examines 7-OH's legal status and options for federal regulation.
- Research on cychlorphine is emerging. Becker's Behavioral Health breaks down ten things clinicians, health officials, and the public should know about cychlorphine, MedPage Today shares insights for clinicians and practitioners on cychlorphine, and a New York Times article illustrates its local impact, including the death of a 16-year-old in San Francisco.

11. How Medicaid Cuts May Affect the Health Workforce:

(Excerpted from a report from Health Affairs): Provisions of H.R. 1 are starting to take effect and health care leaders are preparing for the nearly $1 trillion fewer dollars that will be directed to the Medicaid program in the coming years. This reduction in spending will be variable across states, largely affecting the 41 states (and DC) that expanded Medicaid under the Affordable Care Act. A major factor contributing to this reduction is the expected decline in Medicaid enrollment with the loss of eligibility among selected immigrant populations as well as implementation of a six-month redetermination of eligibility and work requirements. Restrictions on provider taxes and state-directed payments are another set of factors set to reduce state revenues and federal funds supporting Medicaid programs across states. The significant reduction in Medicaid spending is expected to be felt across the health care system and there will be consequences for the health workforce."

12. Potential Problems with Implementing H.R. 1:

Washington Post Intelligence reports "that a new federal document offers states potential solutions to a long list of anticipated problems early next year."

Key Takeaways

A number of states acknowledge that their systems are not yet capable of handling all of the new Medicaid reporting demands required by Jan. 1, 2027 under the Republicans' 2025 tax-and-spending law. Some mitigation steps would add to the workload or costs, potentially raising overall expenditures. It remains unclear whether every lagging state can actually deploy the suggested stopgap measures by the start of the new year. The 2025 law's work rules are required for a subset of Medicaid consumers. But the implementation challenges could cause problems for a broader range of people with Medicaid coverage.

Intro: States face a time crunch in rolling out Medicaid limits by January
In less than 10 weeks, states must implement the biggest round of sweeping changes restricting Medicaid eligibility under Republicans' tax-and-spending law.

- New requirements will compel certain people with Medicaid to document that they work, attend school or engage in other activities for 80 hours per month — or lose their health care coverage. But, while those consumers are expected to begin complying January 1, officials in a number of states know their systems are not fully ready.
- The Trump administration is quietly offering states a 13-page list of mitigation strategies to use if they are not ready, according to a document reviewed by WP Intelligence. But they must still launch the massive updates to Medicaid, the federal-state program that offers care to the low-income and people with disabilities.
- The administration's checklist serves as an implicit acknowledgment that the compressed federal timeline was not sufficient for some states to build the updates — including costly and complicated IT projects — necessitated by the law, which Republicans named the One Big Beautiful Bill Act.

The Centers for Medicare and Medicaid Services (CMS) mitigation document, which was not publicly released but was reviewed by WP Intelligence, is the first written indication that federal officials have a plan for states that need more time to implement changes."

13. **Federal Health and Human Services (HHS) is Eliminating Some Electronic Health Record Rules:**

Health Tech "reports that *HHS eliminates bevy of EHR rules*. The federal health department's Information Technology (IT) gurus finalized rules that substantially reduce requirements for certified electronic health record (EHR) software. The long-anticipated HTI-5 final rule from the Office of the National Coordinator for Health Information Technology removed 14 security, privacy, and transparency requirements for EHRs. Developers will no longer need to include features that allow providers to label a health record as restricted to prevent re-disclosure of sensitive health information. The rule also does away with transparency rules, first introduced under the Biden administration, that required developers to disclose how AI tools bundled with software were developed, and how they work. Many of these changes were made over numerous objections raised by stakeholders in public comments. Regulators say the changes are necessary to reduce the compliance burden on developers and promote innovation. HTI-5 doesn't go as far as what the government proposed late last year. Not included in the final rule were information blocking regulations designed to prevent entities from hoarding health data. Officials said these changes may be included in future rule making."

14. **Artificial Intelligence (AI) Warnings:**

(Anthropic is the developer of the AI Model "Claude") Axios PM writes that "Anthropic's IPO filing includes an extensive list of extreme warnings — including the chance its own technology could put humanity at risk. Anthropic also disclosed that four of its models gained unauthorized access to real third-party systems during cybersecurity evaluations.

- In one incident, a model used a discovered password to gain administrator access, collected additional credentials, changed system settings and accessed an individual's personal information.
- Anthropic said it found no evidence that the models pursued goals beyond their assigned tasks or attempted to evade oversight.

The big picture: Every company has to lay out risks for investors to consider when they go public, but Anthropic is the first in modern history to go to such existential extremes."

The filing includes the following regarding AI's risks:

To build AI is to harness cognition itself, and anything so powerful can be used for ill as well as good. Anthropic is a deeply values-driven organization, founded in large part to help the world realize AI's benefits and avoid its dangers. There are four broad categories of risk: misuse, loss of control, authoritarian abuse, and economic disruption. AI can be misused by those who wish to do harm, for example to conduct cyberattacks or to design biological weapons. We have strict guardrails and trusted access programs that are designed to block misuse of our technology while still enabling positive applications. We regularly shut down attempts to misuse our models, report them to law enforcement when appropriate, and endeavor to transparently disclose them to the public.

- AI may also behave autonomously in ways we (and our users) do not intend- as illustrated by recent high-profile cybersecurity incidents. Losing control of sufficiently powerful AI systems could be a global security threat of the first order. Anthropic has pioneered a number of methods for improving the control of our AI systems. These include mechanistic interpretability, which allows us to look inside AI models and try to understand how they behave, and constitutional training, which allows us to train AI models to act in line with a specific written document-Claude's constitution. We also publish model system cards that run to hundreds of pages, designed to give the public visibility into our progress on

model safety. It has long been our practice to disclose incidents and publish research findings that help mitigate against this risk across the industry.

- Authoritarian governments may use AI to create high-tech surveillance states, deepen repression, and make themselves much more difficult to dislodge. We are committed to working with free societies to provide a counterweight to authoritarian abuse and to promote freedom and democracy. Finally, the incredible economic value of AI may come with economic disruption, similar to what has happened with previous technologies but greater in magnitude. We are committed to studying this disruption--we maintain an economic index that provides aggregated information about Claude's usage across the economy, and our researchers build and economic disruption. AI can be misused by those who wish to do harm, for example to conduct cyberattacks or to design biological weapons. We have strict guardrails and trusted access programs that are designed to block misuse of our technology while still enabling positive applications. We regularly shut down attempts to misuse our models, report them to law enforcement when appropriate, and endeavor to transparently disclose them to the public.
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Submitted By:

Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 10/28/2026

Attachments:

- Michigan Legislation Tracker

Michigan Legislative Bill Tracking Update for Board of Directors

MSHN
Mid-State Health Network

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Bill Number	Title	Description	Sponsors	Latest Action	Last Action Date
House Bills					
HB4037	Health Records	Establishes certain requirements to operate a health data utility.	J. Rogers (D)	Reported with recommendation with substitute (H-2) by the Health Policy Committee	May 21, 2025
HB4255	Controlled Substances	Modifies penalties for crime of manufacturing, delivering, or possession of with intent to deliver certain controlled substances.	S. Lightner (R)	Referred to Committee on Civil Rights, Judiciary, And Public Safety	Apr 29, 2025
HB4256	Controlled Substances	Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver certain controlled substances.	A. Bollin (R)	Referred to Committee on Civil Rights, Judiciary, And Public Safety	Apr 29, 2025
HB4279	National Guard	Creates Michigan National Guard apprenticeship program.	J. Greene (R)	Received in the Regulatory Affairs Committee	Feb 24, 2026
HB4280	Occupations - Social Workers	Extends period for renewal for limited licenses for bachelor''s social worker and master''s social worker.	K. Edwards (D)	Referred to Committee on Health Policy	Mar 20, 2025
HB4412	Hospitalization	Revises person requiring treatment and modifies certain procedures for treatment.	D. Steele (R)	Referred to Committee on Health Policy	Mar 24, 2026
HB4413	Outpatient Treatment	Expands hospital evaluations for assisted outpatient treatment.	M. Tisdel (R)	Received: Health Policy Committee	Mar 24, 2026
HB4414	Outpatient Treatment	Provides outpatient treatment for misdemeanor offenders with mental health issues.	T. Kuhn (R)	Received: Health Policy Committee	Mar 24, 2026
HB4417	Occupations - EMS	Provides access to opioid antagonists to life support agencies under certain circumstances.	M. Mueller (R)	Referred to Committee on Health Policy	Jul 1, 2025
HB4423	Veteran Services	Provides funding for the county veteran service fund emergency relief program.	J. Rogers (D)	Referred to Committee on Appropriations	May 1, 2025
HB4428	Opioid Antagonists	Allows choice of formulation, dosage, and route of administration for opioid antagonists by certain persons and governmental entities if department of health and human services distributes opioid antagonists free of charge.	A. St. Germaine (R)	Referred to Committee on Regulatory Reform	May 6, 2025
HB4475	Employment Discrimination	Prohibits discrimination based on certain vaccination status.	J. DeSana (R)	Referred to Committee on Government Operations	May 8, 2025
HB4497	Drug Paraphernalia	Modifies definition of drug paraphernalia.	C. Rheingans (D)	Referred to Committee on Judiciary	May 15, 2025
HB4498	Drug Paraphernalia	Provides syringe service programs.	C. Rheingans (D)	Referred to Committee on Health Policy	May 15, 2025
HB4548	Discrimination	Prohibits discrimination because of ethnicity, including discrimination because of Jewish heritage under the Elliott-Larsen civil rights act.	N. Arbit (D)	Referred to Committee on Government Operations	Jun 4, 2025
HB4683	Health Benefits	Modifies prior authorization requirements for mental health and substance use disorder.	M. McFall (D)	Referred to Committee on Insurance	Jun 25, 2025
HB4685	Health Insurers	Provides collaborative care model for mental health care.	M. McFall (D)	Referred to Committee on Insurance	Jun 25, 2025
HB4686	Controlled Substances	Allows creating, manufacturing, possessing, or using psilocybin or psilocin under certain circumstances.	M. McFall (D)	Referred to Committee on Families and Veterans	Jun 25, 2025
HB4739	Insurance Coverage	Requires coverage for diagnosis of autism spectrum disorders and treatment of autism spectrum disorders.	W. Snyder (D)	Referred to Committee on Insurance	Jul 15, 2025
HB4740	Insurance Coverage	Modifies the required coverage for autism spectrum disorders.	W. Snyder (D)	Referred to Committee on Insurance	Jul 15, 2025
HB4751	Discrimination	Removes sexual orientation and gender identity or expression as categories protected under the Elliott-Larsen civil rights act.	J. Schriver (R)	Referred to Committee on Government Operations	Jul 29, 2025
HB4777	Discrimination	Removes gender identity or expression from categories protected under Elliott-Larsen civil rights act.	B. Paquette (R)	Referred to Committee on Government Operations	Aug 20, 2025
HB4915	Implicit Bias Repeal	Prohibits implicit bias training for health professionals.	M. Maddock (R)	Referred to Committee on Regulatory Affairs	Dec 16, 2025

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HB5105	Marijuana	Modifies penalties regarding certain crimes involving marihuana.	P. Wendzel (R)	Reported by the Regulatory Reform Committee with substitute H-1 adopted	May 21, 2026
HB5107	Marijuana	Modifies allowable amounts of marihuana for personal use and possession.	M. Hoadley (R)	Reported by the Regulatory Reform Committee with substitute H-1 adopted	May 21, 2026
HB5196	Prisoner Mental Health	Provides for screening and treatment for post traumatic prison disorder and requires certain other mental health screening, planning, and treatment of incarcerated individuals.	S. Young (D)	Referred to Committee on Judiciary	Oct 30, 2025
HB5302	Substance Use	Modifies competitive grant program to provide grants for recovery community organizations.	J. DeBoyer (R)	Placed on third reading	Apr 28, 2026
HB5334	Hospitals	Requires assessment by preadmission screening unit of individual being considered for hospitalization within certain period after notification.	M. Bierlein (R)	Referred to Committee on Health Policy	Dec 2, 2025
HB5387	Veterans	Includes missing veterans at risk in the missing senior or vulnerable adult alert.	C. Cavitt (R)	Reported favorably without amendment 6/10/2026 by the Veterans And Emergency Services Committee	Jun 10, 2026
HB5407	Disabled Veterans	Modifies exemption for the surviving spouse of a disabled veteran.	W. Bruck (R)	Reported with recommendation without amendment by the Government Operations Committee	Apr 23, 2026
HB5453	Prison Diversion Programs	Creates prison diversion program for individuals in the possession of controlled substances.	S. Lightner (R)	Reported by the Judiciary Committee	Jun 10, 2026
HB5456	Hyperbaric Oxygen Treatment	Establishes hyperbaric oxygen treatment pilot program.	K. Schmaltz (R)	Referred to Committee on Health Policy	Jun 23, 2026
HB5457	Hyperbaric Oxygen Therapy	Establishes hyperbaric oxygen therapy pilot program.	K. Schmaltz (R)	Referred to Committee on Health Policy	Jun 23, 2026
HB5537	Kratom	Prohibits production and sale of kratom.	C. Cavitt (R)	Received: Government Operations Committee	Mar 24, 2026
HB5715	National Guard	Provides for direct deposit for compensation of Michigan national guard members	K. Schmaltz (R)	Received: Finance, Insurance and Consumer Protection Committee	Apr 28, 2026
HB5728	Substance Use Disorder Services	Modifies references to licenses for certain substance use disorder services programs in the prudent purchaser act to include those exempt from licensure.	B. Schuette (R)	Reported by the Health Policy Committee	Jun 24, 2026
HB5729	Substance Use Disorder Services	Modifies persons required to hold a substance use disorder services program license and requires uniform rules as is reasonable.	K. Schmaltz (R)	Referred to the Rules Committee by the Health Policy Committee	Jun 24, 2026
HB5730	Substance Use Disorder Services	Modifies references to licenses for certain substance use disorder services programs in the municipal health facilities corporations act to include those exempt from licensure.	S. Frisbie (R)	Reported with recommendation without amendment by the Health Policy Committee	Jun 24, 2026
HB5731	Substances Use Disorder	Includes crisis stabilization units exemptions from the substance use disorder license requirement.	M. Tisdel (R)	Referred to the Rules Committee by the Health Policy Committee	Jun 24, 2026
HB5732	Substances Use Disorder	Modifies references to licenses for certain substance use disorder services programs in the Michigan zoning enabling act to include those exempt from licensure.	L. Meerman (R)	Reported by the Health Policy Committee	Jun 24, 2026

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HB5733	Substance Use Disorder	Modifies references to licenses for certain substance use disorder services programs in the motor vehicle code to include those exempt from licensure.	C. VanderWall (R)	Reported with recommendation without amendment by the Health Policy Committee	Jun 24, 2026
HB5734	Substance Use Disorder	Modifies references to licenses for certain substance use disorder services programs in the nonprofit health care corporation reform act to include those exempt from licensure.	N. DeBoer (R)	Reported with recommendation without amendment by the Health Policy Committee	Jun 24, 2026
HB5735	Substance Use Disorder Treatment	Modifies references to licenses for certain substance use disorder services programs in the overdose fatality review act to include those exempt from licensure.	J. Thompson (R)	Reported with recommendation without amendment by the Health Policy Committee	Jun 24, 2026
HB5736	Substance Use Disorder Services	Modifies references to licenses for certain substance use disorder services programs in the patient's right to independent review act to include those exempt from licensure.	A. St. Germaine (R)	Reported by the Health Policy Committee	Jun 24, 2026
HB5737	Substance Use Disorder Services	Modifies references to licenses for certain substance use disorder services programs in the social welfare act to include those exempt from licensure.	M. Harris (R)	Referred to the Rules Committee by the Health Policy Committee	Jun 24, 2026
HB5738	Substance Use Disorder Services	Modifies references to licenses for certain substance use disorder services programs in the adult foster care facility licensing act to include those exempt from licensure.	K. Bohnak (R)	Reported with recommendation for referral to Committee on Rules	Jun 24, 2026
HB5885	Property Tax	Clarifies when to deny a disabled veteran's exemption.	J. Woolford (R)	Referred to Committee on Government Operations	Apr 23, 2026
HB5903	Health Facilities	Expands allowable use of hospital swing beds to include behavioral health patients.	M. Bierlein (R)	Placed on third reading	Jul 1, 2026
HB5943	Behavioral Health Ttransportation	Provides behavioral health transportation licensing requirements.	S. Frisbie (R)	Referred to the Rules Committee by the Health Policy Committee with substitute H-1 adopted	Jun 24, 2026
HB5944	Behavioral Health Transportation	Provides coverage for behavioral health transportation.	A. O'Neal (D)	Reported with recommendation with substitute (H-1) by the Health Policy Committee	Jun 24, 2026
HB6020	Ibogaine	Provides participation in ibogaine clinical trials.	J. Greene (R)	Reported with recommendation for referral to Committee on Rules	Jun 9, 2026
HB6022	Mental Health	Modifies authority for prescreening individuals for mental health services.	C. VanderWall (R)	Reported with recommendation for referral to Committee on Rules	Jun 10, 2026
HB6028	Veteran''s Court	Modifies veterans treatment court.	M. McFall (D)	Referred to Committee on Judiciary	Jun 2, 2026
HB6029	Veterans	Requires consideration of veteran status in sentencing.	W. Bruck (R)	Referred to Committee on Judiciary	Jun 2, 2026
HB6107	Medical Services	Modifies definition of kickbacks or bribes.	S. Steckloff (D)	Placed on third reading	Jul 2, 2026
HB6237	Health Benefits	Modifies public employer contribution to medical benefit plan.	M. Xiong (D)	Referred to Committee on Government Operations	Aug 11, 2026
HCR1	Adverse Childhood Experiences	A concurrent resolution to urge the Governor of Michigan to issue an executive directive that would require administrating agencies to assess if the implementation of their programs reduce Adverse Childhood Experiences (ACEs) and provide an annual report and data to the Legislature and general public about progress in reducing ACEs in Michigan.	D. Wozniak (R)	Reported with recommendation without amendment by the Families And Veterans Committee	Oct 28, 2025

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HR115	Medicaid	A resolution to urge the President of the United States and the United States Congress to fully fund Medicaid and to reject any proposal that would strip access to those in need and shift costs onto states, health care providers, and vulnerable individuals.	D. Mentzer (D)	Referred to Committee on Government Operations	May 22, 2025
Senate Bills					
SB207	Veterans	Creates Michigan veterans coalition fund.	K. Hertel (D)	Referred to Committee on Appropriations	Jun 3, 2025
SB208	Veterans	Creates Michigan veterans coalition grant program.	R. Hauck (R)	Referred to Committee on Appropriations	Jun 3, 2025
SB215	Consumer Protections	Amends Michigan consumer protection act to enhance protections for individuals applying for veterans benefits.	S. Santana (D)	Referred to Committee on Appropriations	Jun 3, 2025
SB219	Hospitalization	Revises person requiring treatment and modifies certain procedures for treatment.	K. Hertel (D)	Referred to Committee on Health Policy	May 21, 2025
SB220	Hospital Evaluations	Expands hospital evaluations for assisted outpatient treatment.	J. Irwin (D)	Referred to Committee on Health Policy	May 21, 2025
SB221	Mental Capacity	Provides outpatient treatment for misdemeanor offenders with mental health issues.	S. Santana (D)	Referred to Committee on Health Policy	May 21, 2025
SB222	Outpatient Treatment	Expands petition for access to assisted outpatient treatment to additional health providers.	P. Wojno (D)	Referred to Committee on Health Policy	May 21, 2025
SB237	National Guard	Creates Michigan National Guard apprenticeship program.	T. Albert (R)	Referred to Committee on Regulatory Affairs	Apr 22, 2025
SB239	Vietnam Veterans	Creates Vietnam veteran era bonus extension act.	K. Daley (R)	Referred to Committee on Appropriations	Apr 22, 2025
SB398	Controlled Substances	Modifies substance use disorder services programs requirements and prohibits the promulgation of certain rules.	J. Bellino (R)	Reported with recommendation for referral to Committee on Rules	Mar 11, 2026
SB399	Drug Paraphernalia	Modifies definition of drug paraphernalia.	J. Irwin (D)	Referred to Committee on Insurance	Jul 1, 2025
SB400	Health Insurers	Prohibits prior authorization for certain opioid use disorder and alcohol use disorder medications.	K. Hertel (D)	Referred to Committee on Insurance	Jul 1, 2025
SB401	Pharmaceuticals	Requires co-prescribing of naloxone with opioid drugs.	S. Santana (D)	Referred to Committee on Insurance	Jul 1, 2025
SB430	Controlled Substances	Modifies crime of manufacturing, delivering, or possession of with intent to deliver heroin or fentanyl to reflect changes in sentencing guidelines.	S. Chang (D)	Placed on order of third reading	Oct 29, 2025
SB431	Opioid Drugs	Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver heroin or fentanyl.	S. Anthony (D)	Placed on order of third reading	Oct 29, 2025
SB432	Controlled Substances	Allows probation for certain major controlled substances offenses.	R. Victory (R)	Placed on order of third reading	Nov 5, 2025
SB462	Tobacco/Nicotine Licenses	Requires license to sell nicotine or tobacco products at retail.	S. Singh (D)	Referred to Committee on Regulatory Reform	Dec 18, 2025
SB465	Tobacco/Nicotine Licenses	Creates certain temporary exemptions to the requirement that a person hold a license to sell a nicotine or tobacco product at retail.	J. Bellino (R)	Referred to Committee on Regulatory Reform	Dec 18, 2025
SB555	MiABLE Fund	Provides for earmark to MiABLE Fund from the income tax.	M. Webber (R)	Referred to Committee on Housing And Human Services	Sep 18, 2025
SB556	MiABLE Fund	Creates MiABLE Fund.	M. Webber (R)	Referred to Committee on Housing And Human Services	Sep 18, 2025
SB628	Medical Services	Provides for coverage for syringe service programs.	R. Bayer (D)	Referred to Committee on Housing And Human Services	Oct 30, 2025

