Mid-State Health Network

Board of Directors Meeting ~ March 4, 2025 ~ 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 – specifically to seek recognition from the chair before making remarks and to limit yourself to two three minute comments on each item.

2. Roll Call

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

   Motion to Approve the Agenda of the March 4, 2025 Meeting of the MSHN Board of Directors

4. Public Comment (3 minutes per speaker)

5. Conflict Free Access and Planning Update [Presentation] (*Page 9*)

6. **ACTION ITEM**: MSHN FY2025 Compliance Plan and FY2024 Annual Compliance Effectiveness and Summary Report (*Page 21*)

   Motion to acknowledge receipt of and approve the FY2025 MSHN Corporate Compliance Plan and approve the FY2024 Compliance Effectiveness and Summary Report

7. **ACTION ITEM:** FY2024 Board Self-Assessment (*Page 91*)

   Motion to receive and file the FY2024 Board Self-Assessment report

8. Chief Executive Officer's Report (*Page 96*)

9. Deputy Director's Report (*Page 111*)

10. Chief Financial Officer's Report

    A. FY 2025 Financial Analysis (*Page 114*)

    B. Financial Statements Review for Period Ended January 31, 2025 (*Page 118*)

    ACTION ITEM: Receive and File the Preliminary Statement of Net Position and Statement of Activities for the Period ended January 31, 2025, as presented

11. **ACTION ITEM:** Contracts for Consideration/Approval (*Page 127*)

    The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2025 Contracts, as Presented on the FY 2025 Contract Listing

MSHN
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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:
Click **HERE**
or visit MSHN's website at:
https://midstatehealthnetwork.org/stakeholders-resources/board-councils/board-of-directors/fy2025-meetings

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Upcoming FY25 Board Meetings

Board Meetings convene at 5:00pm unless otherwise noted

May 13, 2025
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

July 1, 2025
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

September 9, 2025
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

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

12. Executive Committee Report
13. Chairperson's Report
14. **ACTION ITEM:** Consent Agenda

    Motion to Approve the documents on the Consent Agenda

    14.1 Approval Board Meeting Minutes 01/07/2025 *(Page 130)*

    14.2 Receive SUD Oversight Policy Board Meeting Minutes 10/16/2024 *(Page 135)*

    14.3 Receive Board Executive Committee Minutes 02/21/2025 *(Page 139)*

    14.4 Receive Policy Committee Meeting Minutes 02/04/2025 *(Page 141)*

    14.5 Receive Operations Council Key Decisions 01/27/2025 *(Page 143)*

    14.6 Approve the following policies:

    14.6.1 Assessment of Member Experiences *(Page 148)*
    14.6.2 Behavior Treatment Plans *(Page 151)*
    14.6.3 Critical Incidents *(Page 154)*
    14.6.4 External Quality Review *(Page 159)*
    14.6.5 Incident Review for Substance Use Disorder Providers *(Page 161)*
    14.6.6 Medication Event Verification *(Page 165)*
    14.6.7 Michigan Mission Based Performance Indicator System *(Page 168)*
    14.6.8 Monitoring and Oversight *(Page 171)*
    14.6.9 Performance Improvement *(Page 174)*
    14.6.10 Quality Management *(Page 176)*
    14.6.11 Regional Provider Monitoring and Oversight *(Page 179)*
    14.6.12 Research *(Page 184)*
    14.6.13 Sentinel Events *(Page 186)*
    14.6.14 Cultural Competency *(Page 188)*
    14.6.15 Artificial Intelligence *(Page 190)*
    14.6.16 Document Sharing *(Page 194)*

15. Other Business
16. Public Comment (3 minutes per speaker)
17. Adjourn

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POLICIES AND PROCEDURES MANUAL

Chapter:	**General Management**		
Title:	**Board Member Conduct and Board Meetings**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle: Biennial** **Author:** Chief Executive Officer	**Adopted Date: 01.06.2015** **Review Date:** 09.10.2024	**Related Policies:** Compliance & Program Integrity Conflict of Interest Confidentiality and Notice of Privacy

Purpose

The Mid-State Health Network (MSHN) Board exists to represent and make decisions in the best interest of the entire organization and its regional stakeholders. The Board is established to assure development and approval of effective policies that provide for compliance with the approved strategic direction, the MSHN Corporate Compliance Plan, the Board's fiduciary responsibility, approved policies, and authorized contracts.

Each Board Member is expected to adhere to a high standard of ethical conduct and to act in accordance with MSHN's Mission and Core Values. The good name of MSHN depends upon the way Board Members conduct business and the way the public perceives that conduct.

Policy

A. MSHN Board members shall be guided by the following principles in carrying out their responsibilities:

Loyalty: Board members shall act so as to protect MSHN's interests and those of its employees, assets and legal rights, and Board Members shall serve the interests of MSHN, its beneficiaries, partner Community Mental Health Service Programs, contracted providers, and the consumers they serve. If an individual Board member disagrees with a decision made by the Board, he/she shall identify if speaking on the matter after the meeting that they are speaking as an individual and not for the Board.

Care: Board members shall apply themselves with seriousness and diligence to participating in the affairs of MSHN and shall act prudently in exercising governance oversight of the organization. Board Members are expected to be familiar with MSHN's business and the environment in which the organization operates, and understand MSHN's policies, strategies, and core values.

Inquiry: Board members shall take steps necessary to be sufficiently informed to make decisions on behalf of MSHN and to participate in an informed manner in Board activities.

Compliance with Laws, Rules, and Regulations: Board members shall comply with all laws, rules, policies (including Board-approved operational plans, such as but not limited to the Corporate Compliance Plan) and regulations applicable to MSHN.

Observance of Ethical Standards: Board members must adhere to the highest of ethical standards in the conduct of their duties. These include honesty, fairness, and integrity. Unethical actions, or the appearance of unethical actions, are not acceptable.

Integrity of Records and Public Reporting: Board members shall promote accurate and reliable preparation and maintenance of MSHN's financial and other records to assure full, fair, accurate, timely, understandable, open, and transparent disclosure.

Conflicts of Interest: Board members must act in accordance with the Conflicts of Interest Policy adopted by the MSHN Board, and as amended from time to time.

Confidentiality: Board members shall maintain the confidentiality of information entrusted to them by or about MSHN its business, consumers, or providers, contractors except when disclosure is authorized or legally mandated.

Board Interaction with Payers, Regulators, the Community and Media: The Board recognizes that payers/regulators, members of the media, MSHN's stakeholder groups and the public at large have significant interests in the organization's actions and governance, therefore the Board seeks to ensure appropriate communication, subject to concerns about confidentiality. The Board designates the Chief Executive Officer as the primary point of contact and spokesperson for MSHN.

- If comments from the MSHN Board are appropriate, they should be reviewed and discussed by the Board in advance, and, in most circumstances, come from the Chairperson of the Board.

B. **Enforcement**: Board members will discuss with the Board Chairperson any questions or issues that may arise concerning compliance with this policy. Breaches of this policy, whether intentional or unintentional, shall be reviewed in accordance with the MSHN Operating Agreement (Article VIII - Section 8.1) "Dispute Resolution Process." Action to remove a Board member shall occur in accordance with approved bylaws (Section 4.5) "Removal."

Board Meeting Procedures:

A. MSHN Board meetings shall be conducted in accordance with board bylaws and parliamentary procedures. Specifically, the process of decision and order of procedures shall occur as outlined in the bylaws, applicable policies, or established parliamentary procedures.

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.

Applies to:

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

Definitions:

Boardsmanship: Describes the competencies and skills necessary to be an effective Board member
CEO: Chief Executive Officer
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health and Human Services
PIHP: Pre-Paid Inpatient Health Plan

Other Related Materials:
MSHN Corporate Compliance Program
MSHN Operating Agreement
Board By-Laws
SUD Intergovernmental Agreement

References/Legal Authority:
MSHN Operating Agreement
MSHN Board Bylaws
MDHHS-PIHP Contract section 29.0 Ethical Conduct; 30.0 Conflict of Interest

Change Log:

Date of Change	Description of Change	Responsible Party
01.06.2015	New	Chief Executive Officer
11.2015	Annual Review	Chief Executive Officer
03.2017	Annual Review	Chief Executive Officer
11.2018	Follow-up Review	Chief Executive Officer
01.2019	Annual Review	Chief Executive Officer
07.2020	Biennial Review	Chief Executive Officer
07.2022	Biennial Review	Chief Executive Officer
07.2024	Biennial Review	Chief Executive Officer

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FY25 MSHN Board Roster

Last Name	First Name	Email 1	Email 2	Phone 1	Phone 2	Appointing CMHSP	Term Expiration
Bock	Patty	pjb1873@gmail.com		989.975.1094		HBH	2026
Bohner	Brad	bbohner@tds.net		517.294.0009		LifeWays	2025
Brodeur	Greg	brodeurgreg@gmail.com		989.413.0621		Shia Health & Wellness	2027
DeLaat	Ken	kend@nearnorthnow.com		231.414.4173		Newaygo County MH	2026
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	2026
Hicks	Tina	tinamariemshn@outlook.com		989.576.4169		GIHN	2027
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2027
McFarland	Pat	pjmcfarland52@gmail.com		989.225.2961		BABHA	2026
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	2026
Palmer	Paul	ppalmer471@ymail.com		517.256.7944		CEI	2025
Pawlak	Bob	bopav@aol.com		989.233.7320		BABHA	2025
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	2026
Purcey	Linda	dpurcey1995@charter.net		616.443.9650		The Right Door	2025
Raquepaw	Tracey	tl.raquepaw@icloud.com	raquepawt@michigan.gov	989.737.0971		Saginaw County CMH	2025
Scanlon	Kerin	kscanlon@tm.net		502.594.2325		CMH for Central	2025
Swartzendruber	Richard	rswartzn@gmail.com		989.269.2928	989.315.1739	HBH	2026
Twing	Susan	set352@hotmail.com		231.335.9590		Newaygo County MH	2025
Vacant						CEI	2025
Williams	Joanie	joanie.williams@leonagroupmw.com		989.860.6230		Saginaw County CMH	2026
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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ACRONYMS - Following is a list of commonly used acronyms you may read or hear referenced in a MSHN Board Meeting:

ACA: Affordable Care Act

ACT: Assertive Community Treatment

ARPA: American Rescue Plan Act (COVID-Related)

ASAM: American Society of Addiction Medicine

ASAM CONTINUUM: Standardized assessment for adults with SUD needs

ASD: Autism Spectrum Disorder

BBA: Balanced Budget Act

BH: Behavioral Health

BHH: Behavioral Health Home

BPHASA – Behavioral and Physical Health and Aging Services Administration

BH-TEDS: Behavioral Health–Treatment Episode Data Set

CC360: CareConnect 360

CCBHC: Certified Community Behavioral Health Center

CAC: Certified Addictions Counselor
Consumer Advisory Council

CEO: Chief Executive Officer

CFO: Chief Financial Officer

CIO: Chief Information Officer

CCO: Chief Clinical Officer

CFR: Code of Federal Regulations

CFAP: Conflict Free Access and Planning (Replacing CFCM)

CLS: Community Living Services

CMH or CMHSP: Community Mental Health Service Program

CMHA: Community Mental Health Authority

CMHAM: Community Mental Health Association of Michigan

CMS: Centers for Medicare and Medicaid Services (federal)

COC: Continuum of Care

COD: Co-occurring Disorder

CON: Certificate of Need (Commission) – State

CPA: Certified Public Accountant

CQS: – Comprehensive Quality Strategy

CRU: Crisis Residential Unit

CS: Customer Service

CSAP: Center for Substance Abuse Prevention (federal agency/SAMHSA)

CSAT: Center for Substance Abuse Treatment (federal agency/SAMHSA)

CW: Children's Waiver

DAB: Disabled and Blind

DEA: Drug Enforcement Agency

DECA: Devereux Early Childhood Assessment

DMC: Delegated Managed Care (site visits/reviews)

DRM: Disability Rights Michigan

DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

D-SNP: Dual Eligible Special Needs Plan

EBP: Evidence-Based Practices

EEO: Equal Employment Opportunity

EMDR: Eye Movement & Desensitization Reprocessing therapy

EPSDT: Early and Periodic Screening, Diagnosis and Treatment

EQI: Encounter Quality Initiative

EQR: External Quality Review (federally mandated review of PIHPs to ensure compliance with BBA standards)

FC: Finance Council

FI: Fiscal Intermediary

FOIA: Freedom of Information Act

FSR: Financial Status Report

FTE: Full-time Equivalent

FQHC: Federally Qualified Health Centers

FY: Fiscal Year (for MDHHS/CMHSP runs from October 1 through September 30)

GAIN: Global Appraisal of Individual Needs assessment for adolescents with SUD needs.

GF/GP: General Fund/General Purpose (state funding)

HB: House Bill

HCBS: Home and Community Based Services

HHP: Health Home Provider

HIPAA: Health Insurance Portability and Accountability Act

HITECH: Health Information Technology for Economic and Clinical Health Act

HMP: Healthy Michigan Program

HMO: Health Maintenance Organization

HRA: Hospital Rate Adjuster

HSAG: Health Services Advisory Group (contracted by state to conduct External Quality Review)

HSW: Habilitation Supports Waiver

ICD-10: International Classification of Diseases – 10th Edition

ICO: Integrated Care Organization (a health plan contracted under the Medicaid/Medicare Dual eligible pilot project)

ICTS: Intensive Community Transitions Services

I/DD: Intellectual/Developmental Disabilities

IDDT: Integrated Dual Diagnosis Treatment

IOP: Intensive Outpatient Treatment

ISF: Internal Service Fund

IT/IS: Information Technology/Information Systems

KPI: Key Performance Indicator

LBSW: Licensed Baccalaureate Social Worker

LEP: Limited English Proficiency

LLMSW: Limited Licensed Masters Social Worker

LMSW: Licensed Masters Social Worker

LLPC: Limited Licensed Professional Counselor

LPC: Licensed Professional Counselor

LOCUS: Level of Care Utilization System

LTSS: Long Term Supports and Services

MAHP: Michigan Association of Health Plans (Trade association for Michigan Medicaid Health Plans)

MAT: Medication Assisted Treatment (see MOUD)

MCBAP: Michigan Certification Board for Addiction Professionals

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ACRONYMS - Following is a list of commonly used acronyms you may read or hear referenced in a MSHN Board Meeting:

MCO: Managed Care Organization

MDHHS: Michigan Department of Health and Human Services

MDOC: Michigan Department of Corrections

MEV: Medicaid Event Verification

MHP: Medicaid Health Plan

MI: Mental Illness

Motivational Interviewing

MichiCANS: Michigan Child and Adolescent Needs and Strengths

MiHIA: Michigan Health Improvement Alliance

MiHIN: Michigan Health Information Network

MLR: Medical Loss Ratio

MMBPIS: Michigan Mission Based Performance Indicator System

MOUD: Medication for Opioid Use Disorder (a sub-set of MAT)

MP&A (MPAS): Michigan Protection and Advocacy Service

MPCA: Michigan Primary Care Association (Trade association for FQHC's)

MPHI: Michigan Public Health Institute

MRS: Michigan Rehabilitation Services

NACBHDD: National Association of County Behavioral Health and Developmental Disabilities Directors

NAMI: National Association of Mental Illness

NASMHPD: National Association of State Mental Health Program Directors

NCQA: National Committee for Quality Assurance

NCMW: National Council for Mental Wellbeing

OC: Operations Council

OHCA: Organized Health Care Arrangement

OHH: Opioid Health Home

OIG: Office of Inspector General

OMT: Opioid Maintenance Treatment - Methadone

OP: Outpatient

OTP: Opioid Treatment Provider (formerly methadone clinic)

PA: Public Act

PA2: Liquor Tax act (funding source for some MSHN funded services)

PAC: Political Action Committee

PASARR: Pre-Admission Screening and Resident Review

PCP: Person-Centered Planning

Primary Care Physician

PEP: Performance Enhancement Plan

PFS: Partnership for Success

PEO: Professional Employer Organization

PEPM: Per Eligible Per Month (Medicaid funding formula)

PI: Performance Indicator

PIP: Performance Improvement Project

PIHP: Prepaid Inpatient Health Plan

PMV: Performance Measure Validation

PN: Prevention Network

Project ASSERT: Alcohol and Substance abuse Services and Educating providers to Refer patients to Treatment

PRTF: Psychiatric Residential Treatment Facility

PS: Protective Services

PTSD: Post-Traumatic Stress Disorder

QAPIP: Quality Assessment and Performance Improvement Program

QAPI: - Quality Assessment Performance Improvement

QHP: Qualified Health Plan

QM/QA/QI: Quality Management/Assurance/Improvement

QRT: Quick Response Team

RCAC: Regional Consumer Advisory Council

REMI: MSHN's Regional Electronic Medical Information software

RES: Residential Treatment Services

RFI: Request for Information

RFP: Request for Proposal

RFQ: Request for Quote

RHC: Rural Health Clinic

RR: Recipient Rights

RRA: Recipient Rights Advisor

RRO: Recipient Rights Office/Recipient Rights Officer

SAMHSA: Substance Abuse and Mental Health Services Administration (federal)

SAPT: Substance Abuse Prevention and Treatment (when it includes an "R", means "Recovery")

SARF: Screening, Assessment, Referral and Follow-up

SCA: Standard Cost Allocation

SDA: State Disability Assistance

SED: Serious Emotional Disturbance

SB: Senate Bill

SIM: State Innovation Model

SMI: Serious Mental Illness

SPMI: Severe & Persistent Mental Illness

SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income (Social Security)

SSN: Social Security Number

SUD: Substance Use Disorder

SUD OPB: Substance Use Disorder Regional Oversight Policy Board

SUGE: Bureau of Substance Use, Gambling and Epidemiology

TANF: Temporary Assistance to Needy Families

THC: Tribal Health Center

UR/UM: Utilization Review or Utilization Management

VA: Veterans Administration

VBP: Value Based Purchasing

WM: Withdrawal Management (formerly "detox")

WSA: Waiver Support Application

WSS: Women's Specialty Services

YTD: Year to Date

ZTS: Zenith Technology Systems (MSHN Analytics and Risk Management Software)

Conflict Free Access and Planning (CFA&P) Update
MSHN Board of Directors
03/04/2025

*Presentation Current as of: 2/19/2025.
Intervening changes will be shared as appropriate.

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

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The Reason for Conflict Free Access and Planning

Legal precedent is set by 42 CFR 441.730(b) and 441.301(c)(1)(vi).

It is a part of the Home and Community Based Services (HCBS) Rule of 2014, in federal law

Promulgated upon approval by the Centers for Medicare and Medicaid Services (CMS): these roles must be separated to mitigate conflict of interest and as a condition of C-Waiver and 1915(i) application approvals:

1) Assessment and Planning Role="Case management"
2) Direct Services Role=HCBS Services

Home and Community-Based Services

Covering 21 services

Service
Community Living Supports
Enhanced Medical Equipment and Supplies
Enhanced Pharmacy
Environmental Modifications
Family Support and Training
Fiscal Intermediary/Financial Management Services
Therapeutic Family Care
Goods and Services
Housing Assistance
Massage Therapy
Non-Family Training
Overnight Health and Safety Supports
Overnight Therapeutic Camp
Personal Emergency Response System
Prevocational Services
Private Duty Nursing
Respite
Skill Building/ Out of Home Non-Vocational Training
Specialty Services
Supported Employment
Vehicle Modifications

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Waiver and 1915(i) Application Approvals by CMS

- Submitted by the Michigan Department of Health and Human Services (MDHHS) to the Centers for Medicare and Medicaid Services (CMS) every five years (state plan amendments more frequent based on other factors).
- December 2024 Approvals
  - Waiver for Children with Serious Emotional Disturbance (SEDW)
  - Habilitation Supports Waiver (HSW)
- January 2025 Approvals
  - Children's Waiver Program (CWP)
  - 1915(i) State Plan Amendment ("1915(i)")

CFA&P Requirements

- Updated requirements for beneficiary choice of provider and given information on all HCBS services.
- Plan development/needs assessment function separated from direct service provider function.
- Exception language: the Only Willing and Qualified Provider (OWQP).
- The Pre-Paid Inpatient Health Plan (PIHP)
  - Further guidance required (unclear currently):
    - Responsible for utilization management-cannot delegate.
    - Approval of the individual plan of service (IPOS).
      - Complies with CFA&P and Medicaid Provider Manual Policy.

OWQP Criteria

- Provider is in a rural or critical access county (2020 Census Data).*
- The MSHN region has only three counties that meet rural criteria:
  - **Arenac**
  - **Huron**
  - **Osceola**
- Provider is a tribal provider.*
- Provider is only entity offering service planning in the county.*
- Provider delivers HCBS services (i.e., direct services) due to lack of other direct service providers.*

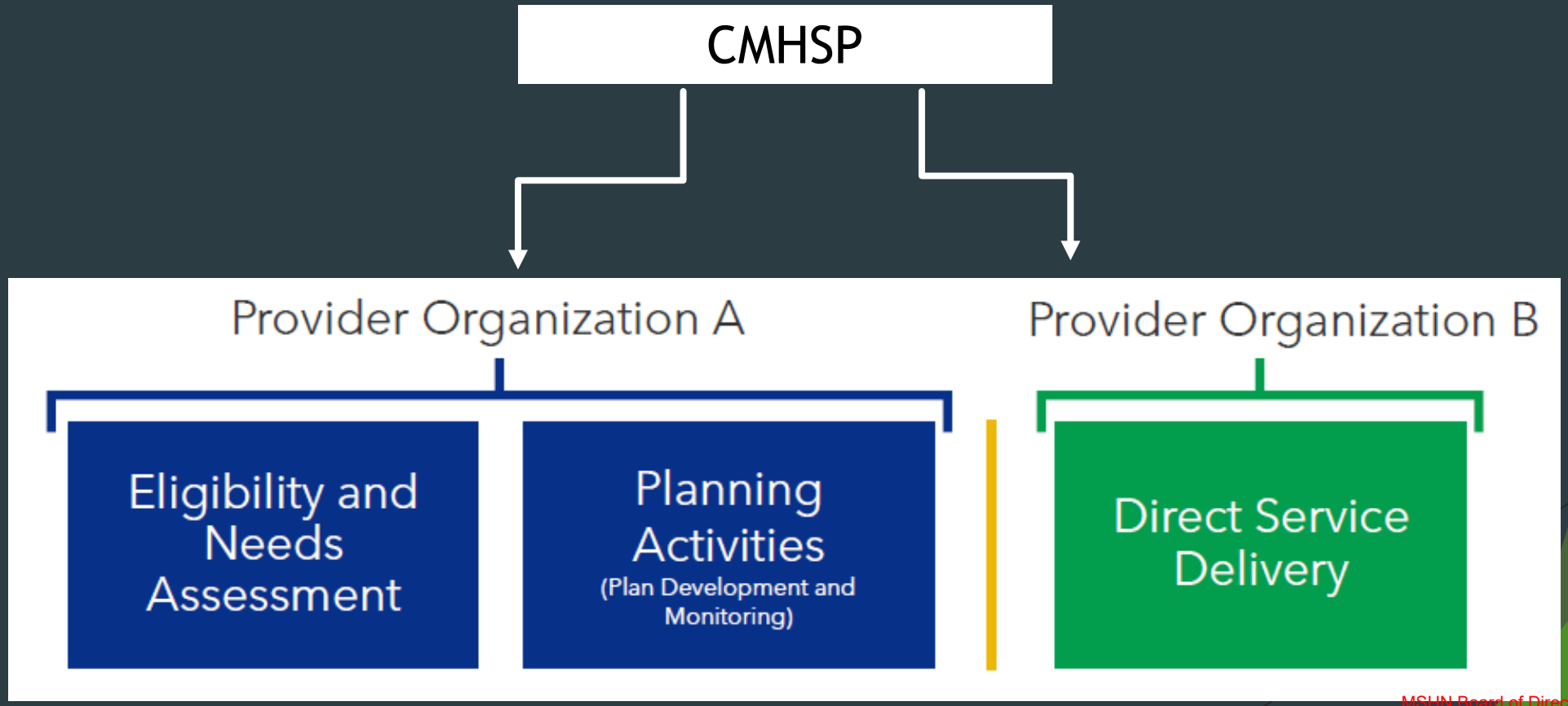
* MDHHS defines each of these-anticipated in upcoming Medicaid policy.

OWQP Designation

- MDHHS will directly oversee and monitor OWQPs through:
  - State Policy
  - Medicaid Provider Manual
  - Contract Language
  - Site Reviews
  - Data Analysis
  - Monitor efforts to expand the provider network
  - Retrospective reviews of OWQP designation applications
- MDHHS designates OWQP every three years.
  - MDHHS still expects Community Mental Health (CMH) effort to expand its network during this time-unclear on what must be done to come into compliance.
- OWQPs may provide *both* assessment/planning and direct services.
- PIHPs verify and monitor adequacy of separations outlined in OWQP designation.

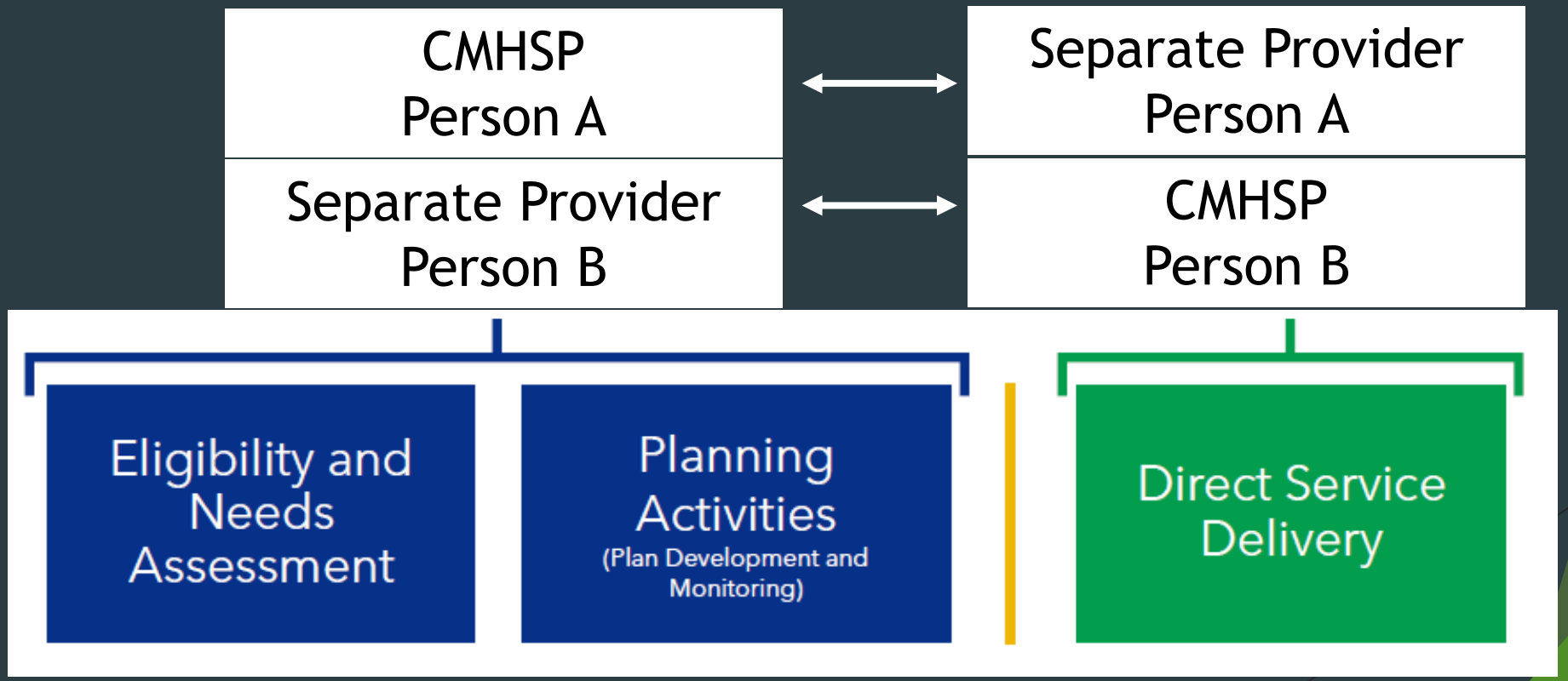
Three Acceptable CFA&P Scenarios: #1

- **SCENARIO 1**: The CMH contracts out both service planning and direct service functions to providers. The Community Mental Health Service Program (CMHSP) must ensure that a member is referred to provider A for service planning and a separate provider B for direct services.



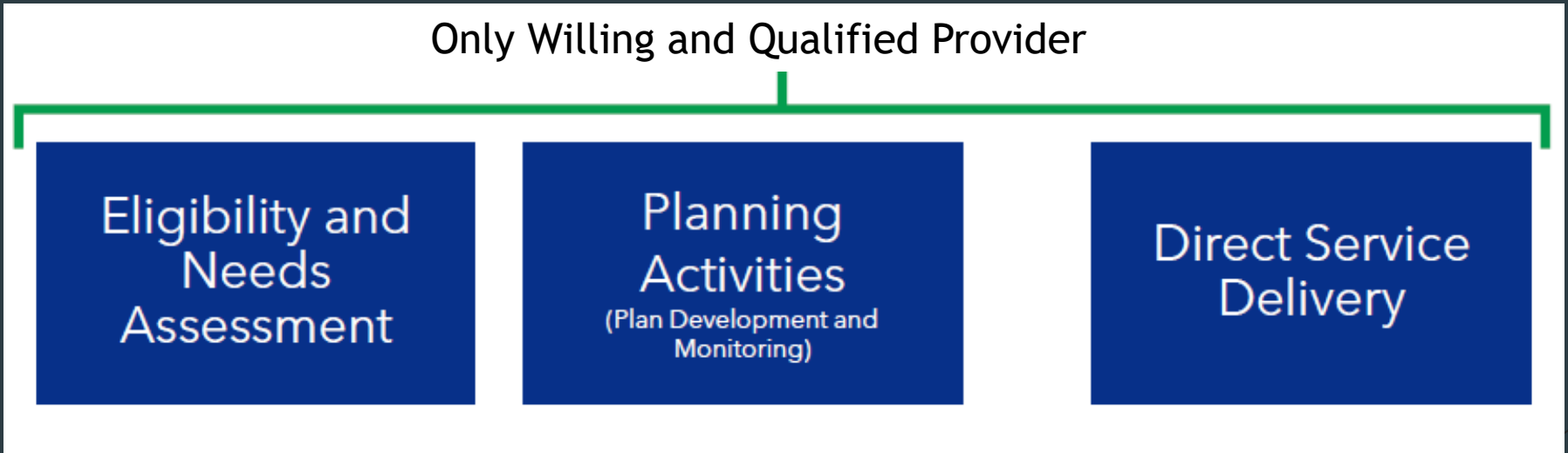
Acceptable CFA&P Scenarios: #2

- SCENARIO 2: The CMH directly offers both service planning and direct services and contracts with providers for these functions. The CMH may continue to provide service planning or direct services to a single member but must ensure a member is referred to a separate provider A to conduct the remaining function.



Acceptable CFA&P Scenarios: #3

- SCENARIO 3: Only Willing and Qualified Provider designees must be in a rural or critical access county (driven by 2020 census and population density dimensions) and must have additional protections against conflict of interest and will receive additional MDHHS oversight.



Next Steps

- Expecting guidance imminently from MDHHS.
- OWQP and Utilization Management (UM) processes will be defined further “as defined by MDHHS.”
- February 18, 2025 MDHHS Memo:
  - “Youth C-Waivers” CWP and SEDW
  - Application elements effective upon approval of forthcoming policy-Anticipated in 4-6 months.
  - Likely time when full planning will begin.
- FY25: PIHPs responsible for regional plan with oversight.
- FY25-26: MDHHS will establish due dates for compliance and MSHN and CMHs will create a workplan.
- FY27 (10/1/2026): Full compliance and implementation.

Sources

- 42 CFR 441.730(b) eCFR :: 42 CFR 441.730 -- Provider qualifications.
- 42 CFR 441.301(c)(1)(vi) eCFR :: 42 CFR 441.301 -- Contents of request for a waiver.
- Application for 1915(c) HCBS Waiver: Children's Waiver Program 1915(c) Renewal Approval Letter [post 11.11.23 w App k provisions]
- Application for 1915(c) HCBS Waiver: Waiver for Children with Severe Emotional Disturbance 1915(c) Renewal Approval Letter [post 11.11.23 w App k provisions]
- Application for 1915(c) HCBS Waiver: Habilitation Supports Waiver 1915(c) Renewal Approval Letter [post 11.11.23 w App k provisions]
- Application for 1915(i) Home and Community Based Services State Plan Amendment SPA_24-0008_approved.pdf
- MDHHS Memo, February 18, 2025, *Update on 1915(c) Waivers and Related State Plan Services for Children, Youth, and Families*

Background

To comply with the PIHP/MDHHS Services Contract, specifically as it relates to the General Requirement Section: Program Integrity, which includes the following:

> The Contractor must have a program integrity compliance program as defined in 42 CFR 438.608. The program integrity compliance program must include the following:
>
> i. Written policies and procedures that describe how the Contractor will comply with federal and State fraud, waste and abuse standards, and well publicized disciplinary standards for failure to comply.
> ii. The designation of a compliance officer who reports directly to the Chief Executive Officer and the Board of Directors, and a compliance committee, accountable to the senior management or Board of Directors, with effective lines of communication to the Contractor's employees.
> iii. Effective training and education for the compliance officer, senior management, and the Contractor's employees regarding fraud, waste and abuse, and the federal and State standards and requirements under this Contract. While the compliance officer may provide training to Contractor employees, "effective" training for the compliance officer means it cannot be conducted by the compliance officer himself/herself.
> iv. Provisions for internal monitoring and auditing. Audits must include post payment reviews of paid claims to verify that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities, etc.). Acceptable audit methodology examples include:
> 1. Record review, including statistically valid random sampling and extrapolation to identify and recover overpayments made to providers
> 2. Beneficiary interviews to confirm services rendered
> 3. Provider self-audit protocols
> 4. The frequency and quantity of audits performed should be dependent on the number of fraud, waste and abuse complaints received as well as high risk activities identified through data mining and analysis of paid claims
> v. Provisions for the Contractor's prompt response to detected offenses and for the development of corrective action plans. "Prompt response" is defined as action taken within 15 business days of receipt by the Contractor of the information regarding a potential compliance problem.

The 2025 Corporate Compliance Plan and 2024 Annual Compliance Summary Report was reviewed by the MSHN Compliance Committee, Regional Compliance Committee and the Operations Council with recommendation for approval to the MSHN Board of Directors. The attached Summary of Recommended Changes to the 2025 Corporate Compliance Plan provides an overview of the recommended revisions to the plan. The attached Executive Summary for the Compliance Summary Report 2024 provides an brief overview of the full report. In addition, the Corporate Compliance Plan as proposed is in compliance with and supports the MSHN Policy: General Management - Compliance and Program Integrity.

Recommended Motion:
The MSHN Board approves and acknowledges receipt of the 2025 Corporate Compliance Plan and the 2024 Annual Compliance Summary Report.

Summary of Changes: Compliance Plan 2025

The following changes were made to be in compliance with contract changes to the program integrity section of the MDHHS/PIHP Contract.

I. Overview/Mission Statement
- *No Changes*

II. Value Statement
- *No Changes*

III. Scope of Plan
- *No Changes*

IV. Definitions
- *No Changes*

V. Compliance Program
  A. Plan
    - *No Changes*
  B. Policies and Procedures
    - *No Changes*

VI. Structure of the Compliance Program
  A. General Structure
    - *No Changes*
  B. Compliance Officer
    - *Added: The CEO, chief financial officer (CFO), and chief operating officer (COO), or any other individuals operating in these roles, may not operate in the capacity of the compliance officer.*
  C. Regional Compliance Committee
    - *No Changes*
  D. MSHN Corporate Compliance Committee
    - *No Changes*

VII. Compliance Standards
  A. Conduct and Ethical Guidelines Standards
    - *No Changes*
  B. Legal & Regulatory Standards
    - *No Changes*

C. Environmental Standards
   - *No Changes*

D. Workplace Conduct Standards
   - *No Changes*

E. Contractual Relationships
   - *No Changes*

F. Purchasing and Supplies
   - *No Changes*

G. Marketing Standards
   - *No Changes*

H. Financial Systems Reliability and Integrity
   - *No Changes*

I. Information Systems Reliability and Integrity
   - *No Changes*

J. Confidentiality and Privacy
   - *No Changes*

VIII. Areas of Focus
- *Added: Areas of focus are developed from recommendations from the previous year compliance effectiveness review*

IX. Training

A. MSHN Employee Training
   - *No Changes*

B. Provider Network Training
   - *No Changes*

X. Communication
- *No Changes*

XI. Monitoring and Auditing
- *No Substantial Changes*

XII. Reporting and Investigation

A. Reporting of Suspected Violations or Misconduct
   - *Added: To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code*
   - *Added: MSHN will follow the procedures and examples contained within the processes and associated guidance provided by MDHHS-OIG.*
   - *Added: Narrative that MSHN will include a provision in all contracts with subcontractors and/or network providers giving MSHN the right to*

recover overpayments directly from providers for the post payment evaluations initiated and performed.

B. Process for Investigation
- *No Changes*

XIII. Corrective Action/Prevention/Disciplinary Guidelines
- *No Changes*

XIV. Submission of Program Integrity Activities/Report
- *Added: The report will include an attestation confirming compliance with the requirements found in 42 CFR 438.608 and 42 CFR 438.610.*

XV. Communication of Requirements
- *No Changes*

XVI. References and Supporting Documents
- *Updated links*

Attachments:

A. List of MSHN Compliance Policies/Procedures
  - *Updated link*

B. MSHN Compliance Organizational Chart
  - *No Changes*

C. MSHN Areas of Focus
  - *Removed current areas of focus and replaced with FY2025 recommendations*
  - *Added: Monitor to ensure effectiveness and compliance with identified standards for SUD access implementation*

D. MSHN Compliance Violation Reporting Posting
- *Updated contacts*

CORPORATE COMPLIANCE PLAN
20254

Mid-State Health Network, Corporate Compliance Committee: January 15, 2025
Mid-State Health Network, Regional Compliance Committee: January 17, 2025
Mid-State Health Network, Operations Council Approved: ~~2024; Revisions approved May 22, 2024~~
Mid-State Health Network PIHP Board Adopted: ~~March 05, 2024: Revisions approved July 2, 2024~~

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I. OVERVIEW/MISSION STATEMENT

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid-State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5, that includes services for behavioral health and substance use disorders. The CMHSP Participants include Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, The Right Door for Hope, Recovery and Wellness (formerly Ionia County CMH), Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness and Tuscola Behavioral Health Systems. In addition, MSHN also manages a network of substance use treatment, recovery, and prevention providers.

The mission of Mid-State Health Network is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members.

II. VALUE STATEMENT

MSHN and its provider network are committed to consumers, employees, contractual providers, and the community to ensure business is conducted with integrity, in compliance with the requirements of applicable laws, regulations, contractual obligations, and sound business practices, and with the highest standards of excellence. MSHN has adopted a compliance model that provides for prevention, detection, investigation, and remediation.

III. SCOPE OF PLAN

The MSHN Compliance Plan encompasses the activities (operational and administrative) of all MSHN board members, employees, and contractual providers. It is the expectation the Provider Network will follow the standards identified in the MSHN Compliance Plan or develop their own Compliance Plan that minimally meets the standards identified in the MSHN Compliance Plan and in accordance with the Code of Federal Regulations, Title 42, Part 438.608: Program Integrity Requirements.

All MSHN board members, employees and contractual providers are required to comply with all applicable laws, rules and regulations including those not specifically addressed in this Compliance Plan.

IV. DEFINITIONS

These terms have the following meaning throughout this Compliance Plan.

1. Abuse: Practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the payor, or in reimbursement for services that are not medically necessary or failure to meet professionally recognized standards for healthcare.

2. Behavioral Health: Refers to individuals with a Mental Health, Intellectual Developmental Disability and/or Substance Use Disorder or children with Serious Emotional Disturbances.

3. CMHSP Participant: Refers to one of the Community Mental Health Services Program (CMHSP) participants in the Mid-State Health Network region.

4. Fraud: An intentional deception or misrepresentation by a person could result in unauthorized benefit to him/herself or some other person. Includes any act that constitutes fraud under applicable Federal or State laws.

5. Subcontractors: Refers to an individual or organization that is directly under contract with a CMHSP or Substance Use Provider to provide services and/or supports.

6. Contractual Provider: Refers to an individual or organization under contract with the MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP participants who hold retained functions contracts.

7. Employee: Refers to an individual who is employed by the MSHN PIHP.

8. 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.

9. Staff: Refers to an individual directly employed and/or contracted with a Community Mental Health Service Provider and/or Behavioral Health Provider.

10. Waste: Overutilization of services, or other practices that result in unnecessary costs. Generally, considered not caused by criminally negligent actions, but rather the misuse of resources

V. COMPLIANCE PROGRAM

A. Compliance Plan

The Compliance Plan is prepared as a good-faith effort to summarize MSHN's rules, policies and procedures. To the extent that the Plan conflicts with, or misstates any applicable law or regulation, the law takes precedence.

The purpose of the Compliance Plan is to provide the framework for MSHN to comply with applicable laws, regulations, and program requirements. The overall key principles of the Compliance Plan are to:

- Minimize organizational risk and improve compliance with billing requirements of Medicaid,

and all other applicable federal health programs.

- Maintain adequate internal controls (paying special attention to identified areas of risk).
- Reduce the possibility of misconduct and violations through prevention and early detection.
- Being proactive in Compliance to reduce exposure to civil and criminal sanctions.
- Encourage the highest level of ethical and legal behavior from all employees, contractual providers, and board members.
- Educate employees, contractual providers, board members and stakeholders of their responsibilities and obligations to comply with applicable local, state, and federal laws and regulations.
- Promote a clear commitment to compliance by taking actions and showing good faith efforts to uphold such laws, regulations, and standards.

The following elements have been identified by the Medicaid Alliance for Program Safeguards and the Office of Inspector General as being essential to an effective compliance program for Managed Care Organizations and Prepaid (Inpatient) Health Plans (PIHP):

- *Standards of Conduct, Policies and Procedures* – the organization must have written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable statutory, regulatory and Medicaid requirements.
- *High level oversight and delegation of authority* – the PIHP must designate a Compliance Officer and a Compliance Committee.
- *Training* – the PIHP must provide for effective training and education for the Board of Directors, Compliance Officer, and the organization's employees. The PIHP must assure adequate training is provided through the provider network. Training should be provided at hire and annually thereafter.
- *Communication* - Effective lines of communication must be established between the Compliance Officer and the organization's employees.
- *Monitoring and auditing* – The organization must take reasonable steps to achieve compliance with defined standards by utilizing reasonably designed monitoring and auditing systems and practices.
- *Enforcement and disciplinary mechanisms* – Standards must be enforced through well-publicized disciplinary guidelines.
- *Corrective actions and prevention* – After an offense *(non-compliance)* has been detected, the organization must take reasonable steps to respond appropriately and promptly to the offense and to develop corrective action initiatives and performance improvement. This includes follow-up monitoring and review to ensure the performance improvement plan is effective.

B. Compliance Policies and Procedures

While the Compliance Plan provides the framework of the Compliance Program, the Compliance Policies and Procedures provide more specific guidance.

Written policies and procedures which direct the operation of the compliance program, include, at a minimum, the following elements:

- Duties and responsibilities of the compliance officer and Compliance Committees.
- How and when employees will be trained.
- How employee reports of noncompliance will be handled.
- Guidelines on how the compliance department will interact with the internal audit department.

- Guidelines on how the compliance department will interact with the legal department.
- Guidelines on how the compliance department will interact with the Human Resources department.
- Duties and responsibilities of management in promoting compliance among employees and responding to reports of non-compliance.
- Ensuring that prospective employees receive appropriate background screening and agree to abide by the Contractor's code of conduct.
- Conducting periodic reviews, at least annually, of the code of conduct and the compliance policies and procedures.
- Monitoring of compliance in Contractor and Subcontractor/Network Provider systems and processes.
- Monitoring of potential Fraud, Waste and Abuse in provider billings and beneficiary utilization.
- Performing an investigation of targets selected for audit, including triage and review processes.
- Confidentiality and non-retaliation.
- Appropriate disciplinary action for non-compliance with applicable statutory and Medicaid program requirements as well as failure to report actual or suspected non-compliance.
- Reasonable and prudent background background investigations for current employees and employees of subcontractors/network providers.

Refer to **Attachment A** for a list of the Policy and Procedure categories that are part of the Compliance Program.

VI. STRUCTURE OF THE COMPLIANCE PROGRAM

A. General Structure

- *MSHN Board of Directors*: MSHN's Board of Directors is responsible for the review and approval of the Compliance Plan and Policies, review of the Annual Compliance Report, and review of matters related to the Compliance Program. The MSHN Board of Directors has the highest level of responsibility for the oversight of the Compliance Program. The Executive Committee of the Board shall review reports annually from the MSHNCompliance Officer (CO)

- *MSHN Corporate Compliance Committee*: The Corporate Compliance Committee provides guidance, supervision, and coordination for compliance efforts at MSHN. MSHN's Corporate Compliance Committee (CCC) is comprised of the Chief Executive Officer (CEO), Deputy Director, Chief Information Officer (CIO), Chief Finance Officer (CFO), and the Chief Compliance and Quality Officer (CCQO). The Medical Director and Compliance Counsel will be ad-hoc members of the CCC. In addition, Ex-officio members may be asked to attend as non-voting members to provide consultation on specific areas of expertise.

