MSHN
Mid-State Health Network

Board of Directors Meeting
January 10, 2017 - 5:00 p.m.
Lawson Center at Gratiot County CMHA
Board Meeting Agenda

1. Call to Order
2. Roll Call
3. ACTION ITEM: Approval of the Agenda for January 10, 2017

MSHN 16-17-013: APPROVAL OF AGENDA FOR JANUARY 10, 2017

(*Request for additional agenda items, or for any items contained in the Consent Agenda to be removed from the Consent Agenda and placed on the regular agenda for discussion.*)

4. ACTION ITEM: Consent Agenda (Items 4.1 to 4.9.6, Pages 3-62)

MSHN 16-17-014: APPROVAL OF CONSENT AGENDA

(Consent Agenda items are being presented for review and action by a single vote without discussion. If a member believes that an item requires discussion, then a request is made to pull that one item from the Consent Agenda, and add it to the regular agenda as an item to be discussed.)

- Approval of MSHN Board Meeting Minutes, 11.01.16 (Item 4.1)
- Receive SUD-Oversight Policy Board Minutes, 10.19.16 (Item 4.2)
- Receive Board Executive Committee Minutes 11.18.16 (Item 4.3)
- Receive Board Executive Committee Minutes 12.16.16 (Item 4.4)
- Receive Board Policy Committee Minutes 12.07.16 (Item 4.5)
- Receive Operations Council Key Decisions 11.14.16 (Item 4.6)
- Receive Operations Council Key Decisions 12.19.16 (Item 4.7)
- MSHN Risk Management Strategy (Item 4.8)
- Policy Approval (Items 4.9.1-4.9.6)
  - Finance: Transfer of CMHSP Care Responsibility (COFR) 1.0 (4.9.1)
  - Provider Network Mgmt: Credentialing/Re-credentialing 3.0 (4.9.2)
  - Provider Network Mgmt: Provider Network Management 2.0 (4.9.3)
  - Provider Network Mgmt: Service Provider Reciprocity 2.0 (4.9.4)
  - Utilization Mgmt: Access System 5.0 (4.9.5)
  - Utilization Mgmt: Utilization Management 5.0 (4.9.6)

5. Public Comment (3 minutes per speaker)
6. MSHN Board Chair Update

MSHN

Meeting Purpose/Goals

- Provide Strategic Direction
- Establish MSHN Policy
- Assure Compliance
- Monitor MSHN Performance

Meeting Location

Gratiot County CMHA
The Lawson Center
608 Wright Avenue
Alma, MI

Teleconference Information:

Call in: 1.888.585.9008
Conference Room: 182 260 353

Please call/email Merre Ashley to confirm your attendance
517.253.7525
merre.ashley@midstatehealthnetwork.org

Future FY17 Board Meetings

- **March 7, 2017**
  Gratiot County CMH Services
  608 Wright Ave., Alma
- **May 2, 2017**
  CMH for Central Michigan
  301 S. Crapo, Mt. Pleasant
- **July 11, 2017**
  Saginaw County CMHA
  500 Hancock, Saginaw
- **September 12, 2017**
  Newaygo County Mental Health
  1049 Newell, White Cloud

7. ACTION ITEM: Autism Cost Settlement Plan Implementation (Items 7.1-7.2, Pages 63-67)

MSHN 16-17-015: RATIFY BOARD EXECUTIVE COMMITTEE APPROVAL OF AUTISM COST SETTLEMENT PLAN IMPLEMENTATION

8. Finance Report (Items 8.1-8.4, Pages 68-78)

   ACTION ITEM: Compliance Examination Report (Items 8.1-8.2)

MSHN 16-17-016: APPROVAL OF COMPLIANCE EXAMINATION REPORT

   ACTION ITEM: Preliminary Financials (Items 8.3-8.4)

MSHN 16-17-017: APPROVAL RECEIVE PRELIMINARY FINANCIALS, FOR THE PERIOD ENDING NOVEMBER 30, 2016

9. Section 298 Presentation/Discussion

10. Board Education: Integrated Care/Population Health Management
    (Hardcopy of presentation to be provided onsite within Board Folders)

11. ACTION ITEM: Managed Care Information System (MCIS) Presentation/Recommendation
    (Hardcopy of presentation and recommended Motion to be provided onsite within Board Folders)

MSHN 16-17-018: APPROVAL MANAGED CARE INFORMATION SYSTEM (MCIS)

12. ACTION ITEM: FY16 Compliance Summary Report (Items 12.1-12.2, Pages 79-88)

MSHN 16-17-019: APPROVAL FY16 COMPLIANCE SUMMARY REPORT

13. MSHN Deputy Director Report (Item 13.1, Pages 89-90)
    - Balanced Scorecard Update

14. ACTION ITEM: FY17 Contract Listing – Amended and New Contracts (Items 14.1-14.2, Pages 91-92)

MSHN 16-17-020: APPROVAL OF FY17 CONTRACT LISTING

15. MSHN Chief Executive Officer (CEO) Report

16. Other Business

17. Public Comment (3 minutes per speaker)

18. Adjourn

Mid-State Health Network
Staff Directory

Last Name	First Name	Position
Ashley	Merre	Executive Assistant
Calabris	Hope	Claims Processor
Davis	Melissa	Treatment Specialist
Diver	Jeanne	Customer Svc & Rights Specialist
Emmenecker	Rebecca	Treatment Specialist
English	Heather	Prevention Specialist
Goodrich	Forest	Chief Information Officer
Gulvas	Kari	Prevention Specialist
Hammack	Katy	Waiver Coordinator
Hodge	Leathia	Office Assistant/Receptionist
Horgan	Amanda	Deputy Director
Jaskulka	Kyle	Contract Manager
Jones	Nicole	Utilization Management Specialist
July	Tammy	Claims Processor
Keinath	Amy	Finance Manager
Lewicki	Todd	Utilization Management & Waiver Director
Locke	Megyn	Treatment Specialist
Marar	Shyam	Project Manager
Meier	Dani	Chief Clinical Officer
Myers	Shannon	Medicaid Event Internal Auditor
Myers-Mattice	Cammie	Utilization Management Specialist
Pletcher	Skye	Utilization Management Specialist
Proper	Linda	Business Analyst/Tech Support
Vacant		Accountant/Financial Analyst
Sedlock	Joe	Chief Executive Officer
Thomas	Leslie	Chief Financial Officer
Wager	Joe	Data and Report Manager
Watters	Carolyn	Credentialing Specialist
Worden	Jill	Treatment & Prevention (Lead)
Zimmerman	Kim	Quality, Compliance & Cust Svc Director
Vacant		Treatment Specialist

Mid-State Health Network (MSHN) Regional Board of Directors Meeting
Tuesday, November 1, 2016, 5:00 P.M.
Gratiot County CMH Services – The Lawson Center

Meeting Minutes

1. Call to Order

Chairperson Ed Woods called the MSHN Regional Board of Directors Meeting to order at 5:00 p.m.

Chairperson Woods introduced Mr. Bruce Cadwalleder, Shiawassee County Community Mental Health's new appointee. Chairperson Woods and the Board welcomed Mr. Cadwalleder, and thanked him for his service to Mid-State Health Network, and the people they serve.

Mr. Joseph Sedlock requested Board Members keep Brad Bohner and Beverly Wiltse in their thoughts as they battle ongoing illness.

2. Roll Call

Secretary Jim Anderson provided the Roll Call for Board Members in attendance.

Board Member(s) Present: Jim Anderson (Bay-Arenac), Mary Anderson (Newaygo), Joe Brehler (CEI), Bruce Cadwallender (Shiawassee), David Griesing (Tuscola), Phil Grimaldi (Saginaw), Dan Grimshaw (Tuscola) (via phone), Mike Hamm (Newaygo), Tina Hicks (Gratiot), John Johansen (Montcalm), Pam Kahler (Huron), Colleen Maillette (Bay Arenac), Deb McPeek-McFadden (Ionia), Gretchen Nyland (Ionia), Irene O'Boyle (Gratiot), Kurt Peasley (Montcalm) (via phone), Joe Phillips (CMH for Central Michigan), Kay Pray (CEI), Kerin Scanlon (CMH for Central Michigan), Robyn Spencer (Shiawassee), Leola Wilson (Saginaw), and Ed Woods (LifeWays)

Board Member(s) Absent: Brad Bohner (LifeWays), Beverly Wiltse (Huron)

Staff Members Present: Joe Sedlock (CEO), Amanda Horgan (Deputy Director), Merre Ashley (Executive Assistant), Forest Goodrich (Chief Information Officer), Leslie Thomas (Chief Finance Officer), Carolyn Watters (Director of Provider Network Management), and Kim Zimmerman (Director of Compliance, Customer Services and Quality Improvement)

3. Approval of Agenda for November 1, 2016

Board approval was requested for the Agenda of the November 1, 2016 Regular Business Meeting.

MSHN 16-17-001 MOTION BY MARY ANDERSON, SUPPORTED BY DEB MCPEEK-MCFADDEN, FOR APPROVAL OF THE AGENDA OF THE NOVEMBER 1, 2016 REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 21-0.

4. Approval of Consent Agenda

Board approval was requested for Meeting Minutes of the September 6, 2016 Regular Business Board Meeting, September 6, 2016 Public Hearing, August 17, 2016 SUD Oversight Policy Board Meeting, September 16, 2016 and October 21, 2016 Board Executive Committee Meetings, October 7, 2016 Board Policy Committee, September 19, 2016 and October 17, 2016 Operations Council Key Decisions, and Policies, as presented.

MSHN 16-17-002 MOTION BY MARY ANDERSON, SUPPORTED BY JOHN JOHANSEN, TO APPROVE THE MEETING MINUTES OF THE SEPTEMBER 6, 2016 REGULAR BUSINESS BOARD MEETING, SEPTEMBER 6, 2016 PUBLIC HEARING, AUGUST 17, 2016 SUD OVERSIGHT POLICY BOARD MEETING, SEPTEMBER 16, 2016 AND OCTOBER 21, 2016 BOARD EXECUTIVE COMMITTEE MEETINGS, OCTOBER 7, 2016 BOARD POLICY COMMITTEE MEETING, SEPTEMBER 19, 2016 AND OCTOBER 17, 2016 OPERATIONS COUNCIL KEY DECISIONS; AND POLICIES, AS PRESENTED. MOTION CARRIED: 21-0.

Mr. Dan Grimshaw joined the meeting via telephone at 5:33 p.m.

5. Board Meeting Follow-Up (09.06.2016): Overview of Substance Use Disorder (SUD) Services Financing Methods

As a follow-up to questions posed by Board Members at the September 6, 2016 Regular Business Meeting, Mr. Joseph Sedlock provided a presentation focused on Substance Use Disorder (SUD) Services and corresponding financing methods. He reminded Board Members that until October of 2015, Region 5 had three SUD coordinating agencies; MDHHS required MSHN consolidate into one standardized, cost effective administration of the SUD benefit for the region. To optimally achieve this, MSHN administration and clinical staff have worked diligently throughout the past year to analyze the systems of contracted SUD providers; the objective is to increase utilization, value of services, and establish where it is appropriate to standardize financing methods of services. Mr. Sedlock stated MSHN's administrative responsibility is to hold all providers to the standards and policies of the Board of Directors. To improve communication around regional provider contracts, he reported contract listings for board approval have been reformatted to allow incorporation of additional detail pertinent to the contracting process. Following discussion, Chairperson Woods thanked Board Members for their questions, comments and attention.

6. Public Comment

There was no public comment.

7. MSHN Board Chair Update

Chairperson Woods reported the following:

- Board Member Updates
  - Joan Durling, former Board Member from Shiawassee County CMH, has resigned due to health reasons. Mr. Bruce Cadwallender has been appointed to fill her vacated seat.
  - Mary Anderson, Board Member from Newaygo County CMH, has announced her resignation, effective November 30, 2016. He stated Ms. Anderson has been a great mentor and friend, and presented her with a card on behalf of MSHN's Board and staff.
    - Ms. Anderson said MSHN is a premier organization, and it has been a blessing and wonderful experience to serve on its Board of Directors. She thanked Board Members for their continuing service and commitment.
- Board Member Conduct Policy
  - Recommended and provided for Board Member education by the Board Executive Committee
- MACMHB/PIHP FY17 Membership Renewal

MSHN 16-17-003 MOTION BY MARY ANDERSON, SUPPORTED BY COLLEEN MAILLETTE, FOR APPROVAL THE RENEWAL OF MACMHB FY117 MEMBERSHIP IN THE AMOUNT OF TWO-THOUSAND, FIVE-HUNDRED AND FOUR DOLLARS ($2,504). MOTION CARRIED: 22 -0.

8. FY16 Finance Report

Ms. Leslie Thomas reported on preliminary September 2016 financials, and provided an overview to amendments made to the current year (FY16) budget. Mr. Sedlock stated additional detail would be included within the CEO Report. Chairperson Woods thanked Ms. Thomas for her presentation, and called the question.

MSHN 16-17-004 MOTION BY JOHN JOHANSEN, SUPPORTED BY PHIL GRIMALDI, FOR APPROVAL TO RECEIVE AND FILE THE PRELIINARY FINANCILAS FOR THE PERIOD ENDING SEPTEMEBER 30, 2016, AS PRESENTED. MOTION CARRIED: 22-0.

9. Deputy Directors Report

Ms. Amanda Horgan provided updates and information on the following:

- MDHHS Site Review Final Report
- MHP/PIHP Collaboration Update
- Health Information Exchange
- Value-Base Purchasing Pilot Update
- Managed Care Information Systems RFP Update
    - Through the RFP process, MSHN administration has narrowed the field to two (2) vendors
    - Recommendation to the Board will occur at their January 2017 meeting

10. Mid-State Health Network Contract Listings

Ms. Horgan requested Board Members refer to the revised contract listing, provided onsite within Board folders. She stated changes to the original listing were highlighted, and addressed the revised format; implemented to display more information and transparency of contracts recommended for Board approval. Ms. Horgan provided an overview of each section of the revised contract listing, and requested Board Members provide feedback of additional areas deemed helpful to further their review.

MSHN 16-17-005 MOTION BY COLLEEN MAILETTE, SUPPORTED BY DAVID GRIESING, TO AUTHORIZE ITS CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS, AS PRESENTED AND LISTED ON THE FY17 CONTRACT LISTING. MOTION CARRIED: 22-0.

MSHN 16-17-006 MOTION BY COLLEEN MAILETTE, SUPPORTED BY MARY ANDERSON, TO AUTHORIZE ITS CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE AMENDED CONTRACTS, AS PRESENTED AND LISTED ON THE FY16 CONTRACT LISTING. MOTION CARRIED: 22-0.

11. FY16 COMPLIANCE PLAN REVIEW AND APPROVAL

Mr. Sedlock introduced Ms. Kim Zimmerman, Director of Compliance, Customer Service and Quality Improvement. Ms. Zimmerman provided a brief presentation of MSHN's Compliance Plan, defining it as a two-part presentation; to address the requirement of annual Board training on the compliance plan, and to provide an overview of the compliance plan, recommended for Board approval. Chairperson Woods thanked Ms. Zimmerman for her presentation, and called the question.

MSHN 16-17-007 MOTION BY TINA HICKS, SUPPORTED BY KAY PRAY, TO APPROVE THE REVISED 2016/2017 CORPORATE COMPLIANCE PLAN, ACKNOWLEDGE RECEIPT OF SAID

PLAN, AND SUPPORT THE COMPLIANCE EFFORTS CONTAINED THEREIN. MOTION CARRIED: 22-0.

12. FY16 Assessment of Network Adequacy

Mr. Sedlock introduced Ms. Carolyn Watters, Director of Provider Network Management. Ms. Watters directed Board Members to the PowerPoint presentation provided hardcopy with Board folders, and provided an overview of the report. She stated the plan has been reviewed by the Provider Network Management Committee (PNMC) and the Operations Council, and recommended for Board approval. Ms. Watters explained next steps include development of an action plan, which will tie directly to MSHN's strategic plan. She advised the Board quarterly reports related to network adequacy will be incorporated into the MSHN strategic plan quarterly updates. Chairperson Woods thanked Ms. Watters for her presentation, and called the question.

MSHN 16-17-008 MOTION BY DEB MCPEEK-MCFADDEN, SUPPORTED BY TINA HICKS, TO RECEIVE AND FILE THE MSHN 2016 ASSESSMENT OF NETWORK ADEQUACY, AND SUPPORT THE IMPLEMENTATION OF THE RECOMMENDATIONS CONTAINED THEREIN. MOTION CARRIED: 22-0.

13. Chief Executive Officer Report

Mr. Sedlock provided information on the following topics:

- Section 298/System Redesign Update
  - Payer Affinity Group
    - Statewide meeting inclusive of PIHPs and Medicaid Health Plans (MHPs) will occur on November 3, 2016
      - Mr. Sedlock and Ms. Horgan will be in attendance
      - Draft from MDHHS scheduled for release near the third week of November, followed by a three (3) week public comment period
        - Board Members will be alerted when the public comment period is occurring, via email with a link to MDHHS' draft document.
        - MDHHS will amend the report based on public comment; completed report scheduled for release to the legislature on January 17, 2017.
  - Focus of all is series of questions, rooted in the "original 298 Stakeholder Workgroup" design elements

- Collaboration with Other PIHPs
  - Chief Medical Officer – MSHN/SWMBH
  - Care Management – MSHN/SWMBH (Integrated Health Care position)
  - Provider Performance Monitoring Reciprocity
  - MCIS – MSHN/LRE
  - Information Technology, QI/PI – MSHN/SWMBH/LRE
  - NCQA Accreditation – MSHN/Region 10 PIHP/LRE
  - Managed Care Rules – All PIHPs
  - Statewide Training Reciprocity – Workgroup of all PIHPs
  - PIHP/MHP Collaboration Workgroup – All PIHPs and MHPs
- CMHSP Cash Flow and Related
  - CMHSP FY15 Cost Settlement Status
  - Autism Payment Lag
- Michigan Consortium for Healthcare Excellence (formerly MASACA)
  - Approval of the Articles of Incorporation by the members (PIHPs) is formal requirement
  - Documentation received following release of the November 1 Board Meeting packet
    - Board Executive Committee to approve on behalf of the MSHN Board of Directors

14. 2016 Chief Executive Officer Performance Assessment

Mr. Sedlock requested discussion of this item within closed session.

Chairperson Woods called for a roll-call vote, to recess the Regular Business Meeting and enter Closed Session for discussion of the 2016 Chief Executive Officer Performance Assessment.

MSHN 16-17-010 ROLL CALL VOTE TO ENTER CLOSED SESSION. VOTING FOR: JIM ANDERSON, MARY ANDERSON, JOE BREHLER, BRUCE CADWELLENDER, DAVID GRIESING, PHIL GRIMALDI, DAN GRIMSHAW, MIKE HAMM, TINA HICKS, JOHN JOHANSEN, PAM KAHLER, COLLEEN MAILLETTE, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KAY PAY, KERIN SCANLON, ROBYN SPENCER, LEOLA WILSON, AND ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 22-0.

The Regular Business Meeting Recessed at 6:44 p.m.

MSHN 16-17-011 MOTION BY JOHN JOHANSEN, SUPPORTED BY DEB MCPEEK-MCFADDEN, TO COME OUT OF CLOSED SESSION, AND RESUME REGULAR BUSINESS MEETING. MOTION CARRIED: 22-0.

The Regular Business Meeting Resumed at 7:06 p.m.

MSHN 16-17-009 MOTION BY DEB MCPEEK-MCFADDEN, SUPPORTED BY DAVID GRIESING, FOR APPROVAL TO RECEIVE AND FILE THE 2016-2016 CHIEF EXECUTIVE OFFICER (CEO) EVALUATION SUMMARY, AND SUPPORT FEEDBACK AND RECOMMENDATIONS CONTAINED THEREIN. MOTION CARRIED: 22-0.

15. Other Business

There was no other business.

16. Public Comment

There was no public comment.

17. Adjourn

MSHN 16-17-012 MOTION BY JOHN JOHANSEN, SUPPORTED BY DAVID GRIESING, TO ADJOURN THE NOVEMBER 1, 2016 REGULAR BUSINESS MEETING. MOTION CARRIED: 22-0.

The MSHN Regional Board of Directors Regular Business Meeting adjourned at 7:07 p.m.

Meeting minutes submitted respectfully by:

Merre Ashley, MSHN Executive Assistant

Mid-State Health Network (MSHN) SUD Regional Oversight Policy Board
Wednesday, October 16, 2016, 4:00 p.m.
Michigan Association of CMH Boards (MACMHB)

Meeting Minutes

1. Call to Order

Chairperson Carl Rice, Jr. called the MSHN SUD Regional Oversight Policy Board Meeting to order at 4:00 p.m.

Board Member(s) Present:	Bruce Caswell (Hillsdale), Larry Emig (Osceola), John Hunter (Tuscola), Jerry Jaloszynski (Isabella), Steve Johnson (Newaygo), Carol Koenig (Ingham), Tom Lindeman (Montcalm), John McKellar (Saginaw), Carl Rice (Jackson), Vicky Schultz (Shiawassee), Sabrina Sylvain (Gratiot) (via phone), Debbie Thalison (Ionia) (via phone), Kim Thalison (Eaton), and Kam Washburn (Clinton)
Alternate Board Members Present:	John Kroneck (Montcalm), Howard Spence (Eaton)
Board Member(s) Absent:	Clark Elftman (Huron), Richard (Dick) Gromaski (Bay), Susan Guernsey, Jim Leigeb (Midland), Leonard Strouse (Clare), Virginia Zygiel (Arenac)
Staff Members Present:	Amanda Horgan (Deputy Director), Dr. Dani Meier (Chief Clinical Officer), Joseph Sedlock (Chief Executive Officer), Carolyn Watters (Director of Provider Network Management), Ashley Kniceley (Treatment Specialist), Merre Ashley (Executive Assistant)

2. Welcome New Board Member

Chairperson Rice and Ms. Amanda Horgan welcomed Commissioner Carol Keonig to MSHN's SUD Oversight Policy Advisory Board, stating Ms. Keonig has been appointed by the Ingham County Board of Commissioners to fill the seat vacated by Patricia Wheeler. Chairperson Rice expressed his appreciation to the Ingham County Board of Commissioners.