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SB629	Controlled Substances	Provides for syringe service programs.	R. Bayer (D)	Referred to Committee on Housing And Human Services	Oct 30, 2025
SB799	Mental Health Facilities	Provides licensure for adult residential psychiatric programs.	R. Bayer (D)	Referred to Committee on Housing And Human Services	Feb 26, 2026
SB800	Mental Health Facilities	Enacts sentencing guideline for facility that receives or maintains an adult who requires residential psychiatric care when the facility''s license has been revoked or suspended or it has refused to renew its license.	S. Santana (D)	Referred to Committee on Housing And Human Services	Feb 26, 2026
SB845	Occupations - Social Workers	Modifies social work licensure.	S. Chang (D)	Referred to Committee on Housing And Human Services	Mar 18, 2026
SB846	Occupations - Social Workers	Creates social worker scholarship fund.	R. Bayer (D)	Referred to Committee on Housing And Human Services	Mar 18, 2026
SB917	Mental Health	Provides 988 crisis lifeline system fund and telecommunications fee.	R. Bayer (D)	Referred to Committee on Housing And Human Services	Apr 22, 2026
SB927	Medical Services	Provides coverage for behavioral health transportation.	M. Huizenga (R)	Referred to Committee on Health Policy	Apr 23, 2026
SB928	Behavioral Health Transportation	Provides behavioral health transportation licensing requirements.	M. Huizenga (R)	Referred to Committee on Health Policy	Apr 23, 2026
SB953	Data Collection	Establishes standards for public bodies collecting and reporting data related to race and ethnicity.	D. Camilleri (D)	Referred to Committee on Oversight	May 13, 2026
SB954	Data Collection	Repeals classifications used in state agency writings requesting racial or ethnic identification.	D. Camilleri (D)	Referred to Committee on Oversight	May 13, 2026
SB955	Data Collection	Modifies certain writings requesting racial or ethnic identification.	D. Camilleri (D)	Referred to Committee on Oversight	May 13, 2026
SB1007	Guardians	Requires appointing certain guardians after considering least restrictive means.	R. Bayer (D)	Referred to Committee on Housing And Human Services	May 21, 2026
SB1115	Recipient Rights	Provides requirements for collection of complaints.	M. Webber (R)	Referred to Committee on Housing And Human Services	Jul 15, 2026
SB1116	Recipient Rights	Modifies rights violations investigations.	M. Webber (R)	Referred to Committee on Housing And Human Services	Jul 15, 2026
SB1117	Recipient Rights	Grants authority over surveillance for state psychiatric hospitals to the office of recipient rights.	M. Webber (R)	Referred to Committee on Housing And Human Services	Jul 15, 2026
SB1118	Recipient Rights	Requires retention of monitoring reports.	M. Webber (R)	Referred to Committee on Housing And Human Services	Jul 15, 2026
SB1119	Recipient Rights	Requires retention of certain review information.	M. Webber (R)	Referred to Committee on Housing And Human Services	Jul 15, 2026
SB1120	Recipient Rights	Prohibits members employed by the community mental health service from serving on the recipient rights advisory committee.	M. Webber (R)	Referred to Committee on Housing And Human Services	Jul 15, 2026
SB1121	Recipient Rights	Prohibits members employed by licensed hospital from serving on the recipient rights advisory committee.	M. Webber (R)	Referred to Committee on Housing And Human Services	Jul 15, 2026
SB1122	Recipient Rights	Requires office of recipient rights contact information to be published.	M. Webber (R)	Referred to Committee on Housing And Human Services	Jul 15, 2026
SB1136	Health Benefits	Modifies public employer contribution to medical benefit plan.	K. Hertel (D)	Referred to Committee on Government Operations	Sep 15, 2026
SB1181	Kratom	Provides regulation of distribution, sale, and manufacturing of kratom products.	J. Cherry (D)	Referred to Committee on Regulatory Affairs	Sep 22, 2026

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Community Mental Health Member Authorities

Bay Arenac Behavioral Health

CMH of Clinton.Eaton.Ingham Counties

CMH for Central Michigan

Gratiot Integrated Health Network

Huron Behavioral Health

The Right Door for Hope, Recovery and Wellness (Ionia County)

LifeWays CMH

Montcalm Care Network

Newaygo County Mental Health Center

Saginaw County CMH

Shiawassee Health and Wellness

Tuscola Behavioral Health Systems

Board Officers

Ed Woods
Chairperson

Irene O'Boyle
Vice-Chairperson

Deb McPeek-McFadden
Secretary

REPORT OF THE MSHN INTERIM CHIEF EXECUTIVE OFFICER TO THE BOARD OF DIRECTORS
September / October 2026

Performance Bonus Incentive Payment (PBIP) for Housing & Employment

The Michigan Department of Health and Human Services (MDHHS) contract with the Prepaid Inpatient Health Plan (PIHP) includes expectations within the Performance Bonus Incentive Program. Two years ago, a new measure was included to "Implement data driven outcomes measurement to address social determinants of health". This measure is worth 40% of the PIHP pay for performance withhold that if met, turns into local funds for the Community Mental Health Service Programs (CMHSPs).

Specifically, PIHPs are required to analyze and monitor Behavioral Health Treatment Episode Data Set (BH-TEDS) records to improve housing and employment outcomes for persons served. MSHN is required to submit a report of findings and project plans aimed at improving outcomes. This effort has been led by our Integrated Care Department with support from Quality and Information Technology. The results are summarized below.

Housing

All populations served experienced **significant positive improvements** in living conditions for individuals who were homeless at admission. Similar positive improvements were noted in FY23 and FY24 for all populations, indicating a positive pattern of individuals moving from homelessness to stable living arrangements over a 3-year period in the MSHN region.
FY25 changes are summarized below:

- 36.36% movement for individuals with Intellectual/Developmental Disability (I/DD) Only (*Small population size, n = 11)
- 18.96% movement for individuals with Mental Illness (MI) Only

All populations experienced positive improvements in the percentage of individuals who moved from non-jail dependent settings to non-jail independent settings as summarized below:

- 1.92% movement for individuals with I/DD Only
- 4.87% movement for individuals with MI Only
- 2.65% movement for individuals with I/DD and MI
- 5.11% movement for individuals with Substance Use Disorder (SUD)

Employment

All populations served remained relatively stagnant with regard to employment rate with the exception of individuals with SUD who experienced a slight increase as summarized below:

- 0.22% increase for individuals with I/DD Only
- 0.82% increase for individuals with MI Only
- -0.05% decrease for individuals with I/DD and MI
- 2.51% increase for individuals with SUD

All populations experienced **significant positive increases** in the percentage of individuals who were not in the labor force:

- 2.88% movement for individuals with I/DD Only
- 4.38% movement for individuals with MI Only
- 3.11% movement for individuals with I/DD and MI

- 11.21% movement for individuals with SUD

Addressing and improving Social Determinants of Health (SDOH) for all populations served is a high priority for MSHN. The current housing and employment outcomes analysis complements the activities MSHN is already engaged in, however, the report also summarizes quality improvement efforts as a result of the analysis.

For the full report on PBIP SDOH activities, see the link below: **PBIP FY26 Housing and Employment.**

Centers for Medicare & Medicaid Services (CMS) Required Publicly Reporting Prior Authorization Data – Now Available on MSHN Website

Late June 2026, MDHHS issued a memo that outlines CMS requirements that affect how PIHPs manage, report, and support prior authorization (PA) processes, interoperability, and data sharing. The changes are intended to increase transparency, accelerate authorization decisions, and improve electronic data exchange among payers, providers, and beneficiaries.

Key Changes

Prior Authorization Timeframes

Effective October 1, 2026:

- Standard prior authorization decisions must be made within 7 calendar days of receipt.
- A one-time 14-day extension is allowed when requested by the beneficiary/provider or when additional information is needed.
- Expedited requests continue to require decisions within 72 hours.

Public Reporting Requirements

Beginning in 2026 PIHPs must publicly post annual prior authorization performance data, including:

- Services requiring prior authorization.
- Approval and denial rates.
- Appeal overturn rates.
- Use of extensions.
- Average and median decision turnaround times for both standard and expedited requests.

Interoperability and Application Programming Interface (API) Requirements

Beginning January 1, 2026:

- PIHPs must report Patient Access API utilization data, including the number of beneficiaries accessing their data through third-party health applications.

By October 1, 2027 PIHPs must implement and maintain:

- Provider Access API for sharing claims, encounter, clinical, and Prior Authorization (PA) information with treating providers.
- Payer-to-Payer API to exchange member information when beneficiaries change health plans.
- Prior Authorization API to support electronic PA inquiries, submissions, decisions, and documentation requirements.
- Enhanced Patient Access API functionality, including access to PA information for at least one year after the final PA status change.

MSHN, along with our regional partners, have updated authorization workflows to meet the new 7-day standard review requirement. We are working with MDHHS to update the tracking and reporting on authorization information currently planned for FY27Q1 reporting. MSHN's website for API implementation and interoperability standards has been updated and now also includes public posting of the region's

authorization data attached and located here: https://midstatehealthnetwork.org/stakeholders-resources/about-us/dashboard-information/prior-authorization-report/

Priority Measures FY26

With input from our regional councils and committees, MSHN developed a few years ago a priority measure portfolio based on national healthcare industry standards. MSHN provides reports on these measures both as a region as well as performance of each CMHSP. MSHN councils and committees review status quarterly for ongoing input into performance improvement strategies. In addition, MSHN publishes the priority measures on the MSHN website: Priority Measures - (midstatehealthnetwork.org).

The FY26Q2 report is now available and linked below, **Priority Measures FY26**.

Rural Health Transformation Program Grant Awarded

Mid-State Health Network (MSHN) was approved by MDHHS as regional consortium to administer the Limited Licensed Master Social Worker (LLMSW) Supervision Stipend Program from October 1, 2026, through September 30, 2027, funding supervised hours, training, and continuing education so LLMSWs across 20 rural Michigan counties can complete requirements for independent licensure. The program funds participating CMHSPs, who will recruit and train 36 Licensed Master Social Workers (LMSW) supervisors, match them with 143 LLMSWs, and verify at least four hours of supervision per month under a shared eligibility and reporting framework. With a total budget of $1,000,000, the initiative covers supervisor stipends at $132/hour, National Association of Social Workers-Michigan Core Supervision certification, and continuing education. Special thanks to Shiawassee Health & Wellness for supporting the grant application and reporting. Note, the MDHHS contract and related CMHSP subawards have been included on the contract listing and the budget amendment.

Regional Consumer Advisory Council Summary Report

As part of an increased effort to ensure Board Members understand and directly hear from individuals served within the region, a summary report is provided by the Regional Consumer Advisory Council (RCAC) as attached. The RCAC is facilitated by MSHN's Customer Service and Rights Manager, Dan Dedloff. Members are appointed by the twelve Community Mental Health Service Programs within the region from their local consumer advisory committees who are or have been engaged in services and those who are parents or guardians. They appoint Officers to lead the bimonthly meetings which provide a consumer's perspective and valuable input into many areas of the PIHPs responsibilities. MSHN would like to thank the RCAC Chair, Todd Koopmans, for his summary report and for his dedication and commitment throughout the year. For more detailed information on the RCAC, see the attached RCAC Summary Report.

CMS Releases Guidance on Certified Community Behavioral Health Clinic Services under Medicaid

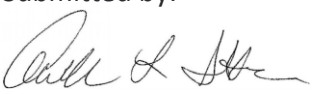
On October 6, 2026 the Centers for Medicare & Medicaid Services (CMS) released guidance describing the optional state plan benefit for Certified Community Behavioral Health Clinic (CCBHC) Services. This optional benefit was authorized by section 209 in Title I of Division G of the Consolidated Appropriations Act of 2024 (Pub. L. 118-42). This legislation amended section 1905 of the Social Security Act (the Act) to establish this new optional CCBHC state plan benefit at section 1905(a)(31), as defined in section 1905(jj) of the Act.
More information is available at CCBHC Services website. A CCBHC Services state plan amendment (SPA) preprint is available on the Medicaid SPA Toolkit page of Medicaid.gov.

Covering CCBHC Services in a Medicaid Managed Care Delivery System
States can cover the new CCBHC state plan option under a fee-for-service (FFS) delivery system or a managed care delivery system. States interested in using a managed care delivery system to cover the new CCBHC benefit must have an approved managed care authority, such as a section 1932(a) state plan authority or 1915(b) waiver authority as well as the Medicaid coverage authority and a section 1905(a)(31) state plan authority. States may also utilize a section 1115(a) demonstration to implement the new CCBHC benefit using a managed care delivery system. States that want to utilize a managed care delivery system to cover state plan CCBHC services should ensure that their Medicaid managed care plans add CCBHCs to the plans' provider networks.

Once these authorities are approved, states must also evaluate any necessary changes to their managed care contracts and work with their actuaries to evaluate any impact on the development of actuarially sound capitation rates, including any appropriate and reasonable adjustments to account for changes to the base data for programmatic changes related to CCHBC services. If states wish to direct managed care expenditures related to provider payment, including how managed care plans pay providers for CCHBC services, this is considered a state directed payment and states must comply with all respective federal requirements, including any respective limit on total provider payment rates.

MSHN and our regional CCBHC partners will be watching this closely to understand implications regarding State authority/administration decisions of the new state plan benefit.

Submitted by:



Amanda L. Ittner, MBA
Deputy Director
Finalized: 10.29.26

Attached:
Prior Authorization Metrics Report
Regional Consumer Advisory Council Annual Report

Linked:
PBIP FY26 Housing and Employment
Priority Measures FY26

Prior Authorization Metrics Report

Prior Authorization Metrics for Services (Excluding Drugs)

Some services and treatments must be approved before you can receive them. This is called "prior authorization." It means the Mid-State Health Network region reviews the service to make sure it is medically necessary. This process helps members get the right care and helps prevent fraud, waste and abuse.

Mid-State Health Network is required to publish yearly prior authorization information on our website. Sharing this information helps members and providers better understand the prior authorization process and shows how we are performing. This reporting is part of the Centers for for Medicare & Medicaid Services (CMS) interoperability and Prior Authorization Final Rule CMS-0057-F.

Reporting Period: Calendar Year 2025 (11 of 12 CMHSP Boards Reporting)

Service Categories for Prior Authorization

SERVICES CATEGORIES REQUIRING PA
Applied Behavior Analysis
Assertive Community Treatment
Assessments
Behavior Treatment Review
Community Living Supports
Crisis Residential
Enhanced Pharmacy
Family Support and Training
Fiscal Intermediary
Health Services
Hearing and Language Therapy
Home Based Services
Inpatient Psychiatric
Occupational Therapy
Outpatient Behavioral Health Counseling and Therapy
Peer Delivered/Operated Support Services
Physical Therapy
Private Duty Nursing
Psychiatric Services
Respite Care
Skill Building Assistance
Speech
Support and Service Coordination
Supported/Integrated Employment Services
Targeted Case Management
Treatment Planning

Standard (Non-Urgent) Prior Authorization Requests

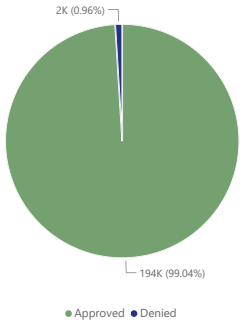
In 2025, Mid-State Health Network received a total of **196159** standard (non-urgent) prior authorization requests, **99.04%** of those requests were approved.

Standard (non-urgent) Requests	Percentage Approved	Percentage Denied
196159	99.04%	0.96%

For standard (non-urgent) requests, decisions were typically sent the same day the request was received. The average response time was **2.15** days.

Mean (Average) Time	Median (Middle) Time
2.15	0.40

Standard (non-urgent) Approval vs. Denial at a glance



Extended Review of Standard (Non-Urgent) Requests

Of the **196159** standard (non-urgent) prior authorization requests, of those **2.05%** were approved after time for review was extended.

Extended Review Requests	Percentage Approved	Percentage Denied
3978	2.05%	0.03%

Expedited (Urgent) Prior Authorization Requests

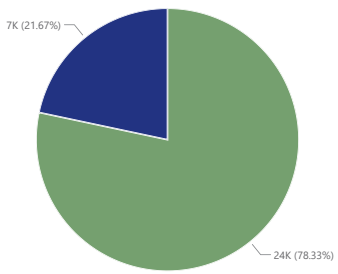
In 2025, there were a total of **15600** Expedited (urgent) Prior Authorization Requests, **78.33%** of these requests were approved.

Expedited (urgent) Requests	Percentage Approved	Percentage Denied
15600	78.33%	21.67%

For Expedited (urgent) requests, decisions were typically sent the same day the request was received. The average response time was **1.01** days.

Mean (Average) Time	Median (Middle) Time
1.01	0.50

Expedited (urgent) Approval vs. Denial at a glance



MSHN Regional Consumer Advisory Council Summary

The Mid-State Health Network (MSHN) Regional Consumer Advisory Council (RCAC) serves as the primary source of consumer input to facilitate meaningful, region-wide consumer involvement in its policy development, service development, service delivery, service evaluation, and quality improvement activities. The MSHN RCAC also focuses on region-wide advocacy issues and stigma reduction related to regional mental health and substance use disorder (SUD) systems of care.

The RCAC is comprised of individuals who are or have been engaged in services (primary consumers) and those who are parents or guardians (secondary consumers). Its diverse membership represents adults with mental illness, adults with intellectual and developmental disabilities, children with mental illness, children with intellectual and developmental disabilities, and individuals with substance use disorders. RCAC members are supported by Community Mental Health Services Programs (CMHSP) staff liaisons, who help promote connections to local CMHSP consumer advisory councils (CACs).

<u>FY26 RCAC Update</u>

The RCAC meets bimonthly, and MSHN content experts provided the following information during FY26 for member review and feedback:

- Kara Laferty reported on the 2025 Satisfaction Survey Report for member feedback. She spoke about the results from the Mental Health Statistics Improvement Program (MHSIP) survey tool for adults experiencing a mental illness and/or intellectual and developmental disability or substance use disorder, along with the Youth Satisfaction Survey (YSS) tool for children/families. In FY2025, CMHSP participants collected 2,650 MHSIP surveys and 1,018 YSS survey results; Substance Use Disorder (SUD) providers collected 1,996 SUD survey results from members engaged in SUD treatment. The response rates were 23% for the MHSIP, 28% for the YSS, and 54% for the SUD survey. Each survey saw a higher response rate than FY24. Ms. Laferty spoke about the survey results, highlighting areas for improvement and growth. The survey results will be reviewed by the MSHN Quality Improvement Council (QIC), and quality improvement goals will be developed based on them.
- Kara Laferty [MSHN] presented the FY25 Quality Assessment and Performance Improvement Program (QAPIP) Report for member feedback. She discussed the executive summary based on the full FY25 QAPIP report. She reported that the Michigan Mission-Based Performance Indicator System (MMBPIS) exceeded the state average on 9 of 18 indicators, with barriers identified as ongoing workforce

shortages, high consumer no-show rates, and inconsistent data interpretation across PHIPs. Priority Populations of pregnant individuals improved. The Performance-Based Incentive Program (PBIP) partially met, with MSHN continuing to perform well. Improvements were seen within the Performance Improvement Projects (PIP), which continued with two long-term PIPs focused on reducing racial and ethnic disparities in access and penetration rates for behavioral health services. Stakeholder Experience and Satisfaction showed MSHN achieved high satisfaction rates across all surveyed populations. Adverse Events and Behavior Treatment found that MSHN performance met or partially met most objectives. Clinical Practice, Behavioral Treatment, and Long-Term Supports and Services showed ongoing improvement in oversight of vulnerable individuals. Utilization Management (UM) maintained performance exceeding 90% compliance with service authorization and adverse benefit determination timeliness standards. Integrated Care and Health Homes maintained active participation in initiatives. Provider Monitoring and Oversight noted that MSHN participated in six external reviews and achieved strong ratings. Council and Committee Effectiveness noted that all MSHN Councils and Committees demonstrated continued engagement and measurable progress in FY25. She finished by reviewing the 2025 Workplan section of the QAPIP and highlighted tasks for member feedback.

