MSHN
Mid-State Health Network

Board of Directors Meeting

November 1, 2016 - 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 November 1, 2016

MSHN 16-17-0001: APPROVAL OF AGENDA FOR November 1, 2016

(*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 4.9.9, Pages 4-50)

MSHN 16-17-002: 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, 09.06.16 (Item 4.1)
- Approval of FY17 Budget Public Hearing Minutes, 09.06.16 (Item 4.2)
- Receive SUD-Oversight Policy Board Minutes, 08.17.16 (Item 4.3)
- Receive Board Executive Committee Minutes 09.16.16 (Item 4.4)
- Receive Board Executive Committee Minutes 10.21.16 (Item 4.5)
- Receive Board Policy Committee Minutes 10.07.16 (Item 4.6)
- Receive Operations Council Key Decisions 09.19.16 (Item 4.7)
- Receive Operations Council Key Decisions 10.17.16 (Item 4.8)
- Policy Approval (Items 4.9.1-4.9.9)
  - Compliance: Compliance Line 2.0 (4.9.1)
  - Compliance: External Quality Review 2.0 (4.9.2)
  - Compliance: Required Reporting 3.0 (4.9.3)
  - Compliance: Investigations Summary Reporting 1.0 (4.9.4)
  - Compliance: Compliance Reporting & Investigations 1.0 (4.9.5)
  - Compliance: Compliance & Program Integrity 2.0 (4.9.6)
  - Customer Service: Confidentiality/Notice of Privacy 2.0 (4.9.7)
  - Quality: Research 2.0 (4.9.8)
  - Quality: MMBPIS Performance Indicator 2.0 (4.9.9)

5. Board Meeting Follow-Up (09.06.2016): Overview of Substance Use Disorder (SUD) Services Financing Methods (Item 5, Pages 51-60)

6. Public Comment (3 minutes per person)

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

FY17 Board Meetings

- **January 10, 2017**
  Gratiot County CMH Services
  608 Wright Ave., Alma
- **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. MSHN Board Chair Update (Items 7.1-7.2, Pages 61-64)
    - Board Member Updates
    - Board Member Conduct Policy
    - MACMHB/PIHP FY17 Membership Renewal

MSHN 16-17-003 APPROVAL OF RENEWAL OF MACMHB FY17 MEMBERSHIP

8. Finance Report (Items 8.1-8.2, Pages 65-70)

    ACTION ITEM: FY16 Financial Report

MSHN 16-17-004: APPROVAL TO RECEIVE AND FILE FY16 FINANCIAL REPORT

9. MSHN Deputy Director Report

10. ACTION ITEM: MSHN Contract Listing (Items 10.1-10.3, Pages 71-74)

MSHN 16-17-005: APPROVAL OF FY17 CONTRACTS

MSHN 16-17-006: APPROVAL OF FY16 AMENDED CONTRACTS

11. ACTION ITEM: FY16 Compliance Plan Review and Approval (Items 11.1-11.2, Pages 75-104)

MSHN 16-17-006: APPROVAL TO REVIEW, RECIEIVE AND FILE THE FY16 COMPLIANCE PLAN

12. ACTION ITEM: FY16 Assessment of Network Adequacy (Items 12.1-12.2, Pages 105-164)

MSHN 16-17-007: APPROVAL TO RECEIVE AND FILE FY16 ASSESSMENT OF NETWORK ADEQUACY

13. MSHN Chief Executive Officer Report

14. ACTION ITEM: 2016 Chief Executive Officer (CEO) Performance Assessment (Items 14.1-14.2, Pages 165-174)

MSHN 16-17-008: APPROVAL TO REVIEW, RECEIVE AND FILE RESULTS OF THE 2016 BOARD CEO PERFORMANCE ASSESSMENT

15. Other Business

16. Public Comment (3 minutes per person)

17. 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
Kniceley	Ashley	Treatment Specialist
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		Director of Care Management

Mid-State Health Network (MSHN) Regional Board of Directors Meeting
Tuesday, September 6, 2016, 5:15 P.M.
Montcalm Area Independent School District (MAISD) – Michigan Room

Meeting Minutes

1. Call to Order

Chairperson Ed Woods called the MSHN Regional Board of Directors Meeting to order at 5:15 p.m.

Chairperson Woods advised of the passing of fellow Board Member, Nick Lawson; a moment of silence was called in his memory.

Vice-Chairperson Irene O'Boyle introduced Ms. Tina Hicks, Gratiot County Community Mental Health's new appointee. Chairperson Woods and the Board welcomed Ms. Hicks, and thanked her for her service to Mid-State Health Network, and the people they serve.

Ms. Tammy Quillan, Montcalm Care Network (MCN) Executive Director, welcomed MSHN Board Members to Stanton. She voiced her appreciation for those members who took the time to tour the MCN facilities. Ms. Quillan praised her community partners for their ongoing support and assistance in MCN health integration efforts and for accommodating the MSHN Board of Directors. Chairperson Woods thanked Ms. Quillan and the Montcalm Care Network Board of Directors for hosting today's meetings.

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), David Griesing (Tuscola), Phil Grimaldi (Saginaw), Dan Grimshaw (Tuscola), Mike Hamm (Newaygo), John Johansen (Montcalm), Pam Kahler (Huron), Colleen Maillette (Bay Arenac), Deb McPeek-McFadden (Ionia), Gretchen Nyland (Ionia), Irene O'Boyle (Gratiot), Kurt Peasley (Montcalm), 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), Joan Durling (Shiawassee), 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 September 6, 2016

Board approval was requested for the Agenda of the September 6, 2016 Regular Business Meeting. Following discussion, the agenda was revised and modified to include consideration of a Motion for Reconsideration as Agenda Item 12.5.

MSHN 15-16-036 MOTION BY IRENE O'BOYLE, SUPPORTED BY COLLEEN MAILLETTE, FOR APPROVAL OF THE AGENDA OF THE SEPTEMBER 6, 2016 REGULAR BUSINESS MEETING, AS MODIFIED. MOTION CARRIED: 19-0.

Ms. Kerin Scanlon arrived at 5:20 p.m.

4. Approval of Consent Agenda

Board approval was requested for Meeting Minutes of the July 5, 2016 Regular Business Board Meeting, June 15, 2016 SUD Oversight Policy Board Meeting, July 15, 2016 and August 19, 2016 Board Executive Committee Meetings, August 19, 2016 Board Policy Committee, July 18, 2016 and August 15, 2016 Operations Council Key Decisions, and Policies, as presented.

MSHN 15-16-037 MOTION BY MARY ANDERSON, SUPPORTED BY JOHN JOHANSEN, TO APPROVE THE MEETING MINUTES OF THE JULY 5, 2016 REGULAR BUSINESS BOARD MEETING, JUNE 15, 2016 SUD OVERSIGHT POLICY BOARD MEETING, JULY 15, 2016 AND AUGUST 19, 2016 BOARD EXECUTIVE COMMITTEE MEETINGS, AUGUST 19, 2016 BOARD POLICY COMMITTEE MEETING, JULY 18, 2016 AND AUGUST 15, 2016 OPERATIONS COUNCIL KEY DECISIONS; AND POLICIES, AS PRESENTED. MOTION CARRIED: 20-0.

5. Public Comment

There was no public comment.

6. Public Hearing

Chairperson Woods called for roll call vote to recess the Regular Business Meeting and convene the MSHN Public Hearing for FY17 Budget Presentation.

MSHN 15-16-038 ROLL CALL VOTE TO CONVENE THE PUBLIC HEARING. VOTING FOR: MARY ANDERSON, JIM ANDERSON, JOE BREHLER, DAVID GRIESING, PHIL GRIMALDI, DAN GRIMSHAW, MIKE HAMM, JOHN JOHANSEN, PAM KAHLER, COLLEEN MAILLETTE, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE OBOYLE, KURT PEASLEY, JOE PHILLIPS, KAY PRAY, KERIN SCANLON, ROBYN SPENCER, LEOLA WILSON, ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 20-0.

Chairman Woods called for a recess of the Regular Business Meeting at 5:22 p.m.

Chairman Woods reconvened the Regular Business Meeting at 5:32 p.m.

7. Approval of the FY 2017 Mid-State Health Network Budget

MSHN 15-16-039 MOTION BY DAN GRIMSHAW, SUPPORTED BY MARY ANDERSON, TO APPROVE THE MID-STATE HEALTH NETWORK FY2017 ORIGINAL BUDGET FOR THE PERIOD OF OCTOBER 1, 2016 THROUGH SEPTEMBER 30, 2017, AS PRESENTED. MOTION CARRIED 20-0.

8. MSHN Board Chair Update

Chairperson Woods reported the following:

- Chief Executive Officer (CEO) Evaluation
  - Board CEO Evaluation Committee, led by Vice-Chairperson Irene O'Boyle, has been charged with building a tool and with conducting the Board's annual evaluation of its CEO.
  - Vice-Chairperson O'Boyle stated Board Members were welcome to serve on the Committee and encouraged feedback related to development of the tool.
- MACMHB Fall Conference Voting Delegates
  - If attending the conference, and interested in performing the duties of a voting delegate, members should contact a member of the Executive Board Committee or MSHN leadership team.

9. Board Self-Assessment

MSHN 15-16-040 MOTION BY COLLEEN MAILLETTE, SUPPORTED BY JOHN JOHANSEN, FOR APPROVAL TO RECEIVE AND FILE THE 2016 MSHN BOARD SELF-ASSESSMENT, AS PRESENTED. MOTION CARRIED: 20-0.

10. FY 2017 MSHN/MDHHS Contract

Chairperson Woods advised that the Board Executive Committee, gave approval for the MSHN CEO to execute and submit the FY17 MDHHS contract due to timing; response was required by August 26, 2016 and holding until the official board meeting of today would have caused the submission to be late. Formal Board ratification of the Executive Committee action was recommended.

MSHN 15-16-041 MOTION BY MARY ANDERSON, SUPPORTED BY JIM ANDERSON, TO RATIFY THE ACTION OF THE AUGUST 19, 2016 ACTION OF THE MSHN BOARD EXECUTIVE COMMITTEE TO APPROVE THE FY 2017 MDHHS/PIHP CONTRACT, AND TO AUTHORIZE AND DIRECT ITS CHIEF EXECUTIVE OFFICER TO EXECUTE AND SUBMIT THE CONTRACT TO MDHHS, AS PRESENTED. MOTION CARRIED: 20-0.

MSHN 15-16-042 MOTION BY MARY ANDERSON, SUPPORTED BY DAN GRIMSHAW, TO AUTHORIZE THE MSHN CHIEF EXECUTIVE OFFICER TO EXECUTE AMENDMENT #3 TO THE FY 2016 MDHHS/MSHN CONTRACT AND SUBMIT TO MDHHS BY THE ESTABLISHED DEADLINE OF SEPTEMBER 27, 2016. MOTION CARRIED: 20-0.

11. Finance Report: FY 2016 Mid-State Health Network Budget Amendment

Ms. Leslie Thomas provided an overview to amendments made to the current year (FY16) budget.

MSHN 15-16-043 MOTION BY JOHN JOHANSEN, SUPPORTED BY KURT PEASLEY, TO APPROVE THE FY 2016 MID-STATE HEALTH NETWORK BUDGET AMENDMENT, AS PRESENTED. MOTION CARRIED: 20-0.

12. Deputy Directors Report

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

- Certificate of Need (CON) Pilot Update
- Health Innovation Grant Application
- Medicaid Health Plan (MHP)/Pre-Paid Inpatient Health Plan (PIHP) Collaboration Update
- HSAG/MDHHS Audit
- Board Policy Committee
    - Change in Policy Review Process
- Satisfaction Surveys
    - Summary and Link to Full Survey Reports to Follow
- New Managed Care Rules
    - PIHPs Working with HMA to Obtain Review Tool
    - Distributed to CMHs with Regional Action Plan
    - Councils/Committees to Implement and Monitor

12.5. National Committee for Quality Assurance (NCQA) Accreditation Consultation

Chairperson Woods stated per earlier discussion, the agenda was modified to add this action item; allows the reconsideration process to be in place related to Agenda Item 13.

MSHN 15-16-049 MOTION BY GRETCHEN NYLAND, SUPPORTED BY DEB MCPEEK-MCFADDEN TO RECONSIDER APPROVAL TO AUTHORIZE ITS CHIEF EXECUTIVE OFFICER NEGOTIATE AND SIGN A CONTRACT WITH THE MIHALIK GROUP THROUGH SEPTEMBER 30, 2017, WITH A CONTRACT MAXIMUM AMOUNT NOT TO EXCEED $180,000 ($60,000 PER PIHP). MOTION CARRIED: 19-1.

13. National Committee for Quality Assurance (NCQA) Accreditation Consultation

Mr. Joe Sedlock reviewed information made available to the Board within this month's meeting packet. After considerable discussion, Chairperson Woods called for a roll call vote.

MSHN 15-16-044 MOTION BY COLLEEN MAILLETTE, SUPPORTED BY PHIL GRIMALDI, FOR APPROVAL TO AUTHORIZE ITS CHIEF EXECUTIVE OFFICER TO NEGOTIATE AND ENTER INTO CONTRACT WITH THE MIHALIK GROUP THROUGH SEPTEMBER 30, 2017, WITH A CONTRACT MAXIMUM AMOUNT NOT TO EXCEED $180,000 ($60,000 PER PIHP), AS PRESENTED. MOTION CARRIES: 13-7. (VOTING FOR: JIM ANDERSON, MARY ANDERSON, PHIL GRIMALDI, JOHN JOHANSEN, PAM KAHLER, COLLEEN MAILLETTE, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KERIN SCANLON, ROBYN SPENCER, LEOLA WILSON, ED WOODS; VOTING AGAINST: JOE BREHLER, DAVID GRIESING, DAN GRIMSHAW, MIKE HAMM, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, KAY PRAY)

14. Mid-State Health Network FY 2016 Contracts

Ms. Horgan provided an overview of the Fiscal Year 2016 Contract Listing, recommended for approval and authorization of Chief Executive Officer signature, as presented.

MSHN 15-16-045 MOTION BY ROBYN SPENCER, SUPPORTED BY IRENE O'BOYLE, TO AUTHORIZE ITS CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FISCAL YEAR 2016 CONTRACT LISTING. MOTION CARRIED: 20-0.

15. Mid-State Health Network FY 2017 Contracts

Ms. Horgan provided an overview of the Fiscal Year 2017 Contract Listing, as amended and provided in Board Member folders. She explained FY17 contracts have been incorporated into the previously approved FY17 budget. Ms. Horgan summarized SUD provider contracts, including a very small number of contracts that are extensions for limited time periods due to ongoing discussions with the provider about the method and amounts of reimbursement. After agreement is reached, administration will bring those few contracts back to the Board

per the established process. Mr. Sedlock provided background on MSHN evaluations of utilization and costs across the SUD provider system, and the focus on MSHN and providers on stewardship for funds, equity in fund distribution, and accountability for major variances. Primary focus is on achieving an understanding of major variances and justifying those variances. Secondary focus is on consistency and standardization across the region. If large variances cannot be justified, MSHN is asking providers to implement corrective actions and/or will finance the services on a different basis. Providers are being engaged in dialog throughout the process, with the goal of reaching agreement. Because some dialog is ongoing, we have proposed partial-year contracts or contract extensions until resolution is achieved. In many cases, contract amounts are based on historical utilization estimates and, in most cases, do not necessarily represent "not to exceed" amounts.

MSHN 15-16-046 MOTION BY DAVID GRIESING, SUPPORTED BY MIKE HAMM, TO AUTHORIZE ITS CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FISCAL YEAR 2017 CONTRACT LISTING.

Mr. Joe Brehler moved to amend the original motion, to approve only FY17 contracts titled the Retained Function Contracts, Other Contracts, Medicaid Sub-Contracts, and Revenue Contracts. After considerable discussion and explanation of the process and rationale of some provider contract changes, Chairperson Woods called the question on the Amended Motion *(To Authorize Its Chief Executive Officer to Sign and Fully Execute the Contracts Titled Retained Functions, Other, Revenue, and Medicaid Sub-Contracts, As Identified).*

MSHN 15-16-050 MOTION BY JOE BREHLER, SUPPORTED BY DEB MCPEEK-MCFADDEN, TO AMEND THE MOTION PREVIOUSLY ADOPTED TO NOW READ: AUTHORIZE ITS CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS TITLED RETAINED FUNCTIONS, OTHER, REVENUE, AND MEDICAID SUBCONTRACTS, AS IDENTIFIED. MOTION FAILED: 4-16.

Chairperson Woods stated the Motion to Amend was defeated, and called the question for the original motion (*To Authorize Its Chief Executive Officer to Sign and Fully Execute the Contracts as Presented and Listed on the Fiscal Year 2017 Contract Listing*).

MSHN 15-16-046 MOTION BY DAVID GRIESING, SUPPORTED BY MIKE HAMM, TO AUTHORIZE ITS CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FISCAL YEAR 2017 CONTRACT LISTING. MOTION CARRIED: 16-4.

16. Chief Executive Officer Report

Mr. Sedlock provided information on the following topics:

- Section 298 Process Continues – Informational Article (Crain's/Gongwer)

- Meeting every Friday through the end of the year
- Co-facilitating 3 Infinity Groups
  - How to Implement Section 298

- Record Profits for Medicaid Health Plan Industry
- Addressing Opioid Epidemic
- Inter-regional Collaborations
- Board Executive Committee Notes

17. Michigan Association of Substance Abuse Coordinating Agencies Bylaws and Membership

Mr. Sedlock advised the Board that the Board Executive Committee voted to recommend the adoption of the proposed resolution of membership in the Michigan Association of Substance Abuse Coordinating Agencies, and to approve the proposed bylaws of the Michigan Association of Substance Abuse Coordinating Agencies, as presented and provided.

MSHN 15-16-047 MOTION BY IRENE O'BOYLE, SUPPORTED BY COLLEEN MAILLETTE, FOR APPROVAL TO ADOPT THE PROPOSED RESOLUTION OF MEMBERSHIP IN THE MICHIGAN ASSOCIATION OF SUBSTANCE ABUSE COORDINATING AGENCIES (MASACA), INCLUDING APPOINTMENT OF THE MSHN CEO TO THE MASACA BOARD OF DIRECTORS. MOTION CARRIED: 20-0.

MSHN 15-16-048 MOTION BY LEOLA WILSON, SUPPORTED BY JOHN JOHANSEN, FOR APPROVAL OF THE PROPOSED BYLAWS OF THE MICHIGAN ASSOCIATION OF SUBSTANCE ABUSE COORDINATING AGENCIES, AS PRESENTED. MOTION CARRIED: 20-0.

18. Other Business

19. Public Comment

Vice-Chairperson O'Boyle announced the Gratiot County Community Mental Health Board of Directors has approved a change in name to Gratiot Integrated Health Network.

Ms. Sara Lurie (CEO of CMH for Clinton, Eaton and Ingham Counties) thanked the Board for their spirited conversation, and for their attention and continued dialogue related to funding.

Chairperson Woods thanked Ms. Lurie for her comments and participation in the meeting.

20. Adjourn

The MSHN Regional Board of Directors Meeting adjourned at 7:21 p.m.

Meeting minutes submitted respectfully by:

Merre Ashley, MSHN Executive Assistant

Mid-State Health Network (MSHN) Public Hearing
Tuesday, September 6, 2016
Montcalm Area Independent School District (MAISD) – Michigan Room

Meeting Minutes

1. Call to Order

Chairperson Edward Woods called the Mid-State Health Network Public Hearing to order at 5:22 p.m.

2. Roll Call

Roll call vote occurred to recess the Board's Regular Business Meeting and convene the Public Hearing.

Board Member(s) Present: Jim Anderson (Bay-Arenac), Mary Anderson (Newaygo), Joe Brehler (CEI), David Griesing (Tuscola), Phil Grimaldi (Saginaw), Dan Grimshaw (Tuscola), Mike Hamm (Newaygo), John Johansen (Montcalm), Pam Kahler (Huron), Colleen Maillette (Bay Arenac), Deb McPeek-McFadden (Ionia), Gretchen Nyland (Ionia), Irene O'Boyle (Gratiot), Kurt Peasley (Montcalm), 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), Joan Durling (Shiawassee), 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 September 6, 2016 Mid-State Health Network (MSHN) Public Hearing

Board approval was requested for the Agenda of the September 6, 2016 MSHN Public Hearing.

MOTION BY MARY ANDERSON, SUPPORTED BY GRETCHEN NYLAND, FOR APPROVAL OF THE AGENDA OF THE SEPTEMBER 6, 2016 MID-STATE HEALTH NETWORK PUBLIC HEARING, AS PRESENTED. MOTION CARRIED: 20-0.

4. Fiscal Year 2017 Budget Presentation

Ms. Leslie Thomas, Chief Financial Officer, provided the presentation of the FY17 Mid-State Health Network Budget, to include an overview of the summary and sections of the budget report, provided within Board Meeting Packets.

Mr. Joseph Sedlock provided additional information, stating the difference between the revenue and total expenditures represents a positive variance; the related disposition options Ms. Thomas referenced will be addressed at the end of the year, when measuring MSHN performance. Mr. Sedlock stated MSHN administration is seeking Board approval of the FY17 Budget following conclusion of the Public Hearing.

5. Public Comment

There was no public comment.

6. Board Comment

Mr. Dan Grimshaw requested clarification of Mr. Sedlock's previous statements/conclusion. Mr. Sedlock responded, referencing page 95 of the Board Meeting Packet, and stated that MSHN has identified some allowable contributions and savings to the Internal Service Fund (ISF) would be based on current figures. He stressed this is based on the budget figures displayed on the FY17 budget report; final budget figures will not be available until the end of the year, so the disposition options listed are part of the plan for the FY17 budget presentation. Mr. Grimshaw stated, for clarification, that MSHN administration is requesting Board adoption of the budget; not a future plan. Mr. Sedlock confirmed this was the case.

Mr. Brehler asked for clarification related to SUD expenses displayed on the FY17 budget report. Ms. Thomas addressed his questions, and highlighted related sections, satisfying Mr. Brehler's inquiry.

7. Conclusion

Chairman Woods thanked Ms. Thomas and Mr. Sedlock for the presentation and information, and called to adjourn the Public Hearing and reconvene the MSHN Board of Directors Regular Business Meeting.

8. Adjourn

MOTION BY PHIL GRIMALDI, SUPPORTED BY DAVID GRIESING, TO ADJOURN THE MID-STATE HEALTH NETWORK PUBLIC HEARING. MOTION CARRIED: 20-0.

The MSHN Public Hearing Meeting adjourned at 5:32 p.m.

Meeting minutes submitted respectfully by:

Merre Ashley
Executive Assistant, MSHN

Mid-State Health Network (MSHN) SUD Regional Oversight Policy Board
Wednesday, August 17, 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 of Directors Meeting to order at 4:00 p.m.

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

2. Roll Call

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

3. Approval of Agenda for August 17, 2016 Regular Business Meeting

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

ROPB 15-16-024 MOTION BY DICK GROMASKI, SUPPORTED BY JOHN HUNTER, FOR APPROVAL OF THE AGENDA OF THE AUGUST 17, 2016 REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 14-0.

4. Approval of Minutes from June 15, 2016 Regular Business Meeting

Board approval was requested for the meeting minutes of the June 15, 2016 Regular Business Meeting, as presented.

ROPB 15-16-025 MOTION BY JIM LEIGEB, SUPPORTED BY JERRY JALOSCZYNSKI, FOR APPROVAL OF THE MINUTES OF THE JUNE 15, 2016 REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 14-0.

5. Public Comment

There was no public comment.

6. Board Chair Report

Chairperson Rice brought member's attention to the proposed FY17 SUD Oversight Policy Board Meeting Calendar; recommended for approval, as presented. Following discussion, further consideration of the December meeting date will occur at the October Board Meeting.

ROPB 15-16-026 MOTION BY JOHN HUNTER, SUPPORTED BY VIRGINIA ZYGIEL, FOR APPROVAL OF THE FY17 SUD OVERSIGHT POLICY BOARD MEETING CALENDAR, AS PRESENTED. MOTION CARRIED: 14-0.