3. Roll Call

Ms. Merre Ashley provided the Roll Call for Board Attendance.

4. Approval of Agenda for October 19, 2016 Regular Business Meeting

Board approval was requested for the Agenda of the October 19, 2016 Regular Business Meeting, as presented.

ROPB 16-17-001 MOTION BY LARRY EMIG, SUPPORTED BY JOHN HUNTER, FOR APPROVAL OF THE AGENDA OF THE OCTOBER 19, 2016 REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 14-0.

5. Approval of Minutes from August 17, 2016 Regular Business Meeting

Board approval was requested for the meeting minutes of the August 17, 2016 Regular Business Meeting, as presented.

ROPB 16-17-002 MOTION BY KAM WASHBURN, SUPPORTED BY JERRY JALOSCZYNSKI, FOR APPROVAL OF THE MINUTES OF THE AUGUST 17, 2016 REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 14-0.

6. Public Comment

Dr. Meier introduced Ashley Kniceley, recently hired MSHN Treatment Specialist. He added Ms. Kniceley's experience at Washtenaw CMH and extensive work with SUD providers adds well to MSHN's clinical team. Dr. Meier explained her work will center around provider services in the western portion of Region 5.

7. Board Chair Report

Chairperson Rice addressed the Board Meeting Calendar, specifically referencing the December 21 meeting date, and opened the floor for discussion. Following board member input, the decision was made to maintain the established schedule until it is determined if there are items requiring board action prior to the next scheduled meeting in February 2017.

Chairperson Rice announced Gladwin County's appointee, Paul Graveline, resigned effective September 30, 2016, as he relocated out of Gladwin County. Communications with the county have occurred, however a replacement has not yet officially been named by Gladwin County Board of Commissioners.

Chairperson Rice reported that a bill that has been put forth to raise the beer tax, proceeds from which are partially earmarked for SUD treatment and prevention. Ms. Kim Thalison added the beer tax has not been raised since 1964; statistically, 80 percent of beer is consumed by 20 percent of the population, making it a user tax basically. She encouraged board members to continue to work and advocate through community prevention coalitions. Ms. Thalison stated work around the coalition table includes looking at gaps which are occurring within services and ways to blend the available dollars as much as possible to build capacity. She stated it would be helpful if information was provided specifically delineating what PA2 funding could be requested for, with further definition of the combination of block

grant and PA2 funding allocations to assist in building capacity in prevention services. In response, Vice-Chairperson Hunter stated the performance measurement tool for prevention deals essentially with a moving target; outcomes and results are not readily available for reporting which presents a challenge when making requests for additional funding. Dr. Meier agreed, and stated he would work with MSHN's prevention team to bring additional data related to evidence based prevention methods. Following further discussion and board member request, it was determined an educational presentation for board member development would be provided at a future meeting, to include information on the types of prevention activities, respective target populations, and evidence based practices and other aspects of SUD prevention.

8. Deputy Director Report

Ms. Amanda Horgan provided information on the following:

- FY17 SUD Projected Allocations – Block Grant
  - Letter and information included within board meeting packets
- MDHHS SUD Site Review Update
  - Summary Report
    - On-site audits conducted of SUD administration
    - Results included in the summary provided
  - Full compliance was achieved in all but two standards
    - Review went very well
    - Partial compliance received as full round of site reviews have not been completed due to MSHN being in its first year of directly operating and managing the SUD benefit of twenty-one counties
    - Methods and tools received full compliance
    - Expectation is that MSHN will achieve full compliance next year

9. Approval of FY17 SUD PA2 Funding Requests/Contract Listing

Ms. Carolyn Watters provided an overview of contracts included on the listing; recommended for approval, as presented. She provided an overview of the reports and contract listing, included within board meeting packets.

Mr. John McKellar asked a procedural question, stating he represents one of the agencies proposed for funding on the contract listing, and asked whether he should abstain from voting or make known for the record. Chairperson Rice stated a conflict of interest policy is in place to address this issue. Ms. Horgan advised that per established policy, board members should abstain from voting on any matter affecting the agency/organization with which the OPB member is directly affiliated.

Following discussion, Mr. Joseph Sedlock addressed the board, and stated it is important for members to declare conflicts which they believe may exist. He also clarified the FY17 contract listing is approval to recommend to the MSHN Board of Directors for their action and approval, as the PA2 funding components are typically only a portion of a contract. Parliamentarian Jalosczynski supported Mr. Sedlock's recommendation for board member declaration, adding no conflict of interest exists if sitting on a coalition board, as participants are not paid.

Chairperson Rice requested board members review the FY17 Contract Listing, as provided, to determine if a conflict exists, and if so, please state for the record.

Ms. Carol Keonig stated written conflict of interest statements have been completed and provided by all board members previously, and referenced the Conflict of Interest Policy, reading aloud to the board. She concluded if any member who has a personal financial conflict should abstain.

Chairperson Rice reiterated if a board member has a conflict in terms of money being allocated to a specific agency in which they are in a position to influence the money, it should be stated.

Vice-Chairperson Hunter recommended a round-table disclosure of agency involvement for simplicity. If a member discloses information which raises a red flag, the board could implore him/her to provide additional details regarding the member's involvement. All disclosures and resulting recusals should be reflected within the minutes, and the vote be taken.

Mr. John McKellar disclosed his relationship with the Saginaw County Department of Public Health, as the Saginaw County Health Officer.

Ms. Kim Thalison disclosed her relationship with Eaton County RESA, which receives PA2 funding.

Ms. Carol Keonig disclosed she is an Ingham County Commissioner and Chair of CMH for Clinton, Eaton & Ingham Counties (CEI) Board of Directors.

Ms. Vicky Schultz disclosed she is the Chief Executive Officer of Catholic Charities of Shiawassee and Genesee Counties, and is paid through the agency.

Mr. Jerry Jalosczynski disclosed he is a member of his county's local coalition, but receives no reimbursement for participation.

Mr. Kam Washburn disclosed he is on the CMH for Clinton, Eaton & Ingham (CEI) Board.

Following board member disclosure, Chairperson Rice inquired of Parliamentarian Jalosczynski whether based policy, recusal of board member(s) is required. The parliamentarian and Ms. Vicky Schultz agreed she would abstain from voting on approval of the FY17 contract listing due to conflict of interest.

Chairperson Rice called the question, stating for the record that Ms. Vicky Schultz would abstain from voting due to conflict of interest.

ROPB 16-17-003 MOTION BY LARRY EMIG, SUPPORTED BY JERRY JALOSCZYNSKI, FOR APPROVAL OF THE FY17 SUD FUNDING REQUESTS/CONTRACT LISTING, AS PRESENTED. MOTION CARRIED: 13-0. Abstained: Ms. Vicky Schultz

10. Approval to Receive and File the Financial Report

Ms. Amanda Horgan provided an overview of the PA2 funding report, displaying figures through September 30, 2016, and recommended Board approval, as presented.

ROPB 16-17-004 MOTION BY JOHN MCKELLAR, SUPPORTED BY JERRY JALOCZYNSKI, FOR APPROVAL TO RECEIVE AND FILE THE FINANCIAL REPORT, AS PRESENTED. MOTION CARRIED: 14-0.

11. Operating Update

Dr. Dani Meier provided information on the following:

- Three-year SUD Strategic Plan Update
  - Hardcopy provided onsite, within board folders
  - Approved by the Michigan Department of Health & Human Services (MDHHS)
  - Defines efforts of the region, through the end of year two
  - Members should contact Dr. Meier with any questions following review of the information contained within the plan as presented Review
  - Continuation of Strategic Plan, organized by categories for clarity
  - Provided as information on projects and efforts being done by the clinical team as well as those which have been completed, which is representative of the large scope of work underway throughout the region
- Treatment and Utilization Report
  - Average Cost per Person
  - Average Cost per Service Category Per Person
    - Hardcopy of both sections of the report, provided onsite within board folders, were referenced. Dr. Meier provided brief review of the information contained therein.
  - Questions which arise from review of the report related to board member's respective counties should be directed to Dr. Meier

12. Board Member Development

Ms. Horgan stated Board Member Development is a standard agenda item. She referenced Dr. Meier's presentation provided at the August meeting and requested board member feedback on items they would be interested in receiving education and information on. She stated prevention would be addressed, per the lengthy discussion during this meeting. Ms. Horgan encouraged members to provide feedback on additional topics to Merre Ashley.

13. Other Business

Vice Chairperson Hunter reported on his recent attendance at the Michigan Association of Community Mental Health Board's (MACMHB) Co-Occurring Disorder (COD)/Substance Use Disorder (SUD) conference. He provided information on the keynote speakers and seminars in which he participated, and encouraged members to visit the MACMHB website at www.macmhb.org for notes and presentation materials which contain a great deal of useful information.

Vice Chairperson Hunter stated that out of all the speakers and sessions, the best outcome was recognition of MSHN at the state conference, for their excellence in addressing the needs of its 21-county region, and thanked MSHN for their continuing efforts and hard work.

14. Public Comment

There was no public comment.

15. Board Member Comment

There was no board member comment

16. Adjournment

The MSHN SUD Regional Oversight Policy Board of Directors Meeting adjourned at 5:46 p.m.

Meeting minutes submitted respectfully by:

Merre Ashley
Executive Assistant, MSHN

Mid-State Health Network Board of Directors
Executive Committee Meeting

Friday, November 18, 2016 * 9:00 a.m. (Teleconference)

Present: Ed Woods; Irene O'Boyle; Jim Anderson; Mary Anderson (All Members Present)
Staff: Amanda Horgan; Joe Sedlock

1. Call to order - This meeting of the MSHN Executive Committee was called to order by Chairperson E. Woods at 9:00 a.m.

2. Approval of Agenda - Motion by M. Anderson, supported by J. Anderson to approve the agenda as presented. Motion carried.

3. Board Matters -
   3.1. Board Meeting Follow-Up: None
   3.2. Board Member Attendance Report: Administration provided the board member attendance report for the fiscal year ended 9/30/16 for review. No follow-up recommended.
   3.3. Contract List Revisions – Administration requested feedback on improvements implemented relative to the contract list presented to the Board of Directors. Executive Committee members expressed that the changes improve information available to board members and made no further recommendations.

4. Routine Matters –
   4.1. Chief Medical Officer Update – J. Sedlock reported that MSHN and Southwest Michigan Behavioral Health (SWMBH, a PIHP) made an offer to a candidate, who subsequently withdrew from further consideration. Bay-Arenac Behavioral Health will continue to provide PIHP Medical Director services under the current contract with MSHN until a satisfactory successor arrangement is achieved.

5. Action Requests -
   5.1. Contract Approvals Requested – J. Sedlock presented a schedule of two administrative contracts for approval. Both contracts have been discussed with the Executive Committee and the Board of Directors in the past and are now ready for approval.

   Motion by I. O'Boyle, supported by J. Anderson to approve the contracts as presented. Motion carried.

   5.2 Articles of Incorporation for the Michigan Consortium for Healthcare Excellence (MCHE) –J. Sedlock presented the proposed Articles of Incorporation for the MCHE ("Articles"). The Articles formalize the name change of the organization to MCHN from Michigan Association of Substance Abuse Coordinating Agencies and are updated to reflect bylaws changes recently adopted by the MSHN (and other participating PIHP) board.

   Motion by I. O'Boyle, supported by M. Anderson to approve the Articles of Incorporation of the Michigan Consortium for Healthcare Excellence. Motion carried with a request that administration make the MSHN Board of Directors specifically aware of this action at the January

2017 board meeting.

6. Finance Matters –

6.1. FY16 Regional Autism Cost Settlement Plan – J. Sedlock presented MSHN's plan to cover CMHSP FY16 autism costs. These issues have been discussed for the past eight months in relation to CMHSP cash flow concerns. History and current status was reviewed, including noting that CMHSPs are carrying autism cost for five months before partial reimbursement is made by the State of Michigan. Total carried costs for the MSHN region is just over $10M. The process for developing the plan was summarized and it was noted that the MSHN Operations Council endorsed and recommended approval by MSHN governance at its meeting on November 14, 2016.

Motion by I. O'Boyle, supported by J. Anderson to approve the FY16 Regional Autism Cost Settlement Plan. Motion carried.

6.2. Saginaw CMHSP FY15 Cost Settlement Proposal – J. Sedlock reviewed status of cost settlement with Saginaw CMHSP, which owes MSHN in excess of $7.5M. J. Sedlock noted that pushing a part of the cost settlement into FY18, as proposed by Saginaw CMHSP, is problematic for MSHN, and this is still under discussion with Saginaw CMHSP. J. Sedlock also noted that other elements of the proposed repayment plan detailed in the 11/1/16 letter from Saginaw are generally acceptable to MSHN. The MSHN Executive Committee expressed concern about releasing FY 16 Autism Cost Settlement payments to any CMHSP that has an outstanding repayment obligation to MSHN.

Motion by I. O'Boyle, supported by. J. Anderson to direct the MSHN Chief Executive Officer to release FY16 Autism Cost Settlement payments as detailed in the just approved FY16 Autism Cost Settlement Plan net of any outstanding obligations by CMHSPs to MSHN and to direct the MSHN Chief Executive Officer to negotiate terms with Saginaw CMHSP so that its outstanding obligation to MSHN is retired within the FY17 fiscal year. Motion carried.

6.3. FY17 MSHN Regional Risk Management Plan – J. Sedlock presented the FY17 MSHN Regional Risk Management Plan. Revisions to the plan included updates to current financial figures and notifications to the MDHHS of MSHN actions relative to abatement of ISF to implement the MSHN FY 16 Autism Cost Settlement Plan.

Motion by J. Anderson, supported by I. O'Boyle to approve the FY 17 MSHN Regional Risk Management Plan and to direct to the MSHN Chief Executive Officer to submit it to the MDHHS by the established deadline. Motion carried.

7. Other –

7.1. Staffing Review – A. Horgan provided a summary of actions being undertaken to analyze staffing needs relative to the ongoing and new responsibilities of the PIHP. Two positions were budgeted for FY17. Informational.

7.2. Grant Award for Inpatient Denials Pilot Statewide Expansion – A. Horgan announced that MSHN was awarded a grant by the State of Michigan to expand the Inpatient Denials Pilot statewide. Most of the information technology-related work will be contracted to an external vendor. Expect statewide expansion in the Spring of 2017. MSHN and State officials are planning a presentation at the MACMHB Winter Conference on this topic.

7.3. Staff Holiday Gathering – As has been MSHN's practice since inception, MSHN staff meeting and annual training will take place on December 16, 2016 followed by a meal for staff.

7.4. Other - E. Woods provided an update from the National Council on Community Behavioral Healthcare relative to the logistics associated with the incoming federal administration's intention to repeal the Affordable Care Act.

8. **Next Meeting: December 16, 2016, 9:00 a.m.** MSHN Administration will also arrange for a luncheon for the Executive Committee at 11:30 a.m. in the Lansing area for those members that can attend.

9. **Adjourn –** Chairperson E. Woods adjourned the meeting at 9:40 a.m.

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

Friday, December 16, 2016 * 9:00 a.m.

Members Present: Ed Woods, Chairperson; Irene O'Boyle, Vice-Chairperson; James Anderson, Secretary
Staff Present: Amanda Horgan, Deputy Director; Joseph Sedlock, Chief Executive Officer

1. Call to order - Chairperson Woods called the meeting to order at 9:00 a.m.

2. Approval of Agenda - Motion to approve the agenda as presented by I. O'Boyle, Supported by J. Anderson. Motion Carried

3. Board Matters -
   3.1. Draft November 1, 2016 Board Meeting Minutes – Motion by I. O'Boyle, supported by J. Anderson to recommend that the MSHN Board of Directors approve the 11/1/16 board meeting minutes. Motion carried.
   3.2. Draft November 18, 2016 Executive Committee Meeting Minutes - – Motion by J. Anderson, supported by I. O'Boyle to recommend that the MSHN Board of Directors approve the 11/18/16 executive committee meeting minutes. Motion carried.
   3.3. Draft January 10, 2017 Board Meeting Agenda) – Discussion of board meeting agenda took place. Executive Committee made recommendations for ordering of the agenda items and asked that the planned discussion of the 298 report under the CEO's report be made a separate agenda item.

4. Other –
   4.1. Staff Holiday Gathering – Motion by J. Anderson, supported by I. O'Boyle to request that the MSHN Chief Executive Officer convey the appreciation of the MSHN Board of Directors for the consistently excellent work of the MSHN Staff to the MSHN Staff at today's holiday gathering. Motion Carried.
   4.2. 298 Update - Mr. Sedlock highlighted several areas of the 298 Interim Report to the Legislature that was released earlier this week. Executive Committee attention was drawn to Pilots language on page 9, Retention of PIHPs on page 10, Independent Complains Entity on page 19, Governance matters on page 24, Administrative Layers on page 31 and uniformity on page 32-33. Discussion of themes in the report (person centered planning, self-determination, uniformity, consistency and standardization) along with next steps in the process were discussed.
   4.3. Other -
      4.3.1. HCBS Transition Staffing: Mr. Sedlock informed the executive committee of PIHP responsibilities for implementation of the HCBS Transformation project and the fact that these MDHHS-required responsibilities will require an additional 1.0 FTE. Resources to support the position are available within the existing MSHN FY16 budget. The Executive Committee was told to expect a posting in the very near future, and was informed that a hiring decision will not be made until the PIHP is informed of exactly what it's non-delegable responsibilities will be, expected mid-to-late January or early February.
      4.3.2. Employee Resignation: Mr. Sedlock informed the Executive Committee that a recently hired employee is resigning effective 12/22/16 for personal reasons. MSHN will post for

the position today.

4.3.3. Employee Health Benefits: Mr. Sedlock and Ms. Horgan informed the Executive Committee that administration will not be recommending any changes to employee health benefits. Open enrollment will be in January 2017 for health insurance. Comparable plans were received and while there is a modest increase in premium under the existing employee health insurance program, MSHN is still under the cap and will continue to offer the same benefit plan at no out of pocket cost to employees.

4.3.4. Autism Cost Settlement Plan: Executive Committee members asked for an update on the implementation of the Autism Cost Settlement Plan approved last month, and the status of FY15 cost settlement obligations of CMHSPs to MSHN. Mr. Sedlock provided the update, noting that one CMHSPs obligation to MSHN is larger than the Autism Cost Settlement amount, and the involved CMHSP will need to renegotiate the repayment time frame (not the amount) after it closes its fiscal year (expected early January 2017).

5. Next Meeting: January 20, 2017, 9:00 a.m.

6. Adjourn – this meeting was adjourned at 9:40- a.m.

Mid-State Health Network

BOARD POLICY COMMITTEE MEETING

Wednesday, December 7, 2016

Teleconference – 10:30 a.m.

MEETING MINUTES

1. Call to Order

A. The MSHN Board Policy Committee Meeting convened at 10:31 a.m.

B. Policy Committee Members Participating: John Johansen, Colleen Maillette, Irene O'Boyle, Kurt Peasley

C. Policy Committee Members Not Participating: Mike Hamm

D. MSHN Staff Participating: Amanda Horgan (Deputy Director), Merre Ashley (Executive Assistant), Leathia Hodge (Office Assistant)

2. Approval of the Agenda

Ms. Amanda Horgan requested committee support and approval of the December 7, 2016 meeting agenda, as presented.

MOTION by Kurt Peasley, supported by Irene O'Boyle, to approve December 7, 2016 Board Policy Committee Meeting Agenda, as presented. Motion Carried: 4-0.

3. New Policy Review

Ms. Horgan explained the new policy related to County of Financial Responsibility (COFR) is the outcome of Operations Council discussion to obtain/ensure administrative savings throughout the region. The policy allows individuals the opportunity to choose where they reside and allow access to services consistent throughout the region, and is reflective of efforts to save administrative time while ensuring all COFR situations are handled effectively, efficiently and appropriately. Ms. Horgan stated the Operations Council has reviewed the policy in its entirety, and has recommended it for approval by the Board Policy Committee and the full board.

A. Financial Management: County of Financial Responsibility (COFR)

MOTION by Irene O'Boyle, supported by John Johansen, to approve and recommend presentation of the MSHN County of Financial Responsibility 1.0 Policy to the full board, as provided and presented. Motion carried: 4-0.

4. Policies Under Annual Review with No Committee Recommended Edits

Ms. Horgan stated the Provider Network Management and Utilization Management policies for annual review were included in the Policy Committee Meeting packet; per committee feedback, no edits were recommended. She provided background and overview of each Provider Network Management policy, and each Utilization Management policy and inquired whether the committee had suggestions or needed additional information or explanation. Ms. Horgan then referenced Attachment B (Delegation Grid) of the UM: Utilization Management 5.0 policy, and advised of two minor necessary edits, recognized after the policy had been sent to the Committee for first reading. She stated

the following are recommended for revision prior to review by the full board. Both instances involve a change to the **third column of the Delegation Grid**, titled "***If retained: Conducted internally by MSHN or contracted?***" She said an update has been made within the **checkboxes related to PIHP Delegated Activity** for "***Persons who are enrolled on a habilitation supports waiver must be certified as current enrollees and be recertified annually…***" and "***Review and Analysis of the CMHSP's quarterly utilization activity and reporting of services…***" to appropriately indicate the activities are now conducted internally by MSHN, versus contracted. The Committee approved of the updated revisions to the UM: Utilization Management 5.0 policy as identified, and recommended policies for annual review be distributed to the full board for review, as revised and presented.

A. Provider Network Management: Credentialing/Re-Credentialing 3.0
B. Provider Network Management: Provider Network Management 2.0
C. Provider Network Management: Provider Network Reciprocity 2.0
D. Utilization Management: Access 5.0
E. Utilization Management: Utilization Management 5.0

MOTION by John Johansen, supported by Kurt Peasley, to approve and recommend presentation of the MSHN Policies Under Annual Review to the full board, as provided and presented. Motion carried: 4-0.

5. **New Business**

There was no new business.

6. **Adjournment**

MOTION by Irene O'Boyle, supported by Colleen Maillette, to adjourn the December 7, 2016 MSHN Board Policy Committee Meeting. Motion carried: 4-0.

The MSHN Board Policy Committee Meeting adjourned at 10:39 a.m.