- *Compliance Officer:* The MSHN Compliance Officer has primary responsibility for ensuring that MSHN maintains a successful Compliance Program. In particular, the Compliance Officer oversees the implementation and effectiveness of the Compliance Plan and Compliance Policies, serves as the Chair of the Regional Compliance Committee and MSHN Corporate Compliance Committee, provides consultative support to the provider network and has responsibility for the day-to-day operations of the compliance program. The CEO, chief financial officer (CFO), and chief operating officer (COO), or any other individuals operating in these roles, may not operate in the capacity of the compliance officer.

- *Regional Compliance Committee*: The Compliance Committee advises on matters involving compliance with contractual requirements and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608. The committee is comprised of the MSHN Chief Compliance and Quality Officer and the compliance officers of each CMHSP Participant.

- *Operations Council*: The Operations Council reviews reports concerning compliance matters as identified by the Regional Compliance Committee and reported by the MSHN Chief Executive Officer. The Operations Council shall be comprised of the Chief Executive Officers or Executive Directors of each CMHSP Participant and the MSHN Chief Executive Officer.

- See **Attachment B** – MSHN Compliance Process/Governance

B. MSHN Compliance Officer

MSHN designates the Chief Compliance and Quality Officer as the PIHP Compliance Officer, who will be given sufficient authority and control to oversee and monitor the Compliance Program related Policies and Procedures, including but not limited to the following:

- Oversight of internal (PIHP Audits) and external provider network audits (MDHHS Audit and EQR Audit) and monitoring activities outlined in the compliance plan.
- Directs and is accountable for the implementation and enforcement of the Compliance Plan.
- Serves as chair of the MSHN's Corporate Compliance Committee and Regional Compliance Committee
- Provides leadership to MSHN compliance activity and consultative support to CMHSP Participants/SUD Providers.
- Responsible for oversight of MSHN efforts to maintain compliance with federal and state regulations and contractual obligations.
- Serves as the Privacy Officer for MSHN.
- Ensures that effective systems are in place by which actual or suspected compliance violations are reported in a timely manner to appropriate governing bodies.
- Reviews all reports of actual or suspected compliance violations received by MSHN from any source and ensures that effective investigation and/or other action is taken.
- Completes investigations referred by, and under the direction of, the Office of Inspector General
- Monitors changes in federal and state health care laws and regulations applicable to MSHN operations and disseminate to the region.
- Works collaboratively with other MSHN employees and CMHSP Participants/SUD Providers to ensure that auditing and monitoring protocols are designed to detect and deter potential compliance violations.
- Coordinates compliance training and education efforts for all MSHN staff and Board Members
- Ensures that performance improvement plans are adequate to ensure compliance and assures effective implementation of corrective action occurs to reduce risk of future occurrences.
- Authority and independence to make reports directly to the board of directors and/or senior management concerning actual or potential cases of non-compliance.
- Reports compliance related matters to the Chief Executive Officer.
- Prepares and submits the quarterly Office of Inspector General program integrity report

- Prepares and delivers an annual compliance report to the MSHN Board covering the fiscal year, including:
  - A summary of trends in the frequency, nature and severity of substantiated compliance violations;
  - A review of any changes to the Compliance Plan or program; and
  - An objective assessment of the effectiveness of the Compliance Plan and Program.

The authority given to the MSHN Compliance Officer will include the ability to review all documents and other information relevant to compliance activities, including, but not limited to, consumer records, billing records, employee records, and contracts and obligations of MSHN.

Each MSHN CMHSP Participant/SUD Provider shall designate a Compliance Officer who has the authority to perform the duties listed for the MSHN Compliance Officer at their respective organization, as appropriate.

C. Regional Compliance Committee

The MSHN Regional Compliance Committee will consist of the MSHN Chief Compliance and Quality Officer, and the CMHSP Participants' Compliance Officers appointed by MSHN CMHSP Participant's. The Committee will meet at regular intervals and shall be responsible for the following:

- Advising the MSHN Compliance Officer and assisting with the development, implementation, operation, and distribution of the Compliance Plan and supporting MSHN policies and procedures.
- Reviewing and recommending changes/revisions to the Compliance Plan and related policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the Compliance Plan.
- Determining the appropriate strategy/approach to promote compliance with the Compliance Plan and detect potential violations and areas of risk as well as areas of focus.
- Recommending and monitoring the development of internal systems and controls to carry out the Compliance Plan and supporting policies as part of daily operations.
- Reviewing compliance related audit results and corrective action plans, making recommendations when appropriate.

D. MSHN Corporate Compliance Committee

The MSHN Corporate Compliance Committee meets every other month and its responsibilities include:

- Reviewing the Compliance Plan and related policies to ensure they adequately address legal requirements and address identified risk areas
- Assisting the CO with developing policies and procedures to promote compliance with the Compliance Plan
- Analyze the effectiveness of the compliance program and make recommendations accordingly
- Assisting the CO in identifying potential risk areas and violations
- Advising and assisting the CO with compliance initiatives
- Receiving, interpreting, and acting upon reports and recommendations from the CO
- Providing a forum for the discussion of compliance related issues

VII. COMPLIANCE STANDARDS

MSHN will ensure the development of written policies and procedures, standards, and documentation of practices that govern the PIHP's efforts to identify risk and areas of vulnerabilities and are in compliance with federal regulations and state contract requirements.

A. Standards of Conduct and Ethical Guidelines

MSHN and its Provider Network are committed to conducting the delivery of services and business operations in an honest and lawful manner and consistent with its Vision, Mission, and Values. As such, MSHN minimally establishes the following Standards of Conduct to clearly delineate the philosophy and values concerning compliance with the laws, regulations, contractual obligations, government guidelines and ethical standards applicable to the delivery of behavioral health care. The standards of conduct will be distributed to all employees and all employees will be required to certify that they have read, understand, and agree to comply with the standards.

- Provide through its Provider Network, high quality services consistent with MSHN Vision, Mission, and Values;
- Dedicated to ensuring that equality in voice and governance exists, and that the benefit to the citizens meets Medicaid standards while being provided in ways that reflect the needs and resources of the communities in which each CMHSP Participants/SUD Providers operate;
- Shared operating structure, using a committee-based system that creates many venues, allowing voices from across the region to be heard;
- MSHN operations are for service to the CMHSP Participants/SUD Providers in achieving high levels of regulatory compliance, quality of service, and fiscal integrity;
- MSHN exists to serve in the best interest of and to the benefit of all CMHSP Participants/SUD Providers and their consumers;
- Foster each CMHSP Participants/SUD Providers integration activities and locally driven work.
- Conduct business in an honest, legal and competent manner to prevent fraud, abuse and waste;
- Perform all duties in good faith and refrain from knowingly participating in illegal activities;
- Report any actual or suspected violation of the Compliance Plan, Standards of Conduct, MSHN policies or procedures, contract requirements, state and federal regulations or other conduct that is known or suspected to be illegal;
- Provide accurate information to federal, state, and local authorities and regulatory agencies when applicable;
- Promote confidentiality and safeguard all confidential information according to policy;
- Practice ethical behavior regarding relationships with consumers, payers, and other health care providers;
- Protect through its Provider Network, the integrity of clinical decision-making, basing care on identified medical necessity;
- Seek to continually maintain and improve work-related knowledge, skills, and competence; and
- Actively support a safe work environment, free from harassment of any kind.

These Standards of Conduct provide guidance for MSHN Board members and employees, as well as the provider network in performing daily activities within appropriate ethical and legal standards and establish a workplace culture that promotes prevention, detection, and resolution

of instances of conduct that do not conform with applicable laws and regulations. While the above standards are expected to be a framework for compliance, the issues addressed are not exhaustive. Therefore, MSHN Board Members, employees and its provider network staff are responsible for conducting themselves ethically in all aspects of business avoiding even the appearance of impropriety and in accordance with established policies and procedures.

B. Legal and Regulatory Standards

It is the policy of MSHN to ensure compliance with all state and federal regulatory agency standards and applicable laws and regulations including, but not limited to, the following:

State/Federal Laws and Rules

- Michigan Mental Health Code, Public Health Code and Administrative Rules
- Requirements as identified in the MDHHS contract
- Requirements as identified by the Office of Inspector General
- Technical Assistance Advisories, as required
- Medicaid State Plan
- Waiver Applications
- Medical Services Administration (MSA) Policy Bulletins
- Michigan Whistleblowers Act, Act 469 of 1980
- Home and Community Based Final Rules

Federal Medicaid Law, Regulations and Related Items

- Social Security Act of 1964 (Medicare and Medicaid)
- Balanced Budget Act of 1997
- Deficit Reduction Act/Medicaid Integrity Program of 2005
- Anti-kickback Statute
- Code of Federal Regulations
- 42 CFR Part 2 Confidentiality of Alcohol and Drug Use Patient Records
- State Operations Manual
- Letters to State Medicaid Directors
- Technical Assistance Tools
- Quality Improvement Systems for Managed Care (QISMC)
- Guide to Encounter Data Systems
- Office of Management and Budget (OMB) Circulars
- Government Accounting Standards Board (GASB)
- Affordable Care Act

Other Relevant Legislation

- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- False Claim Act (Federal and Michigan)
- Provisions from Public Act 368 of 1978 – revised – Article 6 Substance Abuse
- Office of Inspector General Annual Work Plan
- Stark Law
- HITECH Act
- American with Disabilities Act of 1990

C. Environmental Standards

MSHN shall maintain a hazard-free environment in compliance with all environmental laws and regulations. MSHN shall operate with the necessary security systems, permits, approvals and controls. Maintenance of a safe environment is the responsibility of all employees and contractual providers. In order to maintain a safe environment, MSHN shall enforce policies and procedures (as needed) designed to protect consumers, employees, staff, providers, visitors, the

environment, and the community.

D. Workplace Standards of Conduct

In order to safeguard the ethical and legal workplace standards of conduct, MSHN shall enforce policies and procedures, per the MSHN Personnel Manual, that address employee behaviors and activities within the workplace setting, including but not limited to the following:

1. Confidentiality: MSHN is committed to protect the privacy of its consumers. MSHN Board members, employees, and contractual providers are to comply with the Michigan Mental Health Code, Section, 330.1748, Code of Federal Regulations (CFR), Title 42 and all other privacy laws as specified under the Confidentiality section of this document.
2. Drug and Alcohol: MSHN is committed to maintain its property and to provide a drug-free work environment that is both safe for our employees and visitors, as well as conducive to efficient and productive work standards.
3. Harassment: MSHN is committed to maintaining a work environment free of harassment for Board members, employees, and contractual providers. MSHN will not tolerate harassment based on sex, race, color, religion, national origin, disability, citizenship, chronological age, sexual orientation, union activity, or any other condition, which adversely affects their work environment.
4. Conflict of Interest: MSHN Board members, employees, and contractual providers shall avoid any action that conflicts with the interest of the organization. All Board members, employees, and contractual providers must disclose any potential conflict of interest situations that may arise or exist in accordance with established policies and procedures.
5. Reporting Suspected Fraud: MSHN Board, employees, and contractual providers shall report any suspected or actual "fraud, abuse or waste" of any funds, including Medicaid funds, to the organization.
6. Solicitation and Acceptance of Gifts: MSHN Board members, employees and contractual providers shall not solicit gifts, gratuities or favors. MSHN Board members, employees and contractual providers will not accept gifts worth more than $25, gratuities or favors of any kind from any individual, consumer, or organization doing business or seeking to do business with MSHN.
7. Workplace Bullying: MSHN defines bullying as "repeated" inappropriate behavior, either direct or indirect, whether verbal, physical, or otherwise, conducted by one or more persons against another or others, at the place of work and/or during the course of employment. Such behavior violates MSHN Code of Ethics, which clearly states that all employees will be treated with dignity and respect.
8. Workplace Violence and Weapons: MSHN takes violence and threats of violence extremely seriously. Any act or threat of violence by or against any employee, customer, supplier, partner, or visitor is strictly prohibited.
9. Political Contributions: MSHN shall not use agency funds or resources to contribute to political campaigns or activities of any political party.

E. Contractual Relationships

MSHN shall ensure that all contractual arrangements with providers are structured in accordance with federal and state laws and regulations and are in the best interest of the organization and the consumers served. In order to ethically and legally meet all standards, MSHN will strictly adhere to the following:

1. MSHN and its Provider Network shall not pay or accept payment of any tangible or intangible kind for referrals. Consumer referrals and intakes will be accepted based on the consumer's needs, eligibility, and the ability to provide the services needed. No organization, or employee, covered by this plan who is acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of consumers. Similarly, when making consumer referrals to another healthcare provider, MSHN and the Provider Network will not take into account the volume or value of referrals that the provider has made (or may make).
2. The Provider Network shall not enter into financial arrangements with physicians that are designed to provide inappropriate remuneration to the organization in return for the physician's ability to provide services to federal health care program beneficiaries at MSHN.
3. MSHN does not enter into contractual relationships with individuals or agents/agencies that have been convicted of a criminal offense related to health care or that are listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in federal health care programs. Reasonable and prudent background investigations will be completed prior to entering into contractual relationships with all individuals and agents/agencies.
4. MSHN and its contractual providers, as well as the Provider Network and its contractors, are responsible for properly conducting credentialing and re-credentialing in accordance with State Policy and the MSHN policies and procedures. The Provider Network and contractual providers are responsible for reporting suspected fraud, abuse and licensing violations to MSHN as soon as suspected.
5. The Provider Network and its contractors shall be responsible, and held accountable, to provide accurate and truthful information in connection with treatment of consumers, documentation of services, and submission of claims.

F. Purchasing and Supplies

MSHN shall ensure that all rental, lease, and purchasing agreements are structured in accordance with applicable federal and state self-referral and anti-kickback regulations as well as federal guidelines regarding tax-exempt organizations. All agreements must be commensurate with the fair market value for equipment or space.

All contractor and supplier arrangements shall be managed in a fair and reasonable manner, consistent with all applicable laws and good business practices. Subcontractors, suppliers, and vendors shall be selected based on objective criteria including quality, technical excellence, price, delivery, and adherence to schedules, services and maintenance of adequate sources of supply.

G. Marketing

Marketing and advertising practices are defined as those activities used by MSHN to educate the public, provide information to the community, increase awareness of services, and recruit employees or contractual providers. MSHN will present only truthful, fully informative and non-deceptive information in any materials or announcements.

The federal Anti-Kickback Statute (section 1128B[b] of the Social Security Act) makes it a felony, punishable by criminal penalties, to offer, pay, solicit, or receive "remuneration" as an inducement to generate business compensated by Medicare or Medicaid programs.

H. Financial Systems Reliability and Integrity

MSHN shall ensure integrity of all financial transactions. Transactions shall be executed in accordance with established policies and procedures and with federal and state law and recorded in conformity with generally accepted accounting principles or any other applicable

criteria.

MSHN shall develop internal controls and obtain an annual independent audit of financial records and annual compliance examination; shall ensure that reimbursement for services billed is accurate, appropriate, and based on complete claims documentation; and shall maintain accountability of assets. The Federal Civil False Claims Act prohibits the knowing submission of false or fraudulent claims for payment to the federal or state government, the knowing use of a false record or statement to obtain payment on a false or fraudulent claim, or a conspiracy to defraud the federal or state government by having a false or fraudulent claim allowed or paid.

In accord with the 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005) MSHN's fiscal processes shall monitor contractual providers of Medicaid services to assure appropriate documentation is available as needed to support claims payments and cost reimbursements.

I. Information Systems Reliability and Integrity

The MSHN Chief Information Officer shall serve as the Security Officer and shall ensure the reliability and integrity of the information systems utilized to support the effectiveness of the MSHN compliance program, including but not limited to the following:

- Maintaining security, assuring integrity, and protecting consumer confidentiality.
- Controlling access to computerized data.
- Assuring reliability, validity and accuracy of data.
- Following procedures that assure confidentiality of electronic information pursuant to HIPAA, the Michigan Mental Health Code and other applicable laws and regulations.

J. Confidentiality and Privacy

The MSHN Chief Compliance and Quality Officer serves as the Privacy Officer. MSHN is committed to protecting the privacy of its consumers and shall strictly govern the disclosure of any information to anyone other than those authorized in compliance with applicable privacy laws, regulations and contractual requirements. To ensure that all consumer information remains confidential, employees and contractual providers are required to comply with all confidentiality policies and procedures in effect, specifically to include the HIPAA Privacy Regulations, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 C.F.R. Part 2, 45 C.F.R. Part 160 &164 as outlined below:

- MSHN will follow the HIPAA requirements, as well as all applicable federal and state requirements, for the use of protected health data and information.
- MSHN will immediately report to the MDHHS any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements.
- Any breach of protected health information shall result in notification of the affected individuals as well as the HHS Secretary and the media in cases where the breach affects more than 500 individuals.
- Privacy Notice - MSHN will have a notice of privacy practices.
- Authorization - If protected mental health information is shared to an entity outside of MSHN for any purpose other than coordination of care, treatment, or payment of services, a signed authorization will be obtained from the consumer prior to sharing information. If substance use treatment information is being shared, for any purpose, to an entity outside of MSHN, a signed authorization, by the consumer, will be obtained. The Michigan Behavioral Health Consent Form will be utilized for obtaining authorizations.
- MSHN will perform any necessary internal risk analysis or assessments to ensure

compliance.

- Physical and electronic safeguards shall be in place for MSHN employees and premises, including, but not limited to, door locks, unique logins and secure passwords, firewall and virus protection, disaster recovery mechanisms, and secure email.
- Business Associate Agreement – MSHN will obtain assurances with all Business Associates that protected health care information shared with them, will be protected and appropriately safeguarded consistent with all applicable State and Federal laws and requirements.
- Qualified Service Organization Agreement (QSOA) - Third-party service providers must become qualified to service Part 2 Programs. This is achieved through the entity entering into a written agreement with the Part 2 Program in which it acknowledges that it is bound by the Part 2 confidentiality regulations and agrees to resist in judicial proceedings any efforts to obtain unauthorized access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment that may come into its possession.

VIII. AREAS OF FOCUS

The MSHN Compliance Officer under the direction of the MSHN Board of Directors, MSHN Corporate Compliance Committee and the MSHN Regional Compliance Committee, will identify ~~strategic~~ areas of focus developed from recommendations from the previous year compliance effectiveness review ~~a risk analysis~~ that will guide the direction of MSHN compliance activities (**Attachment C**).

IX. TRAINING

A. MSHN Employees and Board Members

All MSHN Employees and Board members shall receive a copy of the MSHN Compliance Plan and training on the MSHN Compliance Plan, Compliance Policies, Standards of Conduct and applicable Medicaid statutory, regulatory, and contractual requirements. Additional training may be required for employees involved in specific areas of risk or as new regulations are issued. Records shall be maintained on all formal training and educational activities and staff are required to sign certifications that they have completed the appropriate training. The Compliance Officer must receive training by an entity other than himself/herself.

Training will be provided upon hire for new employees within 90 days of the date of hire and during orientation for new Board Members. All current staff and Board Members will receive annual training that re-emphasizes Medicaid statutory, regulatory, and contractual requirements and the Contractor's code of conduct. In addition, annual training will be provided to promote information sharing between departments and to enhance referrals regarding fraud, waste and abuse.

The Compliance Officer will provide ongoing information and education on matters related to health care fraud and abuse as disseminated by the Office of Inspector General, Department of Health and Human Services or other regulatory bodies.

It is the responsibility of MSHN staff to obtain training in order to maintain licensure and certifications that are specific to their job responsibilities.

Training is considered a condition of employment and failure to comply will result in disciplinary action up to and including termination.

B. MSHN Provider Network

The MSHN Provider Network Committee will review and recommend a Regional Training Requirement to assure and provide consistent training requirements throughout the provider network. MSHN will monitor the provider network to ensure adherence to the identified training requirements. Where viable, MSHN will offer related compliance training and educational materials to the Provider Network. The Regional Training Requirements are available on MSHN's website.

X. COMMUNICATION

Open lines of communication between the MSHN Compliance Officer, the CMHSP Participant/SUD Provider Compliance Officer(s) and CMHSP Participant/SUD Provider staff within the region are essential to the successful implementation of the Compliance Plan and the reduction of any potential for fraud or abuse. Methods for maintaining open lines of communication may include, but not be limited to the following:

- There shall be access to the MSHN Compliance Officer for clarification on specific standards, policies, procedures, or other compliance related questions that may arise on a day-to-day basis.
- Access to a dedicated toll-free compliance line that allows for anonymous reporting
- Utilization of interpreter as needed/requested.
- Information will be shared regarding the results of internal and external audits, reviews, and site visits, utilization data, performance and quality data, and other information that may facilitate understanding of regulations, and the importance of compliance.
- Information may be communicated through a variety of methods such as formal trainings, e-mails, newsletters, intranet resource pages, or other methods identified that facilitate access to compliance related information as a preventative means to reduce the potential for fraud and abuse.
- Compliance contact information shall be available to stakeholders through a variety of methods such as the MSHN & CMHSP Participants/SUD Provider customer service handbook, websites, posters, and/or other methods (or processes) identified consistent with standards associated with MSHN Policies.

XI. MONITORING AND AUDITING

Monitoring and auditing of MSHN's operations is key to ensuring compliance and adherence to policies and procedures and contractual requirements. Monitoring and auditing can also identify areas of potential risk and those areas where additional education and training is required. Results of the below activities will be communicated through the appropriate council/committee and summarized results will be provided to the Operations Council, MSHN Corporate Compliance Committee, MSHN Regional Compliance Committee and MSHN Board of Directors through the Annual Compliance Report.

The compliance program will be evaluated, no less than annually, for overall effectiveness.

MSHN shall assure the provision and adequacy of the following monitoring and auditing activities:

Financial and Billing Integrity

- An independent audit of financial records each year;
- An independent compliance examination in accordance with the MDHHS guidelines (if applicable);

- Contractual providers have signed contracts and adhere to the contract requirements;
- Fiscal Monitoring reviews for all SUD providers
- Explanation of benefits (annually to 5% of the consumers receiving services)
- Medicaid Event Verification Reviews

Information Systems Reliability and Integrity

- MSHN Information System employees and Provider Network staff monitor the reliability and integrity of the information system and data;
- Assure appropriate security and system backup and recovery processes are inplace to address loss of information and that provide sufficient disaster recovery plans; and
- MSHN employees and Provider Network staff are trained on use of information systems and provided access based on role and job function.

Clinical/Quality of Care

- Performance indicators are monitored and reviewed in an effort to continually improve timeliness and access to services;
- MSHN employees are evaluated in writing on their performance and are provided with detailed job descriptions;
- MSHN employees are hired through a detailed pre-employment screening and hiring process and complete a comprehensive orientation program;
- Assuring qualification and competency of organizational and practitioner credentialing and privileging directly operated by or under sub-contract with the Provider Network;

Consumer Rights and Protections

- Rights complaints and issues are reviewed and investigations are completed as required;
- MSHN shall ensure that the Provider Network has a designated individual (Recipient Rights Officer or Advisor) and that the responsibilities of the Recipient Rights Office are completed in accordance with state and federal requirements.
- Risk events and incident reports are completed, reported and follow up action is taken as needed
- A root cause analysis is completed on each sentinel event reported as defined in MDHHS contract.

Environmental Risks

- Comprehensive maintenance reviews of facilities and equipment are completed as required;
- Accommodations are provided in accordance with the Americans with Disabilities Act (ADA);
- Privacy reviews of facility/office are completed;
- Ensure appropriate environmental licensures; and
- Initial and ongoing education on health, safety, and emergency issues are provided.

Quality and Utilization Reviews

- Review of delegated managed care functions (as identified in the MSHN/CMHSP Medicaid Subcontract);
- Review of SUD Provider Network in accordance with contracted functions
- Review of adherence and compliance with Quality Assessment and Performance Improvement Program (QAPIP) Plan; and
- Review of adherence and compliance with the Utilization Management (UM) Plan.

Additional Internal Monitoring and Auditing Activities

- Assessment of initial capacity and competency to perform delegated PIHP functions;
- Consumer Satisfaction Surveys;
- Review of MSHN contracts for administrative services;
- Contract Expense Monitoring;

- Monitor capacity and demand for services in the PIHP region through the Assuring Network Adequacy Report
- Review of Policies and Procedures for any needed revisions or development of new ones
- Questionnaires to poll staff and the provider network regarding compliance matters including effectiveness of training/education and related policies and procedures
- Questionnaire for exiting employee regarding any observed violations of the compliance program, including the code of conduct, was well as violations of applicable statutes, regulations, and Medicaid program requirements.

Additional External Monitoring and Auditing Activities:

- External Quality Reviews
- CMS Site Visits
- MDHHS Site Visits
- Accreditation Surveys

Data Mining Activities:

Methods may include, but not limited to, ~~Utilize~~ statistical models, complex algorithms, and pattern recognition programs to detect possible fraudulent or abusive practices.

XII. REPORTING AND INVESTIGATIONS

MSHN will have a distinct unit that has adequate staffing and resources to investigate incidents and develop and implement corrective action plans to assist in preventing and detecting potential fraud, waste and abuse activities.

A. Reporting of Suspected Violations and/or Misconduct

MSHN shall maintain a reporting system that provides a clear process and guidelines for reporting potential offenses or issues.

MSHN board members, employees, contractual providers, consumers, and others are to report suspected violations or misconduct to the MSHN Compliance Officer or the appropriate CMHSP Participant/SUD Provider Compliance Officer and/or designee as outlined below. Suspected violations or misconduct may be reported by phone/voicemail, email, in person, or in writing (mail delivery). See **Attachment D** for contact information.

MSHN employees, consumers, contractual providers, and CMHSP Participant/SUD Provider staff who make good faith reports of violations of federal or state law are protected by state and federal whistleblower statutes, which includes protections from disciplinary actions such as demotions, suspension, threats, harassment or other discriminatory actions against the employee by the employer.

Violations Involving Suspected Fraud, Waste or Abuse:

- MSHN board members, employees, contractual providers and the provider network will report all suspected fraud, waste, and abuse to the MSHN Compliance Officer. The report will be submitted in writing utilizing the Office of Inspector General (OIG) Fraud Referral Form.
- The MSHN Compliance Officer will complete a preliminary investigation, as needed, to determine if a suspicion of fraud exists. Questions regarding whether suspicions should be classified as fraud, waste or abuse will be directed to MDHHS-OIG prior to referral.
- If there is suspicion of fraud, and an overpayment of $5,000 or greater is identified, the MSHN Compliance Officer will report the suspected fraud to the MDHHS Office of Inspector General and the Attorney General – Health Care Fraud Division (AG-HCFD) using the OIG Fraud Referral Form using the designated secure File Transfer Process

(sFTP) for each entity.

- The MSHN Compliance Officer will inform the appropriate provider network member when a report is made to the MDHHS Office of Inspector General.
- MSHN Compliance Officer and provider network member staff will present the fraud referral case to the OIG and the AG-HCFD.
- MSHN Compliance Officer will defend potential credible allegation of fraud in any appeal should the referral result in suspension issued by the MDHHS OIG.
- MSHN will cease all efforts to take adverse action against or collect overpayments from the provider until authorized by the MDHHS OIG and follow the guidance/direction provided by the MDHHS Office of Inspector General regarding investigation and/or other required follow up.
- To the extent consistenbt with applicable law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code,MSHN and the provider network will cooperate fully with investigations or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation must include providing, upon request, information, access to records, and access to interview employees and consultants, including but not limited to those with expertise in administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation or prosecution. MSHN will follow the procedures and examples contained within the processes and associated guidance provided by MDHHS-OIG.
- Overpayments due to fraud, waste, or abuse must be reported to MDHHS-OIG.
    1. If MSHN identifies an overpayment involving potential fraud prior to identification by MDHHS-OIG, the findings will be referred to MDHHS-OIG and MSHN will wait for further instruction from MDHHS-OIG prior to recovering the overpayment.
    2. If MSHN identifies an overpayment involving ~~due to~~ fraud, waste, or abuse prior to identification by MDHHS- OIG, MSHN will void or correct applicable encounters, recover the overpayment, and report the overpayment on the quarterly report to OIG.
- If MSHN's provider network identifies an overpayment, they will:
    1. Notify the contracted entity, in writing, of the reason for the overpayment and the date the overpayment was identified.
    2. Return the overpayment to the contracted entity within 60 days of the date the overpayment was identified.
    3. MSHN will include a provision in all contracts with subcontractors and/or network providers giving MSHN the right to recover overpayments directly from providers for the post payment evaluations initiated and performed. These overpayment provisions do not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.
        - MSHN must specify:
            - The retention policies for the treatment of recoveries of all overpayments from the Contractor and/or Subcontractors to provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.
            - The process, timeframes, and documentation

required for reporting the recovery of all overpayments.

- The process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the Contractor and/or Subcontractor is not permitted to retain some or all recoveries of overpayments.

OIG Guidance for Violations over $5,000.00

When overpayments of $5,000.00 or greater or identified involving a potential credible allegation of fraud, this must be promptly referred to MDHHS-OIG and the Attorney General's Health Care Fraud Division (AG-HCFD using the MDHHS-OIG Fraud Referral Form. MSHN and the provider network will not take any of the following actions unless otherwise instructed by MDHHS-OIG.

- Contact the subject of the referral about any matters related to the referral.
- Enter into or attempt to negotiate any settlement or agreement regarding the referral with the subject of the referral; or
- Accept any monetary or other thing of valuable consideration offered by the subject of the referral in connection with the findings/overpayment.

If the State makes a recovery from an investigation and/or corresponding legal action where Contractor has sustained a documented loss, the State shall not be obligated to repay any monies recovered to the Contractor.

When MDHHS-OIG sanctions (suspends and/or terminates from the Medicaid Program) providers, including for credible allegations of fraud 42 CFR § 455.23, the Contractor must, at

minimum, apply the same sanction to the provider upon receipt of written notification of the sanction from MDHHS-OIG. The Contractor may pursue additional measures/remedies independent of the State. If MDHHS OIG lifts a sanction, the Contractor may elect to do the same.

Suspected Violations (NOT Involving Fraud, Waste, or Abuse) and/or Misconduct:

- MSHN employees will report all suspected violations or misconduct (not involving suspected fraud or abuse) directly to the MSHN Compliance Officer for investigation. If the suspected violation involves the MSHN Compliance Officer, the report will be made to the MSHN Chief Executive Officer. Information provided shall at a minimum include the following:
    1. Provider Information, if applicable (Name, Address, Phone Number, NPI Number, Email)
    2. Complainant Information (Name, Address, Phone Number, NPI number [if applicable], Medicaid ID # [if applicable], Email)
    3. Consumer Information, if applicable (Name, Address, Phone Number, Email)
    4. Summary of the violation and/or misconduct
    5. Date(s) of the violation and/or misconduct
    6. Supporting documentation, if any (i.e. claims data, audit findings, etc.)
    7. Action, if any, taken prior to submitting the violation
- Any suspected violations regarding the MSHN Chief Executive Officer will be reported to the MSHN Compliance Officer and/or the MSHN Board Chairperson/Executive Committee for investigation.
- CMHSP Participant/SUD Provider staff with firsthand knowledge of activities or omissions that may violate applicable laws and regulations (not involving suspected fraud or abuse) are required to report such wrongdoing to the MSHN Compliance Officer or to the CMHSP Participant/SUD Provider Compliance Officer. The CMHSP Participant/SUD Provider Compliance Officer will review reported violations to determine the need to report to the MSHN Compliance Officer. The review will be based on but not limited to: external party involvement, Medicaid recipient services, practices and/or system-wide process applicability.
- The Provider Network (CEO)/Executive Director(ED) and/or designee, shall inform, in writing, the MSHN Chief Executive Officer (CEO) of any material notice to, inquiry from, or investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory (excluding Recipient Rights related to non-PIHP activities), prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of a recipient of Medicaid services. The Provider Network CEO/ED shall inform, in writing, the MSHN CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.
- Reports of suspected violations or misconduct may be made on a confidential basis to the extent possible.

B. Process for Investigation

All reports involving suspected fraud, waste and abuse will follow the guidance/direction of the MDHHS Office of Inspector General for any required investigation.

All reports of suspected wrongdoing shall be investigated promptly following the process outlined in the MSHN Compliance Investigation Procedure. “Prompt response” is defined as action taken within 15 business days of receipt by the PIHP of the information regarding a potential compliance problem.

The investigation process and outcome will be documented and will be reported on the OIG Quarterly Program Integrity Report.

In conducting the investigation, judgment shall be exercised, and consideration shall be given to the scope and materiality consistent with the nature of the concern. Each investigation must be carefully documented to include a report describing the disclosures, the investigative process, the conclusions reached and the recommended corrective action, when such is necessary. No one involved in the process of receiving and investigating reports shall communicate any information about a report or investigation, including the fact that a report has been received or an investigation is ongoing, to anyone within MSHN who is not involved in the investigation process or to anyone outside of MSHN without the prior approval of the MSHN Compliance Officer. All MSHN employees, Provider Network staff and subcontractors are expected to cooperate fully with investigation efforts.

The MSHN Compliance Officer and the CMHSP Participant/SUD Provider Compliance Officers must report any conflict of interest that may exist when investigating a report of suspected wrongdoing or misconduct. If a conflict of interest does exist, the MSHN Compliance Officer will be responsible for securing an appropriate source to complete the investigation, which may include utilizing the MSHN Compliance Officer, one of the Provider Network Compliance Officers or an external source if necessary.

XIII. Corrective Actions/Prevention/Disciplinary Guidelines

Where an internal investigation substantiates a reported violation, corrective action will be initiated as identified within MSHN policies and procedures and the MSHN subcontracts with the CMHSP Participant/SUD Providers including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, the provision of a corrective action plan from the designated Provider Network member (as necessary) including follow-up monitoring of adequate implementation, and implementing system changes to prevent a similar violation from recurring in the future.

Corrective Action Plans should minimally include the following description:

- How the issue(s) identified will be immediately corrected, or the reason why it cannot be immediately corrected.
- Steps taken to prevent further occurrences
- Process for monitoring to ensure implementation and effectiveness of corrective action plan

In all cases, disciplinary action must be applied on a case-by-case basis and in a consistent manner.

Depending on the seriousness of the offense, the resulting action for MSHN staff could include additional training, written reprimand, suspension or termination of employment. The resulting action for the provider network would also depend on the seriousness of the offense and could include additional training, letter of contract non-compliance and termination of contract. Failure by Board Members to adhere to the requirements in the Compliance Plan will be addressed in accordance with the MSHN By-Laws.

XIV. Submission of Program Integrity Activities/Report

The PIHP, and the provider network will log and track all program integrity activities performed. The provider network will utilize the MDHHS OIG Quarterly Program Integrity Report template to report quarterly to the PIHP. The PIHP will report the program integrity activities to the MDHHS Office of Inspector General, according to Schedule E requirements, using the provided template.

The PIHP will submit to MDHHS-OIG an annual Program Integrity Report containing details of the improper payments identified, overpayments recovered, and costs avoided for the program integrity activities conducted by the Contractor for the preceding year. The report will also address the plan of activities for the current and upcoming fiscal year and all provider and service-specific program integrity activities. The report will include an attestation confirming compliance with the requirements found in 42 CFR 438.608 and 42 CFR 438.610.

The PIHP will submit to MDHHS-OIG an annual Compliance Program Crosswalk which includes completion of the MDHHS-OIG report template in addition to policies, procedures, and other documentation related to the standards on the report template.

XV. Communication of Requirements

The PIHP will issue a contract, Provider Manual, Bulletins, and/or other means of communication to the provider network regarding services covered under contract. This communication will serve as a source of information for providers regarding Medicaid covered services, policies and procedures, statutes, regulations, and special requirements.

The communication will provide all Providers with, at a minimum, the following information:

- Description of the Michigan Medicaid managed care program and covered populations;
- Scope of Benefits;
- Covered Services;
- Emergency services responsibilities;
- Grievance/appeal procedures for both Enrollee and Provider;
- Medical necessity standards and clinical practice guidelines;
- Policies and procedures including, at a minimum, the following information:
    - Policies regarding provider enrollment and participation;
    - Policies detailing coverage and limits for all covered services;
    - Policies and instructions for billing and reimbursement for all covered services;
    - Policies regarding record retention;
    - Policies regarding Fraud, Waste and Abuse;
    - Policies and instructions regarding how to verify beneficiary eligibility;
- Primary Care Physician responsibilities;
- Requirements regarding background checks;
- Other Subcontractors'/Network Providers' responsibilities;
- Prior authorization and referral procedures;
- Claims submission protocols and standards, including instructions and all information necessary for a clean claim;
- Medical records standards;
- Payment policies;
- Enrollee rights and responsibilities.
- Self-reporting mechanisms and polices.

The Provider Manual, Bulletins and all Provider policies and procedures will be reviewed at least annually to ensure that current practices and contract requirements are reflected in the written policies and procedures.

XVI. References, Legal Authority and Supporting Documents

1. Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans, Medicaid Alliance for Program Safeguards, May 2002
   https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf

2. Anti-kickback Statute (section 1128B[b] of the Social Security Act)
   http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm
   https://oig.hhs.gov/compliance/safe-harbor-regulations
   https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

3. False Claims Act
   https://oig.hhs.gov/fraud
   http://www.legislature.mi.gov
   https://www.justice.gov/civil/false-claims-act

4. 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005)
   https://www.cms.gov/regulations-and-guidance/legislation/deficitreductionact/downloads/guide.pdf

5. Michigan Mental Health Code
   http://www.legislature.mi.gov/(S(alilhmd3eeauncuk5s0ey4hu))/mileg.aspx?page=GetObject&objectname=mcl-Act-258-of-1974

6. Department of Health and Human Services, Office of Inspector General
   https://oig.hhs.gov

7. Michigan Public Health Code
   http://www.legislature.mi.gov/documents/mcl/pdf/mcl-act-368-of-1978.pdf

8. Code of Federal Regulations (Title 42, Part 2 and Title 45, Part 160 & 164)
   http://www.ecfr.gov/cgi-bin/ECFR?page=browse

ATTACHMENT A

MSHN's Policies and Procedures can be found at the following link:

https://midstatehealthnetwork.org/provider-network-resources/provider-requirements/policies-procedures/policies

Policy and Procedure Categories Include:

Compliance

Customer Service

Finance

General Management

Human Resources

Information Technology

Provider Network

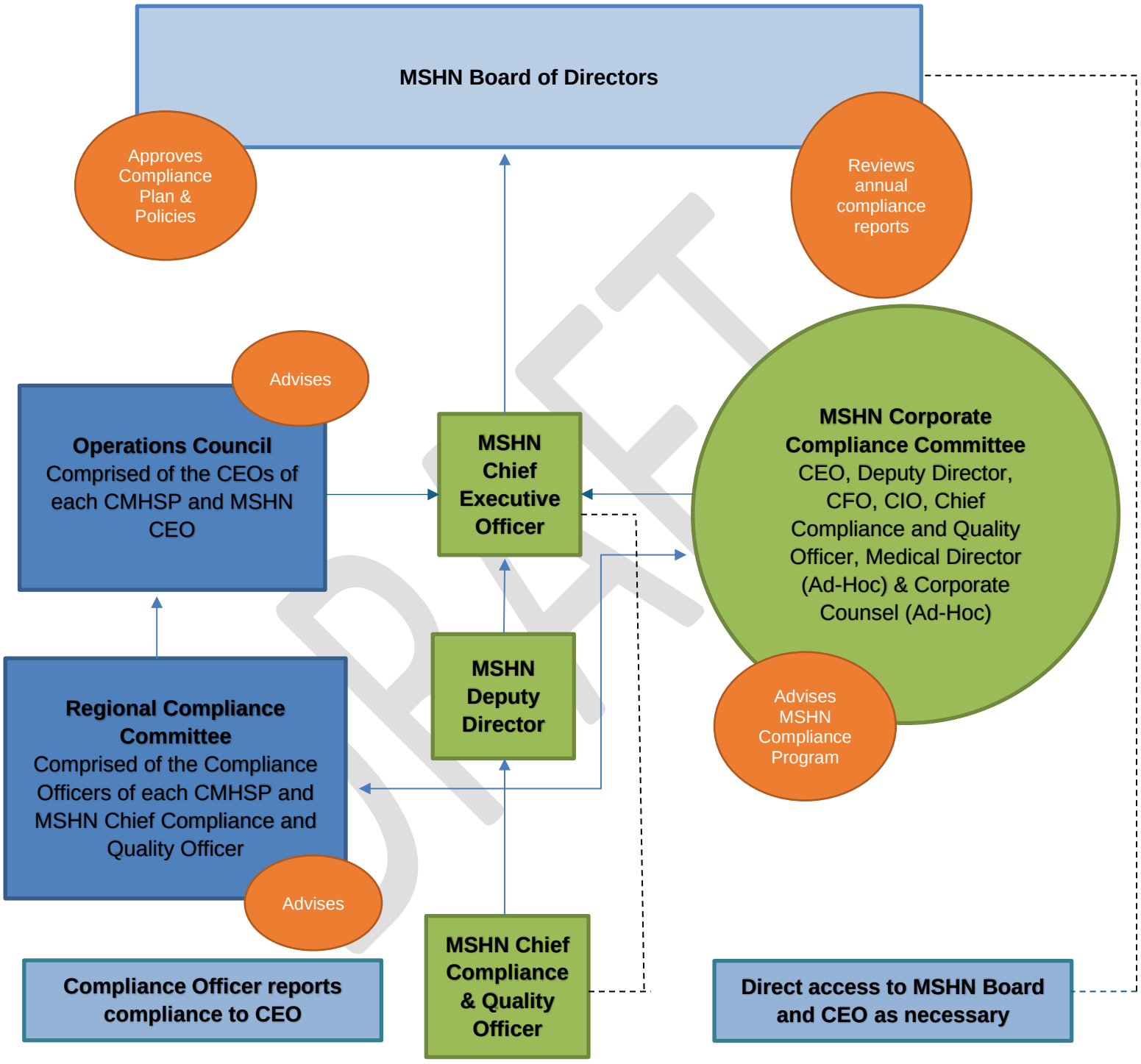
Quality

Service Delivery System

Utilization Management

Attachment B

Mid-State Health Network Compliance Process/Governance



ATTACHMENT C

MSHN Compliance Officer in coordination with the MSHN Corporate Compliance Committee and the Regional Compliance Committee shall focus its efforts on overseeing compliance in the below key areas as identified and prioritized:

Area of Focus	Task
~~Credentialing and Provider Qualifications~~ Compliance with established Compliance and Program Integrity related standards.	~~Implement processes and monitoring to ensure compliance with statecontract requirements~~ 1) Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies region wide. 2) Identify additional region wide data mining activities to detect possible deficiencies and/or non-compliance with established standards. 3) Develop training opportunities to promote compliance with state and federal requirements.
~~Remote Work Environment~~ Delegated Managed Care Reviews	~~Review process for Home Office/Off Site Office security and privacy of protected health information to ensure compliance with established standards.~~ 1) CMHSP standards: MSHN Behavioral Health team, and the corresponding workgroups, will address and identify ways in which the region can improve compliance in areas that are continually below the established standards or expectations 2) SUD Standards: MSHN will incorporate training topics into the Lunch and Learn training series provided quarterly to the provider network and focus on areas that fall below 80% compliance. This will be coordinated with the MSHN SUD Treatment team as they facilitate the trainings.
~~Compliance Training Requirements~~ Compliance with external quality review requirements (Health Services Advisory Group (HSAG) – Performance Measure Validation Review)	~~Develop/review training to promote compliance with state and federal requirements~~1) MSHN will perform additional spot checks prior to submitting data to HSAG to ensure that the cases meet eligibility requirements. 2) A causal/barrier analysis will be completed annually to ensure the barriers identified are reduced or eliminated, and to identify if any new barriers exist that require the development of interventions for both subgroups. The effectiveness of each intervention will be evaluated to determine if the interventions will continue, be revised, or discontinued based on the data reviewed.
~~HCBS Planning and implementation of changes~~	~~Review capacity, changes in waiver requirements and implementation to meet compliance~~
~~OHH, BHH, CCBHC, 1915i~~ Substance Use Disorder (SUD) Access Department Implementation	~~Ensure new initiatives and PIHP responsibilities meet expected criteria and compliance with requirements.~~ New initiative – Monitor to ensure effectiveness and compliance with identified standards.