7. Deputy Director Report

Ms. Amanda Horgan provided information on the following:

- FY17 PIHP/MDHHS Contract Received
  - Thorough review of the contract for new requirements and changes is underway
    - CMHSP and SUD provider network subcontracts may require slight revision, based on MSHN's review
  - Nothing significant to be addressed at this time
- New Managed Care Rules
  - CMS published revised Medicaid Managed Care Rules
    - Includes standards on Delegated Managed Care functions
    - Working with all 10 PIHPs towards statewide implementation plan
      - Work plan development beginning with effective dates for 2016 then moving on to 2017 – 2020 implementation dates
  - Not applicable to PA2 funds
- Medicaid Health Plan (MHP) Integrated Care Activities

- Integrated Care Coordination Meetings have occurred with four (4) of the eight (8) MHPs
- By end of August will have completed all eight (8) MHP Care Coordination meetings
  - Starting with a small risk stratification list, but hope to increase the numbers of consumers receiving a Care Coordination Plan as we develop our process
  - Working on obtaining individual consent authorizations to allow MSHN to share information related to consumers regarding entire service array (e.g. SUD)
- MSHN is coordinating with CMHSPs and SUD Providers on obtaining consumer information related to current status

- Audit Update: HSAG and MDHHS
  - Health Services Advisory Group (HSAG) conducted a compliance review related to the managed care functions of the PIHP
    - MSHN received 100% compliance rating
  - Michigan Department of Health & Human Services (MDHHS) Audits occurring at MSHN and CMHSPs
    - Includes administrative review, review of Habilitation Supports Waiver (HSW), Children's Waiver, Serious Emotional Disorder (SED) Waiver, and Substance Use Disorder (SUD) Program
    - Exit interview occurring in the next week
    - Full report will be provided once MDHHS' report is complete

Mr. Howard Spence arrived at 4:13 p.m.

8. Approval of SUD Contract Listing

Chairperson Rice stated Board approval is requested for the SUD contract listing. Ms. Horgan advised of the revised contract listing, provided within Board Member folders.

Ms. Carolyn Watters addressed the revised contract listing, specifying that discretionary funding is being made available to community coalitions. Some coalitions represent multiple counties; therefore, the provider contracted to lead the coalition would receive discretionary funds for each of those counties. Ms. Watters reported discretionary funding can be used for special projects, trainings, etc., as approved by the coalition. MSHN clinical staff are available to assist the coalitions, but ultimately the projects/programs should be approved and/or acted on at the county level. She provided an overview of contracts included on the listing; recommended for approval, as presented.

Mr. John Kroneck arrived at 4:19 p.m.

ROPB 15-16-027 MOTION BY KAM WASHBURN, SUPPORTED BY JERRY JALOSCZYNSKI, FOR APPROVAL OF THE SUD CONTRACT LISTING, AS PRESENTED. MOTION CARRIED: 15-0.

Mr. John McKellar arrived at 4:26p.m.

9. Approval to Receive and File Financial Report

Ms. Amanda Horgan provided an overview of the financial report, which included a standard report of PA2 funds received and distributed; recommended for approval, as presented.

ROPB 15-16-028 MOTION BY RICHARD GROMASKI, SUPPORTED BY LARRY EMIG, TO RECEIVE AND FILE THE FINANCIAL REPORT, AS PRESENTED. MOTION CARRIED: 16-0.

10. Approval of Public Act 2 (PA2) Dollars Interest Allocation Policy

Ms. Amanda Horgan provided an overview of the policy; recommended for Board approval, as presented.

ROPB 15-16-029 MOTION BY VIRGINIA ZYGIEL, SUPPORTED BY JERRY JALOSCZYNSKI, FOR APPROVAL OF THE PUBLIC ACT 2 (PA2) DOLLARS INTEREST ALLOCATION POLICY, AS PRESENTED. MOTION CARRIED: 16-0.

Ms. Debbie Thalison arrived at 4:35 p.m. (Ms. Thalison participated via phone until onsite arrival)

Mr. Steve Johnson arrived at 4:41 p.m.

Ms. Kim Thalison arrived at 4:43 p.m.

11. Receive SUD Quarterly Reports

Dr. Dani Meier directed board members to hardcopy of their county-specific third quarter report, found within board folders; recommended for Board approval, as presented. Discussion around provider network monitoring, funding and measuring treatment and prevention outcomes ensued. Dr. Meier stated as related processes are built, additional information will be provided to the board for feedback.

ROPB 15-16-030 MOTION BY LARRY EMIG, SUPPORTED BY PAUL GRAVELINE, TO RECEIVE SUD QUARTERLY REPORTS, AS PRESENTED. MOTION CARRIED: 17-0.

12. Operating Update

Dr. Dani Meier provided information on the following:

- Treatment Specialist who formerly was designated as the point person for the western part of the region is no longer with MSHN. Until a replacement is hired, contact Dr. Meier directly for information and/or support related to SUD Treatment within the counties of Newaygo, Montcalm, Isabella, Midland, Gladwin, Claire, Osceola or Mecosta.

13. Board Member Development

Dr. Dani Meier provided PowerPoint presentation and hardcopy documentation related to Opiate and Meth, treatment, prevention, recovery and activity occurring throughout Mid-State Health Network, per expressed Board Member interest on the 'big picture' of related treatment and prevention activities within the region. Dr. Meier specified the presentation provides an overview only, and includes basic information.

- The information contained within the presentation is accessible; links provided to allow individuals the ability to explore information specific to their counties
- The presentation will be forwarded electronically to board members following the meeting
- Mr. John Kroneck requested additional data be provided related to *MSHN Response: Treatment* (slide 14) at the next meeting if possible.

14. Other Business

Ms. Amanda Horgan provided information on FY15-17 PA2 Funding Projections, and directed members to hardcopy of reference materials provided within their meeting folders.

15. Public Comment

There was no public comment.

16. Board Member Comment

Chairperson Rice stated Dr. Meier's PowerPoint presentation as well as the Marijuana Talk Kit will be forwarded to the Board following the meeting.

17. Adjournment

The MSHN SUD Regional Oversight Policy Board of Directors Meeting adjourned at 5:35 p.m.

Meeting minutes submitted respectfully by:

Merre Ashley
Executive Assistant, MSHN

MSHN
Mid-State Health Network

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

Friday, September 16, 2016, 9:00 a.m.

MEMBERS PRESENT: Ed Woods; Jim Anderson; Irene O'Boyle; Mary Anderson;
STAFF PRESENT: Joe Sedlock; Amanda Horgan

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

2. Approval of Agenda – Motion by Irene O'Boyle, support by Jim Anderson, to approve the agenda as presented. Motion carried

3. Contract List Format – Administration suggested formatting changes to the Board Contract List that may help to convey information more completely, including contract term and a notes section. Executive Committee supports improvements that lead to improved understanding and utility for board members.

4. Provider Financing Reviews – Administration reviewed MSHN processes for provider engagement in dialog around service costs and service utilization. More than 80-85% of MSHN non-CMHSP contracts are financed on a fee for service basis, as are the vast majority of CMHSP contracts. MSHN has asked providers for service costs through Annual Plan submissions and has used that information to inform its work. MSHN is evaluating situations where there is a significant variance in costs and/or utilization among like providers of similar size across the region, and is attempting to understand and justify those cost and/or utilization variances. (An example was provided where all but one or two providers of a particular service were financed on fee-for-service basis and had average costs per case within a very close range of one another, while another agency providing the same service financed on a cost reimbursement basis, was 250% more expensive on a cost per case basis). Where these variances cannot be adequately explained or justified, MSHN will initiate changes with the provider. Another objective is to standardize, to the extent feasible and appropriate, purchasing arrangements across the region. In every case, providers have been engaged in dialog with MSHN and in most cases, agreement between MSHN and the provider have been reached on the mechanics of financing and performance monitoring. In general, variations in contracting amounts from the prior year to the current year have been driven by utilization estimate adjustments. Contract amounts show on contract lists are estimates and are not contract caps (unless specified in the contract itself). All providers have been assured of our ongoing commitment to evaluating whether the changes MSHN and the provider have agreed to are working, and to make adjustments along the way should that be warranted. Executive Committee encouraged continued work to ensure accountability for MSHN's decisions and actions, and the accountability in the provider system and to work to improve communication with stakeholders.

5. MSHN Chief Executive Officer Performance Review – Irene O'Boyle will chair the ad hoc performance review committee. One board member and several executive committee members have volunteered to participate. Irene O'Boyle will review and recruit additional members. Merre Ashley, Executive Assistant, is available to the committee for all administrative work associated with the performance review process.

6. Next Meeting – Friday, October 21, 2016 – 9:00 a.m.

7. Adjourned at 9:41 am

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

Friday, October 21, 2016 * 9:00 a.m.

Members Present: Ed Woods; Irene O'Boyle; James Anderson; Mary Anderson
Staff Present: Joseph Sedlock; Amanda Horgan

1. Call to order – This meeting was called to order by Chairperson Ed Woods at 9:00 a.m.

2. Approval of Agenda – Motion by Irene O'Boyle support by Mary Anderson to approve the draft agenda for this meeting. Motion carried

3. Board Member Transitions – Mr. Joseph Sedlock referred to Mary Anderson's retirement letter included in the meeting packet. Mary will be retiring from board service at the end of November, 2016. MSHN has also been notified that Joan Durling, who is recuperating from a medical condition, will not be continuing her service on the MSHN Board.

4. Routine Matters – A motion to recommend to the Board of Directors the approval of the Draft Minutes of the September 6, 2016 Board of Directors Meeting, the Draft Minutes of the September 6, 2016 FY17 Budget Public Hearing, the Draft Minutes of the September 16, 2016 Executive Committee Meeting and the Draft Minutes of the October 7, 2016 Policy Committee Meeting was made by Jim Anderson supported by Mary Anderson. Motion carried.

5. Policy Committee Recommendation – The MSHN Policy Committee of the Board of Directors recommended that the Executive Committee review the Board Member Conduct and Board Meeting Procedures Policy. The recommendation included consideration for board education on this established policy. Policy to be included in the board packet and addressed under the Board Chair's report.

6. Draft Board Agenda for November 1, 2016 – Draft agenda for the November 1, 2016 board meeting was reviewed and adjusted.

7. Chief Executive Officer Performance Review Process – Status Report – Ms. Irene O'Boyle reported that 17 board members have submitted performance review forms (71% response rate). Ms. O'Boyle indicated many board members provided comments. The compiled CEO performance review is to be provided to Mr. Sedlock and is to be included in the board packet. Ms. O'Boyle will provide an overview and lead discussion at the November 2016 Board Meeting.

8. Inter-PIHP Collaborations – Updates – Mr. Sedlock and Ms. Horgan provided general updates on the many inter-PIHP collaborations that are occurring. The key points for attention are that our MSHN team is working effectively with other PIHPs to standardize systems of major importance across (portions of) the State, to share resources that reduce total expenditures (making more funds available for service) and that create synergies that make each participating PIHP more effective. Existing collaborations include but aren't necessarily limited to:
   - Chief Medical Officer – MSHN/Southwest Michigan Behavioral Health (SWMBH)

- Care Management – MSHN/SWMBH
- Provider Performance Monitoring Reciprocity – MSHN/SWMBH/Lakeshore Regional Entity (LRE); Workgroup of all 10 PIHPs
- MCIS – MSHN/LRE
- Information Technology, QI/PI – MSHN/SWMBH/LRE
- NCQA Accreditation – MSHN/Region 10 PIHP/LRE
- Managed Care Rule – all 10 PIHPs
- Statewide Training Reciprocity – Workgroup of all 10 PIHPs
- PIHP/Medicaid Health Plan (MHP) Collaboration Workgroup – All 10 PIHPs and 11 MHPs

9. Finance Matters –

9.1. FY15 Cost Settlement – Cash Flow Impacts – Resolution Status Update

Mr. Sedlock reported that all but one of the CMHSPs that have not finalized FY 15 cost settlements have provided acceptable payment arrangements. Work continues with the remaining CMHSP. Operations Council with MSHN executive staff are reviewing options available to provide funds from MSHN resources to cover CMHSP autism costs pending receipt of payment from the State.

9.2. Value Based Purchasing – MSHN/MHP/Provider Pilot

Ms. Amanda Horgan described a pilot project focused on value based purchasing that involves two willing/able SUD providers and two Medicaid Health Plans. The focus of the pilot is to improve health outcomes for persons living with a substance use disorder, to decrease costs associated with emergency room utilization, and to implement other performance measures and outcomes. This pilot is relatively small scale and is still in the design phases.

10. Other –

10.1. "The Great Center" of the Gratiot County Community Mental Health has been renamed "The Lawson Center" in honor of Nick Lawson.

10.2. Mr. Sedlock reported that all 10 Michigan PIHPs have written a letter to Director Heidi Washington of the Michigan Department of Corrections inviting dialog around the transfer of substance use disorder provider network and benefit management systems from MDOC to the PIHPs. There has not yet been a response from Director Washington, and we are very early in the process. Mr. Sedlock will be the lead for Michigan's PIHPs.

11. Next Meeting: November 18, 2016, 9:00 a.m.

12. Adjourn – The meeting was adjourned at 9:36 a.m.

Mid-State Health Network
BOARD POLICY COMMITTEE MEETING
Friday, October 7, 2016
Teleconference – 10:00 a.m.

MEETING MINUTES

1. Call to Order

A. The MSHN Board Policy Committee Meeting convened at 10:01 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)

2. Approval of the Revised Agenda

Ms. Amanda Horgan noted the meeting agenda was revised to allow sequential numbering of Agenda Items. She requested committee support and approval of the October 7, 2016 meeting agenda, as revised and presented.

MOTION by Colleen Maillette, supported by Kurt Peasley, to approve October 7, 2016 Revised Board Policy Committee Meeting Agenda, as presented. Motion Carried: 4-0.

3. Change Log: Review Date(s)

Ms. Horgan explained MSHN's practice related to policy change logs to include the following: Each policy's change log is displayed within a table on its last page, and includes the date which the MSHN staff lead and committee/council last reviewed and/or revised the policy. Each policy also includes a header, at the top of its first page, which displays Board action (i.e. the date the policy was Board adopted, and the most recent date it was annually reviewed/approved by the Board). She stated this practice is maintained throughout the policy development/review/approval process for all MSHN policies; continuation is recommended. Following discussion, all committee members voiced their agreement to continuation of the current practice.

4. Policy for First Review

Ms. Horgan advised the policy, due for annual review, was inadvertently left out of the original Policy Committee meeting packet, and was forwarded to the Committee on Monday, October 3, 2016 for first review. Following discussion, the committee voiced their approval and recommended the policy for presentation to the full board, as provided and presented.

A. Compliance Line: Compliance Line 2.0

MOTION by Collen Maillette, supported by John Johansen, to approve and recommend presentation of the MSHN Compliance Line 2.0 Policy to the full board, as provided and presented. Motion Carried: 4-0.

5. **Policies Under Annual Review with No Committee Recommended Edits**

Ms. Horgan stated the Compliance, Customer Service and Quality policies for annual review were included in the Policy Committee Meeting packet; per committee feedback, no edits were recommended. She inquired whether the committee had suggestions or needed additional information or explanation. Committee members voiced their approval and satisfaction, and recommended the policies for presentation to the full board, as provided and presented.

A. Compliance: External Quality Review 2.0
B. Compliance: Required Reporting 3.0
C. Compliance: Compliance Investigations Summary Reporting 1.0
D. Compliance: Compliance Reporting and Investigations 1.0
E. Compliance: Compliance and Program Integrity 2.0
F. Customer Service: Confidentiality and Notice of Privacy 2.0
G. Quality: Research 2.0
H. Quality: MMBPIS Performance Indicator 2.0

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.

6. **New Business**

Ms. Horgan requested committee feedback on the new policy review/approval process, initiated with this set of Compliance, Customer Service and Quality policies. Committee members stated the process created efficiencies during their review, and recommended continuation of the process. Ms. Horgan thanked them for their feedback, and reported Provider Network Policies would be the next chapter/section for committee review.

Mr. John Johansen reported that upon a review of policies displayed on the MSHN website, he noticed some that were not up to date and/or were past their annual review dates. After a brief discussion, Ms. Horgan stated Board annual review/approval had been achieved, however the website was not appropriately up-to-date; immediate attention will be paid to the issue to ensure policy documentation is, and remains, current and accessible from the website.

7. **Adjournment**

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

The MSHN Board Policy Committee Meeting adjourned at 10:15 a.m.

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

MSHN
Mid-State Health Network

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

Members Present: J. Obermesik, S. Lurie, R. Lathers, M. Geoghan, S. Prich, S. Lindsey, S. Beals, T. Quillan, L. Hull, C. Pinter, and M. Leonard

Members Absent: S. Vernon

MSHN Staff Present: J. Sedlock, A. Horgan

Agenda Item	Key Decisions	Action Required			
Agenda	Added: Ops Council Calendar	Approved			
Consent Agenda	Approved as presented with the removal of the below: CON Pilot Expansion				
	Edit the Quarterly SUD contract listing under Ingham County to include CEICMH.	By Who	C. Watters	By When	Next Qrtly Report to Ops
2016 Provider Network Adequacy Assessment	J. Pinter presented the edits to the Provider Network Adequacy Assessment, asking for specific review and feedback on the recommendations as they will be distributed to MSHN councils for action.				
	CMHs to send edits to A. Horgan by 10.3.16; A. Horgan will forward on to Carolyn and Janis. J. Pinter to complete edits and send to MSHN by 10.7.116 Final version to be included in October Ops packet	By Who	CMH CEO's J. Pinter	By When	10.3.16 10.7.16
FY16/17 MSHN Compliance Plan	K. Zimmerman reviewed the changes to the Compliance Plan; including adding SUD provider information Approved by Ops Council				
	N/A	By Who	N/A	By When	
Clinical Leadership Committee Charter	Reviewed revisions to include removal of recorder as a voting member - Approved by Ops Council				
	N/A	By Who	N/A	By When	
Ops Council Calendar - 2017	Reviewed and changed January and February to the following Tuesday. Approved with changes				
	MSHN to finalize locations and send out invites	By Who	M. Ashley	By When	9.30.16
298 Update	J. Sedlock reviewed the affinity workgroup and discussions/status. Once final draft ready it will be communication via a process similar to the Medicaid Policy promulgation process. Three affinity groups (consumers/families/eligibles; providers; payers) with multiple input mechanisms (in person, written).				
	Recommend: written feedback to be submitted at the appropriate time	By Who	All	By When	

Agenda Item	Key Decisions	Action Required			
Transfer of County/CMHSP Care Responsibility Policy	October final version will be included in packet with feedback from CMHs				
	C. Pinter to submit final version to Joe by October 10	By Who	C. Pinter	By When	10.10.16
MSHN SUD Cost-Reimbursement Funding	J. Sedlock discussed the SUD contract review process currently being conducted by MSHN.				
	Feedback received to improve communications, start process earlier, expand information on the Board Contract listing, ensure providers see and understand the proposed amounts.	By Who	A.Horgan	By When	10.30.16
MDHHS Clarification of Nighttime CLS	J. Obermesik and B. Lathers reviewed current legal cases regarding CLS services, medical necessity and sleeping hours.				
	Awaiting legal results to share with council	By Who		By When	
2017 Contracting for ASD Services	S. Lindsey discussed Autism contract networking regarding rates.				
	Develop Autism provider network contract listing that includes provider, rates, and counties served to be brought back to Ops Council when complete	By Who	C. Watters/Provider Network Committee	By When	10.30.16
Inpatient Contracting	J. Sedlock reviewed status of inpatient contracting. Due to time constraints today, this topic will be added to future agenda.				
	Add to October agenda	By Who	J. Sedlock	By When	10.7.16
HCBS Transition – Regional Survey Systems	S. Lindsey gave update: Survey questions that providers unable to answer; S. Lindsey will ask for group to provide guidance to CMHs regarding the questions; Phase II beginning soon; Phase I remediation with providers should be initiated sooner rather than later				
	PIHP Waiver Coordinator and CMHSP Waiver Coordinators working on Phase I remediation and Phase II survey processes	By Who		By When	
Information Technology Update	F. Goodrich reviewed the below: BH-TEDS v. Encounters: MSHN at 60% submission of BH-TEDS when compared to consumers served in encounters MiHIN Use Case Agreement – Med Rec: Informational that this function will be coming in 30-60 days.				

Agenda Item	Key Decisions	Action Required			
	N/A	By Who	N/A	By When	
Finance Report	Reviewed financial documents.				
	Recommend add'l financial information: • Add more info in headers (or as footnotes – e.g. Medicaid, where projections come from, FRS submission to state, as of what date, any assumptions/caveats, etc.) • Compare 5 year spending to approved smoothing plan • Trending graphs by fund source and smoothing targets • Autism spending Question for Rate Setting: HM rates were to be updated 6months, why is it only annually now?	By Who	L. Thomas	By When	10.30.16
Cost Settlement and Related Cash Flow Concern	J. Sedlock reviewed letter sent out regarding cash flow and cost settlement.				
	Create a small workgroup and schedule meeting: S. Lindsey & CFO, L. Hall & CFO, J. Sedlock, A. Horgan, L. Thomas – scope: Use of MSHN-controlled resources to pay CMHSP Costs around autism.	By Who	J. Sedlock	By When	10.30.16
CMHSP-Level Financial Management Learn and Share	Tabled till next meeting				
	Send feedback on the questions sent out to J. Sedlock to be revised and sent back out two weeks in advance of next meeting.	By Who	J. Sedlock	By When	10.1.16
CON Pilot – pulled from consent	A.Horgan reviewed the meeting with MDHHS, CON and the direction to apply for the healthcare innovation grant to provide funds to expand the Pilot state-wide and expand the denial tracking elements.				
	N/A	By Who	N/A	By When	
CCBHC	M. Leonard wanted a status update on the CCBHCs in our region. All reported still awarded and in the CCBHC.				
	N/A	By Who	N/A	By When	

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

Members Absent:

MSHN Staff Present: J. Sedlock, A. Horgan

Agenda Item	Key Decisions	Action Required			
Agenda	Added: Affirmant partner – action G PIHP Care Coordination requests – action F MSHN Medical Director – planning & discussion Section 942 – action H	Approved			
Consent Agenda	Approved as presented:				
	N/A	By Who	N/A	By When	N/A
CMHSP Financial Learn and Share Prompt Questions	Discussed and shared GF funding reduction strategies Discussed and shared debt and long-term debt strategies Discussed and shared short-term and long-term HR benefits Shared % of unrestricted fund balance Local sources of revenue Administrative reductions Cash flow				
	N/A	By Who	N/A	By When	N/A
Financial Reporting to Operations Council	Requested feedback on what financial information would be helpful to Ops: • Already aware of the smoothing plan, status and variance (bi-monthly) include stop light for ease in evaluation • Trending information, within the year, over the year • Information/analysis when financial factors are now available, regional implications – e.g. Autism Rates, • Would like an ongoing list of issues that affect future financial/operational planning				
	Review and prepare financial information and possible procedure for reporting to Operations Council	By Who	L. Thomas	By When	12/1/2016
CFI Highlights	Reviewed CFI notes from September 2016 meeting				
	MSHN to conduct analysis for the cost settlement of HSW, 8% increase vs. no recoupment.	By Who	L. Thomas	By When	11/4/2016

Agenda Item	Key Decisions	Action Required			
CMHSP & MSHN Cash Flow Follow-Up; Autism Costs	Discussed and clarified the communication from Tom Renwick and that MSHN cannot use ISF to cover the autism cash flow. Reviewed the cash settlement status of CMHSPs. All payment plans received except for Saginaw which MSHN is expecting beginning of November.				
	N/A	By Who	N/A	By When	N/A
MSHN Provider Network Adequacy Assessment – Final Version	Revised version in the packet for approval (noting some CMH changes to be incorporated that were received after packet distribution)				
	Approved to proceed with Board of Directors	By Who	A.Horgan	By When	10/31/2016
PIHP/MHP Collaboration	Discussed communication from PIHP to CMHSPs and struggling to receive feedback. CEO's approved ongoing monthly meeting with each CMH's representative to touch base on care coordination cases.				
	MSHN to follow up with specific CMHSP CEO to ensure coordination follow up.	By Who	A.Horgan	By When	10/31/2016
Affirmant Partnership	CMHSPs will review, discuss local interest in collaboration				
	On agenda for next month	By Who	J. Sedlock	By When	10/31/2016
298 Update	298 Workgroup continues to meet; expect imminent revision to "Consumers, Eligibles and their Family Members" affinity group questions; Encourage CMHSPs and member of the provider networks to attend "Provider Affinity Group" being scheduled (one of which is at the MACMHB Fall Conference"; expect one "Payer Affinity Group" statewide (PIHPs and MHPs)				
	N/A	By Who	N/A	By When	N/A
Transfer of County/CMHSP Care Responsibility Policy	Draft sent out for review from the workgroup's product Discussed questions and clarifications				
	Add "and financial under number 4"	By Who	C.Pinter	By When	10/31/2016
Managed Care Information System Update	Discussed and reviewed update on the MCIS project				
	N/A	By Who	N/A	By When	N/A
MSHN Measurement Portfolio	Discussed and reviewed MSHN Measurement Portfolio				

Agenda Item	Key Decisions	Action Required			
	N/A	By Who	N/A	By When	N/A
MDHHS Standard Consent Form	Reviewed PIHP Contract Requirement to for PIHP to have a policy to accept, use and honor the MDHHS consent.				
	MSHN to develop policy through QIC/CSC in compliance with PIHP contract, considering federal law, 42 CFR, etc.	By Who	A.Horgan	By When	10/31/2016
Geomapping	Reviewed and discussed MSHN agreement with Dale Howe				
	CMHSPs to send interest in local geomapping to A.Horgan	By Who	CMHSPs	By When	10/31/2016
MDHHS Site Review	Discussed receipt of review, CAP due the 20th, still in need of a few responses from the CMHs				
	J. Sedlock to email CMHs to request feedback on the site review process	By Who	J. Sedlock	By When	10/31/2016
Medicaid Managed Care Final Rule - Update	Discussed state-wide workgroup progress; Workplan distributed to MSHN Leadership Team and assigned to Council/Committees				
	A.Horgan to send out the Medicaid Managed Care Rules Workplan to the CEOs and to follow up in the future on what is requirement of posting from MSHN on everything?	By Who	A.Horgan	By When	10/31/2016
Regional Crisis Response Systems/Common Ground Visit					
	Tabled till November Meeting	By Who	J. Sedlock	By When	10/31/2016
Medical Director Update	MSHN and SWMBH in final stages of discussions around sharing a full time medical director/chief medical officer; candidate involved in bi-lateral discussions; expect to take contracts to MSHN Board in the near future.				
	N/A	By Who	N/A	By When	N/A
Inpatient Contracting	Deferred to Nofember meeting (Lack of available time in this meeting)				
	Further discussion at November meeting	By Who	J. Sedlock	By When	10/31/2016
Section 942	Discussed 30day notice in appropriations only applicable to non-Medicaid individuals per Tom Renwick				
	MSHN will follow up with J. Duvendeck to ensure discussion inclusion in State GF discussion.	By Who	A.Horgan	By When	10/31/2016

POLICIES AND PROCEDURE MANUAL

Chapter:	**Compliance**		
Title:	**Compliance Line**		
Policy: ☑ **Procedure:** ☐ **Version:** 2.0 **Page:** 1 pf 2	**Review Cycle:** Annually **Author:** Chief Compliance Officer, QI Council	**Adopted Date: 07.01.2014** **Review Date:** 11.01.2016 **Revision Eff. Date:**	**Related Policies:** Compliance and Program Integrity

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To ensure Mid-State Health Network (MSHN) maintains a compliance line that is available to receive reports from employees, network providers, contractors and/or consumers about suspected fraud or regulatory violations.