Meeting minutes respectfully submitted by:
Merre Ashley, MSHN Executive Assistant

Regional Operations Council/CEO Meeting
Key Decisions and Required Action
Date: November 14, 2016

Members Present: J. Obermesik (phone), S. Lurie, R. Lathers (phone), M. Geoghan, S. Prich, S. Lindsey, S. Beals (phone), T. Quillan, L. Hull, S. Vernon and M. Leonard (phone)

Members Absent: C. Pinter

MSHN Staff Present: J. Sedlock, A. Horgan, T. Lewicki, D. Meier, L. Thomas

Agenda Item	Key Decisions	Action Required			
Agenda	Added: CON Grant Award CMO Update CMHCM discussion with Affirmas	Approved			
Consent Agenda	Approved as presented: PIHP CEO meeting				
	N/A	By Who	N/A	By When	N/A
Utilization Management Plan - Approval	Todd L. reviewed the UM Plan changes				
	Clean up CMHSP's – not including apostrophes Ops Council approved with noted CMHSP's edit	By Who	T. Lewicki	By When	11.30.16
SIS Status Update, Gap Analysis and Next Steps	Todd L. discussed status, completion rate, contract with MORC				
	Ops Council approved to move forward with a contract with MORC while developing a backup plan, discussions with the CMHSPs that provide the SIS Assessor to ensure continued compliance.	By Who	T. Lewicki	By When	11.30.16
SUD 24/7/365 Access	Todd L. reviewed the report – count of individuals by CMHs referred to Carenet. Want to ensure CMHs are providing warm handoff as part of the 24/7/365 access to the SUD provider system				
	Informational only – December agenda item	By Who	N/A	By When	N/A
Narcan/Naloxone System	D. Meier provided summary of Narcan Regional project MSHN will manage this project on directly				
	• Order forms distributed with a deadline of 11/21. MSHN will place orders and distribution will be direct to CMHSPs. • D. Meier will confirm distribution methodology and email information to CMHSPs	By Who	CMHSPs D. Meier	By When	11.16.16 11.17.16

Agenda Item	Key Decisions	Action Required			
CMHSP Access to MSHN Addictionologist Dr. Bruce Springer	D. Meier discussed his follow up with Clinical Leadership Team regarding availability of the Addictionologist to the CMHSPs. Offered a monthly informational and educational session. Individual consultation available to Dr. Springer from CMH. Requests should flow through D. Meier. CLC meets again on the 17th and will discuss topics for future monthly session.				
	CMHSPs to offer to Medical staff MSHN to complete an intro to Dr. Springer that can be sent to CMHs to inform their staff.	By Who	CMHSPs D. Meier	By When	11.30.16 11.18.16
Cash Flow/Autism Payments/Cost Settlement	L. Thomas reviewed the Autism proposal				
	Ops Council approved and supports this proposal. Joe S. will take to ET on Friday for review and approval.	By Who	J. Sedlock	By When	11.18.16
Timing of Financial Reports	Handouts provided after packet. L. Thomas reviewed the reports. Discussed spending according to plan and status. L. Thomas discussed the timing of the Financial Reports as requested by Ops Council every other month. Finance council recommends only quarter for the first two quarters to ensure accurate information. For the last two quarters every other month would be provided. Qrt 1 report in February Qrt 2 report in May April 30th Financials – July June 30th Financials – September August 31st Financials – November Interim Year End Financials – December Final Year End Financials – March				
	Ops Council endorsed the Finance Council recommendations. L. Thomas to finalize financial reporting schedule to Ops.	By Who	L. Thomas	By When	11.30.16
Inter-PIHP Reciprocity (Draft Agreement)	PIHP/MDHHS contract includes reciprocity technical requirement. J. Sedlock reviewed the PIHP – Statewide process				
	Informational Only	By Who	N/A	By When	N/A
298 Update	Affinity group process has provided a lot of feedback. Now the smaller group of 20 need to process the feedback. Matt Lori has now begun to participate. Phil G. runs the majority of the meetings. About four meeting in the next two weeks. By 11.28.16,				

Agenda Item	Key Decisions	Action Required			
	a draft will be out to be followed by 3 weeks of public comment, to be reviewed and final document be provided to Legislation Jan. 1.				
	Informational Only MSHN to develop a Legislative Orientation, Information, Luncheon, Breakfast, etc. reach out to Association	By Who	J. Sedlock & A. Horgan	By When	12.15.16
Transfer of County/CMHSP Care Responsibility Policy	No update from C. Pinter (absent)				
	Tabled to next month agenda J. Sedlock to request final draft from C. Pinter	By Who	N/A J. Sedlock	By When	N/A 11/21/2016
Inpatient Contracting	J. Sedlock provided review of last year's discussion, along with Ops decision that approved a regional template. Members recall, but would like to have this revisited. Recommend an improvement process on our communication to the CMHs once an Ops decision has been determined.				
	J. Sedlock will convene a subgroup with reps from ES supervisors/staff, CLCL, Provider Network, Finance, Ops, to review template and improve language in preparation for FY18, add reciprocity on contract review, clinical practice and uniformity, HIE.	By Who	J. Sedlock	By When	12.15.16
Licensing – MALA	L. Hull reviewed the email communication sent out regarding licensing of apartments that are rented by consumers. CEI had similar situation with ROI and had to close the homes. Hearing that LARA are implementing strict licensing regulations indicating these situations are adult foster care arrangements. Waiting to hear on court case from MALA. PIHPs and BHDDA aware.				
	Discussion only	By Who	N/A	By When	N/A
Integrated Care Update/PIHP Collaboration	Discussed inability to fill staff position, now working with SWMBH who has capacity with their RN/UM/Care Coordination staff. Contract language finalizing now along with BBA/QSO/DUAs, etc. Spend the next two months orienting SWMBH staff on MSHN process, systems, MHPs, etc. Intent by Feb. 1 to transition daily operations to SWMBH, with oversight and administration by PIHP.				
	Informational Only	By Who	N/A	By When	N/A
Data Use Agreements	MDHHS requiring CMHSPs to have DUAs for cc360 and the data extract. Merre will be sending out today/tomorrow and ask for a quick turnaround.				

Agenda Item	Key Decisions	Action Required			
	CMHSPS to sign and submit DUAs.	By Who	CMHSPs	By When	11.18.16
Assessment of Operations Council Effectiveness	Reviewed last year's report. J. Sedlock will revise and email out for input.				
	J. Sedlock will send out draft and then final for review and approval	By Who	J. Sedlock	By When	12.1.16
CON Award	A.Horgan reviewed the con pilot grant award to expand state-wide. Survey will be sent out to CMHs asking for feedback on improvements on the current process.				
	Informational Only	By Who	N/A	By When	N/A
CMO Update	The CMO offer was not accepted and MSHN will continue to look at other options.				
	Informational Only	By Who	N/A	By When	N/A
PIHP CEO Meeting	Pg. 10 IMD – Memo to Chris Priest Discussed Performance Metric				
	Joe S. will follow up on Memo Add Performance Metrics Withhold on agenda in December Add PIHP/MHP Dec 8th results of FUH metric	By Who	J. Sedlock	By When	12.15.16
CMHCM Affirmant	John O. reported continued work with Affirmant. Meeting with Mid-Michigan and Sparrow.				
	Informational Only	By Who	N/A	By When	N/A

Regional Operations Council/CEO Meeting
Key Decisions and Required Action
Date: December 19, 2016

Members Present: C. Pinter (phone), J. Obermesik, S. Lurie, M. Geoghan, S. Prich (phone), **S. Lindsey (phone),** T. Quillan, S. Vernon (phone) and M. Leonard.

Members Absent: R. Lathers, S. Beals, L. Hull

MSHN Staff Present: J. Sedlock, A. Horgan

Agenda Item	Key Decisions	Action Required			
Agenda	Added: 4.g DMC Review tools 4.h Confidentiality Statue 4.i Home & Community Based Transition Plan	Approved			
Consent Agenda	Approved as presented				
	N/A	By Who	N/A	By When	N/A
SPECIAL PRESENTATION	John Obermesik and Dr. Angela Pinheiro – Affirmant/Health Systems Collaborations On Quality Slides available for use				
	John would like to get a meeting together with Affirmant; work on uniform clinical pathways (as developed and coordinated for Affirmant) for MSHN and other PIHPs. John will send an email to Sandy, Maribeth, Sara, Mike, Tammy – to respond to John to see if there is interest in participating in a meeting with Affirmant as CMHCMs partner. Joe Sedlock with represent MSHN.	By Who	John Obermesik.	By When	12.31.16
MSHN Regional Inpatient Workgroup Charter	Discussed group be led by MSHN CEO and Saginaw CEO Recommendation to add ORR reviews to the charter Other PIHPs have this process, so information will be sought by the workgroup. Add EHR data elements as needed Recommend adding membership to include CMH level UM staff – for feedback on Continuing stay, transition planning, etc. Change title on B. Krogman				
	Joe S. will send out an email with a deadline indicating your group representation and ask that you respond by 12.30.16	By Who	J. Sedlock & CMH CEOs	By When	12.30.16

Agenda Item	Key Decisions	Action Required			
	Joe to obtain relevant materials from other PIHPs Charter was adopted with the edits noted above		J .Sedlock		2/1/17
Inpatient Management Systems Development (Central Bed Inventory/Need Matching	MSHN will check out programs in other states operating this. All ten PIHPs are also interested in establishing this. Discussed MSHN staffing for central registry and access. MDHHS FY18 budget to include funding for a statewide registry. Joe to work on drafting a concept for this project for the group to review and bring feedback.				
	Joe S. to develop a draft concept for a project.	By Who	J. Sedlock	By When	02.28.2017
Inpatient Denials Pilot Expansion – Reports	Grant received to expand statewide. Check out if we want data on if this is the 2nd, 3rd, etc. time calling the same hospital. Info will come out from the state with directions to report				
	Informational Only	By Who	N/A	By When	N/A
PIHP/MHP Performance Measure – Follow-Up After Hospitalization for Mental Illness	Discussed work flow process developed to collaborate with the MHPs regarding FUH. Discussed proposal be presented on MHPs reporting Medical info to ensure population health measures and follow up that adds value to the PIHP. MSHN will coordinate with Utilization Management and Clinical Leadership Committee to discuss and propose a data collection process.				
	Informational Only	By Who	N/A	By When	N/A
Consent to Share Information Policy	Add to Reference: Mental Health Code as amended				
	Policy approved with amendment to move forward Customer Service Committee to work with region, state and other PIHPs to develop an education piece, amend the notice, etc. for consumers.	By Who	A.Horgan K. Zimmerman	By When	12.31.2016 1.31.2017
Financial, Smoothing and Benefit Stabilization Reports	L. Thomas reviewed the financial reports included in the packet				

Agenda Item	Key Decisions	Action Required			
	Informational Only	By Who	N/A	By When	N/A
298 Update	Discussed Interim Report on 298 Requests for pilots expected to be out in January from state. CEI discussed they will be proposing a pilot to hold the full risk for the three counties as they align with the prosperity region. Discussed MSHN should submit a pilot program(s) • Moving Mild to Moderate into the PIHP BH services • Implementation of Pathways model to enhance overall care for physical and social determinates				
	Next Operations Council meeting set aside considerable time to discuss pilot programs	By Who	J. Sedlock	By When	N/A
Operations Council Reporting Calendar	Reviewed schedule provided in packet as a draft of the reporting schedule for regional reports.				
	Informational Only	By Who		By When	
SIS Update (MORC & CMA)	MSHN has signed contracts with MORC & CMA. T. Lewicki will coordinate with the SIS assessors and workgroup to implement the contracts.				
	Informational Only	By Who	N/A	By When	N/A
FY 2016 Balanced Scorecard	Recommended FY17 – shade performance items associated with contractual performance withholds or incentives	A. Horgan			
	Informational Only	By Who		By When	
DMC Review Tools	Need to check and amend: BHT service – provider qualification chart – 10.13 – review Service auth. – clinical record review 5.1. – 5.7 – check to see for a standard reference.				
	Informational Only	By Who	N/A	By When	N/A
Medicaid Managed Care Rule - Website	Website available for all individuals to receive updates on the work plan, review Q & As, conference presentation materials and a way to send in questions to the group. https://sites.google.com/view/miphipfinalrule				

Agenda Item	Key Decisions	Action Required			
	Informational Only	By Who	N/A	By When	N/A
Home & Community Based Transition Plan	MSHN is preparing a posting to complete the functions of the work beginning in March. • B3 survey's, resurveying, provider compliance				
		By Who	N/A	By When	N/A

Mid-State Health Network

Risk Management Strategy
For the Period of
October 1, 2016 – September 30, 2017

Medicaid and Healthy Michigan Risk

The Mid-State Health Network (MSHN), in its role of PIHP, retains the Medicaid and Healthy Michigan Savings as well as the Medicaid and Healthy Michigan Internal Service Funds (ISF) for the twelve Community Mental Health Service Programs (CMHSPs) and its Substance Use Disorder (SUD) network within our region consisting of the following: Bay-Arenac, Huron, Montcalm, Shiawassee, Tuscola, Central Michigan, CEI, Gratiot, Ionia, Newaygo, Lifeways, and Saginaw. Our region has elected not to carry insurance to cover the risk associated with our Medicaid contract with the Michigan Department of Health and Human Services (MDHHS). Therefore, our intention annually is to cover our annual Medicaid expenditures first with Medicaid Savings, followed by current year Medicaid and Medicaid ISF.

Maximum Risk Exposure:

The Medicaid contract with MDHHS is a risk sharing arrangement that requires MSHN, and its member CMHSPs to be responsible for the first 5% of expenses that exceed Medicaid revenue (B, B3, Healthy Michigan, DHS Incentive, HSW, MiChild, Autism), and an additional 50% of costs overruns between 5 -10%. Beginning January 2016, the PIHP must also cover spending in excess of fee screens for Autism services. Total liability for expenses that exceed revenue shall not exceed 7.5% of Medicaid and Healthy Michigan revenue. Based on projected capitated Medicaid revenue of $501,381,646 for the period of October 1, 2016 through September 30, 2017, the following are maximum possible risk amounts:

First 5% overrun to be funded 100% by MSHN:	$25,069,082
1/2 of second 5% overrun to be funded by MSHN:	$12,534,541
Maximum MSHN Risk Liability for Medicaid Cost Overruns	$37,603,623

Our total Projected Medicaid/HMP savings and Medicaid/HMP reserves, as of September 30, 2016, are $41,432,314. The total savings amount and the total ISF/reserve amount fall within the maximum allowed by the MDHHS contract.

Medicaid Savings	$ 4,052,289
Medicaid ISF	$23,063,441
HMP Savings	$10,126,943
HMP ISF	$ 4,189,641

MSHN is projected to end Fiscal year 2017 with Medicaid/HMP savings and Medicaid HMP ISF of $35,331,380. The total savings amount and the total ISF/reserve amount fall within the maximum allowed by the MDHHS contract.

Medicaid Savings	$16,451,251
Medicaid ISF	$13,063,441
HMP Savings	$ 1,627,047
HMP ISF	$ 4,189,641

MSHN is budgeted to end Fiscal Year 2017 with a Medicaid and HMP ISF of $17,619,713. The $10,000,000 reduction from Fiscal Year 2016's Medicaid ISF balance relates to risk associated with payment delays to cover Autism expenses and insufficient rates screens for the service benefit This amount is within the 7.5% allowed ISF limit of $37,603,623.6 for the period of October 1, 2016 through September 30, 2017. Therefore, no funds will be lapsed.

FY 2016 PIHP Anticipated Unrestricted Fund Balance

MSHN	$1,366

Detailed Information FY 2017:

FY 2017 Projected Medicaid Expenditures (Excluding Taxes, HRA and PIHP Administration) October 1, 2016 through September 30, 2017.

Bay-Arenac	$44,060,000
CEI	91,543,776
Central Michigan	82,703,416
Gratiot	11,320,114
Huron	9,350,000
Ionia	13,020,011
Lifeways	63,413,818
Montcalm	14,010,000
Newaygo	11,453,506
Saginaw	62,572,592
Shiawassee	18,107,000
Tuscola	16,890,000
MSHN SUD	19,300,000
Total	$457,744,233

POLICIES MANUAL

Chapter:	Finance		
Title:	Transfer of CMHSP Care Responsibility		
Policy: ☒ **Procedure:** ☐ **Version:** 1.0 **Page:** 1 of 2	**Review Cycle:** Annually **Author:** Operations Council	**Adopted Date: 01.10.2017** **Review Date:** **Revision Eff. Date:**	**Related Policies:**

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

Lack of statutory clarity with respect to establishing County of Financial Responsibility (COFR) has, in some cases, resulted in delays of appropriate services to consumers, protracted disputes and inconsistency of resolution across the state. This is particularly true for consumers who have never received services from a state operated facility and for whom financial responsibility is thus not addressed directly by Chapter 3 of the Mental Health Code. Community Mental Health Services Programs (CMHSPs) are statutorily responsible for serving persons 'located' in their jurisdiction even when responsibility for payment is in question.

In order to respect the residency preferences of persons served in the geographic area, offer seamless regional access to specialty mental health services and reduce administrative burden, the Mid-State Health Network (MSHN) Prepaid Inpatient Health Plan (PIHP) and its CMHSP Participants have agreed to a regional Transfer of Care Responsibility policy as a supplement to existing COFR practices for Medicaid and Healthy MI recipients.

Policy

1. As a general rule, MSHN and its CMHSP Participants will abide by the County of Financial Responsibility Technical Requirement for CMHSPs, Attachment C.1.3.1 of the Michigan Department of Health and Human Services/CMHSP Managed Mental Health Supports and Services Contract. This document is incorporated to this policy by reference and will be applied to all existing service arrangements and new service requests received by CMHSPs in the MSHN region.

2. MSHN and its CMHSP Participants will consider exceptions to the general COFR rule in section II.A of the County of Financial Responsibility Technical Requirement for CMHSPs regarding change in residency of persons that have an established COFR in the 21 county MSHN PIHP geographic area, provided all of the following requirements are met:
    a. Person requesting the change is an adult and has a personal or familial interest in the residency change that is unrelated to specialty mental health services and supports.
    b. Person is presumed competent or if not, the change is authorized by a duly established legal guardian or representative.
    c. Person is seeking a change in residency to another county within the MSHN region.
    d. Person intends to reside in the county permanently or indefinitely.

3. CMHSP Participants that have persons in service that meet exception requirements to the general COFR rule will discuss the potential change in care responsibility during the contract negotiation process with the destination CMHSP in the MSHN region. CMHSP Participants will work collaboratively to obtain a consensus that supports the person's change in residency and ensures a seamless transition of services.

4. The CMHSP Participants will establish a mutually agreeable timeline for permanent change in the CMHSP care and financial responsibility that honors the person's desired timeline for change in residency, but will not exceed 6 months.

5. CMHSP Participants that are unable to reach mutual agreement regarding permanent transfer of COFR within the MSHN region may pursue remedy through the Dispute Resolution Process as outlined in the MSHN Operating Agreement, Article VIII.

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

Definitions:
Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Michigan Mental Health Code-Act 258 of 1974 as amended.
County of Financial Responsibility: As defined in Section 1306 of the Mental Health Code, the county of financial responsibility is the county in which the individual maintained his or her primary place of residence at the time he or she entered 1 of the following: (a) A dependent living setting, (b) A boarding school or (c) A facility.
MSHN/Mid-State Health Network: A regional entity formed for the purpose of carrying out the provisions of Section 1204b of the Mental Health Code relative to serving as the prepaid inpatient health plan to manage Medicaid specialty supports and services.
PIHP: An organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR part 401, as amended, regarding Medicaid managed care.

Other Related Materials:
"County of Financial Responsibility Technical Requirement for CMHSPs", Attachment C.1.3.1 of the Michigan Department of Health and Human Services/Community Mental Health Services Program Managed Mental Health Supports and Services Contract, FY 2016.

References/Legal Authority:
1. The Social Welfare Act, Act 280 of 1939, MCL 400.32(2), "resident of state" defined.
2. Michigan Mental Health Code, Act 258 of 1974, MCL 330.1306 (1), "determining individual's county of residence".

Change Log:

Date of Change	Description of Change	Responsible Party
August 2016	New Policy	Operations Council

POLICIES AND PROCEDURE MANUAL

Chapter:	Provider Network Management		
Title:	Provider Network Credentialing/Re-Credentialing		
Policy: ☒ **Procedure:** ☐ **Version:** 3.0 **Page:** 1 of 5	**Review Cycle:** Annually **Author:** Provider Network Management Committee, Chief Executive Officer	**Adopted Date:** 04.07.2015 **Review Date:** 01.10.2017 **Revision Effective Date:**	**Related Policies:** Provider Network Management Service Provider Reciprocity

Purpose

In accordance with statutory and funding requirements, Mid-State Health Network (MSHN) is responsible to assure that providers (practitioners and organizations) within the region are appropriately qualified and competent to provide covered and authorized services. All professionals who provide clinical services within the MSHN network must be properly credentialed and re-credentialed.

Policy

MSHN seeks to ensure the competency and qualifications of the service delivery network in the provision of specialty services and supports covered services and programs. To achieve that goal, it is the policy of MSHN that specific credentialing and re-credentialing activities shall occur and be documented to ensure that staff, regional network providers, and their subcontractors are operating within assigned roles and scope of authority in service delivery or business functions. MSHN shall adopt procedures that assure credentialing and re-credentialing practices require providers and sub-contractors obtain and maintain proper credentials for their job position and responsibilities as required by statute, policies, and/or job description qualifications.

The policy applies to Community Mental Health Service Programs (CMHSPs) and Substance Use Disorder providers contracted directly with MSHN. The policy includes clinical professionals working through employment, as an independent contractor and/or organizational contractors.