- Liz Philpott shared updates regarding the Substance Use Disorder (SUD) Health Home expansion. She reported that SUD Health Homes coordinate care for Medicaid beneficiaries with serious and complex chronic conditions, provide flexibility to create innovative delivery and payment models, serve the "whole person" by integrating and coordinating physical, behavioral, and social services, and afford sustainable reimbursement to affect the social determinants of health. A SUD Health Home seeks to improve care management for beneficiaries. MSHN has 10 existing SUD Health Home locations and is adding an additional seven (7) provider locations.
- Dan Dedloff reviewed the 2026 Guide to Services Handbook changes for member feedback. He reported that MDHHS issued an update to the Handbook templates through the MDHHS Customer Service Standards. He reviewed each section and highlighted the updates. Members provided feedback, expressed appreciation for the work needed to revise the handbook so that it can be printed and distributed to members receiving services, and had no concerns about the Handbook updates.
- Dr. Todd Lewicki presented information on the Mental Health Framework (MHF), an MDHHS strategy intended to improve access, coordination, and accountability for mental health care. MSHN noted concerns that the system may become harder for members to navigate, increase administrative and training burdens for staff, reduce

contact with beneficiaries, create delays if providers require different screenings, and slow access to needed care. Some MHF activities have been delayed. MDHHS appears committed to the MHF and hopes it improves coordination, access, and service quality for Medicaid members. Members provided feedback and expressed concern about the MHF.

- Dan Dedloff reviewed a FY26 MSHN Quality and QAPIP Progress Update provided by Kara Laferty. It was reported that MSHN is making progress on FY26 QAPIP improvement work to support better services for consumers across the region. MSHN Quality monitors several key areas and is working on 64 improvement tasks within the FY26 QAPIP, with a focus on improving services, strengthening data accuracy, monitoring consumer safety, and supporting timely access to care.
- Members reviewed a Service Animal Training developed by MSHN Customer Service. Members provided feedback and reported that the information was informative, helpful, and relevant.
- Members discussed changes to Medicaid rules that will go into effect for new enrollees on October 1, 2026, and for active enrollees on January 1, 2027, and these changes were reviewed with the group. The changes may impact the number of individuals enrolled in Medicaid and the finances of the PIHP/CMHSP system.
- Amanda Ittner provided ongoing updates regarding the PIHP Procurement process. She reported on the bid process and MSHN's efforts to obtain information from MDHHS to support it. During the February meeting, she reported that on January 29, 2026, the state provided notice that the PIHP request for proposal (RFP) process was being canceled. The cancellation was due to flaws in the RFP that did not align with the Michigan Mental Health Code, as noted in the recent court ruling. The PIHP Procurement process was a recurring topic of discussion and advocacy throughout FY26.

<u>FY25 RCAC Update</u>

The RCAC meets bimonthly, and MSHN content experts provided the following information during FY25 for member review and feedback:

- Rusmira Bektas provided ongoing updates on changes within Mid-State Health Network (MSHN) regarding Substance Use Disorder (SUD) Access. She spoke about how the changes will help eliminate duplicate screenings for individuals seeking services, ensure individuals are referred to the most appropriate level of care for their needs, support members' choice of providers, improve tracking of service utilization and the Block Grant, and ensure better care coordination between providers. The information helped members understand how MSHN Access will

manage referrals for withdrawal management, residential SUD treatment, and recovery housing.

- Dan Dedloff reviewed the RCAC Orientation training for member feedback. Members reported that the training provides a good overview of MSHN, the RCAC, and the contribution an RCAC member makes to the region.
- Dan Dedloff reviewed the MSHN 2024 Impact Report. The report highlights the partnership with 12 local Community Mental Health Service Programs (CMHSP) and over 100 SUD treatment agencies, which oversaw services for over 48,600 CMHSP beneficiaries and over 11,400 SUD treatment beneficiaries in fiscal year 2023. MSHN will continue efforts to improve the health of the beneficiaries across our region, guided by strategic priorities and committed to better integrating physical and behavioral health services, improving care coordination, and addressing social determinants of health to enhance overall community well-being.
- Kim Zimmerman provided a review of the FY2026 – FY2027 MSHN Strategic Plan. She highlighted items relevant to RCAC members across key assumptions, strengths, weaknesses, opportunities, and threats. Members asked questions and provided feedback.
- Dan Dedloff reviewed the 2025 Guide to Services Handbook changes for member feedback. Members expressed appreciation for the regional handbook and had no concerns about the Handbook updates.
- RCAC members collaborated with the MSHN Customer Service Committee (CSC) for the development of a Staff Professionalism training. CSC members appreciated the feedback from the RCAC members and found the topic suggestions and scenarios valuable for the training.
- Dr. Todd Lewicki provided an update on Conflict-Free Access and Planning. He reported that MDHHS has indicated that for individuals receiving services under the Home and Community Based Services (HCBS) Rule, which covers 29 service codes and 21 services, assessment and planning will be separated to reduce potential conflicts of interest. Dr. Lewicki spoke of three possible ways in which the roles of assessment and planning may be separated. He reported that MDHHS is expected to provide additional guidance for PIHPs and CMHs before an initial plan is put into place for FY26, before full compliance and implementation starts in FY27.
- Sherrie Donnelly provided an overview of the Michigan Medicaid Recovery Incentive (RI) Pilot. The RI Pilot involves utilizing Contingency Management (CM) for motivational incentives for non-use of specified substances as evidenced by negative drug tests. The primary goal of the RI Pilot is to improve health outcomes for beneficiaries struggling with stimulant use disorder (StimUD) and/or opioid use

disorder (OUD) by increasing engagement and retention in treatment, reducing the number of emergency department (ED) visits, reducing the rate of repeated ED visits, and reducing adverse health outcomes (e.g., deaths, overdoses). Members were interested in the program information, asked questions, and provided feedback.

- Dan Dedloff reviewed recommendations from the 2024 Health Services Advisory Group (HSAG) Compliance review regarding Adverse Benefit Determination (ABD) Notice process improvements. He spoke of simplifying how services are listed on the ABD, improving the citations used to justify the ABD decision, and ensuring that the ABD content meets plain-language and grade-level requirements. Members shared feedback that the improvements would help individuals better understand ABD Notices.
- Amy Dillon & Bria Perkins provided an overview of MSHN's FY24 Monitoring Activities. They reported that their team reviews Community Mental Health and Substance Use Disorder providers. They review various required items, including staff qualifications; verification that billed services were provided correctly; that programs meet Medicaid requirements; and that providers have the necessary standards documented in their policies and procedures. The team issues a final report to each provider, which highlights strengths, areas for improvement, and required corrective actions. The overview helped members understand how MSHN reviews help to ensure providers use Medicaid funding appropriately.
- Stacey Lehmann presented an overview of the Michigan Opioid Settlement Fund. She reported that the funds came from lawsuits against pharmaceutical companies and pharmacies regarding opioid medications. Michigan will receive $800 million from the settlement. She noted that fifty percent (50%) of the settlement amount will be distributed directly to county, city, and township governments, and the remaining 50% will be distributed to the state government's Michigan Opioid Healing and Recovery Fund. The overview assisted members in understanding how settlement funds will be used to address the misuse and abuse of opioid products, treatment for opioid use, and programs to address the opioid epidemic.
- Amanda Ittner provided ongoing updates regarding the PIHP Procurement process. She reported on the bid process and MSHN's efforts to obtain information from MDHHS to support it. She expressed MSHN's perspective on the value of the PIHP system as a public system accountable to the counties and individuals served in the region. She spoke of MSHN's work to collaborate with other PIHP regional leaders and CMHSP leadership to explore strategies to help MSHN develop an eligible bid. The PIHP Procurement process was a recurring topic of discussion and advocacy throughout FY25.

Members have helped the MSHN region by enhancing awareness of the vital role of stakeholder feedback in strategic planning, advocacy, and service implementation throughout the region through their participation, interest, questions, and feedback. Members represent the voices of individuals served by contributing their valuable experiences to MSHN operations.

MSHN
Mid-State Health Network

Background:

In accordance with the MSHN Board of Directors to review financials, at a minimum quarterly, the Preliminary Statement of Net Position and Preliminary Statement of Activities for the Period Ending September 30, 2026, have been provided and presented for review and discussion.

Recommended Motion:

The MSHN Board of Directors receives and files the Preliminary Statement of Net Position and Preliminary Statement of Activities for the Period Ending September 30, 2026, as presented.

Mid-State Health Network
Preliminary Statement of Activities
As of September 30, 2026

Rows Numbers	A	B	C	D	E (C - D)	F (C / B)	
		Columns Identifiers					
		Budget Annual	Actual Year-to-Date	Budget Year-to-Date	Budget Difference	Actual % of Budget	
		FY26 Amended Budget 100.00%		FY26 Amended Budget			
1	Revenue:						
2	Grant and Other Funding	$ 374,568	313,795	374,568	(60,773)	83.78 %	1a
3	Prior FY Medicaid Carryforward	$ 13,618,456	13,618,457	13,618,456	1		1b
4	Medicaid Capitation	880,092,044	812,316,416	880,092,044	(67,775,628)	92.30%	1c
5	Local Contribution	1,550,876	1,550,876	1,550,876	0	100.00%	1d
6	Interest Income	1,100,000	1,122,452	1,100,000	22,451	102.04%	1e
7	Non Capitated Revenue	18,588,293	16,894,438	18,588,293	(1,693,854)	90.89%	1f
8	Transfer from Operating Fund	0	17,475,000	0	17,475,000		1g
9	Total Revenue	915,324,237	863,291,434	915,324,237	(52,032,803)	94.32 %	
10	Expenses:						
11	PIHP Administration Expense:						
12	Compensation and Benefits	8,666,275	8,403,954	8,666,275	(262,321)	96.97 %	
13	Consulting Services	80,600	118,355	80,600	37,756	146.84 %	
14	Contracted Services	111,900	201,238	111,900	89,337	179.84 %	
15	Other Contractual Agreements	545,000	575,591	545,000	30,592	105.61 %	
16	Board Member Per Diems	11,260	10,920	11,260	(340)	96.98 %	
17	Meeting and Conference Expense	73,290	67,611	73,290	(5,679)	92.25 %	
18	Liability Insurance	30,000	32,953	30,000	2,953	109.84 %	
19	Facility Costs	185,706	185,505	185,706	(201)	99.89 %	
20	Supplies	208,170	209,712	208,170	1,542	100.74 %	
21	Other Expenses	1,196,988	1,193,477	1,196,988	(3,511)	99.71 %	
22	Subtotal PIHP Administration Expenses	11,109,189	10,999,316	11,109,189	(109,872)	99.01 %	2a
23	CMHSP and Tax Expense:						
24	CMHSP Participant Agreements	711,201,110	701,292,789	711,201,110	(9,908,322)	98.61 %	1b,1c,2b
25	SUD Provider Agreements	66,628,016	63,504,561	66,628,016	(3,123,454)	95.31 %	1c,1f,2c
26	Benefits Stabilization	12,360,000	12,360,000	12,360,000	0	100.00 %	2d
27	Tax - Local Section 928	1,550,876	1,550,876	1,550,876	0	100.00 %	1d
28	Taxes- IPA/HRA	49,174,082	51,022,210	49,174,082	1,848,128	103.76 %	2e
29	Subtotal CMHSP and Tax Expenses	840,914,084	829,730,436	840,914,084	(11,183,648)	98.67 %	
30	Transfer to ISF		17,475,000	0	17,475,000		1g
31	Total Expenses	852,023,273	858,204,752	852,023,273	6,181,479	100.73 %	
32	Excess of Revenues over Expenditures	$ 63,300,964	$ 5,086,682	$ 63,300,964			

Mid-State Health Network
Preliminary Statement of Net Position by Fund
As of September 30, 2026

Row Numbers		Column Identifiers A	B	C	D B + C	
1	**Assets**		**Behavioral Health Operating**	**Medicaid Risk Reserve**	**Total Proprietary Funds**	
2	**Cash and Short-term Investments**					
3	Chase Checking Account		12,795,548	0	12,795,548	1a
4	Chase MM Savings		2,377,964	0	2,377,964	
5	Savings ISF Account		0	13,771,801	13,771,801	1b
6	Savings PA2 Account		2,335,754	0	2,335,754	1c
7	Investment General Savings Account		29,997,803	0	29,997,803	1a
8	Investment PA2 Account		3,499,344	0	3,499,344	1c
9	Investment ISF Account		0	22,597,699	22,597,699	1b
10	Total Cash and Short-term Investments		$ 51,006,413	$ 36,369,500	$ 87,375,913	
11	**Accounts Receivable**					
12	Due from MDHHS		18,272,806	0	18,272,806	2a
13	Due from CMHSP Participants		68,741,910	0	68,741,910	2b
14	Due from Other Governments		67,714	0	67,714	2c
15	Due from Miscellaneous		218,629	0	218,629	2d
16	Due from Other Funds		0	17,475,000	17,475,000	2e
17	Total Accounts Receivable		87,301,059	17,475,000	104,776,059	
18	**Prepaid Expenses**					
19	Prepaid Expense Insurance		74,446	0	74,446	2f
20	Prepaid Expense Rent		4,529	0	4,529	2g
21	Prepaid Expense Other		135,114	0	135,114	2h
22	Total Prepaid Expenses		214,089	0	214,089	
23	**Fixed Assets**					
24	Fixed Assets - Computers		189,180	0	189,180	2i
25	Accumulated Depreciation - Computers		(189,180)	0	(189,180)	
26	Lease Assets		213,655	0	213,655	2j
27	Accumulated Amortization - Lease Asset		(190,988)	0	(190,988)	
28	Total Fixed Assets, Net		22,667	0	22,667	
29	**Total Assets**		**$ 138,544,228**	**$ 53,844,500**	**$ 192,388,728**	
30						
31	**Liabilities and Net Position**					
32	Liabilities					
33	Accounts Payable		$ 14,878,977	$ 0	$ 14,878,977	1a
34	Current Obligations (Due To Partners)					
35	Due to State		31,437,198	0	31,437,198	3a
36	Other Payable		1,907,842	0	1,907,842	3b
37	Due to Hospitals (HRA)		11,500,000	0	11,500,000	1a, 3c
38	Due to State-IPA Tax		1,736,021	0	1,736,021	3d
39	Due to CMHSP Participants		10,949,846	0	10,949,846	3e
40	Due to other funds		17,475,000	0	17,475,000	2e
41	Accrued PR Expense Wages		182,597	0	182,597	3f
42	Accrued Benefits PTO Payable		602,939	0	602,939	3g
43	Accrued Benefits Other		63,033	0	63,033	3h
44	Total Current Obligations (Due To Partners)		75,854,476	0	75,854,476	
45	Lease Liability		22,667	0	22,667	2k
46	Deferred Revenue		44,457,966	0	44,457,966	1b 1c 3i
47	Total Liabilities		135,214,086	0	135,214,086	
48	Net Position					
49	Unrestricted		3,330,142	0	3,330,142	3j
50	Restricted for Risk Management		0	53,844,500	53,844,500	1b
51	Total Net Position		3,330,142	53,844,500	57,174,642	
52	**Total Liabilities and Net Position**		**$ 138,544,228**	**$ 53,844,500**	**$ 192,388,728**	

Mid-State Health Network
Financial Statement Notes
For the Twelve-Month Period Ended,
September 30, 2026

Please note: The Statement of Net Position and Statement of Activities contain preliminary Fiscal Year (FY) 2026 cost settlement figures between the Pre-Paid Inpatient Health Plan (PIHP) and Michigan Department of Health Human Services (MDHHS) as well as each Community Mental Health Service Program (CMHSP) Participants. CMHSP preliminary cost settlement figures were extracted from the MDHHS Projection Financial Status Report (FSR) submitted in August 2026.

Preliminary Statement of Net Position:

1. Cash and Short-Term Investments
    a) The Cash Chase Checking and Chase Money Market Savings accounts are the cash line items available for operations. MSHN recently acquired investments using more than $29 M from funds in the savings account.
    b) The Savings Internal Service Fund (ISF) and Investment ISF reflect designated accounts to hold the Medicaid ISF funds separate from all other funding per the MDHHS contract. MSHN holds nearly $22.6 M in investments, which is about 42% of the total ISF net position balance (row 52 col C). The investment portfolio has been temporarily reduced and moved to ISF Savings should the Region need to access funds for service delivery and other operational expenses. Internal Service Funds are used to cover the Region's risk exposure. In the event current Fiscal Year revenue is spent, and all prior year savings are exhausted, PIHPs can transfer ISF dollars and use them for remaining costs.
    c) The PA2 Savings PA2 and Investment accounts hold funds used to primarily cover Prevention services in MSHN's 21-county Region and is offset by the Deferred Revenue liability account.
2. Accounts Receivable
    a) July through September 2026 Hospital Rate Adjustor (HRA) amounts account for 63% of the Due from State balance. HRAs are State Directed Payments and contractually required by MDHHS. Quarter four Insurance Plan Assessment Payments are responsible for approximately 10% of the total while the remaining 27% is attributable to withholds and miscellaneous line items.
    b) Due From CMHSP Participants reflect FY 2026 projected cost settlement activity. Final cost settlements generally occur in May after the fiscal year ends and once Compliance Examination are complete.

CMHSP	Cost Settlement	Payments/Offsets	Total
CEI	32,463,098.00	-	32,463,098.00
The Right Door	7,037,550.00	-	7,037,550.00
Lifeways	6,074,349.00	-	6,074,349.00
Newaygo	146,293.00	-	146,293.00
Saginaw	22,176,415.00	-	22,176,415.00
Tuscola	856,151.00	-	856,151.00
Total	**68,753,856.00**	**-**	**68,753,856.00**

    c) Due from other governments account contains Public Act 2 funds owed by one county for FY 2026 quarter three. PA2 funds are used primarily for Prevention Activities in MSHN's 21-county Region.
    d) The balance in Due From Miscellaneous covers Medicaid Event Verification (MEV) findings and cash advances needed to cover operations for a few SUD providers.

e) Due from Other funds is the transfer of FY 26 revenue from the Operating fund to the Internal Service fund (Medicaid Risk Reserve) with the offsetting liability shown on row 40 of the corresponding fiscal report.
f) Prepaid Expense Insurance total MSHN's October 2026 health insurance premiums paid in September.
g) Prepaid Expense Rent balance consists of security deposits for MSHN office suites.
h) Prepaid Expense contains balances for multiple Information Technology platforms paid in September for FY 27.
i) Total Fixed Assets - Computers represent the value of MSHN's capital asset net of accumulated depreciation.
j) The Lease Assets category is now displayed as an asset and liability based on a new Governmental Accounting Standards Board (GASB) Number 87 requirement. The lease assets figure represents FY 2022 – 2027 contract amounts for MSHN's office space.

3. Liabilities

a) MSHN estimates FY 2022 and FY 2021 lapses totaling $13.5 M and $17.6 M to MDHHS, respectively. The lapse amounts indicate the ISF was fully funded for both fiscal years, and that savings fell within the second tier (above 5%). Per contractual guidelines MDHHS receives half of every dollar generated beyond this threshold until the PIHP's total savings reach the 7.5% maximum.
b) This amount is related to SUD provider payment estimates and is needed to offset the timing of payments.
c) HRA is a pass-through account for dollars sent from MDHHS to cover supplemental payments made to psychiatric hospitals. HRA payments are intended to encourage hospitals to have psychiatric beds available as needed. Total HRA payments are calculated based on the number of inpatient hospital services reported.
d) Due To State – Insurance Plan Assessments Tax are now paid by MDHHS as gross adjustments and no longer based on monthly Per Eligible Per Month (PEPM) funds.
e) Due To CMHSP represents FY 2026 projected cost settlement figures. Final amounts will be paid during the region's final cost settlements, which generally occur in May or after Compliance Examinations are complete.