ATTACHMENT D

MID-STATE HEALTH NETWORK

COMPLIANCE OFFICER CONTACT INFORMATION

PIHP Compliance Officer:

Mid-State Health Network	Kim Zimmerman, 517-657-3018, kim.zimmerman@midstatehealthnetwork.org

CMHSP Compliance Officers (or designee):

Bay Arenac Behavioral Health,	Karen Amon, 989-895-2214, kamon@babha.org
CMH for Central Michigan,	~~Kara Laferty, 989.772.5938, klaferty@cmhcm.org~~ Renee Raushi, 989.772.5938, rraushi@CMHCM.org
Clinton, Eaton, Ingham CMH,	~~Jessica Scutt, 517.237.7115, compliance@ceicmh.org~~ Emily Ryan, 517-346-8193, ryane@ceicmh.org
Gratiot County CMH,	Pam Fachting, 989.466.4143, pfachting@gihn-mi.gov
Huron Behavioral Health,	Levi Zagorski, 989.269.9293, levi@huroncmh.org
The Right Door,	Susan Richards, 616.527.1790, srichards@rightdoor.org
LifeWays CMH,	Ken Berger, 517.789.2526, ken,berger@LifeWayscmh.org
Montcalm Care Network	Sally Culey, 989.831.7523, sculey@montcalmcare.net
Newaygo CMH,	Andrea Fletcher, 231.689.7542, afletcher@newaygocmh.org
Saginaw County CMH,	AmyLou Douglas, 989-797-3506 amylou.douglas@sccmha.org
Shiawassee County CMH,	Vickey Hoffman, 989-723-0757, vhoffman@shiabewell.org
Tuscola Behavioral Health Systems	Julie Majeske, 989-673-6191, jmajeske@tbhs.net

A complete listing of SUD Providers, with contact information, is located on the MSHN website at the following link: https://midstatehealthnetwork.org/provider-network-resources/provider-information/directory

MSHN Compliance Line: 1-844-793-1288
MDHHS Medicaid Fraud Hotline: 1.855.MI.FRAUD (643.7283)
HHS/OIG Hotline: 1.800.HHS.TIPS (447.8477)

Executive Summary - Annual Compliance Report 2024

Background

The Annual Compliance Report provides an overview of the effectiveness of activities performed throughout Fiscal Year 2024.

Summary Recommendations for FY2025

Summary recommendations for FY2025 include areas identified via findings from internal and external monitoring and oversight site reviews, and feedback received from Customer Service Complaints.

2025 Recommendations Include:

- Review methods of assessing risks for detection of fraud and abuse for potential improvements and efficiencies region wide.
- Focus on implementation of corrective action plans related to external quality review results.
- Increase Performance Improvement Project performance results
- Provide additional training related to areas identified above

Summary of Activities Completed in FY2024

2024 Completed activities included:

- Reviewed grievance and appeal quarterly data to improve compliance with Customer service standards
- Provided education on new compliance and program integrity standards and implemented a new tracking and monitoring system
- Updated compliance policies and procedures to include new program integrity contract language
- Implemented region wide quality improvement efforts for standards with ongoing lower compliance scores
- Implemented corrective action to ensure compliance with external quality review results from prior years
- Reviewed standards with ongoing lower compliance scores to determine if region-wide quality improvement efforts were needed

Summary of CMHSP Reviews

FY24 was Year 1 of MSHN 3-year review cycle that included Administrative Standards, Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP), Serious Emotional Disturbance Waiver (SEDW) and iSPA.

Delegated Managed Care Review Results

MDHHS Review	# of Standards FY23	2023 Results	# Of Standards	2024 Results
Administrative Standards	220	94.82%	24	100%
HSW	62	93.47%	19	74.27%
CWP	73	93.47%	23	78%
SEDW	73	93.47%	22	73%
iSPA	N/A	N/A	20	88%

Summary of SUDSP Treatment Reviews

During FY2024, both full and interim reviews were completed. There were eight (8) full reviews and 16 (sixteen) interim reviews from October 1, 2023 – September 30, 2024.

Review	# Of Standards	2023 Results	2024 Results
Delegated Functions	98	92%	94%
Program Specific	15	67.6%	90.54%
Chart Review	44	65%	67%

Summary results on Medicaid Event Verification Reviews

The attributes tested during the Medicaid Event Verification (MEV) review include A.) The code is allowable service code under the contract, B.) Beneficiary is eligible on the date of service, C.) Service is included in the beneficiary's individual plan of service, D.) Documentation of the service date and time matches the claim date and time of the service, E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed, F.) Amount billed/paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

The CMHSP reviews are completed bi-annually (twice a year) for all twelve (12) CMHSPs. The SUD reviews include all SUD providers.

	A	B	C	D	E	F	G
CMHSP	99.55%	99.73%	97.05%	98.13%	88.01%	97.99%	91.60%
SUD Providers	99.81%	100%	93.35%	95.90%	95.82%	98.86%	85.65%

Summary Results on External Reviews

MDHHS Waiver Review

The Michigan Department of Health and Human Services (MDHHS) conducted a full review for our region May – July 2024. MDHHS reviewed 149 clinical records and a total of 868 staff files (236 professional staff and 632 aide-level staff).

Results/Trends

HSW

Of the Twenty-five (25) measures reviewed related to charts the following trends were identified by MDHHS:

- Increase in compliance: 2 measures
- Maintained Compliance: 5 measures
- Decreased Compliance: 9 Measures

CWP

Of the Twenty-seven (27) measures reviewed related to charts/files, the following trends were identified by MDHHS:

- Increase in compliance: 7 measures

- Maintained Compliance: 5 measures
- Decreased Compliance: 3 Measures

SEDW

Of the Twenty-five (25) measures reviewed related to charts/files, the following trends were identified by MDHHS:

- Increase in compliance: 7 measures
- Maintained Compliance: 3 measures
- Decreased Compliance: 4 Measures

iSPA

2024 was the first year that iSPA was reviewed. MSHN received an overall compliance score of 84%.

The Waiver reviews result in specific individual case follow up at the local level and regional policy/systemic changes as appropriate.

MDHHS- Health Services Advisory Group (HSAG): Performance Measurement Validation Review

HSAG validated a set of performance indicators that were developed and selected by the Michigan Department of Health and Human Services (MDHHS).

Results/Trends

MSHN received a status of "Reportable" indicating the performance indicators were compliant with the State's specifications and the rate can be reported.

- Data Integration and Control- Thirteen Standards: 100%
- Denominator Validation - Seven Standards (2 NA): 100%
- Numerator Validation – Five Standards: 100%
- Performance Measures- Fourteen Measures Fully Validated: 100%

MDHHS- Health Services Advisory Group (HSAG): Compliance Monitoring Review

The Compliance Site Review is conducted over a period of three (3) years and includes a review of thirteen (13) different standards.

Results/Trends

MSHN achieved an overall compliance score of 85%.
Standard I – Member Rights and Member Information: 76%
Standard III – Availability of Services: 100%
Standard IV- Assurances of Adequate Capacity and Services: 100%
Standard V- Coordination and Continuity of Care: 93%
Standard VI – Coverage and Authorization of Services: 68%

MDHHS- Health Services Advisory Group (HSAG): Performance Improvement Project

MSHN's Performance Improvement Project for 2022 through 2025 is: *Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population without a decline in performance for the white population.*

- The remeasurement 1 data for 01/01/2023 through 12/31/2023 was 59.70% for the percentage of new persons who are Black/African- American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

- The remeasurement 1 data for 01/01/2023 through 12/31/2023 was 63.00% for the percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

Results/Trends

Validation Rating: Design and Implementation

- Percentage of Evaluation Elements Met: 100%
- Percentage of Critical Elements Met: 100%
- MSHN Validation resulted in a *High Confidence* rating.

MSHN met 100 percent of the requirements for the data analysis and implementation of improvement strategies. MSHN used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers. Timely interventions were implemented and were reasonably linked to the corresponding barriers.

Validation Rating: Outcomes

- Percentage of Evaluation Elements Met: 33%
- Percentage of Critical Elements Met: 100%
- MSHN Validation resulted in a *No Confidence* rating.

MSHN did not demonstrate statistically significant improvement over the baseline performance for the disparate subgroup (Black/African American population). The PIHP did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups without a decline in performance for the comparison subgroup (White population) with the first remeasurement period.

Summary Results on Customer Service and Compliance Reporting

The total number of Customer Services contacts received in FY2024 was 115, a 25.8% decrease from FY2023. By comparison, there were 155 contacts in FY2023.

Results/Trends

The following trends/changes were noted during FY2024:

- Overall Customer Service contacts decreased by 26% in FY2024 (115) from FY2023 (155).
- Consumer contacts requiring follow-up action decreased by 39% from 75 in FY2023 to 46 of Consumer contacts in FY2024.
- The highest number of consumer-based customer service complaints originated from Consumers themselves (25% / n=29) and MDHHS (9% / n=10).
- The highest number of non-consumer customer service contacts originated from CMHSP staff (24% / n=28)
- The highest consumer complaint categories addressed Access to Treatment (23% / n=26) and Complaint/Dissatisfaction (14% / n=16). Access to Treatment was a 29% decrease in FY24 (n=29) over FY23 (41). Complaint/Dissatisfaction saw a 30% decrease in FY24 (n=16) over FY23 (n=23).
- The highest non-consumer contact category involved requests for General Assistance (23% / n=26)

Compliance Reporting

The total number of compliance investigations completed by the MSHN Compliance Officer in FY2024 was 32. By comparison, there were 26 completed in FY2023. This resulted in an increase of 23.07% in FY2024 from FY2023.

Compliance investigations:

- There was an increase in the total number of compliance issues reported during FY2024
- Suspected Fraud/Waste/Abuse continues to be the highest reported category at 56.25%.
- Twenty-seven (27) investigations were completed and achieved a closed status.

- Five (5) investigation is still pending closure by the OIG.

OIG quarterly report:

- FY2024 had a slight decrease in the number of reported activities from FY2023.
- The largest number of findings reported include the following:
    - Lack of documentation to support the claims submitted
    - Use of incorrect modifiers or lack of modifiers
    - Duplicated claims/Overlapping claims
    - Services not provided as billed

Subpoenas:

- There was a slight decrease in the number of subpoenas received during FY2024, but the increase was not notable.
- No subpoenas required action as they were not for clients served by MSHN or for the identified timeframe of the request.

Breaches:

- There was a slight decrease in the number of privacy breaches from FY2023 to FY2024.
- In all instances, the cases were remediated following MSHN's breach notification policy.

MSHN

Mid-State Health Network

Annual Compliance Summary Report

October 2023 – September 2024

Prepared By: MSHN Compliance Officer/Compliance Administrator – November 2024
Approved By: MSHN Compliance Committee – January 15, 2025
Reviewed By: Regional Compliance Committee – January 17, 2025
Operations Council –
MSHN Board –

Table of Contents

Introduction

The Compliance Summary Report provides an overview of the effectiveness of activities performed throughout Fiscal Year 2024 as part of the MSHN Compliance Program and identified within the MSHN Compliance Plan. Those activities include internal and external monitoring and oversight reviews; customer service complaints; compliance investigations and compliance related training and review.

Each section includes an overview of activity results, trends, and analysis of the data. Recommendations for areas of quality improvement for the upcoming year are identified.

Recommendations for FY2025

Recommendation focus areas are identified from the MSHN Compliance Plan tasks and activities related to the MSHN strategic plan that are supported by findings and outcomes from internal and external monitoring and oversight site reviews, and contractual requirements and issues identified through the Customer Service and Compliance System.
Note: If there is already an established process in place for monitoring and oversight where a deficiency was noted, recommendations were not made to avoid duplication of efforts.

Area of Risk: Compliance with established Compliance and Program Integrity related standards.

Recommendation: Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies region wide.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Area of Risk: Delegated Managed Care Reviews

Recommendation: CMHSP standards: MSHN Behavioral Health team, and the corresponding workgroups, will address and identify ways in which the region can improve compliance in areas that are continually below the established standards or expectations.

Lead Staff: Amy Dillon, Compliance Administrator

Recommendation: SUD Standards: MSHN will incorporate training topics into the Lunch and Learn training series provided quarterly to the provider network and focus on areas that fall below 80% compliance. This will be coordinated with the MSHN SUD Treatment team as they facilitate the trainings.

Lead Staff: Amy Dillon, Compliance Administrator.

Area of Risk: Compliance with external quality review requirements (Health Services Advisory Group (HSAG – Performance Measure Validation Review and Performance Improvement Project)

Recommendation: MSHN will perform additional spot checks prior to submitting data to HSAG to ensure that the cases meet eligibility requirements.

Lead Staff: Kara Laferty, Quality Manager

Recommendation: A causal/barrier analysis will be completed annually to ensure the barriers identified are reduced or eliminated, and to identify if any new barriers exist that require the development of interventions for both subgroups. The effectiveness of each intervention will be evaluated to determine if the interventions will continue, be revised, or discontinued based on the data reviewed.

Lead Staff: Kara Laferty, Quality Manager

The following recommendations were identified for FY2024 and are being continued for FY2025. Progress has been made, but the recommendations have not been fully implemented.

Area of Risk: Compliance with established Compliance and Program Integrity related standards.

Recommendation: Identify additional region-wide data mining activities to detect possible deficiencies and/or non-compliance with established standards.

Status: Data mining activities have been explored with the Chief Information Officer. Activities explored included:

- Monitoring ABA services for over 21 years of age - This did not result in a data mining activity, but did result in adding an edit that is being tracked through REMI to ensure compliance.
- Monitor ABA supervision – This includes the 97156 code which includes more than just behavior technician services – would need to ensure correct use of codes prior to proceeding with this as a data mining activity
- Discussed potential for reviewing duplicate billing for health homes (such as targeted case management) – more discussion needs to happen on this before proceeding

The Chief Compliance and Quality Officer also received information from the other PIHP Compliance Officers as to what data mining activities they are completing. Due to the system requirements within MSHN's information management system, many of the activities recommended by the Office of Inspector General are not necessary. This will continue to be explored internally to identify potential data mining activities.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Recommendation: Develop training opportunities to promote compliance with state and federal requirements.

Status: Training opportunities have been explored with the Regional Compliance Committee and the PIHP Compliance Officers workgroup. The RELIAS training is in the process of being updated and the Office of Inspector General has been consulted on potential trainings for the completion of compliance investigations. In addition, the new compliance software vendor will also offer trainings related to compliance with State and Federal requirements. This will continue to be explored during FY2025.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Status of FY2024 Recommendations

The following is a status update on the FY2024 areas of risk and progress made toward implementing the recommendations. These recommendations are considered complete. Any recommendations that were not completed have been moved to the FY2025 Recommendations section for continuation.

Area of Risk: Compliance with established Customer Service standards.

Recommendation: Implement quality improvement initiatives based on data from the quarterly Appeal and Grievance Regional Analysis Report.

Status: Complete. The MSHN Customer Service Committee (CSC) has reviewed the quarterly reporting of the Appeal and Grievance Regional Analysis Report to track and trend the data. Any CMHSP that did not meet the timeliness requirements for the Appeal and/or Grievance

report is required to complete a plan of correction to evaluate the factors that led to the non-compliance and to provide a plan to mitigate future timeliness issues.

Lead Staff: Dan Dedloff, Customer Service and Rights Manager

Area of Risk: Compliance with established Customer Service standards.

Recommendation: Develop a process to gather data related to limited English proficiency (LEP) from local county analysis for the prevalence of non-English languages and monitor compliance with LEP standards.

Status: The MSHN CSC members have worked together to clarify the expectation for each CMHSP to capture data related to limited English proficiency (LEP) for local county analysis regarding the prevalence of non-English languages and monitoring compliance with LEP standards. MCL Public Act 241 of 2023 went into effect in February 2024 and established a biennial reporting requirement to monitor compliance with LEP standards. This will continue to be monitored for compliance if this becomes part of the PIHP/MDHHS Contract. Compliance with LEP standards is also monitored as part of the Network Adequacy Assessment. This will not continue as a recommendation but will be reviewed periodically during the Regional Customer Service Committee meeting.

Lead Staff: Dan Dedloff, Customer Service and Rights Manager

Area of Risk: Compliance with established Compliance and Program Integrity related standards.

Recommendation: Utilize communication means such as newsletters, emails, website, etc. to provide updates and education to providers.

Status: Complete. These different forms of communication, as well as council/committee meetings, have been used to provide updates and education to providers. This recommendation is considered complete but will continue to occur as new information/education is available for the provider network.

Recommendation: Research options and implement a new process for tracking compliance investigations and documentation.

Status: Complete. Three vendors completed demonstrations for compliance software to appropriate MSHN staff, CMHSP Compliance Officers and PIHP Compliance Officers. A vendor has been chosen with input from MSHN staff and the CMHSP Compliance Officers. MSHN is in process of reviewing the contract and will then establish an implementation plan.

Recommendation: Update Compliance related policies and procedures and MSHN Compliance Plan to ensure compliance with new program integrity contract language.

Status: Complete. The Compliance related policies and procedures were updated to reflect changes in contract requirements and to ensure compliance with the review completed by the Office of Inspector General. The policies and procedures will continue to be updated as needed for future changes in contract requirements and the requirements of the Office of Inspector General.

Recommendation: Develop processes to track new OIG data requirements such as cost avoidance, recoupments, etc.

Status: Complete. A template has been developed to track data requirements for the provider network for FY2024. In addition, this information will be reviewed for inclusion into the

compliance software that MSHN is purchasing and implementing during FY2025.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Area of Risk: Delegated Managed Care Site Reviews

Recommendation: Review standards that have ongoing lower compliance scores to determine if region-wide quality improvement efforts are needed as well as provider education.

Status: Complete. The QAPI team has established a process to share the results of reviews with internal departments. This process includes bi-monthly coordination meetings, sharing results and recommendations via the quarterly report, and participating and making recommendations in Lunch and Learn trainings hosted by MSHN for the provider network. QAPI provides an annual report of scores and trends over the years to the MSHN SUD Treatment team which they use for determining their annual training plan for the provider network. QAPI continues to provide technical assistance with individual providers during the review process.

Lead Staff: Amy Dillon, Compliance Administrator

Area of Risk: Complete. Compliance with external quality review requirements (Health Services Advisory Group-Performance Measure Validation review).

Recommendation: MSHN will complete the proposed corrective action to review all abnormal disposition completed dates and times as part of its validation check.

Status: Complete. The corrective actions and incorporated improvement efforts as proposed by HSAG have been implemented.

Recommendation: MSHN will continue its efforts to meet with CMHSPs and provide further training when errors occur.

Status: Complete. Training occurs during monthly QIC meetings and as requested by CMHSPs. MSHN also provides additional training if needed after quarterly data analysis is completed.

Recommendation: MSHN will employ additional enhancements to the PIHP's validation process to ensure appropriate categorization of compliant cases and capture of exceptions.

Status: Complete. Additional validations, including primary source verification, have occurred at the local level to ensure accurate data submission.

Recommendation: MSHN will perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases for future reporting.

Status: Complete. Additional validations, including primary source verification, have occurred at the local level to ensure accurate data submission..

Lead Staff: Sandy Gettel, Quality Manager & Steve Grulke, Chief Information Officer

Area of Risk: Compliance with external quality review requirements (Health Services Advisory Group-Performance Improvement Project review).

Recommendation: MSHN should ensure that it follows the approved PIP methodology to calculate and report the remeasurement data accurately in next year's submission.

Status: Complete. The measure data has been reported accurately, consistent with the PIP methodology.

Recommendation: MSHN should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to identify if any new barriers exist that require the development of interventions.

Status: Complete. A causal factor analysis is completed annually.

Recommendation: MSHN should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.

Status: Complete. MSHN uses data to evaluate each intervention to determine if the interventions should be continued, revised or discontinued.

Lead Staff: Sandy Gettel, Quality Manager

Area of Risk: MSHN staff and provider network training/education on compliance regulations and rules.

Recommendation: Develop a compliance webpage on MSHN's website providing current information on healthcare rules and regulations, education on current trends of non-compliance as identified through internal and external site reviews and identification of trainings on compliance related activities. The webpage will be updated as new information is available, including links to information regarding high-risk areas such as the Deficit Reduction Act (DRA). Staff will also receive monthly compliance related education via email. The email will also include links to the compliance webpage.

Status: The webpage has not been completed. There continue to be discussions during the Regional Compliance Committee regarding the information that should be included on the webpage. There are numerous documents, templates and resources currently on the MSHN webpage, but will be organized into a format that is more easily accessible. This will be completed during this fiscal year.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Area of Risk: Compliance with Person Centered Planning standards defined in the MDHHS Person-Centered Planning (PCP) Practice Guideline, Delegated Managed Care site review and the MDHHS waiver site review.

Recommendation: PCP toolkit/training resource will be updated on a quarterly basis and made available to the provider network.

Status: A workgroup convened that included CMHSPs, PIHPs, MDHHS and TBD Solutions consulting firm and developed guidance documents for the PCP process. The MDHHS training document "IPOS Goal and Objective Writing" has been added to website and shared with the provider network. Weblink: https://midstatehealthnetwork.org/provider-network-resources/provider-resources-1/provider-trainings

In addition, the MDHHS/ARC conducted monthly trainings covering PCP which was shared with the regional training coordinators and regional waiver coordinators. Weblink: https://arcmi.org/projects/pcpqi/

Recommendation: MSHN will provide templates, formats and/or guidelines as identified through semi-annual review by CLC and QIC.

Status: The Clinical Leadership Committee and Quality Improvement Council have been consulted regarding MSHN providing templates, format, guidelines, etc. regarding PCP. While both groups remain receptive to having options provided, there have not been any identified. This can be reviewed with these groups as appropriate.

It is recommended that both of these recommendations be removed as an area of risk. Updates to the website will continue to be made when new trainings or resources are available,

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Monitoring and Auditing

Mid-State Health Network Provider Network Reviews

The following is a snapshot of the site review results for both the Community Mental Health Service Providers (CMHSP) and the Substance Use Disorder (SUD) Providers.

CMHSP Provider Delegated Managed Care Reviews

With the support and approval from the CMH Quality Improvement Council and Operation's Council, MSHN modified the Delegated Managed Care Review process beginning in FY24. The new process covers all required review sections, but rather than reviewing all in one year, the reviews are being conducted using a three-year review cycle. MSHN has aligned Delegated Managed Care reviews with external reviews (i.e. MDHHS, HSAG) when possible, which typically require CMHs provide duplicate documentation for each review. These changes were implemented to improve efficiencies, reduce duplication, and to ensure the review process is more manageable for CMHs. MSHN also changed the review cycle from calendar year to fiscal year.
FY24 was Year 1 of MSHN 3-year review cycle. The Year 1 review was conducted in alignment with the MDHHS Wavier review of MSHN Region 5. MSHN conducted waiver reviews for Bay-Arenac Behavioral Health, Community Mental Health for Central Michigan, Community Mental Health for Clinton, Eaton and Ingham Counties, Gratiot Integrated Health Network, Huron Behavioral Health, Lifeways Community Mental Health Authority, Montcalm Care Network, Newaygo County Mental Health Center, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door, and Tuscola Behavioral Health Systems. The review included Habilitation Supports Waiver (HSW), the Children's Waiver Program, the Children's Serious Emotional Disturbance Waiver (SEDW), and the 1915(i) State Plan Amendment (iSPA).

Delegated Managed Care Review Results

Five (5) different reviews tools were used which include a total of 105 standards. The focus of this section is to provide an overview of CMH compliance with programs and areas indicated below. The results for each review tool are provided below.
MSHN has also included the scores from the last full review of CMHs. Any sections FY24 results that indicated "N/A" were sections not included in the review for 2024.

2024 Administrative Standards (2023 Delegated Managed Care Tool)

Standards	# of Standards FY23	2023 Results	# Of Standards	2024 Results
Administrative (2023: Ensuring Health and Welfare)	16	97%	6	100%
Information/Customer Service	12	97%	N/A	N/A
24/7/365	18	100%	N/A	N/A
Enrollee Rights and Protections	9	100%	N/A	N/A

Provider Network Sub-Contract Providers	14	100%	N/A	N/A
Authorizations/Claims *2023: Service Authorization and Claims*	7	99%	3	100%
Grievance and Appeals	19	90%	N/A	N/A
Person Centered Planning	30	90%	N/A	N/A
Coordination of Care/Integration	6	96%	N/A	N/A
Behavior Treatment Plan Review Committee	21	94%	7	100%
Consumer Involvement	3	100%	N/A	N/A
Provider Staff Credentialing	22	93%	N/A	N/A
Compliance	7	99%	N/A	N/A
Information Technology	9	100%	N/A	N/A
Trauma Informed Care	6	99%	N/A	N/A
Environmental Modifications	N/A	N/A	1	100%
Behavior Treatment Plan Review Committee	21	94%	7	100%
Overall Regional Compliance		94.82%		100%

**The review elements for each standard change from year to year. "N/A" should not be assumed that standards related to the sections were not reviewed. The elements within each standard may be located in a different section of past review tools based on the new review tools and process.*
***2023 Results reflect reviews completed FY23 Q2-Q4 (9 of the 12 CMHs).*

Habilitation Supports Waiver (HSW) Charts

Clinical Chart Standards	**# of Standards FY23**	**2023 Results**	**# Of Standards FY24**	**2024 Results**
Freedom of Choice (2023: Pre Planning)	10	91%	2	77%
Intake and Assessment	13	97%	N/A	N/A
Pre-Planning	10	91%	N/A	N/A
Implementation of Person Centered Plan (2023: PCP/IPOS)	21	94%	7	84%
Plan of Service Documentation and Requirements (2023: Delivery and Evaluation)	3	80%	3	67%
Documentation	2	100%	N/A	N/A
Discharges/Transfers	4	80%	N/A	N/A
Integrated Physical/Mental Health Care	3	97%	N/A	N/A
Behavior Treatment Plans/Restrictions	N/A	N/A	7	52%
Waiver/iSPA Participant Health and Welfare (2023: Program Specific Services Delivery)	17	93%	2	82%
Overall Regional Compliance		*93.47%*		*74.27%*

**FY23 Scores reflect overall compliance for all programs and all charts reviewed and are not specific to HSW.*

Children's Waiver Program (CWP) Charts

Clinical Chart Standards	# of Standards FY23	2023 Results	# Of Standards FY24	2024 Results
Eligibility (2023: Intake/Assessment)	13	97%	2	100%
Freedom of Choice (2023: Pre Planning)	10	91%	2	100%
Implementation of Person Centered Plan (2023: PCP/IPOS)	21	94%	4	63%
Plan of Service and Documentation Requirements (2023: Delivery and Evaluation)	3	80%	6	61%
Documentation	2	100%	N/A	N/A
Discharge and Transfers	4	80%	N/A	N/A
Integrated Physical/Mental Health Care	3	97%	N/A	N/A
Behavior Treatment Plan/Restrictions	N/A	N/A	7	N/A**
Waiver/iSPA Participant Health and Welfare (2023: Program Specific Services Delivery)	17	93%	2	100%
Overall Regional Compliance		*93.47%*		*78%*

**FY23 Scores reflect overall compliance for all program charts reviewed and are not specific to CWP.*
***None of the 2024 CWP chats reviewed had behavior treatment plans*

Serious Emotional Disturbance Waiver (SEDW) Charts

Clinical Chart Standards	# of Standards FY23	2023 Results	# Of Standards FY24	2024 Results
Eligibility (2023: Intake/Assessment)	13	97%	1	78%
Freedom of Choice (2023: Pre Planning)	10	91%	2	100%
Implementation of Person Centered Plan (2023: PCP/IPOS)	21	94%	4	64%
Plan of Service and Documentation Requirements (2023: Delivery and Evaluation)	3	80%	6	54%
Documentation	2	100%	N/A	N/A
Discharge and Transfers	4	80%	N/A	N/A
Integrated Physical/Mental Health Care	3	97%	N/A	N/A
Behavior Treatment Plan/Restrictions	N/A	N/A	7	100%
Waiver/iSPA Participant Health and	17	93%	2	83%

Welfare (2023: Program Specific Services Delivery)		
Overall Regional Compliance	*93.47%*	*73%*

1915i State Plan Amendment (iSPA) charts (MSHN did not review 1915i in 2023)

Clinical Chart Standards	# Of Standards	2024 Results
Eligibility	3	95%
Freedom of Choice	2	87%
Implementation of Person Centered Plan	3	95%
Plan of Service and Documentation Requirements	3	82%
Behavior Treatment Plan/Restrictions	7	11%
Waiver/iSPA Participant Health and Welfare	2	92%
Overall Regional Compliance		*88%*

SUDSP Treatment Provider Delegated Function Reviews

During FY2024, both full and interim reviews were completed. The interim reviews are conducted to ensure compliance and implementation of approved corrective action plans for findings identified in the previous review. Interim reviews do not receive a score. Full reviews consist of chart reviews, validation of process requirements, staff files, policies, and procedures. For providers that are outside of the MSHN region, MSHN honors the monitoring and auditing conducted by the PIHP in the region where the providers are located.

Scores are shared quarterly and annually with MSHN departments to assist those departments in identifying training opportunities for our provider network.

The QAPI team conducted eight (8) full reviews and 16 (sixteen) interim reviews from October 1, 2023 – September 30, 2024.

Delegated Functions Tool Results

The Delegated Functions Review tool includes a review of 98 standards. Overall compliance is 94%.

FY24 SUD Delegated Functions Scores

Sections	# Of Standards	2023 Results	2024 Results
Access and Eligibility	4	84%	95%
Information and Customer Service	17	96%	93%
Enrollee Rights and Protections	14	95%	97%
Grievance and Appeals	16	93%	79%
Compliance	10	95%	79%
Quality	4	86%	94%
Individualized Treatment & Recovery Planning & Documentation	13	88%	97%

Coordination of Care	4	83%	80%
Provider Staff Credentialing	11	94%	73%
IT Compliance/IT Management	1	100%	86%
Trauma Informed Care	4	93%	100%

Note: All percentages are rounded to the nearest percent.

The following identifies additional information regarding the sections that fell below 90% compliance.

The Delegated Functions review is largely focused on policy and procedure language. While a provider may be able to show compliance with the standard in chart reviews or other file reviews, MSHN has placed additional requirements that providers must also have a policy and/or procedure for the standards. Based on this, it should not be assumed that if there are findings in this section that providers are not compliant with the process.

Grievance and Appeals: 79% Compliance

- There are sixteen (16) standards in this section. Ten (10) of the standards scored under 90% compliance. Those standards included compliance in the areas of adverse benefit determination letters being sent and including the correct language, using REMI for adverse benefit determination letters, sending letters within the required timeframes and when required, processes for expedited appeals are followed, sending appropriate acknowledgement and disposition letters as appropriate and through REMI for grievance and appeals, Maintaining logs of grievances and appeals in REMI. It should be noted that these specific standards were applicable only to five (5) of the eight (8) providers reviewed in this fiscal year timeframe.

Coordination of Care: 80% Compliance

- There are four (4) standards in this section and one (1) of those scored under 90% compliance. The standard was related to providers having processes in place to coordinate care with clients supervising agents when referred by MDOC. This was applicable to five of the eight providers reviewed.

Provider Staff Credentialing: 73% Compliance

- There are eleven (11) standards in this section and seven (7) of those scored under 90% compliance. The standards under 90% compliance were related to providers not having a staff development/training program or staff not meeting training requirements, criminal background checks not conducted as required, central registry checks not conducted as required for staff providing services to children, state and federal sex offender checks not being conducted as of 10/1/23 and assigning practitioners to provide services without all credentialing being completed.

Program Specific Review Results

The SUDSP program specific review tool includes a total of fifteen (15) standards. Overall compliance is 90.54%.

Program Specific Review

Sections	# Of Standards	2023 Results	2024 Results
Residential (2)	1	63%	100%
Peer Recovery Supports Services (3)	1	69%	100%
Women's Specialty Services (3)	2	78%	83%
Medication Assisted Treatment (1)	3	52%	100%
Recovery Residence (3)	8	76%	90%

**Not all providers offer each program/service. The number next to the section name represents the number of providers that were reviewed for these services in FY24.*

The program specific is focused on policy, procedure, process or other supporting documents to ensure the providers are meeting the requirements of the specialty program. While a provider may be able to show compliance with the standard in chart reviews or other file reviews, MSHN has placed additional requirements that providers must also have a policy and/or procedure for the standards. Based on this, it should not be assumed that if there are findings in this section that providers are not compliant with the process.

Women's Specialty Services: 83% Compliance

- There are two (2) standards in this section. Each standard scored at total of five (5) out of six (6) possible or 83.33%. While the score was under 90%, there were only three providers that were reviewed and only one was partially non-complaint. The QAPI team has determined this would not warrant additional regional attention.

Recovery Residence: 90%

- There were three (3) providers reviewed that offer recovery residence services. Of the eight (8) standards reviewed, six (6) standards scored 100%. There were two (2) standards that scored less than 90 percent. These were related to providers having explicit written admission criteria meeting requirements (4/6 points or 67%) and evidence of weekly house meetings 3/6 points or 50%).

Clinical Chart Review Results

The SUDSP treatment chart review tool includes a total of forty-four (44) standards. Overall compliance during this timeframe for full reviews is 67%.

SUD Chart Review Scores

Sections	# Of Standards	2023 Results	2024 Results
Screening, Admission, Assessment	5	73%	63%
Treatment/Recovery Planning	9	72%	69%
Progress Notes	3	69%	78%
Coordination of Care	5	59%	52%
Discharge/Continuity of Care	3	64%	76%
Residential	5	64%	50%
Medication Assisted Treatment	8	54%	57%

Women's Designated/Women's Enhanced	2	68%	86%
Recovery Housing	4	59%	68%

The following identifies additional information regarding the sections and standard(s) that fell below 90% compliance.

MSHN typically reviews four (4) charts for each provider. MSHN may review more than four (4) charts if necessary to ensure review of all services/programs offered and funded by MSHN. In rare instances, a provider may not have (4) consumers enrolled in services to review at which point, MSHN reviews at least two (2) files.

Findings are often organization specific, meaning findings identified by standard are in all charts reviewed for that provider making the issue a system issue. However, there are occasions where one chart may have a finding, but the others are compliant, which may be an employee specific issue that requires additional training or sometimes could be an issue of the employee not documenting clearly that it was completed. Providers are required to submit corrective action for all findings identified in each chart and follow-up (interim) reviews are conducted to ensure implementation of the plans of correction for each provider.

Screening, Admission, Assessment: 63% Compliance

- There are five (5) standards in this section, four (4) of which scored under 90% compliance.. The findings included accurately documenting initial contact in REMI, establishing the correct ASAM level of care, screening for HIV/Aids, STD/Is, TB, Hepatitis, and trauma, and unclear or lack of detail for the individual's presenting problem.

Treatment Planning and Recovery: 69% Compliance

- There are nine (9) standards in this section and of those, only one standard reached 90% or higher compliance. Areas that scored low include the following: appropriate amount scope and duration in the treatment/recovery plan; timeliness of treatment plan development; plans addressing needs and issues identified in the assessment or clear documentation of why it is not being addressed; individualized plans being in the clients words, and clear intervention strategies identified; goals and objectives are created using SMART criteria, frequency of periodic reviews; progress reviews include all elements required; case management services are clearly identified and documented; and an evidence-based practice is used and documented in the record for trauma.

Progress Notes: 78% Compliance

- This section includes three (3) standards, of which none reached 90% compliance or higher. Findings in this section were related to progress notes identifying which goals and objectives were addressed in session and the progress or lack of progress toward meeting those goals; and consumer strengths were not identified within he record and used to drive the planning process.

Coordination of Care: 52% Compliance

- There are five (5) standards in this section and none of those standards reached 90% compliance or higher. Regionally, coordination of care has been identified as an issue for several years. These findings include lack of evidence of coordination of care with primary care physicians, other external entities such as legal, child welfare, behavioral health, other providers when transitioning from one level of care to another, and evidence of appropriate referrals and documented follow-up.

Discharge/Continuity of Care: 76% Compliance

- There are three (3) standards in this section. Two of the standards were scored and did not

meet 90% compliance, the other standard was not scored as it was not applicable to any of the charts reviewed. Findings include discharge summaries not including all continuum of care detail including next provider contact information, date/time of intake appt, etc. Additionally, consumers discharge is not always fully summarized including status at time of discharge, prognosis, stage of change, met and unmet needs and goals, summary of services received and participation.

Residential: 50% Compliance

- This section includes a total of five (5) standards, three (3) of which were not applicable. Of the two standards that were scored, neither reached 90% compliance. These standards were related to review of medications prior to prescribing medications in residential detoxification programs and related to assuring consumers entering residential treatment are tested for TB and results are known in five (5) days of admission.

Medication Assisted Treatment: 57% Compliance

- This section includes fifteen (8) standards. Of those, two (2) standards were fully compliant and the remaining six (6) standards did not meet 90% compliance. These standards were related to documented use of MAPS, documenting all alcohol and illicit drug use, ensuring individuals are provided informed consent on use of methadone treatment, evidence of client-signed consent to contact other OTPs within 200 miles, take-home doses occurring in accordance with regulations, and providers informing Supervision agents when MDOC referred individuals receive medication assisted treatment.

Women's Designated/Enhanced: 86% Compliance

- There are two (2) standards reviewed in this section. One standard scored under 90% related to assessment of needs completed on consumer and each independent child.

Recovery Housing: 68% Compliance

- There are four (4) standards included in this section. None of the four (4) standards reached 90% compliance. Findings were related to eligibility confirmed via outpatient treatment engagement/attendance, resident charts including all required documentation, completed screens and applications, and service plans not including all required elements.

Medicaid Event Verification Site Reviews

MSHN conducts oversight of the Medicaid claims/encounters submitted within the region by completing either an onsite review or a desk review of the provider networks policy and procedures and the claims/encounters submitted for services provided for all twelve (12) of the CMHSPs and for all substance use disorder treatment providers who provide services using Medicaid funding within the MSHN region.

The attributes tested during the Medicaid Event Verification (MEV) review include A.) The code is allowable service code under the contract, B.) Beneficiary is eligible on the date of service, C.) Service is included in the beneficiary's individual plan of service, D.) Documentation of the service date and time matches the claim date and time of the service, E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed, F.) Amount billed/paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

The following is a summary of the MEV reviews conducted in FY2024. For complete information, please see the Medicaid Services Verification Methodology Report for Fiscal Year 2024 which will be available in December 2024.

CMHSP

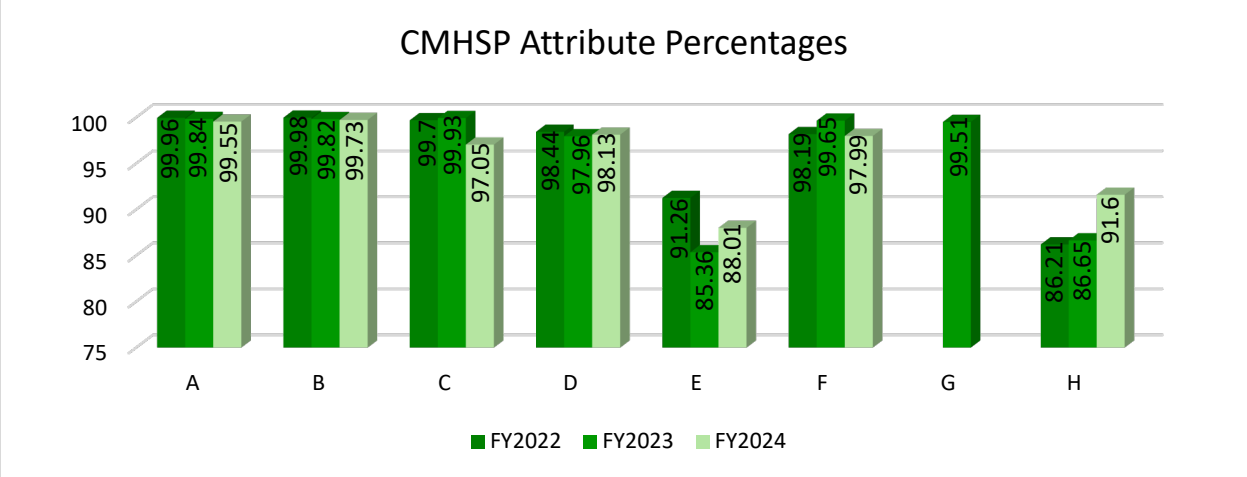
The CMHSP reviews are completed bi-annually (twice a year) for all twelve (12) CMHSPs. The table below

includes the score per CMHSP for all attributes reviewed. Data presented in the below chart is relative to the twelve (12) CMHSP's for the full fiscal year, October 1, 2023 – September 30, 2024.

CMHSP	A	B	C	D	E	F	G
BABHA	100%	100%	100%	98.04%	86.75%	96.75%	88.27%
CEI	100%	100%	100%	99.52%	96.94%	100%	93.49%
CMHCM	99.63%	100%	96.42%	98.69%	91.74%	99.63%	90.53%
Gratiot	98.94%	100%	100%	99.57%	93.62%	98.94%	91.75%
Huron	100%	100%	100%	99.69%	97.20%	100%	97.95%
Lifeways	96.86%	99.69%	97.17%	96.74%	84.58%	96.59%	86.49%
Montcalm	100%	98.99%	82.59%	98.48%	80.06%	99.75%	99.60%
Newaygo	100%	98.68%	97.19%	98.18%	97.11%	100%	86.33%
Saginaw	99.35%	100%	99.10%	98.19%	89.49%	96.48%	93.11%
Shiawassee	100%	99.60%	100%	95.04%	79.16%	98.28%	92.63%
The Right Door	100%	100%	99.46%	97.83%	79.49%	100%	89.56%
Tuscola	100%	100%	94.13%	98.38%	84.59%	90.48%	92.65%
MSHN Average	**99.55%**	**99.73%**	**97.05%**	**98.13%**	**88.01%**	**97.99%**	**91.60%**

Note: CMHSP reviews are completed twice during the fiscal year. The percentages displayed are an average of the scores for both reviews (with the exception of Huron which only has data for one review as the second review had pending results at the end of the quarter and will be reported in FY2025 data).

The following chart provides a comparison from FY2022 through FY2024 for the attributes tested:



Note: In FY22 there were 7 (A-G) attributes tested compared to 8 (A-H) in FY23. In FY24, MSHN went back to 7 attributes (A-G) for the MEV review. For the purposes of this graph, FY22 and FY24 data for attribute G.) Modifiers are used in accordance with the HCPCS guidelines is included under attribute H.

FY22 and FY24:
A.) The code is allowable service code under the contract
B.) Beneficiary is eligible on the date of service
C.) Service is included in the beneficiary's individual plan of service or in the treatment plan
D.) Documentation of the service date and time matches the claim date and time of the service
E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
F.) Amount billed and paid does not exceed contractually agreed upon amount
G.) Modifiers are used in accordance with the HCPCS guidelines

FY23:
A.) The code is allowable service code under the contract
B.) Beneficiary is eligible on the date of service
C.) Service is included in the beneficiary's individual plan of service or in the treatment plan
D.) Documentation of the service date and time matches the claim date and time of the service
E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
F.) Amount billed does not exceed contractually agreed upon amount
G.) Amount paid does not exceed contractually agreed upon amount
H.) Modifiers are used in accordance with the HCPCS guidelines

SUD

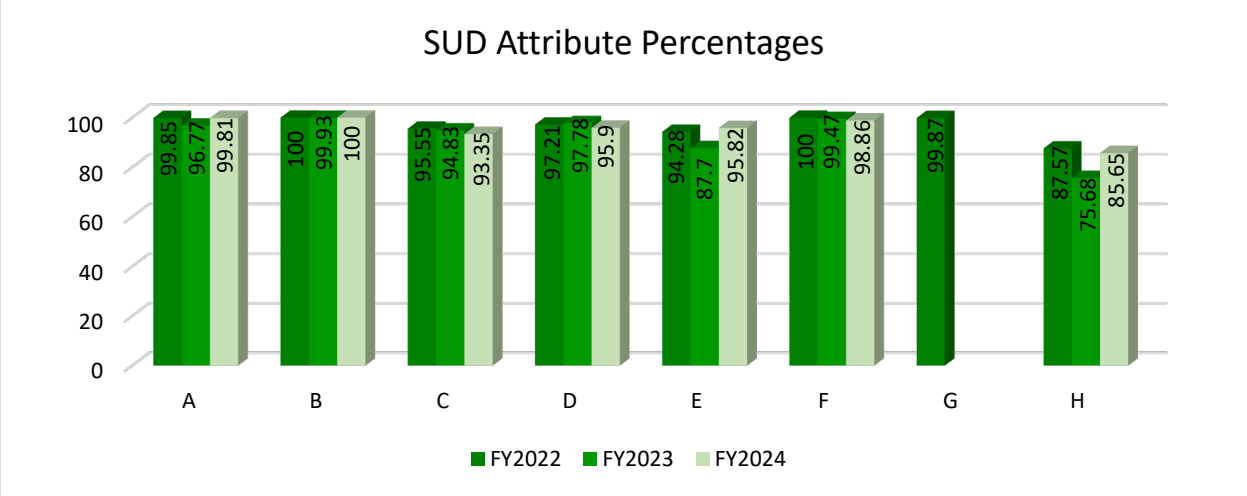
The Substance Use Disorder site reviews are completed annually. The data presented in the below chart is relative to the seventeen (17) SUD treatment providers reviewed for the full fiscal year, October 1, 2023 – September 30, 2024.

The chart below includes the score for all SUD providers combined for each attribute reviewed.

SUD

	A	B	C	D	E	F	G
SUD Providers	99.81%	100%	93.35%	95.90%	95.82%	98.86%	85.65%

The following chart provides a comparison from FY2022 through FY2024 for the attributes tested:



Note: The above chart does not include the same SUD providers from year to year but is representative of the region.

Note: In FY22 there were 7 (A-G) attributes tested compared to 8 (A-H) in FY23. In FY24, MSHN went back to 7 attributes (A-G) for the MEV review. For the purposes of this graph, FY22 and FY24 data for attribute G.) Modifiers are used in accordance with the HCPCS guidelines is included under attribute H.