All credentialing/re-credentialing practices shall be conducted in accordance with the Michigan Department of Health and Human Service Technical Requirements, and at a minimum, this policy, and applicable procedures, require:

- Initial credentialing upon hire or contracting,
- Re-credentialing at least every two years,
- An update of information obtained during the initial credentialing, and
- A process for ongoing monitoring, and intervention when appropriate, of provider sanctions, complaints, and quality issues, pertaining to the provider, which must include, at a minimum, a review of:
    - Medicare/Medicaid sanctions
    - State sanctions or limitations on licensure, registration, or certification
    - Beneficiary concerns, which include grievances (complaints) and appeals information
    - Community Mental Health Services Program (CMHSP) quality issues

The health care professionals addressed in this policy, to be credentialed, include at minimum: Physicians (MDs or DOs); physician assistants; psychologists (licensed, limited licensed and temporary licensed); social workers (licensed master's, licensed bachelor's, limited licensed and registered social work technician); licensed professional counselors; nurse practitioners, registered nurses and licensed practical

nurses; occupational therapists and occupational therapist assistants; physical therapists and physical therapist assistants; speech pathologists, and registered dietitian. MSHN is also responsible to assure ongoing verification of Officers and Executives to confirm their eligibility to administer Medicaid programs.

Administration of credentialing/re-credentialing activities and oversight is the responsibility of the Credentialing Specialist, under the direction of the Provider Credentialing Committee (PCC). The PCC charter details the membership and roles/responsibilities for credentialing activities.

Credentialing and re-credentialing processes shall not discriminate against: (a) a health care professional solely on the basis of license, registration, or certification; or (b) a health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

MSHN shall assure when a CMHSP contracts with an organization employing professional clinical staff that the organization's credentialing policy and practices have been evaluated consistent with these requirements; and that at least every two years the CMHSP validates the implementation of the organizational provider's credentialing/re-credentialing practices through tests of credentialing/re-credentialing records.

MSHN prohibits either the employment of, or contracts with, individuals or any providers who are excluded from participation under either Medicare or Medicaid or who otherwise have Medicare or Medicaid sanctions; MSHN credentialing procedure requires compliance with these federal requirements that prohibit such excluded job functions, including officers, directors, significant purchasers, and board as well as contractor(s)' provider-level staff.

MSHN contract and provider network applications, employment applications, credentialing processes, and background checks for professionals, directors, officers and persons involved in significant purchasing, will ensure the verification that such parties are not listed as federally excluded. For purposes of this policy, individuals defined as included in addition to applicable providers, are: MSHN Officers, Directors, Employees and Contractors.

Additionally, MSHN and its provider network shall maintain written procedures to address:

I. Standards and responsible parties for credentialing functions;
II. Initial and renewal application (including primary source verification and evidence that minimum training requirements are met);
III. Background checks and primary source verification;
IV. Temporary and provisional credentialing;
V. Record organization and retention including preparation and completeness prior to submission to the credentialing committee;
VI. Use of Quality Assessment and Performance Improvement information and findings as part of the re-credentialing process;
VII. Suspension, revocation, and appeals (including Notification of Adverse credentialing decisions);
VIII. Deemed Status;
IX. Monitoring of credentialing/re-credentialing practices including the practices of organizational providers; and
X. Reporting improper known or organizational provider or individual practitioner conduct that results in suspension or revocation.

When MSHN delegates the responsibilities of credentialing/re-credentialing or selection of providers that are required by this policy, it retains the right to approve, suspend, or terminate from participation in the provision of Medicaid funded services a provider selected by that entity. MSHN shall provide ongoing oversight for all delegated credentialing or re-credentialing decisions.

MSHN and its CMHSPs are encouraged to recognize and exchange credentialing/re-credentialing information with other organizations within the MSHN provider network or with other Pre-paid Inpatient Health Plans (PIHPs) in lieu of completing their own credentialing activities. In instances where MSHN/CMHSPs choose to accept the credentialing decision of another PIHP/CMHSP, they must maintain copies of the credentialing PIHP/CMHSP's decisions in the provider credentialing file records. Sharing of information is intended to support administrative efficiency and shall be conducted on a need to know basis in accordance with MSHN's policy on Service Provider Reciprocity and in accordance with accrediting and policy requirements for primary source verification.

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

Definitions:
Credentialing: Confirmation system of the qualification of healthcare providers.
CMHSP: Community Mental Health Services Program
MDHHS: Michigan Department of Health & Human Services
MSHN: Mid-State Health Network
Organizational Providers: are entities that directly employ and/or contract with individuals to provide behavioral health/health care services. Examples of organizational providers include, but are not limited to: Community Mental Health Services Programs; hospitals; nursing homes; homes for the aged; psychiatric hospitals, units and partial hospitalization programs; substance abuse programs; and home health agencies.
PIHP: is a Prepaid Inpatient Health Plan under contract with the Michigan Department of Health and Human Services to provide managed behavioral health services to eligible individuals.
PNMC: Provider Network Management Committee
Re-credentialing: Process of updating and re-verifying credential information
Verification: Securing proof of authentication for an individual's credential(s).

References/Legal Authority:
Internal
MSHN Policies: MSHN Employee Handbook sections: Equal Employment Opportunity; Competency Requirements for the MSHN Provider Network; Network Management & Development; Network Service Provider Appeals & Dispute Resolution; Minimum Training Requirements; Prohibited Affiliations; Regulatory Compliance; Standard Provider Monitoring Process
MSHN Policies: MSHN Provider Manual sections: Minimum Training Requirements; Standard Provider Monitoring Process
MSHN Employment Application

External
MDHHS Policy Credentialing & Re-credentialing Processes
MDHHS PIHP/Regional PIHP CMSHP Contract: Provider Credentialing
MDHHS Medicaid Provider Manual

Attachments:
Attachment A: A Word About Professional Licensure
Attachment: MDHHS Credentialing and Staff Qualification Requirements for the Coordinating Agency Provider Network

Change Log:

Date of Change	Description of Change	Responsible Party
03.2015	New policy	PNMC
07.2015	Address compliance requirements with MDHHS Contract attachment– P7.1.1 in accordance with MSHN's External Quality Review Plan of Correction	Director of Provider Network Management
09.2016	Annual Review; Registered Dietitian added to list of professionals requiring credentialing	Director of Provider Network Management

Attachment A: A Word About Professional Licensure

Proof of Licensure at Hire (where required)

MSHN job descriptions are generally written based on the minimum qualifications for positions/classifications within the MSHN network. If licensure is required, the individual must provide proof of licensure in order to apply for the specific position/classification. For example, if the position/classification requires a minimum of a 'limited license' then the individual must have proof of having obtained the limited licensure at the time of employment/job application. If the position requires a full license, then that is what is required at the time of application or hire. Any candidate who does not have the licensure, or otherwise does not meet the minimum qualifications, will not be considered.

Full or Limited Licensure

MSHN may elect to use a limited license or a full license as the minimum qualification, in keeping with Medicaid/MDHHS requirements. For example, for case management positions within the MSHN network, one of the minimum qualifications according to the Medicaid QMHP definition is limited license social worker, so this minimum qualification is acceptable. When either MSHN or Medicaid requires a full licensure status, a limited license is not acceptable.

Job/Classification Title vs. Professional Licensure

With very few exceptions as so specified in certain job descriptions, even if licensure status is required, most professional position/classification titles are not specific to a certain licensure status or credential. For example, although Client Service Manager positions require (per Medicaid standards) a QMHP (Qualified Mental Health Professional) status - which includes social worker licensure as one possible means of qualification - the position/classification duties and responsibilities are that of a case manager, not a social worker, as other licensure or credentials could also meet the QMHP status minimum requirement. Another example is a position/classification that requires the professional to conduct individual or group therapy; generally these positions/classifications require a master's degree, but the specific type of licensure may vary and the job/classification title may not be specific to a certain licensure expectation.

Supervision of Limited Licensure Individuals

MSHN as an organization is supportive of the promotion of the completion of licensure for individuals where applicable, however, the oversight of specific licensure supervision, for any individual who might be hired in a position/classification who has a limited licensure status is up to the individual, with the support of their supervisor, in securing their own arrangements for licensure supervision as needed. There is no prohibition by MSHN preventing any such arrangement to occur between an individual and their supervisor, and in fact work hours at MSHN are appropriate to use to meet or address licensure requirements; it is up to each individual limited licensure status professional, however, and their supervisor (or another professional if other than the supervisor) to make all specific arrangements and/or keep documentation. It is up to the supervisor or other individual who voluntarily agrees to provide licensure supervision to make any needed accommodations. This support of the supervisor in assisting persons to obtain licensure would be considered an appropriate professional courtesy. If any individual who is hired with a limited license as required by their position fails to obtain full licensure in the time frame allowed by statute, they could be subject to loss of their position of employment for failure to meet the minimum job qualifications, in the same manner that any individual might fail to obtain or retain the licensure needed in order to continue their employment/job status at MSHN if required by the job classification. All conditions or allowances related to salaried employees, HIPAA/confidentiality, work environment standards and other work requirements apply in any MSHN work settings when licensing supervision oversight activities are occurring.

MID-STATE HEALTH NETWORK
POLICIES MANUAL

Chapter:	**Provider Network**		
Section:	**Provider Network Management**		
Policy: ☒ **Procedure:** ☐ **Version:** 2.0 **Page:** 1 of 4	**Review Cycle:** Annually **Author:** Provider Network Management Committee	**Adopted Date:** 12.03.2013 **Review Date:** 01.10.2017 **Revision Eff. Date:**	**Related Policies:** SUD Direct Service Provider Procurement Policy MSHN Procurement Policy

Purpose

To establish guidelines for the development and management of the Mid-State Health Network (MSHN) provider network and CMHSP Service Delivery System; to establish standardized systems and processes for the provider network and contract management administration and oversight across MSHN.

Policy

A. Network Monitoring and Oversight

1. MSHN shall execute a standard written agreement with each CMHSP Participant/Substance Use Disorder Service Provider (SUDSP) to establish CMHSP Participant/SUDSP responsibilities and ensure compliance with all applicable federal and state standards and requirements including those of the Balanced Budget Act, Medicaid Provider Manual and the Medicaid Specialty Services and Supports Contract.

2. The PIHP will monitor CMHSP Participants/SUDSPs at least annually in order to assure the safety, protection, and welfare of consumers/service recipients and to assure compliance with MSHN Policies and all applicable laws and contractual obligations. Such monitoring shall include, but not be limited to, Medicaid claims verification, provider training and credentialing, clinical documentation review, utilization management, and the review of customer services, person-centered planning, and quality assurance activities.

3. CMHSP Participants/SUDSPs unable to demonstrate acceptable performance shall be required to provide corrective action including but not limited to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN.

B. Network Adequacy/Sufficiency

1. MSHN shall ensure an adequate and sufficient network of providers through a variety of mechanisms including, but not limited to, the development of a comprehensive list of all providers in the region, regular reviews of access and availability data, review of annual CMHSP Community Needs Assessments and Demand for Services data, review of utilization reports, and solicitation of stakeholder input.

2. Each CMHSP Participant shall conduct a local assessment of community need consistent with the MDHHS Guidelines for Community Needs Assessment. This assessment shall aid in informing decisions related to the sufficiency and adequacy of the provider network to address local needs and priorities. The assessment shall also determine whether services are available in accordance with MDHHS and Medicaid Provider Manual requirements.

3. Annually MSHN shall evaluate the needed and actual capacity of its provider network via a review of available data sources. MSHN shall consider, at a minimum, anticipated Medicaid enrollment, expected utilization, and required numbers and types of providers, number of network providers not accepting new beneficiaries, geographic location of providers and beneficiaries, the distance, travel time, and the availability of transportation including physical access for beneficiaries with disabilities. MSHN shall also consider the availability of local inpatient beds, crisis capacity, local alternatives to residential care, and regional alternatives to segregated day service in its decisions about network capacity and sufficiency. Consumer satisfaction with the existing service array shall also be reviewed and considered in this annual assessment.

4. Based on this analysis MSHN may redistribute resources per the Operating Agreement where necessary to ensure timely access and necessary service array to address consumer demands. MSHN will explore economies of scale in purchasing, rate setting, regional capacity development and other efficiencies. MSHN shall also annually produce a plan from its evaluation findings and shall develop recommendations for network development.

C. CMHSP Service Delivery System

1. Development and management of the CMHSP Service Delivery System are functions delegated by the PIHP to the CMHSP Participants. Contracts executed between CMHSPs and subcontractors shall be consistent in terms of provider expectations, though documents may differ among CMHSPs. CMHSP Participants shall develop mechanisms for sharing application materials, provider monitoring/auditing reports, and provider training and credentialing when contracting with common providers in the region.

2. MSHN shall require each CMHSP Participant to have written policies and procedures and to maintain evidence of compliance with network development standards that meet state and federal requirements. This includes:
   i. Public, fair, and open processes for provider selection, provider qualification programs or other similar valid processes taking place on a regular or reoccurring basis.
   ii. Consumer input in CMHSP provider selection processes where feasible, that includes new program development or service array expansion to meet local needs where indicated.
   iii. Provider orientation and training for specific service delivery needs that meet requirements and conforms with applicable best practices, and methods to identify new workforce training needs.
   iv. Verification of provider qualifications and credentials required for service delivery responsibilities.
   v. An assigned individual at each CMHSP who is responsible to maintain compliance and consistency with standards and requirements in this area.
   vi. Compliance with State and Federal Procurement Guidelines.

3. Each CMHSP Participant shall assign staff to carry out the network development and management functions delegated by the PIHP in a manner consistent with the standards and requirements established by MDHHS, the BBA and MSHN.

D. SUDSP Service Delivery System

1. Development and management of the SUDSP service delivery system is a retained function of the PIHP. MSHN impanels SUDSPs in accordance with the MSHN SUD Direct Service Provider Procurement Policy. Contracts executed between MSHN and SUDSPs shall be consistent in terms of provider expectations, though documents may differ among SUDSPs.
2. MSHN shall require each SUDSP to have written policies and procedures and to maintain evidence of compliance with network development standards that meet state and federal requirement. This includes:

i. Provider orientation and training for specific service delivery needs that meet requirements and conform with applicable best practices, and methods to identify new workforce training needs.
ii. Verification of provider qualifications and credentials required for service delivery responsibilities.
iii. An assigned individual who is responsible to maintain compliance and consistency with standards and requirements in this area.
iv. Compliance with State and Federal Procurement Guidelines.

E. Provider Qualifications and Privileging
1. MSHN shall ensure that CMHSP Participants/SUDSP comply with all MDHHS guidelines and federal regulations related to credentialing, re-credentialing, and primary source verification of professional staff, as well as the qualifying of non-credentialed staff. The PIHP will monitor CMHSP/SUDSP credentialing and qualifying activities at least annually to ensure compliance with these standards.

F. Conflict of Interest
1. All CMHSP Participants/SUDSPs will consistently function with integrity, in compliance with requirements of all applicable laws, utilizing sound business practices, and with the highest standards of excellence.

G. Payment Liability
1. MSHN shall ensure that CMHSP Participants/SUDSPs comply with enrollee rights related to payment liability. Written agreements shall ensure that beneficiaries are not held liable when the PIHP does not pay the health care provider furnishing services under the contract.

Applies to

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

Definitions/Acronyms:

CMHSP: Community Mental Health Service Programs
MDHHS: Michigan Department Health and Human Services
PIHP: Prepaid Inpatient Health Plan
SUDSP: Substance Use Disorder Service Provider

Related Procedures

N/A

Monitoring and Review Completed By:

This policy shall be reviewed annually by the MSHN Chief Compliance Officer in collaboration with CMHSP Participants. Compliance with this policy shall be ensured through any of the following: Annual monitoring of CMHSP Participants (i.e. delegated managed care), review of data and submitted reports, and/or on-site visits. External monitoring by MDHHS and/or accreditation bodies may also occur.

References/Legal Authority

1. BBA 438.214(b)(2) Provider Selection
2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program (which

includes attachment P.7.1.1)

3. Medicaid Provider Manual
4. Federal Procurement Guidelines (The Office of Federal Procurement Policy (OFPP) - Office of Management and Budget)
5. MSHN Procurement Policy
6. MSHN SUD Direct Service Provider Procurement Policy

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New Policy	Provider Network Mgmt Committee
12.2014	Annual Review	Provider Network Mgmt Committee
03.2016	Annual Review and Revisions	Provider Network Mgmt Committee

POLICIES MANUAL

Chapter:	**Provider Network**		
Title:	**Service Provider Reciprocity**		
Policy: ☒ **Procedure:** ☐ **Version: 2.0** **Page:** 1 of 2	**Review Cycle:** Annually **Author:** MSHN Provider Network Management Committee	**Adopted Date: 0**1.06.2015 **Review Date:** 01.10.2017 **Revision Eff. Date:**	**Related Policies:** Provider Network Management

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To provide a framework for the MSHN commitment to service providers in all key aspects of provider network management and relations, which seeks to promote reasonable levels of reciprocity and efficiencies wherever feasible to reduce duplication of resources and expedite provider related processes.

Policy

It is the policy of MSHN that CMHSP Participants will promote and facilitate reciprocity and efficiencies in the provision of processes for service delivery providers for mental health and substance use disorder services.

A. MSHN will provide regional leadership in the development of region-wide common practices, documents and processes where ever feasible.

B. Each CMHSP Participant will have demonstrated reciprocity practices that facilitate provider efficiency and/or expedition of provider consideration relative to credentialing, monitoring and training.

C. MSHN CMHSP Participants will readily share and accept documents and records within MSHN and with other PIHPs in order to engender provider reciprocity, including provider review reports, transcripts and/or training protocols/curriculums.

D. CMHSP Participants of MSHN will seek to promote both simplification and readily available access for service providers regarding needed information, reporting conditions and overall communications.

E. While it is understood that each CMHSP Participant may have unique approaches or procedures, common policies and simplification efforts to support common provider experience across the region will be pursued.

F. MSHN CMHSP Participants will support the ability of partner training/continuing education leaders, whenever feasible to 1) collaborate on resources, 2) share teaching curriculums/protocols, 3) facilitate mutual programs, 4) share mutual training resources, and 5) allow for attendance access upon request in MSHN CMHSP Participant programs on a reciprocal basis.

G. This policy applies to all CMHSP Participants who are involved in provider processes in the MSHN region.

Applies to:

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

Definitions:

CMHSP: Community Mental Health Service Program Participant
MSHN: Mid-State Health Network
PNMC: Provider Network Management Committee
Behavioral Health Systems: The system is inclusive of individuals who encompass one or more of the following disorders: Substance use, Severe and persistent mental illness, Autism, Serious emotional disturbances, Intellectual/Developmentally disabilities and Co-occurring disorders.

Other Related Materials:

N/A

References/Legal Authority:

MDCH Policy/ 2014 - 2015

Change Log:

Date of Change	Description of Change	Responsible Party
11.22.2014	New policy	G. Reed
01.2016	Annual Review	Provider Network Management Committee
09.28.2016	Annual Review	Provider Network Management Committee

POLICIES AND PROCEDURE MANUAL

Chapter:	**Utilization Management**		
Title:	**Access System**		
Policy: ☒ **Procedure:** ☐ **Version:** 5.0 **Page:** 1 of 9	**Review Cycle:** Annually **Author:** UM Director UM Committee	**Adopted Date: 11.22.2013** **Review Date:** 01.10.2017 **Revision Eff. Date:** 11.2015	**Related Policies:** Service Philosophy Utilization Management

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

MSHN shall ensure regional access to public behavioral health services in accordance with the Michigan Department of Health & Human Service (MDHHS) contracts, relevant Medicaid Provider Manual, Mental Health Code and regional adopted access and authorization criteria. MSHN shall maintain criteria for determining medical necessity, information sources and processes that are used to review and approve provision of services.

Policy

MSHN's provider network administers a welcoming, responsive, access system 24 hours a day, 7 days a week, 365 days a year for all individuals who reside in the MSHN region. Residents of the region may contact any CMHSP seeking information, services, and/or support systems for behavioral health care needs including:

- Intellectual/ Developmental Disabilities,
- Mental Illnesses,
- Serious Emotional Disturbance
- Substance Use Disorders, and/or
- Co-occurring Disorders

Access System Management:
MSHN shall create, implement and maintain access system standards that are uniform throughout the region. The MSHN provider network shall develop written policies, procedures and plans demonstrating the capability of its access system to comply with those standards.

- MSHN will ensure that screening/outcomes tools and admission criteria are based on eligibility criteria established in contract and regulations are reliably and uniformly administered. The MSHN UM Plan is designed to integrate system review components that include PIHP contract requirements and CMHSPs' roles and responsibilities concerning UM/quality assurance/improvement issues.
- CMHSP Participants within the MSHN region will manage all requests with prompt, consistent screening and assessment for Medicaid eligible adults and children requesting service.
- MSHN has delegated its access system to CMHSP Participants. Each CMHSP Participant shall adopt access policies and procedures that assure compliance with MSHN's policy and provide for efficient and effective access practices.

- MSHN and the CMHSP Participants shall determine the individual's eligibility for Medicaid specialty services and supports, Healthy Michigan Plan, Substance Abuse Block Grant (SABG) or, for those who do not have any of these benefits as a person whose presenting needs for behavioral health services make them a priority to be served.
- The access system shall operate or arrange for an access line that is available 24 hours per day, seven days per week; including in-person and by-telephone access for hearing impaired individuals.
- CMHSP Participants are responsible to ensure appropriate treatment, supports, and services to Medicaid beneficiaries through the use of a review/authorization process. The system also provides crisis screening and authorization for high urgent/emergent services (inpatient, crisis residential, and crisis stabilization).
- Beneficiaries with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR 438.208(c)(4). This standard does not apply to SUD Community Grant services.
- MSHN shall assure, through delegation monitoring reviews, that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, is made by a health care professional who has appropriate clinical licensure and expertise in treating the beneficiary's condition.
- The access system shall provide information regarding confidentiality (42 CFR) and recipient rights of substance use disorder clients to all individuals requesting services.
- Should a Medicaid beneficiary not meet criteria for the priority population and/or requested service, referring the responsible CMHSP Participant shall provide timely written notice to the individual of the adverse action. Written notice shall include the reason for the action and the beneficiary's options for appealing the action. CMHSP Participant referring subcontractors shall be notified of the authorization disposition at the time of the denial.
- When a clinical screening is conducted, the access system shall provide a written (hard copy or electronic) screening decision of the person's eligibility based upon established admission criteria. The written decision shall include:
    - Presenting problems and needs for services and supports,
    - Initial identification of the population group that qualifies the person for services and supports,
    - Legal eligibility and priority criteria (where applicable),
    - Urgent and emergent needs including how linked for crisis services,
    - Screening deposition, and
    - Rationale for admission or denial.
- No individual meeting eligibility and medical necessity criteria for specialty mental health services shall be denied service solely because of individual/family income or third party payer sources.
- Individuals with behavioral health needs but who are not eligible for Medicaid or Healthy Michigan may be referred to other community services or placed on a waiting list with a written explanation related to the individual's service needs, consistent with MDHHS Waiting List guidelines.
- MSHN is responsible for maintaining an SABG waiting list by contacting clients who are placed on it every 30 days to check their status/well-being and continued interest in services until they are linked with the appropriate level of care. Attempts and contacts shall be documented to ensure that the list is properly maintained. Those clients who are not able to be contacted, or who do not respond after 90 days, may be removed.
    - SABG priority population clients placed on a waiting list are required to be offered interim services. Interim services must minimally include:
      a. Counseling and education about the human immunodeficiency virus (HIV) and tuberculosis (TB).
      b. The risks of needle sharing.

c. The risks of transmission to sexual partners, infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
d. HIV or TB treatment service referrals.
e. Counseling on the effects of alcohol and drug use on a fetus and referral for prenatal care are required for pregnant women.