Policy

The Mid-State Health Network will develop and maintain a dedicated compliance line for the purpose of receiving reports from employees, network providers, contractors and/or consumers about suspected fraud or regulatory violations.

The telephone number for the compliance line will be included in MSHN's Standards of Conduct and posted prominently in all office locations and on the MSHN website. Calls will be treated confidentially and in accordance with the protections provided in the Michigan Whistleblower's Act (PA 469 of 1980).

The MSHN Compliance Officer (CO) will listen to the compliance line messages and receive calls daily. For periods of absence the Deputy Director shall assure appropriate and designated coverage for the line. The MSHN Compliance Officer, will prepare a call report for each call. The call report will summarize the call, and clearly identify the concern and the indicated follow up of the MSHN CO.

The MSHN CO may perform investigations in accordance with the Corporate Compliance Plan. If an investigation reveals an indication of a significant regulatory violation or fraud, the MSHN CO will inform the MSHN Chief Executive Officer (CEO) and the need for additional investigation will be evaluated.

An investigation report will be prepared by the MSHN CO and submitted to the MSHN CEO. The need for corrective action will be evaluated by the MSHN CEO with consultation of the MSHN CO and corporate counsel if necessary.

The MSHN CEO will determine if a self-report action should be taken by the Mid-State Health Network and will initiate such a report or delegate such action in writing to the MSHN Compliance Officer and/or corporate counsel.

The MSHN Board of Directors will receive an annual compliance report summarizing compliance activities of MSHN.

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

MSHN: Mid-State Health Network
MSHN- CEO: Mid-State Health Network Chief Executive Officer
MSHN-CO: Mid-State Health Network Compliance Officer

Related Materials

Compliance Line Poster
MSHN Corporate Compliance Plan (CCP)
MSHN CCP, Attachment G - Compliance Investigation, Resolution and Documentation Process

References/Legal Authority

Michigan Whistleblower's Act (PA 469 of 1980)
Michigan Medicaid Managed Special Supports and Service Contact FY 14 – 6.9 Regulatory Management

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New policy	Chief Compliance Officer
08.25.2016	Annual Review	Director of Compliance, Customer Service, & Quality

POLICIES AND PROCEDURE MANUAL

Chapter:	**Compliance**		
Title:	**External Quality Review**		
Policy: ☑ **Procedure:** ☐ **Version:** 2.0 **Page:** 1 of 2	**Review Cycle:** Annually **Author:** Chief Compliance Officer, Quality Improvement (QI) Council	**Adopted Date: 09.02.2014** **Review Date:** 11.01.2016 **Revision Effective Date:** 11.2015	**Related Policies:** Quality Management

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To ensure Mid-State Health Network (MSHN) and its Provider Network participate and comply with the expectations of the External Quality Review process conducted and/or arranged by the Michigan Department of Health and Human Services.

Policy

MSHN and its Provider Network shall participate in the External Quality Review (EQR) process arranged by the Michigan Department of Health and Human Services (MDHHS). MSHN and its Provider Network will strive to achieve full compliance of the standards as set forth in the MDHHS, Medicaid Specialty Supports, and Services Contract.

MSHN shall address the findings of the external review through its Quality Assessment Performance Improvement Program (QAPIP). MSHN will develop and implement performance improvement goals, objectives, and activities in response to the external review findings as part of MSHN's QAPIP through the Quality Improvement Council. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in QAPIP and provided to the MDHHS upon request.

MSHN staff will coordinate the EQR site review process and inform the Provider Network of applicable dates and timelines. MSHN staff will confirm provider network achievement of required EQR corrective action as a part of routine site reviews.

MSHN's Provider Network will comply with any findings and related improvement goals as developed in the QAPIP.

Applies to:

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

Definitions:

EQR: External Quality Review
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Pre-paid Inpatient Health Plan

Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors.
QAPIP: Quality Assessment Performance Improvement Program

Other Related Materials:
MDHHS – PIHP Contract

References/Legal Authority:
MDHHS, Medicaid Specialty Supports and Services Contract, 6.7.2. – External Quality Review

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New policy	Chief Compliance Officer
08.2015	Update to MDHHS and add follow-up to EQR required corrective action.	Chief Compliance Officer Chief Executive Officer
08.2016	Annual Review	Director of Compliance, Customer Service & Quality

POLICIES AND PROCEDURE MANUAL

Chapter:	Compliance		
Title:	**Required Reporting**		
Policy: ☑ **Procedure:** ☐ **Version:** 3.0 **Page:** 1 of 2	**Review Cycle:** Annually **Author:** Chief Compliance Officer, Quality Improvement (QI) Council	**Adopted Date: 09.02.2014** **Review Date:** 11.01.2016 **Revision Eff. Date:** 11.2015	**Related Policies:** Quality Management Critical Incidents

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To ensure Mid-State Health Network (MSHN) and its Provider Network comply with the reporting requirements as set forth in the Michigan Department of Health and Human Services (MDHHS), Medicaid Specialty Supports and Services Contract.

Policy

MSHN staff and the MSHN provider network shall comply with reporting requirements and timelines as defined in the MDHHS Medicaid Managed Specialty Supports and Services Contract (attachment P7.7.1.1), including but not limited to:

1. Quality Improvement Data (monthly)
2. Encounter Data (monthly)
3. Medicaid Utilization and Net Cost Data (annually)
4. Performance Indicators (quarterly)
5. Consumer Satisfaction (annually)
6. Child and Adolescent Functional Assessment Scale - CAFAS (annually)
7. Critical Incidents (monthly)
8. Treatment Episode Data Set (TEDS) Data (monthly)
9. Substance Use Disorder (SUD) Prevention Data
10. Supports Intensity Scale (SIS)
11. Level of Care Utilization System (LOCUS)

Other Reports as determined to meet Pre-paid Inpatient Health Plan (PIHP) Obligations

- Compliance / Complaint Reports (per occurrence, annual aggregate)
- Litigation Reports (annually)
- Medicaid Fair Hearing Reports (per occurrence, annual aggregate)
- Medicaid Grievance and Appeals Report
- Fraud & Abuse Report (per occurrence and annual aggregate)
- Medicaid Event Verification Methodology Report (annually)

MSHN shall monitor compliance with reporting requirements through the Quality Improvement Council. The Quality Improvement Council will support resolution and provide assistance through communication and identification of best practice to resolve non-compliant areas, in an effort to maintain high reporting standards. Ongoing non-compliance will be resolved in accordance with the applicable contract resolution process.

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:
CAFAS: Child and Adolescent Functional Assessment Scale
LOCUS: Level of Care Utilization System
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Pre-paid Inpatient Health Plan
Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors.
TEDS: Treatment Episode Data Set
SIS: Supports Intensity Scale
SUD: Substance Use Disorder

Other Related Materials:
Michigan Department of Health and Human Services Medicaid Managed Specialty Supports and Services Contract

References/Legal Authority:

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer
08.2015	Update MDHHS and definition for Provider Network	Chief Compliance Officer
08.2016	Annual Review	Director of Compliance, Customer Service and Quality

POLICIES AND PROCEDURE MANUAL

Chapter:	Compliance		
Title:	Compliance Investigations Summary Reporting		
Policy: ☑ Procedure: ☐ Version: 1.0 Page: 1 of 2	Review Cycle: Annually Author: MSHN Chief Compliance Officer, Quality Improvement (QI) Council	Adopted Date: 04.07.2015 Review Date: 11.01.2016 Revision Eff. Date:	Related Policies: Compliance & Program Integrity

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To ensure MSHN staff and its Provider Network report suspected Medicaid fraud and abuse and complete investigations in accordance with the MSHN Compliance Plan; Reporting and Investigations.

Policy

MSHN staff and its Provider Network, shall report all suspected Medicaid fraud and abuse to the MSHN Compliance Officer and/or the CMHSP Participant/SUD Provider designated Compliance Officer in accordance with standards established in the MSHN Compliance Plan and MSHN Compliance Reporting and Investigations Policy. Investigations shall be conducted in accordance with the MSHN Compliance Plan; Reporting and Investigations.

MSHN's Provider Network shall submit compliance activity reports semi-annually to the MSHN Compliance Officer in a format as requested by MSHN. Minimally the report will include the following:

1. Number of complaints of fraud and abuse that warrant preliminary investigation
2. For each instance that warrants a full investigation, supply the:
    a. The providers name and number;
    b. The source of the complaint;
    c. The type of provider;
    d. The nature of the complaint;
    e. The approximate range of dollars involved; and
    f. The legal and administrative disposition of the case, including actions taken by law enforcement official (if case was referred)

The MSHN Compliance Officer will prepare a semi-annual summary report of the Provider Network and direct MSHN compliance activities and present to the Quality Improvement Council, MSHN Compliance Committee, MSHN Operations Council and MSHN Board of Directors.

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:
CMHSP: Community Mental Health Service Program
MSHN: Mid-State Health Network
Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors.
SUD: Substance Use Disorder

Other Related Materials:
MSHN Compliance Plan
MSHN Compliance Investigation Reports

References/Legal Authority:
1. 42 Code of Federal Regulations 455.17 – Reporting Requirements
2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY17 contract, Fraud and Abuse Reporting Responsibilities, Part III, section 2.0
3. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY17 contract, Attachment P 7.7.1.1: PIHP Reporting Requirements

Change Log:

Date of Change	Description of Change	Responsible Party
03.2015	New Policy	Chief Compliance Officer
03.2016	Annual Review	Quality, Compliance and Customer Service Director
08.2016	Annual Review	Director of Compliance, Customer Service & Quality

POLICIES AND PROCEDURE MANUAL

Chapter:	Compliance		
Title:	Compliance Reporting and Investigations		
Policy: ☒ Procedure: ☐ Version: 1.0 Page: 1 of 2	Review Cycle: Annually Author: Chief Compliance Officer, QI Council	Adopted Date: 04.07.2015 Review Date: 11.01.2016 Revision Eff. Date:	Related Policies: Compliance & Program Integrity

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To ensure MSHN staff and its Provider Network report suspected violations or misconduct and complete investigations in accordance with the MSHN Compliance Plan; Reporting and Investigations.

Policy

MSHN staff and its Provider Network, shall report all suspected violations or misconduct to the MSHN Compliance Officer and/or the appropriate CMHSP Participant/SUD Provider designated Compliance Officer. Reporting and Investigations shall be conducted in accordance with the MSHN Compliance Plan; Reporting and Investigations.

Where internal investigation substantiates a reported violation, corrective action plans will be initiated by MSHN staff or its Provider Network. Corrective action plans developed by the Provider Network, shall be submitted to the MSHN Compliance Officer within thirty (30) days of the approved plan.

The MSHN Compliance Officer shall review corrective action plans and ensure, as appropriate, prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, coordinating with the CMHSP designee for follow-up monitoring and oversight, and implementing system changes to prevent a similar violation from recurring in the future.

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:

CO: Compliance Officer
CMHSP: Community Mental Health Service Programs
MSHN: Mid-State Health Network
PIHP: Pre-paid Inpatient Health Plan
Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors
SUD: Substance Use Disorder

Other Related Materials:

MSHN Compliance Plan

References/Legal Authority:

1. 42 Code of Federal Regulations 455.17 – Reporting Requirements

2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY17 contract, Fraud and Abuse Reporting Responsibilities, Part III, section 2.0
3. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY17contract, Attachment P 7.7.1.1: PIHP Reporting Requirements

Change Log:

Date of Change	Description of Change	Responsible Party
03.2015	New Policy	Chief Compliance Officer, QI Council
03.2016	Annual Review	Quality, Compliance & Customer Service Director
08.2016	Annual Review	Director of Compliance, Customer Service & Quality

MIDSTATE HEALTH NETWORK
POLICIES AND PROCEDURE MANUAL

Chapter:	**Compliance**		
Section:	**Compliance and Program Integrity**		
Policy: ☒ **Procedure:** ☐ **Version:** 2.0 **Page:** 1 of 3	**Review Cycle:** Annually **Author:** Chief Compliance Officer	**Adopted Date: 11.2013** **Review Date:** 11.01.2016 **Revision Effective Date:** 01.05.2016	**Related Policies:** NA

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

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

Policy

A. Corporate Compliance:

1. MSHN shall establish, implement and maintain a region-wide Corporate Compliance Plan that is in accordance with federal and state statutes, laws and regulations. MSHN will furthermore adhere to regulations required by the Attorney General's Office, Office of Inspector General, Centers for Medicaid and Medicare, and relevant accrediting bodies.
2. The MSHN Corporate Compliance Plan provides the framework for MSHN to comply with applicable laws, regulations and program requirements, minimize organizational risk, maintain internal controls, and encourage the highest level of ethical and legal behavior.
3. The CMHSP Participant's and the SUD Prevention and Treatment Provider System shall have policies and procedures necessary to comply with the MSHN CCP and shall ensure effective processes for identifying and reporting suspected fraud, abuse and waste, and timely response to detected offenses with appropriate corrective action.
4. The CMHSP Participant's and the SUD Prevention and Treatment Provider System shall identify a Corporate Compliance Officer.
5. The CMHSP Participant's and the SUD Prevention and Treatment Provider System shall provide staff training in compliance with the CCP and will maintain records of staff attendance. Trainings shall include, but are not limited to: Federal False Claims Act, Michigan False Claims Act and Whistleblowers Protection Act.
6. The CMHSP Participant's and the SUD Prevention and Treatment Provider System shall require all Board members, employees and contractors to comply with corporate compliance requirements including any necessary reporting to other agencies.
7. The CMHSP Participant's and the SUD Prevention and Treatment Provider System shall review their own compliance activities at least annually and will participate in the annual review of the MSHN CCP, and provide recommendations for revisions as needed.

B. Ethical Standards/Program Integrity

1. All services within the MSHN shall be provided with commitment to appropriate business, professional and community standards for ethical behavior.
2. MSHN shall develop and maintain Standards of Conduct applicable to all MSHN staff, CMHSP Participant's and the SUD Prevention and Treatment Provider System.
3. MSHN shall conduct business with integrity and not engage in inappropriate use of public resources.
4. MSHN shall ensure that services are provided in a manner that maximizes benefit to consumers while avoiding risk of physical, emotional, social, spiritual, psychological or financial harm.
5. All MSHN staff, CMHSP Participant's and the SUD Prevention and Treatment Provider System shall conduct themselves in such a way as to avoid situations where prejudice, bias, or opportunity for personal or familial gain, could influence, or have the appearance of influencing, professional decisions.

Applies to:

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

Definitions/Acronyms:

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

Related Materials:

Mid-State Health Network Corporate Compliance Plan
CMHSP Participant and the SUD Prevention and Treatment Provider System

References/Legal Authority:

1. Department of Health and Human Services, Office of Inspector General, Publication of the OIG Compliance Program Guidance for Hospitals.
2. Michigan False Claims Act (Act 72 of 1997)
3. Michigan Whistleblowers Protection Act (Act 469 of 1980)
4. Deficit Reduction Act of 2005

Change Log:

Date of Change	Description of Change	Responsible Party
11.2013	New Policy	Chief Compliance Officer
11.2014	Annual Review	Chief Compliance Officer
11.2015	Annual Review & Updates	Director of Compliance, Customer Services and QI
08.2016	Annual Review	Director of Compliance, Customer Services and Quality

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	**Confidentiality and Notice of Privacy**		
Policy: ☑ **Procedure:** ☐ **Version:** 2.0 **Page:** 1 of 2	**Review Cycle:** Annually **Author:** Chief Compliance Officer, Customer Service Committee	**Adopted Date: 09.02.2014** **Review Date:** 11.01.2016 **Revision Eff. Date:** 11.03.2015	**Related Policies:** Customer Service

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To assure the information contained in the records of the beneficiaries of Mid-State Health Network (MSHN) or other such recorded information required to be held confidential by Federal Drug and Alcohol Confidentiality Law (42 CFR, Part 2), Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 CFR 160 and 164) and/or Mental Health Code (PA 258 of 1974) and Public Health Code (PA 368 of 1978), as amended, in connection with the provision of services or other activity under this agreement shall be confidential and protected communication.

Policy

MSHN staff and the provider network shall comply with confidentiality and protected communication in accordance with the Michigan Department of Health and Human Services (MDHHS) Medicaid Managed Specialty Supports and Services Contract.

1. Confidential and protected communication shall not be divulged without the written consent of either the recipient or a person responsible for the recipient except as may be otherwise required or allowed by applicable law or regulation. Such information may be disclosed in summary, statistical, or other form, which does not directly or indirectly identify particular individuals.
2. Beneficiaries will receive information regarding privacy and confidentiality as defined in attachment 6.3.1.1 of the MDHHS contract.
3. Non-compliance with confidentiality and notice of privacy will be addressed as outlined in the MSHN Personnel Manual (MSHN staff) or contractual language provisions (contracted personnel and providers) that may result in suspension/termination of employment or contract.

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:
HIPPA: Health Insurance Privacy and Portability Act
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network

Other Related Materials:
N/A

References/Legal Authority:

Federal Drug and Alcohol Confidentiality Law (42 CFR, Part 2)
Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 CFR 160 and 164) Mental Health Code (PA 258 of 1974)
Public Health Code (PA 368 of 1978)

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer
08.2015	Update MDHHS	Chief Operating & Finance Officer
07.2016	Annual Review	Customer Service and Recipient Rights Specialist

POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	**Research Policy**		
Policy: ☒ **Procedure:** ☐ **Version: 2.0** **Page: 1 of 3**	**Review Cycle:** Annually **Author: Chief Compliance Officer, Quality Improvement (QI) Council**	**Adopted Date: 09.02.2014** **Review Date:** 11.01.2016 **Revision Eff. Date:** 11.2015	**Related Policies:** Quality Management

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To protect the rights and well-being of human subjects of research conducted by Mid-State Health Network (MSHN) and/or its provider network and to ensure compliance with the Protection of Human Subjects Act, 45 CFR, Part 46 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Policy

Prior to initiation of research by MSHN and/or its provider network MSHN will submit Institutional Review Board (IRB) application material for all research involving human subjects that is conducted in programs sponsored by the Michigan Department of Health and Human Services (MDHHS) or in programs that receive funding from or through the State of Michigan. The application and approval material will be submitted to the MDHHS's IRB for review and approval or for acceptance of the review by another IRB. All such research must be approved by a federally assured IRB, but the MDHHS's IRB can only accept the review and approval of another institution's IRB under a formally-approved interdepartmental agreement. The manner of the review will be agreed upon between the MDHHS's IRB Chairperson and the Contractor's IRB Chairperson or Executive Officer(s).

Research initiated prior to MSHN contracting shall be acceptable provided, upon request, the responsible CMHSP can provide evidence of appropriate MDHHS IRB or alternative review.

All research and related projects shall be conducted in such a manner as to ensure the rights, benefits, and privileges guaranteed by law.

All research involving MSHN consumers must be reviewed and approved by a MSHN or MSHN Contractor Research Review Committee before involvement of MSHN subjects in the project. Externally funded projects involving the use of MSHN consumers are to be approved by a MSHN Research Review Board. MSHN acknowledges that grant application time frames may require submission prior to MSHN review; however, approval by the MSHN research review board is required prior to acceptance and implementation of the grant award.

The Research Review Board shall include minimally:

1. A Senior officer of MSHN or its contractors
2. A senior clinician with expertise with the identified population
3. A recipient rights officer
4. A medical director for medically related research

The Research Review Board is responsible for reviewing proposed research projects involving human subjects before submission to the MDHHS's IRB for approval of the research project to ensure that:

1. The rights and welfare of the subjects are protected;
2. Written informed consent is obtained from each subject using appropriate methods;
3. The risks and potential benefits are disclosed to participating subjects; and
4. Review completed (IRB) application material

MSHN may request additional expertise when necessary for adequate review by the Research Review Board.

The research review board shall maintain a written record of all research proposals and publication submissions and report at least annually to the MSHN Operations Council.

Applies to:

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

Definitions:
HIPAA: Health Insurance Portability & Accountability Act.
Human subject: (as defined by 45 CFR, Part 46.102) means a living individual about whom an investigator (whether professional or student) conducting research obtains
(1) Data through intervention or interaction with the individual, or
(2) Identifiable private information.
IRB**:** Institutional Review Board reviews, approves, and monitors research that directly or indirectly involves living persons, their issues or personal information, in order to protect the rights of the participants.
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health & Human Service
Provider Network: Refers to a Community Mental Health Services Program (CMHSP) Participant and a Substance Abuse Coordinating Agency (CA) that is directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's and CA's subcontractors.
Research Review Board: A body of appointed MSHN or MSHN contractor staff with the knowledge and experience required to function as an IRB.
Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

Other Related Materials:
N/A

References/Legal Authority:
45 CFR 46: Human Subjects Research

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer
08.2015	Update to MDHHS and to include accommodation to research prior to contracting with MSHN	Chief Operating & Finance Officer; Chief Executive Officer
08.2016	Annual Review	Director of Compliance, Customer Service & Quality

POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	**Michigan Mission Based Performance Indicator System**		
Policy: ☑ **Procedure:** ☐ **Version:** 2.0 **Page:** 1 of 3	**Review Cycle:** Annually **Author:** Quality Improvement Council, Chief Compliance Officer	**Adopted Date: 09.02.2014** **Review Date:** 11.01.2016 **Revision Eff. Date:** 11.2015	**Related Policies:** Quality Mgmt. Policy Required Reporting

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To clearly delineate the dimensions of quality that must be addressed by the Public Mental Health System (inclusive of Substance Use Disorder Programs) as reflected in the Mission statement, in Delivering the Promise, and in the needs and concerns expressed by consumers and the citizens of Michigan. Those domains are Access, Efficiency, and Outcomes.

A. To develop a statewide aggregate status report, to address issues of public accountability for the public mental health system, to provide a data-based mechanism, and to assist the Michigan Department of Health and Human Services (MDHHS) in the management of Pre-Paid Inpatient Health Plan (PIHP) contracts that impact the quality of the service delivery system statewide.

B. To the extent possible, facilitate the development and implementation of local quality improvement systems, link with existing healthcare planning efforts, and establish a foundation for future quality improvement monitoring within a managed health care system for consumers of public mental health services in the state of Michigan. (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program FY14: Attachment P6.5.1.1)

Policy

A. The Provider Network is responsible for collecting and reporting to Mid-State Health Network (MSHN) all performance indicators as specified in the MDHHS Medicaid Specialty Supports and Services Contract.

B. The Provider Network reports the performance indicator data as required to MSHN for analysis. MSHN then reports to the MDHHS the performance indicator data as required and in accordance with the Medicaid Managed Specialty Supports and Services Contract.

C. MSHN will provide a summary report/analysis demonstrating performance to each Provider Network participant following the submission of the Michigan Mission Based Performance Indicator System (MMBPIS) to MDHHS. All Provider Network participants who exhibit performance below the standard for an indicator during the reported quarter will be subject to an improvement plan. The Provider Network is responsible for ensuring a process is in place to implement corrective action plans and quality improvement processes in an effort to improve the access, efficiency, and outcomes of services provided by the Provider Network participant as monitored through the performance indicator system. It is an expectation that the Provider Network manage their subcontractors to ensure compliance and to provide evidence of the reported data.