FY22 and FY24:
A.) The code is allowable service code under the contract
B.) Beneficiary is eligible on the date of service
C.) Service is included in the beneficiary's individual plan of service or in the treatment plan
D.) Documentation of the service date and time matches the claim date and time of the service
E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
F.) Amount billed and paid does not exceed contractually agreed upon amount
G.) Modifiers are used in accordance with the HCPCS guidelines

FY23:
A.) The code is allowable service code under the contract
B.) Beneficiary is eligible on the date of service
C.) Service is included in the beneficiary's individual plan of service or in the treatment plan
D.) Documentation of the service date and time matches the claim date and time of the service
E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
F.) Amount billed does not exceed contractually agreed upon amount
G.) Amount paid does not exceed contractually agreed upon amount
H.) Modifiers are used in accordance with the HCPCS guidelines

Results/Trends

Based on the MEV reviews for FY2024, all twelve (12) CMHSPs were placed on a new plan of correction and of the seventeen (17) substance use disorder treatment providers reviewed, twelve (12) were placed on a new plan of correction. In addition, all CMHSPs and substance use disorder treatment providers who were placed on a plan of correction during FY2023, were removed from those plans during FY2024.

The overall findings included a total dollar amount of invalid claims identified for CMHSP's direct and contractual services of $663,687.94 and $20,821.42 for substance use disorder treatment providers. All invalid claims were corrected based on MSHN's established process.

Note: Many of the invalid claims were corrected by submitting additional documentation and by resubmitting claims with correct modifiers, dates, times, etc. These claims, units and dollars are included in the summary of disallowed amounts as they were original findings that documentation did not support during the review.

Regionally the CMHSPs have shown slight improvements from FY2023 to FY2024 for the following attributes:
1. D. Documentation of the service date and time matches the claim date and time of the service
2. E. Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
3. G. Modifiers are used in accordance with the HCPCS guidelines
Note: Attribute G.) Modifiers are used in accordance with the HCPCS guidelines was listed as Attribute H in FY23. There is no longer an Attribute H as Attributes F and G from FY23 have been combined.

These improvements may be attributed to an increased focus on improving the quality of documentation, improved staff trainings, ongoing monitoring and oversight, and increased education and technical assistance provided by the Medicaid Event Internal Auditor during the review process. In

addition, the telehealth modifier was discontinued near the end of FY23 which had been a particularly common finding for CMHSPs and SUDSPs in the past. Furthermore, MSHN has safeguards in place to guard against duplicate and incomplete claims being submitted.

Alternatively, the SUD providers have shown considerable improvements from FY2023 to FY2024.
1. A. The code is allowable service code under the contract
2. B. Beneficiary is eligible on the date of service
3. E. Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
4. G. Modifiers are used in accordance with the HCPCS guidelines

This may be attributed to continued training and technical assistance provided by MSHN to the providers as part of the MEV site reviews. The SUD provider network is also improving their understanding of the required supporting documentation to show compliance with the attributes.

External Reviews

MDHHS Waiver Review

The Michigan Department of Health and Human Services (MDHHS) conducted a full review for our region May – July 2024. The purpose of the review was to ensure compliance with state and federal requirements related to the Habilitation Supports Waiver (HSW), Waiver for Children with Serious Emotional Disturbance (SEDW), Children's Waiver Program (CWP), and 1915i SPA (iSPA).
MDHHS reviewed 149 clinical records and a total of 868 staff files (236 professional staff and 632 aide-level staff). A final report was sent to MSHN on August 28, 2024, with a request for a plan of correction to be submitted. The corrective action planning process carried over into fiscal year 2025.

Results/Trends

HSW

Of the Twenty-five (25) measures reviewed related to charts the following trends were identified by MDHHS:

- Increase in compliance: 2 measures
- Maintained Compliance: 5 measures
- Decreased Compliance: 9 Measures

Of the 38 charts reviewed, 50% or more of clinical records reviewed identified citations in the following areas:

- Specific services and supports aligning with individuals assessed needs including measurable goals/objectives, with amount scope and duration and timeframe for services for implementing. Thirty three (33) of thirty eight (38) or 87% of clinical records reviewed had findings for this measure.
- Services and treatment identified in the IPOS were provided as specified in the plan. Nineteen (19) of thirty eight (38) or 58% of clinical records reviewed had findings for this measure.

CWP

Of the Twenty-seven (27) measures reviewed related to charts/files, the following trends were identified by MDHHS:

- Increase in compliance: 7 measures
- Maintained Compliance: 5 measures

- Decreased Compliance: 3 Measures

Of the twelve (12) charts reviewed, 50% or more of clinical records reviewed identified citations in the following areas:

- IPOS addresses all service needs reflected in the assessments. Six (6) of the twelve (12) files or 50% of clinical records reviewed had findings for this measure.
- Services and supports are provided as specified in the IPOS, including type, amount, scope duration and frequency. Nine (9) of the twelve (12) files or 75% of clinical records reviewed had findings for this measure.

SEDW

Of the Twenty-five (25) measures reviewed related to charts/files, the following trends were identified by MDHHS:

- Increase in compliance: 7 measures
- Maintained Compliance: 3 measures
- Decreased Compliance: 4 Measures

Of the twenty-three (23) charts reviewed, 50% or more of clinical records reviewed identified citations in the following areas:

- The IPOS is developed in accordance with MDHHS policies and procedures i.e. measurable goals/objectives and timeframes, prior authorization of services correspond to services identified in the plan, etc. Fifteen (15) of the twenty-three (23) or 65% of clinical records reviewed had findings for this measure.
- Services and supports are provided as specified in the IPOS including amount, scope, duration, and frequency. Nineteen (19) of the twenty-three (23) or 83% of clinical records reviewed had findings for this measure.

iSPA

2024 was the first year that iSPA was reviewed. There are no trends to report.

Of the seventy-six (76) clinical records reviewed, 50% or more of clinical records reviewed identified citations in the following areas:

- Specific services and support align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, duration of services and timeframes for implementing are identified in the IPOS. Sixty-five (65) of the seventy-six (76) or 87% of the clinical records reviewed had findings for this measure.
- Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objectives, the type, amount scope duration, frequency, and timeframe for implementing. Fifty-one (51) of the seventy-six (76) or 67% of the clinical records reviewed had findings for this measure.

Recommendations

The final report and a summary of trends and outcomes has been provided to the MSHN Behavioral Health Team and the MSHN Quality Improvement Council to identify and address any recommendations or areas for regional improvement.

MDHHS- Health Services Advisory Group (HSAG): Performance Measurement Validation Review

Validation of performance measures is one of three mandatory external quality review (EQR)

activities required by the Balanced Budget Act of 1997 (BBA). State Medicaid agencies must ensure that performance measures reported by their managed care organizations (MCOs) are validated. Health Services Advisory Group, Inc. (HSAG), the EQRO for the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration, conducted the validation activities for the prepaid inpatient health plans (PIHPs) that provided mental health and substance abuse services to Medicaid-eligible recipients. The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements. HSAG completed MSHN's review remotely on July 30, 2024.

HSAG validated a set of performance indicators that were developed and selected by the Michigan Department of Health and Human Services (MDHHS). The review consisted of interviews, system demonstrations, review of data output files, primary source verification, observation of data processing and review of data reports.
Compliance was assessed through a review of the following:

- Information Systems Capabilities Assessment Tool (ISCAT)
- Source Code (programming language) for performance indicators
- Performance Indicator reports
- Supporting documentation
- Evaluation of system compliance

The following is a summary of the PMV site review report. For complete information, please see the Health Services Advisory Group Validation of Performance Measures State Fiscal Year 2024.

Results/Trends

MSHN received a status of "Reportable" indicating the performance indicators were compliant with the State's specifications and the rate can be reported.

- The Data Integration and Control- Thirteen Standards: 100%
- Denominator Validation - Seven Standards (2 NA): 100%
- Numerator Validation – Five Standards: 100%
- Performance Measures- Fourteen Measures Fully Validated: 100%

Recommendations

Among the recommendations from this review were the following:

- HSAG recommends that MSHN perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet eligibility requirements. Data validation is a crucial step in ensuring an accurate submission. Incorporating additional spot checks could add value, especially when data are being integrated from multiple sources.
- HSAG recommends that MSHN proceed with its outlined remediation plan. Additionally, HSAG recommends that MSHN continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #2 and #3 data. This should include implementing another level of validation for reviewing a statistically significant sample of cases each quarter to confirm that their associated population designations are accurately reported.
- HSAG recommends that MSHN implement the programming logic updates and also perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements. Additionally, HSAG recommends that MSHN continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #3 data..
- HSAG recommends that MSHN perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements. Additionally, HSAG recommends that MSHN continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator

#4a data. Retraining on how to appropriately document various scenarios in the REMI system should be provided if found necessary.

- HSAG recommends that MSHN continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 75th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.
- HSAG recommends that MSHN continue with its improvement efforts related to indicator #3 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and accessible ongoing covered services following completion of a biopsychosocial assessment. The timeliness of ongoing services is critical to consumer engagement in treatment and services.

MDHHS- Health Services Advisory Group (HSAG): Network Adequacy Review

Title 42 of the Code of Federal Regulations (CFR) §438.350(a) requires states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), or a primary care case manager (PCCM) entity to have a qualified external quality review organization (EQRO) perform an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP, or PCCM entity. In accordance with 42 CFR §438.358(b)(1)(iv), the EQR must include validation of MCO, PIHP, or PAHP network adequacy to comply with requirements set forth in §438.68 and, if the State enrolls Indians in the MCO, PIHP, or PAHP, §438.14(b)(1). As the EQRO for the Michigan Department of Health and Human Services (MDHHS), Health Services Advisory Group, Inc. (HSAG) is responsible for conducting the annual network adequacy validation (NAV) for all PIHPs contracted with MDHHS.

The focus of the review included network adequacy data collection, integration, calculation, accuracy, and reporting of indicators for each required standard. Specifically, HSAG reviewed the logic used specific to the time and distance standard.

At the time of this report, MSHN has received approval for our process of calculating time and distance. HSAG is expected to finalize the NAV audit aggregate report December 2024.

MDHHS- Health Services Advisory Group (HSAG): Compliance Monitoring Review

According to federal requirements located within the Code of Federal Regulations (CFR), 42 CFR §438.358, the state, its agent that is not a Medicaid prepaid inpatient health plan (PIHP), or an external quality review organization (EQRO) must conduct a review to determine a Medicaid PIHP's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To comply with the federal requirements, the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) contracted with Health Services Advisory Group, Inc. (HSAG), as its EQRO to conduct compliance monitoring reviews of the PIHPs.

The Compliance Site Review is conducted over a period of three (3) years and includes a review of thirteen (13) different standards. FY2024 was year one of the review cycle and included review of five (5) of the thirteen (13) standards. The review took place on August 26, 2024. MSHN has received a draft copy of the final report. MSHN expects to receive the finalized report in December 2024 and to submit a plan of correction January 2025.

Results/Trends

MSHN achieved an overall compliance score of 85%.
Standard I – Member Rights and Member Information: 76%
Standard III – Availability of Services: 100%
Standard IV- Assurances of Adequate Capacity and Services: 100%
Standard V- Coordination and Continuity of Care: 93%
Standard VI – Coverage and Authorization of Services: 68%

Recommendations

HSAG made several recommendations throughout the review specific to standards. Below is an abbreviated summary of some of the recommendations that were made. Full recommendations can be viewed in the final report when added to the MSHN website.

Standard I – Member Rights and Member Information

- There were several recommendations to update language in the Member Handbook, policies, and procedures to ensure compliance with all federal and state requirements and standards reviewed in this section.
- Recommendation to update MSHN audit review tools to include more specific elements.
- MSHN should develop tracking mechanisms to confirm timely member notification when there are changes to the member handbook and provider directory.
- MSHN should develop a process for reporting and tracking members who request the information in 42 CFR §438.10 in paper format are provided with the requested information within five business days of the request.
- MSHN should develop definitions for provider types that must be in the PIHPs provider directory for clarity about the services that fall under each provider.

Standard III - Availability of Services

- To enhance the PIHP's monitoring processes of its CMHSPs, HSAG recommends that the PIHP consider developing a standardized reporting template for its CMHSPs to report data pertaining to the access standards to the PIHP.
- To enhance the PIHP's monitoring processes of its providers, HSAG recommends that the PIHP consider developing a secret shopper survey or other mechanism for monitoring provider office hours as required in contract.

Standard IV- Assurances of Adequate Capacity and Services

- HSAG recommends that the PIHP review the results, findings, and recommendations determined through the HSAG network adequacy validation (NAV) activity and take action to ensure that the PIHP fully aligns with MDHHS' expectations regarding the methodology and calculation of time and distance standards.

Standard V – Coordination and Continuity of Care

- As the PIHPs were not consistently applying the same screenings or assessments to this initial screening requirement, HSAG recommends that the PIHPs consult with MDHHS to confirm which screening or assessment (e.g., screening at access, assessment conducted within 14 days of a request for services) is required and update policies and procedures are updated to reference the appropriate screening or assessment.
- HSAG recommends that the PIHPs collaborate with MDHHS to develop a definition for LTSS that will be used by all PIHPs. As part of the definition, MDHHS and the PIHPs could develop a list of services and benefits under the PIHPs' scope of work (SOW) that are considered LTSS. Based on this collaboration and, with confirmation by MDHHS, the PIHP should update its policies and procedures and other utilization management (UM)-related program documents, as well as its quality assessment and performance improvement program (QAPIP) description to include the State's definition of LTSS. The PIHP should also ensure that its policies and procedures, UM-related program documents, and QAPIP description identify which members it has identified as having special health care needs (e.g., all members, a subset of members). If MDHHS declines to define LTSS and/or members having special health care needs, the PIHP should ensure that it has defined LTSS and members with special health care needs in its program documents. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.
- HSAG recommends that the PIHP reiterate to its staff members and/or its delegates the importance of ensuring that the IPOS includes documentation of the names of all IPOS meeting attendees and their roles in the meeting (e.g., member's guardian). If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a

Not Met score.

- As MDHHS' expectation is that all PIHPs will be in compliance with the requirements under 42 CFR §441.301(c)(4)(vi)(F)(1–8) by the end of calendar year 2024, and because MDHHS has added two performance measures for SFY 2025 with the waiver renewal that will assess whether completed person-centered plans with identified restrictions/modifications comply with Home and Community-Based Settings requirements and that the PIHP has effective administrative policies in place regarding Home and Community-Based Settings compliance and monitoring processes, HSAG strongly recommends that the PIHP prioritize the inclusion of all required documentation when there is a modification of the conditions that are required for Home and Community-Based Settings directly within the person-centered plan. HSAG also recommends that the PIHP consider developing a modifications section template within the person-centered plan that will be required to be used by all PIHP staff and/or its delegated entities when there is a modification to the Home and Community-Based Settings required under 42 CFR §441.301(c)(4). The template should have sections that address sub-elements (a) through (h) of this element, with detailed instructions for the documentation that must be included for each section to ensure compliance with the expectations set by MDHHS and the requirements under federal rule. Further, the PIHP must ensure that it maintains a robust and ongoing auditing process to confirm that its delegated entities are also complying with the modification requirements stipulated by federal rule and in alignment with the expectations required by MDHHS and the PIHP. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will likely receive a *Not Met* score.
- HSAG strongly recommends that the PIHP enhance its SUD chart review tool to specifically review a sample of treatment case files to ensure that both the PCP's name and address are documented in the member's treatment plan. Additionally, HSAG strongly recommends that the PIHP educate its SUD treatment providers that the treatment case files must specifically include the PCP's name and address, in addition to having the copy of the signed release of information in the treatment case file.

Standard VI – Coverage and Authorization of Services

- HSAG recommends that the PIHP include the federal Medicaid managed care definition of "medically necessary services," in its UM program description, or at minimum, cross-reference 42 CFR §438.210(a)(5) under the PIHP's internal definition of "medically necessary services.".
- HSAG recommended several updates to the MSHN monitoring tools and processes to ensure compliance with federal requirements and network delegated activities.
- HSAG recommended several policy and procedure, member handbook, and UM plan updates to ensure all federal requirements are incorporated.
- HSAG recommends that the PIHP include a list of services categorized as LTSS in its UM program description.
- HSAG recommends that the PIHP develop a procedure document that outlines the criteria for sending an ABD notice for a denial of payment as well as the coordination efforts between the UM and claims teams to ensure that an ABD notice is sent to the member on the date that the decision to deny the payment on the claim is made. HSAG also recommends that the PIHP conduct staff training to ensure their understanding of the requirements of this element and how the requirements should be implemented. Further, HSAG recommends that the PIHP conduct a review to validate that the CMHSPs have no claim payment denials for the Medicaid program, and that the CMHSPs have adequate mechanisms to ensure that ABD notices are sent when a claim payment denial occurs. HSAG recommends that the PIHP periodically (e.g., quarterly) review reports that display the number of claims received and paid for in full, and the number of claims received in which payment, in full or in part, were denied. For any payment denials, the PIHP must confirm that an ABD notice was provided to the member. If the PIHP does not provide evidence to demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.

MDHHS- Health Services Advisory Group (HSAG): Encounter Data Validation Review

MDHHS contracted with Heath services Advisory Group (HSAG) to conduct a validation of encounter data reported by PIHPs. Initially proposed to PIHPs as a study and gathering of information in FY23, MDHHS announced HSAG

would conduct documentation reviews in FY24 and every three years following. The review purpose is to ensure that encounter documentation accurately reflects the provider rendered a specific service under a managed care delivery system.

HSAG initially requested documentation for 411 encounters in addition to documentation from the encounter following, for a total of approximately 822 encounters. MDHHS and HSAG then sent communication that they would lower the 411 requested encounters by 25%, or to 308 files to include the follow up encounter, approximately 616 encounters.

Required documentation included demographic information, provider information, service date, diagnosis code, procedure code and procedure modifiers, and charts/visit notes. Files were to be uploaded in smaller numbers May 3, 3024-July 15, 2024. CMHs and MSHN met all due dates as required.

An aggregated report for Michigan is expected to be sent directly to MDHHS. The expected date has not been provided to PIHPs however, MDHHS typically sends electronic notification to PIHP CEO's informing them when the report is available.

MDHHS- Health Services Advisory Group (HSAG): Performance Improvement Project

MDHHS requires that the PIHP conduct and submit a Performance Improvement Project (PIP) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid consumers in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves. By assessing PIPs, HSAG assesses each PIHP's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients," according to the Code of Federal Regulations (CFR) at 42 CFR 438.364(a)(2).

MSHN's Performance Improvement Project for 2022 through 2025 is: *Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population without a decline in performance for the white population.*

The remeasurement 1 data for 01/01/2023 through 12/31/2023 was 59.70% for the percentage of new persons who are Black/African- American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

The remeasurement 1 data for 01/01/2023 through 12/31/2023 was 63.00% for the percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

Results/Trends

Validation Rating: Design and Implementation

- Percentage of Evaluation Elements Met: 100%
- Percentage of Critical Elements Met: 100%
- MSHN Validation resulted in a *High Confidence* rating.

MSHN met 100 percent of the requirements for the data analysis and implementation of improvement strategies. MSHN used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers. Timely interventions were implemented and were reasonably linked to the corresponding barriers.

Validation Rating: Outcomes

- Percentage of Evaluation Elements Met: 33%

- Percentage of Critical Elements Met: 100%
- MSHN Validation resulted in a *No Confidence* rating.

MSHN did not demonstrate statistically significant improvement over the baseline performance for the disparate subgroup (Black/African American population). The PIHP did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups without a decline in performance for the comparison subgroup (White population) with the first remeasurement period.

Based on recommendations from HSAG, MSHN will address the following:

- The performance indicators have not yet achieved the goals for the PIP. MSHN should consider evidence-based intervention efforts and the risk factors in quality of care for each subgroup, independently.
- MSHN should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to identify if any new barriers exist that required development of interventions for both subgroups.
- MSHN should continue to evaluate the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.

Customer Service/Compliance Reporting

Customer Service Contacts

The total number of Customer Services contacts received in FY2024 was 115, a 25.8% decrease from FY2023. By comparison, there were 155 contacts in FY2023.

Customer Service Originator of Contact

Originator	Number	Percentage*
Advocate	4	3%
Authorized representative	1	1%
CMHSP	28	24%
Family Member	4	3%
Guardian	1	1%
MDHHS	18	16%
Other	13	11%
Parent of a minor	5	4%
Self/Consumer	30	26%
SUDSP	11	10%

*(*the percentage indicates the originator category number compared to the total number of contacts*
Note: Numbers are rounded up, so the sum of the percentages equals slightly more than 100)

Customer Service Inquiry Category

Category	Number	Percentage*
Access to Treatment	29	25%
Appeal	2	2%
Complaint/Dissatisfaction	18	16%
Consumer Discharge	4	3%
General Assistance	28	24%
Interaction with Provider or Plan	1	1%
LEP Assistance	4	3%
Medicaid Fair Hearing	2	2%

Notification Letter	6	5%
Provider Practices	16	14%
Provider Staff Concern	1	1%
Recipient Rights Assistance	4	3%

*(*the percentage indicates the originator category number compared to the total number of contacts*
Note: Numbers are rounded up, so the sum of the percentages equals slightly more than 100%)

Conclusion/Resolution Type

Type of Resolution	Number	Percentage*
No follow-up required	46	40%
Resolution pending	4	3%
Resolved in favor of consumer	4	3%
Resolved in favor of provider	14	12%
Resolved through follow up actions	47	41%

*(*the percentage indicates the originator category number compared to the total number of contacts*
Note: Numbers are rounded up, so the sum of the percentages equals slightly more than 100%)

Results/Trends

The following trends/changes were noted during FY2024:

- Overall Customer Service contacts decreased by 26% in FY2024 (115) from FY2023 (155).
- Consumer contacts requiring follow-up action decreased by 39% from 75 in FY2023 to 46 of Consumer contacts in FY2024.
- The highest number of consumer-based customer service complaints originated from Consumers themselves (25% / n=29) and MDHHS (9% / n=10).
- The highest number of non-consumer customer service contacts originated from CMHSP staff (24% / n=28)
- The highest consumer complaint categories addressed Access to Treatment (23% / n=26) and Complaint/Dissatisfaction (14% / n=16). Access to Treatment was a 29% decrease in FY24 (n=29) over FY23 (41). Complaint/Dissatisfaction saw a 30% decrease in FY24 (n=16) over FY23 (n=23).
- The highest non-consumer contact category involved requests for General Assistance (23% / n=26)

As part of MDHHS' State monitoring activities, PIHPs are required to submit Grievance reporting information using the state developed reporting template. Report data submissions are on a quarterly basis, and the final report covers FY24 Q1-Q4.

FY24 MDHHS Grievance Reporting Results (Q1-Q4)							
Grievance Category	Number of Cases Closed	Number of Cases Per 100 Members	Number of Cases Substantiated	Number of Cases Substantiated Per 100 Members	Number of Interventions	Number of Cases Resolved within 90 Calendar Days	Average Number of Days for Resolution*
QUALITY OF CARE	35	0.09	21	0.06	93	34	29
ACCESS AND AVAILABILITY	21	0.06	13	0.04	54	21	37
INTERACTION WITH PROVIDER OR PLAN	32	0.09	14	0.04	77	32	26
MEMBER RIGHTS	5	0.01	3	0.01	13	5	33
TRANSPORTATION	1	0.00	0	0.00	2	1	6
ABUSE, NEGLECT, OR EXPLOITATION	0	0.00	0	0.00	0	0	#DIV/0!
FINANCIAL OR BILLING MATTERS	0	0.00	0	0.00	0	0	#DIV/0!
SAFETY/RISK MANAGEMENT	4	0.01	2	0.01	11	4	10
SERVICE ENVIRONMENT	7	0.02	7	0.02	18	7	9
OTHER	9	0.02	5	0.01	22	9	25
Total	114	0.31	65	0.18	290	113	28
*Field will display “DIV/0!" if there are no reported cases per category.							

As part of MDHHS’ State monitoring activities, PIHPs are required to submit Appeals reporting information using the state developed reporting template. Report data submissions are on a quarterly basis and the report covers FY24 Q1-Q4.

FY24 MDHHS Appeals Reporting Results (Q1-Q4)								
Reason for Adverse Decision on Appeal	Number of Cases Closed	Number of Cases Per 100 Members	Number of Decisions Made Timely-Standard	Number of Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited	Percent Timely-All Cases	Percent Untimely-All Cases
MEDICAL NECESSITY CRITERIA NOT MET	63	0.17	57	1	2	3	94%	6%
NOT A PIHP-COVERED BENEFIT	5	0.01	5	0	0	0	100%	0%
CLINICAL DOCUMENTATION NOT RECEIVED	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
TREATMENT/SERVICE PLAN GOALS MET	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
MEMBER NOT ELIGIBLE FOR SERVICES	7	0.02	7	0	0	0	100%	0%

MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN	24	0.06	24	0	0	0	100%	0%
FAILURE OF THE PIHP/CMHSP/SUD PROVIDER TO RENDER A DECISION TIMELY	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
OTHER	15	0.04	15	0	0	0	100%	0%
NOT APPLICABLE	333	0.90	328	3	2	0	99%	1%
MEDICAL NECESSITY CRITERIA NOT MET	63	0.17	57	1	2	3	94%	6%
Total	63	0.17	57	1	2	3	94%	6%

*Field will display "DIV/0!" if there are no reported cases per category.

	Count	Percentage
Appeals	447	
Appeals Upheld	95	21%
Appeals Overturned	340	76%
Appeals Partially Upheld/Overturned	12	3%

For FY2024, the grievance and appeal data were reviewed through the Regional Customer Service Committee (CSC) to identify trends and potential quality improvement efforts. The quarterly MDHHS grievance and appeal data will continue to be reviewed through the CSC.

Activities Implemented in FY2024

The following activities were implemented during FY2024.

- The quarterly Appeal and Grievance Regional Analysis Report was utilized to evaluate the quarterly MDHHS Grievance and Appeal data for regional trends and quality improvement.
- The MSHN Customer Service Committee reviewed, revised, and facilitated the publication of thirteen (13) local versions of the FY24 MSHN Guide to Services Handbook. Additionally, the thirteen (13) local versions were translated into Spanish for electronic distribution to CMHSP and SUDSP providers throughout the MSHN region.
- MSHN Customer Services continued to collaborate with MSHN staff to provide technical assistance to improve the quality of services through providers within MSHN's SUDSP network.
- MSHN provided ongoing technical support and training to the provider network in customer service, grievance and appeals, and recipient rights.

Recommendations for FY2025

Based on FY24 Customer Service data, the following is being recommended:

- The review of FY24 Customer Service data did not identify systemic issues but identified issues at the individual provider level requiring technical assistance. Quality improvement initiatives will occur during the Customer Service Committee utilizing the quarterly Appeal and Grievance Regional Analysis Report to support provider compliance.
- Based on the Meaningful Language Access to State Services Act, which became effective on February 28, 2024, was reviewed. Regional LEP practices will be evaluated to gather LEP information from local county analysis for non-English language prevalence for a biennial report of language access within the Act. CSC members will develop a process and template in preparation for the report to ensure compliance with LEP requirements.

Compliance Reporting

Compliance Investigations

The total number of compliance investigations completed by the MSHN Compliance Officer in FY2024 was 32. By comparison, there were 26 completed in FY2023. This resulted in an increase of 23.07% in FY2024 from FY2023.

Compliance Investigations:
(The percentage indicates the percent the originator represents of the total complaints.)

Originator:	***Number:***	***Percent:***
SUD Provider Staff	1	3.13%
CMHSP Staff	16	50.00%
MSHN Staff	2	6.25%
Office of Inspector General (OIG)	9	28.12%
Community/Stakeholder	4	12.50%

Type of Compliance Investigation:
(The percentage indicates the percentage the type represents of the total complaints.)

Category:	***Number:***	***Percent:***
Fraud/Abuse/Waste	18	56.25%
Treatment/Services	3	9.37%
Duplicate Claims	2	6.25%
Over Payment for Services	2	6.25%
Credentialing/Qualifications	6	18.75%
Confidentiality	1	3.13%

Conclusion/Resolution:
(The percentage indicates the percentage the resolution represents of the total complaints.)

Type of Resolution:	***Number:***	***Percent:***
CMHSP	15	46.87%
SUD Provider	3	9.38%
OIG	9	28.13%
Pending	5	15.62%

Referrals to/from Outside Regulatory Bodies: (based on contractual requirements)
(The percentage indicates the percent the referral represents of the total complaints.)

Agency:	***Number:***	***Percent:***
OIG	13	40.63%

Office of Inspector General Quarterly Report for FY2024

PIHPS are required to track and report program integrity activities performed within the region. The program activities must include, but are not limited to, the following activities: data mining, analysis of paid claims, audits performed, overpayments collected, identification of fraud, waste and abuse, provider dis-enrollments and contract terminations.

Below is a breakdown of activities reported for each quarter in FY24. Activities that are not closed out or finalized in the quarter reported carry over to the following quarterly report until resolved. Additionally, Medicaid Event Verification reviews are reported the quarter that they are considered completed/closed/finalized.
FY2024 Q1: 48 activities were reported (33 previously initiated, 15 initiated, 46 resolved)
FY2024 Q2: 46 activities were reported (23 previously initiated, 23 initiated, 32 resolved)
FY2024 Q3: 46 activities were reported (27 previously initiated, 19 initiated, 31 resolved)

FY2024 Q4: 62 activities were reported (43 previously initiated, 27 initiated, 43 resolved)

Most of the activities reported were a result of local and region wide Medicaid Event Verification activities, clinical record reviews and internal audits. The activities reported included inappropriate credentials/training, lack of supporting documentation, wrong use of modifiers, billing for incorrect dates and times, incorrect service codes and overpayment.

The total amount of overpayments that were adjusted as a result of the QIG quarter report activities was $552,077.76. While this was identified as an overpayment, many of the encounters could be corrected and resubmitted after the claims were voided which may have resulted in a lower recoupment/cost settled amount for FY2024.

Data Mining Activities

Data mining is a process for finding anomalies, patterns and correlations within data sets.
During FY2024, MSHN completed the following data mining activities.

1) Death Data Report (Q1, Q2, Q3, and Q4)
    a. This report compares the death list from Care Connect 360 to service data from MSHN's information management system. There should be no instance where a service is provided to a recipient after the date of death.

Results/Trends

The following are the data mining activities and results for FY2024 Q1.

1) Death Data Report
   Results: There were 32 unique individuals that included 394 encounters. It was concluded that there were no instances where a service was provided after the date of death.

The following are the data mining activities and results for FY2024 Q2.

1) Death Data Report
   Results: There were 46 unique individuals that included 370 encounters. It was concluded that 2 (two) services, involving 2 (two) beneficiaries, reported past the identified date of death. The errors were corrected.

The following are the data mining activities and results for FY2024 Q3.

1) Death Data Report
   Results: There were 10 unique individuals that included 47 encounters. It was concluded that there were no instances where a service was provided after the date of death.

The following are the data mining activities and results for FY2024 Q4.

1) Death Data Report
   Results: There were 13 unique individuals that included 181 encounters. It was concluded that there were no instances where a service was provided after the date of death.

Subpoena(s)

MSHN received 3 (three) subpoenas during FY2024 requesting records. No action was needed regarding these requests as MSHN was not in possession of any requested records. MSHN was not named as a defendant in any of the subpoenas.

Notification of Breach(s)

During FY2024, within the MSHN region, there were 4 (four) instances reported involving a breach of protected health information. Out of the instances, 2 (two) were reported from Substance Use Providers and 2 (two) were reported from MSHN staff. In all situations, MSHNs breach policy and procedure was followed to remediate the situation and lessen the probability for future reoccurrence.

Overall Results/Trends

While there were fluctuations in numbers and percentages from the previous year, there were no discernible trends identified that warrant systemic changes. However, potential quality improvement efforts will be discussed with the MSHN Compliance Committee and the Regional Compliance Committee.

Compliance investigations:

- There was an increase in the total number of compliance issues reported during FY2024
- Suspected Fraud/Waste/Abuse continues to be the highest reported category at 56.25%.
- Twenty-seven (27) investigations were completed and achieved a closed status.
- Five (5) investigation is still pending closure by the OIG.

OIG quarterly report:

- FY2024 had a slight decrease in the number of reported activities from FY2023.
- The largest number of findings reported include the following:
    - Lack of documentation to support the claims submitted
    - Use of incorrect modifiers or lack of modifiers
    - Duplicated claims/Overlapping claims
    - Services not provided as billed

Subpoenas:

- There was a slight decrease in the number of subpoenas received during FY2024, but the increase was not notable.
- No subpoenas required action as they were not for clients served by MSHN or for the identified timeframe of the request.
- The number of subpoenas received cannot be influenced by any actions by MSHN.

Breaches:

- There was a slight decrease in the number of privacy breaches from FY2023 to FY2024.
- In all instances, the cases were remediated following MSHN's breach notification policy.

Activities Implemented in FY2024

The following activities were implemented during FY2024.

- Data Mining Activities included:
    - Death Audit Compared to Encounters (Q1, Q2, Q3, and Q4)
- Reviewed updates OIG referral process and quarterly OIG report
- Provide ongoing education, and ensure compliance with, updates to state and federal policies and regulations
- Provided feedback and approval for the FY2023 Annual Compliance Summary Report
- Reviewed revisions to the Program Integrity section of the PIHP/MDHHS contract
- Clarified documentation requirements for MEV reviews
- Provided feedback on the revised Delegated Managed Care (DMC) site reviews Quality Assessment Performance Improvement Program Committee Council Annual Report Process
- Received information/trends from the DMC site reviews
- Reviewed changes to SAMHSA SUD confidentiality of patient records
- Provided feedback on data analytics platform
- Reviewed trends in the OIG Quarterly Reports for needed systemic changes, etc.
- Provided consultation on local compliance related matters
- Coordinated with the PIHP Compliance Officers and representatives from MDHHS related to need to streamline and revise HSAG standards related to the Compliance site review
- Revised region wide privacy notice and standardized processes for providing protected health information

Recommendations for FY2025

The following are recommendations for improvements in FY2025.

- Continue to explore, and identify, additional region wide data mining activities to detect possible deficiencies and/or non-compliance with established standards
- Utilize the Constant Contact, emails, and other communication means for compliance related updates for providers including trends and quality improvement efforts
- Complete a workplan and implement the identified compliance software for tracking compliance investigations and documentation
- Continue to advocate with the OIG on expectations of the PIHPs when they are not identified as contractual, state, or federal requirements or value added to our system
- Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies
- Identify compliance related educational opportunities including those aimed at training compliance officers

Compliance Training/Review

Internal

MSHN Compliance Committee
Review Compliance Plan
Review of Compliance Policies and Procedures
Review Annual Compliance Summary Report

MSHN Regional Compliance Committee
Review Compliance Plan
Review Compliance Policies and Procedures
Review Annual Compliance Summary Report

MSHN Operations Council
Review Compliance Plan
Review Compliance Policies and Procedures
Review Annual Compliance Summary Report

MSHN Staff and Leadership
Receive Compliance Training as part of new hire orientation
Compliance Training for ongoing staff training through Relias
Review Compliance Plan
Review Compliance Policies and Procedures

Board of Directors
Review and approve Compliance Plan
Review and approve Compliance Policies
Review and approve Annual Compliance Summary Report

External

MSHN Compliance Plan and Compliance Line Available on Website- Compliance calls are received through the Compliance Line, the main line of MSHN or through the direct line to the Chief Compliance and Quality Officer.

MSHN Customer Service Line Available on Website - Customer Service calls are received through the Customer Services Line, the main line of MSHN or through the direct line to the Customer Services and Rights Specialist.

MSHN Contact information and reporting process located in Consumer Member Handbook "Guide to Services."

References

The following documents were used in the completion of the Compliance Summary Report and can be found in their entirety on Mid-State Health Networks website at: https://midstatehealthnetwork.org/

1. Medicaid Services Verification Methodology Report for Fiscal Year 2024
2. Health Services Advisory Group State Fiscal Year 2024 Validation of Performance Measures Report
3. Health Services Advisory Group State Fiscal Year 2024 Compliance Report
4. Health Services Advisory Group 2023-2024 PIP Validation Report

MSHN
Mid-State Health Network

FY2024 Board of Directors Self-Assessment Report

Background

As part of the annual process, the MSHN Board of Directors complete a Self-Assessment Performance Evaluation. An annual Board evaluation gives everyone a chance to exercise responsibility for self-review and to re- affirm the public trust and ownership in Mid-State Health Network (MSHN). Such evaluations prohibit shortcomings that might otherwise go undetected. By completing such an assessment, the Board is accepting responsibility for accountability, self-regulation and advancement of Mid-State Health Network's mission. Evaluating performance produces opportunities for improvement and often re-energizes the Board through the knowledge that it is performing well.

Recommended Motion:

Motion to receive and file the FY2024 MSHN Board of Directors Self-Assessment report.

March 4, 2025

Mid-State Health Network Board of Directors Annual Self-Evaluation: Trending Report

Submitted by Irene O'Boyle February 17, 2024

It should be noted that only 12 of the 23 Board members completed the evaluation and not all of the respondents answered every question. These are small numbers and one or two answers can make a big difference in response percentages. It should also be noted that several responding board members are new and indicated they are still in the learning phase and don't feel 100% comfortable answering some questions.

Mission, Vision & Strategic Direction: Overall response YES was 73%. The lowest response question was, "The Board receives adequate information, analysis, plans, proposals, and background materials that enable decision making. One comment noted: "I believe that EC of the board should spend more time on the SP so that the board can adjust that SP to better align with emerging issues.

CEO/Board Roles & Responsibilities: Overall response YES was 85%.

Resource Utilization & Risk Management: Overall response YES was 85%. One comment noted that "Financial reporting to the board should be less about specific numbers and more about implications and trends which nonprofessional board members can grasp.

Public Trust: Overall response YES was 75%. This category has the highest response (100%) for the question: "The public has opportunities to address concerns to the Board." This category also had the lowest response (50%) for the question: "Board members provide information and support Board positions with the media, key local/state decision-makers, and legislators.

Boardmanship: Overall response was YES 74%. The lowest question was: Members refrain from intruding on administrative issues that are the responsibility of the Mid-State Health Network CEO/Staff except to monitor results and prohibit methods that conflict with policy.

Board Evaluation of Support Staff: Overall response YES was 92%. This was the highest category overall. Board members indicate staff members are very helpful.

Diversity, Equity and Inclusion: Overall response YES was 53.6%. This was the lowest overall category. It should be noted that this was the first year these questions were included in the self-evaluation survey.

Visioning: Most Board members responding to the survey want our PIHP to continue to grow and serve our consumers. Board members are most afraid of MDHHS and potential changes and threats. Board members want trust between MDHHS and our PIHP.

FY24 Response Rate 52% (12 out of 23 standing members) Note: Comments were extracted and provided verbatim

	MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY20-FY24)	Yes					No					Needs Improvement					Unsure				
		19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24
Mission, Vision and Strategic Direction	1. The Board participates in strategic planning	95%	86%	95%	81%	92%	0%	0%	0%	0%	0%	5%	5%	0%	19%	0%	0%	9%	5%	0%	8%
	2. The Board has a clear sense of needs and priorities for the region	82%	71%	89%	67%	84%	5%	5%	0%	0%	0%	5%	14%	11%	24%	8%	8%	10%	0%	9%	8%
	3. MSHN has a clear sense of direction	86%	86%	100%	76%	75%	0%	0%	0%	0%	0%	5%	5%	0%	10%	17%	9%	9%	0%	14%	8%
	4. The Board is advised on national, state and local trends for their effect on behavioral health services	100%	90%	84%	86%	75%	0%	0%	0%	0%	0%	0%	10%	5%	14%	8%	0%	0%	11%	0%	17%
	5. The Board is presented with information about the strengths and weaknesses of MSHN	86%	85%	74%	66%	67%	0%	0%	0%	10%	0%	14%	5%	5%	10%	16%	0%	10%	21%	14%	17%
	6. The Board receives adequate information, analysis, plans, proposals and background materials that enable decision making	86%	95%	89%	71%	50%	0%	0%	0%	5%	0%	9%	5%	0%	10%	33%	5%	0%	11%	14%	17%
	7. MSHN's strategic priorities are clear, specific and measurable	73%	86%	74%	86%	83%	0%	5%	0%	4%	0%	9%	5%	10%	5%	0%	19%	4%	16%	5%	17%
	8. The Board evaluates progress of opportunities for improvement that are identified	77%	67%	74%	62%	58%	5%	5%	5%	9%	0%	5%	19%	16%	5%	25%	13%	9%	5%	24%	17%
	Comments: 1) DHHS presents us with ongoing challenges with greatly complicates the delivery of services - Just have to keep pushing on. 2)I believe the EC of the board should spend more time on the SP so that the board can adjust our SP to better align with emerging issues. 3)Difficult time for all. Difficult to plan when so much out of our control. 4)I just joined the board so I really can't answer these questions yet. 5)Great job. 6)Annual strategic planning is excellent.																				
CEO/Board Roles & Responsibilities	10. The Board asks "What" and "Why" and Expects the CEO to provide the "How"	86%	90%	100%	81%	75%	5%	5%	0%	0%	0%	9%	5%	0%	14%	0%	0%	0%	0%	5%	25%
	11. There is a mutual respect and open discussion between the Board and the CEO	100%	100%	100%	100%	92%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	8%
	12. Board communication to staff and providers is channeled through the CEO	91%	86%	90%	100%	92%	0%	0%	0%	0%	0%	0%	0%	5%	0%	0%	9%	14%	5%	0%	8%
	13. Revisions to all policies are reviewed and approved by the Board	100%	95%	95%	90%	91%	0%	0%	5%	0%	0%	0%	0%	0%	10%	0%	0%	5%	0%	0%	9%
	14. The Board receives timely and accurate communication	86%	95%	100%	95%	75%	0%	0%	0%	0%	0%	9%	5%	0%	0%	17%	1%	0%	0%	5%	8%
	Comments: 1)I just joined the board so I can't answer these questions yet. 2)Agree. 3)Excellent relationship.																				
Resource Utilization & Risk Management	16. Board members are advised of key laws, rules and regulations and the implications for MSHN	91%	100%	100%	81%	84%	0%	0%	0%	0%	0%	9%	0%	0%	5%	8%	0%	0%	0%	14%	8%
	17. The Board has established policies, by-laws and operating agreements to reduce the risk of liability for the Board and MSHN	91%	90%	89%	86%	92%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	9%	10%	11%	14%	8%
	18. Annually, or more often, the Board establishes priorities for the use of resources	77%	95%	79%	71%	67%	9%	5%	0%	5%	0%	9%	0%	10%	10%	25%	5%	0%	11%	14%	8%
	19. The Board receives routine financial reports including investment and risk management strategies	100%	100%	95%	90%	75%	0%	0%	0%	0%	0%	0%	0%	5%	5%	17%	0%	0%	0%	5%	8%
	20. The Board has an approved compliance plan and receives routine updates of compliance monitoring activities	91%	95%	94%	95%	92%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	9%	5%	6%	5%	8%
	21. The Board receives regular reports of external quality review, audits and other monitoring activities inclusive of planned corrective action	95%	95%	94%	86%	92%	0%	0%	6%	5%	0%	0%	0%	0%	0%	0%	5%	5%	0%	9%	8%
	Comments: 1)The lawsuits have become a key issue. The board needs to more education and understanding of MSHN's actions around this issue. 2)Financial reporting to board should be less about specific numbers and more about implications and trends which non-professional board members can grasp. 3)I just joined the board so I can't answer these questions yet. 4)Agree.																				

	MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY20-FY24)	Yes					No					Needs Improvement					Unsure				
		19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24
Public Trust	23. The public has opportunities to address concerns to the Board	95%	100%	95%	90%	100%	0%	0%	0%	0%	0%	5%	0%	0%	10%	0%	0%	0%	5%	0%	0%
	24. Public requests for action/change are addressed as appropriate	68%	81%	89%	76%	67%	0%	5%	0%	0%	0%	0%	0%	0%	5%	0%	32%	14%	11%	19%	33%
	25. Board members provide information and support Board positions with the media, key local/ state decision makers and legislators	59%	71%	68%	65%	50%	5%	0%	5%	0%	8%	9%	10%	0%	5%	8%	27%	19%	27%	30%	34%
	26. The Board reviews customer satisfaction feedback and evaluates concerns	59%	57%	79%	71%	84%	0%	5%	5%	0%	0%	14%	19%	5%	5%	8%	27%	19%	11%	24%	8%
	Comments: 1)Most members of the public have no idea what a PIHP does. How does this board improve their standing in the public. 2)I just joined the board so I can't answer these questions yet. 3)Question #25-In some occasions Board members have stated their position which does not represent the position of the board.																				
Boardmanship	28. Members refrain from intruding on administrative issues that are the responsibility of the Mid- State Health Network CEO/staff except to monitor results and prohibit methods that conflict with policy	77%	90%	100%	81%	50%	0%	5%	0%	0%	8%	18%	5%	0%	9%	17%	5%	0%	0%	10%	25%
	29. Members do not exercise authority apart from the authorization of the full Board	64%	95%	95%	90%	75%	0%	5%	5%	0%	0%	5%	0%	0%	0%	8%	32%	0%	0%	10%	17%
	30. Members serve the best interest of Mid-State Health Network rather than personal or other professional interests	77%	90%	95%	86%	84%	0%	0%	0%	0%	0%	18%	5%	0%	9%	8%	5%	5%	5%	5%	8%
	31. Members are respectful of one another	100%	95%	100%	90%	84%	0%	0%	0%	0%	0%	0%	5%	0%	10%	8%	0%	0%	0%	0%	8%
	32. I am satisfied with the personal contribution I make to the Board	55%	67%	79%	67%	75%	5%	0%	0%	5%	0%	32%	33%	21%	29%	8%	8%	0%	0%	0%	17%
	Comments: 1)Overall the board makes a good effort to put its "parochial" issues in place to allow an understanding of the MSHN perspective. 2)I just joined the board so I can't answer these questions yet. 3)Hopefully all are true.																				
Board Evaluation of Support Staff	34. I am satisfied that meetings are set up efficiently and in a timely manner	100%	100%	100%	86%	92%	0%	0%	0%	0%	0%	0%	0%	0%	9%	0%	0%	0%	0%	5%	8%
	35. I am satisfied that Board Packets are sent in a timely and complete manner and copies are made accessible	86%	95%	100%	95%	92%	9%	0%	0%	0%	0%	5%	0%	0%	0%	0%	0%	5%	0%	5%	8%
	36. Responsiveness to information requested is adequate, of good quality and timely	100%	100%	100%	86%	92%	0%	0%	0%	0%	0%	0%	0%	0%	5%	0%	0%	0%	0%	9%	8%
	37. Board member requests are handled in a polite, friendly and professional manner	100%	95%	100%	95%	92%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	5%	0%	5%	8%
	38. Board meeting minutes are accurate and presented in a timely manner	100%	95%	100%	95%	92%	0%	0%	0%	0%	0%	0%	5%	0%	0%	0%	0%	0%	0%	5%	8%
	Comments: 1)The staff provides expert support to the board relating to meetings and communication. 2)Support staff is very helpful. 3)I just joined the board so I can't answer these questions yet. 4)These items are a very strong strength of MSHN. 5)Very satisfied with this section. 6)Excellent support staff.																				

MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY20-FY24)		Yes					No					Needs Improvement					Unsure				
		19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24
Diversity, Equity and Inclusion	40. As a board member, I have a deep understanding of the health equity work of the agency.	N/A	N/A	N/A	N/A	42%	N/A	N/A	N/A	N/A	8%	N/A	N/A	N/A	N/A	33%	N/A	N/A	N/A	N/A	17%
	41. As a board member, I deliberately establish consistent communication channels and bring the perspectives, feedback, needs and priorities of diverse communities, especially those affected by health disparities, into board decisions.	N/A	N/A	N/A	N/A	42%	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	33%	N/A	N/A	N/A	N/A	25%
	42. As a board member, I have a deep level of understanding of the diversity, equity and inclusion work of the agency.	N/A	N/A	N/A	N/A	50%	N/A	N/A	N/A	N/A	17%	N/A	N/A	N/A	N/A	25%	N/A	N/A	N/A	N/A	8%
	43. The board ensures principles of diversity, equity and inclusion are incorporated into all MSHN policies.	N/A	N/A	N/A	N/A	67%	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	33%
	44. The board ensures the agency actively engages people affected by health disparities in developing, planning and implementing health equity activities.	N/A	N/A	N/A	N/A	67%	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	33%
	Comments: 1)Not sure if I ever will be able to feel I have the "deep" levels this section talks about. Not sure with DHHS in charge that they will allow us to get beyond what they feel is the basis of "deep." So, will keep putting in the effort to make it all fit. 2)I am not sure that our federal partners will continue to support this work. 3)I know little to nothing about DEI activities. 4)I just joined the board so I can't answer these questions yet.																				
Visioning	46. My dream for Mid-State Health Network is: 1)Survive. 2)That we can work with our association to reestablish communication with the department. PIHP operations and trust should not become a victim due to a lawsuit. When we talk, our consumers win. 3)Financial soundness. 4)I just joined the board so I can't answer these questions yet. 5)That the state will let us do our job and provide the required financial support. 6)To Continue. 7)Continue to be able to serve the local community mental health system. 8)To continue to serve consumers with adequate resources.																				
	47. My greatest concern for Mid-State Health Network is: 1)We will get consumed by that mystical concept of "best practices" and lose the ability for the "unconditional positive regard" that makes counseling work. Robots are getting bet at it then we humans are. Scary. 2)Dissolution of our current system. 3)Financial soundness. 4)I just joined the board so I can't answer these questions yet. 5)That the state will continue it's efforts to privatize the system. 6)Ensuring financial stability to provide consumer services. 7)Changes in state/federal policies. 8)Financial. 9)MDHHS indecisions.																				
	48. With respect to Mid-State Health Network, I am proudest of: 1)Our dedication to continue meeting our mission in spite of everchanging challenges presented by DDDS.. 2)The professional manner in which the board resolves differences. 3)Work seems genuinely about ultimately helping people with mental health problems not peoples careers. 4)I just joined the board so I can't answer these questions yet. 5)Our senior leadership and staff. 6)Being a member of the board of directors of MSHN. 7)Fiscal accountability and openness between board and MSHN staff.																				
	49. I feel that Mid-State Health Network's greatest opportunity for improvement is: 1)Expand services for youth and not fall back to having ODD classified in the Mild to Moderate category as a way to pass them on to "other" Medicaid providers. 2)Development of trust between the association and the department. 3)Unsure. 4)I just joined the board so I can't answer these questions yet. 5)Better communication of other views of issues facing MSHN from CMHs within MSHN and also from other PIHPs and our CMA to provide a more unified stand on issues of concern. 6)Continue to work towards compromise and collaboration with MDHHS.																				
	50. Other recommendations/feedback: 1)I just joined the board so I can't answer these questions yet.																				

MSHN
Mid-State Health Network

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
January/February 2025

- After over three decades of service, Jim Johnson, the Chief Executive Officer (CEO) of Region 10 Pre-paid Inpatient Health Plan (PIHP) has stepped down effective 02/14/25. I have worked directly with Jim for over three decades and will experience his departure as a personal loss and a loss to our public system. Kelly VanWormer has been appointed Interim CEO while the Region 10 board conducts a candidate search.
- My recent surgery and ongoing recovery are going extremely well. My thanks to Deputy Director Amanda Ittner and our entire leadership team for covering things during my absence. Thank you to those of you that reached out to check in.

PIHP/REGIONAL MATTERS

1. Conflict Free Access and Planning (CFAP) Update:

Please refer to my previous board reports for additional detailed background if needed. As the MSHN Board is aware, Michigan Department of Health and Human Services (MDHHS) has stated its expectation that Pre-paid Inpatient Health Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs) will come into compliance with the CFAP requirements (separation of entity conducting service planning from entity responsible for service delivery). Several waiver renewals have been submitted by MDHHS to Centers for Medicare and Medicaid Services (CMS) that include this compliance requirement. Those waiver renewals have now all been approved by CMS. See this link for the 1915(i) State Plan Amendment Approval (search for "Conflict of Interest").

MSHN still awaits official communications from MDHHS on these important new requirements and the answers to questions MSHN and the field submitted now almost a year ago. Because Dr. Todd Lewicki, MSHN's Chief Behavioral Health Officer, will provide a detailed update on what we know – and what we don't – at this board meeting, my report will not detail newer developments.

2. MDHHS Site Review – Repeat Citation for Use of Ranges in Plans of Service:

As reported first in my March 2023 board report, and several subsequent updates (the most detailed is in my January 2025 report), MSHN has been cited by the MDHHS site review team a number of times (first in 2020) for the use of ranges in person-centered plans of service. MSHN has appealed these citations over the years and has maintained that there are no regulatory requirements that require the use of a finite number or that prohibit the use of ranges. Our position is supported by research we commissioned through Health Law Partners. MSHN as a region has not implemented the requirement to use a finite number and/or eliminate the use of ranges, although a number of CMHSP Participants in our region have chosen to do so.

MSHN administration met with MDHHS to explain our position, our desire for compliance with established standards, the absence of a regulatory or contractual standard, and requested MDHHS pause any contract action they may be contemplating while these disagreements are resolved. MDHHS agreed to take the matter up internally and to pause any contract actions until further notice.

Under the leadership of Dr. Todd Lewicki, our region will be proposing a definition of "appropriate ranges" for use in person-centered planning processes for MDHHS consideration (at their request).

3. **Regional Crisis Residential Program Update:**

(Excerpted from MSHN Behavioral Health Department Quarterly Report): Healthy Transitions (HT) was approved by MDHHS to begin crisis residential services on June 12, 2024. MSHN meets with HT monthly and as needed at this time. HT reports that their daily census fluctuates but is generally around three to four residents per day. Ending FY24Q4, HT's availability for services was shared with Northern Lakes CMH, the North Michigan Regional Entity PIHP, and Lakeshore Regional Entity PIHP. These organizations will ensure that information on HT is shared with their systems and will contract as needed. HT has indicated a desire to "tier" the approach to marketing awareness of their availability in Michigan to ensure that they are not inundated. The State PIHP Utilization Management (UM) group will also be informed in the coming months as to HT service availability.

MSHN has worked with HT to institute a series of data and performance measures as well. These include average length of stay, denials, development of the IPOS within 48 hours of admission, percent of adults discharged in 14 calendar days or less, count of monthly admissions, average daily census, count of discharges by month, total individuals with greater than or equal to three discharges during the previous 90 days, total planned discharges, recidivism within 30 days of discharge, completed consumer surveys, and surveys indicating satisfaction with services. Data collection began in January 2025. MSHN will be supporting reports where possible and will share this with HT and the region.

4. **Regional Implementation of the Michigan Child and Adolescent Needs and Strengths Assessment:**

(Excerpted from MSHN Behavioral Health Department Quarterly Report): The regional Michigan Child and Adolescent Needs and Strengths (MichiCANS) Implementation Workgroup was established to initiate and oversee coordination of the MichiCANS tool for the region. The MichiCANS Workgroup is comprised of MSHN staff responsible for children's services and the Community Mental Health Service Provider (CMHSP) staff.

The workgroup continues to report frustration and confusion related to the scores flagging clinical outcomes in a much higher level of care than clinician findings. The region is indicating a recommendation for more training. The workgroup will continue to work at identifying of areas of standardization and improvement of operating guidelines. MDHHS has begun to offer supervisor trainings and Severe Emotional Disturbances Waiver (SEDW) workflow meetings to address these issues on a state level with the PIHPs and CMHSPs. This new work will inform the MichiCANS workgroup and processes that will be used. The recent approval of the SEDW application by CMS may also affect efforts relative to MichiCANS and the previously used (but required to continue) Child and Adolescent (and Pre-School and Early Childhood) Functional Assessment Scale CAFAS/PECFAS efforts. Further guidance on this is expected from MDHHS.

5. **Substance Use Disorder Oversight Policy Board (OPB):**

State law requires each Community Mental Health Entity (a legal reference to what we call PIHPs) to contract with each county in its catchment area to appoint a representative to the MSHN Oversight Policy Board, which has the legal responsibility for overseeing liquor tax monies which are provided by those counties to MSHN to fund prevention and other services and supports for individuals in those contributing counties. MSHN has structured OPB operations to include seeking its counsel on substance use disorder operations and services. Deputy Director Amanda Ittner staffs the regional OPB.

The OPB operates under bylaws within this limited scope. The OPB was presented with edits to its bylaws consistent with recent MSHN Governing Board bylaws edits and other needed updates at its February 2025 meeting for consideration at its April meeting. Note that unlike the MSHN Governing Board bylaws which empowers its CMHSP Participants exclusively to amend the bylaws, the MSHN Oversight Policy Board may act to amend its bylaws as a board.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

6. **DHHS Will Be A Target of Scrutiny Under New (MI) House Committee Structure:**

From Gongwer Capitol News Service, 01/27/25: The Department of Health and Human Services (DHHS) will be a primary target of the House Oversight Committee and the House appropriations process, Republican sources speaking with Gongwer on background said.

House Speaker Matt Hall (R-Richland Township) has repeatedly stressed his desire to cut the state budget since taking control of the House, and, as the department with the biggest budget, sources said that DHHS is viewed as an area with ample room for cuts.

"When you see this expansion of government, 43 percent under Whitmer, are we getting that value for your dollars?" Hall said at a press conference earlier this month when he announced the chair and vice chairs of the House Appropriations Committee . "Are we getting a return on investment for the taxpayers? So, we're going to look at the budget with that emphasis and that focus, and that's the value we're going to approach it from."

The size of the DHHS budget was a driving factor for creating multiple subcommittees under House Appropriations and the House Oversight Committee, sources speaking on background said.

For Appropriations, the Department of Health and Human Services budget was divided into three subcommittees, including Medicaid and Behavioral Health, Human Services and Public Health. The House Oversight Committee will also have three DHHS focused subcommittees, including the Child Welfare Subcommittee, the Public Health and Food Security Subcommittee and the State and Local Public Assistance Subcommittee.

Another factor in the House's focus on the department was the way it worked with lawmakers during the COVID-19 pandemic, sources speaking on background said.

Hall was the chair of the House Oversight Committee during that time, and he and other lawmakers were frustrated with the "stonewalling" they received from the department while they were trying to get questions answered, sources said.

Rep. Jay DeBoyer (R-Clay), the newly appointed chair of the House Oversight Committee, said he wasn't starting his position with any preconceived notions of what should be cut or examined.

"(DHHS) make(s) up a third or greater of the state budget, so that's a giant segment of dollars that just, by the nature of the beast, needs to have oversight," he said. "It's important that we look into those things and make sure that the service that should be being provided in a safe and effective way is being provided."

DeBoyer said that the approach to each of the subcommittees under Oversight and Appropriations was still being worked out because subcommittee chairs have yet to be appointed.

"It's going to be serious," he said. "We really mean what we're saying: We want to find waste, fraud and abuse. We want to find the mismanagement … the door is wide open on all of those things, whether it be DHHS or DNR."

Separating Oversight from Appropriations will help provide multiple angles to evaluate departments, DeBoyer said, DHHS included.

"In the past, there's been, if not demonstratable, at least the appearance of coziness between Appropriations chairs and department heads, and at times, that can cause not the most efficient government to be produced," he said. "What Oversight will be able to do, they won't be navigating in that back-and-forth relationship from an allocating of funds … they'll be looking at it from a singular angle of what is the most efficient and best way for this department to operate."

That approach is intended to make it easier to right-size department budgets, DeBoyer said.

"With oversight, appropriations and policy, you're taking away the single person problem, which, when you have a single person, you can have biased results. You can have ulterior motives. You can have backdoor deals," he said. "When you have a comingle of policy, appropriations and oversight, the likelihood of that happening is much less."

DeBoyer said the expectation is not that House committees will uncover fraud, but rather they will discover more efficient ways for government to operate.

Department heads will need to acknowledge they don't have all the answers and should be willing to work with lawmakers, DeBoyer said.

"That is a very different approach than to stonewall or to hide. Even if you didn't do anything nefarious, if you stonewall or you hide, you don't deserve to be in some of those positions," he said. "Your attitude should be we want to deliver the best services there are for the best possible cost that we can, to only the individuals that genuinely qualify for those services."

DeBoyer said the committees want to be an asset to the departments.

"The department heads have nothing to fear if they're doing what they're supposed to be doing," he said. "We're here to put another set of eyes on things to be able to make it better."

Even as DeBoyer said he plans to take an even-handed approach to all departments, Republican sources with knowledge of Hall's thinking said on background that DHHS in particular has reason to expect close scrutiny this term under the new committee structure.

In response to House Republican plans to target the department, DHHS did not address the special focus directly.

"The department looks forward to working with the Legislature throughout the budget process," said Lynn Sutfin, spokesperson for the Department of Health and Human Services.

7. **Waskul (Federal) Lawsuit Update:**

From Gongwer Capitol News Service, 01/30/25: A federal district court judge this week approved a settlement between the Department of Health and Human Services and a community health advocacy program after the case spent nearly a decade in court.

Waskul v. Washtenaw County Mental Health (USEDM Docket No. 16-10936) was filed in 2016 by several people who participate in the state's Community Living Supports program and the Washtenaw Association for Community Advocacy, a nonprofit organization that advocates for support services for people with intellectual and developmental disabilities.

The plaintiffs claimed the defendants, which include Washtenaw County Community Mental Health, DHHS and Director Elizabeth Hertel, violated state and federal law, as well as contracts shared among the defendants, by modifying the methodology by which the plaintiff's program budgets were calculated.

After nearly a decade in court, the parties engaged in settlement negotiations in 2023 and reached a pending settlement with the help of a mediator. The plaintiffs asked U.S. District Judge Linda Parker of the Eastern District of Michigan to approve the settlement, and a fairness hearing was held December 3, 2024.

Although there were numerous objections, Parker found the settlement to be fair, reasonable and in the public interest. An oral ruling was given from the bench, but Parker made it official with an opinion and order issued this week.

Details of the settlement include DHHS agreeing to a minimum fee provision through September 2029, which will provide all CLS recipients a $31 hourly rate for services and an approximately $21 hourly rate for overnight health, safety and support services subject to inflation.

The plaintiffs have been promised the increased rates as soon as possible after the settlement agreement is approved, but no later than 60 days after execution of the agreement.

The rates are to continue until the minimum fee provision take hold or, if failure to provide the rate occurs, until 60 days after a drop dead date of June 1 or any extension of that date.

The settlement agreement also aims to strengthen the administrative process, changing what a Community Mental Health Services Program or Prepaid Inpatient Health Plan must document when declining or rejecting services, and bolstering the administrative appeals process. The settlement

provisions are intended to protect the due process rights of beneficiaries, Parker wrote, adding that they also confer more authority and power on administrative law judges to enforce a beneficiary's individual plan of service when the PIHP and/or CMHP decline or reject services.

An important contingency is for the execution of an amended contract between DHHS and Community Mental Health Partnership of Southeast Michigan, and for the Legislature to approve appropriations to fund the agreement.

Further, while the minimum fee schedules are not required if the contingencies do not occur, DHHS agrees in that instance to amend the Medicaid Provider Manual to reflect the 'costing out' procedure outlined in … the agreement," Parker wrote. "This procedure is designed to ensure that each component of a recipient's CLS budget (such as staff wages, community activities, transportation) is built up separately based on each beneficiary's (individual plan of service) to create a total, individualized … CLS rate. In other words, it is designed to assure that sufficient funding is budgeted to implement what is required in the (individual plan of service)."

The plaintiffs had also asked Parker for a declaration that the settlement be binding on the more local defendants, which Parker denied.

The judge also denied the defendants' request to strike the declarations submitted by two of the plaintiffs, which Parker said there was no reason to do.

8. **MSHN/MDHHS "Master Contract" for FY 25:**

I have provided detailed updates in several of my previous board reports. I reported in my January 2025 board report that three PIHPs (Region 10, NorthCare, and NMRE) filed suit against MDHHS in the Michigan Court of Claims. A fourth PIHP (CMH Partnership of Southeast Michigan) has joined the suit. These four PIHPs, and LakeShore Regional Entity, signed their FY 25 contracts with strike through edits, which MDHHS did not agree with nor did MDHHS sign the contracts. Those five PIHPs are operating under the termination/transition clause of the last contract they signed (FY 24) which requires "up to two years" of continued operations and cooperation in a transition to a successor contractor.

As noted, my previous board reports and emails have summarized the issues involved. The State of Michigan (Attorney General) has filed its response to the suit. In very brief summary please note that the State has moved for summary disposition based on the following main points (in my words and I have greatly oversimplified but have attempted to ensure fidelity to the issues):

- Litigating PIHPs have not signed their FY 25 contract, so there is no basis for suing to enforce it.
- Because the PIHPs have not signed the FY 25 contract, the litigating PIHPs lack standing to sue for its breach or enforcement.
- Even if these issues could be overcome:
    - The FY 24 contract language affecting the Internal Service Funds (ISF) is unambiguous, is in compliance with federal and state law, and has been approved by CMS.
    - The *Waskul* language included in the contract is a placeholder, is lawful, and if the several contingencies are met must be implemented "because PIHPs have no authority to pick and choose which of MDHHS's Medicaid policy decisions they will follow."
- The state's filing also makes its position on contracting with PIHPs clear, per the following: Citing the Michigan Social Welfare Act [MCL 400.109f(1)]: ""Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans *chosen by the*

department." MCL 400.109f(1) (emphasis added). The plain language of this statute supports a process wherein MDHHS is required to use PIHPs to manage and deliver services, but MDHHS can *choose* which PIHP to contract with. *Id.* Nothing in MCL 400.109f(1) suggests that MDHHS has *any* obligation to contract with any *specific* PIHP."

MSHN will await further action of the Court of Claims, especially on the State's motion for summary disposition and/or any hearing on these matters. If any board member would like a copy of these filings, please contact my office and we'd be pleased to send you copies of interest to you.

9. **MDHHS Announces "Reconfiguration" of MDHHS/PIHP CEO Meetings and MDHHS/PIHP Contract Meetings:**

Quoted from a 01/23/25 email from Kristen Morningstar, MDHHS Specialty Behavioral Health Services Director. Note that as of the date of this report, those meetings have not been re/scheduled nor has there been any communication on details of this reconfiguration:

"Our team is currently working on reconfiguring some of our meeting series, including the contract meetings and the PIHP CEO meetings. We will soon be pulling down the calendar appointments for both and getting new series added."

"Going forward, the contract meetings will be used to cover a broader array of operational topics. These meetings will be held monthly, which I believe is more consistent than the existing series, with the goal of including Subject Matter Expert's (SME's) for the particular agenda items to ensure more robust discussion. Stay tuned for additional correspondence on structure and agenda building. "

"Additionally, the PIHP CEO meetings are going to shift to a bi-monthly structure. If there is a need for an ad hoc meeting outside of the regular cadence, we'll certainly make that happen. As we discussed at our last meeting, we'd like the agenda to be finalized a week before the meeting occurs."

10. **MDHHS Announced CMS Approval of a Michigan "Re-Entry" Waiver:**

CMS has approved a new section 1115 demonstration for the State of Michigan titled *Reentry Services*. This reentry demonstration will allow the state to provide limited pre-release demonstration coverage to certain incarcerated individuals under Medicaid, as well as for applicable youth who are or would be eligible for Children's Health Insurance Program (CHIP) if not for their incarceration status, for up to 90 days pre-release. Michigan has selected to provide pre-release services in state prisons, county jails, tribal correctional facilities, and juvenile facilities (including Juvenile Justice Facilities and County-Operated Juvenile Detention Centers). The approval is for operations through December 31, 2029.

FEDERAL/NATIONAL UPDATES AND ACTIVITIES

11. **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.

12. **Federal Prison Oversight Act (Report):**

The Journal of the American Medical Association (JAMA) Network Internal Medicine has published an article entitled *Establishing National Standards for Carceral Health Care—The Federal Prison Oversight Act*. "The US incarcerates more of its population than any other nation, with prisons and jails serving as health care organizations for those detained. While imprisoned, unhealthy and unsafe conditions compound existing health disparities resulting in excess morbidity and a 2-year decrease in life expectancy for each year served. Carceral conditions also negatively affect the health of facility staff, with correctional officers experiencing elevated rates of posttraumatic stress disorder, traumatic injury, and suicide. With 95% of incarcerated individuals eventually returning to our communities and tens of thousands of employees cycling through carceral facilities daily, prison health is public health.

- The Eighth Amendment to the US Constitution protects incarcerated individuals from deliberate indifference to their serious medical needs, including access to care, enactment of ordered care, and care without bias to status. Despite such protections, the US lacks uniform regulation and monitoring of carceral health care. The US, however, holds no stated goal of equivalent care to the general population, so the health care quality that individuals receive while incarcerated differs and is often deficient to that provided to patients who are not incarcerated. With most incarcerated people eventually released, community health care systems often bear the brunt of these untreated medical conditions.
- In the community, public insurance programs such as CMS may withhold funds if care standards are not met. Overarching accreditation bodies, such as the Joint Commission, regulate standards across medical facilities along CMS guidelines. Those incarcerated, however, are excluded from public reimbursement programs under the Social Security Act's Inmate Exclusion Policy, meaning the requisite oversight that follows public reimbursement does not penetrate jail or prison walls. Instead, carceral health care regulation often arises reactively through lawsuits following patient harm, a process curtailed in federal courts by the 1996 Prison Litigation Reform Act. The 2018 First Step Act introduced more protections for individuals in federal custody but still failed to require proactive monitoring or oversight.
- In late July 2024, President Biden signed into law the Federal Prison Oversight Act (H.R.3019/S.1401) with overwhelming bipartisan support.
    - The legislation establishes transparent monitoring in all 122 Federal Bureau of Prisons (BOP) sites across the nation, including ensuring access to medical and psychiatric care for both incarcerated people and correctional staff.
    - The Act creates an Inspector General to provide regular facility surveillance and an Ombudsman to investigate concerns from staff, incarcerated persons, or others.
    - The bill also requires an inspection regime inclusive of community input by formerly incarcerated people, families, and community advocates and public reporting on facility conditions and corrective plans. Organizations including both the American Civil Liberties Union and correctional officer unions support the legislation.
- With passage of the Federal Prison Oversight Act, the Inspector General will be required to create a tool for assessing conditions within BOP facilities, which will then guide monitoring and remediation. The quality metrics composing this assessment are not yet established but should include access to medical, psychiatric, and substance use treatment either not previously found or inconsistent across carceral centers, such as preventive services, trauma-informed care, violence interruption and de-escalation training for staff, and effective medications for opioid use disorder.

- Though the US correctional system is fragmented across federal, state, and municipal systems, the largest single correctional agency is the BOP, holding over 158 000 of the 2 million incarcerated individuals in the US. Policies and procedures established at the federal level can influence practices in state prisons and municipal jails, and vice versa.
- Improving the health of those in federal prisons requires adapting community quality improvement and tracking methods to the carceral setting, while incorporating lessons learned from individual state correctional systems.
    - The Partnership for Quality Management (PQM), a central repository for quality standards drawn from CMS, nongovernmental organizations, academic medical centers, and professional societies, also endorse many of these metrics. While inexhaustive and requiring adaptation to the carceral health care setting, HEDIS and PQM metrics offer a starting point for organizing and tracking carceral health care structures and processes. Similarly, the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, which measure care access and patient-reported health status, should be tested in correctional settings. Ideally, quality metrics should be refined that assess the clinical impact of carceral health care services following release.

The passage of the Federal Prison Oversight Act represents a unique opportunity to improve the health of those living and working in carceral facilities, as we currently have few standardized tools or systems to monitor, regulate, and publicly report on the quality of care provided within these sequestered environments. It is imperative that medical professionals partner with the Inspector General and advisory board when crafting metrics for judging the adequacy of medical and mental health care within our federal prison system and assessing balance measures."

13. **Medicaid Reductions On the Horizon:**

An opinion piece by the President/CEO of Kaiser Family Foundation entitled *The Biggest Health Policy Decisions Now Facing the Trump Administration*.

"Decisions about two things—paying for tax cuts, and whether President Trump wants another big fight about health care—more than any other factors, will drive the biggest health policy decisions in the early days of the Trump administration.

- The first big decision is the one Republicans will make about paying for their $5 trillion tax cut (coincidentally about the same amount as we spend on health care each year). After plans were floated in the House for Medicaid cuts totaling an astronomical $2.3 trillion, Republicans appear to be circling around plans for Medicaid cuts in the neighborhood of almost $900 billion over 10 years.
- That leads to the second big decision. Does President Trump want another big health care debate? Any of the big Medicaid proposals floated so far—a per capita cap, drastic cuts in federal Medicaid expansion matching rates effectively killing the expansion in 40 states and DC, or significant cuts in the regular Medicaid matching rate, and Medicaid work requirements—will bring a divisive debate.

With margins tight in the House, the President may not want to run the risk of another defeat on a big health care package, having suffered a dramatic defeat on the Affordable Care Act (ACA) repeal in his first term. Instead, he may decide to keep health care, with its incendiary politics, out of the picture and avoid handing Democrats a hammer to use to drive down his popularity and wield in the midterms. Conservative Republicans in the House have a clear policy agenda to reduce federal health spending and the federal role in health.

Among the policies under consideration Medicaid work requirements (see related item below) are the most certain to survive. They will not be an easy sell, however. The idea of work is popular. But Medicaid work programs don't actually achieve gains in employment, are a heavy lift for states to administer, and are bitterly opposed by Democrats and advocates. They save real money—about $10 billion a year in federal spending over 10 years according to one Congressional Budget Office estimate—but not a lot in the context of $5 trillion in tax cuts and the challenges of implementing work programs. Ninety-two percent of the adult Medicaid population is likely exempt from the requirements for various reasons (they are working already, may be disabled, or caring for a family member), but every beneficiary has to prove that by jumping through hoops or by that being determined electronically. When they fail to comply with the red tape, they are dropped from Medicaid (the real purpose of the programs, many believe). The jobs some of the remaining 8% can get often come with lousy or no health coverage, a disincentive to take them."

14. Medicaid Work Requirements:

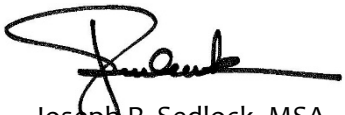
The Kaiser Family Foundation has published an article entitled *As States Mull Medicaid Work Requirements, Two With Experience Scale Back*. Georgia is proposing to scale back key parts of the nation's only active program. And Arkansas announced an effort to revive — with fundamental changes — a program that ended after a legal judgment in 2019.

- The Georgia and Arkansas proposals, from the only two states to have implemented Medicaid work requirements, reveal the disconnect between rhetoric behind such programs and the realities of running them, said consumer advocates and health policy researchers.
- More than a dozen states had Medicaid work requirement programs approved during Trump's first administration.
- After an expensive and bumpy rollout, Georgia in January posted a draft renewal plan for its Georgia Pathways to Coverage program. The plan removes the requirement to document work every month and to pay premiums. Those key elements — which supporters have argued promote employment and personal responsibility — were never implemented, the state said. Enrollees would still have to meet the work requirement when they first apply and when they renew each year.
- Arkansas' latest request to federal officials doesn't require enrollees to report their work hours. Instead, it proposes checking whether people are working, caregiving, or fulfilling other qualifying activities by using data, which could include income, job history, educational status, whether a child lives at home, and other criteria.

More than 90% of U.S. adults eligible for Medicaid expansion are already working or could be exempt from requirements. Still, several states are quickly moving to restart Medicaid work requirements. Besides the three states of Arkansas, Ohio, and South Carolina, Iowa and South Dakota are considering similar proposals. Lawmakers in Montana are weighing them as they debate renewing the state's Medicaid expansion.

- There is no evidence showing such programs improve economic outcomes for people; the requirements don't help people find jobs, but not having health insurance can keep them from working, health policy researchers say.
- Consumer advocates, health policy analysts, and researchers said the scaling back seen in recent work requirement proposals speaks to the challenges of mandating them for public benefits — and could serve as a cautionary tale for Republicans in Washington, D.C., and across the country. The programs can eliminate people from the Medicaid rolls or suppress enrollment, while adding costly layers of bureaucracy, they said.
- "As a matter of health policy, work-reporting requirements in Medicaid are fundamentally flawed," said Leo Cuello, a researcher at the Georgetown Center for Children and Families."

Submitted By:



Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 02/18/2025

Attachments:

- MSHN Fiscal Position Memo to MDHHS
- MSHN Michigan Legislation Tracker (expertly compiled and tracked by Sherry Kletke)

MSHN
Mid-State Health Network

February 18, 2025

TO: MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
- Kristen Morningstar, Director, Bureau of Specialty Behavioral Health Services
- Jackie Sproat, Director, Division of Contracts and Quality Management
- Keith White, Director, Actuarial Division, Bureau of Medicaid Policy, Operations and Actuarial Services

FROM: MID-STATE HEALTH NETWORK

RE: FYE 24 Results of Operations; FY25 Projected Financial Status

The purpose of this memorandum is to alert Michigan Department of Health and Human Services (MDHHS) to the FYE 24 Results of Operations for the Mid-State Health Network ("MSHN"; Region 5) and FY 25 Projected Financial Status. Specifically, MSHN is alerting MDHHS to serious actual and projected deficits assuming revenue and healthcare operations continue on current projected trajectories. MSHN is also requesting MDHHS assistance to address and resolve the issues summarized below.

FYE 2024 Results of Operations:

It is important to note that MSHN had benefit of a fully funded internal service fund (ISF) at the start of the fiscal year 2024 of approximately $56.9M. Unlike previous fiscal years, MSHN began FY 24 with minimal prior year savings of $8.6M.

The MSHN Interim Financial Status Report submitted to the MDHHS in November 2024 indicated a region-wide deficit (revenues under expenses) of approximately $25M. (Note that MSHN will update this memo and related figures when the final FSR is submitted to MDHHS). While this is a large and significant deficit, the deficit is under 105%. Thus, the MDHHS/MSHN contract and MSHN's approved risk management strategy requires that MSHN use available ISF to cover its 100% share of the deficit within risk corridor. MSHN acknowledges that this is the very reason for the ISF, but alerts MDHHS that doing so will reduce the available ISF for FY 25 to approximately $32M. MSHN also notes that it has no way to immediately replenish this use of ISF to cover

its share of future risk corridor events.

The natural question is what is driving this excess of expenses over PEPM revenue. While we intend to detail this separately in a requested future meeting with MDHHS officials, the most important drivers to convey at this time are a combination of significantly increased demand (especially for community living supports, psychiatric inpatient, and autism services), worsening acuity of existing beneficiaries, and region-wide workforce cost increases.

FY 25 Status and Projections:

It is important to emphasize that prior year trends noted above continued, even while the region was under (self-imposed) cost containment plans during the FY 24. While some significant reductions in costs were achieved, they were largely offset by utilization/demand increases.

MSHN began FY 25 with zero prior year savings to carry forward for the first time in its 11-year history, along with a significantly reduced Internal Service Fund (~$32M) for the first time since this PIHP was established in 2014.

As you know, MDHHS did not publish final rates until just prior to the beginning of FY 25. In our FY 25 budgeting process, MSHN used June 2024 draft rates to estimate the bulk of regional revenue. After analyzing expense trends, cost containment activities, increased demand/utilization, and revenue estimates, MSHN presented its board with a FY 25 budget showing a projected FY 25 deficit of over $29M. Please note, a revenue analysis was performed with final Rate Certification figures and the results showed a smaller deficit of about $19M. Neither draft nor final rates are sufficient to cover medically necessary services for Region 5.

If nothing changes in the underlying drivers of this region's projections (which is unlikely given known expense increases such as mandated ABA rate increases), the MSHN internal service fund will be nearly depleted by FYE 25, with a balance of only about $8M. The available internal service funds projected to include year-end results of operations will not be sufficient to cover the MDHHS/MSHN contractually required 100% share of deficits up to 105% of revenues and 50% share of deficits between 105% and 110% of revenues. MSHN again notes that it has no way to immediately replenish this use of ISF to cover its share of future risk corridor events.

However, on the revenue side, MSHN has already been impacted by a change in revenues received. Specifically, (through period 3, 12/31/24) the amount of revenue originally budgeted based on the draft rate certification letter when compared to actual revenues received, projected to year end, is trending approximately less by $57M. If this revenue trend holds as observed, MSHN will end the year in a deficit position of $19.1M which will leave approximately $8M in ISF. This is a significant concern since expense figures will likely increase from the December amounts used for the projections.

This is a frightening place to be fiscally, is unacceptable from a prudent management and contractual compliance standpoint and is unsustainable from a regional and local services/supports management perspective.

We need your help to address the revenue side of this problem while we continue our work to address the expense side.

We urgently seek a meeting with MDHHS officials to present additional details, answer your questions, and secure commitment to collaboration to achieve better results than described herein.

In partnership –

FOR MID-STATE HEALTH NETWORK

By:

Joseph P. Sedlock
Chief Executive Officer

Amanda I. Ittner
Deputy Director

Leslie D. Thomas
Chief Financial Officer

C: Region 5 CMHSP Chief Executive Officers

MSHN
Mid-State Health Network

Compiled and tracked by Sherry Kletke

Below is a list of Legislative Bills MSHN is currently tracking and their status as of February 18, 2025:

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 4001	Minimum Wage (Roth) Modifies minimum hourly wage rate.	Received in Senate (2/4/2025; To Regulatory Affairs Committee)
HB 4002	Benefits (DeBoyer) Modifies requirements for an employer to provide earned sick time.	Received in Senate (2/4/2025; To Regulatory Affairs Committee)
HB 4037	Health Records (Rogers) Establishes certain requirements to operate a health data utility.	Introduced (1/29/2025; To Health Policy Committee)
HB 5077 (from 2023-2024 session)	Naloxone (VanderWall) Provides distribution of naloxone under the administration of opioid antagonist act to any individual.	Signed by the Governor 01/17/25; effective 04/10/25
HB 5078 (from 2023-2024 session)	Controlled Substances (Rheingas) Provides distribution of opioid antagonists by employees and agents of agencies under the administration of opioid antagonists act.	Signed by the Governor 01/17/25; effective 04/10/25
SB 8	Minimum Wage (Hertel, K.) Modifies minimum hourly wage rate.	Passed in Senate Regulatory Affairs Committee (2/13/2025; 20-12; earlier reported by the Regulatory Affairs Committee and advanced to Third Reading with substitute S-10 adopted)
SB 15	Benefits (Singh) Modifies earned sick time.	Reported in Senate (2/12/2025; Substitute S-1 adopted; By Regulatory Affairs Committee)
SB 74	Worker's Compensation (Cherry) Modifies various provisions to worker's disability compensation benefits.	Introduced (2/11/2025; To Labor Committee)
SB 75	Worker's Compensation (Cavanagh) Modifies compensation for death resulting from personal injury.	Introduced (2/11/2025; To Labor Committee)
SR 3	102nd Legislature (Brinks) A resolution to authorize the Senate Majority Leader to commence legal action, on behalf of the Senate, to compel the House of Representatives to fulfill its constitutional duty to present to the Governor the nine remaining bills passed by both houses during the One Hundred Second Legislature.	Passed in Senate (1/22/2025; Voice Vote)

REPORT OF THE MSHN DEPUTY DIRECTOR
to the Board of Directors
January / February

Staffing Update

Mid-State Health Network (MSHN) is pleased to announce we have filled the following positions.

- Evan Godfrey has accepted the Utilization Management Specialist position effective January 27, 2025, transferring from his previous role as the SUD Care Navigator.
- Elizabeth (Liz) Philpott joined MSHN as the Integrated Health Administrator on January 13, 2025. Liz has a master's in social work, as well as certified as advanced alcohol and drug counselor and years of experience, most recently working for Calhoun County Community Mental Health Authority as the Director of Certified Community Behavioral Health and Training.
- Cathy Todd will be joining MSHN as the Database and Report Coordinator on March 17, 2025. Cathy comes to us with a master's in social work, certified associate in project management, and years of experience, most recently working for Community Mental Health Authority for Central Michigan as the Clinical Services Project Manager.

MSHN is still looking to fill the **SUD Care Navigator** located on MSHN's website at: https://midstatehealthnetwork.org/stakeholders-resources/about-us/Careers.

Health Insurance Update

MSHN currently provides our employees with three health insurance plan options: Blue Cross Blue Shield PPO $550 Deductible with a 30% coinsurance, Blue Care Network HMO, $0 deductible with a 10% coinsurance and a Blue Care Network HMO, $500 deductible with a 20% coinsurance. The health insurance renewals for MSHN's plan year beginning February 2025 realized an above average increase of 11-15% as compared to previous year increases of 8-11%. Since MSHN is limited by Public Act 152, which caps the amount public employers pay toward employee medical benefit plans, any amount over the annual limit must be covered by the employee. The employee premiums therefore have more than doubled with the renewal. MSHN obtained quotes for other plans that would reduce the premium cost. MSHN also surveyed our staff to understand our employees' priorities when it comes to health insurance. We were awaiting Governor signature on HB 6058 that would increase the employer cap, however, it was never signed and executed. Therefore, MSHN had to pass on the increased cost to our employees. We were able to continue a "free" plan, the BCN HMO, $500 deductible with a 20% coinsurance.

Earned Sick Time Act

MSHN has been tracking the Earned Sick Time Act that has an effective date of February 21, 2025. The Senate and House have been working on substitute language and presented a substitute version of HB 4002 that was passed by the Senate and House just prior to the deadline. ***The Governor signed the substitute bill on February 21, 2025.***

The substitute language still includes assurances that workers can earn one hour of paid sick time for every 30 hours worked, and employers with 11 or more employees would be required to provide 72 hours of paid time, with a 72-hour carryover cap from year to year.

However, some of the changes include:

- Small businesses with 10 or fewer employees have until October 1 to comply with the act's requirements. Those small businesses must provide 40 hours (previously 32) of paid sick time under the bill.
- Allow employers to designate paid time off as a combined paid time off/sick leave bank, explicitly allow employers to provide all sick time hours frontloaded at the start of the year and exempt employers frontloading time at the start of the year from having to record the accrual of sick time.
- For employers using a combined leave bank, 72 hours of time would be subject to Earned Sick Time Act provisions, with anything beyond that being able to be used according to an employer's vacation or paid time off policy or usage requirements.

MSHN currently operates with a combined leave bank (PTO – Paid Time Off) for sick, vacation and personal and employees are not required to track PTO by category. The PTO rate is sufficient to be in compliance with the 72 hours sick time requirement. However, MSHN has a fiscal year end cap carryforward of 240 hours that also allows employees to buy out hours above 240 or risk forfeit of the hours. To ensure compliance, MSHN will be presenting changes to the Personnel Manual Policy to remove the fiscal year cap on carryforward, expected to be presented to the Board of Directors in July 2025.

Increased Services to Veterans – FY24Q4 Report

Mid-State Health Network is committed to ensuring that our veterans, service members, and military families gain increased awareness and access to behavioral health and substance use disorder (SUD) services through cultural sensitivity and support services provided by our Veteran Navigator (VN). MSHN provided services to about 2,000 individuals that identified a veteran status in the demographic data. During FY24Q4, MSHN connected a total of 46 new veteran/military families to services, resources and supports along with warm handoffs, follow-up both directly and in collaboration with providers, the Veterans Administration, and community stakeholders. A new focus in FY24 was to increase connections to housing services, reducing the homeless rate. MSHN is able to focus on this population via the grant funding that employs a Veteran Navigator for the region. The position has been working with the local Veteran's Administration to increase knowledge of available behavioral health services. MSHN has also been working with the provider network to ensure identification of veteran status in the region, with a goal to increase connection to appropriate services. The most common requests for assistance are programs to address homelessness, referral to a Veteran Service Officer (VSO) to file a claim related to benefits, and financial assistance programs. Veterans may also be receiving assistance through alternate resources in the community such as a county veteran service officer. MSHN has also updated our website with a page dedicated to veteran and family resource guides located here: https://midstatehealthnetwork.org/consumers-resources/search-for-provider/veterans-navigator.

For more information related to MSHN's VN initiatives, see the link below ***Veterans FY24Q4 Report.***

Regional Council Advisory Council (RCAC)

The Consumer Advisory Council is the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of behavioral health specialty services and supports for the region. The Consumer Advisory Council includes representatives from all twelve (12) Community Mental Health Service Program (CMHSP) Participants of the region and meets every other month. They advise MSHN on a multitude of programs, initiatives, strategic priorities, satisfaction and provide a valuable perspective to the improvement opportunities and quality services within the region. During the January meeting, the RCAC focused on reviewing the 2025 Guide to Services and Handbook and approved the contents to proceed with production and distribution. RCAC also received a presentation from MSHN to begin the process to develop and discuss strategic planning for FY26-27. The RCAC will continue the strategic planning dialogue at their April meeting and plan to provide feedback to the Board of Directors for consideration. MSHN staff will be providing the Board of Directors with a

presentation in July related to the voice of individuals served that will include updates from the regional and local consumer advisory councils.

For more information related to the activities of the Consumer Advisor Council see MSHN's website: https://midstatehealthnetwork.org/stakeholders-resources/board-councils/councils-committees/consumer-advisory-council

Information Technology Report FY24Q4

Mid-State Health Network's Information Technology (IT) team provides services related to technology for the region. This includes assisting and supporting the region in meeting the contractual obligations for Michigan Department of Health and Human Services (MDHHS), supporting the participating CMHSPs and SUD providers through managed care processes, strategic direction for technology initiatives and technical assistance with the MSHN team. This report includes updates that:

- **Display statistics** of the MSHN region as it relates to MDHHS reporting.
- **Status projects** as impacting MSHN and the region through this reporting period.
- **Identifies future initiatives** for FY25 and beyond.

Information Technology staff work with CMHSPs and SUD providers to submit Behavioral Health-Treatment Episode Data Set (BH-TEDS) and encounters on a weekly and monthly basis. The staff identify any potential concerns or higher than normal error rates and follow up with providers as needed. The report also includes the volume of files processed, based on consumers and services provided. It also includes the region's completion rate as compared to other Pre-paid Inpatient Health Plans (PIHPs).

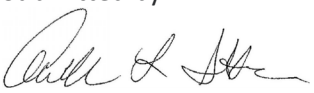
MSHN has large technology projects occurring simultaneously this year outside of the standard MDHHS requirements that include:

- Implementation of new Access PCE system and related Call Center Phone System
- Implementation of Regional Compliance Software
- Implementation of Client Portal
- Implementation of Michigan Health Endowment Fund related to Predictive Modeling, and
- Review of request for proposals for regional data analytics software.

I want to extend an appreciation to the IT team to ensure MSHN remains up to date with the demanding and every increasing technology standards.

For the full report, ***see the link below in Information Technology Department FY24Q4 Report.***

Submitted by:



Amanda L. Ittner
Finalized: 02.21.25

Links to Reports:

Veterans FY24Q4 Report
Information Technology Department FY24Q4

Chief Financial Officer – FY 25 Financial Analysis

The contractual relationship between Mid-State Health Network (MSHN) and Michigan Department of Health and Human Services (MDHHS) is a shared risk Arrangement. The calculations below were generated using actual FY 2025 figures from first quarter (10/1/24 – 12/31/24) trended for the full year.