- MSHN CMHSP Participants shall assure that an individual who has been discharged back into the community from outpatient services, and is requesting entrance back into the CMHSP or provider, within one year, will not have to go through a duplicative screening process.

Eligibility Determination:
MSHN's provider network shall serve individuals with serious mental illness, serious emotional disturbance, substance use disorders, and intellectual/developmental disabilities, giving priority to persons with the most serious forms of illness and those in urgent and emergent situations. Once the needs of these individuals have been addressed, MDHHS expects that individuals with other diagnoses of mental disorders with a diagnosis found in the most recent Diagnostic and Statistical Manual of Mental Health Disorders (DSM), will be served based upon agency priorities and within the funding available.

The determination of eligibility will be based upon the target populations as provided in the MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract. This includes persons who may be eligible for the Habilitation Supports Waiver (HSW) and/or the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit that further delineates eligibility for autism services (also referred to as the expanded Autism Benefit). The HSW and EPSDT policies are referenced in the subsequent References/Legal Authority Section.

Mental Illness:
- The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities.
- The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse.
- The beneficiary has been treated by the health plan for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year.

Serious Emotional Disturbance:
- A minor that possesses a diagnosable mental, behavioral, or emotional disorder that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association.
- Functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities.
- The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:
  (a) A substance abuse disorder.
  (b) A developmental disorder.
  (c) "V" codes in the diagnostic and statistical manual of mental disorders.

Intellectual/Developmental Disability: If applied to an individual older than 5 years, a severe, chronic condition that meets all of the following requirements:

- Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
- Is manifested before the individual is 22 years old.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in three (3) or more of the following areas of major life activity: Self-care, Receptive and Expressive language, Learning, Mobility, Self-direction, Capacity for Independent Living, Economic Self-sufficiency.
- Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

Substance Use Disorder:

- Determination of medical necessity.
- A diagnosis of one or more substance use disorders found in the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Determination of the initial level of care (LOC) based on the most current edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC), including:
    1. Dimension 1 – Alcohol Intoxication and/or Withdrawal Potential.
    2. Dimension 2 – Biomedical Conditions and Complications.
    3. Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications.
    4. Dimension 4 – Readiness to Change.
    5. Dimension 5 – Relapse, Continued Use or Continued Problem Potential.
    6. Dimension 6 – Recovery Environment.

- Determination of priority population status-priority population client must be admitted to services as follows:

Population	**Admission Requirement**	**Interim Service Requirement**
Pregnant Injecting Drug User	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. d) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Pregnant Substance Use Disorders	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) HIV and TB. b) Risks of transmission to sexual partners and infants. c) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care.

		3. Early intervention clinical services.
Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 hours – maximum waiting time 120 days:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. 2. Early intervention clinical services.
Parent At-Risk of Losing Children	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 business hours:* Early intervention clinical services.
All Others	Screened and referred within seven calendar days. Capacity to offer admission within 14 days.	Not required.

The MSHN region will operate within a common definition of medical necessity for service entry, which must be consistently applied region-wide according to the Medicaid Provider Manual. The eligibility/coverage determination decision shall be the result of integrating eligibility criteria and clinical needs with current insurance benefits.

Eligibility determinations occur at initial entry into an episode of care, and on an ongoing basis during an episode of care. Initial eligibility is determined through the Access screening process that occurs as the individual/family requests services to determine the likelihood of a mental illness, serious emotional disturbance, substance use disorder, or intellectual/developmental disability. The screening process shall be used to determine the coverage eligibility that qualifies individuals for services and authorizes their initial entry into the publicly funded mental health system for a clinical assessment. Ongoing eligibility is determined by provider clinical reviews and/or UM continued stay reviews. Ongoing eligibility reviews shall be used to ensure that the individual continues to qualify for ongoing services. Components that go into eligibility decisions include, but are not limited to:

- Data from the practitioner's comprehensive clinical interview and complete mental status examination
- Past clinical history (medical and psychiatric, including response to medication)
- Assessment of the current support system available to the patient including resources, individual's strengths and resources, financial, housing, government programs, community treatment facilities, etc. that are available
- Family history
- Current medical status
- Comprehensive risk assessment, including consideration of relevant demographic factors (age, ethnicity), comorbid substance use, medical conditions and support system, among other factor

Regarding eligibility for SUD services, MSHN may not limit access to the programs and services funded only to the residents of the MSHN's region, because the funds provided by MDHHS come from federal and statewide resources. Members of federal and state-identified priority populations must be given access

to screening and to assessment and treatment services, consistent with the requirements, regardless of their residency. However, for non-priority populations, MSHN may give its residents priority in obtaining services when the actual demand for services by residents eligible for services exceeds the capacity of the agencies.

MSHN is committed to culturally competent service delivery acknowledging enrollee rights and responsibilities as established in Federal and State law. To ensure and monitor consumer rights, each Medicaid Service Provider will maintain an Office of Recipient Rights that is in substantial compliance with the requirements of Chapter 7 of the Michigan Mental Health Code.

Medical Necessity Determination:
The following medical necessity criteria apply to the MSHN Medicaid behavioral health and substance use disorder supports and services.

- Necessary for screening and assessing the presence of a mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder and/or
- Required to identify and evaluate a mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

The determination of a medically necessary support, service or treatment must be:
- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or intellectual/developmental disabilities, based on person-centered planning, and for beneficiaries with substance disorders, individualized treatment planning; and
- Made by appropriately licensed and trained mental health, intellectual/developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose;
- Based on documented evidenced-based criteria for determination of scope, duration and intensity; and
- Documented in the individual plan of service.

Supports, Services and Treatment Authorized by the PIHP (through the CMHSP Participant) must be:
- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and\

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

Using criteria for medical necessity, a PIHP (through its Provider Network) may deny services that are:

- Deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
- Experimental or investigational in nature;
- For which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

The MSHN provider network may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

MSHN assures that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

Level of Care Determination:

MSHN ensures there are sufficient and appropriate processes in place at each Network Provider for level of care determination and consistent application of eligibility criteria. Screening tools and admission criteria shall be valid, reliable and uniformly administered. Level of care criteria shall be sufficient to address the severity of illness and define the intensity of service required. CMHSP Participants shall administer level of care reviews that are structured to monitor and evaluate under/over and appropriate utilization of services provided to beneficiaries while also ensuring that consistent standards are being applied. Reviews shall match medical necessity and MSHN Practice Guidelines (Medicaid Provider Manual) to provide for appropriate amount, scope and duration of services necessary to achieve treatment outcomes and consistent with approved practice guidelines.

A. Severity of Illness: the nature and severity of the signs, symptoms, functional impairments and risk potential related to the consumer's disorder.
B. Intensity of Services: the setting of care, usually corresponding to the types and frequency, duration, restrictiveness, and level of support needed to treat the consumer.

Coordination of Care with the Court System

The access system must be able to utilize the substance use disorder screening information and treatment needs provided by district court probation officer assessments when the probation officer has the appropriate credentialing through the Michigan Certification Board for Addiction Professionals (MCBAP). A release of information form must accompany the district court probation officer referral. The information provided by the probation officer should supply enough information to the access system to apply ASAM Criteria to determine LOC and referral for placement. In situations where information is not adequate, the release of information will allow the access system to contact the district court probation officer to obtain other needed information. The access system must be able to authorize these services based on medical necessity, so PIHP funds can be used to pay for treatment.

Measurement of Outcomes:
The MSHN UM model places less emphasis or attention to the specific number, type and duration of services and units delivered; rather, MSHN focuses on the outcome/effectiveness of those services. Outcomes shall be standardized and measurable, where feasible. The MSHN UM model follows use of all contractually mandated outcomes instruments, including the Child and Adolescent Functional Assessment Scale (CAFAS), the Level of Care Utilization System (LOCUS), and the Supports Intensity Scale (SIS). Measurement of outcomes must be consistently assessed and monitored and known intervals and applied across all services and service populations. Specific outcome measures include:

- Clinical stability
- Effectiveness in addressing service needs
- Psychosocial factors
- Cost
- Satisfaction/experience with care.
- Individual, family, and community indicators of health and wellness, including benchmarks of quality-of-life changes for people in recovery.

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

Definitions/Acronyms:
ASAM-PPC: American Society of Addiction Medicine-Patient Placement Criteria
BH-TEDS: Behavioral Health Treatment Episode Data Set
EPSDT: Early Periodic, Screening, Diagnosis, and Treatment
CAFAS: Child and Adolescent Functional Assessment Scale
CMHSP: Community Mental Health Service Program (inclusive of substance Use Service Provision, coordination and administrative oversight)
Contractual Provider: refers to an individual or organization under contract with MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP Participants who hold retained functions contracts
DLA-20: Daily Living Activities Scale
Employee: refers to an individual who is employed by the MSHN PIHP
LOCUS: Level of Care Utilization System
MDHHS: Michigan Department of Health & Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
Subcontractors: refers to an individual or organization that is directly under contract with CMHSP and/or MSHN to provide behavioral health services and/or supports
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
SED: Serious Emotional Disturbance
SIS: Supports Intensity Scale
Staff: refers to an individual directly employed and/or contracted with a CMHSP Participant or SUD providers

SUD: Substance Use Disorder
UMC: Utilization Management Committee

References/Legal Authority:

1. Access System Standards: MDHHS, revised: September 2015 (Contract Attachment P.4.1.1)
2. Customer Service System Standards: MDHHS, 2/27/07
3. Early Periodic, Screening, Diagnosis, and Treatment Policy: MSHN
4. Habilitation Supports Waiver Policy: MSHN
5. 42CFR 438.206: Access Standards
6. 42 CFR 438.208(c)(4)
7. 42CFR 438.210: Enrollee Rights
8. Michigan Mental Health Code 330.1124: Waiting Lists for Admission
9. Michigan Mental Health Code 330.1208: Individuals to Whom Service is Directed
10. MDHHS Medicaid Provider Manual, Mental Health/ Substance Abuse chapter
11. MDHHS Bureau of Substance Abuse and Addiction Services, Treatment Policy #07

Other References:

N/A

Change Log:

Date of Change	Description of Change	Responsible Party
11.22.2013	New Policy	UMC
09.2014	Annual Review and update of definitions and acronyms	MSHN CEO
06.2015/07.2015	Update to integrate with UMP	UMC and MSHN CEO
07.23.2015	Clarify clinical eligibility for SUD, clarify FY15 contract provisions.	UMC
04.26.2016	Differentiated SED from MI, 2015 MDHHS Access Policy, and added assessment tools and reference to HSW and EPSDT policies.	UMC
10.27.2016	Updated the policy to reflect Access Management System changes in FY17 MDHHS/PIHP contract.	UMC

POLICIES AND PROCEDURE MANUAL

Chapter:	**Utilization Management**		
Title:	**Utilization Management**		
Policy: ☒ **Procedure:**☐ **Version:** 5.0 **Page:** 1 of 7	**Review Cycle:** Annually **Author:** UM Director and UM Committee	**Adopted Date: 11.22.2013** **Review Date:** 01.10.2017 **Revision Eff. Date:** 11.2015	**Related Policies:** UM-Access Service Philosophy

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

Mid-State Health Network (MSHN), either directly or through delegation of function to its provider network, is responsible for the region's Utilization Management (UM) system. Through contract, MSHN has identified the retained and delegated functions of the networks UM system. MSHN is responsible for oversight and monitoring of all UM functions.

UM is a set of administrative functions that assure appropriate clinical service delivery. In short, this means the "right service in the right amount to the right individuals from the right service provider". These functions occur through the consistent application of written policies and eligibility criteria

Policy

MSHN UM functions are performed in accordance with approved MSHN policies, protocols and standards and may be delegated to its provider network or directly administered by the Pre-Paid Inpatient Health Plan (PIHP) (see Attachment A). This includes monitoring of local prospective, concurrent and retrospective reviews of authorization and UM decisions, activities regarding level of need and level/amount of services. MSHN maintains a Utilization Management Delegation Grid (see Attachment B) that defines whether a utilization management function is considered retained or delegated.

MSHN provider network shall have mechanisms to identify and correct under/over-utilization of services; as well as procedures for conducting prospective, concurrent, and retrospective reviews. Qualified health professionals shall supervise review decisions. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to provide treatment in consultation with the primary care physician as appropriate. MSHN conducts data-driven analysis of regional utilization patterns, and monitoring for over-and under-utilization across the region.

Principles:
Utilization management must be based on valid data in order to produce reliable reports required to analyze patterns of utilization, determine clinical effectiveness of the service delivery model and compare cost-effectiveness and outcomes of services.

- Value-based purchasing assures appropriate access, quality, and the efficient and economic provision of supports and services.
- The MSHN UM framework is not a mandate for clinical decision-making, but instead aims to define and standardize criteria, factors, and outcomes for evaluation purposes.

- The MSHN Utilization model will be consistent with MDHHS contract requirements, Balance Budget Act of 1997, and national accreditation standards
- National standards and metrics are utilized throughout the model wherever possible (standardized tools, recognized process metrics, and outcome measures)

Utilization Management Structure:
The UM Committee is the primary body responsible for evaluating the utilization of MSHN provider network services and making recommendations to the MSHN Chief Executive Officer (CEO), Chief Compliance Officer (CCO) and the Operations Council (OC). The UM Committee is responsible for reviewing aggregated and trend data related to the implementation and effectiveness of the UM plan.

- *Utilization Management Committee:* The UM Committee is comprised of the MSHN CEO, MSHN CCO, and the CMHSP Participants' Utilization Management staff appointed by the respective CMHSP Participant CEO/Executive Director (ED). All CMHSP Participants shall have equal representation on this committee. Retain and delegated UM functions are outlined in the MSHN Utilization Organization Chart.
- *Operations Council*: The Operations Council reviews reports concerning utilization and quality improvement matters as identified by the Quality Improvement Council (QIC) and UM Committee and makes recommendations for regional planning and improvement to the MSHN CEO. The Operations Council shall be comprised of the CEO/ED of each CMHSP Participant.

Utilization Management Plan:
MSHN shall create, implement and maintain a region-wide UMP that complies with applicable federal and state statutes, laws and regulations. The MSHN UMP shall adhere to regulations established by governing bodies including the Michigan Department Health & Human Services (MDHHS), Medicaid Services Administration, Centers for Medicaid and Medicare, and relevant accrediting bodies.

A. The MSHN UM Plan shall be implemented in a manner which remains true to MSHN Service Philosophies, particularly person/family centeredness, self-determination, cultural sensitivity, trauma informed/sensitive, and responsiveness to co-occurring (dual-diagnoses) conditions.
B. All CMHSP Participants/Provider Network shall create policies and procedures necessary to fulfill all aspects of the CMHSP UMP that include criteria for evaluating medical necessity and processes for reviewing and approving the provision of services.
C. MSHN will monitor CMHSP Participant/Provider Network follow-through, specifically evidence of local monitoring for over/under utilization, consistent and responsive to regionally identified patterns and trends.
D. All CMHSP Participants/ Provider Network shall establish procedures for prospective (preauthorization), concurrent, and retrospective authorizations. Procedures shall ensure that:
    1. Review decisions that deny or reduce services are supervised by qualified professionals who have appropriate clinical expertise.
    2. Efforts are engaged to obtain all necessary information, including pertinent clinical data and consultation with the treating physician or prescriber as appropriate for decision making.
    3. Reasons for decisions are clearly documented and readily available to service recipients.
    4. Appeals mechanisms for both providers and service recipients are well-publicized and readily-available. Notification of denial decisions shall include a description of how to file an appeal, and shall be provided to both the beneficiary and the provider.
    5. Decisions and appeals are conducted in a timely manner as required by the exigencies of the situation.
    6. Mechanisms are implemented to evaluate the effects of the program using data related to consumer satisfaction, provider satisfaction, or other appropriate measures.

Authorization for Treatment & Support Services:
Initial and ongoing approval or denial of requested services is delegated to the local CMHSP Participants. This approval or denial includes the screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community mental health services. Communication with individuals regarding UM decisions, including adequate and advance notice, right to second opinion, and grievance and appeals shall be provided in accordance with the Medicaid Managed Specialty Supports and Services contract with the MDHHS. The reasons for treatment decisions shall be clearly documented and available to Medicaid beneficiaries. Information regarding all available appeals processes and assistance through customer services is communicated to the consumer. MSHN shall monitor affiliate authorization, second opinions and appeals processes to ensure compliance with PIHP, State and Federal requirements.

1. Utilization reviews are conducted using medical necessity criteria adopted or developed specifically to guide the level of care and appropriate care planning (Medicaid Provider Manual). This may include, but is not limited to, appropriate length of stay for each level of care according to identified needs of the beneficiary in order for payment to be authorized.

2. The responsibility for managing the utilization of clinical care resources is delegated to the MSHN provider network/professional staff members who assess the needs of and authorize care for beneficiaries receiving services funded by the PIHP.

3. Decisions regarding the type, scope, duration and intensity of services to authorize or deny must be:
    a. Accurate and consistent with medical necessity criteria;
    b. Consistent with Medicaid eligibility, entry, continuing stays and discharge criteria as applicable;
    c. Consistent with formal assessments of need and beneficiary desired outcomes;
    d. Consistent with established guidelines (Medicaid Provider Manual);
    e. Adjusted appropriately as beneficiary needs, status, and/or service requests change;
    f. Timely;
    g. Provided to the consumer in writing as to the specific nature of the decision and its reasons;
    h. As applicable, shared with affected service providers verbally or in writing as to the specific nature of the decision and its reasons if there are any concerns with decisions made;
    i. clearly documented as to the specific nature of the services authorized or denied and the reasons for denial; and
    j. Accompanied by the appropriate notice to consumers regarding their appeal rights with a copy of the notice placed in the consumer's clinical case record.

4. Additional mental health services (through authority of 1915(b)(3) of the Social Security Act ("B3" services) are intended to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. Authorization and use of Medicaid funds for any B3 supports and services (including amount, scope, and duration) are dependent upon:
    a. The Medicaid beneficiary's eligibility for specialty services and supports;
    b. Services have been identified during person-centered planning;
    c. Services are medically necessary;
    d. Services are expected to achieve one or more of the goals listed in 4;

e. Decision to authorize B3 services (including amount scope and duration) must take into account MSHN's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services.

5. MSHN CMHSP Participants shall not deny the use of a covered service based on preset limits of units or duration; but instead reviews the continued medical necessity on an individualized basis.

6. MSHN assures that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

Outlier Management:
Consistent with Balanced Budget Act (BBA) requirements addressed in Title 42 -Public Health, Part 438.240 (Quality Assessment and Performance Improvement Program), MSHN is responsible to ensure that all Provider Network Members have in effect mechanisms to detect both under-utilization and over-utilization of services. The intent of the outlier management approach is to identify under-utilization or over-utilization and explore and resolve it collaboratively with involved CMHSP Participants.
Oversight and Monitoring:
Annually MSHN and the UM Committee shall conduct a review of this plan and its stated priorities for action (Attachment B) to assure program effectiveness. MSHN's Medical Director shall be involved in the review and oversight of access system policies and clinical practices.

Additionally, MSHN shall provide oversight and monitoring to ensure that the CMHSP participants meet the following standards:

1. CMHSP participants shall ensure that the access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual, the Michigan Mental Health Code and the MDHHS/PIHP contract.
2. CMHSP participants shall ensure that there is no conflict of interest between the coverage determination and the access to, or authorization of, services.
3. CMHSP participants shall monitor provider capacity to accept new individuals, and be aware of any providers not accepting referrals at any point in time.
4. CMHSP participants shall routinely measure telephone answering rates, call abandonment rates and timeliness of appointment and referrals at any point in time. Any performance issues shall be addressed through the PIHP Quality Assurance and Process Improvement Plan.
5. CMHSP participants shall assure that the access system maintains medical records in compliance with state and federal standards.
6. The CMHSP participants shall work with individuals, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation.