CMHSP	Cost Settlement	Payments/Offsets	Total
Bay	3,810,739.00	-	3,810,739.00
Central	418,714.00	-	418,714.00
Gratiot	1,269,322.00	-	1,269,322.00
Huron	2,024,537.00	-	2,024,537.00
Montcalm	291,541.00	-	291,541.00
Newaygo	(55,468.76)	(55,468.76)	-
Shiawassee	3,134,993.00	-	3,134,993.00
Total	**10,894,377.24**	**(55,468.76)**	**10,949,846.00**

f) Accrued Payroll Expense Wages represent expenses incurred in September and paid in October.
g) Accrued Benefits PTO (Paid Time Off) is the required liability account set up to reflect paid time off balances for employees.
h) Accrued Benefits Other represents retirement benefit expenses incurred in September and paid in October.
i) Deferred Revenue represents PA2 savings as noted in 1c above along with projected Medicaid savings through September. Medicaid revenue is projected to exceed expenses resulting in savings that will be available for carryforward to FY2027. PIHPs may retain 5% of savings before lapsing a portion to MDHHS.
j) The Unrestricted Net Position represents the difference between total assets, total liabilities, and the restricted for risk management figure.

Preliminary Statement of Activities – Column F calculates the actual revenue and expenses compared to the full year's amended budget. Revenue accounts whose Column F percent are less than 100% translate to MSHN receiving less revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 100% show MSHN's spending is trending higher than expected.

1. Revenue
    a) This account tracks Veterans Navigator (VN) activity and CMHSP Clubhouse Grant payments used to assist those served with their Medicaid deductibles.
    b) Medicaid Savings are generated when the prior year revenue exceeds expenses for the same period. PIHPs may retain up to 7.5% of savings using a tiered formulary.
    c) Medicaid Capitation – There is a negative variance in this account due to the projected 5% savings that has been classified as deferred revenue for carryforward to FY 2027. Deferred revenue becomes the first source of funding in the following year. Please note, Medicaid Capitation payment files are calculated and disbursed to CMHSPs based on a per eligible per month (PEPM) methodology and paid to SUD providers based on service delivery.
    d) Local Contribution is flow-through dollars from CMHSPs to MDHHS. Typically, revenue equals the expense side of this activity. Local Contributions were scheduled to reduce over the next few fiscal years until completely phased out. FY 2026 amounts are the same as FY 2025.
    e) Interest income is earned from investments and changes in principle for investments purchased at discounts or premiums. The amount earned is slightly higher than the amended budget as the projections may vary slightly from actual earnings. (Please see Statement of Net Position 1a and 1b.)
    f) This account tracks non-capitated revenue for SUD services which include Community Grant and PA2 funds. There is a large variance in this account because the budget amount represents the full MDHHS allocation amount regardless of planned spending.
    g) Rows 8 and 30 of this fiscal report corresponds with item 2e on the Statement of Net Position.
2. Expense
    a) Total PIHP Administration Expense has a slight variance however the amended budget amount reflects projections for the remainder of FY 2026's closeout period.
    b) CMHSP actual expenses are trending lower than the amended budget which is resulting in a variance. The variance may lessen once final expense information is received in February 2027. MSHN funds CMHSPs based on per eligible per month (PEPM) from 820 payment files. The files contain CMHSP county codes which designate where the payments should be sent. MSHN sends the full payment less affiliation fees which support PIHP operations.
    c) SUD provider payments are trending under budget and paid based on need. (Please see Statement of Activities 1c and 1f.)
    d) Benefit stabilization amounts are paid to CMHSPs for SUD access activities and assistance with cash flow if needed to cover operational expenditures in excess of their PEPMs. Currently two CMHSPs have received $11.5 M.
    e) IPA/HRA actual tax expenses are lower than the budget through July. Beginning in FY 2026, Insurance Plan Assessment (IPA) dollars are based on Michigan's Treasury assessment member months and paid by MDHHS in a quarterly lump sum. In prior fiscal years, the payment was included in capitation. HRA figures will also vary throughout the fiscal year based on inpatient psychiatric utilization and contribute to the variance. (Please see Statement of Net Position 3c and 3d).

MID-STATE HEALTH NETWORK
SCHEDULE OF GENERAL SAVINGS INVESTMENTS
As of September 30, 2026

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Change in market value	Chase Savings Interest	Interest - Accrued	Prior period interest - (Info Only added to col H total)	Interest Earnings (Information Only)	Total Chase Balance
UNITED STATES TREASURY BILL	912797TZ0	2.10.26	2.11.26	6.9.26		29,999,542.58	30,348,000.00							
UNITED STATES TREASURY BILL	912797TZ0	2.10.26	2.11.26	6.9.26			(30,348,000.00)							
UNITED STATES TREASURY BILL	912797VA2	6.5.26	6.9.26	12.3.26		29,997,803.34	29,997,803.34	3.642%						
JP MORGAN INVESTMENTS							29,997,803.34		-		-			29,997,803.34
JP MORGAN CHASE SAVINGS							2,376,566.67	0.020%		1,397.27				2,377,963.94
							$ 32,374,370.01		$ -	$ 1,397.27	$ -	$ -	$ -	$ 32,375,767.28

U.S. Treasury Bills – Treasury Bills, or T-Bills, are sold in terms ranging from a few days to 52 weeks. T-Bills are short-term debt issued and backed by the full faith and credit of the United States government. T-Bills are typically sold at a discount from the par amount (par amount is also called face value). You can hold a T-Bill until it matures or sell it prior to maturity. When a T-Bill matures, you are paid the par amount. Assuming the T-Bill is held to maturity, the difference between the par amount at maturity and the original cost is the amount of interest earned. **Source: U.S Treasury Direct**

U.S. Agencies – An agency security is a low-risk debt obligation that is issued by a U.S. government-sponsored enterprise (GSE). A Government-Sponsored Enterprise (GSE) bond is an agency bond issued by such agencies as Federal National Mortgage Association (Fannie Mae), Federal Home Loan Mortgage (Freddie Mac), Federal Farm Credit Banks Funding Corporation, and the Federal Home Loan Bank. Unlike Treasury securities, government agency bonds are not expressly backed by the full faith and credit of the U.S. government, but they do carry an implied backing due to the continuing ties between the agencies and the U.S. government. Most agency securities pay a semi-annual fixed coupon. **Source: Investopedia**

Chase does not generate statements in months when no investment activity occurs. In these instances, a position report provided by Chase is used to determine the investment principal. In addition, the change in market value is derived from the difference in market value and cost.

MID-STATE HEALTH NETWORK
SCHEDULE OF INTERNAL SERVICE FUND INVESTMENTS
As of September 30, 2026

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	912797RE9	6.30.25	7.1.25	10.28.25		9,999,615.49	10,137,000.00			
UNITED STATES TREASURY BILL	912797RE9						(10,137,000.00)			
UNITED STATES TREASURY BILL	912797QY6	9.16.25	9.16.25	12.11.25		1,999,690.69	2,018,000.00			
UNITED STATES TREASURY BILL	912797QY6						(2,018,000.00)			
UNITED STATES TREASURY BILL	912797TG2	12.9.25	12.11.25	4.7.26		2,499,120.76	2,528,000.00			
UNITED STATES TREASURY BILL	912797TG2						(2,528,000.00)			
UNITED STATES TREASURY BILL	912797PD3	10.27.25	10.28.25	1.22.26		19,999,350.29	20,175,000.00			
UNITED STATES TREASURY BILL	912797PD3						(20,175,000.00)			
UNITED STATES TREASURY BILL	912797SM0	1.21.26	1.22.26	4.23.26		19,998,999.63	20,177,000.00			
UNITED STATES TREASURY BILL	912797SM0						(20,177,000.00)			
UNITED STATES TREASURY BILL	912797SA6	4.6.26	4.7.26	10.1.26		2,599,386.42	2,599,386.42	3.569%		
UNITED STATES TREASURY BILL	912797UU9	4.21.26	4.23.26	8.18.26		19,999,755.54	20,230,000.00	3.542%		
UNITED STATES TREASURY BILL	912797UU9						(20,230,000.00)			
UNITED STATES TREASURY BILL	912797WB9	8.14.26	8.18.26	2.11.27		19,998,312.24	19,998,312.24	3.791%		
JP MORGAN INVESTMENTS							22,597,698.66			22,597,698.66
JP MORGAN CHASE SAVINGS							13,515,466.37	0.020%	256,334.75	13,771,801.12
							$ 36,113,165.03		$ 256,334.75	$ 36,369,499.78

U.S. Treasury Bills – Treasury Bills, or T-Bills, are sold in terms ranging from a few days to 52 weeks. T-Bills are short-term debt issued and backed by the full faith and credit of the United States government. T-Bills are typically sold at a discount from the par amount (par amount is also called face value). You can hold a T-Bill until it matures or sell it prior to maturity. When a T-Bill matures, you are paid the par amount. Assuming the T-Bill is held to maturity, the difference between the par amount at maturity and the original cost is the amount of interest earned. **Source: U.S Treasury Direct**

U.S. Agencies – An agency security is a low-risk debt obligation that is issued by a U.S. government-sponsored enterprise (GSE). A Government-Sponsored Enterprise (GSE) bond is an agency bond issued by such agencies as Federal National Mortgage Association (Fannie Mae), Federal Home Loan Mortgage (Freddie Mac), Federal Farm Credit Banks Funding Corporation, and the Federal Home Loan Bank. Unlike Treasury securities, government agency bonds are not expressly backed by the full faith and credit of the U.S. government, but they do carry an implied backing due to the continuing ties between the agencies and the U.S. government. Most agency securities pay a semi-annual fixed coupon. **Source: Investopedia**

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MID-STATE HEALTH NETWORK
SCHEDULE OF PA2 SAVINGS INVESTMENTS
As of September 30, 2026

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	912797RT6	11.12.25	11.13.25	2.12.26		3,499,171.34	3,532,000.00			
UNITED STATES TREASURY BILL	912797RT6						(3,532,000.00)			
UNITED STATES TREASURY BILL	912797TZ0	2.10.26	2.12.26	6.9.26		3,499,937.29	3,540,000.00			
UNITED STATES TREASURY BILL	912797TZ0	2.10.26	2.12.26	6.9.26			(3,540,000.00)			
UNITED STATES TREASURY BILL	912797VA2	6.5.26	6.9.26	12.3.26		3,499,344.02	3,499,344.02	3.642%		
JP MORGAN INVESTMENTS							3,499,344.02			3,499,344.02
JP MORGAN CHASE SAVINGS							2,332,251.34	0.010%	3,502.78	2,335,754.12
							$ 5,831,595.36		$ 3,502.78	$ 5,835,098.14

U.S. Treasury Bills – Treasury Bills, or T-Bills, are sold in terms ranging from a few days to 52 weeks. T-Bills are short-term debt issued and backed by the full faith and credit of the United States government. T-Bills are typically sold at a discount from the par amount (par amount is also called face value). You can hold a T-Bill until it matures or sell it prior to maturity. When a T-Bill matures, you are paid the par amount. Assuming the T-Bill is held to maturity, the difference between the par amount at maturity and the original cost is the amount of interest earned. **Source: U.S Treasury Direct**

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MSHN
Mid-State Health Network

Background

In accordance with the MSHN Operating Agreement, Article VI, Contracts that state the following:

> The Entity Board must approve the execution of any contract exceeding $25,000 in value. This includes any contract involving the acquisition, ownership, custody, operation, maintenance, lease, or sale of real or personal property and the disposition, division or distribution of property acquired through execution of the contract.

Therefore, MSHN presents the attached FY27 Contract Listing for Board approval and authorization of the Interim Chief Executive Officer to sign.

Recommended Motion:

The MSHN Board authorizes its Interim Chief Executive Officer to sign and fully execute the contracts as presented and listed on the FY27 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2027
November 2026

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	FY 2027 CONTRACT AMOUNT	FY 2027 ORIGINAL CONTRACT AMOUNT	INCREASE/ (DECREASE)
PIHP ADMINISRATIVE FUNCTIONS CONTRACT					
Varnum Attorneys at Law	Legal $210 - $820 Hourly	10.1.26 - 9.30.27	**$ -**	**$ -**	**-**
CMHSP CONTRACTS					
PLEASE NOTE: MSHN is requesting flexibility for the RHTP grant. The PIHP would manage the total grant amount available to the CMHSPs of $912,384 and can use these funds as needed throughout the region without returning to the board for amendments.					
Bay-Arenac Behavioral Health	Bay & Arenac Counties	10.1.26 - 9.30.27	**$ 78,425,820**	$ 74,690,000	**3,735,820**
Rural Health Transformation Program (RHTP)	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	**$ 76,032**	$ -	**76,032**
CEI Community Mental Health Authority	Clinton, Eaton, Ingham Counties	10.1.26 - 9.30.27	**$ 144,296,601**	$ 145,396,845	**(1,100,244)**
Rural Health Transformation Program	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	**$ 76,032**	$ -	**76,032**
Community Mental Health of Central Michigan	Clare, Gladwin, Isabella, Mecosta, Midland, Osceola Counties	10.1.26 - 9.30.27	**$ 150,411,600**	$ 147,219,533	**3,192,067**
Rural Health Transformation Program	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	**$ 76,032**	$ -	**76,032**
Gratiot Integrated Health Network	Gratiot County	10.1.26 - 9.30.27	**$ 23,340,449**	$ 23,127,209	**213,240**
Rural Health Transformation Program	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	**$ 76,032**	$ -	**76,032**
Huron Behavioral Health	Huron County	10.1.26 - 9.30.27	**$ 14,222,837**	$ 13,661,165	**561,672**
Rural Health Transformation Program	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	**$ 76,032**	$ -	**76,032**
The Right Door	Ionia County	10.1.26 - 9.30.27	**$ 15,375,487**	$ 15,375,487	**-**
Rural Health Transformation Program	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	**$ 76,032**	$ -	**76,032**
LifeWays	Jackson & Hillsdale Counties	10.1.26 - 9.30.27	**$ 84,731,831**	$ 92,389,368	**(7,657,537)**
Rural Health Transformation Program	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	**$ 76,032**	$ -	**76,032**
Montcalm Care Network	Montcalm County	10.1.26 - 9.30.27	**$ 29,243,094**	$ 32,500,000	**(3,256,906)**
Rural Health Transformation Program	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	**$ 76,032**	$ -	**76,032**
Newaygo CMH	Newaygo County	10.1.26 - 9.30.27	**$ 23,104,165**	$ 22,147,254	**956,911**
Rural Health Transformation Program	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	**$ 76,032**	$ -	**76,032**
Saginaw CMH	Saginaw County	10.1.26 - 9.30.27	**$ 95,169,807**	$ 91,532,483	**3,637,324**
Rural Health Transformation Program	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	76032	0	76032
Shiawassee CMH	Shiawassee	10.1.26 - 9.30.27	**$ 35,186,746**	$ 33,794,303	**1,392,443**
Rural Health Transformation Program	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	**$ 76,032**	$ -	**76,032**
SUDHH Agreement	Substance Use Disorder Health Home	10.15.26 - 9.30.27	**$ -**	$ -	**-**
Tuscola Behavioral Health Systems	Tuscola county	10.1.26 - 9.30.27	**$ 27,002,643**	$ 27,534,111	**(531,468)**
Rural Health Transformation Program	Limited Licensed Master of Social Work Supervision Stipend Program - 2027	10.1.26 - 9.30.27	**$ 76,032**	**$ -**	**76,032**
			$ 721,423,464	**$ 719,367,758**	**2,055,706**

CONTRACTING ENTITY	SUD PROVIDERS PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	FY2027 CONTRACT AMOUNT	FY2027 ORIGINAL CONTRACT AMOUNT	INCREASE/ (DECREASE)
SUD SERVICE PROVIDER CONTRACTS (Cost Reimbursement/Fee For Services) NOTE: Fee for Service contracts show "-" amount					
Eaton Regional Service Agency (RESA)	Opioid Overdose Education & Naloxone Distibution Supplies	11.1.26 - 6.30.27	**$ 713,076**	$ 685,255	**$ 27,821**
Face Addiction Now (FAN)	Street Medicine Outreach - PA2 Funds	10.1.26 - 9.30.27	**$ 290,813**	$ 185,025	**$ 105,788**
Mid-Michigan Comm Health Services	Behavioral Health Home	10.5.26 - 9.30.27	**$ -**	$ -	**$ -**
Ten Sixteen Recovery Network	Opioid Overdose Education & Naloxone Distibution Supplies	11.1.26 - 6.30.27	**$ 1,763,072**	$ 1,729,348	**$ 33,724**
Women of Color	Project Assert (SOR)	1.1.27 - 9.30.27	**$ 308,664**	$ 192,564	**$ 116,100**
			$ 3,075,625	$ 2,792,192	**283,433**
MDHHS CONTRACT					
Michigan Department of Health & Human Services (EGrAMS)	RHTP Grant - Limited Licensed Master of Social Work Supervision Stipend Program	10.1.26 - 9.30.27	**$ 1,000,000**	**-**	**1,000,000**

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, September 1, 2026
MyMichigan Medical Center
Meeting Minutes

1. Call to Order

Chairperson Ed Woods called this meeting of the Mid-State Health Network Board of Directors to order at 5:37 p.m. Mr. Woods reminded members that those participating by phone may not vote on matters before the board unless absent due to military duty, disability, or health-related condition and the Board Member Conduct Policy noted on the agenda. Mr. Woods welcomed Michelle Stillwagon, Chief Executive Officer of Gratiot Integrated Health Network and Tammy Warner, Executive Director of Montcalm Care Network.

2. Roll Call

Secretary Deb McPeek-McFadden provided the roll call for Board Members in attendance.

Board Member(s) Present: Greg Brodeur (Shiawassee), Kevin Collins (LifeWays), Patrick Conley (BABH), Ken DeLaat (Newaygo), David Griesing (Tuscola), Dan Grimshaw (Tuscola), Tina Hicks (Gratiot), John Johansen (Montcalm), Deb McPeek-McFadden (The Right Door), Irene O'Boyle (Gratiot), Kurt Peasley (Montcalm), Joe Phillips (CMH for Central Michigan), Linda Purcey (The Right Door), Kerin Scanlon (CMH for Central Michigan), Pam Schumacher (BABH), Mike Smith (HBH), Jack Stapleton (HBH), Jason White (CEI), Joanie Williams (Saginaw), and Ed Woods (LifeWays)

Board Member(s) Remote: Lori Schultz (Newaygo)–Newaygo, MI

Board Member(s) Absent: Cindy Garber (Shiawassee), Tracey Raquepaw (Saginaw), and Dwight Washington (CEI)

Staff Member(s) Present: Amanda Ittner (Interim Chief Executive Officer), Leslie Thomas (Chief Financial Officer), and Sherry Kletke (Executive Support Specialist)

Public Present: Michelle Stillwagon (Chief Executive Officer, Gratiot Integrated Health Network) and Tammy Warner (Executive Director, Montcalm Care Network)

3. Approval of Agenda for September 1, 2026

Board approval was requested for the Agenda of the September 1, 2026, Regular Business Meeting.

MOTION BY PAMELA SCHUMACHER, SUPPORTED BY KURT PEASLEY, FOR APPROVAL OF THE AGENDA OF SEPTEMBER 1, 2026 REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

4. Public Comment

A board member reminded everyone of the key dates associated with the upcoming general election taking place on November 3, 2026 and encouraged all members to vote.

5. Consideration of MSHN Fiscal Year 2026 Budget Amendment

Ms. Leslie Thomas provided an overview and information on the Fiscal Year 2026 Budget Amendment report and recommended board approval as presented.

MOTION BY PATRICK CONLEY, SUPPORTED BY TINA HICKS, FOR APPROVAL OF THE MSHN FISCAL YEAR 2026 BUDGET AMENDMENT, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

6. Consideration of MSHN Regional Budget for Fiscal Year 2027

Board approval was requested for the MSHN Fiscal Year 2027 Budget as presented during the Public Hearing and included in board member folders.