D. Noncompliance with the above indicators and related improvement plans will be addressed per the contract provisions.

E. Oversight and monitoring will be conducted by MSHN through the review of reports and analysis by the Quality Improvement Council and provider network monitoring desk audit and site reviews.

F. The Performance Indicators as defined by MDHHS:

1. Access:

1. The percent of all Medicaid adults and children beneficiaries that receive a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three (3) hours.
2. The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within fourteen (14) calendar days of non-emergency request for service (MI Adults, MI Children, DD Adults, DD Children, and Medicaid SUD). *
3. The percent of new persons starting any needed ongoing service within fourteen (14) days of a non-emergent assessment with a professional (MI Adults, MI Children, DD Adults, DD Children, and Medicaid SUD). *
4. (a) The percent of discharges from psychiatric inpatient unit who are seen for follow-up care within seven (7) days (All children and all adults (MI, DD).

4. (b) The percent of discharges from a substance use disorder detox unit who are seen for follow-up care within seven (7) days (All Medicaid SUD). *

5. The percent of Medicaid recipients having received PIHP managed services (MI adults/MI children/DD Adults/DD children, and SUD). **

2. Adequacy/Appropriateness:

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one (1) HSW service per month that is not support coordination. **

3. Efficiency:

7. The percent of total expenditures spent on managed care administrative function for PIHPs. **

4. Outcomes:

8. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who are in competitive employment. **
9. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who earn minimum wage or more from employment activities (competitive, supported employment, or sheltered workshop). **
10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within thirty (30) days of discharge.
11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and DD served in the categories of Abuse I and II, and Neglect I and II.
12. The percent of adults with developmental disabilities served who live in a private residence alone or with spouse or non-relative(s). **
13. The percent of adults with serious mental illness served who live in a private residence alone or with spouse or non-relative(s). **

14. Percentage of children with developmental disabilities (not including children in the Children Waiver Program) in the quarter who receive at least one service each month other than Case Management and Respite. **

* Calculated by the PIHP from CareNet.
**MDHHS Calculates. The PIHP does not submit data through this process.

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

Definitions:
CMHSP: Community Mental Health Service Plan
DD: Developmental Disability
HSW: Habilitation Supports Waiver
MDHHS: Michigan Department of Health and Human Services
MI: Mental Illness
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
Provider Network: refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through CMHSP subcontractors.
SUD: Substance Use Disorder

Other Related Materials:
The Performance Indicator Description of Project Study
The Performance Indicator Detail Data Collection Instructions

References/Legal Authority:
MDHHS-Medicaid Managed Specialty Support and Services Contract
Attachment P.7.7.1.1
Attachment P.7.9.1
FY14_PI_PIHP_Code Book

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer
11.2015	Annual review and update to MDHHS	Director of Compliance, Customer Service & Quality
08.2016	Annual Review	Director of Compliance, Customer Service & Quality

Background

- 80-85% of SUD contracts (non CMHSP) are financed under a fee-for-service model, as are a vast majority of CMHSP contracts
- MSHN's objective is to standardize, where appropriate, purchasing arrangements across the region
- MSHN is evaluating contracts where there is a significant variance in costs and/or utilization among like providers in an attempt to understand and justify variance
  - If variance cannot be adequately justified, changes will be initiated with the provider
- Providers impacted by the transition were notified in May during a provider meeting and subsequent email communique
- MSHN has engaged in dialogue with providers, and in most cases, agreements were reached

Process - Financial Analysis

The following steps were taken for all providers during the financial analysis process:

1) Review Fiscal Year 2016 allocation
2) Project full year expenses based on claims received to date during analysis period
3) Project revenue based on HCPCS/CPT codes that were billed utilizing MSHN's regional rates for each service
4) Identified activities not defined by HCPCS/CPT codes. If not easily defined, the activity would remain cost reimbursement with MSHN developing new reporting requirements
5) Use information from steps 3 & 4 to establish FY 17 budget

Process – Evaluate Data and Engage Providers

- Understand and confirm program operates within federal and state rules/regulations
- Understand and confirm fund source designations
- Understand and explain variances
  - Justify differences as appropriate
  - Propose alternate purchasing arrangement if not justified
- For situations which require additional time to collect meaningful data, contracts were extended

Process - Clinical Review

- Through providers annual plan submission, clinical staff reviewed service array to ensure clinical appropriateness
- Ensure services follow a recovery oriented systems of care; often recommending expanding services to include peer supports, women's specialty services, recovery housing
- In some instances, clinical charts were randomly selected for review to ensure compliance with state and federal standards/policies, determine eligibility requirements were met, etc.

Provider A

costs per unit/per consumer are 250% greater than other like providers in the region; 6 of 7 of the comparison group were financed through MSHN's regional rates

Provider Feedback

- 2 of 4 programs could be sustained under MSHN's regional rates
- 2 of 4 programs would not be sustainable under MSHN's regional rates

Resolution/Next Steps

- 2 programs will be reimbursed under MSHN's regional rates
  - Internal "soft" allocation set based on projected utilization
- 2 programs will be further evaluated over the next 6 months
  - 6 month contract extension
  - Obtained additional information from provider
  - Scheduled working session with provider to conduct a full review of expenses, discuss variances, etc.

Provider B

consumer and encounter data has not been reported; uncertain if consumers funded have a primary SUD diagnosis; unable to determine impact of moving to an alternative funding model

Provider Feedback

- Uncertain as to how they would report encounters
- Some activities do not have HCPCS/CPT codes associated
- Concerns that they would need to eliminate staff
- Compliance with state and MSHN policies would fundamentally change the structure of their program

Resolution/Next Steps

- Renewed contract under cost reimbursement
- Clinical chart review conducted to ensure documentation is appropriate and program meets BSAAS treatment policy requirements; corrective action plan developed to address deficiencies
- Established encounter reporting expectations (CareNet) effective 10/1/16
- Mid-year meetings scheduled to review clinical and encounter documentation; cost analysis review
- Possibly develop bundled payment methodology

Provider C

consumer and encounter data has not been reported; uncertain if consumers funded have a primary SUD diagnosis; unable to determine impact of moving to an alternative funding model

Provider Feedback

- MSHNs regional rates would not cover program expenses
- Program was developed to serve the mild-moderate population which could not access services elsewhere

Resolution/Next Steps

- Renewed contract under cost reimbursement
- Clinical chart review conducted to ensure documentation is appropriate and program meets BSAAS treatment policy requirements
- Established encounter reporting expectations (CareNet)
- Possibly involve Medicaid Health Plans
- Possibly develop bundled payment methodology

Provider D

providers costs are substantially higher than other like providers offering similar services

Provider Feedback

- Volume will not sustain program at current MSHN regional rates
- Not all services have an associated HCPCS/CPT code
- Estimate substantial reduction in funding
- Organizational barriers would not permit a transition in preparation for FY17

Resolution/Next Steps

- Extended existing contract through Q2
- Worked with provider to ensure all encounters are being reported in CareNet
- Scheduled on-site meeting to obtain information about services, review clinical documentation, and discuss how to report direct and indirect expenses; discuss expectation to increase volume of persons served
- Present contract amendment to BOD in January

Provider E

most services provided have an associated HCPCS/CPT codes

Provider Feedback

- Several services were implemented as part of OROSC grant funding; would like time to build program
- In agreement that transition to funding under MSHN's regional rates is appropriate for FY18
- Concerned with potential cash flow issues during certain months when business ebbs and flows

Resolution/Next Steps

- Purchased/reimbursed services as appropriate according to MSHN's regional rates
- Continued several new programs under cost reimbursement for FY17
- Developed a risk reserve for provider to request during times when cash flow is an issue
- Evaluating revenue and engage in dialogue quarterly with the understanding that reserve *may* be recouped

Provider F

most services provided have an associated HCPCS/CPT codes

Provider Feedback

- Newly implemented program in FY16 needed time to build sustainability
- Historically, unable to support program expenses under FFS financing method
- Indirect, non-billable activities are necessary to be accepted by the community
- Rural setting leads to high no-show rates

Resolution/Next Steps

- Purchased/reimbursed services as appropriate according to MSHN's regional rates
- Continued several new programs under cost reimbursement for FY17
- Continued newly implemented program under cost reimbursement with the agreement that it would be purchased/reimbursed according to MSHN's regional rate in FY18

POLICIES MANUAL

Chapter:	General Management		
Title:	**Board Member Conduct and Board Meetings Procedure**		
Policy: ☒ **Procedure:** ☐ **Version:** 2.0 **Page:** 1 of 3	**Review Cycle:** Annually **Author:** Chief Executive Officer	**Adopted Date:** 01.06.2015 **Review Date: 01.2016** **Revision Eff. Date:**	**Related Policies:** Program Integrity Conflict of Interest Privacy & Confidentiality

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

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

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

Policy

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

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

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

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

Compliance with Laws, Rules and Regulations: Board members shall comply with all laws, rules and regulations applicable to MSHN.

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

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

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

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

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

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

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

Board Meeting Procedures

A. MSHN Board meetings shall be conducted in accordance with board bylaws and parliamentary procedures. Specifically the process of decision and order of procedures shall occur as outlined in the bylaws section 5.6-5.12.

B. After being recognized by the Chairperson, each Board member may speak on items presently before the Board twice, for up to three (3) minutes each time. The Chairperson may extend an additional (3) minute speaking period at the request of the individual board member or if duly authorized by board action.

C. Any member can motion to close debate, which motion must be seconded and is not debatable. If the motion passes, such debate shall terminate.

Applies to

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

Definitions

Boardsmanship: Describes the competencies and skills necessary to be an effective Board member
CEO: Chief Executive Officer
MSHN: Mid-State Health Network

MDHHS: Michigan Department of Health and Human Services
PIHP: Pre-Paid Inpatient Health Plan

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

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

Change Log:

Date Of Change	Description of Change	Responsible Party
01.06.2015	New	Chief Executive Officer
11.2015	Annual Review	Chief Executive Officer

Background:

Renewal of MSHN annual membership with the Michigan Association of Community Mental Health Boards (MACMHB) is recommended to allow MSHN access to the full range of membership benefits, and support PIHP related activities within the Association. Fees are annually assessed equally across all ten (10) PIHPs. The resulting proposed expense for Mid-State Health Network is $2,504.

Recommended Motion:

Motion to approve the renewal of MACMHB FY17 Membership, in the amount of two-thousand, five-hundred and four dollars ($2,504).

Background:

In accordance with established MSHN Board of Directors policy and practice to review the financial status of Mid-State Health Network, at a minimum quarterly, the unaudited preliminary financial statements and reports for the Period Ending September 30, 2016 have been provided and presented for review and discussion.

Recommended Motion:

The MSHN Board of Directors receives and files the preliminary Financials for the Period Ending September 30, 2016, as presented.

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

	Budget Annual amendment 2016	Actual Year-to-Date	Budget Year-to-Date amendment 2016	Budget Difference	Budget Variance	
Revenue:						
Medicaid Use of Carry Forward	$ 22,639,671	$ (4,109,277)	$ 22,639,671	$ (26,748,948)	(118.15) %	1a
Medicaid Capitation	470,923,408	465,942,361	$ 470,923,408	(4,981,047)	(1.06) %	1b
Local Contribution	3,934,868	3,934,868	$ 3,934,868	0	0.00 %	1c
Interest Income	87,631	88,257	$ 87,631	626	0.71 %	1d
Change in Market Value	0	4,197	$ 0	4,197	0.00 %	
Non Capitated Revenue	15,585,173	15,726,297	15,585,173	141,124	0.91 %	1e
Total Revenue	513,170,751	481,586,703	513,170,751	(31,584,048)	(6.15) %	
Expenses:						
PIHP Administration Expense:						
Compensation and Benefits	2,822,518	3,145,133	2,822,518	322,615	11.43 %	
Consulting Services	251,150	205,429	251,150	(45,721)	(18.20) %	
Contracted Services	96,762	88,921	96,762	(7,841)	(8.10) %	
Board Member Per Diems	11,783	12,669	11,783	886	7.52 %	
Meeting and Conference Expense	139,212	145,673	139,212	6,461	4.64 %	
Liability Insurance	41,741	43,966	41,741	2,225	5.33 %	
Facility Costs	136,230	121,591	136,230	(14,639)	(10.75) %	
Supplies	189,884	216,613	189,884	26,729	14.08 %	
Other Expenses	331,315	311,633	331,315	(19,682)	(5.94) %	
Subtotal PIHP Administration Expenses	4,020,595	4,291,628	4,020,595	271,033	6.74 %	2a
CMHSP and Tax Expense:						
CMHSP Participant Agreements	414,868,868	409,215,513	414,868,868	(5,653,355)	(1.36) %	1b
SUD Provider Agreements	33,982,254	34,444,137	33,982,254	461,883	1.36 %	1b
Benefits Stabilization	0	(10,225,905)	0	(10,225,905)	0.00 %	1a
Other Contractual Agreements	1,115,743	1,190,109	1,115,743	74,366	6.67 %	2b
Tax - Local Section 928	3,934,868	3,934,868	3,934,868	0	0.00 %	1d
Taxes-Use/HICA/HRA	38,609,959	38,368,530	38,609,959	(241,429)	(0.63) %	2c
Subtotal CMHSP and Tax Expenses	492,511,692	476,927,252	492,511,692	(15,584,440)	(3.16) %	
Total Expenses	496,532,287	481,218,880	496,532,287	(15,313,407)	(3.08) %	
Excess of Revenues over Expenditures	$ 16,638,464	$ 367,823	$ 16,638,464	$ (16,270,641)		

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

Assets		
Cash and Short-term Investments		
Chase Checking Account	13,188,213	1a
Chase MM Savings	1,003,220	
Savings ISF Account	15,541,039	1b
Savings PA2 Account	3,612,150	1c
Investment PA2 Account	0	
Investment ISF Account	11,712,044	1b
Petty Cash on Hand	200	
Total Cash and Short-term Investments	$ 45,056,866	
Accounts Receivable		
Due from MDHHS	1,551,930	2a
Due from CMHSP Partipants	31,489,808	2b
Due from CMHSP	18,000	2c
Due from other governments	155,827	2d
Due from miscellaneous	510	
Total Accounts Receivable	33,216,075	
Prepaid Expenses		
Prepaid Expense Other	200	
Total Prepaid Expenses	200	
Total Assets	**$ 78,273,141**	
Liabilities and Net Position		
Liabilities		
Accounts Payable	$ 9,437,162	1a
Current Obligations (Due To Partners)		
Due to State	0	
Other Payable	0	
Due to State-Use Tax	914,211	1a
Due to State HRA Accrual	10,956	
Due to State HICA Accrual	815,716	
Due to CMHSP Participants	1,319	3a
Accrued PR Expense Wages	0	
Accrued Benefits PTO Payable	146,544	3b
Total Current Obligations (Due To Partners)	1,888,746	
Deferred Revenue	39,413,762	1c 2a 3a
Total Liabilities	50,739,670	
Net Position		
Unrestricted	280,389	3c
Restricted for Risk Management	27,253,082	1b
Total Net Position	27,533,471	
Total Liabilities and Net Position	**$ 78,273,141**	

Notes to Financial Statements

For the Twelve Month Period Ended September 30, 2016

Please note: The Statement of Net Position and the Statement of Activities contain 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 August 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 $9.26 million of PA2 and $3.9 million of cash available for operations. They also include $9.4 million for the balance due to CMHSPs for September Medicaid with an offsetting liability in Accounts Payable. There is an additional $1.7 million for taxes with an offset to the Use and HICA tax liability accounts.
    b) The Savings ISF and Investment ISF Accounts reflect where MSHN holds the Medicaid ISF funds separate from all other funding per the MDHHS contract. This total of $27.2 million generally offsets the Restricted for Risk Management net position account, however this account contains an ISF transfer from Fiscal Years 2014 and 2015 of $2.2 and 4.2 million respectively.
    c) The Savings PA2 and Investment PA2 Accounts hold the remaining $3.6 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 four CMHSPs.
    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 each 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 amounts owed to CMHSPs for FY 2016 interest distributions.
    b) Accrued Benefits PTO (Paid Time Off) payable is the liability account set up to reflect paid time off balances for the employees.
    c) Unrestricted Net Position represents the difference between totals assets, total liabilities, and the restricted for risk management figure.

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 2016 budgets. We are under budget in this area because potential cost settlement figures have been placed in the Statement of Net Positions deferred revenue. We anticipate the CMHSPs will return the unexpended funds to MSHN and these amounts will then be available as savings for use in Fiscal Year 2017. The current benefit stabilization dollars are sent to CMHSPs based on MSHN's smoothing plan. The number is negative since preliminary year-end journal entries have been completed. This indicates MSHN will most likely receive more funds back from CMHSPs through cost settlement than the amounts sent during the fiscal year.
    b) Medicaid Capitation – we have received $4.9 million less than the budgeted Medicaid amount. This variance will be reduced once the anticipated Fiscal Year 2016 Autism revenue is accrued. There is currently a five-month lag in Autism payments from the MDHHS and the final cost settlement generally occurs more than a year after fiscal year-end. 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.
    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 over the amended budget amount and is related to a PTO accrual that occurred in September. Also, the Social Security refund reduced the amount of expense in this line item which caused an insufficient projection in expense. In addition, credit card accruals impacted the budget variance. The expense will be adjusted once actual credit card statements are coded.
    b) Other contractual agreements are slightly over budget. The budget amendment process includes reviewing expenses at a point in time and then projecting the year-end amounts. Several vendors did not have any expenses until after the amendment process was complete. These additional expenses totaled more than $72 thousand dollars. MSHN recognizes the need for improved communication in this area in order to identify any and all potential vendor expenses.
    c) HRA, HICA and Use taxes are in line with the budget amount.

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

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY
FEDERAL FARM CREDIT BANK	3130A2Y75	9.11.14	9.12.14	3.10.16		1,000,022.22	1,000,000.00	0.400%
FEDERAL FARM CREDIT BANK	3130A2Y75			3.10.16		1,002,000.00	(1,000,000.00)	
FEDERAL FARM CREDIT BANK	3133EEEF3	12.3.14	12.9.14	3.9.17	3.9.15	1,000,000.00	1,000,000.00	0.730%
FEDERAL FARM CREDIT BANK	3133EEEF3			5.9.16			(1,000,000.00)	
FEDERAL FARM CREDIT BANK	3133EEYD6	4.7.15	4.13.15	10.13.17	7.13.15	2,000,000.00	2,000,000.00	0.890%
FEDERAL FARM CREDIT BANK	3133EEYD6			7.15.16			(2,000,000.00)	
FEDERAL HOME LOAN BANK	3134G6VK6	4.22.15	4.28.15	7.26.17	7.28.15	1,000,000.00	1,000,000.00	0.800%
FEDERAL HOME LOAN BANK	3134G6VK6						(1,000,000.00)	
FEDERAL HOME LOAN BANK	3130A4ZX3	4.23.15	5.14.15	5.14.18	8.14.15	1,000,000.00	1,000,000.00	1.448%
FEDERAL HOME LOAN BANK	3130A4ZX3						(1,000,000.00)	
FEDERAL HOME LOAN BANK	3134G7C66	9.28.15	10.15.15	10.15.18	1.15.16	2,000,000.00	2,000,000.00	0.750%
FEDERAL HOME LOAN BANK	3134G7C66			7.15.16			(2,000,000.00)	
FEDERAL HOME LOAN MTG	3134G7P62	9.28.15	10.26.15	10.26.18	1.26.16	2,000,000.00	2,000,000.00	0.625%
FEDERAL HOME LOAN MTG	3134G7P62			7.26.16			(2,000,000.00)	
FEDERAL HOME LOAN BANK	3130A6JD0	9.28.15	10.27.15	4.27.18	1.27.16	2,000,000.00	2,000,000.00	1.000%
FEDERAL HOME LOAN BANK	3130A6JD0			7.27.16			(2,000,000.00)	
FEDERAL HOME LOAN BANK	3130A6K22	9.29.15	9.30.15	6.28.18	12.28.15	2,000,000.00	2,000,000.00	1.000%
				6.28.16			(2,000,000.00)	
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	1,001,811.00	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	1,025,554.00	0.600%
NORTH BRANCH MI SCHOOLS	657740FP6	7.14.16	7.27.16	5.1.19	no	635,115.60	634,800.00	1.450%
MICHIGAN ST GO SCHOOL	5946106V4	8.15.16	8.18.16	4.15.17	no	1,031,638.33	1,016,073.00	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							11,671,113.00	
JP MORGAN CHASE SAVINGS							15,447,095.21	0.050%
							$ 27,118,208.21	

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 and FY16 Contract Listing for Board approval and authorization of the Chief Executive Officer to sign.

Recommended Motion:

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

The MSHN Board authorizes its Chief Executive Officer to sign and fully execute the amended contracts as presented and listed on the FY16 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2017 NEW AND RENEWING CONTRACTS
November 2016

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	ORIGINAL CONTRACT AMOUNT	FY 2017 TOTAL CONTRACT AMOUNT	INCREASE/ (DECREASE)
CEI Community Mental Health Authority	Behavioral Health Services for Clinton, Eaton & Ingham, (CEI)	10.1.16 - 9.30.17	87,723,830	**97,995,505**	10,271,675
Lifeways Community Mental Health Authority	Behavioral Health Services for Jackson & Hillsdale	10.1.16 - 9.30.17	60,562,243	**59,676,843**	(885,400)
			$ 148,286,073	$ 157,672,348	$ 9,386,275

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					
Dawn Farm	**Residential/Detox (New Provider; Utilization unknown)**	11.1.16 - 9.30.16	-	**50,000**	50,000
Lexington Community Counseling Center	**I.M.P.A.C.T. (Incorporation to Maximize Personal Achievement with Community Training)**	10.1.16 - 9.30.17	-	**56,200**	56,200

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL COST REIMBURSEMENT CONTRACT AMOUNT	FY 2017 TOTAL COST REIMBURSEMENT CONTRACT	INCREASE/ (DECREASE)
Arbor Circle	**Enhanced Women's Specialty/Veteran's Outpatient Programs (Treatment Services being added)**	10.1.16 - 9.30.17	82,309	**180,314**	98,005
Cherry St. Services	**Recovery Supports (PA2 - New prevention program/service)**	10.1.16 - 9.30.17	178,789	**200,969**	22,180
Child & Family Charities	**Outpatient, Recovery Supports, Mentorship; Case Management; SBIRT; Clinton County Adolescent Treatment (Addt'l funding for ongoing programs)**	10.1.16 - 9.30.17	487,616	**795,622**	308,006
Child Advocacy Center	**Prevention Services**	10.1.16 - 9.30.17	149,890	**150,567**	677
Cristo Rey Counseling Services	**OROSC Continuation; SBIRT; Recovery Supports; Women's Specialty Services (Moving FFS estimate amount to CR)**	10.1.16 - 9.30.17	365,100	**562,006**	196,906
DOT Caring Center	**Recovery Support - Bay & Shiawassee (PA2 - New CR Programs for FY17)**	10.1.16 - 9.30.17	-	**10,000**	10,000
Family Services & Children's Aid	**Breakout Program (12 mos. Funding) (New prevention program/services)**	10.1.16 - 9.30.16	152,885	**221,861**	68,976
Family Services & Children's Aid	**Celebrating Families; JUMP Program (both 6 mos. Funding)**	10.1.16 - 3.31.16			

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL COST REIMBURSEMENT CONTRACT AMOUNT	FY 2017 TOTAL COST REIMBURSEMENT CONTRACT	INCREASE/ (DECREASE)
Family Services & Children's Aid	**Children's Case Management Recovery Supports; EPIC Specialist; CC Worker; EWS Program; WS services; OP (Moving FFS to CR)**	10.1.16 - 3.31.16	379,880	**431,661**	51,781
LIST Psychological Services	**Recovery Supports - Huron & Bay (PA2 - New prevention program/services)**	10.1.16 - 9.30.17	69,796	**79,796**	10,000
Peer 360	**Recovery Supports (PA2 - New prevention program provider)**	10.1.16 - 9.30.17	-	**96,440**	96,440
Rise Transitional Housing	**Engagement Center; Equipment; Training & Fees (PA2 - New prevention program/services)**	10.1.16 - 9.30.17	120,000	**136,500**	16,500
Sacred Heart Rehabilitation	**EIP & McLaren Services (PA2 - New prevention program/services)**	10.1.16 - 9.30.17	107,104	**143,693**	36,589
Saginaw Community Mental Health Authority	**Naloxone Project (New SUD provider; program/service)**	10.1.16 - 9.30.17	-	**29,500**	29,500
Ten16 Recovery Network	**Project Star; Project Fresh Start; Drop-In Centers; Recovery Housing (Addt'l funding for addt'l ongoing programs)**	10.1.16 - 9.30.17	676,200	**905,500**	229,300
The Right Door for Hope, Recovery & Wellness	**Jail Services; Peer Recovery (Adding new program/services)**	10.1.16 - 9.30.17	111,000	**212,446**	101,446
Wellness Inx	**PSH Grant ($27,440 thru 12.31.16 only)/Peer Recovery Innovative Strategies**	10.1.16 - 9.30.17	501,470	**583,920**	82,450
			$ 3,382,039	$ 4,740,795	$ 1,358,756

MID-STATE HEALTH NETWORK
FISCAL YEAR 2016 NEW AND RENEWING CONTRACTS
November 2016

CONTRACTING ENTITY	PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL CONTRACT AMOUNT	FY 2016 TOTAL CONTRACT AMOUNT	INCREASE/ (DECREASE)
Maner Costerisan East Lansing, MI	**Accounting & Financial Management**	10.1.15 - 9.30.16	86,580	88,580	2,000
			$ 86,580	$ 88,580	$ 2,000

CONTRACTING ENTITY	SUD PROVIDERS PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL CONTRACT AMOUNT	FY 2016 TOTAL CONTRACT AMOUNT	INCREASE/ (DECREASE)
CareFree Clinic	**Case Management (based on increased utilization)**	10.1.15 - 9.30.16	173,180	**175,418**	2,238
McCullough Vargas & Associates	**Women's Specialty (based on increased utilization)**	10.1.15 - 9.30.16	553,195	**579,260**	26,065
			$ 726,375	$ 754,678	$ 28,303

Background

To comply with the MSHN Medicaid Managed Specialty Supports and Services Contract with MDHHS, specifically as it relates to 7.11 Regulatory Management that states:

> "The PIHP shall have an established process for carrying out corporate compliance activities across its service area. The process includes promulgation of policy that specifies procedures and standards of conduct that articulate the PIHP's commitment to comply with all applicable Federal and State standards. The PIHP must designate an individual to be a compliance officer, and establish a committee that will coordinate analytic resources devoted to regulatory identification, comprehension, interpretation, and dissemination. The compliance officer, committee members, and PIHP employees shall be trained about the compliance policy and procedures. The PIHP shall establish ongoing internal monitoring and auditing to assure that the standards are enforced, to identify other high-risk compliance areas, and to identify where improvements must be made. There are procedures for prompt response to identified problems and development of corrective actions."