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

Definitions/Acronyms:
CMHSP: Community Mental Health Service Program (inclusive of substance Use Service Provision, coordination and administrative oversight)
Contractual Provider: refers to an individual or organization under contract with MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP Participants who hold retained functions contracts.
Employee: refers to an individual who is employed by the MSHN PIHP.
MDHHS: Michigan Department of Health & Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
Subcontractors: refers to an individual or organization that is directly under contract with CMHSP and/or MSHN to provide behavioral health services and/or supports.
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.
Staff: refers to an individual directly employed and/or contracted with a CMHSP Participant or SUD providers.
SUD: Substance Use Disorder
UM: Utilization Management
UMC: Utilization Management Committee

Related Materials:
MSHN Utilization Management Plan

References/Legal Authority:
1. MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P.6.3.2.1: The Appeal and Grievance Resolution Processes Technical Requirement, July 2004.
2. MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P.7.1.1: Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans, Current Year
3. MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P.6.5.1.1: Michigan Mission-Based Performance Indicator System, Version 6.0 for PIHPs
4. MDHHS Medicaid Providers Manual, 4/1/2013 (current edition).
5. MSA Bulletin: Mental Health/Substance Abuse 04-03 (Prepaid Inpatient Health Plans)
6. 42 CFR 438.404c(5)(6)

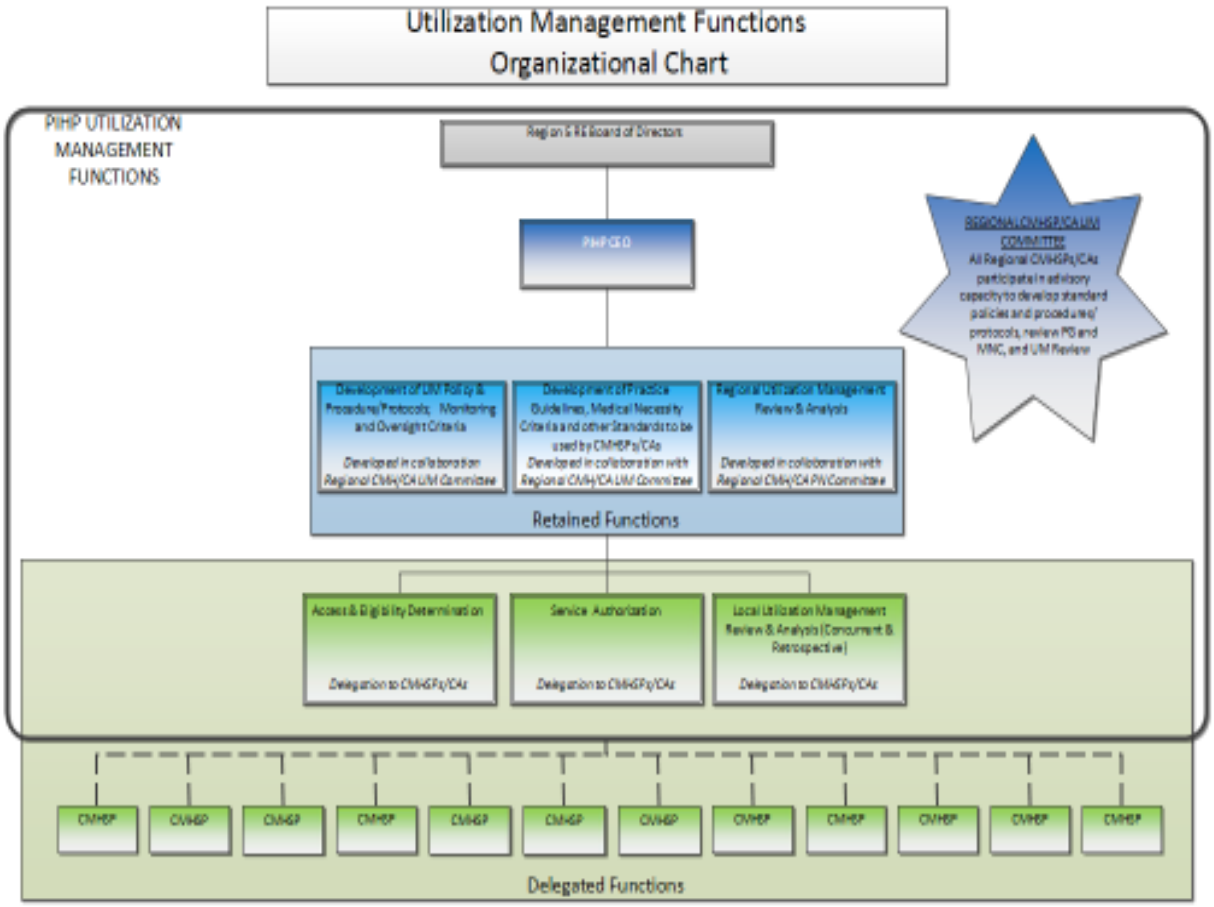
Change Log:

Date of Change	Description of Change	Responsible Party
11.23.2013	New MSHN policy	L. Verdeveld
03.14.2014	Alignment with service philosophy and addition of "prescriber."	Dr. H. Lenhart
04.09.2014	To reflect input of the Utilization Management and Substance Use Disorder Committee/Workgroup	D. McAllister
07.23.2015	UM Committee feedback on MSHN monitoring of over/under utilization; and B3 service clarification of reasonable and equitable, clarify FY15 contract provisions.	UMC

04.25.2016	Moved description of UM delegation grid to UM Policy.	UMC
10.27.2016	Annual review by UMC-no changes.	UMC

Attachment A

MSHN Utilization Management Functions Organization Chart



Attachment B

MSHN Utilization Management Delegation Grid

PIHP Delegated Activity	Retained or delegated?	If retained: Conducted internally by MSHN or contracted?
Initial approval or denial of requested service: - Initial assessment for and authorization of psychiatric inpatient services; - Initial assessment for and authorization of psychiatric partial hospitalization services; - Initial and ongoing authorization of services to individuals receiving community-based services; - Grievance and Appeals, Second Opinion management, coordination and notification; - Communication with consumers regarding UM decisions, including adequate and advanced notice, right to second opinion and grievance and appeal	___ Retained by MSHN ☑ Delegated to local CMHs *This topic has been marked as an implementation issue requiring the development of a specific policy or procedure at the MSHN level.	☐Conducted by MSHN ☐Contracted
Local-level Concurrent and Retrospective Reviews of affiliate Authorization and Utilization Management decisions/activities to internally monitor authorization decisions and congruencies regarding level of need with level of service, consistent with PIHP policy, standards and protocols.	___ Retained by MSHN ☑ Delegated to local CMHs	☐Conducted by MSHN ☐Contracted
Persons who are enrolled on a habilitation supports waiver must be certified as current enrollees and be re-certified annually. A copy of the certification form must be in the individual's file and signed by the local CMHSP representative.	*This will be a **local responsibility** that is **prompted centrally by MSHN**. It will be a central responsibility to manage the resource of waiver slots and provide oversight.	☒Conducted by MSHN ☐ Contracted
Development, adoption and dissemination of Practice Guidelines (PGs), Medical Necessity Criteria, and other Standards to be used by the local CMHSP. 42 CFR: 438.236: Practice Guidelines	☑ Retained by MSHN ___Delegated to local CMHs	☒Conducted by MSHN ☐Contracted
Development, modification and monitoring of related PIHP UM Policy, Procedures and Annual Plan as part of the Affiliation QI Plan.	☑ Retained by MSHN ___Delegated to local CMHs	☒Conducted by MSHN ☐Contracted
Review and Analysis of the CMHSP's quarterly utilization activity and reporting of services. Annual review of each CMHSP's and the PIHP's overall Utilization Activities.	☑ Retained by MSHN ___Delegated to local CMHs	☒Conducted by MSHN ☐Contracted

Background:

MSHN's plan to cover CMHSP FY16 Autism costs were presented to the MSHN Board Executive Committee at their November 18, 2016 meeting by Joseph Sedlock. Implementation of the Autism Cost Settlement Plan was endorsed and recommended for Board Action/Approval by the MSHN Operations Council.

Recommended Motion:

Motion to ratify November 18, 2016 MSHN Board Executive Committee action to approve the Autism Cost Settlement Plan Implementation, as presented.

MSHN
Mid-State Health Network

MID-STATE HEALTH NETWORK
FY 16 AUTISM COST SETTLEMENT PLAN

Background:

CMHSPs in the Mid-State Health Network region have nearly $10.2M in stranded autism benefit related costs due to the delay in payments from the State of Michigan, which are paid roughly five months after the date of service. (Exhibit A, Highlight 1).

FY 16 CMHSP Interim FSR-Reported Expenditures and Payments are shown in Exhibit A. CMHSP Autism expenses are shown comparatively for FY 15 and FY 16, showing variances, along with Autism consumers served by CMHSP for FY 15 and FY 16 in Exhibit B. Exhibit C is a graph of CMHSP Autism Costs for FY 15 and FY16.

Plan:

MSHN projects $14.2M in FY16 cost savings. MSHN will complete its final settlement with the CMHSPs May 2017 however the cost settlement policy states 85% of projected amounts owed be sent when the November interim FSR is submitted. Because the projected savings amounts are not currently available MSHN will abate funds from the ISF to settle the expense to revenue difference for FY16 net autism costs (only).

1) FY16 - MSHN will abate $9.4M from the ISF and make available an additional $800K, totaling $10.2M, in order to meet the regional FY16 net Autism cost settlement with CMHSPs. (Exhibit A).

    - Making the full net cost Autism payments to CMHSPs detailed in Exhibit A now will eliminate the FY16 lag in payments (which would normally be received in October 2016 through February 2017) and will bring CMHSPs current to cost as reported in the 9/30/16 interim FSRs.

2) FY17 - MSHN will continue to distribute the MDHHS calculated Autism-related revenue to the CMHSPs, in the month revenue is received.

    - While the October 2016 to February 2017 ASD payments to MSHN from MDHHS are calculated based on FY16 encounters, which are still paid five months in arrears, the payment lag to CMHSPs will have been eliminated by MSHN's FY16 ASD cost settlement (lump sum) payment to CMHSPs (under #1 above).

    - Going forward MSHN will distribute ASD payments based on MDHHS calculations, and CMHSP will recognize these payments in the month they are received, as identified by MSHN.

    - MSHN recognizes that the services rates used to calculate ASD funding were not sufficient to cover the cost of ASD programs, so it is anticipated that a similar cash settlement (lump sum) payment will be considered in early FY18 for FY17 service delivery.

3) Finance Council will need to develop accounting guidelines because revenue received in the current year for prior year dates of service will have already been paid (by MSHN, under this plan). Details to follow from MSHN CFO Leslie Thomas to CMHSP CFOs.

Exhibit A

FISCAL YEAR 2016 AUTISM COST SETTLEMENT							
	Oct - Dec *			Jan - Sept+			FY 2016 Grand Total Due to
	FSR - expense	Payments	Due to CMHSP	FSR - expense	Payments	Due to CMHSP	
	Col A	Col B	Col C (A+B)	Col D	Col E	Col F (D+E)	Col G (C+F)
Bay	213,087.00	147,143.64	65,943.36	1,031,420.00	315,850.63	715,569.37	781,512.73
CEI	828,464.00	314,925.89	513,538.11	3,371,400.00	1,010,674.81	2,360,725.19	2,874,263.30
Central	180,190.00	164,685.40	15,504.60	894,450.00	380,652.71	513,797.29	529,301.89
Gratiot	120,211.00	25,985.35	94,225.65	422,690.00	107,496.36	315,193.64	409,419.29
Huron	4,159.00	-	4,159.00	108,038.00	7,541.72	100,496.28	104,655.28
Ionia	133,025.00	40,100.55	92,924.45	328,222.00	110,337.31	217,884.69	310,809.14
Lifeways	259,944.00	251,089.88	8,854.12	1,539,513.00	586,058.89	953,454.11	962,308.23
Montcalm	33,661.00	10,693.48	22,967.52	203,794.00	30,058.04	173,735.96	196,703.48
Newaygo	38,837.00	28,446.98	10,390.02	157,900.00	70,684.76	87,215.24	97,605.26
Saginaw	625,447.00	208,207.67	417,239.33	3,416,558.00	561,362.79	2,855,195.21	3,272,434.54
Shiawassee	140,758.00	73,037.63	67,720.37	520,275.00	179,184.99	341,090.01	408,810.38
Tuscola	74,557.00	45,447.29	29,109.71	249,865.00	60,396.32	189,468.68	218,578.39
Total	2,652,340.00	1,309,763.76	1,342,576.24	12,244,125.00	3,420,299.33	8,823,825.67	10,166,401.91

① Potential Payments To CMHSPs

Oct - Dec* MDHHS will fully cost settle with MSHN for all CMHSP reported expenditures by 9.30.17

Jan - Sept+ MDHHS will cost settle for administrative and assessment expense by 9.30.17. All other services will be subject to MDHHS rate screens with any excess expense being covered by Medicaid savings.

AUTISM PAYMENTS									
Autism Revenue Sent to CMHSPs									
Payment Month	Mar 2016	Apr 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Total
Date of Service Month	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	
Bay	49,297.33	49,297.33	48,548.98	52,282.87	57,748.14	65,499.73	67,068.57	73,251.32	462,994.27
CEI	157,837.12	154,415.40	2,673.37	200,320.24	203,582.70	194,045.85	206,439.45	206,286.57	1,325,600.70
Central	54,752.36	52,078.99	57,854.05	56,772.00	74,394.48	77,740.45	84,050.93	87,694.85	545,338.11
Gratiot	-	2,673.37	23,311.98	30,505.30	30,505.30	13,133.35	15,813.44	17,538.97	133,481.71
Huron	-	-	-	-	-	3,262.46	4,279.26		7,541.72
Ionia	13,366.85	13,366.85	13,366.85	18,515.11	21,861.08	21,861.08	23,952.64	24,147.40	150,437.86
Lifeways	85,336.10	81,914.38	83,839.40	100,410.65	108,162.24	113,794.53	135,286.39	128,405.08	837,148.77
Montcalm	2,673.37	2,673.37	5,346.74	6,524.92	3,262.46	3,262.46	9,340.12	7,668.08	40,751.52
Newaygo	7,700.08	10,373.45	10,373.45	9,870.89	15,336.16	13,133.35	17,008.20	15,336.16	99,131.74
Saginaw	71,969.25	60,099.10	76,139.32	93,802.22	96,005.03	106,042.94	128,964.36	136,548.24	769,570.46
Shiawassee	25,237.00	22,563.63	25,237.00	33,767.76	39,233.03	36,054.08	37,338.50	32,791.62	252,222.62
Tuscola	16,040.22	16,040.22	13,366.85	13,049.84	13,049.84	13,049.84	8,196.96	13,049.84	105,843.61
Total	**484,209.68**	**465,496.09**	**360,057.99**	**615,821.80**	**663,140.46**	**660,880.12**	**737,738.82**	**742,718.13**	**4,730,063.09**

Exhibit B

AUTISM EXPENSE COMPARISON						
	FY 2015	FY 2016			Incr (Decr) FY 15 - FY 16	% Change in Expense
		Oct - Dec*	Jan - Sept+	Total		
	Col A	Col B	Col C	Col D (B+C)	Col E (D-A)	Col F (E/A)
Bay	445,238.00	213,087.00	1,031,420.00	1,244,507.00	799,269.00	179.52%
CEI	2,033,356.00	828,464.00	3,371,400.00	4,199,864.00	2,166,508.00	106.55%
Central	736,568.00	180,190.00	894,450.00	1,074,640.00	338,072.00	45.90%
Gratiot	546,535.00	120,211.00	422,690.00	542,901.00	-3,634.00	-0.66%
Huron	3,579.33	4,159.00	108,038.00	112,197.00	108,617.67	3034.58%
Ionia	298,988.00	133,025.00	328,222.00	461,247.00	162,259.00	54.27%
Lifeways	584,057.00	259,944.00	1,539,513.00	1,799,457.00	1,215,400.00	208.10%
Montcalm	19,365.00	33,661.00	203,794.00	237,455.00	218,090.00	1126.21%
Newaygo	159,549.00	38,837.00	157,900.00	196,737.00	37,188.00	23.31%
Saginaw	1,399,101.00	625,447.00	3,416,558.00	4,042,005.00	2,642,904.00	188.90%
Shiawassee	429,532.76	140,758.00	520,275.00	661,033.00	231,500.24	53.90%
Tuscola	310,302.00	74,557.00	249,865.00	324,422.00	14,120.00	4.55%
Total	6,966,171.09	2,652,340.00	12,244,125.00	14,896,465.00	7,930,293.91	

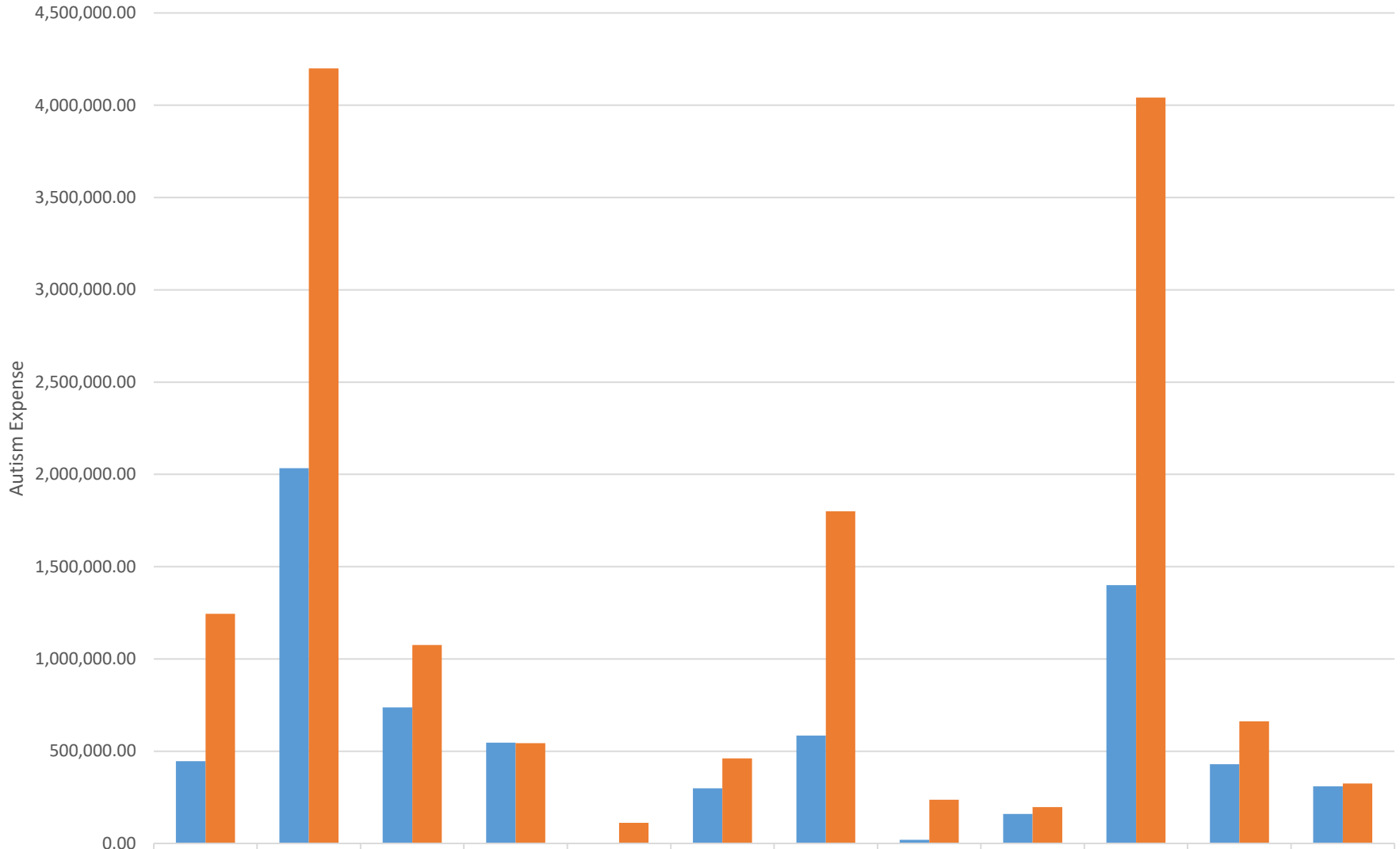
Oct - Dec* MDHHS will fully cost settle with MSHN for all CMHSP reported expenditures by 9.30.17

Jan - Sept+ MDHHS will cost settle for administrative and assessment expense by 9.30.17. All other services will be subject to MDHHS rate screens with any excess expense being covered by Medicaid savings.

Autism Consumers Served by CMHSP				
	FY 2015	FY 2016	Incr (Decr) FY 15 - FY 16	% Change in Cons Served
	Col A	Col B	Col C (B-A)	Col D (C/A)
Bay	28	105	77	275.00%
CEI	118	189	71	60.17%
Central	53	107	54	101.89%
Gratiot	17	41	24	141.18%
Huron	1	6	5	500.00%
Ionia	17	26	9	52.94%
Lifeways	58	103	45	77.59%
Montcalm	11	25	14	127.27%
Newaygo	18	55	37	205.56%
Saginaw	85	194	109	128.24%
Shiawassee	21	35	14	66.67%
Tuscola	16	41	25	156.25%
Total	443	927	484	

FY 15 and FY 16 Autism Cost by CMHSP
Mid-State Health Network

Exhibit C



	Bay	CEI	Central	Gratiot	Huron	Ionia	Lifeways	Montcalm	Newaygo	Saginaw	Shiawassee	Tuscola
FY 2015	445,238.00	2,033,356.	736,568.00	546,535.00	3,579.33	298,988.00	584,057.00	19,365.00	159,549.00	1,399,101.	429,532.76	310,302.00
FY 2016	1,244,507.	4,199,864.	1,074,640.	542,901.00	112,197.00	461,247.00	1,799,457.	237,455.00	196,737.00	4,042,005.	661,033.00	324,422.00

Background:

A compliance examination by an independent auditing firm examines the degree to which MSHN has established internal controls sufficient to detect and prevent fraud and to operate its organization in compliance with state and federal laws and regulations, including requirements of its contracts with MDHHS and other payers. The independent auditing firm is retained by and responsible to the board of directors. The auditing firm's responsibility is to express an opinion on management's operations and related compliance matters and to report non-compliance.

The compliance examination was recently completed for fiscal year 2015 by Rosland Prestage & Company. The report was due to MDHHS by June 30, 216. MSHN's compliance examination cannot be completed until all twelve Community Mental Health Services Programs' compliance examinations are completed and on file with MSHN. Community Mental Health for Clinton-Eaton-Ingham did not submit a completed compliance examination until November 2016.

The opinion rendered by Rosland Prestage & Company, that MSHN complied in all material respects, with known compliance requirements, is the highest that can be achieved. There were no known control deficiencies, non—compliance with statutory, regulatory or contractual provisions, and no known fraud.

Recommended Motion:

The MSHN Board of Directors receives and files the Fiscal Year 2015 Compliance Examination, as presented.

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT ACCOUNTANT'S REPORT ON COMPLIANCE

Mid-State Health Network
Lansing, Michigan

Report On Compliance
We have examined Mid-State Health Network's (the Entity) compliance with the requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Community Health that could have a direct and material effect on its Medicaid Contract, General Fund Contract, and Community Mental Health Services Block Grants (including various programs included therein) for the year ended September 30, 2015.