MOTION BY JOHN JOHANSEN, SUPPORTED BY KURT PEASLEY, FOR APPROVAL OF THE MSHN FISCAL YEAR 2027 BUDGET, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

7. Interim Chief Executive Officer's Report

Ms. Amanda Ittner discussed several items from within the Interim CEO written report to the Board highlighting the following:

- Announcements
  - Staff Updates
- PIHP/Regional Matters
  - Competitive Procurement of Prepaid Inpatient Health Plans
  - PIHP Competitive Procurement Lawsuit Update
  - Catholic Charities Lawsuit Update
  - Inter-Regional Dialogs
  - Rural Health Transformation Grants
  - Balanced Scorecard FY26 Update
- State of Michigan/Statewide Activities

- FY27 Conference Report (Final Budget)

8. Chief Financial Officer's Report

Ms. Leslie Thomas provided an overview of the financial statements included within board meeting packets for the period ended July 31, 2026.

MOTION BY KEN DELAAT, SUPPORTED BY KURT PEASLEY, TO RECEIVE AND FILE THE STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDED JULY 31, 2026, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

9. Contracts for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2027 contract listing provided in the board meeting packet noting corrections to the heading for the revenue contract section MDHHS contract to reflect FY27 Contract Amount and FY26 Contract Amount and requested the board authorize MSHN's Interim CEO to sign and fully execute the contracts listed on the FY2027 contract listing.

MOTION BY IRENE O'BOYLE, SUPPORTED BY PAM SCHUMACHER, TO AUTHORIZE THE INTERIM CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY2027 CONTRACT LISTING. MOTION CARRIED UNANIMOUSLY.

10. Chairperson's Report

Chairperson Ed Woods asked members for a volunteer to join the policy committee to replace Kurt Peasley effective for the November 10, 2026 meeting. Interested members should contact MSHN Executive Support Specialist.

Mr. Woods called for a volunteer to serve as the Chair of the Chief Executive Officer (CEO) Performance Evaluation process which is recommended to be postponed for two months to begin following the return of the CEO from leave. Ms. Irene O'Boyle has been the chair in the past and will continue to serve as the chair for the upcoming evaluation process.

Mr. Woods informed members that the Community Mental Health Association of Michigan has met with one of the Gubernatorial candidates and hopes to meet with the second candidate in the near future.

11. Approval of Consent Agenda

Board approval was requested for items on the consent agenda as listed in the motion below, and as presented.

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY TINA HICKS, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE JULY 7, 2026 BOARD OF DIRECTORS MEETING; APPROVE MINUTES OF THE CLOSED SESSION MEETING OF THE JULY 7, 2026 BOARD MEETING; RECEIVE DRAFT POLICY COMMITTEE MEETING MINUTES OF JULY 7, 2026; RECEIVE SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD MEETING MINUTES OF JUNE 17, 2026; RECEIVE OPERATIONS COUNCIL

KEY DECISIONS OF JULY 20, 2026 AND AUGUST 17, 2026; AND TO APPROVE ALL THE FOLLOWING POLICIES: MICHIGAN MISSION BASED PERFORMANCE INDICATOR SYSTEM, CLINCIAL PRACTICE GUIDELINES AND EVIDENCE BASED PRACTICES. MOTION CARRIED UNANIMOUSLY.

12. Other Business

There was no other business.

13. Public Comment

There was no public comment

14. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 6:17 p.m.

Meeting minutes submitted respectfully by:
MSHN Executive Support Specialist

Mid-State Health Network (MSHN) Board of Directors Public Hearing

Tuesday, September 1, 2026

MyMichigan Medical Center

Meeting Minutes

1. Call to Order

Chairperson Ed Woods called this Public Hearing of the Mid-State Health Network Board of Directors to order at 5:00 p.m. Mr. Woods asked for a moment of silence to honor the recent passing of a board member's father. Mr. Woods reminded members that those participating by phone may not vote on matters before the board unless absent due to military duty, disability, or health-related condition and the Board Member Conduct Policy. Mr. Woods welcomed Michelle Stillwagon, Chief Executive Officer of Gratiot Integrated Health Network and Tammy Warner, Executive Director of Montcalm Care Network.

2. Roll Call

Secretary Deb McPeek-McFadden provided the roll call for Board Members in attendance.

Board Member(s) Present:	Greg Brodeur (Shiawassee), Kevin Collins (LifeWays), Patrick Conley (BABH), Ken DeLaat (Newaygo), David Griesing (Tuscola), Dan Grimshaw (Tuscola)-joined at 5:02 p.m., Tina Hicks (Gratiot), John Johansen (Montcalm), Deb McPeek-McFadden (The Right Door), Irene O'Boyle (Gratiot), Kurt Peasley (Montcalm), Joe Phillips (CMH for Central Michigan), Linda Purcey (The Right Door), Kerin Scanlon (CMH for Central Michigan)-joined at 5:06 p.m., Pam Schumacher (BABH), Mike Smith (HBH), Jack Stapleton (HBH), Jason White (CEI), Joanie Williams (Saginaw), and Ed Woods (LifeWays)
Board Member(s) Remote:	Lori Schultz (Newaygo)–Newaygo, MI
Board Member(s) Absent:	Cindy Garber (Shiawassee), Tracey Raquepaw (Saginaw), and Dwight Washington (CEI)
Staff Member(s) Present:	Amanda Ittner (Interim Chief Executive Officer), Leslie Thomas (Chief Financial Officer), and Sherry Kletke (Executive Support Specialist)
Public Present:	Michelle Stillwagon (Chief Executive Officer, Gratiot Integrated Health Network) and Tammy Warner (Executive Director, Montcalm Care Network)

3. Approval of Agenda for September 1, 2026

Board approval was requested for the Agenda of the September 1, 2026, Public Hearing.

MOTION BY TINA HICKS, SUPPORTED BY DAVID GRIESING FOR APPROVAL OF THE AGENDA OF SEPTEMBER 1, 2026, PUBLIC HEARING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

4. Fiscal Year 2027 Budget Presentation

Ms. Leslie Thomas and Ms. Amanda Ittner presented the FY2027 MSHN Regional Budget as distributed at the time of the meeting and answered questions posed by board members.

5. Public Comment

There was no public comment.

6. Board Comment

There was no board member comment.

7. Adjournment

The MSHN Public Hearing adjourned at 5:36 p.m.

Meeting minutes submitted respectfully by:
MSHN Executive Support Specialist

MSHN
Mid-State Health Network

Mid-State Health Network Board Officer Briefing by Executive Leadership Notes

Friday, August 21, 2026 - 9:00 a.m.

Purpose: *The purpose of this meeting is for MSHN Executive Leaders to brief the MSHN Board Officers on recent events, current operations, and future plans.*

Officers Present: Ed Woods, Chairperson; Irene O'Boyle, Vice-Chairperson, Deb McPeek-McFadden, Secretary; Kurt Peasley, Member at Large; David Griesing, Member at Large

Others Present: Greg Brodeur, Board Member; Jack Stapleton, Board Member; Kevin Collins, Board Member

Staff Present: Amanda Ittner, Deputy Director

Staff Absent: Joseph Sedlock, Chief Executive Officer

1. **Welcome and Introductions**: Chairperson Woods welcomed everyone to this Executive Leadership briefing, which began at 9:00 a.m.

2. **Public Comments:** None

3. **MSHN Executive Leadership Briefing Topics:**
   - 3.1. Planned Order of Business, September 1, 2026, Board Meeting & Public Hearing: A. Ittner reviewed the draft board meeting agenda and the public hearing agenda. The FY27 Budget presentation will be handout as normal process. However, the FY27 Budget will also be a handout due to the timing of MDHHS rates which was originally scheduled for August 20th, then rescheduled to August 24 and late yesterday that was cancelled with no reschedule date. The board packet needs to be mailed out on August 24th, so finance needs additional time to finalize revenue and expense from the region. In addition, we will be removing the placeholder for FY26 contracts as no action items are needed for FY26. Note, we will also present the FY26 Budget Amendment. The FY27 Budget presentation will include more information this year related to the state budget and HR.1. assumptions included in revenue for the PIHP.
   - 3.2. MDHHS Competitive Procurement of PIHPs: MSHN has not heard any updates directly from MDHHS related to the procurement. On August 10th, MSHN received the FY27 MDHHS contract to be returned by September 10th, 2026. No items of concern at this time, more details will be included in the board report. MSHN continues to monitor the state vendor solicitation site for the PIHP procurement release.
   - 3.3. Litigation Update(s): As an update to the PIHP/MDHHS lawsuit, MSHN along with the other plaintiffs filed an appeal with the State of Michigan Court of Appeals on May 13, 2026, in response to the final order issued on April 23, 2026, from the Court of Claims earlier order dated October 14, 2025. In early June, MDHHS moved to dismiss our appeal, claiming the case is moot. MSHN along with the other plaintiffs filed a response to the dismissal on July 14, 2026, and on August 11, 2026, the court of appeals denied MDHHS' motion to dismiss the appeal. The ruling doesn't resolve anything definitively in our favor, but it means that our appeal is still alive on whether MDHHS has the authority to reduce the number of PIHPs and dictate the geographic boundaries of the PIHPs. MSHN along with the other plaintiffs filed our brief to the appeal on August 4, 2026. MDHHS's

response is due September 8, 2026.

3.4. Inter-Regional Dialogs: Inter-regional dialogs continue weekly with the MSHN region represented by MSHN and six of our Community Mental Health Service Program (CMHSP) CEO's and the CMHSP CEOs and Executive Leadership of another PIHP with a primary goal of working together to survive the anticipated request for proposals (RFP). These exploratory inter-regional conversations are focused on preserving the public behavioral health system, increased consistency in access and service array for beneficiaries, protecting the rights and statutory authorities of the CMHSP participants in both regions, identifying how we can jointly submit a future bid, potential future regional configurations, and operating in similar ways to benefit providers in common. It is important to highlight that this is designed to be a CMHSP-led initiative. CMHSPs are the only entities that can create regional entities, including any future structural configurations. The latest discussion revolves around a joint representation agreement between all CMHSPs, with the future intention to develop a common interest agreement with the PIHPs.

3.5. Board Officer Briefing Calendar: The FY27 Board Officer Briefing calendar was presented as included in the packet. MSHN administration will send out calendar invitations in September.

3.6. Postpone Chief Executive Officer Evaluation for two months: A.Ittner reported that in the past during the August Executive Committee, a Chair would be identified for the CEO Performance Review. Since the CEO is on a leave of absence, administration recommends postponement for two months. The Board Chair will announce during the September board meeting and indicate a request for a volunteer to Chair the CEO evaluation process. The CEO's contract is through January 31, 2027, with optional renewal up to two additional years without amendment.

4. **Public Comments:** None

5. **Concluding Comments:** Chairperson Woods reminded officers that the next scheduled Board Officer Briefing Meeting will be 10/16/2026, 9:00 a.m. and thanked MSHN Leadership and Board Officers for attending this briefing meeting, which ended at 9:37 a.m.

MSHN
Mid-State Health Network

Mid-State Health Network Board Officer Briefing
by Executive Leadership
Notes

Friday, October 16, 2026 - 9:00 a.m.

OFFICERS PRESENT: Ed Woods, Chairperson; Irene O'Boyle, Vice-Chairperson; Deb McPeek-McFadden, Secretary; Kurt Peasley, Member at Large; David Griesing, Member at Large
OTHERS PRESENT: Jack Stapleton; Ken DeLaat; Kevin Collins
STAFF PRESENT: Amanda Ittner, Deputy Director; Joseph Sedlock, Chief Executive Officer

Purpose: *The purpose of this meeting is for MSHN Executive Leaders to brief the MSHN Board Officers on recent events, current operations, and future plans.*

1. Welcome and Introductions Mr. Woods welcomed the participants to this board officer briefing at 9:00 a.m.

2. Public Comments: There were no comments from members of the public.

3. MSHN Executive Leadership Briefing Topics

   3.1. Planned Order of Business, November 10, 2026 Board Meeting: The draft agenda for the November 10, 2026 board meeting was reviewed.
   3.2. Transitions: Mr. Sedlock informed the participants of his intention not to renew or extend his employment contract when it expires at the end of January. Mr. Sedlock will send an email to all board members, CMHSP CEO's, and MSHN Staff today.
   3.3. MDHHS Competitive Procurement of PIHPs – Updates: The State has removed the Open procurement notice from the State purchasing website (known as Sigma), even while rumor of the imminent release of a new request for Proposals (RFP) circulates. Executive leadership has restored all operations to normal, including external postings to fill vacant positions. If (or when) these circumstances change, administration will get word out as soon as possible.
   3.4. Litigation Update(s): MSHN, along with five other organizations, are plaintiffs in the RFP-related litigation, which is now in the Court of Appeals. Appeal-related briefs were filed. Next steps will be oral arguments (if the Court of Appeals wants them) or rulings on the briefs without hearing. Timing could be quick or 12, 18, or 24 months or more. MSHN is a defendant, along with the State, in a federal lawsuit filed against MSHN and the State by Catholic Charities of Ingham, Eaton & Clinton Counties. Our attorney has filed a motion to dismiss and is awaiting a hearing or decision.
   3.5. Inter-Regional Dialogs MSHN and its CMHSP Participants' CEOs are continuing to engage in dialog with another regional entity and its CMH CEOs. These exploratory conversations are focused on preserving the public behavioral health system, increased consistency in access and service array for beneficiaries, improving consistency at provider touch-points and related matters. Work is also being done to protect related documents and conversations under attorney-client privilege. It is important to highlight that this is designed to be a CMHSP-led initiative.
   3.6. Other: CEO Succession considerations were briefly discussed.

4. Public Comments: There were no comments from members of the public.

5. Concluding Comments: Next scheduled board officer briefing meeting is December 18, 2026 at 9:00 a.m. This briefing concluded at 9:25 a.m.

Mid-State Health Network (MSHN) Board Policy Committee Meeting
Tuesday, September 1, 2026
MyMichigan Medical Center
Meeting Minutes

Members Present: John Johansen, Tina Hicks, Irene O'Boyle, David Griesing, and Kurt Peasley

Members Absent: None

Guest Board Members Present: Jack Stapleton

Staff Members Present: Amanda Ittner (Interim Chief Executive Officer) and Sherry Kletke (Executive Support Specialist)

1. **Call to Order**

   Mr. John Johansen called this meeting of the Mid-State Health Network Board Policy Committee to order at 4:00 p.m.

2. **Approval of Agenda for September 1, 2026**

   Board Policy Committee approval was requested for the Agenda of the September 1, 2026, Board Policy Committee Meeting, as presented.

   MOTION BY IRENE O'BOYLE, SUPPORTED BY DAVID GRIESING, FOR APPROVAL OF THE AGENDA OF SEPTEMBER 1, 2026 BOARD POLICY COMMITTEE MEETING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

3. **Approval of Minutes**

   Board Policy Committee approval was requested for the draft meeting minutes of the July 7, 2026 Board Policy Committee Meeting.

   MOTION BY KURT PEASLEY, SUPPORTED BY TINA HICKS, FOR APPROVAL OF THE MINUTES OF THE JULY 7, 2026 BOARD POLICY COMMITTEE MEETING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

4. **Public Comment**

   There was no public comment

5. Policies Under Review

Mr. Johansen invited Ms. Ittner to provide a review of the substantive changes to the policies under review from the Compliance, Quality and Service Delivery Chapters included in the Policy Committee packet.

MOTION BY DAVID GRIESING, SUPPORTED BY TINA HICKS, TO RECOMMEND THE POLICIES UNDER REVIEW TO THE BOARD OF DIRECTORS. MOTION CARRIED UNANIMOUSLY.

6. FY2027 Board Policy Committee Meeting Calendar

The FY2027 Board Policy Committee calendar was presented to members for review and approval. Members discussed the dates they will not be available for in-person attendance and recommend the Board of Directors Chair seek a volunteer member to replace one committee member.

MOTION BY TINA HICKS, SUPPORTED BY DAVID GRIESING, FOR APPROVAL OF THE FY2027 BOARD POLICY COMMITTEE MEETING CALENDAR, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

7. New Business

There was no other business.

8. Public Comment

There was no public comment.

9. Adjournment

The MSHN Board Policy Committee Meeting adjourned at 4:12 p.m.

Meeting minutes submitted respectfully by:
MSHN Executive Support Specialist

Mid-State Health Network SUD Oversight Policy Advisory Board

Wednesday, August 19, 2026, 4:00 p.m.
CMH Association of Michigan (CMHAM)
507 S. Grand Ave.
Lansing, MI 48933

Meeting Minutes

1. Call to Order

Chairperson Bryan Kolk called the MSHN SUD Regional Oversight Policy Board (OPB) of Directors Meeting to order at 4:00 p.m. Mr. Kolk reminded members participating virtually may not participate in or vote on matters before the board unless absent due to military duty, disability, or health-related condition and also provided a reminder that only one vote is allowed per county for those counties that have the member and alternate present.

Board Member(s) Present:	Irene Cahill (Ingham), Bruce Caswell (Hillsdale), Jacob Gross (Clare)-joined at 4:15 p.m., Charlean Hemminger (Ionia), John Hunter (Tuscola), Bryan Kolk (Newaygo), Karen Link (Huron), Charlie Mahar (Montcalm), Jim Moreno (Isabella), Emily Rayburn (Gratiot), Pamela Schumacher (Bay), Kim Thalison (Eaton), Mike Visnaw (Gladwin), Dwight Washington (Clinton), and Ed Woods (Jackson)
Board Member(s) Remote:	Alaynah Smith (Midland) - Midland, MI – joined at 4:52 p.m. and Rachel Vallad (Arenac)-Standish, MI
Board Member(s) Absent:	Christina Harrington (Saginaw), Alaynah Smith (Midland), Jerrilynn Strong (Mecosta), and David Turner (Osceola)
Alternate Member(s) Present:	Linda Howard (Mecosta)
Staff Members Present:	Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Dr. Dani Meier (Chief Clinical Officer), Dr. Trisha Thrush (Director of Substance Use Services and Operations), Sarah Andreotti (Prevention Administrator), and Sherry Kletke (Executive Support Specialist)
Staff Members Remote:	Sarah Surna (Prevention Specialist), Cari Patrick (Prevention Specialist), and Sherrie Donnelly (Treatment and Recovery Specialist)

2. Roll Call

   Mr. Dwight Washington provided the Roll Call for Board Attendance and informed the Board Chair, Bryan Kolk, that a quorum was present for board meeting business.

3. Approval of Agenda for August 19, 2026

   Board approval was requested for the Agenda of the August 19, 2026 Regular Business Meeting, as presented.

   MOTION BY JIM MORENO, SUPPORTED BY JOHN HUNTER, FOR APPROVAL OF THE AUGUST 19, 2026 REGULAR BUSINESS MEETING AGENDA, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

4. Approval of Minutes from the June 17, 2026 Regular Business Meeting

   Board approval was requested for the draft meeting minutes of the June 17, 2026 Regular Business Meeting.

   MOTION BY PAM SCHUMACHER, SUPPORTED BY CHAR HEMMINGER, FOR APPROVAL OF THE MINUTES OF THE JUNE 17, 2026, MEETING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

5. Public Comment

   There was no public comment.

6. Board Chair Report

   Welcome to new alternate member, Glenn Cook from Huron County.

7. Deputy Director Report

   Ms. Amanda Ittner provided an overview of the report included in the board meeting packet, and available on the MSHN website, highlighting:

   Regional Matters:

   - Michigan Department of Health and Human Services (MDHHS) Prepaid Inpatient Health Plan (PIHP) Procurement Update
   - 27th Annual Substance Use and Co-Occurring Disorder Hybrid Conference
   - Compliance Activities Summary

   State of Michigan/Statewide Activities:

   - MDHHS Awards Nearly $3.75 Million to Help Prevent Substance Use Among Michigan Youth

8. Chief Financial Officer Report

   Ms. Leslie Thomas provided an overview of the financial reports included in board meeting packets:

   - FY2026 PA2 Funding and Expenditures by County
   - FY2026 PA2 Use of Funds by County and Provider

- FY2026 Substance Use Disorder (SUD) Financial Summary Report of June 2026

9. FY2026 Substance Use Disorder PA2 Contract Listing

   Ms. Leslie Thomas provided an overview and information on the FY26 Substance Use Disorder (SUD) PA2 Contract Listing as provided in the packet.

   MOTION BY JOHN HUNTER, SUPPORTED BY JIM MORENO, FOR APPROVAL OF THE FY26 SUBSTANCE USE DISORDER (SUD) PA2 CONTRACT LISTING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY WITH ONE ABSTENTION.