The attached 2016/2017 Corporate Compliance Plan was revised through a review by the Quality Improvement Council, MSHN Compliance Committee and the Operations Council with recommendation for approval to the MSHN Board of Directors. In addition, the Corporate Compliance Plan, as proposed, is in compliance with, and supports the MSHN Policy: General Management - Compliance and Program Integrity.

Recommended Motion:

The MSHN Board approves the revised 2016/2017 Corporate Compliance Plan, acknowledges receipt of said plan and supports the compliance efforts contained therein.

CORPORATE COMPLIANCE PLAN
~~2015/~~2016/2017

Mid-State Health Network, Quality Improvement Council Approved: ~~July 23, 2015~~ August 25, 2016
Mid-State Health Network, Corporate Compliance Committee: ~~May 13, 2015~~ September 28, 2016
Mid-State Health Network, Operations Council Approved: ~~August 17, 2015~~ September 19, 2016
Mid-State Health Network PIHP Board Adopted: ~~September 01, 2015~~

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I. OVERVIEW/MISSION STATEMENT

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid-State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Community Health as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Community Mental Health Services Authority ~~(located in Gratiot County), Community Mental Health Authority (located in Tuscola County)~~, Huron County Community Mental Health Authority, ~~Ionia County Community Mental Health Authority~~, LifeWays Community Mental Health Authority, Montcalm Care Network~~County Community Mental Health Authority~~, Newaygo County Community Mental Health Authority, The Right Door (formerly Ionia County CMH), Saginaw County Community Mental Health Authority, ~~and~~ Shiawassee County Community Mental Health Authority~~,~~ and Tuscola Behavioral Health Systems. ~~MDHHS~~ As of October 1, 2015, MSHN took over the direct administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers.

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

II. VALUE STATEMENT

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

III. SCOPE OF PLAN

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

IV. DEFINITIONS

These terms have the following meaning throughout this Compliance Plan.

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

2. CMHSP Participant: refers to one of the twelve member Community Mental Health Services Program (CMHSP) participant in the Mid-State Health Network.

3. Subcontractors: refers to an individual or organization that is directly under contract with a CMHSP to provide services and/or supports.

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

5. Employee: refers to an individual who is employed by the MSHN PIHP.

6. Provider Network: refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors.

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

V. COMPLIANCE PROGRAM

A. Compliance Policies

While the Compliance Plan provides the framework of the Compliance Program, the Compliance Policies provide more specific guidance. Refer to **Attachment A** for a list of the Compliance Policies that are part of the Compliance Program.

B. Compliance Plan

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

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

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

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

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

VI. STRUCTURE OF THE COMPLIANCE PROGRAM

A. General Structure

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

- *Corporate Compliance Committee*: The Corporate Compliance Committee provides guidance, supervision, and coordination for compliance efforts at MSHN. MSHN's Corporate Compliance Committee (CCC) is comprised of the MSHN Chief Executive Officer, Deputy Director, Chief Information Officer, Chief Finance Officer~~Chief Operations & Financial Officer~~, Chief Clinical Director and the Director of Compliance, Customer Service and Quality ~~and Director of Health Integration, Treatment and Prevention~~. The Medical Director and Compliance Counsel will be ad-hoc members of the CCC. In addition, Ex-officio members may be asked to attend as non-voting members to provide consultation on specific areas of expertise.
    a. The Corporate Compliance Committee meets at least semi-annually to review and provide feedback on system process and procedures regarding compliance to the MSHN Compliance Officer. The Corporate Compliance Committee will develop the annual areas of focus that will guide MSHN compliance efforts.

- *Compliance Officer:* The MSHN Compliance Officer has primary responsibility for ensuring that MSHN maintains a successful Compliance Program. In particular, the Compliance Officer oversees the implementation and effectiveness of the Compliance Plan and Compliance Policies, ~~.~~serves as the Chair of the Quality Improvement Council, provides consultative support to the provider network and has responsibility for the day-to-day operations of the compliance program.

- ~~*Director of Compliance, Customer Service and Quality:* The Director of Compliance, Customer Service and Quality shall have responsibility for the day-to-day operations of the compliance program. The Director of Compliance, Customer Service and Quality shall serve as the Chair of the Quality Improvement Council and provide consultative support to the CMHSP participants.~~

- *Quality Improvement Council:* The Quality Improvement Council advises the Operations Council and the MSHN Chief Executive Officer concerning quality improvement matters. The Quality Improvement Council is comprised of the MSHN Director of Compliance, Customer Service and Quality and the CMHSP Participants' Quality Improvement staff appointed by the respective CMHSP Participant Chief Executive Officer/Executive Director. All CMHSP Participants shall have equal representation on this council. Substance Use Disorder services is represented by participation of MSHN SUD staff.

- *Operations Council*: The Operations Council reviews reports concerning quality improvement matters as identified by the Quality Improvement Council and reported by the MSHN Chief Executive Officer. The Operations Council shall be comprised of the Chief Executive Officers or Executive Directors of each CMHSP Participant and the MSHN Chief Executive Officer who serves as Chair.

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

B. MSHN Compliance Officer

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

- Coordinating internal (PIHP Audits) and external provider network audits (MDHHS Audit and EQR Audit) and monitoring activities outlined in the compliance plan.
- Directs and is accountable for the implementation and enforcement of the Compliance Plan.
- Serves as chair of the MSHN's Corporate Compliance Committee and provides leadership to MSHN compliance activity and consultative support to CMHSP P~~p~~articipants/SUD Providers.
- Responsible for oversight of MSHN efforts to maintain compliance with federal and state regulations and contractual obligations.
- Serves as the Privacy Officer for MSHN.

- Ensures that effective systems are in place by which actual or suspected compliance violations are reported in a timely manner to appropriate governing bodies.
- Reviews all reports of actual or suspected compliance violations received by MSHN from any source, and ensures that effective investigation and/or other action is taken.
- Monitors changes in federal and state health care laws and regulations applicable to MSHN operations and disseminate to the region.
- Works collaboratively with other MSHN employees and CMHSP Participants/SUD Providers to ensure that auditing and monitoring protocols are designed to detect and deter potential compliance violations.
- Ensures that performance improvement plans are adequate to ensure compliance and assures effective implementation of corrective action occurs to reduce risk of future occurrences.
- Prepares and delivers an annual compliance report to the MSHN Board covering the fiscal year, including:
  - A summary of trends in the frequency, nature and severity of substantiated compliance violations;
  - A review of any changes to the Compliance Plan or program; and
  - An objective assessment of the effectiveness of the Compliance Plan and Program.

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

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

C. Quality Improvement Council

The MSHN Quality Improvement Council will consist of the MSHN Director of Compliance, Customer Service and Quality, and the CMHSP Participants' Quality Improvement staff, or designees appointed by MSHN CMHSP Participant's. Substance Use Disorder services will be represented by participation of MSHN SUD staff. The Council will meet at regular intervals and shall be responsible for the following:

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

the QAPIP and Compliance Plan to encourage continuous quality improvement.

VII. COMPLIANCE STANDARDS

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

A. Standards of Conduct and Ethical Guidelines

MSHN and its Provider Network are committed to conducting the delivery of services and business operations in an honest and lawful manner and consistent with its Vision, Mission, and Values. As such, MSHN minimally establishes the following Standards of Conduct to clearly delineate the philosophy and values concerning compliance with the laws, regulations, contractual obligations, government guidelines and ethical standards applicable to the delivery of behavioral health care.

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

These Standards of Conduct provide guidance for MSHN Board members and employees, as well as the provider network in performing daily activities within appropriate ethical and legal standards and establish a workplace culture that promotes prevention, detection, and resolution of instances of conduct that do not conform with applicable laws and regulations. While the above standards are expected to be a framework for compliance, the issues addressed are not exhaustive. Therefore, MSHN Board Members, employees and its provider network staff are responsible for conducting themselves ethically in all aspects of business avoiding even the appearance of impropriety and in accordance with established policies and procedures.

B. Legal and Regulatory Standards

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

State/Federal Laws and Rules

- Michigan Mental Health Code, Public Health Code and Administrative Rules
- Other Statutes Related to Municipal Organizations and Operations
- Other requirements as identified in the MDHHS contract
- Technical Assistance Advisories, as required
- Medicaid State Plan
- Waiver Applications
- Medical Services Administration (MSA) Policy Bulletins
- Michigan Whistleblowers Act, Act 469 of 1980
- Home and Community Based Final Rules

Federal Medicaid Law, Regulations and Related Items

- Social Security Act, Title XIX (Medicaid)
  - Balanced Budget Act of 1997
  - Deficit Reduction Act/Medicaid Integrity Program of 2005
  - Anti-kickback Statute
- Code of Federal Regulations
- State Operations Manual
- Letters to State Medicaid Directors
- Technical Assistance Tools
  - Quality Improvement Systems for Managed Care (QISMC)
  - Guide to Encounter Data Systems
- Office of Management and Budget (OMB) Circulars
- Government Accounting Standards Board (GASB)

Other Relevant Legislation

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

C. Environmental Standards

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

D. Workplace Standards of Conduct

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

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

E. Contractual Relationships

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

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

F. Purchasing and Supplies

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

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

G. Marketing

Marketing and advertising practices are defined as those activities used by MSHN to educate the public, provide information to the community, increase awareness of services, and recruit

employees or contractual providers. MSHN will present only truthful, fully informative and non-deceptive information in any materials or announcements.

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

H. Financial Systems Reliability and Integrity

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

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

In accord with the 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005) MSHN's processes shall monitor for actions by contractual -providers of Medicaid services to prevent fraud, abuse, and waste, or are likely to result in unintended expenditures.

I. Information Systems Reliability and Integrity

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

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

J. Confidentiality and Privacy

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

- MSHN will follow the HIPAA requirements, as well as all applicable federal and state requirements, for the use of protected health data and information.

- MSHN will immediately report to the MDHHS any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements.
- Any breach of protected health information shall result in notification of the affected individuals as well as the HHS Secretary and the media in cases where the breach affects more than 500 individuals.
- Privacy Notice - MSHN will have a notice of privacy practices.
- Authorization - If information is shared, outside of those described in the Privacy Notice, a signed authorization will be obtained from the consumer prior to sharing information
- MSHN will require the Provider Network –to have a consent form signed prior to treatment for permission to treat, bill for and carry out health care operations.
- -MSHN will perform any necessary internal risk analyses or assessments to ensure compliance.
- Physical and electronic safeguards shall be in place for MSHN employees and premises, including, but not limited to, door locks, unique logins and secure passwords, firewall and virus protection, disaster recovery mechanisms, and secure email.

VIII. AREAS OF FOCUS

The MSHN Compliance Officer under the direction of the MSHN Board of Directors, MSHN Corporate Compliance Committee and the MSHN Quality Improvement Council, will identify strategic areas of focus developed from a risk analysis that will guide the direction of MSHN compliance activities (**Attachment C**).

IX. TRAINING

A. MSHN Employees, Board Members and Advisory Council Members

All MSHN Employees, Board members and Advisory Council members shall receive training on the MSHN Compliance Plan and Standards of Conduct. Additional training may be required for employees involved in specific areas of risk or as new regulations are issued. Records shall be maintained on all formal training and educational activities. Training is considered a condition of employment and failure to comply will result in disciplinary action up to and including termination.

B. MSHN Provider Network

The MSHN Provider Network Committee will review and recommend an Annual Training Plan (**Attachment D**) to assure and provide consistent training requirements throughout the provider network. MSHN will monitor the provider network to ensure adherence to the identified training requirements. Where viable, MSHN will offer related compliance training and educational materials to the Provider Network.

X. COMMUNICATION

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

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

XI. MONITORING AND AUDITING

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

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

Financial and Billing Integrity
- An independent audit of financial records each year;
- An independent compliance examination in accordance with the MDHHS guidelines (if applicable);
- Contractual providers have signed contracts and adhere to the contract requirements;
- Explanation of benefits; and Medicaid Event Verification

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

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

- Clinical supervision is provided and documented to ensure competency, as required by PIHP/MDHHS contract attachment, Credentialing and Re-Credentialing Process and related MSHN Policies and Procedures.

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

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

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

Additional Internal Monitoring and Auditing Activities
- Assessment of initial capacity and competency to perform delegated PIHP functions;
- Consumer~~s~~ Satisfaction Surveys;
- Review of MSHN contracts for administrative services;
- Monitor capacity and demand for services in the PIHP region through the Assuring Network Adequacy contract; and
- Review of Policies and Procedures for any needed revisions or development of new ones.

Additional External Monitoring and Auditing Activities:
- External Quality Reviews
- CMS Site Visits
- MDHHS Site Visits
- Independent Financial Audits
- Independent Compliance Examinations
- Accreditation Surveys

XII. REPORTING AND INVESTIGATIONS

MSHN and its Provider Network shall follow established disciplinary guidelines for their respective employees who have failed to comply with the standards of conduct, policies, and procedures, federal and state law, or otherwise engage in wrongdoing. The guidelines shall be consistently enforced at all levels of the organization.

A. Reporting of Suspected Violations or Misconduct

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

MSHN employees, contractual providers, consumers, and others are to report suspected violations or misconduct to the MSHN Compliance Officer or the appropriate CMHSP Participant/SUD Provider Compliance Officer and/or designee as outlined below. Suspected violations or misconduct involving a local CMHSP may be reported to the CMHSP Compliance Officer or to the MSHN Compliance Officer by phone/voicemail, email, in person, or in writing. See **Attachment E** for contact information. Information submitted in writing shall utilize the Suspected Compliance Violation or Misconduct Report Form **(Attachment F)**.

- MSHN employees, contractual providers and the provider network will report all suspected fraud and abuse to the MSHN Compliance Officer. The report will include the nature of the complaint and the name of the individuals or entity involved in the suspected fraud and abuse, including address, phone number and Medicaid identification number if applicable.
- The MSHN Compliance Officer will report suspected fraud and abuse to the MDHHS Office of Health Services Inspector General.
- The MSHN Compliance Officer will inform the appropriate provider network member when a report is made to the MDHHS Office of Health Services Inspector General.
- MSHN employees will report all suspected violations or misconduct (not involving suspected fraud or abuse) directly to the MSHN Compliance Officer for investigation. If the suspected violation involves the MSHN Compliance Officer, the report will be made to the MSHN Chief Executive Officer.
- Any suspected violations regarding the MSHN Chief Executive Officer will be reported to the MSHN Compliance Officer and/or the MSHN Board Chairperson/Executive Committee for investigation.
- CMHSP Participant/SUD Provider Network staff with firsthand knowledge of activities or omissions that may violate applicable laws and regulations (not involving suspected fraud or abuse) are required to report such wrongdoing to the MSHN Compliance Officer or to the CMHSP Participant/SUD Provider Network Compliance Officer. The CMHSP Participant/SUD Provider Network Compliance Officer will review reported violations to determine the need to report to the MSHN Compliance Officer. The review will be based on but not limited to: external party involvement, Medicaid recipient services, practices and/or system-wide process applicability.
- The Provider Network (CEO)/Executive Director(ED) and/or designee, shall inform, in writing, the MSHN Chief Executive Officer (CEO) of any material notice to, inquiry from, or investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory (excluding Recipient Rights related to non-PIHP activities), prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of a recipient of Medicaid services. The Provider Network CEO/ED shall inform, in writing, the MSHN CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.

- Reports of suspected violations or misconduct may be made on a confidential basis to the extent possible.
- No MSHN employee, consumer, contractual provider, or CMHSP Participant/SUD Provider staff making such a report in good faith shall be retaliated against by MSHN, its employees or contractual providers.

B. Process for Investigation

All reports of suspected wrongdoing, not involving fraud or abuse, shall be investigated promptly following the process outlined in the MSHN Compliance Investigation, Resolution and Documentation Process (**Attachment G**). The investigation process and outcome will be documented using the MSHN Compliance Investigation Report Form (Attachment H). In conducting the investigation, judgment shall be exercised and consideration shall be given to the scope and materiality consistent with the nature of the concern. Each investigation must be carefully documented to include a report describing the disclosures, the investigative process, the conclusions reached and the recommended corrective action, when such is necessary. No one involved in the process of receiving and investigating reports shall communicate any information about a report or investigation, including the fact that a report has been received or an investigation is ongoing, to anyone within MSHN who is not involved in the investigation process or to anyone outside of MSHN without the prior approval of the MSHN Compliance Officer. All MSHN employees, Provider Network staff and subcontractors are expected to cooperate fully with investigation efforts. The MSHN Compliance Officer and the ~~CMHSP~~ CMHSP Participant/SUD Provider Compliance Officers must report any conflict of interest that may exist when investigating a report of suspected wrong doing or misconduct. If a conflict of interest does exist, the MSHN Compliance Officer will be responsible for securing an appropriate source to complete the investigation, which may include utilizing the MSHN Compliance Officer, one of the ~~CMHSP~~ Provider Network Compliance Officers or an external source if necessary.

XIII. Corrective Actions and Prevention

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

XIV. References, Legal Authority and Supporting Documents

1. Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans, Medicaid Alliance for Program Safeguards, May 2002 http://ahca.myflorida.com/medicaid/managed_care/pdf/federal_cms_guidelines_constructing_compliance_program.pdf

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

3. False Claims Act

https://oig.hhs.gov/fraud
http://www.legislature.mi.gov

4. 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005)
http://www.cms.hhs.gov/deficitreductionact

5. Michigan Mental Health Code
http://michigan.gov/documents/mentalhealthcode_113313_7.pdf

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

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

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

ATTACHMENT A

MSHN's Policies and Procedures can be found at the following link:
http://www.midstatehealthnetwork.org/policies/

Policy and Procedure Categories Include:

Compliance

Customer Service

Finance

General Management

Governance and General Management

Human Resources

Information Technology

Provider Network

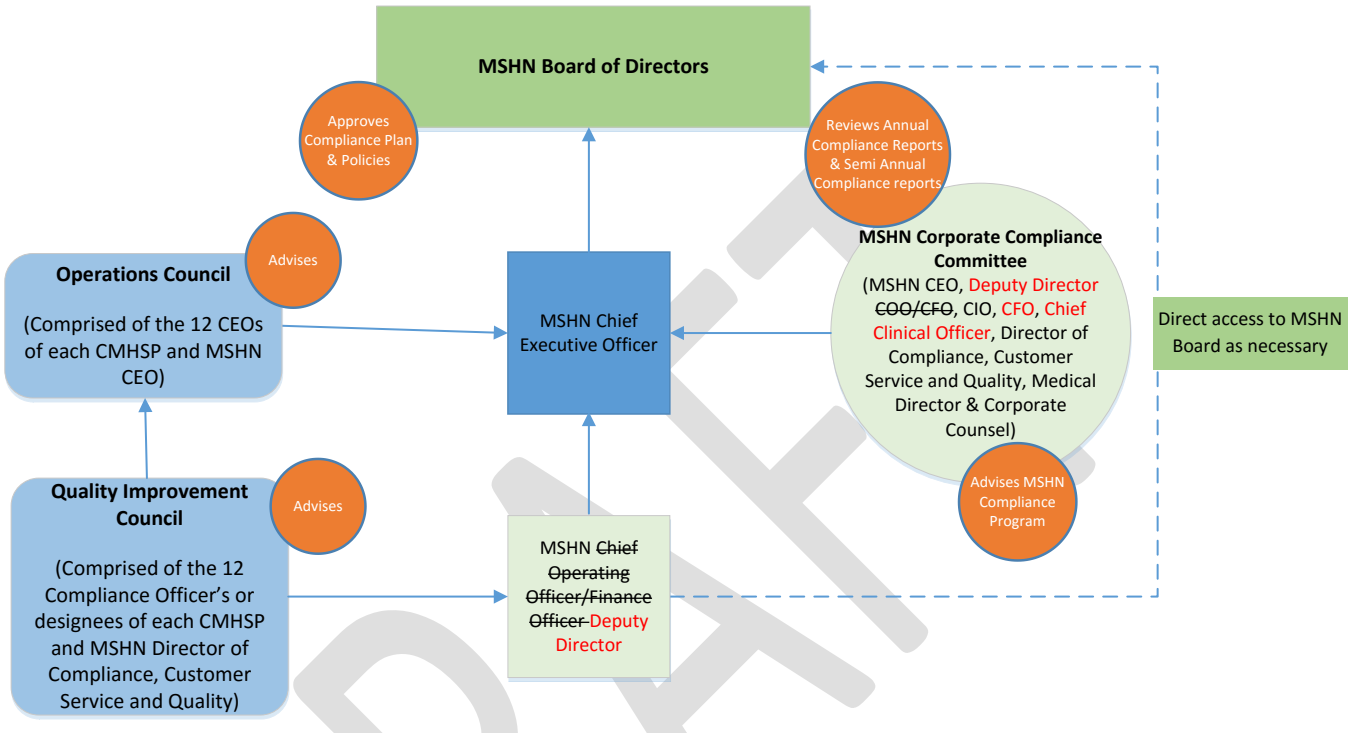
Quality

Service Delivery System

Utilization Management

ATTACHMENT B

Mid-State Health Network Compliance Process/ Governance



ATTACHMENT C

MSHN Compliance Officer in coordination with the MSHN Quality Improvement Council shall focus its efforts on overseeing compliance in the below key areas as identified and prioritized:

Area of Focus	Responsible Party	Task
CMHSP Participants/ SUD Providers ~~Transition~~		
Review of Provider Credentialing and Competency	MSHN	Monitoring through desk audit/site visit
Provider network subcontracted provider monitor	MSHN	Contract Oversight and Monitoring through reporting and compliance with contract terms
MSHN Utilization Management, Access and Authorization	MSHN	Develop regionally adopted Utilization Management Access and Authorization Benefit
BH-TEDS		
CMHSP Implementation/MSHN Oversight	CMHSP/MSHN	Monitoring through internal audit (security, integrity and privacy)
CMHSP/IT Contracts Communication	MSHN/CMHSP	Testing and reporting; accuracy verifications
Compliance with New Initiatives		
~~SUD Provider Network Compliance with State and Federal Requirements~~	~~MSHN~~	
Implementation of New Managed Care Rules	MSHN/CMHSP	Monitor the implementation of the appropriate content areas of the new managed care rules as identified in the workplan.
Improved Coordination of Care and Population Health Management	MSHN	
Waiver Changes		
HCBW Planning and implementation of changes	MSHN / CMHSP	Review capacity, changes in waiver requirements
Autism Compliance and Expansion Capacity & Readiness	MSHN / CMHSP	Communicate information to Provider Network

ATTACHMENT D

MSHN Minimum CMHSP Training Requirements:

MSHN Minimum CMHSP Training Requirements

Source Document Key:
1. Balanced Budget Act
2. Health Insurance Portability and Accountability Act (HIPAA)
3. Deficit Reduction Act
4. Michigan Department of Community Health (MDCH)
5. Michigan Administrative Code
6. Michigan Mental Health Code
7. Occupational Safety & Health Administration (OSHA)
8. Code of Federal Regulations

Renewal Key: I = Initially A = Initially & Annually 2 = Initially & every 2 years

Training	Requirements	Source	CMH-employed Administration Group	Crisis Intervention / Access	Other Professional Service (OT,PT, Dietary, Psychological Testing	CMH-employed Maintenance	Medical Professional	Residential Supervisors /QI/License	AFC Licensed Direct Care Staff	Aide level staff providing service in the community or in unlicensed settings	Students/ Volunteers/ Temporary workers	Primary Service Providers (Case Managers, Supports Coordination, Home Based Staff, MST, Wraparound)	Individual/Group Therapist	Clubhouse / Drop-In/ Peer Supports	CMH-employed Transporters	ACT
Assertive Community Treatment (ACT)	180 days of hire for work in ACT	4														I
Advance Directives	90 days of hire	1										I	I			I
Appeals & Grievances	90 days of hire	1, 4, 6	A	A	A	A	A	A			A	A	A	A	A	A
CAFAS and/or PECFAS (if working with children)	90 days of hire	4		2								2	2			
Corporate & Regulatory Compliance	90 days of hire	1, 3	A	A	A	A	A	A	A	A	A	A	A	A	A	A
CPR & First Aid*	30 days of hire	5							2	first aid only						
Cultural Competency & Diversity	1 year of hire	4, 6, 8	A	A	A	A	A	A	A	A		A	A	A	A	A
Environmental Safety	1 year of hire	5, 6	I	I	I	I	I	I	I	I	I	I	I	I	I	I
Health Management - (Blood Borne Pathogens/Infection Control)	30 days of hire	5, 6, 7	A	A	A	A	A	A	A	A	A	A	A	A	A	A
HIPAA Privacy & Security	30 days of hire	2, 4, 5, 8	A	A	A	A	A	A	A	A	A	A	A	A	A	A
IDDT/COD	90 days of hire	4		COD								COD - if necessary	COD - if necessary			A- if providing IDD
Limited English Proficiency (LEP)	90 days of hire	1, 4	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Medication Administration	90 days of hire	5							I	I - if necessary						
Non-Physical Intervention (Verbal De-escalation)	90 days of hire	8		I					I	I - if necessary		I	I	I		I
Person-Centered Planning	30 days of hire	4, 6, 8	A	A	A		A	A	A	A	A	A	A	A	A	A
Recipient Rights	30 days of hire	4, 5, 8	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Self Determination	90 days of hire	4		A								A	A			
Culture of Gentleness	90 days of hire	4							A-if necessary	A-if necessary						

* Based on Certification Length set by the training entitiy (i.e., American Red Cross)
→ Training with a DHS-approved group home curriculum is required for direct care staff working in licensed specialized AFC settings.
→ Customer Service staff must receive training as defined in Attachment P.6.3.1 of the MDCH/PIHP contract (paragraph F.14)
→ Additional program specific training is requied for programs such as Wraparound, IMH, DBT, TFCBT, MST, Supported Employment, and ABA Aides (Autism Benefit).
→ Child Mental Health Professionals are required to obtain 24 hours annual related to child specific training
→ The following job titles will require Core Elements of Case Management training: Case Manager, Supports Coordinator, Home-based Mental Health Therapy, Multisystemic Therapy, and Wraparound

This is a set of MSHN minimum training requirements and is not all inclusive to each individual CMHSP. Any county, accreditation, evidence-based practice, or CMHSP specific training will be additionally documented by each CMHSP.