Management's Responsibility
Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its Medicaid Contract, General Fund Contract, and Community Mental Health Services Block Grants (including various programs included therein).

Independent Accountants' Responsibility
Our responsibility is to express an opinion on compliance of the Entity's Medicaid Contract, General Fund Contract, and Community Mental Health Services Block Grants (including various programs included therein), based on our examination of the compliance requirements referred to above.

We conducted our examination of compliance in accordance with attestation standards established by the American Institute of Certified Public Accountants. An examination includes examining, on a test basis, evidence supporting the Entity's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our examination provides a reasonable basis for our opinions on compliance for the Medicaid Contract, General Fund Contract, and Community Mental Health Services Block Grants (including various programs included therein). However, our examination does not provide a legal determination of the Entity's compliance.

Opinion on Each Program
In our opinion, the Entity complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its Medicaid Contract, General Fund Contract, and Community Mental Health Services Block Grants (including various programs included therein) for the year ended September 30, 2015.

Other Matters
The results of our examination procedures disclosed instances of noncompliance, which are required to be reported in accordance with *Compliance Examination Guidelines* and which are described in the accompanying Comments and Recommendations as item 2015-01. Our opinion on each program is not modified with respect to these matters.

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

Report on Internal Control Over Compliance
Management is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our examination of compliance,

we considered the Entity's internal control over compliance with the types of requirements that could have a direct and material effect on the Medicaid Contract, General Fund Contract, and Community Mental Health Services Block Grants (including various programs included therein) to determine the examination procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Entity's internal control over compliance.

A *deficiency in internal control* over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, on a timely basis. A *material weakness in internal control* over compliance is a deficiency, or a combination of deficiencies, in internal control over compliance such that there is reasonable possibility that material noncompliance will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* in internal control over compliance is a deficiency, or a combination of deficiencies, in internal control over compliance that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses.

The Entity's response to the internal control over compliance finding identified in our examination is described in the accompanying comments and recommendations. The Entity's response was not subjected to the procedures applied in the examination of compliance and, accordingly, we express no opinion on the response.

Purpose of this Report
The purpose of this report on internal control over compliance is solely to describe the scope of our consideration of internal control over compliance. Accordingly, this report is not suitable for any other purpose.

This report is intended solely for the use of the board and management of the Entity and the Michigan Department of Community Health and is not intended to be, and should not be, used by anyone other than these specified parties.

Roslund, Prestage & Company, P.C.

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

November 17, 2016

During our compliance audit, we may have become aware of matters that are opportunities for strengthening internal controls, improving compliance and increasing operating efficiency. These matters are **not** individually or cumulatively material weaknesses in internal control over the Medicaid Contract, General Fund Contract, and Community Mental Health Services Block Grants (including various programs included therein). Furthermore, we consider these matters to be immaterial deficiencies, not findings. The following comments and recommendations are in regard to those matters.

2015-01 FSR Examination Adjustments

Criteria or specific requirements:
The FSR must include revenues and expenditures in proper categories and follow the reporting instructions. (Contract Section 6.6.1)

Condition:
Mid-State Health Network is not in compliance with FSR instructions.

Examination adjustments:
Examination adjustments were made to the following forms: Medicaid CRCS, Medicaid Contract Settlement Worksheet, Medicaid FSR and Healthy Michigan FSR. See detailed descriptions of these examination adjustments in the Explanation of Examination Adjustments section of this report.

Context and perspective:
Management was aware of the Financial Status Report reporting rules. These examination adjustment were as a result of changes to affiliate CMHSPs' reporting.

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

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

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

Planned corrective action:
MSHN will continue to consult with its CMHSP CFOs regarding all reporting matters. MSHN will also send draft FSRs to its affiliate CFOs to re-confirm numbers they have provided.

Responsible party:
MSHN's Finance Council (Chairperson – Leslie Thomas, MSHN CFO)

Anticipated completion date:
February 28, 2017 (to coincide with the final reporting for FY 2016)

Background:

In accordance with the MSHN Board of Directors to review financials, at a minimum quarterly, the preliminary Statement of Net Position and the Statement of Activities for the Period Ending November 30, 2016 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 the Statement of Activities for the Period Ending November 30, 2016 as presented.

Mid-State Health Network
Statement of Activities
As of November 30, 2016

	Budget Annual	Actual Year-to-Date	Budget Year-to-Date	Budget Difference	Budget Variance	
	FY 17 Orig Budget		FY 17 Orig Budget			
Revenue:						
Medicaid Use of Carry Forward	$ 22,612,720	$ 2,146,245	$ 3,768,787	$ (1,622,542)	(43.05) %	1a
Medicaid Capitation	501,381,646	80,142,052	$ 83,563,607	(3,421,555)	(4.09) %	1b
Local Contribution	3,934,868	928,859	$ 655,812	273,047	41.63 %	1c
Interest Income	87,630	83,411	$ 14,605	68,806	471.11 %	1d
Change in Market Value	0	(57,825)	$ 0	(57,825)	0.00 %	
Non Capitated Revenue	14,255,086	2,296,352	2,375,847	(79,495)	(3.35) %	1e
Total Revenue	542,271,950	85,539,094	90,378,658	(4,839,564)	(5.35) %	
Expenses:						
PIHP Administration Expense:						
Compensation and Benefits	3,459,017	391,019	576,503	(185,484)	(32.17) %	
Consulting Services	180,000	50,549	30,000	20,549	68.50 %	
Contracted Services	118,750	8,235	19,791	(11,556)	(58.39) %	
Board Member Per Diems	5,900	2,380	984	1,396	141.87 %	
Meeting and Conference Expense	186,695	21,063	31,115	(10,052)	(32.31) %	
Liability Insurance	31,650	2,500	5,275	(2,775)	(52.61) %	
Facility Costs	148,950	21,456	24,825	(3,369)	(13.57) %	
Supplies	166,030	29,686	27,672	2,014	7.28 %	
Other Expenses	1,217,199	101,073	202,867	(101,794)	(50.18) %	
Subtotal PIHP Administration Expenses	5,514,191	627,961	919,032	(291,071)	(31.67) %	2a
CMHSP and Tax Expense:						
CMHSP Participant Agreements	436,408,782	69,246,846	72,734,797	(3,487,951)	(4.80) %	1b
SUD Provider Agreements	33,555,086	5,608,262	5,592,514	15,748	0.28 %	1b
Benefits Stabilization	0	2,146,245	0	2,146,245	0.00 %	1a
Other Contractual Agreements	1,439,243	162,386	239,874	(77,488)	(32.30) %	2b
Tax - Local Section 928	3,934,868	928,859	655,811	273,048	41.64 %	1d
Taxes-Use/HICA/HRA	41,311,031	6,482,505	6,885,172	(402,667)	(5.85) %	2c
Subtotal CMHSP and Tax Expenses	516,649,010	84,575,103	86,108,168	(1,533,065)	(1.78) %	
Total Expenses	522,163,201	85,203,064	87,027,200	(1,824,136)	(2.10) %	
Excess of Revenues over Expenditures	$ 20,108,749	$ 336,030	$ 3,351,458	$ (3,015,428)		

Mid-State Health Network
Statement of Net Position
As of November 30, 2016

Assets		
Cash and Short-term Investments		
Chase Checking Account	10,743,371	1a
Chase MM Savings	1,003,354	
Savings ISF Account	6,171,911	1b
Savings PA2 Account	9,612,442	1c
Investment PA2 Account	0	
Investment ISF Account	11,640,768	1b
Petty Cash on Hand	200	
Total Cash and Short-term Investments	$ 39,172,046	
Accounts Receivable		
Due from MDHHS	8,106,303	2a
Due from CMHSP Partipants	17,267,522	2b
Due from CMHSP	18,000	2c
Due from other governments	722,596	2d
Due from miscellaneous	0	
Total Accounts Receivable	26,114,421	
Prepaid Expenses		
Prepaid Expense Other	0	
Total Prepaid Expenses	0	
Total Assets	**$ 65,286,467**	
Liabilities and Net Position		
Liabilities		
Accounts Payable	$ 2,101,218	1a
Current Obligations (Due To Partners)		
Due to State	172,009	3d
Other Payable	2,957,739	3e
Due to State-Use Tax	768,305	1a
Due to State HRA Accrual	1,307,973	
Due to State HICA Accrual	577,997	
Due to Statel Local Obligation	(54,858)	3f
Due to CMHSP Participants	6,353,092	3a
Accrued PR Expense Wages	35,363	3b
Accrued Benefits PTO Payable	146,545	
Total Current Obligations (Due To Partners)	12,264,165	
Deferred Revenue	25,234,236	1c 2a 3a
Total Liabilities	39,599,619	
Net Position		
Unrestricted	7,874,170	3c
Restricted for Risk Management	17,812,678	1b
Total Net Position	25,686,848	
Total Liabilities and Net Position	**$ 65,286,467**	

MID-STATE HEALTH NETWORK
SCHEDULE OF INTERNAL SERVICE FUND INVESTMENTS
As of November 30, 2016

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY
FEDERAL HOME LOAN BANK	3130A6K71	9.29.15	10.5.15	10.5.17	10.5.16	1,000,000.00	1,000,000.00	0.730%
HARTLAND MICH CONS SCH DISTRICT	416848VT3	6.23.16	6.28.16	5.1.17	no	1,004,237.08	1,001,298.00	0.710%
JP MORGAN COMMERCIAL PAPER	46640PQL0	6.23.16	6.23.16	3.20.17	no	992,875.00	992,875.00	0.957%
FEDERAL HOME LOAN MTG	3134G9VV6	7.22.16	7.25.16	1.12.18	10.12.16	1,000,306.94	1,000,000.00	0.850%
FEDERAL HOME LOAN MTG	3134G9P43	7.13.16	7.26.16	1.26.18	10.26.16	1,000,000.00	1,000,000.00	0.750%
FEDERAL HOME LOAN MTG	3134G9N60	7.18.16	7.27.16	7.27.18	10.27.16	1,000,000.00	1,000,000.00	1.000%
FEDERAL HOME LOAN MTG	3134G9Q83	7.21.16	7.27.16	7.27.18	1.27.17	1,000,000.00	1,000,000.00	0.750%
FEDERAL NATIONAL MTG ASSOC	3135G0M75	7.13.16	7.27.16	7.27.18	7.27.17	1,000,000.00	1,000,000.00	0.875%
LAKEVIEW MI SCHOOLS	512264HJ4	6.28.16	7.1.16	5.1.17	no	1,044,843.33	1,018,323.00	0.600%
NORTH BRANCH MI SCHOOLS	657740FP6	7.14.16	7.27.16	5.1.19	no	635,115.60	634,495.00	1.450%
MICHIGAN ST GO SCHOOL	5946106V4	8.15.16	8.18.16	4.15.17	no	1,031,638.33	1,011,150.00	0.501%
FEDERAL HOME LOAN MTG	3130A9AH4	8.24.16	9.6.16	9.6.18	12.6.16	1,000,000.00	1,000,000.00	1.000%
JP MORGAN INVESTMENTS							11,658,141.00	
JP MORGAN CHASE SAVINGS							6,022,462.21	0.050%
							$ 17,680,603.21	

Notes to Financial Statements

For the Two Month Period Ended November 30, 2016

Please note: The Statement of Net Position contains Fiscal Year 2016 potential 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. Cost settlement figures were extracted from Financial Status Report Projections submitted to MDHHS in November 2016. Final figures may vary.

Statement of Net Position:

1. Cash and Short Term Investments
    a) The Cash Chase Checking and Chase Money Market Savings accounts include $3.5 million of PA2 and $8.2 million of cash available for operations. They also include $2.1 million for the balance due to CMHSPs for November Medicaid with an offsetting liability in Accounts Payable. There is an additional $1.88 million for taxes with an offset to the Use and HICA tax liability accounts.
    b) The Savings ISF and Investment ISF reflect designated accounts to hold the Medicaid ISF funds separate from all other funding per the MDHHS contract. This total of $17.8 million generally offsets the Restricted for Risk Management net position account. Per Executive Committee approval on behalf of the Board of Directors the Restricted Risk Reserve amount has been decreased by more than $9 million dollars to settle Fiscal Year 2016 Autism obligations. This ISF abatement will alleviate risk to CMHSPs associated with the Autism program due to the State's payment lag. MSHN has also included language related to the ISF abatement in the Risk Management Plan submitted to MDHHS.
    c) The Savings PA2 and Investment PA2 Accounts hold the remaining $9.6 million of PA2 funds and is also offset by the Deferred Revenue liability account. The remaining portion of deferred revenue relates to Medicaid and Healthy Michigan cost settlement activity with the CMHSPs.
2. Accounts Receivable
    a) The amount reflects retro-active payments due to MSHN for Habilitation Supports Waiver (HSW) and Autism.
    b) Due from CMHSP Participants reflect CMHSP potential cost settlement figures. This figure also includes actual Fiscal Year 2015 balances owed to MSHN from one CMHSP.
    c) The Due from CMHSP account is used to track payments owed to MSHN from the CMHSPs for activities other than service provision and cost settlement. The balance in this account reflects amounts owed by one CMHSP for ZTS licenses.
    d) The amount in Due from other governments consists of Fiscal Year 2016 PA2 payments received in Fiscal Year 2017.
3. Liabilities
    a) This amount reflects estimated amounts owed to CMHSPs for FY 2016 cost settlement amounts.

b) Accrued Benefits PTO (Paid Time Off) payable is the liability account set up to reflect paid time off balances for the employees. It also reflects the portion of November payroll expense paid in December.
c) Unrestricted Net Position represents the difference between totals assets, total liabilities, and the restricted for risk management figure.
d) This amount represents estimates for FY 2016 recoupments.
e) The majority of this amount is related to SUD provider payment estimates and is needed to offset the timing of payments.
f) MSHN pays MDHHS for the Local obligations on or before the due date. In most cases our CMHSPs reimburse MSHN for its portion in the month the payment is sent. In this particular case, two CMHSPs sent their payments in December.

Statement of Activities:

1. Revenue
    a) Medicaid Use of Carry Forward is Medicaid Savings sent to the CMHSPs that are receiving Benefit Stabilization payments to balance their 2017 budgets. The amount of Benefit Stabilization is determined by MSHN's smoothing plan for that fiscal year. We are under budget in this area because the CMHSPs requiring benefit stabilization dollars is less than the amount saved from the prior year.
    b) Medicaid Capitation – we have received $3.4 million less than the budgeted Medicaid amount. This variance is related to the incorrect October Healthy Michigan capitation amount not being paid correctly until December. Another factor related to this variance is the use of 1115 waiver rates being used for Habilitation Supports Waiver (HSW) budgeting purposes. 1115 has been federally approved but not yet implemented and thus funding reflects the most recent approved HSW rates. In addition, there is currently a five-month lag in Autism payments. Although estimates have been added to general ledger for interim payments there are still outstanding amounts not included for the fiscal year-end settlement. The final cost settlement generally occurs more than a year after the fiscal cycle. The expense side of this activity is listed under CMHSP Participant Agreements and SUD provider agreements.
    c) Local Contribution is flow-through dollars from CMHSPs to MDHHS. Typically, revenue equals the expense side of this activity under Tax Local Section 928.
    d) Interest income will now reflect interest earned on investments. A change in market account has been created to record and more clearly identify market fluctuations and changes in principle for investments purchased at discounts or premiums.
    e) This is a new account created to track non-capitated payments which include Community Grant and PA2 funds.
2. Expense
    a) Total PIHP Administration Expense is currently under budget. Recurring expenses have been added to the general ledger in order to provide a clear picture of outstanding obligations. Expense budgeted for the procurement of MSHN's Managed Care Information System (MCIS) and some staff positions added to the budget have not been filled which is also adding to the favorable variance.
    b) Other contractual agreements are under budget. Recurring expenses have been added to the general ledger.
    c) HRA, HICA and Use taxes are slightly lower than budget amounts. This condition follows the amount of revenue received which for this Fiscal Year has been less than anticipated.

Background:

To comply with the MSHN Corporate Compliance Plan, specifically as it relates to the review of the Annual Compliance Report that states:

> "The MSHN 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."

Recommended Motion:

The MSHN Board of Directors has reviewed and acknowledges receipt of the Annual Compliance Summary Report for the period of October 1, 2015 – September 30, 2016, as presented.

Compliance Summary Report

October 2015 – September 2016

Prepared By: MSHN Compliance Officer – December 11, 2016
Approved By: MSHN Compliance Committee – December 14, 2016
MSHN Board –
Reviewed By: Quality Improvement Council –
Operations Council –

Monitoring and Auditing

Internal Audits

CMHSP Delegated Managed Care Functions & Program Specific Audits

The 2016 interim-year audit consisted of a review of corrective action plans established by CMHSP's and approved by MSHN in 2016, new standards review, and BH-TEDS reporting. CMHSP's provided supporting evidence to demonstrate implementation of the corrective action plan and compliance with the standards for which there were findings.

The new standards that went into effect for FY16 included staff training requirements, implementation of the 24/7/365 access standards, and autism/ABA requirements.

CEI in its capacity as the QI/BH-TEDS/Encounter contractor continues to audit the DD Proxy portion of the QI review. This year, they assessed each CMHSP's readiness for reporting BH-TEDS. Any findings and future plans the CMHSP's provided have been documented in the respective CMHSP final audit report.

As of November 14, 2016, MSHN staff completed twelve (12) reviews, with all CMHSP's showing substantial or full compliance with standards requiring follow-up from 2015, new standards for 2016, and BH-TEDS reporting.

In 2017, MSHN will conduct its biennial full review of all DMC and program specific standards.

SUD Delegated Managed Care Functions & Program Specific Audits

MSHN began conducting reviews of substance use disorder treatment and prevention providers in 2016 and is establishing baseline data. The review consists of delegated managed care functions as well as clinical chart reviews (treatment providers only) for program specific standards (i.e. outpatient, medication assisted treatment, and residential programs). With over sixty (60) provider agencies (some with multiple facilities) in MSHN's network, approximately half of the facilities are undergoing a full on-site review in 2016. As of November 14, 2016, twenty-nine (29) reviews were completed with another seven (7) scheduled to be completed by December 31, 2016. In 2017, the remaining facilities will undergo a full on-site review. Additionally, MSHN staff will conduct a follow-up of corrective action plans developed and approved in 2016.

Initial baseline data shows regional compliance scores as follows:

- Delegated Managed Care Standards – 73%
- Consumer Chart Standards – 72%
- Medication Assisted Treatment Program Specific Standards – 80%
- Residential Program Specific Standards – 80%
- Prevention Program Standards – 88%

Findings are issued and corrective action plans are required for standards that fall below 85% compliance. Corrective action plans will be reviewed during interim year reviews, unless the nature of the finding warrants a focused follow-up to ensure consumer safety. A common area of non-compliance is in the development of treatment/recovery plans and progress notes. MSHN's clinical team has conducted a regional training on treatment plan and progress note development and documentation.

MSHN honors the reciprocity of monitoring and evaluation conducted by other PIHP's for out-of-network providers. MSHN collects, reviews, and maintains current copies of annual site review reports and likewise, shares annual site review reports with other PIHP's.

External Audits

MDHHS Habilitation Supports Waiver Site Visit Report: July 18th – August 26th

The Habilitation Supports Waiver (HSW) site review was conducted in coordination with the Waiver for Children with Serious Emotional Disturbance (SEDW) and the Children's Waiver Program (CWP). The SEDW and CWP is the responsibility of the CMHSP and therefore not included in the MSHN summary report. The HSW review was completed by the Michigan Department of Health and Human Services (MDHHS) for 2016 from July 18th through August 26th, 2016. This was a full site review to measure compliance with the service delivery requirements of the 1915 (c) waivers.

The 2016 site review included the review of beneficiary files, staff records and home visits.

Total Cases Reviewed (76)
Total Licensed Staff Records Reviewed (211)
Total Non-Licensed Staff Records Reviewed (827)
Total Home Visits (11)

Summary of the findings:

A. Administrative Procedures (5 Elements): 83%
B. Freedom of Choice (2 Elements): 98%
C. Implementation of Person Centered Planning (7 Elements): 96%
D. Plan of Service and Documentation Requirements (3 Elements): 98%
E. Behavior Treatment Plans and Review Committees (2 Elements): 50%
F. Staff Qualifications (4 Elements): 95%
G. Home Visits/Training/Interviews: Specific to Home

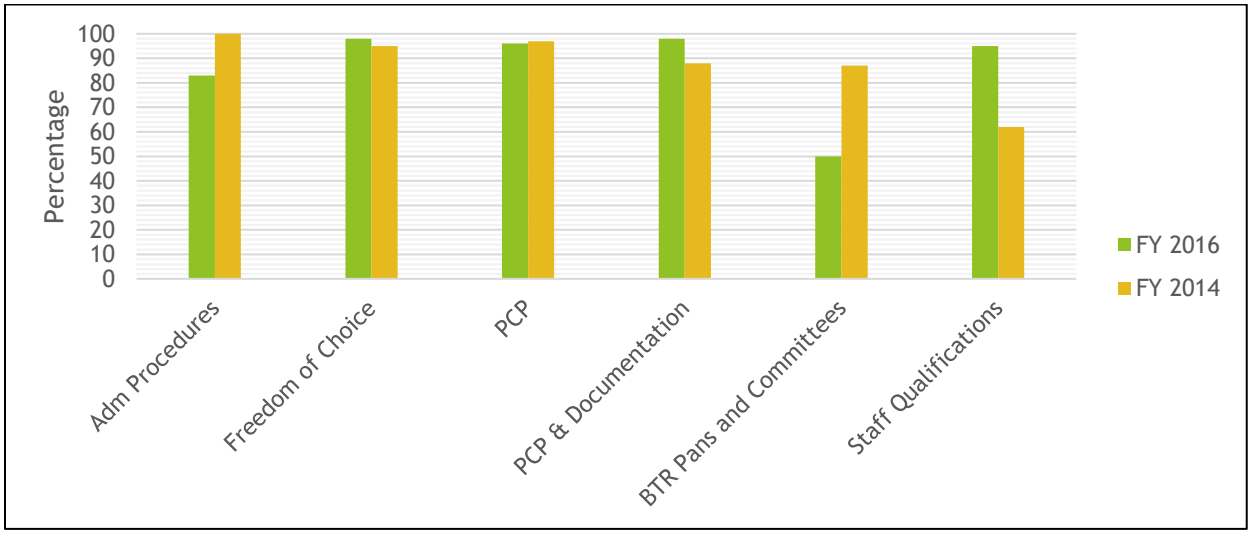
Note: The percentages were calculated by dividing the total number of charts that received a score of "yes" (full compliance) by the total number of charts that received a score of "no" (less than full compliance) for all elements in each section.