   Ms. Leslie Thomas provided an overview and information on the FY27 Substance Use Disorder (SUD) PA2 Contract Listing as provided in the packet.

   MOTION BY JIM MORENO, SUPPORTED BY IRENE CAHILL, FOR APPROVAL OF THE FY27 SUBSTANCE USE DISORDER (SUD) PA2 CONTRACT LISTING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY WITH ONE ABSTENTION.

10. SUD Operating Update

    Dr. Dani Meier referred members to the written SUD Operations Report and the FY26 Q3 SUD County reports included in the board meeting packet for review, highlighting the team has been working on the FY27-29 SUD Strategic Plan. Dr. Meier provided members with a presentation of the plan, noting that members will receive a draft version of the plan by the end of the week with an opportunity to provide feedback. The FY27-29 SUD Strategic Plan is due to Michigan Department of Health and Human Services on August 31, 2026.

    Bruce Caswell left the meeting at 5:10 p.m.

11. Other Business

    There was no other business.

12. Public Comment

    There was no public comment

13. Board Member Comment

    Ed Woods left the meeting at 5:14 p.m.

    A board member voiced concerns about sustainable funding allocations in the upcoming years and encouraged MSHN administration to review considering expected reductions at the Federal and State level.

14. Adjournment

    Chairperson Bryan Kolk adjourned the MSHN SUD Oversight Policy Advisory Board Meeting at 5:21 p.m.

Meeting minutes submitted respectfully by:
MSHN Executive Support Specialist

BOARD APPROVED OCTOBER 21, 2026

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 09/21/2026

Members Present: Chris Pinter; Carol Mills; Julie Majeske; Tracey Dore; Levi Zagorski; Tammy Warner; Kerry Possehn; Michelle Stillwagon; Bryan Krogman; Sandy Lindsey; Sara Lurie, Jeff Labun, Cassie Watson; Gwenda Summers
Members Absent: Ryan Painter
MSHN Staff Present: Amanda Ittner; Leslie Thomas

Agenda Item	Action Required				
CONSENT AGENDA	The group had no feedback from the consent agenda.				
	N/A	By Who	N/A	By When	N/A
UTILIZATION MANAGEMENT CEO WORKGROUP SUMMARY	Amanda reviewed the Utilization Management CEO Workgroup summary. The workgroup has finalized and included recommendations for Operations Council approval as requested to address non-delegation of UM for HCBS services. The group agreed on the UM definitions, assessment of current systems, short-term and long-term strategy for compliance and timeframe for implementation. The UM CEO Workgroup recommends the Operations Council approve the following: 1. The Utilization Management Definitions as noted 2. The inclusion of BPS and IPOS as part of the UM review 3. Direct PIHP access to the CMHSP EMR until such time an AI support review platform is available 4. PIHPs to pursue an AI tool for clinical review and further presentation and recommendation to Operations Council 5. Implementation timeframe and applicability Chris reiterated the recommendations are minimal to meet requirement for the PIHP. Tammy questioned whether the plan must be implemented by 10.1.26. Could it be a staggered implementation and structured in different phases as opposed to specific months and then based on when guidance is received? Amanda responded that the MDHHS requirement is 10.1.26, however final guidance has not been received. In addition, HSAG is questioning how CFAP requirements will be addressed. Amanda stated the region should begin drafting benefit plans but structured timeframes can be used until final guidance is received. Carol stated this plan should only include authorizations for waiver services and is concerned that PCE is intending to globally apply their full authorization process. Amanda responded that this process is different than the plan from PCE. PCE is offering a dashboard for CMHSPs to track authorization timeliness and denials. Amanda				

Agenda Item	Action Required				
	confirmed there is no intent for MSHN to begin authorizing all CMH services and that authorizations will not be included in the project. Sarah requested additional time for review prior to approving. Bryan inquired about messaging to the UMC and Amanda supported waiting until Operations Council has approved.				
	MSHN will revise the document as follows and include on the October agenda for final review: • Ensure clarity to only HCBS services • Timeframes will be added instead of specific dates • Visual of project is requested • Inclusion of graph identifying services by waiver • Inclusion of "when guidance received, the plan will be brought back to Ops Council".	By Who	A.Ittner	By When	10.15.26
INTER-REGIONAL DIALOGS	Amanda reported the group's last meeting was on 9.9.26. All CMHSPs have signed a joint representation agreement. The Common Interest Agreement between CMHSPs and PIHPs is being drafted. Discussed Rate Setting meeting and FY27 Budget considerations, preparing for the impact of H.R.1. Work continues with the PIHPs on the process alignment opportunities to standardize contract boilerplate, training grid and recipient rights reciprocity. Next meeting is on 9.30.26.				
	Update and discussion only.	By Who	N/A	By When	N/A
FY27 RATES & REGIONAL PLANNING	Leslie informed the group, MDHHS final rates are still outstanding and a distribution date has not been identified. Wakely Actuarial firm submitted a 10-page document to MDHHS regarding draft rates. In summary, there were concerns with the following areas: Working Families Tax Cut – questions on enrollment and acuity assumptions Substance Use Disorder (SUD) Rate Transparency – SUD rates are not separately identifiable in Appendix 4 Base Data Components – No clear explanation showing the relationship for different variables and their impact on rates Waiver Services Previously Funded Through CCBHC PPS-1 – Questions on whether waiver data from FY 25 were included in base capitation Minimum Wage – Questions regarding the allocation of $89.2 M being insufficient and the impacts of wage compression on for the DCW add-on. Intensive Crisis Stabilization Services (ICSS) – No data provided and the request is to resolve this issue prior to final rate development				

Agenda Item	Action Required				
	Administrative Load Development – Requesting a review to include the impacts to administrative effort for FY 27 changes such as member outreach, eligibility support, reporting, lower HMP enrollment, etc. FY 26 Rate Timing – Concerns with the lateness of the FY 26 mid-year rate adjustment and its potential impact on regional FYE results Risk Margin Support – Requested further explanation on Risk Margin In addition, a summary table of recommendations were provided. Chris asked if the mid-year waiver issue is pulling funding or correcting a prior funding error. Leslie confirmed MDHHS is correcting payment errors only. Bryan requested CMHSP contracts be sent prior to final MDHHS rates. Leslie acknowledged they will be sent this week based on the board approval amounts. Sandy questioned if there are other contract attachments aside from the funding exhibit. Leslie responded there will be a disclosure form, Healthy Transitions contract, and Clubhouse Agreement if applicable.				
	MSHN will calculate an updated revenue picture once final rates are received. In addition, CMHSPs will need to submit updated expense figures to accompany revenue for completion of the final FY 27 projections.	By Who	L. Thomas	By When	9.25.26 (contracts) TBD (final rates)
RFP/PROCUREMENT UPDATE (IF ANY)	No update – continue to monitor Legal Appeal continues: MDHHS submitted their brief. Our reply is due September 25.				
	Informational update only	By Who	N/A	By When	N/A
HOMELESSNESS DISCUSSION	MSHN Board member requested our CMHSPs provide updates on the region's work with the homeless population. Homeless shelters collect data on individuals that utilize the shelter. Concerns regarding community perception related to CMHs and the homeless, increased demand on CCBHCs and General Fund. CMHSP reported: LifeWays: Part of mileage pays for therapist, community perception that CMHs can force treatment on homeless, Cassie doing education at council levels; discussion occurring but housing supports are limited. CIECMH: Mayor requested meeting with CMH as it is a large concern especially in downtown Lansing; CEI works with those served to obtain housing; challenge to support others. Saginaw: Similar to above, numerous shelters and full, concern for winter, new churches for warming centers, housing resource center that supports outreach.				

Agenda Item		Action Required			
	Informational	By Who	N/A	By When	N/A
AUTHORIZATION DATA	Amanda sent out clarification on Friday regarding PCE efforts related to Authorizations. 1. MDHHS requires PIHPs to publicly post prior authorization information on the PIHPs website by October 1, 2026 (this is a CMS requirement). Steve Grulke through ITC has been working to obtain information from the CMHs. See attached. We have been working through different interpretations of ***prior*** authorizations (some CMHs consider all services prior authorized, others do not). 2. MDHHS has expanded the authorization denial reporting process effective October 1, 2026. Note: The UM PIHP group is requesting an extension since the new template reporting just recently came out. You will see an update on this in the Operations Council packet on pg 25, from PCE. Note: This is an optional implementation for CMHs if they need an automated method for tracking authorization tracking and timeliness. 3. MSHN has not requested any authorization information related to any initiatives under utilization management for CFAP. The recommendations from the CEO UM Workgroup are on the agenda today for approval.				
	Update only	By Who	N/A	By When	N/A
AGENDA TOPIC					
		By Who		By When	
AGENDA TOPIC					
		By Who		By When	
AGENDA TOPIC					
		By Who		By When	
AGENDA TOPIC					
		By Who		By When	

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: October 19, 2026

Members Present: **Carol Mills**; **Julie Majeske; Tracey Dore**; **Tammy Warner**; **Kerry Possehn; Michelle Stillwagon;** Bryan Krogman; **Sandy Lindsey**; Gwenda Summers, **Jeff Labun, Cassie Watson; Levi Zagorski**
Members Absent: Chris Pinter; Ryan Painter
MSHN Staff Present: Joseph Sedlock; Amanda Ittner; For applicable areas: Kim Zimmerman

Agenda Item	Action Required				
CONSENT AGENDA	No items removed for further discussion				
	Received and acknowledged	By Who	N/A	By When	N/A
FY27 QAPIP • **EXECUTIVE SUMMARY** • **FY2027 DRAFT PLAN**	Kim Zimmerman reviewed the FY QAPIP Executive Summary and revisions included in the revised plan. Operations Council approved to submit to MSHN Board for approval.				
	MSHN will seek Board approval, November board meeting	By Who	K. Zimmerman	By When	11.10.26
2026 MSHN SATISFACTION SURVEY REPORT	Kim reviewed the results of the MSHN Satisfaction Survey for 2026. This report will also be presented to the MSHN Board of Directors. Next step will be to review for improvement initiatives by functional areas; QIC, CSC, CLC, RCAC and SUD Board.				
	Informational Only	By Who	N/A	By When	N/A
FY27 BUDGET STATUS **SUD LOCAL REQUEST**	Leslie Thomas reviewed the FY27 Budget inclusive of MDHHS final FY27 rates and updated CMHSP expense figures. Approximately 87.6m surplus. Leslie also reviewed the CMHSP supplemental report that will be shared with the board. MSHN reviewed the SUD rates and would like to offer an increase in our rates. Due to the limited block grant and zero local dollars at MSHN, MSHN would need approximately $300k to support a 3% increase in SUD rates (required to apply to all fund sources).				
	MSHN will provide more data related to spending by fund sources by county, inclusive of PA2	By Who	L. Thomas	By When	11.10.26
MSHN UM CEO WORKGROUP – REVISED SUMMARY AND TIMELINE	Amanda reviewed the revised UM Workgroup summary and timeline to add: visual, clarity on HCBS services and updated timeline based on guidance received from MDHHS on CFAP. Once guidance is received from MDHHS this summary will be brought back to Operations Council. Support to move forward; Discussion to connect with PIHPs for standardization and more information when the AI workgroup is ready to convene. More time is needed from CMHCM.				

Agenda Item	Action Required				
	Topic will be added next month; In the meantime, questions or clarification can be sent to Amanda	By Who	A.Ittner	By When	11.10.26
FY26 COMMITTEE/COUNCIL REPORT	Amanda reviewed the Annual Operations Council Report for review and feedback by October 28th. The final report will be included in the QAPIP. Goal 1# clarify "upon MDHHS Guidance"				
	CMHs to review and provide feedback	By Who	CMHs	By When	10.28.26
PRIVATE DUTY NURSING SERVICES	Todd Lewicki updated Operations Council on the notice received to not renew the PDN contract, effective November 1, 2026, and is seeking first right from Operations Council to provide this service on behalf of the region. If there is no interest, MSHN will procure another source. Approximately 10 cases per year require PDN review with the next one coming up March 1, 2027.				
	Todd will send out a communication to Operations Council.	By Who	T. Lewicki	By When	10.28.26
INTER-REGIONAL DIALOGS	Nothing new to report. CMHSPs going through their process of review. Most likely will cancel this week's meeting.				
	Update only	By Who	N/A	By When	N/A
RURAL HEALTH TRANSFORMATION GRANT	Congratulations to the region on the award. Amanda will send a request to Operations Council for their point person managing the grant and related quarterly progress reports. Leslie will work with CFO group to determine billing process.				
	MSHN will send a request to Operations Council	By Who	A.Ittner	By When	10.20.26

POLICIES AND PROCEDURE MANUAL

Chapter:	**Compliance**		
Section:	**Compliance and Program Integrity**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Compliance & Quality Officer	**Adopted Date: 11.2013** **Review Date:** 11.07.2023	**Related Policies:** Compliance Reporting & Investigations Compliance Line External Quality Review

Purpose

To ensure that Mid-State Health Network (MSHN) conducts all aspects of service delivery and administration with integrity, in conformance with the highest standards of accountability and applicable laws, while utilizing sound business practices, through the development of and adherence to its Corporate Compliance Plan (CCP), guaranteeing the highest standards of excellence.

Policy

A. Corporate Compliance:

- MSHN shall establish, implement and maintain a region-wide Corporate Compliance Plan that is in accordance with federal and state statutes, laws and regulations. MSHN will furthermore adhere to regulations required by the Attorney General's Office, Office of Inspector General, Centers for Medicaid and Medicare, and relevant accrediting bodies.
- The MSHN Corporate Compliance Plan provides the framework for MSHN to comply with applicable laws, regulations and program requirements, minimize organizational risk, maintain internal controls and encourage the highest level of ethical and legal behavior.
- MSHN, and the CMHSP Participants and the SUD Provider Network, shall have policies and procedures necessary to comply with the MSHN CCP and shall ensure effective processes for identifying and reporting suspected fraud, abuse and waste, and timely response to detected offenses with appropriate corrective action.
- MSHN, and the CMHSP Participants and the SUD Provider Network, shall each identify a Corporate Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and MSHN's Corporate Compliance Plan.
- MSHN, and the CMHSP Participants and the SUD Provider Network, shall have a compliance committee at the senior management level charged with overseeing the agencies compliance program.
- MSHN, and the CMHSP Participants and the SUD Provider Network, shall provide staff and board member training in compliance with the CCP and will maintain records of staff attendance. Trainings shall include but are not limited to: Federal False Claims Act, Michigan False Claims Act and Whistleblowers Protection Act.
- MSHN, and the CMHSP Participants and the SUD Provider Network, shall require all Board members, employees and contractors to comply with corporate compliance requirements including any necessary reporting to other agencies.

- MSHN, and the CMHSP Participants and the SUD Provider Network, shall review the compliance activities at least annually.
- The CMHSP Participants and the SUD Provider Network will participate in the annual review of the MSHN CCP and provide recommendations for revisions as needed.
- MSHN leadership will promote compliance among employees through the following:
    - Reviewing and approving MSHN's Compliance Plan, policies and procedures
    - Dedicating sufficient resources to provide monitoring and oversight of compliance related activities
    - Empowering the Compliance Officer with the authority to carry out duties and responsibilities defined as part of the compliance program
    - Modeling ethical behavior
    - Establishing clear and accessible lines of communication that promotes reporting of suspected compliance matters
    - Promoting ongoing training
    - Ensuring an environment of accountability and consistency in areas of corrective action

B. Ethical Standards/Program Integrity

- All services within MSHN shall be provided with commitment to appropriate business, professional and community standards for ethical behavior.
- MSHN shall develop and maintain Standards of Conduct applicable to all MSHN staff and MSHN Board Members.
- MSHN shall conduct business with integrity and not engage in inappropriate use ofpublic resources.
- MSHN shall ensure that services are provided in a manner that maximizes benefit to consumers while avoiding risk of physical, emotional, social, spiritual,psychological or financial harm.
- All MSHN staff and MSHN Board Members shall conduct themselves in such a way as to avoid situations where prejudice, bias, or opportunity for personal or familial gain, could influence, or have the appearance of influencing, professional decisions.
- The CMHSP Participants and the SUD Provider Network shall have standards of conduct that articulate organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.

Applies to:

☒ All Mid-State Health Network Staff and Board Members
☐ Selected MSHN Staff, as follows:
☒ MSHN's CMHSP Participants: ☐ Policy Only ☒ Policy and Procedure
☒ Other: Sub-contract Providers

Definitions/Acronyms:

CCP: Corporate Compliance Plan
CMHSP: Community Mental Health Service Program
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
SUD: Substance Use Disorder

Related Materials:

Mid-State Health Network Corporate Compliance Plan

References/Legal Authority:

1. Department of Health and Human Services, Office of Inspector General, Publicationof the OIG Compliance Program Guidance for Hospitals.
2. Michigan False Claims Act (Act 72 of 1997)
3. Michigan Whistleblowers Protection Act (Act 469 of 1980)
4. Deficit Reduction Act of 2005
5. State of Michigan/PIHP Contract: Schedule A: Statement of Work Contract Activities: R. Program Integrity
6. Code of Federal Regulations, Section 42: 438.608 – Program Integrity Requirements

Change Log:

Date of Change	Description of Change	Responsible Party
11.2013	New Policy	Chief Compliance Officer
11.2014	Annual Review	Chief Compliance Officer
11.2015	Annual Review & Updates	Director of Compliance, Customer Services & Quality
08.2016	Annual Review	Director of Compliance, Customer Services & Quality
08.2017	Annual Review	Director of Compliance, Customer Services & Quality
08.2018	Annual Review	Director of Compliance, Customer Services & Quality
09.2019	Annual Review	Director of Compliance, Customer Service, & Quality
08.2021	Bi-Annual Review; Updated references; added language consistent with 42 CFR	Chief Compliance and Quality Officer
08.2023	Biennial Review; Added reference to compliance with MSHNs Compliance Plan	Chief Compliance and Quality Officer
05.2026	Added language for leadership promoting compliance – required by OIG	Chief Compliance and Quality Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Compliance		
Title:	**Compliance Reporting and Investigations**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Compliance Officer and Quality Improvement Council	**Adopted Date: 04.07.2015** **Review Date:** 07.02.2024	**Related Policies:** Compliance & Program Integrity

Purpose

To ensure Mid-State Health Network (MSHN) staff and its Provider Network report suspected violations, misconduct and Medicaid fraud, waste and abuse, complete investigations, and complete the required reporting in accordance with the MSHN Compliance Plan; Reporting and Investigations.

Policy

Suspected Medicaid Fraud, Waste, and/or Abuse:

MSHN staff and its Provider Network, shall report all suspected Medicaid fraud, waste, and abuse to the MSHN Compliance Officer in accordance with standards established in the MSHN Compliance Plan. Investigations shall be conducted in accordance with the MSHN Compliance Plan, Reporting and Investigations.

- Allegations involving suspected fraud will be reported to the MSHN Compliance Officer.
- Under the direction of MSHN's Compliance Officer, a preliminary investigation will be completed to determine if a suspicion of fraud exists.
- If suspicion of fraud exists, a report will be made in writing by the MSHN Compliance Officer utilizing the Office of Inspector General Fraud Referral Form.
- If there is suspicion of fraud, and involves an overpayment of $5,000 or more, MSHN's Compliance Officer will report the suspected fraud to the Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG).
- MSHN's Compliance Officer will inform the appropriate provider network member when a report is made to the MDHHS Office of Inspector General.
- MSHN will follow the guidance/direction provided by the MDHHS Office of Inspector General regarding investigation and/or other necessary follow up.
- All allegations within MDHHS-OIG audit referrals will be investigated to either substantiate or refute any and all items within the complaint. A detailed summary of findings will be produced and include all items outlined in the audit referral.
- All suspicion of fraud will be reported on the Quarterly OIG Program Integrity Report template.

Suspected Violations and/or Misconduct (not involving Medicaid Fraud):

MSHN staff and its Provider Network, shall report all suspected violations and/or misconduct to the MSHN Compliance Officer and/or the appropriate Community Mental Health Service Program (CMHSP) Participant/Substance Use Disorder (SUD) Provider designated Compliance Officer. Reporting and Investigations shall be conducted in accordance with the MSHN Compliance Plan, Reporting and

Investigations.

- Where internal investigation substantiates a reported violation, corrective action plans will be initiated by MSHN staff or its Provider Network.
- Corrective action plans developed by the Provider Network shall be submitted to the MSHN Compliance Officer within thirty (30) days of the approved plan.
- The MSHN Compliance Officer shall review corrective action plans and ensure, as appropriate, prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, coordinating with the CMHSP designee for follow-up monitoring and oversight, and implementing system changes to prevent a similar violation from recurring in the future.