Excess Per Eligible Per Month (PEPM) Capitation

1. Band 1 – Regional PEPM amounts remaining after all expenses are covered. Amounts that fall between 95% and 100% of total capitation dollars are retained (these dollars can be contributed to the Internal Service Fund (ISF) or held in Savings as carryforward for the next fiscal year).
2. Band 2 – Regional PEPM amounts remaining after all expenses are covered. Amounts that fall between 90% and 95% of total capitation dollars are **shared,** meaning the PIHP retains 50% of this amount 50% is returned to MDHHS (which is called lapse).
3. Band 3 – Regional PEPM amounts remaining after all expenses are covered. Amounts that fall between 0% and 90% of total capitation dollars are fully returned to MDHHS (which is called lapse).

TOTAL PEPM EXCEEDS REGIONAL EXPENSES - SMALL NUMBER EXAMPLE					
This example assumes $10,000 in PEPM Capitation, $9,000 in regional expenses, and $1,000 remaining					
		PIHP Portion	MDHHS Portion	Total	
Band #1 (95 -100%) - PIHP Retains	500	500	-	500	
Band #2 (90 - 95%) - Shared PIHP/MDHHS (2.5% each)	500	250	250	500	
Total		750	250	1,000	
FY 25 Anticipated Capitation Revenue - ITEM A	**753,679,359**				
MSHN'S ACTUAL ANTICIPATED PEPM EXCEEDS REGIONAL EXPENSES					
		PIHP Portion	MDHHS Portion	Total	
	(ITEM A * 5%)				
Band #1 (95 -100%) - PIHP Retains	37,683,968	37,683,968	-	37,683,968	
Band #2 (90 - 95%) - Shared PIHP/MDHHS (2.5% each)	37,683,968	18,841,984	18,841,984	37,683,968	
Total		56,525,952	18,841,984	75,367,936	
Remaining unexpended capitation amounts exceeding $75,367,936 will be lapsed 100% to MDHHS					

Overspending of Per Eligible Per Month (PEPM) Capitation – MSHN's Current Fiscal Position

1. Band 1 – Regional Expense amounts that fall between 100% and 105% of total capitation dollars must be covered by Internal Service Fund Dollars
2. Band 2 - Expenses exceeding 105% to 110% are the **shared** responsibility (50% each) of the PIHP and MDHHS.
3. Band 3 - Expenses exceeding 110% of total capitation dollars are the full responsibility of MDHHS.

REGIONAL EXPENSES EXCEED MSHN'S ACTUAL ANTICIPATED PEPM					
	Total Expenses	Capitation	PIHP Portion	MDHHS Portion	Total
	A	B	C (B * .05)		
Band #1 (100 - 105%) - PIHP Covers (Exceeding Cap)	791,363,327	753,679,359	37,683,968	-	37,683,968
Band #2 (105 - 110%) - Shared PIHP/MDHHS	829,047,295	753,679,359	18,841,984	18,841,984	37,683,968
Total			56,525,952	18,841,984	75,367,936
Expenses exceeding $829,047,295 will be covered by MDHHS					

MSHN'S FISCAL STATUS	
Expenses Trended through Dec 24 (Med/HMP)	772,862,995
Anticipated Capitation	753,679,359
Excess expenses over revenue	**19,183,636**
% Expenses Over Revenue	**2.55%**
FY 25 Beginning ISF	27,217,359
FY 25 ISF to Cover Cost Overruns	19,183,636
Anticipated Ending ISF	**8,033,723**
% Maximum Current Reserves Can Cover	3.61%

Please Note: MSHN's revenue is trending nearly $57 M less than the budgeted amounts. The budget figures were based on MDHHS's draft rate certification letter from June 2024. Based on the final rate letter, MSHN's fiscal position should have improved by an additional $10 M. The revenue lag indicates either the actual number of enrollees is lower than those used for rate setting or the expense information used did not represent the most recent PIHP experience. In addition to enrollees and expenses, the variance between budgeted and actual revenue could also be impacted by other variables such as:

- Regional Factors (Urban/Rural/Frontier (remote)) – Delivering services in rural and frontier areas typically cost more because there are fewer providers.
- Diagnosis Codes for consumers served (acuity) – Populations with certain severe conditions typically cost more.

Cost drivers impacting MSHN's regional expenses included significant utilization increases in Inpatient, Community Living Supports (CLS), and Autism services. FY 25 is anticipating expenses to increase by more than $30 M in these service categories.

Advocacy Efforts

- MSHN has informed MDHHS of the region's fiscal position and requested a meeting to discuss the impact revenue lag is contributing to the issue.
- PIHP Chief Information Officers (CIOs) and Chief Financial Officers (CFOs) are working on a project to identify changes in Disabled Aged and Blind (DABs) noted in recent payment files. DAB individuals receive the highest PEPM rate and moving to other categories such as Healthy Michigan Plan (HMP) and Temporary Aide to Needy Families (TANF) would cause significant decreases in total PEPM payments.
- Habilitation Supports Waiver (HSW) – missing payments in FY 25 are being reported to MDHHS for resolution and requests for payment reconciliation.
- PIHP CFOs are actively collecting and comparing revenue shortfalls for presentation to MDHHS. The goal is to share this information with the Department in order to help with mid-year rate adjustments.
- MSHN is engaging with regional CMHSPs on cost containment strategies to bring anticipated expenses in line with projected revenue.
- PIHPs are engaged with Wakely, an actuarial firm secured to review and evaluate Milliman's rate setting assumptions. A Wakely representative has participated in rate-setting meetings and provided feedback and questions challenging certain assumptions for the FY 25 rates. The scope of Wakely's work will expand during FY 25.

Additional Supplemental Information

- Cost Settlement – MSHN and the CMHSPs – the PIHP is responsible for covering Medicaid and HMP expenses incurred by its CMHSPs regardless of their PEPM. Preliminary and final cost settlements occur every November and May, respectively, following the fiscal year.
- Cost Settlement – MSHN and MDHHS – Cost Settlements are based on the overspending and underspending tables above and generally occur several fiscal years after that period is over.
- PIHPs are not involved with General Fund settlements between MDHHS and CMHSPs.
- Surplus – Regional PEPM funding exceed regional expenses.
- Deficit – Regional expenses exceed regional PEPM funding.
- Internal Service Fund (ISF) – the establishment of an ISF is a method to secure funds as part of an overall strategy for covering the PIHP's total risk exposure. In essence, it is an account used to cover regional expenditures after all PEPM revenue and prior year savings have been exhausted in a given fiscal year.
- Savings – Savings is generated when PEPM funding exceeds regional expenditures.
- Lapse – Money returned to MDHHS after the PIHP achieves maximum savings and ISF of 7.5% each.
- Capitation – MDHHS funding paid to the PIHP based on enrollees in the PIHP counties with amounts noted in the annual Rate Certification Letter.
- Substance Use Disorder (SUD)
- Severe and Persistent Mental Illness (SPMI)
- Prospective Payment System (PPS-1) – daily rates paid to CCBHC sites for service delivery.

SUMMARY

The figures shared in this document represent actual information as of 12.31.24 and should be seen as preliminary. To add perspective, the same report source from FY 24 using 12.31.23's data showed MSHN would end with a fully funded Internal service fund ($55 M) and have a small savings balance ($2.4 M). FY 24 is ending with no savings and using ISF of more than $23 M. There is a potential for the current results to worsen and it will depend on the following factors:

- The impact of MDHHS mid-year rate setting adjustments. Last fiscal year's rate adjustment yielded minimal improvement of $3.2 M (estimated) to the region's PEPM revenue.
- Certified Community Behavior Health Centers (CCBHC) – As stated in the Financial Notes every board meeting, CCBHCs are covered by a combination of PEPM revenue and supplemental revenue. Individuals diagnosed as mild/moderate and typically covered by health plans are fully reimbursed to CCBHC sites with MDHHS supplemental revenue. SUD/SPMI individuals are generally covered with some PEPM capitation and supplemental. MDHHS will update PPS-1 rates and the portion covered by capitation may increase (this will worsen the region's fiscal position).
- Changes in Autism behavioral technicians' rate – the impact to the region is to be determined. Expenses will increase by more than $7 M with the mandatory $66/hour rate. While MDHHS has issued a rate adjustment notification, the change to revenue is unknown at this point.
- If revenue does not improve significantly, MSHN will likely deplete its ISF by the end of this fiscal year.

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 Statement of Activities for the Period Ending January 31, 2025, 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 Statement of Activities for the Period Ending January 31, 2025, as presented.

Mid-State Health Network
Statement of Activities
As of January 31, 2025

Rows Numbers		Columns Identifiers A	B	C	D	E (C - D)	F (C / B)	
			Budget Annual	Actual Year-to-Date	Budget Year-to-Date	Budget Difference	Actual % of Budget	
			FY25 Original Budget		FY25 Original Budget			
			33.33%					
1	Revenue:							
2		Grant and Other Funding	$ 280,000	384,168	93,333	290,834	137.20 %	1a
3		Prior FY Medicaid Carryforward	$ 0	0	0	0		1b
4		Medicaid Capitation	904,524,545	285,091,299	301,508,182	(16,416,882)	31.52%	1c
5		Local Contribution	1,550,876	485,550	516,958	(31,409)	31.31%	1d
6		Interest Income	2,500,000	532,076	833,334	(301,257)	21.28%	1e
7		Non Capitated Revenue	18,132,736	5,202,877	6,044,245	(841,368)	28.69%	1f
8	Total Revenue		926,988,157	291,695,970	308,996,052	(17,300,082)	31.47 %	
9	Expenses:							
10		PIHP Administration Expense:						
11		Compensation and Benefits	9,181,634	2,685,966	3,060,545	(374,579)	29.25 %	
12		Consulting Services	223,800	28,116	74,600	(46,484)	12.56 %	
13		Contracted Services	126,350	36,022	42,116	(6,094)	28.51 %	
14		Other Contractual Agreements	679,700	155,642	226,567	(70,925)	22.90 %	
15		Board Member Per Diems	20,820	3,500	6,940	(3,440)	16.81 %	
16		Meeting and Conference Expense	214,043	46,861	71,348	(24,487)	21.89 %	
17		Liability Insurance	34,590	24,277	11,530	12,747	70.19 %	
18		Facility Costs	192,636	70,396	64,212	6,185	36.54 %	
19		Supplies	371,650	64,297	123,883	(59,587)	17.30 %	
20		Other Expenses	1,076,330	594,344	358,777	235,567	55.22 %	
21	Subtotal PIHP Administration Expenses		12,121,553	3,709,421	4,040,518	(331,097)	30.60 %	2a
22		CMHSP and Tax Expense:						
23		CMHSP Participant Agreements	822,423,444	253,111,257	274,141,148	(21,029,890)	30.78 %	1b,1c,2b
24		SUD Provider Agreements	67,318,827	21,184,449	22,439,609	(1,255,160)	31.47 %	1c,1f,2c
25		Benefits Stabilization	1,610,000	2,661,667	536,666	2,125,000	165.32 %	1b
26		Tax - Local Section 928	1,550,876	485,550	516,959	(31,409)	31.31 %	1d
27		Taxes- IPA/HRA	51,290,698	13,509,055	17,096,899	(3,587,844)	26.34 %	2d
28	Subtotal CMHSP and Tax Expenses		944,193,845	290,951,978	314,731,281	(23,779,303)	30.81 %	
29	Total Expenses		956,315,398	294,661,399	318,771,799	(24,110,400)	30.81 %	
30	Excess of Revenues over Expenditures		$ (29,327,241)	$ (2,965,429)	$ (9,775,747)			

Mid-State Health Network
Preliminary Statement of Net Position by Fund
As of January 31, 2025

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		17,309,149	0	17,309,149	1a
4	Chase MM Savings		10,364,066	0	10,364,066	
5	Savings ISF Account		0	30,523,942	30,523,942	1b
6	Savings PA2 Account		3,512,535	0	3,512,535	1c
7	Investment PA2 Account		3,499,403	0	3,499,403	1c
8	Investment ISF Account		0	11,998,229	11,998,229	1b
9	Total Cash and Short-term Investments		$ 34,685,153	$ 42,522,171	$ 77,207,324	
10	**Accounts Receivable**					
11	Due from MDHHS		43,533,705	0	43,533,705	2a
12	Due from CMHSP Participants		4,733,699	0	4,733,699	2b
13	Due from Other Governments		186,067	0	186,067	2c
14	Due from Miscellaneous		361,199	0	361,199	2d
15	Due from Other Funds		7,591,264	0	7,591,264	2e
16	Total Accounts Receivable		56,405,934	0	56,405,934	
17	**Prepaid Expenses**					
18	Prepaid Expense Rent		4,529	0	4,529	2f
19	Prepaid Expense Other		1,110	0	1,110	2g
20	Total Prepaid Expenses		5,639	0	5,639	
21	**Fixed Assets**					
22	Fixed Assets - Computers		189,180	0	189,180	2h
23	Accumulated Depreciation - Computers		(189,180)	0	(189,180)	
24	Lease Assets		151,169	0	151,169	2i
25	Accumulated Amortization - Lease Asset		(125,974)	0	(125,974)	
26	Total Fixed Assets, Net		25,195	0	25,195	
27	**Total Assets**		**$ 91,121,921**	**$ 42,522,171**	**$ 133,644,092**	
28						
29	**Liabilities and Net Position**					
30	Liabilities					
31	Accounts Payable		$ 7,835,861	$ 0	$ 7,835,861	1a
32	Current Obligations (Due To Partners)					
33	Due to State		32,877,080	0	32,877,080	3a
34	Other Payable		5,216,476	0	5,216,476	3b
35	Due to Hospitals (HRA)		11,691,112	0	11,691,112	1a, 3c
36	Due to State-IPA Tax		81,923	0	81,923	3d
37	Due to State Local Obligation		97,831	0	97,831	3e
38	Due to CMHSP Participants		13,593,829	0	13,593,829	3f
39	Due to other funds		0	7,591,264	7,591,264	3g
40	Accrued PR Expense Wages		114,959	0	114,959	3h
41	Accrued Benefits PTO Payable		453,682	0	453,682	3i
42	Accrued Benefits Other		78,501	0	78,501	3j
43	Total Current Obligations (Due To Partners)		64,205,393	7,591,264	71,796,657	
44	Lease Liability		26,585	0	26,585	2i
45	Deferred Revenue		6,085,789	0	6,085,789	1b 1c
46	Total Liabilities		78,153,628	7,591,264	85,744,892	
47	Net Position					
48	Unrestricted		12,968,293	0	12,968,293	3k
49	Restricted for Risk Management		0	34,930,907	34,930,907	1b
50	Total Net Position		12,968,293	34,930,907	47,899,200	
51	**Total Liabilities and Net Position**		**$ 91,121,921**	**$ 42,522,171**	**$ 133,644,092**	

Mid-State Health Network
Financial Statement Notes
For the Four-Month Period Ended,
January 31, 2025

Please note: The Preliminary Statement of Net Position contains Fiscal Year (FY) 2024 cost settlement figures between the PIHP and Michigan Department of Health Human Services (MDHHS) as well as each Community Mental Health Service Program (CMHSP) Participants. CMHSP cost settlement figures were extracted from the final MDHHS Financial Status Report (FSR) submitted in February 2025. The Statement of Net Position will be final after MSHN's Compliance Examination is completed as the report will also include CMHSP adjustments.

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.
    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 $12 M in the investment account, which is about 28% of the total ISF net position balance (row 49 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 Savings PA2 account holds PA2 funds and is also offset by the Deferred Revenue liability account and investments exceeding $3.49 M.
2. Accounts Receivable
    a) Approximately 41% of the balance results from Certified Community Behavioral Health Centers' (CCBHC) supplemental funding which covers all mild to moderate recipients. Supplemental funding also covers a portion of the Prospective Payment System (PPS-1) for individuals with Severe Mental Impairments (SMI)/Severe Emotional Disturbance (SED)/Substance Use Disorder (SUD). In addition, more than 28% of the balance results from withholds while October through January Hospital Rate Adjustor (HRA) amounts account for 27% of the total. Lastly, the remaining balance stems from miscellaneous items.
    b) Due From CMHSP Participants reflect FY 2024 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	4,718,564.99	-	4,718,564.99
Tuscola	15,133.46	-	15,133.46
Total	**4,733,698.45**	**-**	**4,733,698.45**

    c) Amounts in Due From Other Governments represent FY 25 quarter one PA2 billing. PA 2 dollars are taxes generated from each county's liquor sales.
    d) The balance in Due From Miscellaneous is split 37% and 63% (respectively) for Medicaid Event Verification (MEV) findings and cash advances needed to cover operations for a small number of SUD providers.
    e) Due From Other Funds is the account used to manage anticipated ISF transfers. Approximately $23 M is needed to support FY 24 regional expenses in excess of revenue. This is a small improvement as the board approved FY 24 amended budget projected more than $27 M would be required to support FY 24 regional operations.

MDHHS guidance allows PIHPs 7.5% retention of current FY revenue to manage risk. This amount is in addition to the allowable 7.5% for Savings generated when Medicaid and Healthy Michigan revenue exceed expenses.

f) Prepaid Expense Rent balance consists of security deposits for MSHN office suites.

g) Prepaid Expense Other consists of an FY 26 pre-paid Relias balance.

h) Total Fixed Assets - Computers represent the value of MSHN's capital asset net of accumulated depreciation.

i) The Lease Assets category is now displayed as an asset and liability based on a new Governmental Accounting Standards Board (GASB) requirement. The lease assets figure represents FY 2022 – 2025 contract amounts for MSHN's office space.

3. Liabilities

a) MSHN estimates FY 2022 and FY 2021 lapses totaling $13.5 M and $19.1 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 - IPA Tax contains funds held for tax payments associated with MDHHS Per Eligible Per Month (PEPM) funds. Insurance Plan Assessment taxes are applied to Medicaid and Healthy Michigan eligibles.

e) Due To State Local Obligations has a balance for advance payments made by two CMHSPs. MSHN submits quarterly payments to MDHHS by the State's due date and then collects each CMHSP's portion after.

f) Due To CMHSP represents FY 24 cost settlement figures based on the MDHHS Final FSR. These 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	BHH Settlement	Payments/Offsets	Total
Bay	5,522,352.18	-	3,913,812.00	1,608,540.18
Central	6,232,739.56	(2,495.84)	5,397,005.00	833,238.72
Gratiot	2,453,101.64	(311.98)	1,851,292.00	601,497.66
Huron	2,578,086.91	-	2,222,821.00	355,265.91
The Right Door	763,957.29	-	-	763,957.29
Lifeways	9,193,249.93	-	8,002,409.00	1,190,840.93
Montcalm	187,616.19	(1,559.90)	423,939.00	(237,882.71)
Newaygo	1,531,762.19	-	1,231,576.00	300,186.19
Saginaw	6,837,282.68	(173,148.90)	-	6,664,133.78
Shiawassee	2,197,370.43	150,256.14	833,576.00	1,514,050.57
Total	**37,497,519.00**	**(27,260.48)**	**23,876,430.00**	**13,593,828.52**

g) This liability represents the anticipated remaining ISF transfer that will be made from the Medicaid Risk Reserve fund into Behavioral Health Operations. Please see Statement of Activities 2e for more details.

h) Accrued Payroll Expense Wages represent expenses incurred in January and paid in February.

i) Accrued Benefits PTO (Paid Time Off) is the required liability account set up to reflect paid time off balances for employees.

j) Accrued Benefits Other represents retirement benefit expenses incurred in January and paid in February.

k) The Unrestricted Net Position represents the difference between total assets, total liabilities, and the restricted for risk management figure.

Statement of Activities – Column F calculates the actual revenue and expenses compared to the full year's original budget. Revenue accounts whose Column F percent is less than 33.33% translate to MSHN receiving less revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 33.33% 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. In addition, MSHN received a special grant totaling $300k to work with a predictive analytics vendor. The unplanned grant is responsible for the variance in this account.
    b) MSHN will not have an FY 24 carryforward/savings. As a reminder, Medicaid Savings are generated when the prior year revenue exceeds expenses for the same period.
    c) Medicaid Capitation – There is a negative variance in this account which indicates actual FY 25 revenue is lagging behind anticipated amounts. MDHHS FY 25 revenue rates received in late September seemed to indicate MSHN fiscal position would be better than anticipated however other factors such decreasing enrollments and other fiscal withholds impact this line item. The MSHN Region will continue its advocacy efforts with MDHHS around increased revenue rates and closely monitor capitation payments to evaluate if there is movement in a positive direction. 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 under Tax Local Section 928. Local Contributions were scheduled to reduce over the next few fiscal years until completely phased out. FY 2025 amounts are the same as FY 2024.
    e) Interest income is earned from investments and changes in principle for investments purchased at discounts or premiums.
    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.
2. Expense
    a) Total PIHP Administration Expense is slightly under budget. The are two areas with significant variances. Compensation and Benefits is the first and this variance should decrease throughout the fiscal year as budgeted positions are filled. The other line item is Other Expenses. Charges contributing to the Other Expenses' variance are MiHIN (technology - data exchange) and MCHE (technology provider – Level of Care Determination – acute care) as both FY 25 invoices were paid in full in October.
    b) CMHSP participant Agreement shows a large variance when comparing actual to budget. The variance is related to the notes in item 2c above. MSHN funds CMHSPs based on per eligible per month (PEPM) payment files. The files contain CMHSP county codes which designate where the payments should be sent. MSHN sends the full payment less taxes and affiliation fees which support PIHP operations. In addition, benefit stabilization amounts are paid to CMHSP for SUD access activities and assist with cash flow needs. Two CMHSPs have received extra cash flow to cover operational expenditures in excess of their PEPM.
    c) SUD provider payments are less than anticipated and paid based on need. (Please see Statement of Activities 1c and 1f.)
    d) IPA/HRA actual tax expenses are lower than the budget. IPA estimates are impacted by variability in the number of Medicaid and Healthy Michigan eligibles. 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). Please

note, revenue for this line item is included in the Medicaid capitation line and is equal to the expense.

MID-STATE HEALTH NETWORK
SCHEDULE OF INTERNAL SERVICE FUND INVESTMENTS
As of January 31, 2025

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	912797MA2	7.9.24	7.11.24	11.5.24		29,999,379.63	30,505,000.00			
UNITED STATES TREASURY BILL	912797MA2						(30,505,000.00)			
UNITED STATES TREASURY BILL	912797KZ9	8.26.24	8.27.24	11.21.24		1,999,307.58	2,023,000.00			
UNITED STATES TREASURY BILL	912797KZ9						(2,023,000.00)			
UNITED STATES TREASURY BILL	912797NK9	11.4.24	11.5.24	3.4.25		9,999,247.63	9,999,247.63			
UNITED STATES TREASURY BILL	912797KA4	11.19.24	11.21.24	2.20.25		1,998,981.77	1,998,981.77			
JP MORGAN INVESTMENTS							11,998,229.40			11,998,229.40
JP MORGAN CHASE SAVINGS							30,274,463.84	0.020%	249,478.05	30,523,941.89
							$ 42,272,693.24		$ 249,478.05	$ 42,522,171.29

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 PA2 SAVINGS INVESTMENTS
As of January 31, 2024

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	9127979LK1	6.3.24	6.4.24	10.1.24		3,499,660.72	3,560,000.00			
UNITED STATES TREASURY BILL	9127979LK1	6.3.24	6.4.24	10.1.24			(3,560,000.00)			
UNITED STATES TREASURY BILL	912796ZV4	9.30.24	10.1.24	12.26.24		3,499,843.32	3,537,000.00			
UNITED STATES TREASURY BILL	912796ZV4	9.30.24	10.1.24	12.26.24			(3,537,000.00)			
UNITED STATES TREASURY BILL	912797PA9	12.23.24	12.26.24	4.22.25		3,499,402.50	3,499,402.50			
JP MORGAN INVESTMENTS							3,499,402.50			3,499,402.50
JP MORGAN CHASE SAVINGS							3,509,537.63	0.010%	2,997.80	3,512,535.43
							$ 7,008,940.13		$ 2,997.80	$ 7,011,937.93

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.

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 FY25 Contract Listing for Board approval and authorization of the Chief Executive Officer to sign.

Recommended Motion:

The MSHN Board authorizes its Chief Executive Officer to sign and fully execute the contracts as presented and listed on the FY25 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2025 NEW AND RENEWING CONTRACTS
March 2025

CONTRACTING ENTITY	PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY25 COST REIMBURSEMENT CONTRACT AMOUNT	FY25 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY25 INCREASE/ (DECREASE)
PIHP ADMINISTRATIVE FUNCTION CONTRACTS					
Kelly Services, Inc.	Temporary Staffing	11.1.24 - 9.30.25	50,000	**90,000**	**40,000**
MacDonald Garber Broadcasting	Region-wide media campaign via Connect TV to focus on problem gambling disorder prevention. Focus on online sports betting ads and responsible	1.1.25 - 9.30.25	-	**100,000**	**100,000**
RedHead Creative Consultancy	Implementation of Media Campaign to Reduce SUD Stigma	1.1.25 - 9.30.25	-	**75,000**	**75,000**
			$ 50,000	$ 265,000	$ 215,000

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY25 COST REIMBURSEMENT CONTRACT AMOUNT	FY25 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY25 INCREASE/ (DECREASE)
Catholic Charities of Shiawassee & Genesee County	Community resource list development. Harm reduction supplies and materials for partnership with Punks with Lunch.	4.1.25 - 9.30.25	147,053	**153,553**	**6,500**
Cristo Rey Counseling Services	Technology upgrades for SUD program.	4.1.25 - 9.30.25	285,750	**292,667**	**6,917**
Eaton Regional Education Service Agency (RESA)	Newspaper Naloxone Dispensary Boxes	4.1.25 - 9.30.25	639,126	**640,276**	**1,150**
Gratiot County Child Advocacy Association	Bus ad campaign for medication disposal, med lock boxes, Puncture resistant gloves, Fentanyl test strips.	4.1.25 - 9.30.25	230,000	**256,900**	**26,900**
Home of New Vision	Harm reductions supplies and materials. Printing costs for educational materials. Staffing supports.	4.1.25 - 9.30.25	264,000	**318,286**	**54,286**
Ingham County, on behalf of the Ingham County Health Department	Opioid Use Disorder (OUD) Services Navigation. Harm Reduction Supplies.	4.1.25 - 9.30.25	156,523	**241,525**	**85,002**
Lansing Syringe Services	Harm Reduction Street Outreach in Clinton, Eaton and Ingham	4.1.25 - 9.30.25	95,116	**109,161**	**14,045**
List Psychological Services	Naloxone wall mount medical cabinets, signs, and distribution boxes. Sharps containers and disposal. SUD Treatment in Jail: MOUD in Jail support for medication costs (Buprenorphine & sublingual tablets) and weekly SUD treatment groups.	4.1.25 - 9.30.25	-	**26,520**	**26,520**
McLaren Bay Region (Neighborhood Resource Center)	Summer Camp with Rainbow Days programming for youth. Lock Boxes & Medication Disposal Pouches Narcan newspaper-type dispenser boxes, Sharps Containers, Wound Care Kit supplies, & Fentanyl Test Strips.	4.1.25 - 9.30.25	197,450	**211,411**	**13,961**
Mid-Michigan District Health Department	Fentanyl test strips, first aid kits & eductional materials, sharps containers & disposal, Deterra bags, Naloxone Overdose Emergency Kits, annual Recovery Symposium	4.1.25 - 9.30.25	304,432	**324,082**	**19,650**
Michigan Therapeutic Consultants	Harm reduction supplies and materials.	4.1.25 - 9.30.25	-	**7,145**	**7,145**
Punks With Lunch	Expansion of syringe services and harm reduction supports in Ingham, Eaton, and Shiawassee County. Technology.	4.1.25 - 9.30.25	46,000	**79,028**	**33,028**

Randy's House	Harm Reduction Education Materials Annual SUD Community Event	4.1.25 - 9.30.25	80,281	**89,654**	**9,373**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY25 COST REIMBURSEMENT CONTRACT AMOUNT	FY25 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY25 INCREASE/ (DECREASE)
Recovery Pathways	Funding for transportation supports to/from SUD treatment. Part-Time Adolescent Coordinator.	4.1.25 - 9.30.25	379,942	**409,572**	**29,630**
The Legacy Center	Harm reduction distribution stations, harm reduction supplies and materials, sharps containers and disposal bins, lock boxes, fentanyl tests strips, xylazine test strips, Narcan safety kit.	4.1.25 - 9.30.25	185,000	**203,860**	**18,860**
Victory Clinical Services Lansing	Funds for transportation to/from SUD treatment. Dosing pumps for OTP clinics in Jackson, Ingham, & Saginaw counties.	4.1.25 - 9.30.25	-	**106,800**	**106,800**
			$ 3,010,673	**$ 3,470,440**	**$ 459,767**

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, January 7, 2025
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 5:01 p.m. Mr. Woods reminded members that those participating by phone may not vote on matters before the board and the Board Member Conduct Policy, emphasizing that members seek recognition from the chair and honor time limits. Mr. Woods offered prayers and asked members to keep those in New Orleans in their thoughts following the recent tragedy. Mr. Woods introduced and gave a warm welcome to new board member Cindy Garber, appointed from Shiawassee Health and Wellness. Ms. Amanda Ittner introduced MSHN's newest staff members, Kara Laferty, Quality Manager and Bo Zwingman-Dole, Compliance and Quality Coordinator.

2. Roll Call

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

Board Member(s) Present: Patty Bock (Huron)-arrived at 5:10 p.m., Brad Bohner (LifeWays), Greg Brodeur (Shiawassee), Ken DeLaat (Newaygo), Cindy Garber (Shiawassee), David Griesing (Tuscola), Dan Grimshaw (Tuscola)-arrived at 5:04 p.m., Tina Hicks (Gratiot), John Johansen (Montcalm), Pat McFarland (Bay-Arenac), Deb McPeek-McFadden (The Right Door), Bob Pawlak (BABH), Linda Purcey (The Right Door), Kerin Scanlon (CMH for Central Michigan)-joined at 5:13 p.m., Richard Swartzendruber (Huron), and Ed Woods (LifeWays)

Board Member(s) Remote: Irene O'Boyle (Gratiot), Kurt Peasley (Montcalm), and Joe Phillips (CMH for Central Michigan)

Board Member(s) Absent: Paul Palmer (CEI), Tracey Raquepaw (Saginaw), Susan Twing (Newaygo), and Joanie Williams (Saginaw)

Staff Member(s) Present: Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Sherry Kletke (Executive Support Specialist), Kim Zimmerman (Chief Compliance and Quality Officer), Kara Laferty (Quality Manager), and Bo Zwingman-Dole (Compliance and Quality Coordinator)

Staff Member(s) Remote: Joseph Sedlock (Chief Executive Officer)

3. Approval of Agenda for January 7, 2025

Board approval was requested for the Agenda of the January 7, 2025, Regular Business Meeting.

MOTION BY BRAD BOHNER, SUPPORTED BY DAVID GRIESING, FOR APPROVAL OF THE AGENDA OF JANUARY 7, 2025, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 14-0.

4. Public Comment

There was no public comment.

5. FY2025 Quality Assessment and Performance Improvement Program (QAPIP) and the FY2024 Annual Effectiveness Evaluation

Ms. Kim Zimmerman presented an overview of the FY2025 QAPIP and the FY2024 Annual Effectiveness Evaluation report included within board meeting packets and recommend for board approval.

Two board members requested to see the full plan and report in the future. Ms. Amanda Ittner reminded the board that providing links to documents to reduce bulk of packets was previously instituted at the board's request. Links to the full plan and report are available in the motion sheet in the packet and also on the website. Operations Council members also reviewed and approved the QAPIP plan and the annual report prior to presenting to the board for approval.

MOTION BY KEN DeLAAT, SUPPORTED BY JOHN JOHANSEN, FOR APPROVAL OF THE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) FOR OCTOBER 1, 2024 TO SEPTEMBER 30, 2025 AND THE ANNUAL EFFECTIVENESS AND EVALUATION REPORT FOR OCTOBER 1, 2023 TO SEPTEMBER 30, 2024. MOTION CARRIED: 15-1.

Mr. Ed Woods gave a warm welcome to new board member, Patty Bock, appointed from Huron Behavioral Health.

6. 2025 MSHN By-Laws

Mr. Joe Sedlock informed board members all twelve Community Mental Health Service Programs (CMHSPs) in the region have approved the revisions to the bylaws included in the packet. The clean version of the bylaws will be filed at the Michigan Secretary of State and with each county clerk in the region. Mr. Sedlock reminded members that MSHN does not have a vote in changing the bylaws, that it requires 2/3 majority vote of the CMHSP participants.

7. Chief Executive Officer's Report

Mr. Joe Sedlock discussed several items from within his written report to the Board highlighting the following:

- PIHP/Regional Matters
  - Legislators Allocate $1M in Opioid Settlement Funds to each Michigan Pre-Paid Inpatient Health Plan
  - Conflict Free Access and Planning (CFAP) Update
  - MDHHS Site Review – Repeat Citation for Use of Ranges in Plans of Service
- State of Michigan/Statewide Activities
  - MSHN/MDHHS "Master Contract" for FY25
  - MDHHS Announced a new "Mental Health Framework"

8. Deputy Director's Report

Ms. Amanda Ittner discussed several items in her written report to the board, highlighting the following:

- Staffing Update
- FY2024 Year End Reports
  - Annual Consumers Served Survey Results
  - Population Health Priority Measurement Portfolio
  - Balanced Scorecard
  - Performance Bonus Incentive Pool Report

9. Chief Financial Officer's Report

Ms. Leslie Thomas provided an overview of the financial statements included within board meeting packets for the period ended November 30, 2024.

Board members requested to receive an update on regional cost containment strategies at the March or May 2025 board meeting.

MOTION BY TINA HICKS, SUPPORTED BY BRAD BOHNER, TO RECEIVE AND FILE THE PRELIMINARY STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDED NOVEMBER 30, 2024, AS PRESENTED. MOTION CARRIED: 16-0.

10. Contracts for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2025 contract listing provided in board meeting packet and requested the board authorize MSHN's CEO to sign and fully execute the contracts listed on the FY2025 contract listing.

MOTION BY BRAD BOHNER, SUPPORTED BY DAVID GRIESING, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY25 CONTRACT LISTING. MOTION CARRIED: 16-0.

11. Executive Committee Report

On behalf of Ms. Irene O'Boyle, Mr. Joe Sedlock announced the FY2024 Board Self-Evaluation will be emailed to members in the next couple of days. The Board Self-Evaluation is conducted annually and consists of the same questions as asked every year with the addition of five new Diversity, Equity, Inclusion, and Health Equity related questions in this survey which board members previously reviewed. Ms. Sherry Kletke will send the survey to members by email through Survey Monkey. Members will be given two weeks to complete the survey. Results of the survey will be available at the February Executive Committee Meeting and presented to the full board at the March Board of Directors meeting. Ms. O'Boyle encouraged all Board members to participate by completing the board self-evaluation in the timeframe offered.

12. Chairperson's Report

Mr. Ed Woods announced MSHN will sponsor one board member to attend the National Conference scheduled for May 5-7, 2025, in Philadelphia. Members that are interested should inform Mr. Joe Sedlock. Mr. Woods and the Executive Committee recommend moving the May 6, 2025, meeting to the following Tuesday, May 13, 2025. Mr. Joe Sedlock informed members that the May meeting will include Strategic Planning which usually begins around 10:00 a.m. continuing until the regular board meeting time.

13. 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 BRAD BOHNER, SUPPORTED BY DEB McPEEK-McFADDEN, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE NOVEMBER 12, 2024 BOARD OF DIRECTORS MEETING; RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF DECEMBER 20, 2024; RECEIVE POLICY COMMITTEE MEETING MINUTES OF DECEMBER 3, 2024; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF NOVEMBER 18, 2024 AND DECEMBER 16, 2024; AND TO APPROVE ALL THE FOLLOWING POLICIES: CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC RECIPIENT ELIGIBILITY, AUTISM SPECTRUM DISORDER BENEFIT, BEHAVIORAL HEALTH RECOVERY ORIENTED SYSTEMS OF CARE, AND UTILIZATION MANAGEMENT ACCESS SYSTEM. MOTION CARRIED: 16-0

14. Other Business

There was no other business.

15. Public Comment

There was no public comment.

16. CEO Performance Evaluation

Ms. Irene O'Boyle gave the board members a summary of the 2024 CEO Performance Evaluation.

MOTION BY DAVID GRIESING, SUPPORTED BY TINA HICKS, TO RECEIVE AND FILE THE 2024 MSHN CHIEF EXECUTIVE OFFICER PERFORMANCE EVALUATION RESULTS. MOTION CARRIED: 16-0.

17. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 6:41 p.m.

Mid-State Health Network SUD Oversight Policy Advisory Board
Wednesday, October 16, 2024, 4:00 p.m.
CMH Association of Michigan (CMHAM)
507 S. Grand Ave
Lansing, MI 48933

Meeting Minutes

1. Call to Order

Chairperson Steve Glaser called the MSHN SUD Regional Oversight Policy Board (OPB) of Directors Meeting to order at 4:00 p.m. Mr. Glaser reminded members participating virtually may not participate in or vote on matters before the board.

Board Member(s) Present:	Lori Burke (Shiawassee), Irene Cahill (Ingham), Bruce Caswell (Hillsdale), Steve Glaser (Midland), Charlean Hemminger (Ionia), John Hunter (Tuscola), John Kroneck (Montcalm)-joined at 4:08 p.m., Karen Link (Huron), Jim Moreno (Isabella)-joined at 4:02 p.m., Justin Peters (Bay), Jerrilynn Strong (Mecosta), and Dwight Washington (Clinton)
Board Member(s) Remote:	Nichole Badour (Gratiot)-joined at 4:02 p.m. and George Gilmore (Clare)-joined at 4:05 p.m.
Board Member(s) Absent:	Lisa Ashley (Gladwin), Christina Harrington (Saginaw), Bryan Kolk (Newaygo), Kim Thalison (Eaton), David Turner (Osceola), Rachel Vallad (Arenac), and Ed Woods (Jackson)
Alternate Member(s) Present:	Simar Pawar (Ingham)-joined at 4:08 p.m.
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 Disorder Services and Operations); Sarah Andreotti (SUD Prevention Administrator), Beth LaFleche (Treatment Specialist), Cari Patrick (Prevention Specialist), and Sherry Kletke (Executive Support Specialist)
Staff Members Remote:	Joe Sedlock (Chief Executive Officer), Kate Flavin (Treatment Administrator), and Sarah Surna (Prevention Specialist)

2. Roll Call

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

3. Approval of Agenda for October 16, 2024

   Board approval was requested for the Agenda of the October 16, 2024 Regular Business Meeting, as presented.

   MOTION BY DWIGHT WASHINGTON, SUPPORTED BY JOHN HUNTER, FOR APPROVAL OF THE OCTOBER 16, 2024 REGULAR BUSINESS MEETING AGENDA, AS PRESENTED. MOTION CARRIED: 11-0.

4. Approval of Minutes from the August 21, 2024 Regular Business Meeting

   Board approval was requested for the draft meeting minutes of the August 21, 2024 Regular Business Meeting.

   MOTION BY BRUCE CASWELL, SUPPORTED BY JIM MORENO, FOR APPROVAL OF THE MINUTES OF THE AUGUST 21, 2024, MEETING, AS PRESENTED. MOTION CARRIED: 11-0.

5. Public Comment

   Dr. Dani Meier introduced MSHN newest staff members to the Substance Use Disorder Treatment and Prevention team; Cari Patrick, Prevention Specialist and Beth LaFleche, Treatment Specialist. Dr. Meier wished to recognize Sarah Andreotti for being named "Preventionist of the Year" at the recent Substance Use Disorder and Co-Occurring Disorder conference.

6. Board Chair Report

   Mr. Steve Glaser was happy to see everyone and thanked the members for their time to attend the meeting.

7. Deputy Director Report

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

   Regional Matters:

   - SUD Oversight Policy Board Annual Report
   - Michigan Health Endowment Fund Award Notice

State of Michigan/Statewide Activities

- Michigan Healing and Recovery Fund (State Opioid Settlement Funds)

8. Chief Financial Officer Report

Ms. Leslie Thomas provided an overview of the financial reports and an updated PA2 overview included in board meeting packets along with a FY2025 Budget Overview available in board member folders:

- FY2024 PA2 Funding and Expenditures by County
- FY2024 PA2 Use of Funds by County and Provider
- FY2024 Substance Use Disorder (SUD) Financial Summary Report as of August 2024
- PA2 Overview
- FY2025 Budget Overview

9. Substance Use Disorder PA2 Contract Listing

Ms. Leslie Thomas provided an overview and information on the FY25 Substance Use Disorder (SUD) PA2 Contract Listing as provided in the packet noting a correction to reflect $95,116 to be allocated to Lansing Syringe Services.

MOTION BY JOHN KRONECK, SUPPORTED BY JIM MORENO, FOR APPROVAL OF THE FY25 SUBSTANCE USE DISORDER (SUD) PA2 CONTRACT LISTING WITH A CORRECTION TO REFLECT $95,116 TO LANSING SYRINGE SERVICES. MOTION CARRIED: 12-0.

10. SUD Operating Update

Dr. Dani Meier provided an overview of the written SUD Operations Report included in the board meeting packet, highlighting the below.

- MSHN Prevention staff and many provider staff attended the 25th Annual Michigan SUD and Co-Occurring Conference on September 15 and 16
- Engaging with Michigan Association of Counties (MAC) to discuss status and collaboration with counties for Opioid Settlement Funds activities
- Impact of Cannabis Legalization on Youth Following Passage of Proposal 1 in 2018
- Opioid Task Force Treatment Sub-Committee Medication First White Paper

11. Other Business

There was no other business.

12 Public Comment

There was no public comment.

Mr. Bruce Caswell left the meeting at 5:13 p.m.

13. Board Member Comment

There were no further board member comments.

14. Adjournment

Chairperson Steve Glaser adjourned the MSHN SUD Oversight Policy Advisory Board Meeting at 5:15 p.m.

Meeting minutes submitted respectfully by:
MSHN Executive Support Specialist

MSHN
Mid-State Health Network

Mid-State Health Network Board of Directors
Executive Committee Meeting Minutes

Friday, February 21, 2025 - 9:00 a.m.

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

Staff Present: Amanda Ittner, Deputy Director; Joseph Sedlock, Chief Executive Officer

Others Present: John Johansen

1. **Call to order**: This meeting of the MSHN Board of Directors Executive Committee was called to order by Chairperson Woods at 9:01 a.m.

2. **Adjustments to and Approval of Agenda:** Motion by D. Griesing supported by I. O'Boyle to approve the agenda as presented. Motion carried.

3. **Guest MSHN Board Member Comments:** Mr. Johanssen thanked the board for the notation under call to order to remind members to follow the board member conduct policy. Mr. Johanssen also expressed concern on the poor response rate to the board self-evaluation survey. He noted that his comments are not reflected in the survey results and doesn't understand why his survey was not received. Suggest that board members are asked to confirm receipt of the survey. Ms. O'Boyle will remind board members that these activities are a part of board member responsibilities at the March board meeting.

4. **Board Matters**
   - 4.1 Draft March 4, 2025 Governing Board Meeting Agenda: The Executive Committee reviewed the draft agenda for the March 4, 2025 Board Meeting noting that the agenda is not final until the Board adopts it in open meeting. There were no recommended changes to the agenda. At the last board meeting, a member asked for improved member knowledge of and more member adherence to the Board Member Conduct Policy. Sending the policy with an explanatory statement separately in advance and also include in board packet. The Executive Committee requests a more detailed update on regional cost containment plans from the Chief Finance Officer at the March board meeting.
   - 4.2 MSHN Sponsorship of Board Member for National Conference: MSHN will sponsor David Griesing to attend the National Conference in Philadelphia May 5-7, 2025. Mr. Griesing was the only board member to ask for sponsorship.
   - 4.3 2024 Board Self-Evaluation Summary: Ms. O'Boyle provided a summary of the board self evaluation results in both verbal and written formats. The Committee asks that the written summary be included in the March board packet. The Executive Committee requested that administration include the written summary in the March board meeting packet. The Executive Committee recommends gathering information on how many board members are "BoardWorks" certified. Administration will follow-up and provide that information to the Executive Committee at a future meeting. New health equity questions were included this year for the first time. Discussion held around the region's responsibility to ensure all residents of the region benefit from the services and supports offered and that differences (or health disparities) are the focus of our public facing work. Ms. O'Boyle will provide additional remarks at the board meeting.
   - 4.4 Executive Committee Guidance for Administration on Providing Bulk Copies of Reports for Board Review/Consideration (Follow-Up from January Board Meeting): Mr. Sedlock noted that administration needs more guidance from the officers and/or board on how to comply with a few board member requests for full copies of lengthy reports. The Committee acknowledged that many board members do not want the bulk involved and only a few do. MSHN administration provides the electronic links. The Committee reinforced that it is the responsibility of board members to access the linked documents to educate themselves in advance. The Committee is satisfied with the established process, but does

recommend MSHN make an in-room copy available (paper to start, perhaps an in-room iPad). and does not support making any changes at this time. Alternative methods of handling policy edits was discussed by the Executive Committee and was referred to the Policy Committee.