Next Steps:

MSHN is required to submit a plan of correction to MDHHS for any element that was identified as not being in "Full Compliance." MSHN submitted the plans of correction as required by October 20, 2016 and the plan of correction was approved as submitted. MSHN will continue to work with the regional Habilitation Supports Workgroup to ensure implementation of the corrective action plan.

Comparison of Results (Full Review) for FY2014 and FY2016:

(MDHHS completes a full review every two years)



MDHHS Substance Use Site Review Report: July 18th

The Michigan Department of Health and Human Services (MDHHS) completed a review at Mid-State Health Network (MSHN) on July 18, 2016 to determine compliance with the Substance Use Agreement with the Centers for Medicare and Medicaid Services. The purpose was to review compliance with established standards as well as serve as a quality improvement opportunity to provide technical assistance with the provision of SUD services. The review was completed as a desk audit, as well as an on-site review. The desk audit consisted of the review of supporting documentation to show compliance with each of the identified standards. The on-site review consisted of follow up on any standards that needed clarification from the desk audit as well as discussion with MSHN staff on our process and procedures for providing oversight and monitoring for the provider network.

Summary of Compliance with Standards:
The following information identifies the standards that were reviewed and the score received.
(Scoring: 2 = Full Compliance; 1 = Partial Compliance; 0 = Non-Compliance)

1. Contracting – ***2***
2. Annual Evaluation of SUD Services – ***1***
3. Selected Specific Block Grant Requirements Applicable to PIHPs – ***2***
4. Licensure of Subcontractors – **2**
5. Accreditation of Subcontractors -***2***
6. Subcontractor Information to be Retained at the PIHP - ***2***
7. 12- Month Availability of Services – ***2***
8. Primary Care Coordination – ***1***
9. Charitable Choice - ***2***
10. Women's Specialty Services Federal Requirements - ***2***
11. Women's Specialty Services Requirements Regarding Providers - ***2***
12. Fetal Alcohol Spectrum Disorders (FASD) Prevention Activities - ***2***
13. Fetal Alcohol Spectrum Disorders (FASD) Screening - ***2***

MSHN received an average compliance score of 1.85 which equates to 93% compliance for all standards reviewed.

Next Steps:
MSHN was required to submit a plan of correction to MDHHS for any standard that was identified as not being in "Full Compliance." MSHN submitted a plan of correction for standard 2 (Annual Evaluation of SUD Services) and standard 8 (Primary Care Coordination) as both received a score of "Partial Compliance." The submitted plan of correction was accepted by MDHHS.

For the two standards found to be in "partial compliance," MDHHS reviewed the annual site review findings for five (5) SUD provider agencies. MSHN was found to be in full compliance with the monitoring and review process, requiring plans of correction and making reports available for review. The partial compliance score was given due to the PIHP not completing the reviews of the entire provider network for FY16 at the time of the MDHHS site review.

MSHN will complete the current review cycle to ensure all SUD provider agencies receive an annual review and ensure ongoing monitoring of any required plans of correction.

This year is the first year MDHHS completed a SUD review of the PIHP. A year to year comparison for compliance with the standards will be completed during the next full review.

MDHHS Autism Site Visit:

The Michigan Department of Health and Human Services did not complete a review of the PIHP's for the Autism Benefit during FY16.

MDHHS – Health Services Advisory Group (HSAG) – Performance Measurement Validation Report: July 28th

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.

Data Collection and Analysis:

For this review, HSAG validated a set of performance indicators that were developed and selected by the Michigan Department of Health and Human Services (MDHHS). To conduct the on-site review, HSAG collected information using several methods including interviews, system demonstrations, review of data output files, primary source verification, observation of data processing and review of data reports.

Summary of Findings:

Performance Indicators (12 Elements): **100%**

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

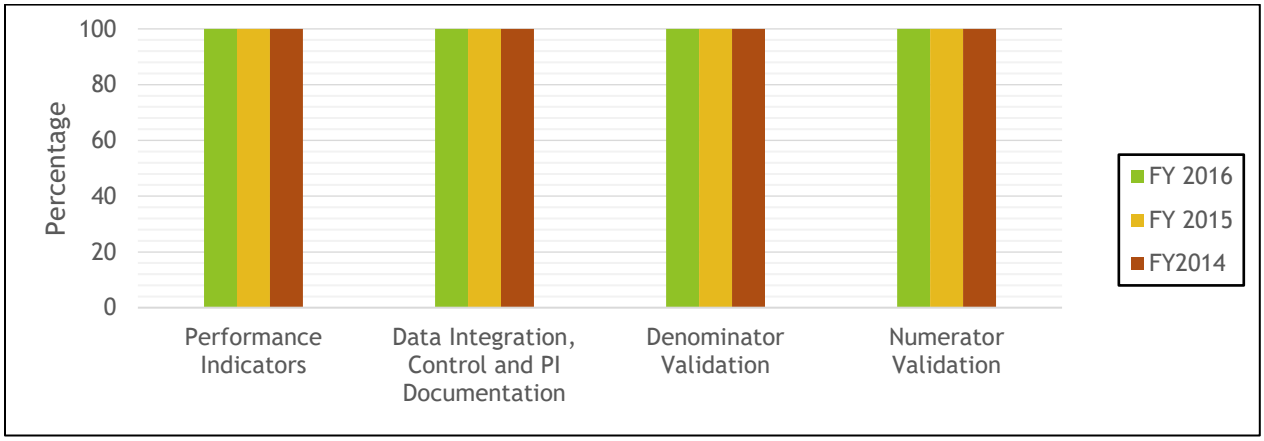
Data Integration, Data Control and Performance Indicator Documentation (13 Elements): **100%**
Denominator Validation Findings (7 Elements): **100%**
Numerator Validation of Findings (5 Elements): **100%**

Next Step(s):

MSHN will continue to monitor performance and review areas for improvement. No corrective action is required to be submitted to HSAG for this review.

Comparison of FY2014, FY2015 and FY2016 Results:

(HSAG completes a full review each year for the PMV site review)



MDHHS- Health Services Advisory Group – Compliance Monitoring Report: July 13th

The Compliance Monitoring Review is completed as a requirement of the Balanced Budget Act of 1997 (BBA), Public Law 105-33, which requires states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations, contractual requirements, and the state's quality strategy.

For the 2015–2016 compliance monitoring review, HSAG completed a follow up review assessing the PIHPs' compliance with federal regulations and contract requirements for the areas that required a plan of correction from the 2014-2015 review.

Summary of Findings:

The standards reviewed included:

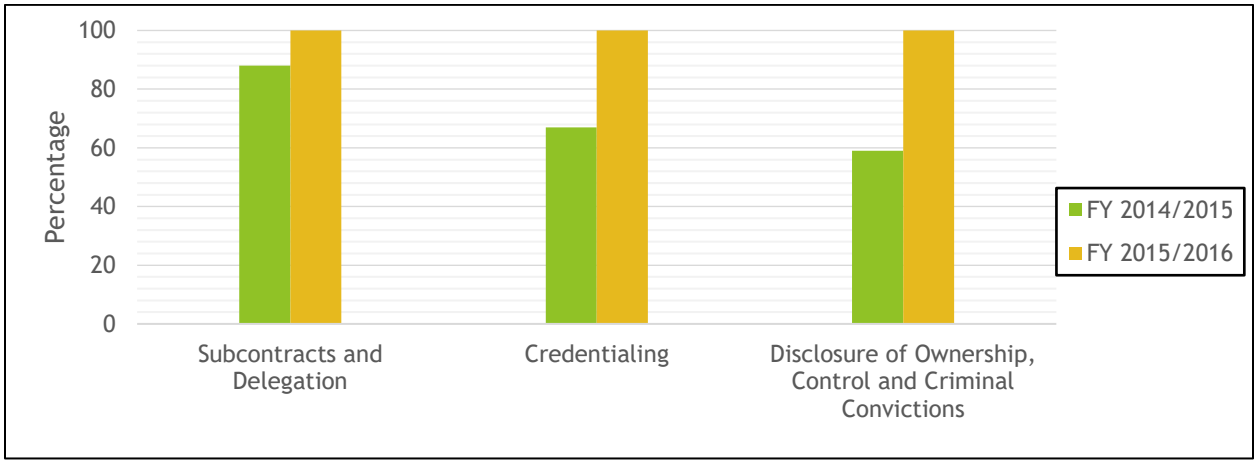
Standard IX: Subcontracts and Delegation (1 Element Reviewed): 100%
Standard XI: Credentialing (2 Elements Reviewed): 100%
Standard XV: Disclosure of Ownership, Control, and Criminal Convictions (6 Elements Reviewed): 100%

HSAG noted that MSHN showed strong performance by demonstrating full compliance in all standards reviewed and stated they were impressed by several of MSHN's forms and processes and noted the Disclosure of Ownership, Control and Criminal Convictions process as a best practice.

Next Steps:

MSHN is not required to submit a plan of correction as all standards were found to be in full compliance.

Comparison of FY2014/2015 and FY2015/2016 Results:
(HSAG completes a full review every other year for the Compliance Monitoring Review)



MDHHS – Health Services Advisory Group –Performance Improvement Project Report: Validation Year3: September 2016

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).

The PIP study topic is: *"Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications."*

The FY2015-2016 PIP Summary Report analyzed the data for Remeasurement One Period (October 1, 2014 – September 30, 2015) and reviewed the identified barriers, interventions and goals that were established by MSHN for Remeasurement Two Period (October 1, 2015 – September 30, 2016).

Summary of Results:

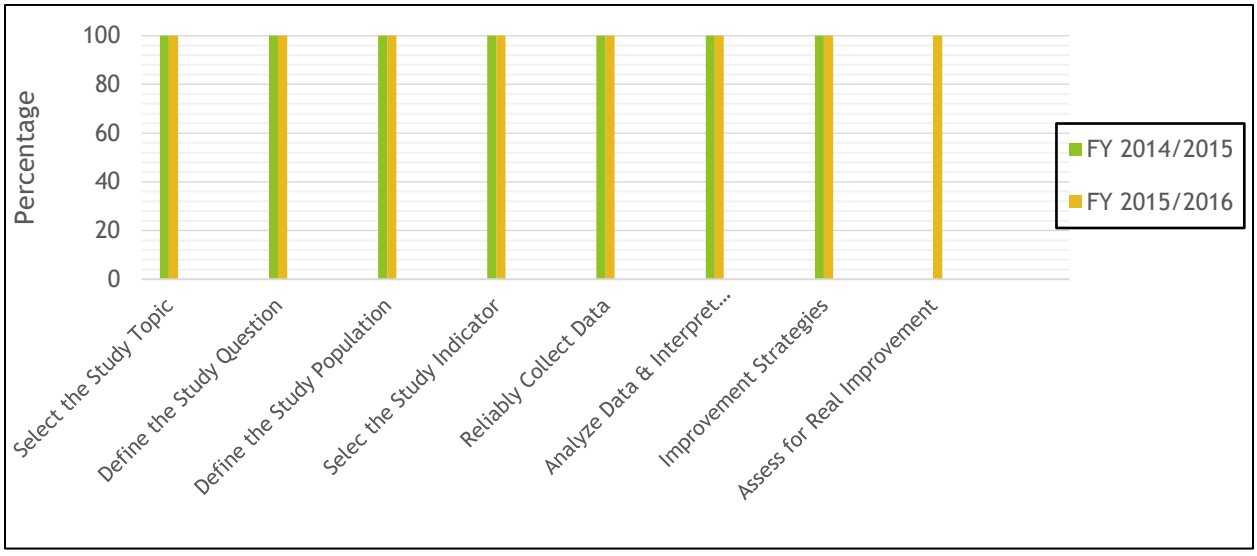
I. Select the Study Topic (2 Elements): 100%
II. Define the Study Question(s) (1 Element): 100%
III. Define the Study Population (1 Element): 100%
IV. Select the Study Indicator(s) (3 Elements): 100%
V. Use Sound Sampling Techniques (6 Elements): N/A for this study topic
VI. Reliably Collect Data (4 Elements): 100%
VII. Analyze Data and Interpret Study Results (8 Elements): 100%
VIII. Improvement Strategies (4 Elements): 100%
IX. Assess for Real Improvement (4 Elements): 100%
X. Assess for Sustained Improvement: Not assessed for this year

MSHN showed an increase from the Baseline Period of 73.7% to 77.5% for Remeasurement One Period. This demonstrated a statistically significant improvement of 3.8 percentage points above the baseline and exceeded the identified goal of reaching 75%.

Next Steps:

MSHN is not required to submit a plan of correction for the PIP. This project will continue to be implemented through FY2016/2017 to assess sustained improvement.

Comparison of FY2014/2015 and FY2015/2016 Validation Results:
(HSAG completes a full review each year for the PIP)



Note: Assessment for Real Improvement was not measured during the FY2014/2015 review

Complaint/Compliance Reporting

Total Customer Services Complaints: (264)

Origin of Complaint:

MDHHS (13), Consumer/Guardian/Family (74), MSHN Staff (12), CMHSP Staff (12), SUD Provider Staff (132), Court (2), Other (19)

Category of Complaint:

(the percentage indicates the percent the category represents of the total complaints)

Access to Treatment (51) *(19%)*
Authorizations (1) *(0.4%)*
CareNet Concerns (27) *(10%)*
Confidentiality (8) *(3.0%)*
Customer Services Reports (68) *(26%)*
Grievance and Appeals (68) *(26%)*
Provider Appeals (3) *(1.0%)*
Recipient Rights (17) *(6.0%)*
Treatment (8) *(3.0%)*
Other (Program Specific, Crisis Services, Reports, Finance, LEP, etc.) (13) *(5.0%)*

Conclusion/Resolution:

Resolved with the Consumer/Family (74)
Resolved with CMHSP/SUD Provider (144)
Resolved with MDHHS (13)
Resolved with MSHN (12)
Resolved with Other (Court System, etc) (21)

Total Compliance Concerns/Complaints: (20)

Origin of Complaint:

MDHHS (4), Consumer/Guardian (2), MSHN Staff (0), CMHSP Staff (13), SUD Provider Staff (1), Other (0)

Type of Complaint:

(the percentage indicates the percent the category represents of the total complaints)

Abuse/Neglect (1) *(5.0%)*
Audit/Review (1) *(5.0%)*
Confidentiality (1) *(5.0%)*
Credentialing/Qualifications (1) *(5.0%)*
Federal Inquiry (1) *(5.0%)*
Hospitalizations (2) *(10%)*
Suspected Fraud/Abuse (8) *(40%)*
Treatment/Services: (5) *(25%)*

Conclusion/Resolution:

Resolved with the Consumer (2)
Resolved with CMHSP/SUD Provider (10)
Resolved with MDHHS (3)
Referred to Office of Health Service Inspector General (OHSIG) (3)
Still Pending Resolution (5)

Compliance Line:

Compliance calls are received through the Compliance Line, the main line of MSHN or through the direct line to the Director of Customer Services, Compliance and Quality.

Customer Services Line:

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.

Training / Communication

Internal

Board of Directors

Received and approved MSHN Compliance Plan on November 1, 2016
Received Compliance Training on November 1, 2016

Regional Consumer Advisory Council

Received Compliance Training on June 10, 2016
Reviewed MSHN Compliance Plan Revisions on October 14, 2016

MSHN Quality Improvement Council

Reviewed and Approved MSHN Compliance Plan on August 25, 2016
Compliance Policies

MSHN Operations Council

Reviewed and Approved MSHN Compliance Plan on September 19, 2016
Compliance Policies

MSHN Staff

Received Compliance Training on September 8, 2016
Compliance Plan
Compliance Policies

External

MSHN Compliance Plan and Compliance Line Available on Website

MSHN Customer Service Line Available on Website

MSHN Contact information located in Consumer Member Handbook “Guide to Services”

MSHN FY16 - Board of Director's - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Actual Value	Target Value	Performance Level	Target Ranges		
Consumer Health Outcomes	Enrollees living independently or in supported living arrangements (Note now using BH-TEDS data)	85.9%	increase over 2015		72.3%	72.0%	70.0%
	Enrollees working or in supported employment arrangements Note now using BH-TEDS data)	17.2%	increase over 2015		12.3%	12.0%	11.5%
	Enrollees receiving an annual primary care assessment	71.2%	increase over 2015		80.3%	80.0%	78.0%
Customer Focus	Access& timeliness standards are met (MMBPIS)	99.0%	100%		95.0%	94.9%	90.0%
	MSHN's Medicaid penetration rate	8.55%	increase over 2015		8.72%	8.70%	8.60%
	The number of enrollees served with Primary SUD	16,566	increase over 2015		8,355	8,000	7,500
Budget, Financial & Market	MSHN reserves (savings & ISF)	8.78% Total	7.5% (Board approved target)		≥ 7% and ≤ 8%	≥ 6.5% and < 7% or >8% and ≤ 8.5%	< 6.5% or > 8.5%
	Performance actual to budget (%)	Jan 17 (prev. 97.4%)	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85%

MSHN FY16 - Board of Director's - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Actual Value	Target Value	Performance Level	Target Ranges		
Workforce, Provider Network & Strategic Partnership Focus	CMHSPs demonstrate an established 24-7-365 access services for individuals with primary SUD	100%	100%		100%	-	99% ≥
	MSHN has established an agreed upon performance improvement project with Medicaid Health Plans operating in the region	On target	increase over 2015		Ahead of target	On target	Behind target
	Number of learning communities within MSHN	5	increase over 2015		> 1	1	1 >
Process Effectiveness	MSHN strategic plan - progress to plan %	72%	84%		≥ 84%	84% > x > 74%	74% ≥
	Medicaid event verification demonstrates improvement over 2015 baseline (Note new PIHP process, FY 15 (97%) was a CMHSP process)	94%	increase over 2015		98%	96%	94%
Leadership	Board perception of communication and advocacy efforts	1	2014 baseline		≥ 76.9%	76.9% > x > 71.9%	71.9% ≥
	Policy/procedure review to plan (%)	86%	≥ 90%		≥ 90%	90% > x > 80%	80% ≥
	MSHN Leadership represents the region in planning meetings with MDHHS as required to meet contract and strategic planning goals.	1	2014 baseline		≥ 83.2%	83.2% > x > 78.2%	78.2% ≥

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 FY17 Contract Listing for Board approval and authorization of Chief Executive Officer signature.

Recommended Motion:

The MSHN Board authorizes its Chief Executive Officer to sign and fully execute the contracts, as presented and listed on the FY17 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2017 NEW AND RENEWING CONTRACTS
January 2017

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	ORIGINAL CONTRACT AMOUNT	FY 2017 TOTAL CONTRACT AMOUNT	INCREASE/ (DECREASE)
Michigan Rehabilitative Services (PA2)	**Vocational Rehabilitation Services** (Clinton, Eaton, Ingham & Shiawassee Counties)	10.1.16 - 9.30.17		**25,571**	25,571
PEC Technologies	**Health Innovation Grant Web Development & Management of current web based application**	1.1.17 - 9.30.17		**35,000**	35,000
TBD Solutions	**Quality Improvement/Information Systems Functional Area Analysis & Shared Service Arrangements**	11.1.16 - 2.28.17		**25,000**	25,000
			$ -	$ 85,571	$ 85,571

CONTRACTING ENTITY	SUD PROVIDERS FFS PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL FFS ESTIMATED CONTRACT AMOUNT	TOTAL FY17 FFS AMOUNT BASED ON UTILIZATION ESTIMATE	INCREASE/ (DECREASE)
CONTRACTS LISTED IN THIS SECTION ARE ALL FEE-FOR-SERVICE FUNDED AMOUNTS BASED ON ESTIMATE ONLY FOR UTILIZATION					
Saginaw County Community Mental Health	**Outpatient; Case Management; Integrated Treatment; SARF; Early Intervention** (pending receipt of license)	2.1.17 - 9.30.17		-	
Wedgwood Montcalm Christian Services	**Risk Reserve**	10.1.16 - 9.30.17	215,530	**265,530**	50,000

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL COST REIMBURSEMENT CONTRACT AMOUNT	FY 2017 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	INCREASE/ (DECREASE)
Addiction Solutions Counseling Center	**Alma Location: Outpatient; Women's specialty** (moving previously approved FFS estimated amount of $205,057 to Cost Reimbursement)	10.1.16 - 9.30.17	48,030	**253,087**	205,057
Arbor Circle	**Suboxone Program** (New program)	12.1.16 - 9.30.17	34,709	**72,962**	38,253
CEI Community Mental Health Authority	**Recovery Center Detox** ($197,560 = PA2); **Clinton County Counseling Center & CATS Program** (Continuing remainder of FY17 at FY16 funding levels)	Original term: 10.1.16-12.31.16 **Amended Term: 10.1.16-9.30.17**	248,617	**1,096,836**	848,219
Eaton Behavioral Health	**Outpatient, Recovery Support's** ($3,629 = PA2), **Women's Specialty**	Original term: 10.1.16-12.31.16 **Amended Term: 10.1.16-9.30.17**	145,993	**583,971**	437,978
Mid-Michigan Recovery Services	**Outpatient; Case Management; Peer Recovery Services & Family Court Participation** ($76,441 = PA2)	10.1.16 - 9.30.17	-	**463,052**	463,052
The Right Door for Hope, Recovery & Wellness (f.k.a. Ionia CMH)	**Outpatient Services** (Taking over Ionia Health Dept. treatment services caseload)	1.1.17 - 9.30.17	212,446	**284,821**	72,375
Wellness, Inx	**Public Supportive Housing Grant** (All PA2; Braided funding - Case Management & Peer Recovery Supports; For the remainder of FY17)	Original term: 10.1.16-12.31.16 **Amended Term: 10.1.16-9.30.17**	583,920	**666,240**	82,320
			$ 1,273,715	$ 3,420,969	$ 2,147,254