ATTACHMENT E

MID-STATE HEALTH NETWORK

CONTACT INFORMATION FOR SUSPECTED COMPLIANCE VIOLATIONS

Please report suspected compliance violations to _____

In person:

By phone:

By email:

By mail:

Reports can also be made to MSHN Compliance Officer:

Kim Zimmerman
530 W. Ionia Street, Suite F
Lansing, MI 48933
P: 517.~~253.7525~~ 657-3018 C: 616-648-0485
kim.zimmerman@midstatehealthnetwork.org

MSHN COMPLIANCE LINE 1-844-793-1288

Or to:

CMHSP Compliance Officers (or designee):

Bay Arenac Behavioral Health, Janis Pinter, 989.895.2760, jpinter@babha.org
CMH for Central Michigan, ~~John Obermesik~~Bryan Krogman, 989.772.~~5938x1408~~1380,
~~jobermesik~~bkrogman@cmhcm.org
Clinton, Eaton, Ingham CMH, Stefanie Zin, 517.346-8193, zinst@ceicmh.org
Gratiot County CMH, Lynn Charping, 989.466.4108, lcharping@gccmha.org
Huron Behavioral Health, Levi Zagorski, 989.269.9293, levi@huroncmh.org
The Right Door~~Ionia County CMH~~, Susan Richards, 616.527.1790, srichards@~~ioniacmhs~~rightdoor.org
LifeWays CMH, ~~Stacy Coleman~~Angie O'Dowd, 517.789.2~~485~~526,
~~stacy.coleman~~Angie.O'Dowd@LifeWayscmh.org
~~The~~ Montcalm Care Network~~Center for Behavioral Health~~ Sally Cul~~e~~ly, 989.831.7523,
sculey@~~mcbh~~montcalmcare.net~~.org~~
Newaygo CMH, Andrea Sturr, 231.689.7542, asturr@newaygocmh.org
Saginaw County CMH, ~~Linda Tilot, 989.797.3594, ltilot@sccmha.org~~ Richard Garpiel,
989.797.3539, Rmgarpiel@sccmha.org
Shiawassee County CMH, Dirk Love, 989.723.0750, dlove@shiacmh.org
Tuscola Behavioral Health Systems ~~Sharon Beals~~Michael Swathwood, 989.67~~3~~2.~~6191~~3014,
~~sebeals~~mswathwood@tbhs.net

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

MDHHS Medicaid Fraud Hotline: 1.855.MI.FRAUD (643.7283)

HHS/OIG Hotline: 1.800.HHS.TIPS (447.8477)

ATTACHMENT F

MID-STATE HEALTH NETWORK

Suspected Compliance Violation or Misconduct Report Form

Please provide the information listed below. You may submit your report anonymously. However, follow-up of your concern may be made easier and timelier by listing your name. Please return completed form to the Compliance Officer.

Name: _____ Date: _____

Phone Number: _____ Agency Program: _____

Suspected Violation: *(Describe details of the suspected violation. Be specific about names, dates and actions. Attach additional documentation if needed.)*

_____

_____

_____

_____

_____

_____

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_____

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_____

ATTACHMENT G

MID-STATE HEALTH NETWORK

Compliance Investigation, Resolution and Documentation Process

I. Investigation

- Within five business days of receiving a report, the MSHN ~~Chief~~ Compliance Officer or CMHSP Participant/SUD Provider Compliance Officer shall provide a written acknowledgment of receipt to the individual making the report (if known) and conduct an initial assessment to determine whether the report has merit and warrants further investigation.
- If it is determined that the matter does not constitute a violation of any applicable laws or regulations and warrants no further action, the issue will be closed following the appropriate documentation and reporting by the MSHN ~~Chief~~ Compliance Officer or CMHSP Participant/SUD Provider Compliance Officer.
- If it is determined that the matter does not constitute a violation of any applicable laws or regulations, but does identify an area for improvement or raises concern for potential future violations, the matter will be referred to the designated CMHSP Quality Improvement Council Member and/or the MSHN Quality Improvement Council for appropriate discussion, assignment and follow up action if appropriate.
- If it is determined that the matter requires further investigation, the MSHN Compliance Officer will first review the information and assess if immediate reporting to the OHSIG should take place. The MSHN CO and/or CMHSP Participant/SUD Provider CO shall take the necessary steps to assure that documents or other evidence are not altered or destroyed through the following means, as applicable:
  - Suspending normal record/document destruction procedures;
  - Taking control of the files of individuals suspected of wrongdoing;
  - Limiting access of files, computers, and other sources of documents by individuals suspected of wrongdoing; and/or
  - Taking additional action as necessary to ensure the integrity of the investigation that could include temporary suspension, or temporary re-assignment of duties, of involved individuals.
- If the MSHN Compliance Officer concludes that reporting to a government agency (CMS, OIG, and DOJ) or a third party may be appropriate, the MSHN CEO and the CMHSP Participant/SUD Provider Compliance Officer will be informed immediately and the MSHN CO shall report to the government agency(s) within five business days
- No further investigation shall occur until the MSHN CO has confirmed with the OHSIG to proceed. However, appropriate steps shall be taken to ensure consumer safety.
- Once confirmation from the OHSIG is obtained, the MSHN CO shall approve further investigation through internal MSHN investigation procedures and/or CMHSP Participant/SUD Provider investigation procedures.
- If OHSIG confirmation is not obtained and/or OHSIG instructs MSHN to not conduct any further investigation, the MSHN CO shall document the OHSIG communication and follow up with the OHSIG within thirty (30) days to obtain an update on the case.

II. Resolution

- Following the investigation, the MSHN ~~Chief~~ Compliance Officer will document and report the findings of the investigation to the MSHN CEO and the MSHN Corporate Compliance Committee. In cases where actions of the MSHN CEO are investigated, the report of findings is made to the Executive Committee of the MSHN Board of Directors.
- If the occurrence involved a MSHN employee, disciplinary action will be taken in accordance with MHSN's policies and procedures and Personnel Manual.

- If the occurrence involved a CMHSP Participant/SUD Provider, the CMHSP Participant/SUD Provider shall submit a remedial action plan to address any confirmed violations or address areas of concerns raised during the investigation.

III. Documentation

- A record will be maintained by the MSHN ~~Chief~~ Compliance Officer and/or the CMHSP Participant/SUD Provider Compliance Officer or designee for all reports of potential/alleged violations utilizing the attached *Compliance Investigation Report* form. The record may also include copies of interview notes and documents reviewed and any other documentation as appropriate.
- Records will be maintained in accordance with the "State of MI, Department of History, Arts and Libraries – Record Management – Records Retention and Disposal Schedule". http://www.michigan.gov/documents/hal/mhc_rm_gs20_195724_7.pdf

ATTACHMENT H

MID-STATE HEALTH NETWORK
Compliance Investigation Report Form

Source of the Complaint (Name/Agency): _____

Date of Complaint: _____

Medicaid ID Number (if Applicable): _____

Type of Provider Involved (If Applicable): _____

Suspected Violation: (Describe the details of the suspected violation. Be specific about the information disclosed including names, dates and actions. Attach additional documentation if needed.)

Findings/Outcome of the Investigation: (Include description of disclosures, the investigative process followed and conclusion/findings/outcome of the investigation.)

Required Plan of Correction (If Necessary) (Include any recommended or required plan of action needed based on the outcome of the investigation.)

Follow up Needed (If Necessary):

Does this investigation need to be reported to MSHN: Yes____ No ____

If yes, please identify the date reported to MSHN: _____

Name(and title) of the individual completing the investigation: _____

Date the investigation was completed: _____

Background

To comply with the MSHN Provider Network Management Policy, specifically as it relates to section B. Network Adequacy/Sufficiency which states:

> "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."

The attached MSHN 2016 Assessment of Network Adequacy was revised through a review by the MSHN Provider Network Management Committee, MSHN Utilization Management Committee, MSHN Clinical Leadership Council, MSHN Quality Improvement Council, MSHN Customer Service Committee, MSHN Substance Use Disorder staff, and MSHN Operations Council, with recommendation for approval to the MSHN Board of Directors.

Recommended Motion:

The MSHN Board receives and files the MSHN 2016 Assessment of Network Adequacy, and supports the implementation of the recommendations contained therein.

MSHN
Mid-State Health Network

Assessment of Network Adequacy

2016

Approved by MSHN Operations Council:
Approved by MSHN Board of Directors:

Mid-State Health Network

Assessment of Network Adequacy

Contents

Definitions

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

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

2. CMHSP Participant Subcontractors: Individuals and organizations directly under contract with a CMHSP to provide behavioral health services and/or supports.

3. Provider Network: MSHN CMHSP Participants and SUD Providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. For CMHSP Participants, services and supports may be provided through direct operations or through the subcontracts.

4. Substance Use Disorder (SUD) Providers: Individuals and organizations directly under contract with MSHN to provide substance use disorder treatment and prevention programs and services.

Background

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

This assessment of the adequacy of its provider network demonstrates MSHN has the required capacity to serve the expected enrollment in its 21 county service area in accordance with Michigan Department of Health and Human Services (MDHHS) standards for access to care, with exceptions only for still evolving service areas for specialty behavioral health services in Michigan, such as the expansion of the Autism Benefit services from individuals through 5 years of age to those under 21 years of age.

The counties in the MSHN service area include:

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

Mid-State Health Network is a free-standing entity, but it was formed on a collaborative basis by twelve Community Mental Health Service Programs (CMHSP Participants). MSHN entered

into agreements with the CMHSP Participants to deliver Medicaid funded specialty behavioral health services in their local areas, so the twelve CMHSP Participants also comprise MSHN's Provider Network. Each CMHSP Participant in turn directly operates or enters into subcontracts for the delivery of services, or some combination thereof. There are twelve CMHSP Participants for the 21 counties, as follows:

- Bay-Arenac Behavioral Health (BABH)
- CMH Authority of Clinton-Eaton-Ingham Counties (CEI)
- CMH for Central Michigan (CMHCM)
- Gratiot County CMH (GCCMHA)
- Huron Behavioral Health (HBH)
- Right Door for Hope, Recovery & Wellness (for Ionia Co.)
- Lifeways CMH (LCMHA)
- Montcalm Care Network (MCN)
- Newaygo County Mental Health (NCMH)
- Saginaw County CMH Authority (SCCMHA)
- Shiawassee County CMH Authority (SHIACMH)
- Tuscola Behavioral Health Systems (TBHS)

As of 10/1/14 the Coordinating Agency designation for substance use disorder (SUD) services was eliminated by the MDHHS and full responsibility for managing and delivering SUD treatment and prevention services funded under Medicaid, Public Act 2 and related Block Grants was transferred to the PIHP's in Michigan. MSHN assumed responsibility for these additional managed care obligations. Effective 10/1/15, MSHN discontinued transitional subcontracts with three sub-regional SUD entities, and began direct management of SUD Providers.

Scope

Since CMHSP Participants have their own subcontracted and direct operated provider networks, primary responsibility for assessing local need and establishing the scope of non-SUD behavioral health services remains with the CMHSP's. MSHN works with the CMHSP Participants to ensure adequate networks are available, and has primary responsibility for SUD service capacity.

The MSHN Assessment of Provider Network Adequacy is intended to support CMHSP and MSHN efforts by generating regional consumer demand and provider network profiles that may precipitate adjustments to local provider arrangements. MSHN and the CMHSP's act upon these opportunities as warranted.

Therefore, this assessment is a global document for provider network capacity determinations, and is intended to generate dialogue between the PIHP and the CMHSP participant regarding the composition and scope of local networks, and ensure that the region is meeting its obligations as a specialty Medicaid Health Plan. In some instances the response to an identified gap in services could result in the implementation of new and creative service delivery models that may not be possible for a single CMHSP or SUD Provider, such as a collaborative initiative to provide a regional level crisis response program, similar to the MDHHS statewide model for

positive living supports or a regional effort to build therapeutic and non-therapeutic recovery oriented housing.

The focus of this assessment of provider network adequacy is both MSHN's mental health and substance use disorder provider networks. The scope of services is Medicaid funded specialty behavioral health services, including 1915(b) State Plan and Autism services, the 1915(b)(3) services, services for adults with developmental disabilities enrolled in the Habilitation Support Waiver program, and specialty behavioral health (mental health and substance use disorder) services under the Healthy Michigan Plan. The scope also includes Block Grant and PA2 funded substance use disorder treatment and prevention programs. Excluded are those services which are exclusively the focus of the CMHSP system through direct contract with MDHHS, such as services financed with General Funds and the waiver programs for Children with Developmental Disabilities and Serious Emotional Disturbance.

MSHN assumes the process of assessing the adequacy of its provider network is a relatively resource independent process. In other words, an objective assessment of enrollee needs is performed that is not tempered by the availability or lack of resources to fulfill that need. Acting upon the results of the assessment to establish and fund a provider network is a separate and distinct process, and of course, is directly tied to the availability of resources.

Assessment Updates

MSHN updates its assessment of provider network adequacy on an annual basis. Through the assessment process the PIHP must prospectively determine:

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

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

- Whether or not the service provider network was adequate to meet the assessed need
- If the network was not adequate, what changes to the provider network are required

Appropriateness of the range of services

MSHN must offer an appropriate range of specialty behavioral health services that is adequate for the anticipated number of enrollees in the service area.[1] MSHN assesses the "appropriateness" of the range of services by comparing the service array available within the region, to the array determined to be appropriate by MDHHS for the target population(s).

The service array is articulated by MDHHS in the Medicaid Managed Specialty Support and Services Concurrent 1915(b)/(c) Waiver Program contract. MSHN is contractually obligated by MDHHS to provide the services described in the aforementioned contract boilerplate and its attachment, for which additional specifications and provider qualifications are articulated for Medicaid funded services in the Michigan Medicaid Provider Manual, Mental Health-Substance Abuse section:

- Michigan 1915(b) Waiver State Plan services
- Michigan State Plan SUD services
- Michigan 1915(c) Waiver Habilitation and Support Waiver (HSW) services
- Michigan 1915(b)3 Waiver alternative community based services
- Michigan 1915(i) Waiver Autism Benefit services
- SUD services funded by Public Act 2 and Block Grants
- Michigan 1115 Demonstration Project Healthy Michigan Plan (HMP) mental health and substance use disorder services authorized through the Affordable Care Act provisions for Medicaid expansion programs.

MSHN believes its service array to be appropriate and adequate for the needs of Medicaid enrollees, with limited exceptions. These exceptions are noted after the tables below which depict the services available for each fund source, and are addressed as recommendations at the end of this assessment.

The array of State Plan mental health services covered under the 1915(b) waiver are to be provided based upon the particular needs of the seriously emotionally disturbed children, adults with mental illness and individuals with intellectual/ developmental disability populations in a given community but MSHN must assure equity and appropriateness in service availability across the region. Table 1 lists the service array and which services are provided by each CMHSP Participant in the MSHN region, based on local needs.

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

Table 1: State Plan Mental Health Services (1915(b) Waiver) Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Applied Behavioral Analysis	X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	X	X	X		X	X	X	X	X	X	X	X
Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Behavior Treatment Review	X	X	X	X	X	X	X	X	X	X	X	X
Child Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Clubhouse Psychosocial Rehabilitation	X	X	X				X	X		X		
Crisis Interventions	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Residential Services	X	X	X		X	X	X	X	X	X	X	X
Family Therapy		X	X	X	X	X	X	X	X	X	X	X
Health Services	X	X	X	X	X	X	X	X	X	X	X	X
Home-Based Services	X	X	X	X	X	X	X	X	X	X	X	X
Home-Based Serv. – Infant Mental Health	X		X	X	X		X	X				X
Individual and Group Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Inpatient Psychiatric Hospital Admission	X	X	X	X	X	X	X	X	X	X	X	X
Intensive Crisis Stabilization Services			X				X			X		
ICF Facility for Ind. w/ Mental Retardation												
Medication Administration	X	X	X	X	X	X	X	X	X	X	X	X
Medication Review	X	X	X	X	X	X	X	X	X	X	X	X
Nursing Facility Mental Health Monitoring	X	X	X	X	X	X	X	X	X	X	X	X
Occupational Therapy	X	X	X	X	X	X	X		X	X	X	X
Outpatient Partial Hospitalization Services				X			X	X				
Personal Care in Licensed Spec. Residential	X	X	X	X	X	X	X	X	X	X	X	X
Physical Therapy	X		X	X	X	X		X	X	X		X
Speech, Hearing and Language Therapy	X	X	X	X	X	X	X	X	X	X		X
Targeted Case Management	X	X	X	X	X	X	X	X	X	X	X	X
Telemedicine	X	X	X	X	X	X	X	X	X	X		X
Transportation		X		X	X		X			X	X	
Treatment Planning	X	X	X	X	X	X	X	X	X	X	X	X

Similarly, Table 2 shows the array of Medicaid funded services for treatment of substance use disorders and which services are delivered by SUD Providers under the auspices of their contracts with MSHN:

Table 2: Medicaid Funded Substance Use Disorder Services Available in the MSHN Provider Network

	Individual Assessment	Individual Treatment Planning	Individual Therapy	Group Therapy	Family Therapy	Crisis Intervention	Referral/ Linking/ Coord./ Mgt of Services	Peer Recovery and Recovery Support	Compliance Monitoring	Early Intervention	Detoxification /Withdrawal Monitoring	Pharma-cological Supports
Arenac	X	X	X	X	X	X	X	X		X		
Bay	X	X	X	X	X	X	X	X		X		
Clare	X	X	X	X	X	X	X	X		X		
Clinton	X	X	X	X	X		X	X		X		
Eaton	X	X	X	X	X		X	X		X		
Gladwin	X	X	X	X	X	X	X	X		X		

	Individual Assessment	Individual Treatment Planning	Individual Therapy	Group Therapy	Family Therapy	Crisis Intervention	Referral/ Linking/ Coord./ Mgt of Services	Peer Recovery and Recovery Support	Compliance Monitoring	Early Intervention	Detoxification /Withdrawal Monitoring	Pharma-cological Supports
Gratiot	X	X	X	X	X	X	X	X		X		
Hillsdale	X	X	X	X	X		X	X				
Huron	X	X	X	X	X	X	X			X		
Ingham	X	X	X	X	X		X	X	X	X	X	X
Ionia	X	X	X	X	X		X	X		X		
Isabella	X	X	X	X	X	X	X	X	X	X	X	X
Jackson	X	X	X	X	X		X	X	X	X	X	X
Mecosta	X	X	X	X	X	X	X	X		X		
Midland	X	X	X	X	X	X	X	X		X		
Montcalm	X	X	X	X	X	X	X	X		X		
Newaygo	X	X	X	X	X		X	X		X		
Osceola	X	X	X	X	X		X					
Saginaw	X	X	X	X			X	X	X	X	X	X
Shiawassee	X	X	X	X	X	X	X	X		X		
Tuscola	X	X	X	X	X	X	X	X		X		

Given recent escalations in the rate of opiate and other addictions in the region, which parallel well documented increases statewide and nationally, MSHN is concerned about the adequacy of regional capacity to provide detox services and Medication Assisted Treatment (MAT).

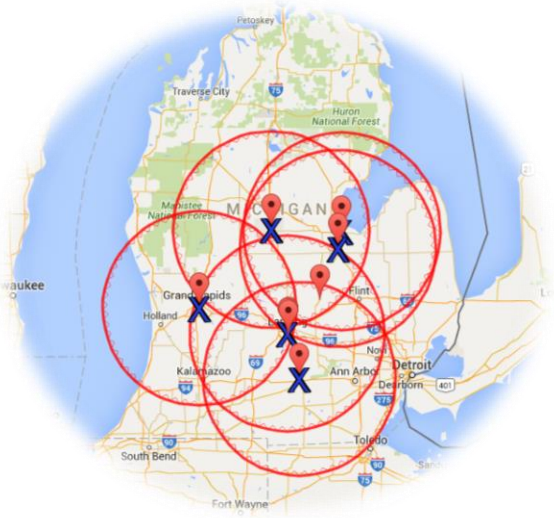
Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.

As shown in Figures 1 and 2, most of the MSHN region is covered with the exception of the tip of the thumb, which is being addressed by MSHN. Additionally, the region would like to expand capacity as 60 min/60 mile can definitely be a barrier for consumers in need of services, particularly with daily dosing. As for urban communities, MSHN is in compliance with the 30 min/30 mile requirement (Lansing, Saginaw, Jackson).

Figure 1: Detox Providers

Name of Organization	City
Addiction Treatment Services	Traverse City
Allegiance Addiction Recovery Center	Jackson
DOT Caring Centers, Inc.	Freeland
Harbor Hall, Inc	Petoskey
Holy Cross Counseling Services - Women's Behavioral Health	Lansing
Karios Healthcare - Queen of Angels Facility	Saginaw
Sacred Heart Rehabilitation Center	Richmond
Salvation Army Turning Point	Grand Rapids
Sunrise Centre	Alpena
Ten16 Recovery Network - Detox	Mt. Pleasant
The Recovery Center	Lansing
Healthsource Saginaw	Saginaw

Figure 2: Medication Assisted Treatment Providers



Name of Organization	City
Cherry Street Services, Southside Health Center	Grand Rapids
DOT Caring Centers, Inc.*	Owosso
DOT Caring Centers, Inc.*	Saginaw
Michigan Therapeutic Consultants, PC	Mt. Pleasant
Michigan Therapeutic Consultants, PC	Lansing
Recovery Pathways, LLC*	Bay City Shiawassee
Red Cedar Clinic	Lansing
Victory Clinical Services	Jackson
Victory Clinical Services	Lansing
Victory Clinical Services	Saginaw

In addition to the geographic accessibility of services, MSHN is addressing MAT guidelines recently adopted by the MDHHS, which promotes the availability of Methadone, Vivotrol, and Suboxone at all MAT locations because research supports different medications for different stages of disease, etc. This will present a challenge given the limitations with Suboxone providers. This will not be possible at all MAT locations, but something MSHN intends to work

toward. The region is also pursuing CMHSPs becoming Narcan kit distribution sites. Several CMHSP's are already thus equipped.