4.5 Other (if any): None

5. **Administration Matters**
   - 5.1 PIHP/MDHHS Contract and Lawsuit Update: Mr. Sedlock provided an update which will also be included within his March board report. The State has submitted its response to the lawsuit to the Court of Claims. The Court has not ruled in the matter.
   - 5.2 MDHHS Reconfiguration of PIHP/MDHHS Operations Meetings and PIHP/MDHHS Contracts Meetings: Mr. Sedlock reviewed the memorandum from MDHHS announcing its intention to reconfigure PIHP/MDHHS meetings. No further information has been received as of the date of this meeting. Administration notes that there has been a significant decrease in top-level communications with the field in the last couple of months.
   - 5.3 Conflict Free Access and Planning Update (Brief): Ms. Ittner provided a brief update on waiver approvals and the now CMS approved state plan for compliance with federal conflict free regulations. Administration plans a presentation for the board at the March board meeting.

6. **Other**
   - 6.1 Any other business to come before the Executive Committee: Double check call in number listed on the agenda for this meeting is correct.
   - 6.2 Special Note: May 13, 2025 Board Activities include an all-day strategic planning meeting followed by regular board meeting! Mark calendars and plan accordingly.
   - 6.3 Next scheduled Executive Committee Meeting: 04/18/2025, 9:00 a.m.

7. **Guest MSHN Board Member Comments:** None

8. **Adjourn:** Chairperson Woods adjourned this meeting at 10:24 a.m.

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, FEBRUARY 4, 2025 (VIDEO CONFERENCE)

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

Members Absent: Tina Hicks

Staff Present: Amanda Ittner (Deputy Director) and Sherry Kletke (Executive Support Specialist)

1. CALL TO ORDER

Mr. John Johansen called the Board Policy Committee meeting to order at 10:00 a.m.

2. APPROVAL OF THE AGENDA

MOTION by David Griesing, supported by Kurt Peasley, to approve the February 4, 2025, Board Policy Committee Meeting Agenda as presented. Motion Carried: 4-0.

3. POLICIES UNDER DISCUSSION

There were no policies under discussion.

4. POLICIES UNER REVIEW

Mr. John Johansen invited Ms. Amanda Ittner to provide a review of the substantive changes within the policies listed below. Ms. Ittner provided an overview of the substantive changes within the policies for the Quality and Service Delivery chapters. The two Information Technology policies are new policies presented for review.

CHAPTER: QUALITY

1. ASSESSMENT OF MEMBER EXPERIENCES
2. BEHAVIOR TREATMENT PLANS
3. CRITICAL INCIDENTS
4. EXTERNAL QUALITY REVIEW
5. INCIDENT REVIEW FOR SUBSTANCE USE DISORDER PROVIDERS
6. MEDICATION EVENT VERIFICATION
7. MICHIGAN MISSION BASED PERFORMANCE INDICATOR SYSTEM
8. MONITORING AND OVERSIGHT
9. PERFORMANCE IMPROVEMENT
10. QUALITY MANAGEMENT
11. REGIONAL PROVIDER MONITORING AND OVERSIGHT
12. RESEARCH
13. SENTINEL EVENTS

Mid-State Health Network | 530 W. Ionia Street, Ste F | Lansing, MI | 48933 | P: 517.253.7525 | F: 517.253.7552

CHAPTER: SERVICE DELIVERY

1. CULTURAL COMPETENCY

CHAPTER: INFORMATION TECHNOLOGY

1. ARTIFICIAL INTELLIGENCE
2. DOCUMENT SHARING

Committee members expressed appreciation to MSHN staff for including their recommendations and changes following their initial review of the policies. Ms. Amanda Ittner wished to thank all the policy committee members for their thorough review.

MOTION by Kurt Peasley, supported by David Griesing, to approve and recommend the policies under biennial review as presented. Motion carried: 4-0.

5. NEW BUSINESS

There was no new business.

6. ADJOURN

Mr. John Johansen adjourned the Board Policy Committee Meeting at 10:09 a.m.

Meeting Minutes respectfully submitted by:
MSHN Executive Support Specialist

Mid-State Health Network | 530 W. Ionia Street, Ste F | Lansing, MI | 48933 | P: 517.253.7525 | F: 517.253.7552

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 01/27/2025

Members Present: Chris Pinter; Ryan Painter; Maribeth Leonard; Carol Mills; Julie Majeske; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; Bryan Krogman; Sara Lurie
Members Absent: Sandy Lindsey; Joseph Sedlock (PTO)
MSHN Staff Present: Amanda Ittner, Leslie Thomas; For applicable sections Todd Lewicki and Skye Pletcher

Agenda Item	Action Required				
CONSENT AGENDA	Acknowledged receipt.				
	No discussion	By Who	N/A	By When	N/A
REGIONAL FINANCIAL POSITION AND COST CONTAINMENT STRATEGY	L. Thomas reported no change since the last Operations Council meeting. The region is anticipating $8.7 M in FY 25 cost containment strategies. A few CMHSPs noted concerns with increased expenses that may impact cost containment.				
	CMHSPs continue to update progress	By Who	N/A	By When	N/A
EARNED SICK TIME/MINIMUM WAGE	Currently effective 2.21.25. Monitoring legislation: HB4002 (no carryover and does not apply to employees than 25hrs/week) & SB 15, (allow a CAP288, unless payout option, then 144). L. Thomas reported on Regional Efforts: Each CMHSP and MSHN sent individual surveys to its Provider Networks to assess readiness. During the 1.15.25 PNMC meeting results were discussed and the group agreed the biggest impact would be self-determination (SD). In addition, some SD staff will need an increase in wages for the new minimum wage law. PNMC members will send me the SD budget impacts by 2.14.25.				
	Results will be shared with the Operations Council in February	By Who	L. Thomas	By When	2.20.15
NETWORK ADEQUACY ASSESSMENT	MDHHS issued a new draft procedure. Submission of provider directories will be required to MDHHS as they will calculate the time and distance standards. Geographical destinations new to align with 42 CFR 422.116, Metro, Micro… based on population size from 2020 census; 85% for micro, rural, 90% metro. MDHHS noted the difference with Micro, Rural for inpatient and have inquired with CMS. The timeline will be tight for response and reporting to MDHHS by April 30, 2025. PIHPs may still need to submit a Provider Directory. Note: It will be important that CMHSPs ensure current upload and errors are addressed. CMHSPs will need to submit FTEs by county, beds by county.				

Agenda Item	Action Required				
	MSHN will send out final instructions by February 7, 2025, due March 14, 2025. CMHSPs to review county designations and draft procedure giving feedback directly to Amanda	By Who	A. Ittner CMHs	By When	2.7.25 1.31.25
HCBS CMS SITE VISIT REPORT & CAP	***(CAP) has now been approved by CMS with a timeline for development AND implementation by April 11, 2025.*** While the MSHN region will not be responsible for any individual remediation, it is expected to address the systemic issues to ensure the region is not only in full compliance, but also, monitoring the system on a regular basis. Note, one area for CFA&P was included: *PIHPs/CMHSPs ensure compliance with CMS/MDHHS conflict-free access and planning implementation requirements and timelines.* Todd reviewed the status of the findings and related CAP.				
	Informational only	By Who	N/A	By When	N/A
MENTAL HEALTH FRAMEWORK (MDHHS MEETING)	Association gathered participants to be a part of the dialogue with MDHHS regarding the Mental Health Framework that is being discussed by MDHHS. Associations review of this proposed framework • The connection of the framework components to the aim of the effort is not clear. • The events or patterns that are leading to this proposal are unknown. • The movement of the management of the psychiatric inpatient benefit, for persons with mild to moderate conditions, to the private Medicaid Health Plans delinka the current coordinated discharge planning and community reintegration work, carried out by the public mental health system (CMHSPs, PIHPs, providers in the CMHSP and PIHP networks) from the inpatient benefit management to be overseen, as outlined in the Framework, by the MHPs. • The development of this framework appears to have excluded key stakeholders such as the state's PIHPs, CMHSPs, providers, persons served, and advocacy groups. • The design appears to move a greater segment of the management of the state's Medicaid Behavioral Health benefit to the private Medicaid Health Plans. No meeting invite yet. Maribeth, Carol and Amanda are participating.				
	CMHSPs to provide feedback to Amanda for inclusion in workgroup meeting discussion.	By Who	CMHs	By When	2.7.25
IBH MODEL GRANT AWARD	• Michigan was awarded this grant from CMS on 12/17; provides $7.5M over 8 years for Duals (Medicare/Medicaid with a BH/SUD Diagnosis) • Directed to improvements in coordination; emphasis also on social drivers of health; payment innovation (VBP models)				

Agenda Item	Action Required					
	• 3 years of planning allowed before implementation; will work with stakeholders to determine best design; including payment reform to incentivize better care coordination; planning to rely on CCBHC and HHs to carry this out in years 4-8 (at least at this time). • Continues to move the needle on integrated health for beneficiaries. Link to CMS integrated health page: https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model					
	Informational Only	By Who	N/A	By When	N/A	
UPDATE: CFA&P WAIVER LANGUAGE	Status updated from Operations Council Packet - Todd reported 1915 I (SPA), SED, CW, and HSW were all approved by CMS. In addition, CFA&P language included in the Waiver application was reviewed with the group along with the expected communication from MDHHS regarding implementation plan and policy.					
	Discussion Only	By Who	N/A	By When	N/A	
UPDATE: PIHPs FY25 CONTRACTS	MDHHS canceled the scheduled meeting on 1.24.25 and canceled the series for PIHP CEO and contract meetings. Per MDHHS, contract meetings will be used to cover a broader array of operational topics. These meetings will be held monthly, with the goal of including SME's for the particular agenda items to ensure more robust discussion. Stay tuned for additional correspondence on structure and agenda building. Additionally, the PIHP CEO meetings are going to shift to a bi-monthly structure. If there is a need for an ad hoc meeting outside of the regular cadence, we'll certainly make that happen. 1.16.25 - Stipulated Order in the PIHP v. MDHHS case. It is agreeing to add Southeast as a Plaintiff and allow them to add an allegation re: FY24 ISF restrictions and agreeing that the PIHPs can implement SUDHH (which Kristen said she wanted to work with them to do anyway, in a meeting like 2 weeks before this lawsuit was filed). MDHHS response to the lawsuit is due to court of claims I believe 2/9.					
	Update only	By Who	N/A	By When	N/A	
MDHHS SITE REVIEW-USE OF RANGES	Joe and Amanda met with Kristen and Jackie to provide background and status of current state. Reinforcing we want to work with MDHHS to meet compliance but disagree as noted for the reasons in the communication. We are more than willing to develop a stronger policy on use of ranges. MDHHS indicated they would hold on any sanctions and will meet internally with their team. When ready they will schedule another meeting with MSHN.					

Agenda Item	Action Required				
	In the meantime, UMC and CLC will be reviewing/creating policy guidance for use of ranges.				
	Update only	By Who	N/A	By When	N/A
IN-REGION COFRs	S. Pletcher reviewed the COFR background summary and worksheet submitted by CMHs. Question: Does this include all the cost – even residential? Saginaw residential expenses were not included as they pay directly to the provider so not included in the COFR. It was unclear in the instructions if that should have been included. Saginaw is supportive of reviewing COFR to apply in a standardized way.				
	Skye will work with UMC to gather more information on the worksheet and ensure it captures all costs.	By Who	Skye	By When	2.20.25
SUD AFTER HOURS ACCESS	S. Pletcher reviewed the status for SUD after hours access. MSHN is going live today with Protocol beginning at 5pm.				
	Information only	By Who	N/A	By When	N/A
SUD OPIOID SETTLEMENT FUNDS	MDHHS is allocating $1 million to PIHPs for FY25. PIHPs must collaborate with local governments to support community engagement and planning activities. PIHPs are required to implement a transparent reporting system accessible to the public. MSHN has released an open proposal process for in-region SUD prevention, community recovery, treatment, recovery housing, and harm reduction providers. The proposal process opened on Friday, 12/20/24 and will close on Monday, 2/3/2025. Contracts will be awarded from April 1, 2025 through September 30, 2025.				
	Informational only	By Who	N/A	By When	N/A
PIHP CONTRACT NEGOTIATIONS UPDATE: CONTRACT AMENDMENT RELATED TO AUTISM	Nothing further to report – meeting canceled – no materials provided. Amanda emailed on 1.24.25 the update from Jackie which included the below: A PIHP rate amendment is being developed by MDHHS to support the ABA behavioral tech rate. The increase in PIHP rates is expected to be issued in March and will include funding to cover November 2024—February 2025.				
	Update only	By Who	N/A	By When	N/A
DISCUSSION ON THE MEDICAID REVENUE GAP DUE TO MIS-ENROLLMENT OF DAB BENEFICIARIES	L. Thomas report that the PIHP Chief Information Officers (CIO) are leading this effort to develop an automated process to track DAB eligibility changes. One CIO met with PCE for assistance. Notes from the initial CIO meeting include the following:				

Agenda Item	Action Required				
	• Discussed looking at a group approach/data collaboration to take to the state. • Discussion on trends across the state. • What collaboratively can we do to review data across the state?				
	MSHN will update Ops Council once report is ready	By Who	L. Thomas	By When	2.20.25
DISCUSSION ON THE PIHP CONTRACT NEGOTIATION/LITIGATION AND MSHNs COST SETTLEMENT WITH MDHHS FOR PRIOR YEARS	Cost Settlement: MSHN's current cost settlements for FY 21 and FY 22 include anticipated lapses of $19.1 M and $13.5 M respectively. FY 23 yielded a small savings carry forward and no lapse. The group requested MSHN hold off lapsing funds for both fiscal years until the other PIHPs' lawsuit is finalized.				
	Discuss internally how we handle MDHHS FY 21 cost settlement.	By Who	Joe, Amanda, and Leslie	By When	TBD
HEALTHY TRANSITIONS	M. Stillwagon asked about how the room and board should be managed. MSHN recommended the services be paid for separately as room and board can only be covered with GF. C. Mills reported using a flat per diem and then backing off room and board during Newaygo's cost settlement with the provider.				
	Discussion 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	

MSHN
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POLICIES AND PROCEDURE MANUAL

Chapter:	**Quality**		
Title:	**Assessment of Member Experiences**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle: Biennial** **Author:** Chief Compliance Officer, Quality Improvement Council	**Adopted Date: 04.07.2015** **Review Date:** 03.07.2023	**Related Policies:**

Purpose

To ensure Mid-State Health Network (MSHN) and its Provider Network utilize members experience of care to assess the quality, availability and accessibility of care for all individuals served in adherence to the Michigan Department of Health and Human Services (MDHHS) Medicaid Contract and MDHHS Quality Assessment Performance Improvement Program (QAPIP) Policy. ~~as required in the Michigan Department of Health and Human Services (MDHHS), Medicaid Contract.~~

Policy

MSHN shall ensure an assessment/survey of ~~an assessment of~~ the member experience is received annually to improve the quality, availability, and accessibility of care provided by the MSHN Provider Network. ~~perception of services for persons receiving treatment are conducted by the Provider Network at least once a year.~~

A. Assessments/surveys will be conducted in accordance with MDHHS contract requirements.
- May~~The assessment may~~ be qualitative and/or quantitative and include a consumer satisfaction survey or focus group.
- Sh~~The assessment sh~~all be representative of all individuals served, including those ~~and include~~ currently receiving long term supports and services and/or individuals who have been ~~active consumers who have been in services for at least 3 months or consumers~~ discharged up to 12 months prior to their participation in the assessment/survey.
- ~~Assessments/surveys may be conducted by mail, electronic, telephone, or face-to-face.~~
- ~~Assessments/surveys will be conducted in accordance with the forms and timelines established in the MDHHS contract reporting requirements.~~
- ~~The assessment shall address the quality, availability, and the accessibility of care, incorporating questions that address the "welcoming" nature of the agency and its services.~~

B. The Provider Network will be responsible for ~~Assessment/survey results will be aggregated and reviewed for continuous~~ quality improvement of organizational assessment/survey findings. ~~by the Provider Network.~~
- Take specific action on individual cases as appropriate, investigating ~~The Provider Network will address~~ individual sources of dissatisfaction for resolution. ~~and quality improvement.~~
- Outline specific action steps for follow up to the findings.
- Evaluate the effectiveness of the action steps to the findings.

C. MSHN will be responsible for quality improvement of regional assessment/survey findings.
- Aggregate the data and complete a regional analysis.
- Review ~~Regional results will be aggregate~~the regional ~~d and reviewed by the~~results with relevant MSHN committees/councils, including but not limited to ~~Quality~~the Quality Improvement Council (QIC), the Regional Consumer Advisory Council (RCAC), and the Substance Use Disorder (SUD) Provider Network~~, and other relevant MSHN committees/councils~~ for determining appropriate systemic action for quality improvement.
- Outline specific regional action steps for follow up to the findings.
- Evaluate the effectiveness of the action steps to the findings. ~~MSHN will compile findings and~~

~~results of the assessments of care client satisfaction surveys and related improvement initiatives~~

- Monitor improvement and compliance with assessment/surveys through reporting to the MSHN QIC, SUD Provider Network, RCAC, Operations Council, and Board of Directors.

~~C.~~ The assessment/survey findings will be made available to the provider network, and the public through the website and/or upon individual request. ~~for all providers and make findings and results, by provider, available to the public.~~

D. ~~MSHN shall monitor improvement and compliance with assessment/surveys through reporting progress and outcomes to the MSHN Quality Improvement Council, the SUD Provider Network meeting, Regional Consumer Advisory Council, other relevant committees/councils, and Operations Council and the Board of Directors.~~

Applies to:

☒ ☒ll Mid-State Health Network Staff ~~Selected MSHN Staff, as follows:~~

☒ ☒MSHN CMHSP Participant's ~~:~~ ☒~~Policy Only~~

☒ ☒Other: Sub-contract Providers

Definitions:
CMHSP: Community Mental Health Service Programs
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
SUD: Substance Use Disorder
Provider Network: Refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements.
RCAC: Regional Consumer Advisory Council
QAPIP: Quality Assessment Performance Improvement Program
QIC: Quality Improvement Council

Other Related Materials
N/A

References/Legal Authority
MDHHS/PIHP Medicaid Contract
MDHHS Quality Assessment and Performance Improvement Program Technical Requirement

Change Log:

Date of Change	Description of Change	Responsible Party
03.2015	New Policy	Chief Compliance Officer, Quality Improvement Council
03.2016	Annual Review	Quality, Compliance and Customer Svc Director
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service & Quality
03.2019	Annual Review	Quality Manager
10.2020	Biennial Review	Quality Manager
10.2022	Biennial Review	Quality Manager
11.2024	Biennial Review-clarify responsibilities	Quality Manager

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POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	Behavior Treatment Plan Review Committees		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Compliance Officer, Quality Improvement Council	Adopted Date: 12.08.2020 Review Date: 03.07.2023	Related Policies: Quality Management

Procedure:
The purpose of this policy is to guide Mid-State Health Network (MSHN) in monitoring the delegated function of Behavior Treatment Plan (BTP) Review Committees to the Community Mental Health Service Program (CMHSP) Participants in accordance with the Michigan Department of Health and Human Services (MDHHS) Medicaid Managed Specialty Supports and Services Contract.

Policy:
MSHN through delegated functions to the CMHSP participants and retained functions by the Prepaid Inpatient Health Plan (PIHP), will adhere to the Technical Requirement for Behavior Treatment Plans.

Each CMHSP Participant shall have a Behavior Treatment Plan (BTP) Committee to review and approve or disapprove any plan that proposes to use ~~restrictive or~~ intrusive interventions in accordance with the Standards.

Any limitations of the recipient's rights, any intrusive treatment techniques, or any use of psychoactive drugs for behavior control purposes shall be reviewed and approved by the Behavior Treatment Plan Review Committee (BTPRC).

Any limitations of the recipient's rights, any intrusive treatment techniques, or any use of psychoactive drugs where the target behavior is due to active symptoms of a substantiated serious mental illness or serious emotional disturbance as defined in Sec. 100d of PA 258 of 1974 does not require review and approval by the BTPRC.

All limitations on recipient's rights shall be justified, time-limited, and clearly documented in the Individual Plan of Service (IPOS). Documentation shall be included that describes attempts that have been made to avoid limitations, as well as what systematic actions will be taken as part of the IPOS to ameliorate (improve) or eliminate the need for the limitations on recipient rights in the future.

~~Evaluation of the BTP Committee's effectiveness by stakeholders, individuals who have a plan, family members and advocates shall occur annually as part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP).~~
Data on the use of the intrusive and restrictive techniques, and emergency interventions will be:

1. Evaluated by the PIHP's Quality Assessment and Performance Improvement Program (QAPIP) and the CMHSP's Quality Improvement Program (QIP). ~~QIP~~
2. Available for review by the PIHP and MDHHS

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

Definitions:

Aversive Techniques: ~~Those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant and may often generate physical painful responses in the average person or would have a specific unpleasant effect on a particular person) by staff to a recipient to achieve the management and/or control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist or other noxious substance to consequate behavior or to accomplish a negative association with target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g., exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive for purposes of this technical requirement. Otherwise, use of aversive techniques is prohibited. Disclaimer: It is the policy of the Pre- Paid Inpatient Health Plan (PIHP) that aversive interventions are prohibited by any direct or contract provider employee.~~
Techniques that require the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may often generate physically painful responses in the average individual or would have a specific unpleasant effect on a particular individual) by staff to a recipient to achieve the management and control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist, or other noxious substance to cons equate target behavior or to accomplish a negative association with a target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the BTP and that are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques for the purpose of this technical requirement.

BTP: Behavior Treatment Plan
BTPRC: Behavior Treatment Plan Review Committee
CMHSP: Community Mental Health Service Provider
Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self- injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.
IPOS: Individual Plan of Service
Limiting Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques as limiting are prohibiting communication with others when that communication would be harmful to the individual; access to personal property when that access would be harmful to the individual; or any limitation of the freedom of movement of an individual for behavioral control purposes. Use of any intrusive techniques for behavior control purposes requires the review and approval of the BTPRC.
MSHN: Mid-State Health Network
MSHN-CO: Mid-State Health Network Compliance Officer
MDHHS: Michigan Department of Health and Human Services
Physical Management: A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff, each agency shall designate emergency physical management techniques to be utilized during emergency situations.
QAPIP: Quality Assessment and Performance Improvement Program
QIC: Quality Improvement Council
QIP: Quality Improvement Program
~~Other Techniques: Those techniques that are insufficiently documented in the established literature, or evidence-based practices, related to behavior management. "Insufficient" means that in the best judgment of the BTPRC, there are too few references in commonly available literature.~~

~~Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code (MMHC) and the federal Balanced Budget Act. Examples of such techniques are limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.~~
Restraint: The use of physical devise to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support.
Seclusion: The temporary placement of a recipient in a room, alone, where egress is prevented by any means. Note: Seclusion is prohibited except in a hospital operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.

Other Related Materials:
MSHN Behavior Treatment Project Description
MDHHS Behavior Treatment Plans Review Committee FAQs

References/Legal Authority:
1. Michigan Department of Health and Human Services Quality Assessment and Performance Improvement Programs Technical Requirement
2. Michigan Mental Health Code
3. Michigan Department of Health and Human Services Technical Requirement ~~for Behavior~~for Behavior Treatment Plans
4. Mid-State Health Network QAPIP Plan

Monitoring and Review Completed by:
This policy shall be reviewed biennially~~annually~~ by the MSHN Quality Manager in collaboration with CMHSP Participants. Compliance with this policy shall be ensured through the following: minimum of annual monitoring of CMHSP Participants, review of data and submitted reports, and/or on-site visits. External monitoring by MDHHS and/or accreditation bodies may also occur.

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New Policy	Chief Compliance Officer
04.2016	Annual Review	Director of Compliance, Customer Service & Quality
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service & Quality
03.2019	Annual Review	Quality Manager
10.2020	Biennial Review	Quality Manager
10.2022	Biennial Review	Quality Manager
12.2024	Biennial Review – added information under policy statement - Removed evaluation of committee effectiveness as this is in the procedure– added definitions	Chief Compliance and Quality Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Quality**		
Title:	**Critical Incidents**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle: Biennial** **Author:** Quality Improvement Council, Chief Compliance Officer	**Adopted Date: 07.01.2014** **Review Date:** 03.07.2023	**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 ~~pre-paid inpatient health plan is in compliance with the~~ Michigan Department of Health and Human Services (MDHHS)/Pre-Paid Inpatient Health Plan (PIHP)Contract, and Critical Incident Reporting and Event Notification ~~Reporting~~ System.

~~A.~~ **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.~~, with oversight and monitoring by MSHN, for collecting, analyzing and reporting to MSHN all critical incidents that meet the criteria as specified in the MDHHS/PIHP Contract.~~

A. ~~The~~ CMHSP Participants
- R~~r~~eport~~s the~~ critical incidents as required to MSHN. ~~for analysis and aggregation.~~

B. Where a County of Financial Responsibility (COFR) agreement exist, the COFR shall report the critical incidents.
- ~~The CMHSP is responsible for e~~nsur~~eing~~ a process is in place to remediate critical incidents and provide remediation documentation within the required timeframes.
- Establish ~~recommend and implement~~ quality improvement processes ~~in an effort to~~to prevent the ~~reoccurrence~~recurrence of critical incidents.

C. MSHN
- R~~r~~eport ~~s to the MDHHS,~~ critical incident data as required to MDHHS
- Analyze critical incident data quarterly to identify regional trends.

~~C. and in accordance with the Medicaid Contract~~
- Conduct o~~O~~versight and monitoring ~~will be conducted by MSHN~~ through the review of reports and analysis by the Quality Improvement Council and provider network monitoring ~~desk audit and~~ site reviews process.

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

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

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.

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 ~~timeframe described in "a" above shall be followed~~CMHSP reports the incident, ~~,~~ with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.

~~1.~~ 2. **Non-suicide death**: ~~I for i~~ndividuals who were actively receiving services and were living in a S~~s~~pecialized Residential (per Administrative Rule R330.1801-09) or a child-caring institution or

~~2.~~ ~~R~~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.~~ 3. **Emergency Medical Treatment due to Injury or Medication Error**: Individuals ~~for people~~ who at the time of the event were actively receiving services and were:

~~A.~~ 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

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 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 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.~~ 4. **Hospitalization due to Injury or Medication Errors**: Individuals~~by consumers~~ who at the time of the event were actively receiving services and met any one of the following two conditions:

- ~~A.~~ A. Living in a 24-hour Specialized Residential setting (per the Administrative Rule R330.1801- 09) or in a Child-Caring Institution, or
- ~~B.~~ B. Receiving any of the following:
  - Habitation Supports Waiver (HSW) Services or
  - Serious Emotional Disturbance (SED) Waiver Services or
  - ~~o~~ Child Waiver Program (CWP) ~~Services Receiving any of the following Habitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.~~
  - ~~o~~ ~~Habitation Supports Waiver Services, SED Waiver Services or Child Waiver~~
  - o 1915 iSPA Services

Reporting must specify whether the hospitalization was due to a 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, falls, are a result of physical management or requested by MDDHS 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. Services.~~

~~6.~~ 5. **Arrests**: Individuals~~of consumers~~ who, at the time of their arrest were actively receiving services and met any one of the following two conditions:

- ~~A.~~ A. Living in a 24-hour Specialized Residential setting (per the Administrative Rule R330.1801- 09) or in a Child-Caring Institution, or
- ~~B.~~ B. Receiving any of the following:
  - Habitation Supports Waiver (HSW) Services or
  - Serious Emotional Disturbance (SED) Waiver Services or
  - o Child Waiver Program (CWP) ~~Services Receiving any of the following Habitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.~~

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

~~7.~~ 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:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
- Involvement of medical personnel in the mortality reviews

- Documentation of the mortality review process, findings, and recommendations
- Use of mortality information to address quality of care
- Aggregation of mortality data over time to identify possible trends.

~~8.~~ 7. **Death-State Operated Service ~~Discharge:a~~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.

2. **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 be submitted electronically, 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.
      The following information is to be included in the submission:
      - ~~a.~~ Name of beneficiary
      - ~~b.~~ Beneficiary ID number (Medicaid, MiChild)
      - ~~c.~~ Consumer I (CONID) if there is no beneficiary ID number.
      - ~~d.~~ Date, time, and place of death (~~if a~~ licensed foster care facility~~,~~ include ~~the~~ license number.)
      - ~~e.~~ Preliminary cause of death
      - ~~f.~~ Contact person's name and Email address.

   B. Relocation of a consumer's placement due to licensing suspension or revocation. Must be reported within 5 business days.
   C. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours. Must be reported within five (5) business days.
   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. Must be reported within five (5) business days.
   E. 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 may be grounds for sanctions. Must be reported within seven (7) days.
   ~~B.~~F. Critical incidents which may be newsworthy or represent a community crisis must be reported to MDHHS immediately.

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:

ACT: Assertive Community Treatment
CMHSP: Community Mental Health Service Programs
~~COFR: County of Financial Responsibility~~
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~~Requirements~~

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

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	**External Quality Review**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Compliance Officer, Quality Improvement Council (QIC)	**Adopted Date: 09.02.2014** **Review Date:** 03.07.2023	**Related Policies:** Compliance Program Integrity Compliance Reporting & Investigations Quality Management

Purpose

To ensure Mid-State Health Network (MSHN) and its Provider Network participate and comply with the expectations of the External Quality Review process conducted and/or arranged by the Michigan Department of Health and Human Services (MDHHS).

Policy

MSHN and its Provider Network shall participate in the External Quality Review (EQR) process arranged by the Michigan Department of Health and Human Services (MDHHS). MSHN and its Provider Network will strive to achieve full compliance of the standards as set forth in the State of Michigan/Prepaid Inpatient Health Plan (PIHP) Contract.

MSHN shall address the findings of the external review through its Quality Assessment Performance Improvement Program (QAPIP). MSHN will develop and implement performance improvement goals, objectives, and activities in response to the external review findings as part of MSHN's QAPIP through the Quality Improvement Council. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in QAPIP and provided to the MDHHS upon request.

MSHN staff will coordinate the EQR site review process and inform the Provider Network of applicable dates and timelines. MSHN staff will confirm provider network achievement of required EQR corrective action as a part of routine site reviews.

MSHN's Provider Network will comply with any findings and related improvement goals as developed in the QAPIP.

Applies to:

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

Definitions:

EQR: External Quality Review
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Pre-paid Inpatient Health Plan
Provider Network: Refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements.
QAPIP: Quality Assessment Performance Improvement Program

Other Related Materials:
MDHHS – PIHP Contract

References/Legal Authority:
State of Michigan/PIHP Contract: Schedule A: Statement of Work Contract Activities: K. Quality Improvement and Program Development, 2.b.

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer
08.2015	Update to MDHHS and add follow-up to EQR required corrective action	Chief Compliance Officer & Chief Executive Officer
08.2016	Annual Review	Director of Compliance, Customer Service and Quality
08.2017	Annual Review	Director of Compliance, Customer Service and Quality
08.2018	Annual Review	Director of Compliance, Customer Service and Quality
09.2019	Annual Review	Director of Compliance, Customer Service, & Quality
08.2021	Bi-Annual Review; Recommending moving to Quality Chapter	Chief Compliance and Quality Officer
10/2022	Biennial Review	Quality Manager
12.2024	Biennial Review	Chief Compliance and Quality Officer

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 3	**Review Cycle: Biennial** **Author:** Quality Manager	**Adopted Date: 07.07.2020** **Review Date: 03.07.2023**	**Related Policies:** Quality-Sentinel Events Policy

Purpose: To ensure that the Mid-State Health Network (MSHN) Ppre-Ppaid Iinpatient Hhealth Pplan (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 analyzing all incidents 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 incidents for those who reside in a 24-hour specialized setting and recovery housing.

- The provider reports the critical incidents as required to MSHN for analysis and aggregation.
- 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.
- MSHN reports to the MDHHS, critical incident data as required and in accordance with the Medicaid Contract
- 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.
  ~~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 within 48 hours to MSHN.~~

Required ~~Critical~~ Incident~~s~~ Reporting:

- ~~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.(24 hour residential and Recovery Housing)~~
- ~~Emergency Medical Treatment or Hospitalization due to Injury: Injury by accident resulting in a visit to an emergency room, medi-center and urgent care clinic/center, and/or admissions to hospital. (24 hour residential and Recovery Housing)~~
- ~~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. (24 hour residential and~~

~~Recovery Housing)~~

- ~~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.~~
- ~~Serious challenging behaviors: Behaviors not already addressed in a treatment plan and include significant (in excess of $100) 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) Serious physical harm is defined by the Administrative Rules for Mental Health (330.7001) 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." (24 hour residential and Recovery Housing)~~
- ~~Arrest or conviction: The criminal activity could have occurred prior to the admission to the residential facility, however, the arrest has occurred during the admission. Probation violations and drug court sanctions for not complying with treatment do not need to be reported under this category. (24 hour residential only)~~
- ~~Administration of Narcan: MSHN required to be reported within 48 hours of occurrence. (24 hour residential and Recovery Housing)~~

- Incident is any of the following, which should be reviewed to determine whether it meets the criteria for 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 sentinel event is a Patient Safety Event that reaches a patient and results in any of the following:
    - Death
    - 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.
- 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.
- 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.
- 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.

- 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)
- 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."
- 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

~~Deaths as a result of staff action or inaction, or subject to a recipient rights investigation, licensing, or police investigation requires additional information to be submitted to the Quality Manager at MSHN for reporting to MDHHS within 48 hours of the notification of an investigation occurring.~~

- 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 within 48 hours to MSHN.
- Events 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.

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)

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

MSHN
Mid-State Health Network

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: 03.07.2023**	**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) Behavioral Health and Developmental Disabilities Administration (BHDDA) 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 or abuse 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:

BHDDA: Behavioral Health and Developmental Disabilities Administration

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) Behavioral Health and Developmental Disabilities Administration (BHDDA) Medicaid Verification Process ~~MDHHS~~
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

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	**Michigan Mission Based Performance Indicator System**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Compliance Officer	**Adopted Date:** 09.02.2014 **Review Date:** 03.07.2023	**Related Policies:** Quality Management Required Reporting

Purpose

To ensure Mid-State Health Network (MSHN) through its Provider Network is monitoring performance in the areas of access, efficiency, and outcomes through standardized performance indicators in accordance with the Michigan Department of Health and Human ~~Services's~~Service's (MDHHS) established measures. To identify causal factors that may interfere with the provision of care and implement a quality improvement program to improve the healthcare received by those individuals served.

Policy

A. MSHN is responsible for meeting the standards established by MDHHS for access, efficiency and outcomes, through an effective performance monitoring and quality improvement program.
B. MSHN will report/submit to MDHHS, all data, as required, in accordance with the MDHHS/Pre-paid Inpatient Health Plan (PIHP) Contract and the Michigan Mission Based Performance Indicator System (MMBPIS) Codebook.
C. The Provider Network will collect and report accurate data to MSHN for all performance indicators as specified by MSHN and MDHHS.
D. MSHN will provide a regional analysis demonstrating the performance of the Provider Network.
E. Remediation efforts will occur at the regional level for indicators that exhibit performance below the standard for the quarter. These remediation discussions and interventions will occur with the MSHN Quality Improvement Council. ~~All Provider Network participants who exhibit performance below the standard for an indicator during the reporting quarter will be subject to an improvement plan.~~
F. The Provider Network is responsible for ensuring a process is in place to implement corrective action plans and quality improvement processes to improve the access, efficiency, and outcomes of services provided by the Provider Network participant as monitored through the performance indicator system. It is an expectation that the Provider Network manage their subcontractors to ensure compliance and to provide evidence of the reported data.
G. Noncompliance with the above indicators and related improvement plans will be addressed per the contract provisions.
H. Oversight and monitoring will be conducted by MSHN through the review of reports and analysis by the Quality Improvement Council and provider network monitoring desk audit and site reviews.
I. The Performance Indicators as defined by MDHHS:

1. Access:

1. The percent of all Medicaid adults and children beneficiaries that receive a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three (3) hours*.
2. The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. (Mental Illness (MI) Adults, MI Children, Intellectual/Developmental Disabled (IDD) Adults, IDD Children) *

2. (e~~b~~) The percentage of new person during the quarter receiving a face-to-face service for treatment or supports within the 14 calendar days of a non-emergency request for service for persons with Substance use Disorders (SUD) (Persons approved for SUD services) **

3. The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. (MI Adults, MI Children, IDD Adults, IDD Children).
4. (a) The percent of discharges from psychiatric inpatient unit who are seen for follow-up care within seven (7) days (All children and all adults (MI, IDD).
   (b) The percent of discharges from a substance use disorder detox unit who are seen for follow-up care within seven (7) days (All Medicaid SUD*).
5. The percent of Medicaid recipients having received PIHP managed services (MI adults/MI children/IDD Adults/IDD children, and SUD).**

2. Adequacy/Appropriateness:

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one (1) HSW service per month that is not support coordination. **

3. Efficiency:

7. The percent of total expenditures spent on managed care administrative function for PIHPs. **

4. Outcomes:

8. The percent of adults with mental illness, the percent of adults with an intellectual developmental disability, and the percent of dual MI/IDD adults served by the CMHSP who are in competitive employment. **
9. The percent of adults with mental illness, the percent of adults with an intellectual developmental disability, and the percent of dual MI/DD adults served by the CMHSP who earn minimum wage or more from employment activities (competitive, supported employment, or sheltered workshop). **
10. The percent of MI and IDD children and adults readmitted to an inpatient psychiatric unit within thirty (30) days of discharge.
~~11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and DD served in the categories of Abuse I and II and Neglect I and II.~~
13. The percent of adults with an intellectual developmental disability served who live in a private residence alone or with spouse or non-relative(s). **
14. The percent of adults with serious mental illness served who live in a private residence alone or with spouse or non-relative(s). **
~~15. Percentage of children with an intellectual developmental disability (not including children in the Children Waiver Program) in the quarter who receive at least one service each month other than Case Management and Respite. **~~

* Calculated by the PIHP from REMI.
** MDHHS Calculates. The PIHP does not submit data through this process.

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:

CMHSP: Community Mental Health Service Plan
IDD: Intellectual Developmental Disability
HSW: Habilitation Supports Waiver
MDHHS: Michigan Department of Health and Human Services
MI: Mental Illness
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
MMBPIS: Michigan Mission Based Performance Indicator System

Provider Network: refers to a CMHSP Participant and Substance use Treatment Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through CMHSP subcontractors.
REMI: Regional Electronic Medical Information (MSHN's Managed Care Information System)
SUD: Substance Use Disorder

Other Related Materials

References/Legal Authority
Medicaid Contract
MDHHS FY25~~0~~_PIHP_MMBPIS_Code Book

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer
11.2015	Annual review and update to MDHHS	Director of Compliance, Customer Service and Quality Improvement
08.2016	Annual Review	Director of Compliance, Customer Service and Quality Improvement
03.2017	Annual Review	Director of Compliance, Customer Service and Quality
03.2018	Annual Review	Director of Compliance, Customer Service and Quality
03.2019	Annual Review	Director of Compliance, Customer Service and Quality
04.2020	Deleted Indicator 2 and 3. Replaced with new Indicators 2, 2a, and 3.	Director of Compliance, Customer Service and Quality
10.2022	Bi~~c~~annual Review	Quality Manager
12/2024	Biennial Review – removed two indicators that are no longer required)	Chief Compliance and Quality Officer

POLICY & PROCEDURE MANUAL

Chapter:	Quality		
Title:	**Monitoring and Oversight**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Compliance Officer Quality Improvement Council	**Adopted Date: 11.04.2014** **Review Date:** 03.07.2023	**Related Policies:** Quality Management

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 its Community Mental Health Service Program (CMHSP) and Substance Use Disorder Service Provider (SUDSP) ~~Provider~~ Network. To ensure compliance with federal and state regulations, and to establish standardized processes for conducting review of all delegated managed care functions.

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 protocols for ~~how~~ monitoring and oversight of any entity to which it has delegated a managed care administrative function and protocols to ensure the delegated provider is appropriately managing its charged responsibilities.

A. MSHN shall conduct a full monitoring and evaluation process of each CMHSP Participant over a three-year review cycle. ~~and~~ MSHN will conduct a full monitoring and evaluation process of each Substance Use Disorder (SUD) Service Provider, at a minimum once every two years. This process will consist of utilizing uniform standards and measures to assess compliance with federal and state regulations, and PIHP contractual requirements. During the interim ~~year~~reviews, the review process will focus on any elements of the previous year's findings in which compliance standards were considered to be partially or not fully met. All delegated functions will be reviewed prior to delegation ~~occurring and every other year thereafter.~~and ongoing.

B. The contract and delegation monitoring and evaluation process may consist of the following components:
    1. ***On-Site Audit****:* This component will consist of an on-site visit to the CMHSP Participant/SUDSP Participant to review and validate process requirements. This component may include staff interviews.
    2. ***Desk Audit****:* This component will include all elements of an on-site audit conducted remotely using MSHN secure file-sharing site.
    3. ***Consumer Chart Review***: The PIHP shall pull a random sample of consumer records to ensure compliance with specific program requirements, Person-Centered Planning requirements, enrollee rights, and documentation requirements, additionally, the PIHP shall pull a sample of consumer records to conduct primary source verification of reported data.
    4. ***Data Review and Analysis****:* This component includes analysis of CMHSP Participant/SUDSP performance and encounter data trends, and compliance with data reporting requirements.

C. Consumer charts and other information/data that will be reviewed by the PIHP will include the time period from the date of the last review to current (or the prior 12 months). The PIHP does reserve the right to request information/data prior to the last 12 months as deemed necessary.

D. Overall responsibility for the contract monitoring evaluation process and updating of the monitoring evaluation tools shall rest with the PIHP. The tools shall be reviewed on an annual basis by the Quality Improvement Council to ensure their functional utility; and updated as necessary due to changing regulations, new contract terms and operational feedback received.

E. MSHN shall create its monitoring schedule at least ninety (90) days in advance of its review.

F. Following the review, MSHN ~~shall develop a Contract Monitoring & Evaluation Report~~will send providers a detailed report of the review ~~detailing the results of its monitoring review~~ for each CMHSP Participant/SUDSP within 30 days of the review. The monitoring report shall include the following:

- A summary report detailing the PIHP's overall review process and findings;
- Detailed findings pertaining to each standard audited/reviewed;
- Quality Improvement (QI) recommendations; and
- "Recommendations" (if applicable) pertaining to any finding that requires remedial action.
- ~~Sanctions as defined in the PIHP contract with the CMHSP Participant/SUDSP.~~

~~The PIHP shall submit the monitoring report to the CMHSP Participant/SUDSP within thirty (30) days of the monitoring review conclusion.~~

G. The CMHSP Participant/SUDSP shall submit remediation plan within thirty (30) days of the monitoring review report date, for any item not meeting the compliance standard. This plan shall include:

1. A detailed action plan which includes individual and systemic remediation to improve and monitor performance
2. Measurement criteria (i.e. how will the PIHP/Provider know the remediation was effective)
3. Timeframes and responsible individual for completing each remediation plan.

When access to care to individuals is a serious issue, the CMHSP Participant/SUDSP may be given a shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference. If, during a MSHN review, the review team member identifies an issue that places a consumer in imminent risk to health or welfare, the review team would invoke an immediate review and response by the CMHSP Participant/SUDSP, which must be completed within seven (7) calendar days. Evidence of the review and appropriate action taken will be required to be submitted to MSHN at the time of completion. A follow up review may be conducted to ensure remediation of issues identified as out of compliance within 90 days of the ~~approve~~approved plan of correction.

Quality Improvement Plans not submitted within the required time frame will be reported to the MSHN Chief Executive Officer and the CMHSP Participant's /SUDSP's Chief Executive Officer/Executive Director for resolution and submission.

H. MSHN will review the remedial action/quality improvement plan, seek clarifying or additional information from the CMHSP Participant/SUDSP as needed, and issue a response within 15 days of receiving required information from the CMHSP Participant/SUDSP. MSHN will take steps to monitor the CMHSP Participant's/SUDSP's implementation of the remedial action/quality improvement plan as part of performance monitoring.

1. If additional information is required, the Provider will have 7 days to respond and provide any additional information requested to MSHN. If the response requires additional follow up MSHN will have 7 days to review and respond to the Provider.
2. It ~~is the expectation~~is expected that all corrective actions will be fully implemented within 30 days of their approval by MSHN. In special circumstances MSHN may approve an extension for the implementation to occur.
3. Any identified health and/or safety issue will need to be corrected immediately and will require submission of evidence that the issue has been corrected within 7 days of the review.

I. If the provider and review team cannot reach mutual agreement on a finding or on required corrective action, the provider may submit an appeal of finding and conflict resolution per the MSHN provider appeal procedure. NOTE: Recommendations do not qualify under the appeal and resolution process as they are recommendations only and do not require a corrective action plan. MSHN will follow the Provider Appeal Procedure. ~~After a review, the MSHN provider appeal committee shall submit to the provider a determination of the appeal and copy the review team. The review team shall adjust and reissue the monitoring report as an outcome of either an informal or formal appeal that changes the report results.~~

J. Report summary findings on PIHP monitoring activities shall be shared with the MSHN Board of Directors, Corporate Compliance Committee, Operations Council and other MSHN councils as appropriate.