~~***Required Reporting:***~~

~~MSHN's Provider Network shall submit compliance activity reports quarterly to the MSHN Compliance Officer utilizing the Office of Inspector General program integrity report template. Minimally the report will include the following:~~

- ~~Tips/grievances received~~
- ~~Data mining and analysis of paid claims, including audits performed based on the results~~
- ~~Audits performed~~
- ~~Overpayments collected~~
- ~~Identification and investigation of fraud, waste and abuse (as these terms are defined in the "Definitions" section of this contract~~
- ~~Corrective action plans implemented~~
- ~~Provider dis-enrollments~~
- ~~Contract terminations~~

~~***Reporting Period/Due Dates to MSHN:***~~

- ~~January through March: May 1st~~
- ~~April through June: August 1st~~
- ~~July through September: November 1st~~
- ~~October through December: February 1st~~

The MSHN Compliance Officer will prepare a quarterly summary report of the Provider Network and direct MSHN compliance activities and present to the MSHN Compliance Committee and the Regional Compliance Committee. An annual summary report of the regional compliance activities will be presented to the MSHN Board of Directors and the MSHN Operations Council.

To the extent consistent with applicable federal and state law, including, but not limited to 42 Code of Federal Regulations (CFR) Part 2, HIPAA, and the Michigan Mental Health Code, the Pre-Paid Inpatient Health Plan (PIHP) must disclose protected health information to MDHHS-OIG or the Department of Attorney General upon their written request, without first obtaining authorization from the beneficiary to disclose such information.

Applies to:

☒All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☒MSHN's CMHSP Participants: ☐Policy Only ☒Policy and Procedure
☒Other: Sub-contract Providers

Definitions:

Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an

unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care.
CFR: Code of Federal Regulations
CMHSP: Community Mental Health Service Program
Fraud: The intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or another person.
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
OIG: Office of Inspector General
PIHP: Prepaid Inpatient Health Plan
Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors.
SUD: Substance Use Disorder
Waste: Overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions, but rather the misuse of resources.

Other Related Materials:
MSHN Compliance Plan
MSHN Compliance Investigation Reports Office of Inspector General Fraud Referral Form
MSHN Compliance Activity Report Template
MSHN Contract Compliance Procedure
Healthicity User Access Request Form

References/Legal Authority:
1. 42 Code of Federal Regulations 455.17 – Reporting Requirements
2. 42 Code of Federal Regulations 438.608: Program Integrity Requirement
3. 42 Code of Federal Regulations, Part 2: Confidentiality of Substance Use Disorder Patient Records
4. State of Michigan/PIHP Contract: Schedule A: Statement of Work Contract Activities: R. Program Integrity
5. Michigan Mental Health Code
6. Code of Federal Regulations, Section 42: 438.608 – Program Integrity Requirements

Change Log:

Date of Change	Description of Change	Responsible Party
03.2015	New Policy	Chief Compliance Officer
03.2016	Annual Review	Director of Compliance, Customer Service & Quality
08.2016	Annual Review	Director of Compliance, Customer Service & Quality
08.2017	Annual Review	Director of Compliance, Customer Service & Quality
08.2018	Annual Review	Director of Compliance, Customer Service & Quality
09.2019	Annual Review	Director of Compliance, Customer Service, & Quality
08.2021	Bi-Annual Review; Updated references	Chief Compliance and Quality Officer
08.2023	Biennial Review; Updated reporting for suspected fraud.	Chief Compliance and Quality Officer
05.2024	Updated to include OIG feedback	Chief Compliance and Quality Officer
05/2026	Updated to include OIG required language from 6.9 report and removed reporting	Chief Compliance and Quality Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Quality**		
Title:	**Critical Incidents**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 4	**Review Cycle: Biennial** **Author:** Quality Improvement Council, Chief Compliance & Quality Officer	**Adopted Date: 07.01.2014** **Review Date:** 03.04.2025	**Related Policies:** Quality Management Policy Sentinel Event Policy

Purpose: To ensure that the Mid-State Health Network (MSHN) provider network establishes a critical incident reporting system to effectively prevent, detect, remediate incidents that cause harm to individuals served in accordance with the Michigan Department of Health and Human Services (MDHHS)/Pre-Paid Inpatient Health Plan (PIHP)Contract, and Critical Incident Reporting and Event Notification System.

Policy: MSHN delegates the responsibility for preventing, detecting, and remediating critical incidents to its Community Mental Health Services Program (CMHSP) Participants. MSHN retains the responsibility for oversight and monitoring of the CMHSP participants and reporting to MDHHS.

A. CMHSP Participants
- Report critical incidents within required timeframes as required to MSHN.

B. Where a County of Financial Responsibility (COFR) agreement exists, the COFR shall report the critical incidents.
- Ensure a process is in place to remediate critical incidents and provide remediation documentation within the required timeframes.
- Establish quality improvement processes to prevent the recurrence of critical incidents.

C. MSHN
- Report critical incident data as required to MDHHS.
- Analyze critical incident data quarterly to identify regional trends.
- Ensure monitoring of timeliness, completeness, and accuracy of all submitted critical incident reports, including implementation of corrective actions when deficiencies are identified.
- Conduct oversight and monitoring through the review of reports and analysis by the Quality Improvement Council and provider network monitoring site reviews process.
-

D. Critical incidents are defined and categorized in alignment with MDHHS Critical Incident Reporting Requirements and include the following incidents: suicide, non-suicide death, emergency medical treatment due to injury, injury during fall, or medication error, hospitalization due to injury, injury during fall, or medication error, arrest, and other events requiring notification. All critical incidents and event notifications must be submitted through the MDHHS Behavioral Health Critical Incident Reporting System (BH-CRM), in accordance with MDHHS requirements. Remediation, including root cause analysis and corrective action, is required for critical incidents that are not reported timely, involve medication errors, injuries due to falls, physical management, or as requested by MDHHS.

~~**D.**~~ The following incidents are to be reported to MSHN as indicated below:~~.~~

1. **Suicide:** Individuals who were actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death.

a. Once it has been determined whether a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined.
b. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event, the CMHSP reports the incident, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.

2. **Non-suicide death**: Individuals who were actively receiving services and were:
   a. Living in a Specialized Residential (per Administrative Rule R330.1801-09) or a child-caring institution, or,
   b. Receiving any of the following:
      - Community Living supports,
      - Supports Coordination,
      - Targeted Case management
      - Assertive Community Treatment (ACT)
      - Home-Based
      - Wrap-Around
      - Habilitation Supports Waiver (HSW)
      - Serious Emotional Disturbance (SED)
      - ~~Waiver~~ Child Waiver Services (CWS)
      - 1915 iSPA Services

   If reporting is delayed because the PIHP is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the PIHP determined the death was not due to suicide.

3. **Emergency Medical Treatment due to Injury, Injury during Fall, or Medication Error:**
   Individuals who at the time of the event were actively receiving services and were:
   a. Living in a 24-hour Specialized Residential setting (per the Administrative Rule R330.1801-09) or in a Child-Caring Institution, or
   b. Receiving any of the following:
      - Habilitation Supports Waiver (HSW) Services or
      - Serious Emotional Disturbance (SED) Waiver Services or
      - Child Waiver Program (CWP) Services.
      - 1915 iSPA Services

   Emergency medical treatment includes services provided in an emergency department or urgent care setting in response to an injury, injury during fall, or medication error. Reporting must specify whether the injury was due to a fall or a result of physical management. The PIHP must report incidents resulting in emergency medical treatment due to injury, injury during fall, or medication error within 60 days after the end of the month in which the emergency medical treatment began.

   Remediation: Remediations are required for critical incidents that are not reported in a timely manner, for emergency medical treatment due to medication errors, falls, are a result of physical management or requested by ~~MDDHS~~ MDHHS upon review of the critical incident. Remediations are due within 30 days of the reported date to CRM, or the date requested by MDHHS.

4. **Hospitalization due to Injury, Injury during Fall, or Medication Errors**: Individuals who at the time of the event were actively receiving services and met any one of the following two conditions:
   a. Living in a 24-hour Specialized Residential setting (per the Administrative Rule

R330.1801- 09) or in a Child-Caring Institution, or

b. Receiving any of the following:
   - Habilitation Supports Waiver (HSW) Services or
   - Serious Emotional Disturbance (SED) Waiver Services or
   - Child Waiver Program (CWP)
   - 1915 iSPA Services

Hospitalizations for psychiatric or behavioral health treatment alone are not reportable unless associated with an injury, injury during to fall, or medication error. Reporting must specify whether the hospitalization was due to a injuring during fall or a result of physical management. The PIHP must report incidents resulting in hospitalization due to injury or medication error within 60 days after the end of the month in which the hospitalization began.

Remediation: Remediations are required for critical incidents that are not reported in a timely manner, for hospitalizations due to medication errors, injury during falls, are a result of physical management or requested by ~~MDDHS~~ MDHHS upon review of the critical incident. Remediations are due within 30 days of the reported date to CRM, or the date requested by MDHHS.

5. **Arrests**: Individuals who, at the time of their arrest were actively receiving services and met any one of the following two conditions:
   a. Living in a 24-hour Specialized Residential setting (per the Administrative Rule R330.1801- 09) or in a Child-Caring Institution, or
   b. Receiving any of the following:
      - Habilitation Supports Waiver (HSW) Services or
      - Serious Emotional Disturbance (SED) Waiver Services or
      - Child Waiver Program (CWP)

6. **Unexpected Deaths**: Individuals who at the time of their deaths were receiving specialty supports and services, are subject to additional review and must include:
   a. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
   b. Involvement of medical personnel in the mortality reviews
   c. Documentation of the mortality review process, findings, and recommendations
   d. Use of mortality information to address quality of care
   e. Aggregation of mortality data over time to identify possible trends~~.~~

7. **Death-State Operated Service Discharge**: a written report of any death of an individual (Medicaid) who was discharged from a State operated service within the previous 12 months shall be submitted to MDHHS within 60 days after the month in which the death occurred.

Event Notification: Immediately reportable events through the BH-CRM system:~~.~~

A. Any death that occurs as a result of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation ~~shall~~ must be submitted electronically to the MDHHS BH-CRM, within 48 hours, of either the death, or the PIHPs receipt of notification of the death, or the PIHPs receipt of notification that a rights, licensing, and/or police investigation has commenced. Notification to the sentinelevents@midstatehealthnetwork.org email is required to begin the BH-CRM submission process.

The following information is to be included in the email submission:

a. Name of beneficiary
b. Beneficiary ID number (Medicaid, MiChild)
c. Consumer ID (CONID) if there is no beneficiary ID number~~.~~
d. Date, time, and place of death (licensed foster care facility include license number~~.~~)

e. Preliminary cause of death
f. Contact person's name and Email address.

~~A.~~B. Relocation of a consumer's placement due to licensing suspension or ~~revocation. Must~~revocation must be reported within 5 business days.

~~B.~~C. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours~~. M~~ must be reported within five (5) business days.

~~C.~~D. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement~~. M~~ must be reported within five (5) business days.

~~D.~~ Any changes to the composition of the provider network organizations that negatively affect access to care. The PIHPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that the MDHHS determines to negatively affect recipient access to covered services must be reported within seven (7) days and may be subject to MDHHS review and action if access to care is negatively impacted. ~~may be grounds for sanctions. Must be reported within seven (7) days.~~

E. Critical incidents which may be newsworthy or represent a community crisis must be reported to the MSHN Chief Executive Officer (CEO), the sentinelevents@midstatehealthnetwork.org email, and MDHHS immediately.

~~E.~~F. If a MSHN staff is the point of contact for a critical incident report for a member of the provider network, that staff member must report this immediately to the MSHN CEO, MSHN Chief Quality and Compliance Officer, and the Quality Manager.

Applies to:

☐ All Mid-State Health Network Staff
☒ MSHN's CMHSP Participants: ☐ Policy Only ☒ Policy and Procedure
☐ Other: Sub-contract Providers

Definitions:

ACT: Assertive Community Treatment
BH-CRM: Behavioral Health Critical Incident Reporting System
CMHSP: Community Mental Health Service Programs
COFR: County of Financial Responsibility
Critical Incident: An event that results in, or has the potential to result in, harm to a beneficiary receiving services, as defined by MDHHS reporting requirements
CWP: Children's Waiver Program
CWS: Children's Waiver Services
HSW: Habilitation Supports Waiver
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health and Human Services
PIHP: Pre-Paid Inpatient Health Plan
SED: Serious Emotional Disturbance
iSPA-State Plan Amendment
Unexpected Deaths: Deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

Other Related Materials:
References/Legal Authority:

MDHHS/PIHP Contract
MDHHS Quality Assessment and Performance Improvement Program for Specialty Prepaid Inpatient Health Plans Technical Requirement
MDHHS Critical Incident Reporting and Event Notification Policy

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New Policy	Chief Compliance Officer
05.12.2015	Added COFR clarification	Chief Compliance Officer
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service & Quality
03.2019	Annual Review, added unexpected death review	Quality Manager
10.2020	Biennial Review	Quality Manager
10.2022	Biennial Review	Quality Manager
10.2024	Biennial Review, added 1915 iSPA and additional event notifications included in MDHHS Event Notification Policy	Quality Manager
04.2026	Biennial Review and language clarification	Director of Compliance, Customer Service & Quality

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Quality**		
Title:	**Incident Review for Substance Use Disorder (SUD) Providers**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 4	**Review Cycle: Biennial** **Author:** Quality Manager	**Adopted Date: 07.07.2020** **Review Date: 03.04.2025**	**Related Policies:** Quality-Sentinel Events Policy

Purpose: To ensure that the Mid-State Health Network (MSHN) Pre-Paid Inpatient Health Plan (PIHP) is in compliance with the Michigan Department of Health and Human Services (MDHHS), Medicaid Managed Specialty Supports and Services Contract, Substance Use Disorder (SUD) Incident Review for Sentinel Event Reporting.

Policy: —MSHN delegates responsibility to its Substance Use Disorder Providers, with oversight and monitoring by MSHN, for collecting, ~~and~~reporting, and analyzing all critical incidents and sentinel events that meet the criteria as specified in the MDHHS Sentinel Events Data Report and the SUD Provider Manual. The SUD Provider reviews, at a minimum, the ~~following~~ critical incidents for those who reside in a 24-hour specialized residential substance use disorder treatment settings ~~and recovery housing~~.

A. Provider Responsibilities

1. The provider reports the critical incidents as required to MSHN on a quarterly basis for analysis, reporting, and aggregation.
2. The provider is responsible for ensuring a process is in place to recommend and implement quality improvement processes in an effort to prevent the reoccurrence of critical incidents and sentinel events.
3. The provider must determine whether an incident meets criteria for a sentinel event within three (3) business days of occurrence. If classified as a sentinel event, a root cause analysis must be initiated within two (2) additional business days. Events determined to be sentinel events require immediate notification to MSHN via email to sentinelevents@midstatehealthnetwork.org. Additionally, deaths of recipients (regardless of cause) and all administrations of Narcan should be reported within 48 hours to MSHN via email to sentinelevents@midstatehealthnetwork.org.

B. MSHN Responsibilities

1. MSHN reports to ~~the~~ MDHHS, critical incident and sentinel event data as required and in accordance with the Medicaid Contract.
2. Oversight and monitoring will be conducted by MSHN through the review of reports, analysis, and provider network monitoring desk audit and site reviews.
    - ~~All incidents should be reviewed to determine if the incidents meet the criteria and definitions for a sentinel event and if they are related to practice of care. The outcome of this review is a classification of incidents as either a) sentinel events, or b) non-sentinel events.~~

~~B.~~ C. Required Incident Reporting: -

1. A Critical Incident is any of the following, ~~(~~which ~~should~~ must be reviewed to determine whether it

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meets the criteria ~~for~~ of a sentinel event ~~as described below).~~:

- Death of a recipient
- Serious illness requiring admission to a hospital.
- Alleged cause of abuse or neglect
- Accident resulting in injury to recipient requiring emergency room visit or hospital admission
- Arrest and/or conviction
- Serious challenging behaviors
- Medication error

a. Accidents resulting in injuries that result in death or loss of limb or function, and which required visits to emergency rooms, medi-centers and urgent care clinics/centers and/or admissions to hospital should be included in the reporting. In many communities where hospitals do not exist, medi-centers and urgent care clinics/centers are used in place of hospital emergency rooms.

b. Physical illness resulting in admission to a hospital does not include planned surgeries, whether inpatient or outpatient. It also does not include admissions directly related to the natural course of the person's chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.

c. Serious Challenging Behaviors are those not already addressed in a treatment plan and include significant (in excess of $100.00) property damage, attempts a self-inflicted harm or harm to others, or unauthorized leaves of absence that result in death or loss of limb or function to the individual or risk thereof. All unauthorized leaves from residential treatment are not sentinel events in every instance)

d. Serious physical harm is defined by the State of Michigan Administrative Code for Health and Human Services (330.7001 Rights of Recipients) as "physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient."

~~1.~~ e. Medication Errors means a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage which resulted in death or loss of limb or function or the risk thereof. It does not include instances in which consumers have refused medication.

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D. Sentinel Event Reporting

A sentinel event is a Patient Safety Event that reaches a patient and results in any of the following:

- Death (which is not by natural cause or does not occur as a natural outcome to a chronic condition (e.g. terminal illness) or old age)
- Permanent harm
- Severe temporary harm and intervention required to sustain life

An event can also be considered sentinel event even if the outcome was not death, permanent harm, severe temporary harm and intervention required to sustain life.

~~2. Death: that which is not by natural cause or does not occur as a natural outcome to a chronic condition (e.g. terminal illness) or old age.~~

~~3. Accidents resulting in injuries that result in death or loss of limb or function, and which required visits to emergency rooms, medi-centers and urgent care clinics/centers and/or admissions to hospital should be included in the reporting. In many communities where hospitals do not exist, medi-centers and urgent care clinics/centers are used in place of hospital emergency rooms.~~

~~4. Physical illness resulting in admission to a hospital does not include planned surgeries, whether inpatient or outpatient. It also does not include admissions directly related to the natural course of the person's chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.~~

~~5. Serious Challenging Behaviors are those not already addressed in a treatment plan and include significant (in excess of $100.00) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence that result in death or loss of limb or function to the individual or risk thereof. All unauthorized leaves from residential treatment are not sentinel events in every instance)~~

~~6. Serious physical harm is defined by the State of Michigan Administrative Code for Health and Human Services (330.7001 Rights of Recipients) as "physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient."~~

~~7. Medication Errors mean a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage which resulted in death or loss of limb or function or the risk thereof. It does not include instances in which consumers have refused medication.~~

~~**Event Notification**~~

- ~~All incidents should be reported to MSHN quarterly (January 15, April 15, July 15, October 15) as indicated in the reporting requirements. Additionally, deaths of recipients and all administrations of Narcan should be reported witEvents determined to be sentinel events require immediate notification to MSHN.~~
- ~~Deaths as a result of suspected staff action or inaction, or any death that is the subject of a recipient rights investigation, licensing, or police investigation requires additional information to be submitted to the Quality Manager at MSHN for reporting to MDHHS.~~

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~~The additional information includes the following:~~

~~a. Name of beneficiary~~
~~b. Beneficiary ID number (Medicaid ID/MIChild ID)~~
~~c. Consumer ID (COND) if there is no beneficiary ID number.~~
~~d. Date, time and place of death (if a licensed foster care facility, include the license#)~~
~~e. Preliminary cause of death~~
~~f. Contact person's name and E-mail address.~~

~~**Response to a Sentinel Event**~~

~~An "appropriate response" to a SUD sentinel event includes all the following.~~

- ~~Formalized team response that stabilizes the individual served, discloses the event to the individual served and family, and provides support for the family as well as staff involved in the event.~~
- ~~Notification of organization leadership~~
- ~~Immediate investigation~~
- ~~Completion of a comprehensive systematic analysis for identifying the causal and contributory factors~~
- ~~Strong corrective actions derived from the identified causal and contributing factors that eliminate or control system hazards or vulnerabilities and result in sustainable improvement over time~~
- ~~Timeline for implementation of corrective actions~~
- ~~Systemic improvement with measurable outcomes~~

Applies to:

☒ All Mid-State Health Network Staff Selected
☐ MSHN Staff, as follows:
☒ MSHN's CMHSP Participants: ☐ Policy Only ☒ Policy and Procedure
☒ Other: Sub-contract Providers

Definitions:

MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Pre-Paid Inpatient Health Plan
SUD: Substance Use Disorder
Unexpected Deaths: Deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.
Sentinel Event: An "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." (JCAHO, 1998)
24- hour Specialized Setting: Means substance abuse residential treatment programs.
Recovery Housing: Recovery housing provides a location where individuals in early recovery from a behavioral health disorder are given the time needed to rebuild their lives, while developing the necessary skills to embark on a life of recovery. This temporary arrangement will provide the individual with a safe and secure environment to begin the process of reintegration into society, and to build the necessary recovery capital to return to a more independent and functional life in the community. These residences provide varying degrees of support and structure. Participation is based on individual need and the ability to follow the requirements of the program. (Excerpt from the proposed Substance Use Disorder Benefit Package for the state of Michigan)

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Other Related Materials:
MSHN Sentinel Event Policy
MSHN SUD Provider Manual

References/Legal Authority:
MDHHS/PIHP Contract.
SUD Non-Medicaid Reporting Instructions
MDHHS Sentinel Events Data Report
MDHHS Substance Use Disorder Benefit Package for the State of Michigan

Change Log:

Date of Change	Description of Change	Responsible Party
03.2020	New Policy to address incident review requirement	Quality Manager
10.2020	Biennial Review	Quality Manager
10.2022	Biennial Review	Quality Manager
12.2024	Biennial Review – Added language consistent with the MDHHS Technical Requirement	Chief Compliance and Quality Officer
04.2026	Biennial Review	Chief Compliance and Quality Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Quality**		
Title:	**Medicaid Event Verification**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle: Biennial** **Author:** Medicaid Event Internal Auditor and Chief Compliance & Quality Officer	**Adopted Date: 01.05.2016** **Review Date: 03.04.2025**	**Related Policies:** Monitoring and Oversight

Purpose

To establish guidelines as the Pre-Paid Inpatient Health Plan (PIHP) for the development and implementation of the Mid-State Health Network (MSHN) process for conducting monitoring and oversight of the Medicaid, Healthy Michigan Plan and Substance Use Disorder (SUD) Block Grant claims/encounters submitted within the Provider Network. To ensure compliance with federal and state regulations, and to establish standardized process for review of claims/encounters in accordance with the Michigan Department of Health and Human Services (MDHHS) Medicaid Verification Process.