Michigan's 1915(c) Habilitation Support Waiver (or HSW) offers community support (mental health) services for those beneficiaries in the MSHN service area who experience intellectual and developmental disabilities, and meet program criteria. Services are offered to consumers based upon need once they are approved by MDHHS for enrollment. The MSHN region in aggregate has been assigned 1,637 HSW slots of which 1603 are filled as of June 2016.

The following table shows the HSW services available in the region:

Table 3: 1915c Habilitation and Support Waiver Services Available in the MSHN Provider Network

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

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

Table 4: 1915(b)(3) Services Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Assistive Technology	Provided on a per request basis											
Crisis Observation Care		X										
Housing Assistance	Provided on a per request basis											
Peer Specialist Services	X	X	X	X	X	X	X	X	X	X	X	X

	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Drop-In Centers (Peer Operated)		X	X	X	X	X	X		X	X	X	X
Prevention Direct Service Models	X	X	X	X	X	X	X	X	X	X	X	X
• Child Care Expulsion Prevention												
• School Success Program												
• Children of Adults w/ MI/ Integ. Serv.												
• Infant Mental Health-Prevention	X	X	X	X				X		X	X	X
• Parent Education		X	X	X	X		X	X		X	X	X
Skill Building Assistance	X	X	X	X	X	X	X	X	X	X	X	X
Wraparound Services	X	X	X	X	X	X	X	X	X	X	X	X
Fiscal Intermediary Services	X	X	X	X	X	X	X	X	X	X	X	X

The Michigan Medicaid Autism Benefit went into effect on April 1, 2013 and provides children ages 18 months to 21 years of age who have a medical diagnosis of Autism Spectrum Disorder (ASD) with Applied Behavioral Analysis services. Services are contracted or directly delivered by the CMHSP Participants as follows:

Table 5: 1915(i) Autism Benefit Services Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Screening Referral	Performed by pediatrician or family physician as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Service											
Diagnosis	X	X	X	X	X	X	X	X	X	X	X	X
Determination of Eligibility	Performed by MDHHS											
Independent Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Early Intensive Behavioral Intervention	X	X	X	X	X	X	X	X	X	X	X	X
Applied Behavioral Intervention	X	X	X	X	X	X	X	X	X	X	X	X

The (non-Medicaid) Public Act 2 of 1986 and Block Grant services contracted by MSHN for FY15 are defined in the MSHN SUD Service Provider Manual and shown in Table 6 below. Priority for access to Block Grant funded services are determined at the federal level and include consumers who are pregnant injecting drug users, pregnant users, injecting drug users or parents of children who have been or are at risk of being removed from their home, in that order.

Table 6: Other Substance Use Disorder Services Available in the MSHN Provider Network

	Block Grant		PA 2 of 1986	
	Outpatient Treatment*	Residential Treatment	Detox Treatment	Treatment and Prevention Programs
Arenac	X	X		X
Bay	X	X		X
Clare	X	X		X
Clinton	X	X		X
Eaton	X	X		X
Gladwin	X	X		X
Gratiot	X	X		X

	Block Grant		PA 2 of 1986	
	Outpatient Treatment*	Residential Treatment	Detox Treatment	Treatment and Prevention Programs
Hillsdale	X	X		X
Huron	X	X		X
Ingham	X	X	X	X
Ionia	X			X
Isabella	X	X	X	X
Jackson	X	X	X	X
Mecosta	X			X
Midland	X	X		X
Montcalm	X	X		X
Newaygo	X			X
Osceola	X	X		X
Saginaw	X	X	X	X
Shiawassee	X	X		X
Tuscola	X	X		X

*Outpatient programming includes individual, group, family therapy, medication assisted treatment, recovery support, case management, early intervention, medication reviews, lab fees and medication dosing.

Recovery housing for consumers with SUD was added as a covered service fairly recently by MDHHS and can be funded using block grant funds in conjunction with treatment services if integral to the treatment process.

Using the guidelines developed by the state of Michigan, MSHN has met with several substance use disorder providers who have begun to offer recovery housing and supportive services (outpatient, case management and peer recovery) in select counties across MSHN region. These initial efforts vary by county in striving to meet initial local community need. MSHN continues to meet with interested providers to encourage the expansion of recovery housing and is working with the State to identify appropriate funding sources for this service.

In 2014 the state of Michigan established a new program, the Healthy Michigan Plan (HMP), for purposes of expansion of Medicaid eligibility to the medically uninsured and underinsured. Mental health services offered through the HMP are similar to those previously offered via the Adult Benefit Waiver program, but the substance use disorder treatment options are expanded from the services previously available through Medicaid. The resulting service array is a comprehensive mix of mental health and substance use disorder services.

MSHN and the CMHSP Participants, as well as the SUD Providers have expanded network capacity in order to provide HMP services.

- Saginaw CMH added two new case management teams and four enhanced outpatient providers during FY16 for limited services for less impaired persons.

- CEI will be adding two new clinical sites during FY16 to accommodate individuals enrolled in Healthy Michigan.

- Newaygo CMH is adding an additional office in the county and will be providing Mental Health and Substance Abuse treatment in both sites in the future.

Limited change has been required because many HMP enrollees were previously served by CMHSP Participants through general funds.

The CMHSP Participants and SUD Providers are still determining optimal access pathways for HMP enrollees requiring concurrent mental health and SUD services. MDHHS is working on refining the Healthy Michigan service array and required provider qualifications, particularly where SUD licensure requirements are different than mental health. As of the time of this assessment, guidance to the field from MDHHS is still pending.

The behavioral health services shown in Table 7 are available for HMP enrollees in the region:

Table 7: Healthy Michigan Plan Services Available In the MSHN Provider Network

	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Osceola	Saginaw	Shiawassee	Tuscola
Assertive Community Treatment	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X
Assessments	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assistive Technology																					
Behavior Treatment Review							X		X							X	X		X	X	
Clubhouse Psychosocial Rehabilitation	X	X		X	X			X		X			X			X			X		
Community Living Supports	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Enhanced Pharmacy							X	X					X						X		
Environmental Modifications																			X		
Family Support and Training			X			X	X		X		X	X		X	X	X	X	X	X	X	
Fiscal Intermediary Services			X			X		X	X		X	X	X	X	X		X	X	X	X	X
Hospital Based Psychiatric Services																				X	
Housing Assistance	x		X			X	X	X	X		X	X	X	X	X		X	X	X	X	
ICF for Individuals w/DD																					
Medication Administration	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medication Review	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Occupational Therapy				X	X		X	X		X	X		X						X	X	X
Outpatient Counseling and Therapy	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peer Delivered/Operated Support Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peer Specialist Services (Recovery Coach)	X	X					X		X		X						X		X	X	
Personal Care in Licensed Spec. Residential			X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X
Physical Therapy																			X		
Prevention – Direct Service Model	X		X			X		X	X			X	X	X	X			X	X	X	
Residential SUD Treatment	X	X		X	X			X	X	X			X						X		

	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Osceola	Saginaw	Shiawassee	Tuscola
Respite Care			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Skill Building Assistance	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Speech, Hearing and Language Therapy											X								X		
Sub-Acute Detoxification	X	X		X	X				X	X									X		
Support and Service Coordination	X	X	X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X
Supported/Integrated Employment Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Targeted Case Management	X	X	X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X
Transportation	X	X	X			X		X	X			X	X	X	X		X	X	X	X	X
Treatment (DPT/CSAT) Approved Pharmacological Supports	X	X		X	X					X									X		
Treatment Planning	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Additional Services																					
Community Psychiatric Inpatient	X	X	X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X
Crisis Residential	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X
Home Based	X	X	X			X	X		X		X	X		X	X	X	X	X	X	X	
Health Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Outpatient Partial Hospitalization							X	X					X								

In addition to the services for mental health and SUD populations described above, MSHN is required by MDHHS to establish 24 hour access system for all target populations. The region's goal for SUD is not a 'single point of entry' system; rather a multi-portal access system – a 'no wrong door' approach, to include 24/7/365 access for individuals with a primary SUD concern. MSHN, CMHSP Participant and SUD Provider efforts during FY16 are focused on building network capacity to:

1) Establish, enhance, or expand relationships between the CMHSP and the SUD provider system within the service area of the CMHSP so that:
   a. SUD service provider phone systems either link directly to the CMHSP access system during non-business hours or their automated response systems instruct callers to contact the CMHSP access system during non-business hours.
   b. The CMHSP and SUD service providers establish a written after hours protocol for handling referrals during non-business hours.
   c. Local first responder systems (i.e., police, sheriff, jail, emergency medical, etc.), hospitals and other potential referral sources are informed of the availability of after-hours availability of access services for individuals in need of substance use-related supports and services.

2) Engage in community coalitions and other substance use disorder prevention collaboratives by:
   a. Identifying and assigning responsibility for one or more CMHSP-employed individuals to perform this function;
   b. Identify opportunities where existing mental health prevention efforts can be expanded to integrate and/or support primary SUD prevention;
   c. With MSHN support general community education and awareness related to behavioral health prevention, access and treatment including outreach (Note that a regional goal is to increase the number of persons served, with emphasis on SUD and persons with HMP).

During site visits MSHN is checking with CMHSP Participants regarding the status of their implementation of 24/7/265 Access Systems for individuals with SUD.

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

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

Training and experience

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

Credentialing and re-credentialing procedures, as well as privileging procedures for psychiatrists, are utilized by each CMHSP with their provider networks. Agencies under contract are overseen by CMHSP staff and residential settings are licensed in accordance with MDHHS requirements.

In Michigan, staff providing certain Medicaid mental health services to specific clinical populations must meet education and work experience criteria for designation as a Child Mental Health Professional (CMHP), a Qualified Intellectual Disability Professional (QIDP), or a Qualified Mental Health Professional (QMHP).

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

Similar credentialing procedures are in place for SUD Providers. Provider agencies must be licensed as Substance Use Disorder Programs by the Michigan Department of Licensing and Regulatory Affairs (LARA). Individual clinicians, specifically treatment supervisors, specialists and practitioners, as well as prevention supervisors and professionals are required to hold certification through the Michigan Certification Board of Addiction Professionals, such as a Certified Addiction and Drug Counselor.

Some CMHSP Participants have achieved SUD Licensure through LARA in order to provide SUD treatment and to support integrated treatment programs as shown in Table 8:

Table 8: CMHSP SUD Licensure

	Prevention (CAIT)	Screening, Assessment, Referral, Follow-Up (SARF)	Outpatient	Case Mgt	Integrated Treatment	Early Intervention	Peer Recovery Support	Outpatient Methadone
BABH	X	X	X	X	X	X		
CEI	X	X	X	X	X	X		
CMHCM								
GCCMHA	X	X	X	X	X	X	X	
HBH	X	X	X	X	X			
RDHRW	X	X	X					
LCHMA			X		X			
MCN			X	X	X	X		
NCMH								
SCCMHA	X	X	X	X	X			
SHIACMH								
TBHS			X	X	X			

The credentialing requirements for Autism Benefit Services are highly specific and have triggered provider network capacity concerns across the MSHN region, as well as other areas of the state. Diagnosis of Autism Spectrum Disorders must be performed by a child mental health professional (CMHP) and validated by a physician (preferably a child psychiatrist) and/or a fully licensed psychologist. Oversight of interventions calls for Behavior Analysts and Assistants certified by the Behavior Analyst Certification Board, which requires an extended period to accomplish. This has created shortages of qualified clinicians in the state, which the MSHN CMHSP Participants are managing as much as possible through assertive recruitment strategies. This remains a priority for MSHN.

In 2014 MDHHS introduced a new clinical assessment/survey for individuals with Intellectual and Developmental Disabilities (IDD), called the Support Intensity Scale or SIS, which the PIHP's

are required to administrate. MSHN elected to say this was a clinical service and delegated it to the CMHSP Participants. MSHN must have an adequate number of trained assessors in the region to provide this service for all IDD consumers aged 18-64 within a 3 year time period. MSHN determined five full time assessors were needed. CMHSP Participants are contractually required to have adequate capacity to complete SIS assessments. In 2015 the MSHN region was 50% behind for scheduled assessments. Earlier in 2016 assessments were on schedule but have since fallen behind once more. MSHN staff are addressing the issue to ensure timelines can be met on an ongoing basis.

MSHN and its CMHSP Participants have developed regional training requirements, which is being expanded to include minimum training standards to ensure a base level of competency across the provider network.

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

Table 9: CMHSP Participant Accrediting Bodies

	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
The Joint Commission (TJC)			X									
Commission on Accreditation of Rehabilitation Facilities (CARF)	X	X		X		X	X	X	X	X	X	X
Council on Accreditation (COA)					X							

SUD Providers are required to have their programs accredited as alcohol and/or drug abuse programs. Most providers utilize similar accrediting bodies to the CMHSP Participants and their subcontracted mental health service providers, as follows:

Table 10: SUD Providers Accrediting Bodies

The Joint Commission (TJC)
Commission on Accreditation of Rehabilitation Facilities (CARF)
Council on Accreditation of Services for Families and Children (COA)
American Osteopathic Association (AOA)
American Association for Ambulatory Health Care (AAAHC)
National Committee on Quality Assurance (NCQA).

Specialization

In addition to pursuit of accreditation, CMHSP programs and SUD service providers must meet MDHHS program certification requirements for certain specialty programs as outlined in the Michigan Medicaid Manual. The certification process entails meeting additional criteria such as

mandatory service components, minimum staff credentials, ongoing training requirements and minimum staffing patterns.

MDHHS Certification is maintained by the CMHSP Participants for the following programs:

Table 11: CMHSP Participant Program Certifications through MDHHS

- Assertive Community Treatment
- Clubhouse Psychosocial Rehabilitation Programs
- Crisis Residential Programs
- Day Program Sites
- Children's Diagnostic and Treatment Services
- Drop-In Programs
- Home Based Services
- Wraparound
- Intensive Crisis Stabilization Services

Clubhouse Psychosocial Rehabilitation Program accreditation by the International Center for Clubhouse Development (ICCD) is now being required by MDHHS and programs must be compliant by September 30, 2018. Table 12 lists the current status of Clubhouse accreditation activities in the region.

Table 12: Status of Clubhouse ICCD Accreditation as of June 2016

	No Clubhouse	Awarded Accreditation	Accreditation in Process	Accreditation Process Not Initiated
Arenac	(can use Bay Co)			
Bay			X	
Clare	(can use Isabella or Mecosta Co)			
Clinton				
Eaton				
Gladwin	X			
Gratiot	X			
Hillsdale	(can use Jackson Co)			
Huron	X			
Ingham		X		
Ionia	X			
Isabella			X	
Jackson		X		
Mecosta			X	
Midland	X			
Montcalm			X	
Newaygo	X			
Osceola	(can use Isabella or Mecosta Co)			
Saginaw			X	
Shiawassee	X			
Tuscola	X			

Sub-contracted substance use disorder service providers must have a Substance Abuse License from the State of Michigan. MDHHS Certification is maintained by SUD Providers and CMHSP Participants providing SUD services for the following programs:

Table 13: SUD Program Certifications and Licensures

Licensure Through MI Licensing and Regulatory Affairs (LARA)	Certification Through MDHHS
▪ Substance Abuse Treatment ▪ Substance Abuse Prevention ▪ Residential Sub-Acute Detoxification ▪ Use of Methadone or Other Controlled Substances in the Treatment of Narcotic Addiction	▪ Women's Specialty Services Program

Each CMHSP Participant provides selected specialty services or treatments based upon evidence-based practice models they have adopted in accordance with local needs. Table 14 lists some examples of the many evidence based (or best) practices currently offered by CMHSP participants in the region:

Table 14: Examples of Evidence Based Practices Utilized by CMHSP Participants in the MSHN Region

	Pop.	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Alternative for Families Cognitive Beh Therapy	Families in Danger of Physical Violence										X		
Applied Behavioral Analysis	I/DD-Autism	X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	MIA	X	X	X		X	X	X	X	X	X	X	X
Brief Behavior Activation Therapy	Adults w Depression			X		X							
Brief Strategic Family Therapy	Families	X		X									
Clubhouse	MIA	X	X					X	X		X		
Cognitive Behavioral Therapy	All	X	X	X	X	X	X	X	X	X	X		X
Communities That Care	All										X		
Dialectical Behavioral Therapy	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Eye Movement Desensitization	PTSD	X					X		X	X	X		
Family Psycho-Education	Families	X	X	X	X	X		X	X		X	X	X
Infant Mental Health	Parents	X	X	X	X	X	X	X	X	X	X	X	X
Integrated Dual-Diagnosed Treatment	Dual SUD/MIA	X	X	X		X	X	X	X	X	X	X	X
Mobile Urgent Treatment Team	Families										X		
Motivational Interviewing	All	X	X	X	X	X	X		X	X	X	X	X
Multi-Systemic Therapy	Juvenile offenders			X				X	X				
Nurturing Parenting Program	Parents			X			X						
Parent-Child Interaction Therapy	Parents			X					X				
Parent Mgt Training – Oregon Model	Parents	X	X	X	X		X		X	X	X	X	X
Parenting Through Change	Parents	X		X							X		X
Parenting Wisely	Parents							X			X		

	Pop.	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Parenting with Love and Limits	**Parents**										X		
Peer Mentors	**I/DD**										X	X	
Peer Support Specialists	**MIA**	X	X	X	X	X	X	X	X	X	X	X	X
Picture Exchange Communication System	**I/DD-Autism**										X		
Positive Living Supports	**I/DD**	X	X		X	X					X	X	
Prolonged Exposure Therapy	**Adults w PTSD**			X		X			X				
Schema-Focused Therapy	**Couples**			X									
Seeking Safety Trauma Group	**SUD & PTSD**	X		X		X	X		X		X	X	X
Self-Management and Recovery Training	**MIA, SUD**	X		X		X							
Seven Challenges	**SUD Adolescents**										X		
Supported Employment	**Adults**	X	X	X	X	X	X	X	X	X	X	X	X
Thinking for a Change	**SUD Offenders**										X		
Trauma Focused Cognitive Beh. Therapy	**Children**	X		X	X	X	X	X	X	X	X		X
Trauma Recovery Empowerment Model	**Adults**			X	X					X	X		
Whole Health Action Management	**Adults**		X	X		X	X		X	X	X		
Wellness Recovery Action Planning	**Adults**	X	X	X			X		X	X	X		
Wraparound	**SED Families**	X	X	X	X	X	X	X	X	X	X	X	X

SUD Providers also utilize evidence based practices, particularly prevention models. Recovery focused approaches are prevalent, and some providers employ staff trained in motivational interviewing, integrated dual-diagnosis treatment, trauma informed and other techniques commonly employed by CMHSP's. The following are evidence-based practices employed by various SUD Providers in the MSHN region:

Table 15: Examples of Evidence Based Practices Utilized by SUD Providers in the MSHN Region

(T-treatment, P-prevention)

Focal Area	EBP Practices	Focal Area	EBP Practices
P	A Second Look	T	Motivational Interviewing
P	Active Parenting Now	T/P	Nurturing Parents
T	Acupuncture	P	OJJDP: Strategies for Success
P	Alcohol and Tobacco Vendor Education	P	Peer Assisted Leaders (PALs)
P	All Stars	P	Parenting Now
T/P	Alternative Routes	T	Partners for Change Outcome Measurement System
T/P	Anger Management	P	Party Patrols
P	Children of Addicted Parents	P	Permanent Drug Disposal Box Initiatives
P	Choices	P	Positive Action
P	CMCA – Communities Mobilizing for Change on Alcohol	P	Prescription Take Back Programs
T	Cognitive Behavioral Therapy (CBT)	P	Project Alert

Focal Area	EBP Practices	Focal Area	EBP Practices
P	Communities that Care	P	Project Cope
P	Community Intervention: Helping Teens Overcome Problems with Alcohol, Marijuana and Other Drugs	P	Project EX
P	Community Trials	P	Promoting Alternative Thinking Strategies
P	Conflict Resolution	P	Protecting You/Protecting Me
T	Correctional Therapeutic Community for Substance Abuse	T	Screening, Brief Intervention, Referral to Treatment (SBIRT)
T	Dialectical Behavior Therapy (DBT)	P	Second Step
P	Diversionary Programs	T	Seeking Safety
P	Early STEP	P	SMART Leaders/SMART Moves
T	Eye Movement Desensitization and Re-Processing	P	Social Norming/Marketing and Media Campaigns
P	Families and Schools Together (FAST)	P	Start Taking Alcohol Risk Seriously (STARS)
T	Family Psycho-Education	P	Step Bullying Prevention
T	Functional Family Therapy	P	Steps to Respect
T	Helping Women Recover/Helping Men Recover	T/P	Celebrating Families
P	Law Enforcement and Civilian Compliance Checks	P	Student Assistance Program
P	Life Skills Training	P	Systematic Training for Effective Parenting (STEP)
P	Lions Quest Skills for Adolescents	T	Tobacco Cessation
P	Mapping-Enhanced Counseling	P	Teen Intervene
P	Michigan Model for Health	T	Thinking for a Change
T	Mindfulness	P	TIPS Training
P	Minor in Possession Program	P	Too Good For Drugs (TGFD)
T	Moral Recognition Therapy	P	Too Good For Violence (TGFV)
T	Motivational Enhancement Therapy	T	Trauma Informed Care

MDHHS has attached a Trauma Technical Requirement to its contracts with PIHP's for FY16, placing increased emphasis on provider network capabilities to provide trauma informed and sensitive treatment for individuals with mental health and substance use disorders. The region will be initiating an evaluation of its compliance with the enhanced requirements, including any changes that may be needed in provider network specializations.

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

The MSHN SUD Strategic Plan for FY2015-2017 identified a plan for implementation of (the evidence based) Recovery-Oriented System of Care (ROSC) which includes specific objectives for expansion of programs that are gender competent and women's specialty programs, among other goals, in order to promote individual's recovery from substance use disorders. MSHN received a $1 million grant to implement a ROSC, including the use of the Screening, Brief Intervention and Referral to Treatment evidence-based practice to identify, reduce and prevent problematic use, abuse and dependence on alcohol and drugs.

Adequacy of services for anticipated enrollees

In addition to ensuring the appropriateness of the range of specialty behavioral health services, MSHN must also determine that services are adequate for the anticipated number of enrollees in the service area.[3] Medicaid enrollment, service penetration rates and community demand are key factors to consider.

Medicaid enrollment

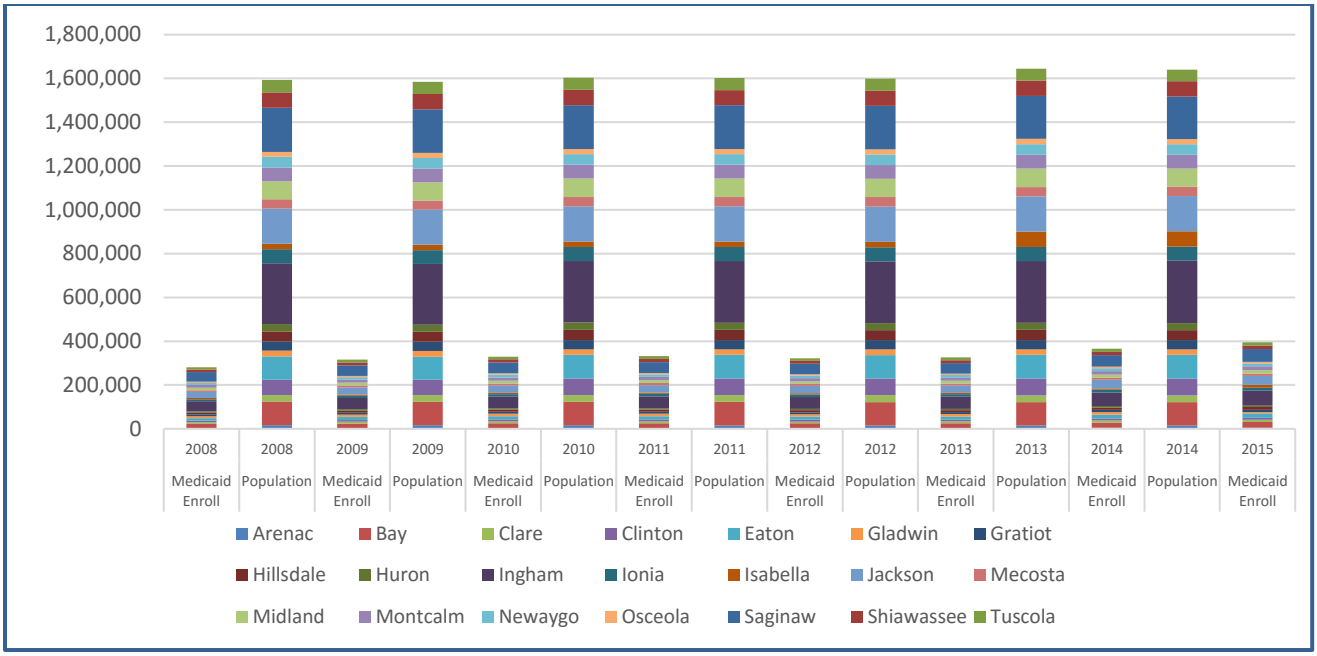
Medicaid enrollment in Michigan has been climbing in the past decade, most likely due to a general deterioration in the state's economy. In the past couple of years enrollment has shown signs of plateauing. Medicaid enrollments in the counties comprising the MSHN region still remain relatively high with MSHN Medicaid remaining over 20% of the total population, based upon CMHSP Participant Data (see graph and table below)[4]. Higher Medicaid enrollment is associated with a relatively greater number of potential consumers of specialty behavioral health services. This suggests the size of the MSHN provider network should remain at least at the existing level for the upcoming year, but begin to expand slightly. As described elsewhere in this assessment, some CMHSP's have been expanding their outpatient clinic offerings in response to Healthy Michigan enrollments.