Applies to:

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

Definitions:

CMHSP: Community Mental Health Service Program
Finding: A federal or state standard found out of compliance. A finding requires corrective action to ensure compliance with federal and state guidelines.
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health and Human Services
PIHP: Prepaid Inpatient Health Plan
Provider Network: Refers to MSHN CMHSP Participants and SUD providers directly under contact with the MSHN PIHP to provide/arrange for behavioral health services and /or supports. Services and supports may be provided through direct operations or through the subcontract arrangements.
~~QI:~~ Quality Improvement Recommendation: A quality improvement suggestion that is meant to guide quality improvement discussion and change. A recommendation does not require a corrective action.
SUD: Substance Use Disorder
SUDSP: Substance Use Disorder Service Provider

Other Related Materials:

MSHN Corporate Compliance Plan

References/Legal Authority:

1. The Code of Federal Regulations (CFR)
2. PIHP managed care administrative delegations made to the CMHSP
3. PIHP/CMHSP contract
4. PIHP/SUD Provider contract
5. PIHP policies, standards and protocols, including both MDHHS and PIHP 'practice guidelines.
6. Medicaid Provider Manual
7. SUDSP Provider Manual
8. Medicaid/PIHP contract
9. Federal Procurement Guidelines (The Office of Federal Procurement Policy (OFPP)-Office of Management and Budget

Date of Change	Description of Change	Responsible Party
08.18.2014	New Policy	Chief Compliance Officer
11.2015	Annual Review	Director of Compliance, Customer Services & Quality
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service and Quality
03.2019	Annual Review	Quality Manager
10.2020	Biennial Review	Quality Manager
10.2022	Biennial Review	Quality Manager
11/2024	Biennial Review – updated process to match current monitoring and oversight	Chief Compliance Administrator

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Quality**		
Title:	**Performance Improvement**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Compliance Officer, Quality Improvement Council	**Adopted Date: 04.07.15** **Review Date:** 03.07.2023	**Related Policies:**

Purpose

To ensure Mid-State Health Network (MSHN) and its Provider Network develop performance improvement projects, consistent with healthcare quality standards and Michigan Department of Health and Human Services expectations, to improve the health outcomes of those individuals served within the MSHN region.

Policy

MSHN shall ensure region-wide performance improvement projects (PIP) are conducted in accordance with the following:

- Projects must address both clinical and non-clinical aspects of care.
    - Clinical areas would include, but not limited to, high-volume services, high-risk services, and continuity and coordination of care
    - Non-clinical areas would include, but not be limited to, appeals, grievances and trends and patterns of substantiated Recipient Rights complaints; and access to, and availability of, services.
- Topics will be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, MSHN's consumers; consumer demographic characteristics and health risks; and the interest of consumers in the aspect of service to be addressed.
- PIPs may be directed at state or MSHN-established aspects of care.
- MSHN will engage in at least two projects during the waiver renewal period.
- MSHN-established PIPs will be developed in collaboration with the Quality Improvement Council.
- State directed PIPs will be conducted in accordance with state requirements and timelines.
- Regional performance improvement project results will be aggregated and reviewed by the Quality Improvement Council, the Regional Consumer Advisory Council, the Medical Directors Committee when relevant, and other relevant committee/councils for determining appropriate initiatives and areas for continuous quality improvement.

MSHN shall monitor Provider Network compliance with the regional performance improvement projects through reporting progress and outcomes to the MSHN Quality Improvement Council, Regional Consumer Advisory Council, Operations Council, the Medical Directors when relevant, and the Board of Directors.

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:

CMHSP: Community Mental Health Service Programs
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network

PIHP: Prepaid Inpatient Health Plan

PIP: Performance Improvement Project
Provider Network: refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements

Other Related Materials
N/A

References/Legal Authority
Medicaid Managed Specialty Supports and Services contract, MDHHS Quality Assessment and Performance Improvement Technical Guideline

Change Log:

Date of Change	Description of Change	Responsible Party
03.2015	New Policy	Chief Compliance Officer
03.2016	Annual Review	Quality, Compliance & Customer Svc Director
03.2017	Annual Review	Director of Compliance, Customer Service and Quality
03.2018	Annual Review	Director of Compliance, Customer Service and Quality
03.2019	Annual Review added PAC and Medical Directors as relevant for committees to review	Quality Manager
10.2020	Biennial Review	Quality Manager
10.2022	Biennial Review	Quality Manager
12/2024	Biennial Review	Chief Compliance and Quality Officer

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POLICIES AND PROCEDURES MANUAL

Chapter:	Quality		
Title:	Quality Management		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: QI Council and Chief Compliance Officer	Adopted Date: 11.22.2013 Review Date: 03.07.2023	Related Policies: General Management

Purpose

The Quality Management (QM) system of Mid-State Health Network (MSHN) is designed to monitor, evaluate, and improve the access, outcomes, efficiency, and appropriateness of the services provided to consumers, and the administrative functions supporting that care.

Policy

MSHN shall develop, implement and maintain a QM system which includes processes for monitoring and oversight of its provider network. The QM system shall conform to the requirements reflected in the Balanced Budget Act of 1997 and the Medicaid Specialty Supports and Services contract.

The following QM functions are retained by MSHN or delegated to Community Mental Health Service Program (CMHSP) Participants and the Substance Use Disorder (SUD) Provider Network as delineated below:

A. **Quality Assessment Performance Improvement Program (QAPIP) Plan and Report**: MSHN retains responsibility for developing, maintaining, and evaluating the annual QAPIP Plan and Report in collaboration with the CMHSP Participants. The plan will be developed in accordance with the requirements identified within the Michigan Department of Health and Human Services (MDHHS) contract with the Pre-Paid Inpatient Health Plans (PIHP). The report is an annual effectiveness review of the QAPIP Plan and includes a review of the required components of the QAPIP description, the tasks associated with improvement activity (workplan), and each performance measure relevant to the QAPIP. ~~The report shall include analysis of critical incidents, risk events and sentinel events, and shall facilitate quality improvement processes.~~ Responsibility for implementation of the QAPIP is delegated to the CMHSP Participants and the SUD Provider Network.~~, including local analysis of risk events, critical incidents, sentinel events, and events requiring immediate notification, with oversight by MSHN.~~

B. **Standard Setting**: MSHN retains responsibility for establishing quality standards in collaboration with the Provider Network~~CMHSP Participants~~. Responsibility for implementing processes for meeting those standards is delegated to the CMHSP participants and SUD Provider Network with oversight and monitoring by MSHN.

~~C. **Regulatory and Corporate Compliance**: MSHN shall comply with 42 CFR Program Integrity Requirements, including designating a MSHN Compliance Officer. Responsibility for establishing processes to achieve compliance consistent with the MSHN Corporate Compliance Plan is delegated to the CMHSP participants and the SUD Provider Network, with oversight and monitoring by MSHN.~~

~~D.~~C. **Performance Assessments and Conducting Quality Reviews**: MSHN retains responsibility for assessing the performance of its provider network, including conducting reviews of performance according to established standards.

~~E.~~D. **External Quality Reviews**: MSHN retains responsibility, in collaboration with the CMHSP Participants, for managing outside entity review processes, including, but not limited to, external quality review.

~~F.~~E. **Research**: Responsibility for assuring compliance with state and federal rules, laws and guidelines regarding conducting research consistent with MSHN policy is delegated to the Provider Network~~CMHSP participants~~. MSHN retains the responsibility for assuring capacity to reach compliance within the region.

~~G.~~F. **Provider Education and Training**: Responsibility for providing training to providers is delegated to the Provider Network~~CMHSP participants~~, with oversight and monitoring by MSHN. Assurances for uniformity and reciprocity shall be established in MSHN provider network policies and procedures.

~~H.~~G. **Practice Guidelines**: Responsibility for the adoption, development, implementation, and continuous monitoring and evaluation of practices guidelines is delegated to the Provider Network~~CMHSP~~

~~participants~~, with oversight and monitoring by MSHN.

Applies to:

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

Definitions:

~~CARF: Commission on Accreditation of Rehabilitation Facilities~~
Corporate Compliance: This sort of compliance is required in the PIHP contract with MDHHS and is intended to prevent, monitor and remediate instances of abuse and fraud of public funds.
CMHSP: Community Mental Health Service Program
~~Critical Incidents: Specific events requiring analysis and reporting to MDHHS. These events include suicides, non-suicide deaths, emergency medical treatment or hospitalizations due to injury or medication error, and arrests of consumers. The population on which these events must be reported differs slightly by type of event (MDHHS Contract, Attachment.). Physical management and/or involvement of law enforcement, permitted for intervention in emergencies only, are considered critical events.~~
Joint Commission: A national organization that accredits healthcare and behavioral health.
~~Risk Events: Additional events that put individuals, in the same population categories as the critical events above, at risk of harm. These events minimally include actions taken by consumers that cause harm to themselves or to others, and two or more unscheduled admissions to a medical hospital, not due to planned surgery or the natural course of a chronic illness, within a 12-month period (MDHHS Contract). These events require analysis. Reporting to MDHHS occurs upon MDHHS request.~~
MSHN: Mid- State Health Network
MDHHS: Michigan Department of Health and Human Services
PIHP: Prepaid Inpatient Health Plan
Provider Network: Refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements
SUD: Substance Use Disorder
SUD Provider Network: Refers to Substance Use Disorder Providers that are directly under contract with the MSHN PIHP to provide services and/or supports.
QAPIP: Quality Assessment and Performance Improvement Program
QIC: Quality Improvement Council
QM: Quality Management
~~Sentinel Events: Unexpected occurrences involving death, serious psychological or physical injury (specifically loss of limb or function) or the risk thereof. This includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response (CARF; Joint Commission.). Also included is injury or death that occurs as a result of the use of a behavioral intervention (MDHHS Contract.). Sentinel Events require root cause analysis and reporting to MDHHS and accrediting entities in accordance with established procedures.~~

References/Legal Authority:

1. BBA 438.240: Quality Assessment and Performance Improvement Program
2. MDHHS/PIHP contract
3. MDHHS Quality Assessment and Performance Improvement Program Technical Requirement
4. Mid-State Health Network QAPIP Plan
5. Mid-State Health Network Compliance Plan

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New policy	QIC
01.06.2016	Annual review, format consistency	Director of Compliance, CS & Quality
03.2017	Annual Review	Director of Compliance, CS & Quality

03.2018	Annual Review	Director of Compliance, CS and Quality
03.2019	Annual Review, added risk events and immediate notification	Quality Manager
10.2020	Biennial Review	Quality Manager
10/2022	Biennial Review	Quality Manager
12/2024	Biennial Review – changed application of standards to "Provider Network," updated information on the plan and report and removed unnecessary definitions	Chief Compliance and Quality Officer

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Mid-State Health Network

POLICY AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	**Regional Provider Monitoring and Oversight**		
Policy: ☑ **Procedure:**☐ **Page:** 1 of 5	**Review Cycle:** Biennial **Author:** Chief Compliance Officer	**Adopted Date:** 11.07.2017 **Review Date:** 03.07.2023	**Related Policies:** Quality Management

Purpose

To establish guidelines for Mid-State Health Network (MSHN) and Community Mental Health Service Program (CMHSP) participants when conducting regional monitoring and oversight of its provider network when regional provider performance monitoring has been implemented (e.g. Financial Management Services (FMS), Licensed Psychiatric Hospitals/Units (LPH), Applied Behavior Analysis (ABA)/Autism, etc., Crisis Residential ~~(Healthy Transitions))~~, or when statewide reciprocity arrangements between Prepaid Inpatient Health Plans (PIHPs) have been enacted pursuant to contractual Michigan Department of Health and Human Services (MDHHS) Reciprocity & Efficiency Policy, and to ensure compliance with federal and state regulations, and contractual obligations and to establish standardized, regional processes.

Policy

MSHN on behalf of the CMHSP participants shall create, implement, and maintain a published process to monitor and evaluate its provider network to ensure compliance with federal and state regulations and contractual requirements as it applies to collective services designated by the Operations Council. This includes protocols for monitoring and oversight and protocols to ensure regional reviewers are appropriately managing its charged responsibilities.

A. MSHN, on behalf of its CMHSP's, shall coordinate a full monitoring and evaluation process of contracted providers once every two (2) years. This process will consist of utilizing uniform standards and measures to assess compliance with federal and state regulations, and regional contractual requirements. An interim year review will focus on any elements of the previous year's findings in which compliance standards were determined to be partially or not fully met and new standards effective since the previous full review.
    1. Regionally approved provider performance monitoring standards and protocols shall be exclusively used.
    2. Statewide approved provider performance monitoring standards and protocols shall be exclusively used and shall supersede any regionally developed/approved performance standards and protocols.
    3. CMHSPs may prefer to facilitate reviews and should work with the assigned MSHN Lead to coordinate. Coordinated review teams will determine task responsibilities based on content expertise and other mitigating factors.

B. The monitoring and evaluation process may consist of the following components:
    1. ***Desk Audit****:* This component will consist of a review of select policies, protocols, chart documentation, staff files, and other resource materials submitted by the provider to the designated secure web-based document management system for review team access and review.
    2. ***On-Site Audit****:* This component will consist of an on-site visit to the provider, if site-based services are provided or site-based records access is required, to review and validate process requirements. This component may include staff interviews. This function will typically be the responsibility of a MSHN-coordinated site review team on behalf of the CMHSP Participants holding the contract responsibility.
    3. ***Consumer File Review****:* Prior to the visit, MSHN shall extract a random 5% sample of consumer record identifiers to ensure compliance with specific program requirements. The random sample will include a sample of consumers from all CMHSP's who contract

with the provider. The sample will include at least one (1) record from each of the regional CMHSPs who hold a contract with the provider. Sample sizes will be no less than two (2) and no more than (12). This function will typically be completed by a MSHN-coordinated site review team on behalf of the contracted CMHSPs. Note: The review team has the right to request additional files should there be justification to do so. If each contracting CMHSP is represented in the record review, the review team may complete less reviews than the original sample identified.

4. ***Personnel File Review:*** This component includes analysis of the personnel records of employees assigned to the selected consumers. On-site reviews and desk reviews will ~~typically~~ be completed by a MSHN-coordinated site review team on behalf of the CMHSP Participants holding the contract responsibility.
    i. For FMS audits, a minimum of ten (10) and a maximum of twenty-five (25) employee personnel files shall be reviewed which will include a sample of all employee types including aide level.
    ii. For LPH reviews, an audit of personnel credentialing records may be waived upon verification of current accreditation and review of credentialing policies and procedures demonstrate compliance with *Department of Health and Human Services Behavioral Health and Developmental Disabilities Administration Credentialing and Re-credentialing Processes.*
    iii. For Autism audits, personnel file review includes actively employed (current) staff engaged with the client (minimum 2 staff /max 8 staff).

5. ***Recipient Rights Specific Review***: For the Recipient Rights portions of the review(s), applicable to LPH and Autism, the following information is relevant:
    i. Rights reviews occur, onsite, no less than every 365-days
    ii. For Autism, p~~P~~olicy reviews are to occur no less than every 3-years and are conducted by the CMHSP Rights Officers

6. Consumer and personnel records and other information/data that will be reviewed will include the time period from the date of the last site review to current (or the prior 24 months). The designated review team does reserve the right to request information/data prior to the last 24 months as deemed necessary.

7. Overall responsibility for regional monitoring and evaluation process and updating of the monitoring evaluation tools shall rest with the MSHN Quality Assurance and Performance Improvement (QAPI) Manager, CMHSPs, in concert with the Provider Network Management Committee (PNMC) and/or designees. Annually, monitoring tools shall be reviewed to ensure functional utility and updated as necessary due to changing regulations, contract terms and operational feedback. In the case of statewide provider performance monitoring protocols, suggestions for edits/updates shall be submitted through the standing statewide PIHP process.
    a. MSHN Regional Recipient Rights Staff shall have an opportunity to review and provide recommended alterations/updates to any related source materials, e.g. regional LPH standardized contract.
        i. PNMC and MSHN Regional Rights Officer Committee will be responsible for sharing information.

8. Site review teams shall consist of a sufficient number of CMHSP representatives to ensure an efficient and effective review with minimal disruption to provider operations. CMHSP representatives will be identified on a voluntary basis.
    a. CMHSP staffing/support should efficiently cover all review responsibilities and account for time, content expertise, review-related tasks. MSHN support is available as needed and requested. If CMHSP volunteers are not identified, the QAPI manager shall recruit a team representative(s) through direct contact with the CMHSP or via Operations Council requests.

b. At least one of the CMHSP representatives shall be from the CMHSP within which the provider's primary service site (or administrative site) is located unless an alternate plan was agreed upon.

c. A recipient rights staff from the CMHSP within which the provider's primary service site is located shall be a part of the site review team and shall conduct the Recipient Rights Review on behalf of the region.

   i. Only the recipient rights staff can review rights-related standards.

   ii. Only the recipient rights staff have authority to approve submitted rights-related corrective action.

   iii. The Rights Staff oversee all matters related to Rights and will ensure the information is shared with the review team, including the Lead, for purpose of carrying out reciprocity plan in which multiple elements / functions are reviewed for compliance during one (1) general review of a unit.

d. MSHN's QAPI manager will be responsible for coordinating a uniform and consistent review process in the region. This includes coordinated communications between MSHN, the CMHSPs and MSHN councils and committees, as necessary.

9. Annually, the MSHN QAPI manager, in concert with CMHSP review teams and, if applicable, other PIHPs, shall create its annual monitoring schedule, based on the calendar year, and notify providers at least ninety (90) days in advance of the scheduled review. Special considerations may include:
   - Ensuring coordination with other PIHPs to support regional monitoring and reciprocity.
   - Avoiding the months of January through April for reviews of Financial Management Services providers.

10. Following the on-site review, the review team lead, shall develop a Contract Monitoring & Evaluation Report detailing the results of its monitoring review. The monitoring report shall include the following:
    i. A summary report detailing the overall review process and findings;
    ii. Detailed findings pertaining to each standard audited/reviewed;
    iii. Quality Improvement (QI) recommendations; and
    iv. Corrective Actions (if applicable) pertaining to any finding that requires remedial action.

11. The review team lead shall submit the monitoring report to the provider within thirty (30) days of the conclusion of the review. Final reports and related documents will be uploaded to applicable file sharing protocol sites (e.g. Box, Teams) for contracting CMHSP's within the MSHN region to access.

12. MSHN review team(s) will adhere to all MDHHS guidance, including but not limited to, timeliness requirements.

13. The provider shall submit a corrective action plan within thirty (30) days of the monitoring review report date, for any item not meeting the compliance standard. The provider may also present information that demonstrates compliance with the standard(s) at the time of the review. The MSHN QAPI Manager, in consultation with the CMHSP Participants holding the contract responsibility shall determine if the new information results in a change to the final report/score. The corrective action plan shall include:
    i. A detailed action plan which addresses steps to be taken to assess and improve performance;
    ii. Measurement criteria (i.e. how will the review team know the objective/outcome will be achieved); and
    iii. Timeframes for completing each improvement plan.

14. If, during an on-site visit, the site review team member identifies an issue(s) that places a consumer in imminent risk to health, safety or welfare, both the MSHN and CMHSP representatives will initiate coordinated action in a manner consistent with federal, state and ethical requirements based on the severity of the issue(s).
15. Corrective Action Plans not submitted within the required time frame will be reported to the MSHN Chief Compliance and Quality Officer and the Provider Network Director of the CMHSP Participants holding the contract responsibility for resolution submission.
16. The review team will review the corrective action plan and issue a response within thirty (30) days of receiving required information from the provider. The Corrective Action Plan shall be provided, as applicable, to other PIHPs and to the contracting CMHSPs within the MSHN region through identified FTP sites.
17. The MSHN QAPI Manager and CMHSP representatives will take steps to monitor the providers implementation of the corrective action plan as part of performance monitoring, with an interim year follow up review. Monitoring activities will include review team member's organizations or other CMHSPs in the region. Based on the severity of the issue(s) requiring a corrective action, a focused review will be conducted, at a timeframe determined by the review team, to ensure remediation.
18. If the provider and review team cannot reach mutual agreement on a finding or on required corrective action, the provider may submit an appeal of finding and conflict resolution to the CMHSP Participants holding the contract responsibility. NOTE: Recommendations do not qualify under the appeal and resolution process as they are recommendations only and do not require a corrective action plan. A final determination will be coordinated by the review team and forwarded to the provider in accordance with provider appeal procedures. The review team shall adjust and reissue the monitoring report as an outcome of either an informal or formal appeal that changes the report results.
19. Report summary findings on provider monitoring activities shall be shared with the contracting CMHSP's, Provider Network Management Committee, and other MSHN councils or committees as appropriate.

Applies to:

☐ All Mid-State Health Network Staff
☒ Selected MSHN Staff, as follows: QAPI, Provider Network, Compliance
☒ MSHN's Participants: ☐ Policy Only ☒ Policy and Procedure
☒ Other: Subcontracted Providers

Definitions:

ABA: Applied Behavioral Analysis
CMHSP: Community Mental Health Service Program
FMS: Fiscal Management Services that assist the adult beneficiary, or a representative identified in the beneficiary's individual plan of services manage and distribute funds contained in the individual budget.
LPH: Licensed Psychiatric Hospital
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network, Region 5 Pre-Paid Inpatient Health Plan
PIHP: Prepaid Inpatient Health Plan
PNMC: Provider Network Management Committee
Provider Network: Refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and /or supports. Services and supports may be provided through direct operations or through the subcontract arrangements.
QAPI Manager: MSHN's Quality Assurance and Performance Improvement Manager
QI: Quality Improvement

Other Related Materials:
1. Regional Monitoring Tools
2. MSHN Provider Appeals Procedure

References/Legal Authority:
1. The Code of Federal Regulations (CFRs)
2. CMHSP/Provider regional contract
3. PIHP managed care administrative delegations made to the CMHSP
4. PIHP/CMHSP contract
5. PIHP policies, standards and protocols, including both MDHHS and PIHP 'practice guidelines.
6. Medicaid Provider Manual
7. MDHHS/PIHP Contract Contract
8. MDHHS Reciprocity Standards
9. MDHHS Self-Directed Services Technical Advisory

Change Log

Date of Change	Description of Change	Responsible Party
08.2017	New Policy	Director Provider Network Management
03.2018	Annual Review	Director of Compliance, Customer Service and Quality
03.2019	Annual Review	Director of Compliance, Customer Service and Quality
06.2020	Updated to include current practice for oversight including addition of Recipient Rights specific review language	Director of Compliance, Customer Service and Quality
11.2022	Biennial Review – References, acronyms and definitions updated	Quality Manager
11/2024	Biennial Review	Compliance Administrator

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POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	**Research**		
Policy: ☐ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle: Biennial** **Author:** Chief Compliance Officer, Quality Improvement Council	**Adopted Date: 09.02.2014** **Review Date:** 03.07.2023	**Related Policies:** Quality Management

Purpose:

To protect the rights and well-being of human subjects of research conducted by Mid-State Health Network (MSHN) and/or its provider network and to ensure compliance with the Protection of Human Subjects Act, 45 Code of Federal Regulations (CFR), Part 46 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Policy:

Prior to initiation of research by MSHN and/or its provider network MSHN will submit Institutional Review Board (IRB) application material for all research involving human subjects that is conducted in programs sponsored by the Michigan Department of Health and Human Services (MDHHS) or in programs that receive funding from or through the State of Michigan. The application and approval material will be submitted to the MDHHS's Institutional Review Board (IRB) for review and approval or for acceptance of the review by another IRB. All such research must be approved by a federally assured IRB, but the MDHHS's IRB can only accept the review and approval of another institution's IRB under a formally approved interdepartmental agreement. The manner of the review will be agreed upon between the MDHHS's IRB Chairperson and the Contractor's IRB Chairperson or Executive Officer(s).

Research initiated prior to MSHN contracting shall be acceptable provided, upon request, the responsible Community Mental Health Service Program (CMHSP) can provide evidence of appropriate MDHHS IRB or alternative review.

All research and related projects shall be conducted in such a manner as to ensure the rights, benefits, and privileges guaranteed bylaw.

All research involving MSHN consumers must be reviewed and approved by ~~a~~ MSHN or MSHN Contractor Research Review Committee before involvement of MSHN subjects in the project. Externally funded projects involving the use of MSHN consumers are to be approved by a MSHN Research Review Board. MSHN acknowledges that grant application time frames may require submission prior to MSHN review; however, approval by the MSHN Research Review Board is required prior to acceptance and implementation of the grant award.

The Research Review Board shall include minimally:

1. A Senior officer of MSHN or its contractors
2. A senior clinician with expertise with the identified population
3. A recipient rights officer/advisor
4. A medical director for medically related research

The Research Review Board is responsible for reviewing proposed research projects involving human subjects before submission to the MDHHS's IRB for approval of the research project to ensure that:

1. The rights and welfare of the subjects are protected.
2. Written informed consent is obtained from each subject using appropriate methods.
3. The risks and potential benefits are disclosed to participating subjects; and
4. Review completed (IRB) application material

MSHN may request additional expertise when necessary for adequate review by the Research Review Board. The research review board shall maintain a written record of all research proposals and publication submissions and report at least annually to the MSHN Operations Council.

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

CFR: Code of Federal Regulations
CMHSP: Community Mental Health Service Program
HIPAA: Health Insurance Portability & Accountability Act.
Human subject (as defined by 45 CFR, Part 46.102) means a living individual about whom an investigator (whether professional or student) conducting research obtains

(1) Data through intervention or interaction with the individual, or
(2) Identifiable private information.

IRB**:** Institutional Review Board reviews, approves, and monitors research that directly or indirectly involves living persons, their issues or personal information, in order to protect the rights of the participants.
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health & Human Service
Provider Network: Refers to a Community Mental Health Services Program (CMHSP) Participant and a Substance Abuse Provider that is directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's and CA's subcontractors.
Research Review Board: A body of appointed MSHN or MSHN contractor staff with the knowledge and experience required to function as an IRB.
Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

Other Related Materials

N/A

References/Legal Authority

45 CFR 46: Human Subjects Research
Medicaid Contract
MDHHS Quality Assessment and Performance Improvement Program for Specialty Prepaid Inpatient Health Plans Technical Requirement

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer
08.2015	Update to MDHHS and to include accommodation to research prior to	Deputy Director, Chief Executive Officer
08.2016	Annual Review	Director of Compliance, Customer Service and Quality Improvement
03.2017	Annual Review	Director of Compliance, Customer Service and Quality
03.2018	Annual Review	Director of Compliance, Customer Service and Quality
03.2019	Annual Review	Quality Manager
10.2020	Biannual Review	Quality Manager
10.2022	Biannual Review	Quality Manager
12.2024	Biennial Review – this will be recommended to move to the Service Delivery Chapter	Chief Compliance and Quality Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	**Sentinel Events**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle: Biennial** **Author:** Quality Improvement Council, Quality Manager	**Adopted Date: 07.07.2020** **Review Date: 03.07.02023**	**Related Policies:** Critical Incident Policy Incident Review for Substance Use Providers Policy

Purpose: To ensure that the Mid-State Health Network (MSHN) pre-paid inpatient health plan is in compliance with the Michigan Department of Health and Human Services (MDHHS), Medicaid Managed Specialty Supports and Services Contract, Quality Assessment and Performance Improvement Plan related to Sentinel Event Reporting.

Policy: MSHN delegates responsibility to its Provider Network, with oversight and monitoring by MSHN, for collecting, analyzing and reporting to MSHN all incidents that meet the criteria as specified in the MDHHS Contract for sentinel events.

- The Provider Network must review critical incidents to determine if it is a sentinel event within three (3) business days of the occurrence/notification of the incident.
- The Provider Network must commence a root cause analysis within two (2) subsequent business days of the identification of a sentinel event.
- Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care.
- Based on the outcome of the root cause analysis or investigation, the provider must ensure that a plan of action is developed and implemented to prevent further occurrence of the event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan.
- The Provider Network must report all sentinel events to MSHN through MSHN's Regional Electronic Medical Record Information (REMI) system within the required timeframes as specified by incident.
- A root cause analysis shall be completed for each sentinel event and be available upon request.
- The Provider Network will have a standard for the timeframe of the completion of the root cause analysis.
- MSHN will submit all sentinel events to MDHHS as required.

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

Definitions:
CMHSP: Community Mental Health Service Programs
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 SUD Treatment and Recovery Providers (ie. 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.

REMI: MSHN's Regional Electronic Medical Information system

Root Cause Analysis: A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

Sentinel Events: Is a Patient Safety Event that reaches a patient and results in any of the following: death, permanent harm, severe temporary harm and intervention required to sustain life. An event can also be considered sentinel even if the outcome was not death, permanent harm, severe temporary harm and intervention required to sustain life. ~~n "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome. (JCAHO, 1998)~~ (The Joint Commission 2022). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. (Medicaid Managed Specialty Supports and Services Program Contract)

Other Related Materials:

N/A

References/Legal Authority:

Medicaid Contract
MDHHS Quality Assessment and Performance Improvement Program for Specialty Prepaid Inpatient Health Plans Technical Requirement
MDHHS Critical Incident and Event Notification Requirements

Change Log:

Date of Change	Description of Change	Responsible Party
03.2020	New Policy-Sentinel Event Reporting Requirements	Quality Manager
10.2020	Biennial Review	Quality Manager
10.2022	Biennial Review	Quality Manager
11.2024	Biennial Review-Updated definition of Sentinel Event	Quality Manager

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Cultural Competency Policy**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Deputy Director	**Adopted Date:** 01.05.2016 **Review Date:** 11.01.2022	**Related Policies:** Enrollee Rights Info Accessibility/Limited English Proficiency Recipient Rights for Substance Use Disorder Personnel Manual Service Philosophy & Treatment

Purpose

This policy is intended to define the expectations for Mid-State Health Network (MSHN) and its Provider Network to provide culturally competent ~~T~~supports and services.

Policy

It is the policy of MSHN and its Provider Network to effectively provide services to ~~recipients~~ individuals of all cultures, ages, races, gender, sexual orientation, socioeconomic status, languages, ethnic backgrounds, spiritual beliefs and religions in a manner that recognizes, values, affirms, ~~and~~ respects, ~~the worth of the individuals and protects~~ and preserves their dignity and honors their culture ~~of each person.~~. In addition, MSHN and its Provider Network value workforce diversity and shall actively engage in culturally competent employment practices.

~~In furtherance of this policy~~ MSHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures timely access ~~and~~ to services and supports, that ~~is~~are person centered.~~meaningful participation for all people in the service area.~~

Such commitment includes ~~non-judgemental~~non-judgmental acceptance and respect for the cultural values, beliefs and practices of the individual ~~of the community~~, as well as the ability to apply an understanding of the relationships of language and culture identity to the delivery of supports and services.

To effectively demonstrate such commitment, MSHN's Provider Network shall have ~~five~~ seven components in place:

(1) A method of community assessment;
(2) ~~Sufficient policy~~Policy ~~and procedure to reflect the PIHP's value and practice expectations~~that supports the elements within MSHN's Cultural Competency Policy;
(3) A procedure that includes the method of service assessment, ~~and monitoring~~evaluation, monitoring, complaint reporting, resolution and continuous improvement;
(4) Ongoing training, resources and ~~to~~supports to ~~assure~~ ensure ~~that~~ staff ~~are aware~~awareness of, and ~~able~~ ability to ~~effectively~~ implement~~,~~ policy and procedure~~; and~~
(5) ~~The provision of~~Availability of supports and services ~~within~~ that reflect and embrace the cultural context of the ~~recipient~~individuals and communities ~~that they serve;~~.~~-~~
(6) A system for outreach to engage target populations/underrepresented communities where disparities exist in service delivery; and
~~(5)~~(7) Evaluation tools that reflect cultural competency, sensitivity, (individual plans of service, discharge plans) and integrate supports unique to the individual's cultural identity.

Cultural ~~C~~competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as

gender, gender identification, sexual orientation, marital status, education, employment and economic factors, etc.

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~~Substance Use Disorder Prevention, Treatment and Recovery Providers

Definitions:
CMHSP: Community Mental Health Service Program
Cultural Competency: is an acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work toward better meeting the needs of minority populations.
Cultural Identity: is a person's sense of belonging to a group or culture and is part of their self-concept. It's made up of a person's cultural beliefs and practices, and can be influenced by a variety of factors, including: nationality, ethnicity, religion, social class, generation, locality, sexuality, and ability.
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
Provider Network: refers to a CMHSP Participant that is directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through CMHSP subcontractors.

Other Related Materials:
~~MSHN Utilization Management Plan~~

References/Legal Authority:
Medicaid Managed Specialty Supports and Services Contract: Concurrent 1915(B)/(c) Waiver Programs, the Health Michigan Program and Substance Use Disorder Community Grant Programs

Change Log:

Date of Change	Description of Change	Responsible Party
03.18.2015	New Policy	Deputy Director
02.28.2018	Annual Review	Deputy Director
02.28.2019	Annual Review	Deputy Director
08.31.2020	Biennial Review	Deputy Director
09.09.2022	Biennial Review	Deputy Director
9.1.2024	Biennial Review	Deputy Director

Chapter:	Information Technology		
Title:	Artificial Intelligence		
Policy: ☒ Procedure: ☐ Page: 1 of 4	Review Cycle: Biennial Author: Chief Information Officer	Adopted Date: 08.01.2024 Review Date:	Related Policies:

Purpose

Artificial intelligence (AI) is rapidly becoming a critical part of business operations. AI-powered tools can help businesses make better decisions, improve efficiency, and deliver better customer experiences. However, the use of AI also raises various governance, ethical, privacy and legal concerns. This policy outlines the principles that the Mid-State Health Network (MSHN) will follow to ensure the effective and responsible use of AI within the organization.

Policy

MSHN is committed to the ethical and responsible use of AI. This policy outlines the principles that staff will follow to ensure that AI is used in a way that is transparent, accountable, fair, and adheres to MSHN's privacy as well as that of its stakeholders. Additional or related procedures may be required to govern other aspects of the use of AI within the organization. This policy will be reviewed and updated regularly to ensure it remains consistent with the latest developments in AI technology.

MSHN will implement the following to ensure the ethical and responsible use of AI:

- **Data governance:** MSHN will define the roles and responsibilities of those involved in the development, use, and oversight of AI tools used to collect, store, and process data. MSHN is setting forth the ethical principles described below that will guide the use of AI in the business, and include procedures for data collection, storage, and processing.
- **Due diligence on AI tools:** Before deploying an AI tool, MSHN will conduct due diligence to ensure that the tool is safe, effective, and aligned with its ethical principles. This due diligence should include reviewing the tool's data collection and usage practices, its potential for bias, and its compliance with applicable laws and regulations.
- **Technical Controls:** MSHN will implement effective technical controls to protect the security and privacy of the data used by AI tools. These controls will include:
    - Data encryption, for data both at rest and in transit.
    - Access controls including strong passwords and Multi Factor Authentication (MFA).
    - Intrusion detection systems.
    - Audit logging with log retention.
- **Risk assessment:** AI tools may introduce new types of risks not previously considered. To identify and mitigate potential risks MSHN will conduct a risk assessment at least yearly for all AI-powered tools in use. Results of the assessment will be documented and retained for review by the Chief Information Officer, Deputy Director and Chief Executive Officer.
- **Training:** MSHN will provide training to employees on the ethical and responsible use of AI. Training will include its potential benefits and risks. This education should be designed to help employees understand how AI works and how it can be used in the workplace so that they make the right decisions in their daily use of the tools. Training topics should include:

    - What is AI?
    - How does AI work?
    - The benefits of AI.
    - The risks of AI.
    - Ethical considerations when using AI-tools in the workplace.

- **Monitoring:** MSHN will monitor the use of AI tools to ensure that they are being used in accordance with its governance framework and ethical principles. This human oversight should include:
    - Reviewing the outputs of AI tools for bias, discrimination, and accuracy.
    - Tracking user activity.
    - Conducting regular audits of AI-generated outputs.
- **Plan for AI failure:** MSHN will have a plan in place for what to do in the event of an AI failure. This plan will include steps to mitigate the failure's impact and steps to investigate the cause of the failure and prevent it from happening again. Any failure analysis activity will be documented and shared with executive leadership promptly.
- **Credit:** When AI is used it should be credited or cited appropriately.

Principles:

To help mitigate the risks, the use of AI at MSHN will be guided by the following principles:

- **Accountability:** MSHN will be accountable for the use of AI. This means staff will be able to explain and justify their decisions.
- **Privacy:** AI-powered tools will be used in a way that respects the privacy of individuals. This means MSHN Information Technology (IT) systems will only collect and use personal data in accordance with applicable laws and regulations.
- **Transparency:** All AI-powered tools will be transparent to users. This means that staff will be able to understand how the tools work and how they are making decisions.
- **Fairness:** AI-powered tools will be used in a fair and non-discriminatory manner. MSHN is committed to providing a workplace that is free from all forms of discrimination based on ethnicity, race, sex, religion, age, pregnancy, marital status, disability, and any other characteristic protected by federal, state, or local law. MSHN staff will strive to ensure that AI tools will not be used to discriminate against individuals or groups based on any protected characteristics.
- **Legal:** The use of AI-powered tools will be strictly compliant with all applicable laws, including those of the State of Michigan and the United States federal government.

Risks:

AI can be utilized to summarize content, identify patterns and can assist with writing.

It is important to carefully consider the risks of using AI tools before deploying them. By taking steps to mitigate these risks, MSHN can use AI tools toward business advantage while minimizing the potential for harm. Before any AI tool or project is deployed a risk assessment must be completed by the Chief Information Officer, or designee, and any risks must be documented and mitigated prior to approval of use.

- **Data privacy and security risks:** AI tools often collect and process substantial amounts of data, which can be vulnerable to hacking and data breaches. This could lead to the unauthorized disclosure of sensitive information, such as customer data or trade secrets.
- **Bias and discrimination:** AI tools can be biased if they are trained on data that is biased. This could lead to AI tools making unfair or discriminatory decisions, such as denying access to people of color or recommending lower salaries for women.

- **Job displacement:** AI tools can automate tasks that are currently done by humans. This could lead to job losses, especially in low-skilled and repetitive jobs.
- **Ethical dilemmas:** AI tools can be used to make decisions that have ethical implications, such as deciding who gets admitted for services or who is hired for a job. It is important to carefully consider the ethical implications of using AI tools before making decisions.
- **Lack of transparency and accountability:** AI tools can be complex and difficult to understand, making it hard to understand how AI tools make decisions, which can lead to concerns about accountability and fairness.
- **Cybersecurity risks:** AI tools can be vulnerable to cyberattacks. This could lead to the unauthorized access or manipulation of AI tools, which could have a significant impact on MSHN.
- **Loss of control:** AI tools can make decisions that are outside of human control. This could lead to unintended consequences, such as a large monetary loss or a public relations disaster.

Restrictions on use of AI:

- **Do not upload confidential or personal data to AI tools:** This includes financial data of any kind, private meeting minutes, as well as personal information such as name, address, phone number, and social security number. AI tools can be hacked, and if this type of confidential data is compromised, it could be used for identity theft or other crimes.
- **Do not use AI tools to generate harmful content:** This includes content that is violent, hateful, or discriminatory. AI tools can be used to create this type of content, and it can have a negative impact on individuals and MSHN.
- **Do not use AI tools to automate tasks that are best done by humans:** Care should be taken to ensure that AI tools are used to augment human capabilities, not replace them. AI can help streamline and standardize processes and administrative tasks.
- **Do not use AI tools to make decisions that could have a negative impact on people:** This includes decisions about hiring, firing, treatment and admissions. AI tools should be used to support human decision-making, not make decisions on their own.
- **Be aware of the limitations of AI tools:** AI tools are not perfect, and they can make mistakes. It is important to be aware of the limitations of AI tools and to use them with caution.

In addition to these specific restrictions, it is also important to be mindful of the general ethical considerations that apply to the use of AI tools. These considerations include fairness, transparency, accountability, and responsibility.

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

Artificial intelligence (AI): AI is a broad term that encompasses a wide range of technologies that allow machines to perform tasks that are typically associated with human intelligence. Some examples of AI include machine learning, natural language processing, Chatbots and Generative AI.
IT: Information Technology
Machine learning: Machine learning is a type of AI that allows software applications to become more accurate in predicting outcomes without being explicitly programmed to do so. Machine learning

algorithms learn from data, and they can be used to solve a wide variety of problems, such as fraud detection, spam filtering, and product recommendations.
MFA: Multi Factor Authentication
MSHN: Mid-State Health Network
Natural language processing (NLP): NLP is a field of computer science that deals with the interaction between computers and human (natural) languages. NLP algorithms can be used to perform various tasks, such as text analysis, machine translation, and question answering, such as chat bot on a website.
Generative artificial intelligence (GAI): GAI is a type of AI that can create content, such as text, images, or music. It does this by learning from existing data and then using that data to generate new outputs that are like the original data.
Chatbots: Chatbots are computer programs that can simulate conversation with human users. They are often used in customer service applications to answer questions, provide support, and resolve issues. Chatbots can be a cost-effective way for business organizations to provide 24/7 customer service without having to hire additional staff.

Other Related Materials

N/A

References/Legal Authority

N/A

Change Log:

Date of Change	Description of Change	Responsible Party
08.01.2024	New Policy	Chief Information Officer

MSHN
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POLICIES AND PROCEDURE MANUAL

Chapter:	Information Technology		
Title:	Document Sharing Policy		
Policy: ☒ Procedure: ☐ Page: 1 of 3	Review Cycle: Biennial Author: Chief Information Officer	Adopted Date: 10.01.2024 Review Date:	Related Policies:

Purpose

This policy establishes the rules for sharing documents when the organization uses Box and/or Microsoft SharePoint as its document management systems. This policy aims to ensure that sensitive information is protected and that the approved methods and conditions for document sharing are followed.

Policy

This policy covers all types of Mid-State Health Network (MSHN) created or possessed documents, including but not limited to reports, proposals, presentations, protected health information, spreadsheets, and images.

The following are the policy statements for document sharing outside the organization:

- All documents must be classified according to their sensitivity and confidentiality level, such as public, internal, confidential, or restricted. Documents other than Public, stored in BOX must be marked with the appropriate classification.
- All documents must be shared with the awareness of the risks and responsibilities involved. The Document Owner must inform the Document Recipient of the expectations and obligations of the document sharing for all non-public classifications, such as not forwarding, copying, modifying, or disclosing the document without permission.
- Documents, other than public, may be shared only when there is a legitimate business need.
- Documents, other than public, may only be shared externally (outside of MSHN) through the approved methods and platforms, namely secure email attachments, Secure File Transfer Protocol (SFTP) servers and Box. Other methods and platforms, such as removable media or personal cloud storage such as DropBox are prohibited.
- Documents, other than public, may only be shared with the appropriate level of access and permissions, such as view-only, download, edit, or co-author. The Document Owner must select the minimum level of access and permissions required for the document sharing purpose.
- Documents, other than public, may be shared with external parties with the option to revoke access at any time. The Document Owner must set an expiration date for the document sharing link and monitor the document access activity. See the Information Protection Procedure for instructions on how to do this.
- Documents, other than public, may be shared with external parties but must have the appropriate disclaimer and confidentiality notice as follows: DISCLAIMER: This communication, and any attachments, is intended only for the use of the addressee and may contain legally privileged and confidential information. If you are not the intended recipient, please do not read it, reply to the sender that you received the message in error, and erase or destroy the message and its attachments without reading, printing, or saving. The Document Owner must include a statement that the document is the property of Mid-State Health Network (MSHN) and that it is intended for the authorized recipient only.

Responsibilities

- The leadership team is responsible for developing, implementing, and enforcing this policy and related procedures.
- The Document Owners are responsible for identifying and setting the document's classification level
- The document sharer is responsible for identifying the documents that need to be shared, obtaining the necessary approvals, and sharing the documents through the approved methods and platforms, setting the expiration date of the sharing link and including the disclaimers
- The Document Recipients are responsible for complying with the terms and conditions of the document sharing, respecting the confidentiality and integrity of the documents, and notifying the Document Owners of any issues or concerns.
- The Information Technology Service Provider is responsible for providing technical support and guidance for using Box and other tools as the document sharing platforms.
- All Users are responsible for adhering to this policy and related procedures, reporting any incidents or violations, and completing any required training and awareness sessions.

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

Confidential: Data that belongs to or is provided by our clients, and whose sensitivity and confidentiality are determined by the client's own policies and agreements. Client Confidential Data must be protected according to the client's requirements and expectations and according to applicable laws such as Health Insurance Portability and Accountability Act (HIPAA).

Document Owner: is the MSHN staff member that is most responsible for the folder or document. In most cases this will be the person that created the document or folder. If the document comes from a source outside of MSHN staff, then the person that either received the file or decided to put it into BOX would be considered the owner.

HIPAA: Health Insurance Portability and Accountability Act

Internal: Data that is moderately sensitive and confidential, and whose unauthorized disclosure, modification, or loss could cause moderate damage to the organization, its clients, or its partners. Internal Data must be protected with a reasonable level of security and access control.

MSHN: Mid-State Health Network

Public: Data that is not sensitive or confidential, and whose disclosure, modification, or loss would not cause any damage to the organization, its clients, or its partners. Public Data can be freely shared and accessed by anyone without any restrictions.

Restricted: Data that is highly sensitive and confidential, and whose unauthorized disclosure, modification, or loss could cause severe damage to the organization, its clients, or its partners. Restricted Data must be protected with the highest level of security and access control.

SFTP: Secure File Transfer Protocol

Other Related Materials
N/A

References/Legal Authority
N/A

Change Log:

Date of Change	Description of Change	Responsible Party
10.01.2024	New Policy	Chief Information Officer