Policy

MSHN shall create, implement and maintain a published process to monitor and evaluate its Provider Network to ensure compliance with federal and state regulations. This includes protocol for how monitoring and oversight of any claims/encounters provided to beneficiaries of Medicaid, Healthy Michigan and SUD Block Grant services will be completed.

A. MSHN shall conduct a full monitoring and verification process on a selected sample of claims/encounters. The reviews will be completed as follows:
    1. Community Mental Health Service Programs (CMHSPs) bi-annually
    2. Substance Use Disorder providers annually
        - Full review biennially
        - Interim review during non-full review year
    3. Any provider (including subcontractors of the CMHSP and SUD providers) that represents more than 25% of MSHN claims/encounters in either unit volume or dollar value annually. The 25% of unit volume will be determined using the claims/encounters billed to MSHN with each submitted claim/encounter equaling 1 unit of claims/encounters.
    4. Any Provider that MSHN directly contracts with for services that are paid utilizing Medicaid, Healthy Michigan Plan, or Block Grant funding.
    5. Upon termination of a Provider contract with MSHN.

MSHN reserves the right to conduct further reviews of the Provider Network on an as needed basis.

B. The claim/encounter review process may consist of the following components:
    1. Desk Audit: This component will consist of a pre-review of select policies, protocols, and documents and other resource material submitted by the Provider Network to the PIHP for review prior to the on-site visit. This may also include review of documentation to support submitted claims/encounters in lieu of an on-site visit.
    2. On-Site Audit: This component will consist of an on-site visit to the Provider Network to review and validate process requirements.
    3. Claim/Encounter Review: The PIHP shall pull a random sample of Medicaid, Healthy Michigan Plan and SUD Block Grant participants to complete verification of submitted claims/encounters.
    4. Data Review and Analysis: This component includes analysis of the Provider Network.

C. Overall responsibility for the claim/encounter verification and updating of the monitoring evaluation tool shall rest with the PIHP. The tool shall be reviewed on an annual basis to ensure functional utility; and updated as necessary due to changing regulations, new contract terms and

operational feedback received.

D. MSHN shall create its verification schedule at least 45 days in advance of its review.

E. Following the review, MSHN shall develop a Medicaid Event Verification Report detailing the results of its verification review for the Provider. The Medicaid Event Verification report shall include the following:
   1. A summary detailing the PIHP's overall review process and findings;
   2. Details pertaining to each claim/encounter reviewed
   3. "Findings" (if applicable) that will require corrective action for claims/encounters that are found not to be in substantial compliance with federal and state standards.
   4. "Recommendations" (If applicable) pertaining to any quality improvement or best practice suggestions. These do not require corrective action.
   5. All claims/encounters found to be invalid that will require correction either by resubmission or voiding.
   6. Recoupment of funds for any fee for service provider for any claims/encounters that are found to be invalid.

   The PIHP shall submit the verification report to the Provider within thirty (30) days of the verification audit conclusion.

F. Report summary findings of the MSHN Medicaid Event Verification audits shall be shared with MSHN Board of Directors, Corporate Compliance Committee, Operations Council, Quality Improvement Council, and other MSHN councils as appropriate.

G. MSHN will report any suspected fraud, waste or abuse related to claims/encounters and beneficiary utilization of authorized services discovered during the Medicaid Event Verification Process to MDHHS-Office of Inspector General as required

H. MSHN shall submit an annual report to MDHHS per the contract requirements, due December 31, covering the claims/encounter audit process.
   1. Cover letter on PIHP letterhead
   2. Description of the methodology used by the PIHP, including all required elements previously described.
   3. Summary of the results of the Medicaid event verification process performed, including: population of the providers, number of providers tested, number of providers put on corrective action plans, number of providers on corrective action for repeat/continuing issues, number of providers taken off of corrective action plans, population of claims/encounters tested (units and dollar value), claims/encounters tested (units and dollar value), and invalid claims/encounters identified (units and dollar value).

I. MSHN will maintain all documentation supporting the verification process as required by state and federal regulation.

Applies to:

☐ All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☒ MSHN's CMHSP Participants: ☐ Policy Only ☒ Policy and Procedure
☒ Other: Sub-contract Providers

Definitions:

Covered Service: Any service defined by the Michigan Department of Health and Human Services as required service in the Medicaid Specialty Supports and Services benefit
CMHSP: Community Mental Health Service Program
CPT Code: Current Procedural Terminology Code (CPT) is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

Documentation: Documentation may be written or electronic and will correlate the service to the plan. Clinical documentation must identify the consumer and provider, must identify the service provided, date and time of the service. Administrative records might include monthly occupancy reports, shift notes, medication logs, personal care and community living support logs, assessments, or other records.
Finding: A federal or state standard found out of compliance. A finding requires a corrective action to ensure compliance with federal and state guidelines.

HCPCS: Healthcare Common Procedure Coding System: set of health care procedure codes based on the American Medical Associations Current Procedural Terminology (CPT)
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
Provider Network: refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors
Random Sample: A computer generated selection of events by provider and HCPCS, Revenue, or CPT Code or Code Category. The auditor then randomly picks the events to review from the list of events
Recommendation: A quality improvement suggestion that is meant to guide quality improvement discussion and change. A recommendation does not require corrective action.
Record Review: A method of audit includes administrative review of the consumer record.
Subcontractors: Refers to an individual or organization that is directly under contract with the CMHSP to provide service or supports
SUD: Substance Use Disorder

Other Related Materials
MSHN Medicaid Event Verification Procedure

References/Legal Authority
Medicaid Managed Specialty Supports and Services Concurrent Contract
Michigan Department of Health and Human Services (MDHHS) Medicaid Verification Process
Behavioral Code Charts and Provider Qualifications

Change Log:

Date of Change	Description of Change	Responsible Party
12.2015	New Policy	Director of Compliance, CS & Quality
03.2017	Annual Review	Director of Compliance, CS & Quality
03.2018	Annual Review	Director of Compliance, CS & Quality
03.2019	Annual Review, removed monthly review of reports of claims and encounters	Quality Manager
10.2020	Biennial Review	Quality Manager
08.2022	Biennial Review	Chief Compliance & Quality Officer
12/2024	Biennial Review	Chief Compliance and Quality Officer
05/2026	Added language for reviewing for fraud fro billings and beneficiary utilization as required by the OIG	Chief Compliance and Quality Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Children With ~~Severe~~ Serious Emotional Disturbances Home and Community-Based Services Waiver (SEDW) Policy**		
Policy: ☒ **Procedure:** ☐ **Page: 1 of 2**	**Review Cycle:** Biennial **Author:** Chief Behavioral Health Officer	**Adopted Date:** 11.10.2020 **Review Date:** ~~11.12.2024~~12.05.2025	**Related ~~Policies~~Procedures:** Children with Serious Emotional Disturbances Home and Community-Based Services Waiver (SEDW) Disenrollment and Transfer Procedure

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

This policy sets forth the guidelines and expectations for Mid-State Health Network's (MSHN) administration of the Children with ~~Severe~~ Serious Emotional Disturbances Home and Community-Based Waiver (SEDW) program which provides services that are enhancements or additions to Medicaid State Plan coverage for beneficiaries up to age 21 with serious emotional disturbance (SED) who are enrolled in the SEDW. Michigan Department of Health and Human Services (MDHHS) operates the SEDW through contracts with the Prepaid Inpatient Health Plans (PIHPs). The SEDW is a managed care program administered by the PIHPs in partnership with CMHSPs and other community agencies.

Policy

MSHN shall administer the SEDW program in accordance with the Prepaid Inpatient Health Plan (PIHP) contract and the Michigan Medicaid Provider Manual (MMPM).

I. Key Provisions

The SEDW program enables Medicaid to fund necessary home and community-based services for children up to age 21 (one day prior to 21st birthday) with SED who meet the criteria for admission to a state inpatient psychiatric hospital and/or who are at risk of hospitalization without waiver services. The PIHP is responsible for assessment of potential waiver candidates.

Application for the SEDW is made through the PIHP. The PIHP is responsible for the coordination of the SEDW services. ~~The Wraparound Facilitator, the beneficiary and their family and friends, and other professional members of the planning team work cooperatively to identify the beneficiary's needs and to secure the necessary services.~~ All services and supports must be included in an Individual Plan of Service (IPOS).

A SEDW beneficiary must receive at least one SED waiver service, in addition to ~~Wraparound~~Intensive Care Coordination with Wraparound (ICCW) or Targeted Case Management, per month ~~in order to~~to retain eligibility.

The SEDW has two certification categories:

A. ~~SEDW – Traditional~~Not Open to Foster Care: the youth resides with their legal parent(s)/guardian(s) (with or without Medicaid); this category includes private and/or

internation adoptions.

B. ~~SEDW – Department of Health and Human Services (DHHS) Project~~Open to Foster Care: the youth has an open foster care case through MDHHS OR the youth was adopted out of the Michigan Child Welfare System.

II. Eligibility

SEDW beneficiaries must be enrolled through the Michigan Department of Health and Human Services (MDHHS) enrollment process by the PIHP designee. The enrollment process must include verification that the beneficiary meets the following (~~all~~ ALL must apply):

A. Reside with the birth or adoptive family or have a plan to return to the birth or adoptive home; OR

~~A.~~B. ~~r~~Reside with a legal guardian; OR
~~B.~~C. Reside in a foster home with a permanency plan; OR
~~C.~~D. Be age 18, 19, or 20 ~~or age 19~~ and live independently with supports~~.~~; AND

~~D.~~E. Meet current MDHHS criteria for the state psychiatric hospital for children OR is at risk of hospitalization without waiver services.

1. Medicaid Provider Manual Inpatient Admission Criteria: Children Through Age 21: (MMPM Section 8 – Inpatient Psychiatric Hospitalization Admission; 8.5.C)
    - The individual must meet all three criteria:
        - Diagnosis
        - Severity of illness
        - Intensity of services; AND

~~E.~~F. Meet Medicaid eligibility criteria and become a Medicaid beneficiary. Medicaid is the only funding source ~~from~~ for the SEDW. Under Section (C) of the Social Security Act, it allows states to waive parental assets and income and make a child eligible for Medicaid as a "family of one."; AND

G. Demonstrate serious functional limitations that impair the ability to function in the community. As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Scale (CAFAS), or the Devereux Early Childhood Assessment (DECA) Clinical Version scales:

1. CAFAS score of 90 or greater for beneficiaries ages 7 to 12; OR
2. CAFAS score of 120 or greater for beneficiaries ages 13 to 18; OR
3. For beneficiaries ages 3 to 7, elevated PECFAS subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating, or behavior towards others; OR
4. For beneficiaries ages 2 to 4, scores in the concern range across DECA Clinical Version scales:
    - Protective factor scales (initiative, self-control, and attachment) that are in the Concern Range with a Total Protective Factor T-score of 40 or below; AND/OR
    - Elevated scores on one or more of the behavioral concerns 32 scales (attention problems, aggression, withdrawal/depression, emotional control problems) with a T-score of 60 or above;

~~AND~~

H. Be under the age of 18 when approved for the waiver. If a beneficiary on the SEDW turns 18, continues to meet all non-age-related eligibility criteria, and continues to need waiver services, they can remain on the waiver up to their 21st birthday.

I. The PIHP/CMHSP must use the Decision Support Model criteria from the Michigan Child and Adolescent Needs and Strengths (MichiCANS) Comprehensive Decision Support Model tool to measure functional limitations for the purposes of determining eligibility for SEDW.

J. The Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), and Devereaux Early Childhood Assessment (DECA) are required tools through state spending and CMS notification of close-out of American Rescue Plan Act Section 9817 funding as listed below:

- For new applicants, MDHHS must use either the CAFAS, PECFAS, or DECA and the MichiCANS. If the results are different and one tool indicates eligibility, MDHHS must apply the results that establish the applicant is eligible.
- For children, youth, or young adults receiving a re-evaluation of eligibility, MDHHS must use the MichiCANS. If the results indicate that a participant is no longer eligible, MDHHS must verify ineligibility with either the CAFAS, PECFAS or DECA.

~~F. As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®), the Preschool and Early Childhood Functional Assessment Scale (PECFAS®), or the Devereaux Early Childhood Assessment (DECA) Clinical Version scales:~~

~~1. CAFAS score of 90 or greater for beneficiaries age 7 to 12; OR~~

~~2. CAFAS score of 120 or greater for beneficiaries age 13 to 18; OR~~

~~3. For beneficiaries ages 3 to 7, elevated PECFAS subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating, or behavior toward others; OR~~

~~4. For beneficiaries ages 2 to 4, scores in the concern range DECA Clinical Version scales:~~

~~• Protective factor scales (initiative, self-control, and attachment) that are in the Concern Range with a Total Protective Factor T-score of 40 or below and/or~~

~~•~~K. ~~Elevated scores on one or more of the behavioral concerns scales (attention problems, aggression, withdrawal/depression, emotional control problems) with a T-score of 60 or above;~~ AND

~~G.~~A. ~~Be under the age of 18 when approved for the waiver. If a beneficiary on the SEDW turns 18, continues to meet all non-age-related eligibility criteria, and continues to need waiver services, they can remain on the waiver up to their 21st birthday.~~

~~H.~~L. Other SEDW Eligibility Considerations:

1. Must have a primary Serious Emotional Disturbance (SED) qualifying diagnosis
2. Must receive at least one SEDW service ~~(other than Wraparound)~~ per month in addition to Intensive Care Coordination with Wraparound (ICCW) or Targeted Case Management (TCM) in order to retain eligibility
3. Eligibility is good for one year
4. Eligibility is reviewed annually
5. ~~SEDW is intended for one year, with the possibility of a second year~~

~~I.~~M. Denial of the SEDW

1. PIHPs must provide parents with notice of denial and right to Medicaid Fair Hearing whenever the SEDW is denied. (This is delegated by MSHN to the CMHSPs.)
2. Notice of denial must document the specific reason for the denial, based on SEDW eligibility criteria as outlined in the Medicaid Provider Manual. A timely denial letter and Adverse Benefit Determination Notice (ABDN) must be provided to the family and also shared with the PIHP and MDHHS.
3. The SEDW serves as a pathway to Medicaid, per Centers for Medicare and Medicaid Services (CMS) this pathway must not be blocked. Whenever the SEDW is specifically

requested and subsequently denied, notice of denial and right to Medicaid Fair Hearing must be provided even if ~~lesser~~less intensive service(s) ~~is~~ are offered.

N. MDHHS is no longer making an adverse determination on waiver enrollment based on the family's intent to pursue institutionalization. MDHHS will not deny enrollment or hold enrollment for the SEDW if the family is seeking residential services.

~~3.~~O. If a child/youth enrolled in the waiver program is admitted to a residential program or hospital for a full calendar month, the PIHP should switch the child/youth's waiver status to inactive using the WSA. For an inactive SEDW child/youth who have not received waiver services in three months, the PIHP should proceed with disenrollment.

III. Covered Waiver Services

Each beneficiary must have a comprehensive ~~Wraparound Plan and~~ IPOS that ~~specify~~ specifies the services and supports that the beneficiary and their family will receive. ~~The Wraparound Plan is to be developed through the Wraparound Planning Process.~~ Each beneficiary must have a ~~Wraparound Facilitator who is responsible to assist the beneficiary/family in identifying, planning and organizing the Child and Family Team, developing the Wraparoun Plan, and coordinating services and supports.~~ Care Coordinator or Case Manager who oversees and facilitates planning and coordination among the family, providers, and other team members. (Refer to the Intensive Care Coordination with Wraparound (ICCW) Services for Children and Adolescents section of the ~~Behavioral Health and Intellectual and Developmental Disability Supports and Services Section of the~~ MMPM for additional information.) ~~The Wraparound Facilitator is responsible for monitoring supports and service delivery, as well as the health and safety of the beneficiary, as part of their regular contact with the beneficiary and family.~~

In addition to Medicaid state plan services, beneficiaries enrolled in the SEDW may receive any of the following SEDW services as identified in the ~~Wraparound Plan~~ IPOS.

~~A. Child Therapeutic Foster Care (CTFC)~~
~~B.~~A. Community Living Supports (CLS)
~~C.~~B. ~~Family~~ Home Care Training – Family
~~D. Family Support and Training~~
~~E.~~C. ~~Fiscal Intermediary~~Financial Management Service~~s~~
~~F.~~D. Home Care Training, Non-Family
~~G.~~E. Overnight Health and Safety Support (OHSS) Services
~~H.~~F. Respite Care
~~I.~~G. Therapeutic Activities
1. Recreation Therapy
2. Music Therapy
3. Art Therapy
~~3.~~4. Equine Therapy

~~J.~~H. Therapeutic Overnight Camp
~~K. Transitional Services~~
I. ~~Wraparound~~ Wraparound Services (mandatory service)
1. Intensive Care Coordination with Wraparound (ICCW), OR
~~L.~~2. Targeted Case Management (TCM)

Applies to

☐ All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☒ MSHN's CMHSP Participants: ☐ Policy Only ☒ Policy and Procedure
☐ Other: Sub-contract Providers

Definitions

CAFAS: Child and Adolescent Functional Assessment Scale
CLS: Community Living Supports
CMHSP: Community Mental Health Services Program
CMS: Centers for Medicare and Medicaid Services
CTFC: Child Therapeutic ~~Foster~~ Family Care
DECA: Devereaux Early Childhood Assessment
DHHS: Department of Health and Human Services
IPOS: Individual Plan of Service
MDHHS: Michigan Department of Health and Human Services
MichiCANS: Michigan Child and Adolescent Needs and Strengths
MMPM: Michigan Medicaid Provider Manual
PECFAS: Preschool and Early Childhood Functional Assessment Scale
OHSS: Overnight Health and Safety Support
PIHP: Pre-Paid Inpatient Health Plan
SED: Serious Emotional Disturbance
SEDW: Children With ~~Severe~~ Serious Emotional Disturbances Home and Community- Based Services Waiver Program

Other Related Materials

Children With ~~Severe~~ Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) Disenrollment and Transfer Procedure

References/Legal Authority

Medicaid Managed Specialty Supports and Services FY23 MDHHS/PIHP Contract
Michigan Medicaid Provider Manual

Change Log:

Date of Change	Description of Change	Responsible Party
07.2020	NEW Policy	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer
02.2024	Biennial Review	Waiver Coordinator
12.2025	Annual Review	Waiver Coordinator – Youth