Table 16: Medicaid Enrollment as Percentage of Total Population as of September

	2008	2009	2010	2011	2012	2013	2014	2015
Mid-State Region	17.67%	19.90%	20.55%	20.70%	20.18%	19.82%	22.23%	24.06%

[3] 42CFR438.207(b)(1) "Offers an appropriate range of preventative, primary care and specialty services that is adequate for the anticipated number of enrollees in the service area."
[4] Population census data and Medicaid enrollments taken from Community Needs Assessment Community Data Sets worksheets provided by each CMHSP.

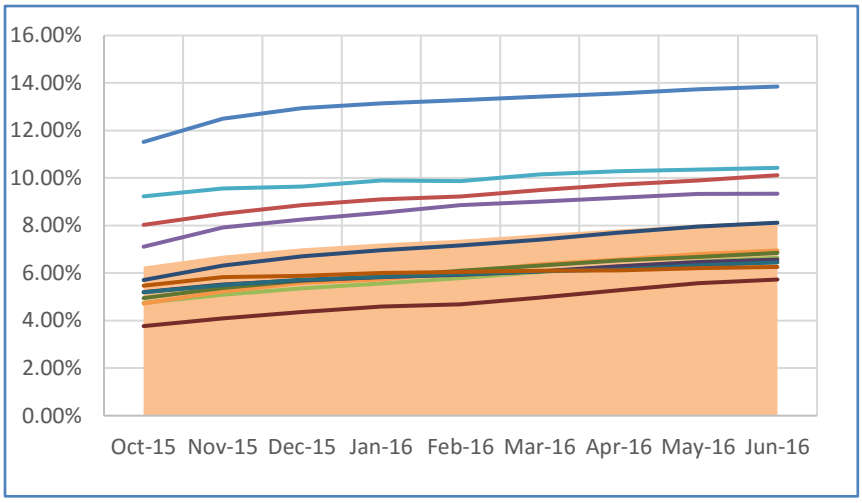
Figure 3: Population (Census) & Medicaid Enrollment by County as of September



Service population penetration rates

The number of Medicaid enrollees residing in the region who received specialty behavioral health services meets or exceeds the state average for most of the counties in the region. Again, this suggests service capacity should remain at or above existing levels and should not be reduced. Figure 4 shows the mental health service penetration rate of traditional Medicaid by month for the current fiscal year.

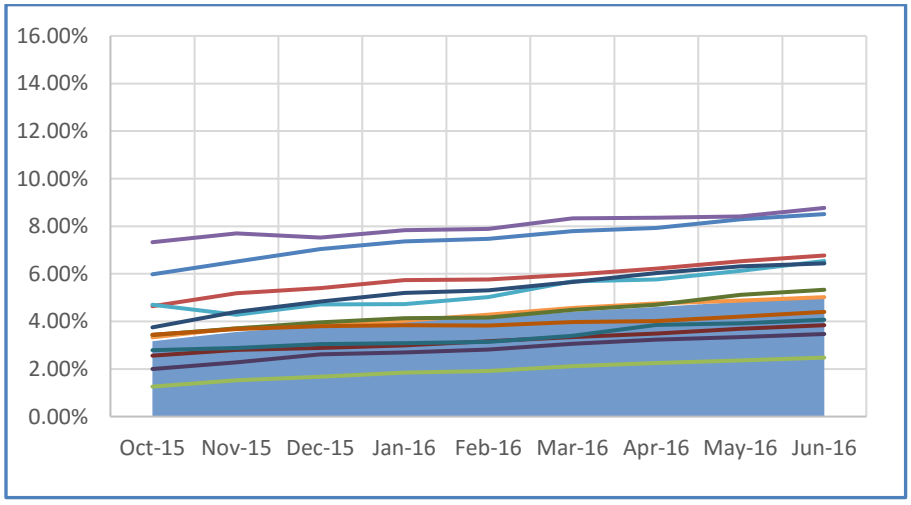
Figure 4: Traditional Medicaid Service Penetration Rates



Variability does exist among the CMHSP Participants in the region relative to population penetration rates, which is being reviewed at the executive level by the MSHN Operations Council to determine if the variance is commensurate with community need or if action by the Council is warranted relative to network capacities.

In 2015 MSHN identified some variance in service penetration rates for HMP Medicaid enrollees across the MSHN region, as shown in Figure 5.

Figure 5: Health Michigan Plan Service Penetration Rates



Anecdotal review suggested a lack of knowledge among HMP enrollees regarding the services available to them and how to access those services may be a causal factor, in addition to local

factors. In response, the region secured the services of a marketing firm to develop communication materials to ensure individuals enrolled in HMP can access needed care. The marketing plan is being rolled out mid-FY16.

Community Needs Assessments: Priority Needs and Planned Actions

Each CMHSP is required by MDHHS to complete a Community Needs Assessment each year. The needs assessment addresses service requests and their disposition, the use of service access waiting lists and other community demand information. This assessment informs decision making related to the sufficiency and adequacy of the provider network to address local needs and priorities. In aggregate, the Needs Assessments are also informative regarding regional provider network adequacy.

The CMHSP Participants in the MSHN region completed either new community stakeholder surveys to assess community needs this year or provided an update of their last assessment. A regional composite of CMHSP Needs Assessment Priority Needs is shown in Table 17.

Table 17: Community Needs Assessment Priorities FY15[5]

Based on the Top Five Priorities per CMHSP Only

Community Needs	Composite Regional Priority	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Services for Individuals with SUD/ Co-Occurring Disorders	1	1	3		3	1	1		2	3	5	2	1
Integrated healthcare and health outcomes	2		4	3					3	5	1	1	2
Services for children	3	2			2	3	3	4			4		3
Access to Psychiatric Services	4			1	1	2							
Community education/ prevention activities/ community outreach	5	5			5		5			5	3		5
Ease of **access to MH care**	6							5	1	4		4	
Services to individuals with mild/ moderate mental health needs; the underinsured	7	3	1					1	4			5	
Affordable and appropriate housing; Homelessness	8		5			4		3			2		
Alternatives to inpatient psychiatric services	9			2					5			3	4
Effect of Trauma	10-11	4								2	5		
Transportation to MH services	10-11				4			2					
Jail Diversion and Post Incarceration Treatment	12		2				5						
Services for the elderly	13-14												
Veteran's Outreach	13-14						4						
Poverty	15					5							

[5] Source: CMHSP Participant Annual Submission and Community Needs Assessment; Attachment E: Priority Needs and Planned Actions

Across the region, services for individuals with substance use disorders or co-occurring mental health and SUD disorders was the number one priority relative to unmet need, both due to increasing rates of occurrence and CMHSP preparations to increased integration of mental health and SUD services. The second highest priority across the region was integration of healthcare and improving health outcomes, and third, services for children, with an emphasis on community stakeholder collaboration and coordination of services.

Of the top three regional unmet community needs, both are already addressed in this assessment, with the exception of children's services. The following list summarizes CMHSP Participant efforts to expand service capacity for families and children and increase the number accessing services, as described in their community needs assessment updates:

- BABH
    - Implemented a new Wraparound program
    - Opened an autism clinic and expanded the service provider network specific to autism services
    - Exploring options with the Health Department for a shared clinic based in the school system.
    - Engaging in community outreach with schools, courts, community corrections, and DHS
    - Screening children in the Juvenile Court to determine if mental illness exists, to prevent children with mental illness from being involved in the juvenile system.
    - Providing school based outpatient services at two of the three Arenac County school districts to improve service access for youths and families.
- CEI
    - Participating in the Breakthrough Collaborative with MDHHS and the Children's Trauma Assessment Center; added screening tools to be used by intake staff; using tool to screen DHS kids and meeting with DHS to make referrals; leadership are meeting to problem solve.
    - Increasing the number of screenings done with Ingham County DHS; meeting with Eaton and Clinton County DHS representatives as well
    - Working on contracting with additional providers in order to meet the increased demand for ABA and evaluative services
    - Contracting with the Michigan State University Laboratory pre-school to provide an Applied Behavioral Analysis clinic in the pre-school setting
    - Developing a set of services designed specifically for families with adolescents or young adults who are experiencing a behavioral crisis:
        - Enhanced crisis services through the addition of urgent care program. This service provides immediate follow up by a Mental Health Therapist after an initial Crisis services contact. Contact is intense through a 2-3 week stabilization period. Service include safety planning, referrals, as well as mental health counseling.
        - Currently, exploring mobile crisis services for children.

- CMHCM
  - Formed a team to review therapeutic foster care resources for children; working with various community partners on action plan development.
  - Continuing to examine crisis placement options for children and teens. Coordinate with Treatment Foster Care if this becomes a possibility within our counties.
  - Coordinating with the Residential Review team regarding any alternatives they are able to identify and or create for young adults that have challenging behaviors that risk their current placements
- GCCMHA
  - Co-located a clinician in area schools
  - Positions were added or capacity increased at the following sites:
    - Emergency Department (local hospital)
    - Health Department
    - Child Advocacy Center
    - Physician's office
    - Court systems
- HBH
  - Part of the Great Starts Collaborative; composed of many providers in the community that work with families and children to provide support and education to parents
  - Active in community events where outreach to families can occur to assist with education and linkages to needed services or supports to strengthen parenting skills
  - Have an active Wraparound program
- RDHRW
  - Have a full time School Outreach Worker to increase the collaboration and referral rate from schools
  - Will offer Mental Health First Aid for Youth in schools in FY16
  - Partnering with local schools to provide social work services as part of a federal grant the school has. We will be adding a second staff as a part of this grant expansion in school year fall of 2016.
  - Participate in Great Start Collaborative in Ionia County.
  - Expanding our wraparound Program to include another Wraparound provider.
  - Participate in School Readiness Advisory Council.
  - Will be presenting at "opening day," a personal development day for all public school teachers – 320 teachers
  - Held educational event on the autism benefit to educators.
  - We are assisting a current ABA Aid employee in obtaining their BCBA to expand capacity of ABA services.
  - Providing screening at the court house to juvenile offenders.
  - Presenting on autism services to primary care providers.
  - Child psychiatrist provides consultation to primary care providers and provides his person cell phone.
  - Are a licensed child placing agency.
  - Provide treatment foster care.

- LCHMA
  - Has increased the availability of BHT services to meet the needs of the Autism expansion
  - Has a Prevention & Wellness Program including participation on the Jackson Substance Abuse Prevention Coalition, which includes the Most Teens Don't effort
  - Partner in the Intermediate School District Project AWARE, bringing Youth Mental Health First Aid to school staff and establishing mental health supports in into pilot schools; includes a Teen Advisory Team, committed to breaking down the stigma of seeking mental health supports
  - Facilitating Youth Mental Health First Aid for the Community-at-large
  - Participated in the iChallengeU by South Central Michigan Works where students were tasked with providing strategies to help teens engage in services when needed
- MCN
  - Initiative to provide community training in Mental Health First Aide Training for Youth
  - Implementation of SAMHSA Drug Free Communities Grant with focus on prevention of underage substance use
  - Expansion of Medicaid Autism services benefit
  - Implementation of integrated health services for children with serious emotional disturbances
  - Expansion of TF-CBT services including training addition clinicians and partnering with DHHS on the parenting group to target children in foster care.
  - Increased collaboration with DHHS in relation to reunification for children in placement or foster care and Family Team Meeting participation for children and youth with active Children's Protective Services cases.
  - Continued implementation of Children's Mental Health Block Grant for a multi-county MST program in partnership with Gratiot and Isabella Counties.
- NCMH
  - Participating in community collaborations, such as NC3, wraparound, Families First
  - Part of the Great Starts Collaborative; composed of many providers in the community that work with families and children to provide support and education to parents
  - Active in community events where outreach to families can occur to assist with education and linkages to needed services or supports to strengthen parenting skills—including annual participation in Tools for School Event, Family Expo, Training provided to all area Head Starts in the county (includes parents and Head Start staff)
  - Have a youth team staff designated as a liaison between CMH and DHHS specific youth services. CMH staff attends monthly staff meetings for foster care and protective services staffs at the local DHHS office and educates on CMH services, the referral process, assists with the SED waiver enrollment
  - Have a contract with juvenile court to provide home based services to adjudicated children in the court system who do not have Medicaid and would not typically qualify for CMH services.
  - Facilitating Youth Mental Health First Aid for the Community-at-large
  - Have an active Wraparound program and have hired an additional (full time) wraparound facilitator to meet the increased demand of referrals to this process

  - Developed a pilot program to offer "Breaking the Silence" curriculum in the upper elementary, middle and high schools (taught in gym and health classes) within Newaygo County to education community youth about mental health issues and help to reduce stigma.
  - CMH staff is a member of the Teen Pregnancy Prevention Initiative recently started in the county
  - Working on contracting with and hiring additional providers in order to meet the increased demand for ABA benefit and evaluative services (interviewing and will be hiring for additional autism aides, one case manager and an additional BCBA)
  - In discussion with NCRESA staff to utilize CMH office space to house one of their Parents as Teachers Workers at NCMH.
- SCCMHA
  - Awarded PA2 funds for the expansion of prevention funding with the Parents as Teachers home visiting model
  - Specific marketing with 'Many Challenges. One Call' brochure and disseminated widely in community to partners (3,900 copies) and available on the website as well.
  - Added a Youth Transition Program
  - Added additional Case Management team for Adults with Mental Illness
  - Added additional Supports Coordination team for individuals with Intellectual and Developmental Disabilities
  - Added full time mental health clinicians in 14 Saginaw City School sites
  - Added mental health services for integrated care at CMH CMU Medical School Family Practice Clinic
  - Initiated a community Saginaw Hoarding Task Force with treatment beginning FY 2017
  - Facilitating Open Table and Mentoring services through the Children's System of Care Expansion grant
- SHIACMH
  - Engaging in community outreach with schools, courts, community corrections, and DHS
  - Participating in the Great Start collaborative and health and human services coalition
  - Board representative for Child Advocacy Center
  - Partnership with Shiawassee Community Health Center (Patient-Centered Medical Home) providing integrated health care in both the primary care setting and behavioral health setting
  - Same-day Access
  - Partnership with DHS in providing continuing education for foster parents
  - Partnership with the ISD and other community agencies in providing trauma-focused care
  - Co-located early childhood staff with ISD, DHS, public health, early on
  - CISM team available to primary and secondary schools if needed
  - Increased the availability of BHT services to meet the needs of the Autism expansion
  - Robust respite program for children
  - Participating in TF-CBT

- TBHS
  - Participate in Great Start Collaborative as well as subcommittees providing education, support and services to children and families.
  - Participate in a court collaboration process which primarily focuses on multi-agency involvement in providing services to children and families.
  - Added screening tools to the intake process for all children.
  - Participating in multiple EBPs such as PMTO, PTC, TF-CBT, TF-CBT Caregiver Education (which has also been offered externally as a part of prevention services).
  - Active in community events where outreach to families occurs.
  - Provide ongoing presentations and education as requested by community agencies (local hospitals, DHHS, courts, etc.).
  - Active in Child Death Review Board to evaluate service delivery as well as services offered, gaps, etc. to assist in preventing county wide child deaths.
  - Have three staff trained in Mental Health First Aid Youth.
  - Participating in a prevention group called Start Now which primarily focuses on providing services to children and families despite eligibility criteria, as well as looking at a trauma informed work force.

MSHN is required to prepare a three year Strategic Plan for Substance Use Disorder Prevention, Treatment and Recovery Services, which analyzes community needs. The MSHN SUD Strategic Plan for FY2015-2017 needs assessment analyzes trends in the primary substance in use at time of admission, rates of alcohol use, and mortality rates due to poisoning.

Through the MSHN SUD Strategic Plan needs assessment, it was determined an increased provider network capacity for opiate and medication assisted treatment was needed in the region. The region issued a request for proposals early in 2015. The proposals received did not result in new providers joining the network so MSHN plans to continue to work with existing providers to enhance regional capacity to meet consumer needs.

Waiting Lists

CMHSP Participants may establish waiting lists for certain services but are not permitted to use waiting lists for Medicaid services.

For SUD services, a hold may be placed on admission referrals to a program if that provider exceeds capacity. MSHN has developed a simple daily reporting mechanism for detox and residential providers to indicate the number of available beds each morning. This helps MSHN assist with placing consumers by reaching out to providers who report immediate availability. Consumers can generally gain entrance into a detox facility within 48 hours if they are willing and able to go to the first available provider in the region. This is the same for residential providers, however, men generally have a longer wait time since there are few beds for men. This is an ongoing area of attention for MSHN. Providers are required to report, on a monthly basis, priority population waiting list deficiencies. Since October 1, 2016, reports indicate consumers are able to access services timely and are not placed on waiting lists.

MSHN and the CMHSP Participants may elect to seek or add providers to regional provider networks to meet existing or new needs of consumers.

Anticipated changes in Medicaid eligibility or benefits

Consideration of anticipated changes in Medicaid eligibility or benefits in the near term and an assessment of their anticipated impact on enrollment in the region is an important consideration relative to the adequacy of provider network capacity.

Autism Spectrum Disorder Services

MDHHS expanded eligibility for Autism services to age 21 effective January 2016. In its FY16 network capacity assessment MSHN analyzed potential impact on the number of children and adolescents likely to be eligible for services. As of March 2015, 342 children aged 18 months through 5 years were receiving services, with 44% of the children being served funded through the Autism benefit. MSHN was also serving over 1,200 additional children and adolescents aged 6 to 21 years who were diagnosed with autism spectrum disorders, suggesting the presence of a potential 269% increase in demand. As of this update to the MSHN network adequacy assessment, the number of individuals served through the Autism Benefit has increased by 257%.

Table 18: Comparison of Autism Spectrum Disorder Population and Service Utilization

	FY15			FY16	
	Number of Children with Autism Spectrum Disorder Diagnoses		Total on Autism Benefit 18 mos -5 yrs	Number of Children with Autism Spectrum Disorder Diagnoses Regardless of Age	Total on Autism Benefit 0-21
CMSHP	Age 18 Mos -5 yrs	Age 6-21			
BABH		102		310	49
CEI		200		1,054	122
CMHCM		261		617	57
GCCMHA		51		136	25
HBH		32		78	2
RDHRW		59		189	13
LCHMA		150		560	100
MCN		49		170	13
NCMH		83		178	14
SCCMHA		149		705	112
SHIACMH		66		224	17
TBHS		61		211	12
MSHN	**342**	**1,263**	**150**	**4,432**	**536**

Since the MSHN region had encountered difficulties in meeting the existing demand for services by children aged 18 months through 5 years, there was concern across the region's CMHSP Participants regarding the adequacy of the network's capacity to absorb such a marked increase in demand for these highly specialized services with limited qualified professionals in local job markets. See the section on sufficiency of number of providers for further analysis of provider network capacity to deliver Autism Benefit services.

Community Safety Net Services

As a primarily publicly funded system of care, MSHN and the CMHSP Participants are expected to provide core community mental health safety net services, such as 24 hour emergency services and care for the indigent. CMHSP's must assist police departments and jails with their inmate's mental health needs. In 2016, CMHSP's no longer received state funding to cover the cost of inpatient psychiatric and state facility care. As a result, this has impacted general funds for some CMHSP's, as those funds are now being used to support the cost of inpatient psychiatric and state facility care.

Management of these funds is not within the scope of authority of MSHN, but the same resources are expended by CMHSP Participants to absorb the cost of uncovered services for Medicaid enrollees who have been assigned a monthly spend-down amount in order to meet eligibility criteria, which they are not able to afford.

In 2015 the MDHHS re-allocated funds dedicated to community safety net services among the CMHSP's in the state, resulting in increased financial resources for many counties in the region. This has decreased the strain on network capacities.

Mild to Moderate (Non-Specialty) Behavioral Health Needs

For those individuals with non-specialty behavioral health service needs (i.e. mild to moderate mental health needs), the Medicaid or Medical Health Plans contracted by the MDHHS are expected to provide the mental health benefit. In some counties in the MSHN region, the availability of such services are limited or non-existent due to service capacity issues, low reimbursements or other barriers. Some Medicaid enrollees rely on services through Federally Qualified Health Centers (FQHC's) who have limited capacity and although nominal, have co-pay requirements which can be difficult for Medicaid enrollees to afford.

A 2014 informal survey by MSHN of the CMHSP Participants in the region yielded the results shown in Table 19:

Table 19: Mid-State Health Network: CMHSP – MHP Service Access and Coordination Survey 3/13/14

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

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

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

A continuing area of concern is consumer access to MHP mental health benefits, with lack of information regarding service access procedures, lack of availability of MHP network providers, low provider reimbursements and transportation issues noted as critical points of concern for PIHP's and CMHSP's.

Home and Community Based Services

The Centers for Medicare and Medicaid Services (CMS) released new rules in 2014 for Home and Community Based Services (HCBS) waivers. In the final rule, CMS is moving toward defining home and community-based settings by the nature of quality of individuals' experiences. The changes related to clarification of home and community-based settings and will maximize opportunities for participants in HCBS programs to have access to the benefits of community living, receive services in the most integrated setting, and effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.

MSHN and its CMHSP Participants are actively participating in MDHHS system assessments, individual consumer surveys, residential, and non-residential service setting surveys. From these surveys, ongoing compliance with the HCBS rule changes is being assessed. Survey timeframes are occurring in FY16 and FY17 and will result in determination of initial and ongoing compliance with the rules, with efforts directed toward reaching full compliance with the requirements and the state's transition plan, by no later than March 2019.

Michigan Public Act 200 (Kevin's Law)

In June of 2014, Michigan Public Act 200 amended Chapter 2A (Substance Abuse Disorder Services) of the Mental Health Code to allow a court to order involuntary treatment for an adult who had a substance use disorder, under particular circumstances. The person would be guaranteed an independent expert evaluation and legal counsel. A judge could order treatment for up to 72 hours or until a hearing could be held.

CMHSP Participants and SUD Providers have not reported a particular impact on demand for services as a result of PA 200 (and consequently, provider network capacity). There has been a lack of clarity regarding what infrastructure is available to support implementation, and some provisions have been the target of revision via House Bill 4674, which is currently making its way through the Michigan legislature. Among other changes, HB 4674 expands the length of time permitted to initiate treatment and adds flexibility regarding present versus historical risk factors.

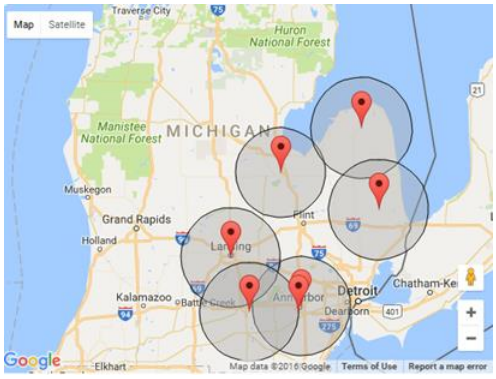
The 2017 legislative appropriations bill includes $2 million for implementation of Kevin's law, which may offer resources for capacity development.

Veteran's Access, Choice and Accountability Act of 2014

Improved access to behavioral health care for veterans is a priority for the State of Michigan and MSHN added a similar strategic priority to its action plan in 2015. In addition, the federal Veteran's Access, Choice and Accountability Act of 2014 allows those veterans who are unable to schedule an appointment within 30 days or if their place of residence is more than 40 miles from the closest Veteran's Administration health care facility, to elect to receive care from eligible non-VA health care entities or providers.

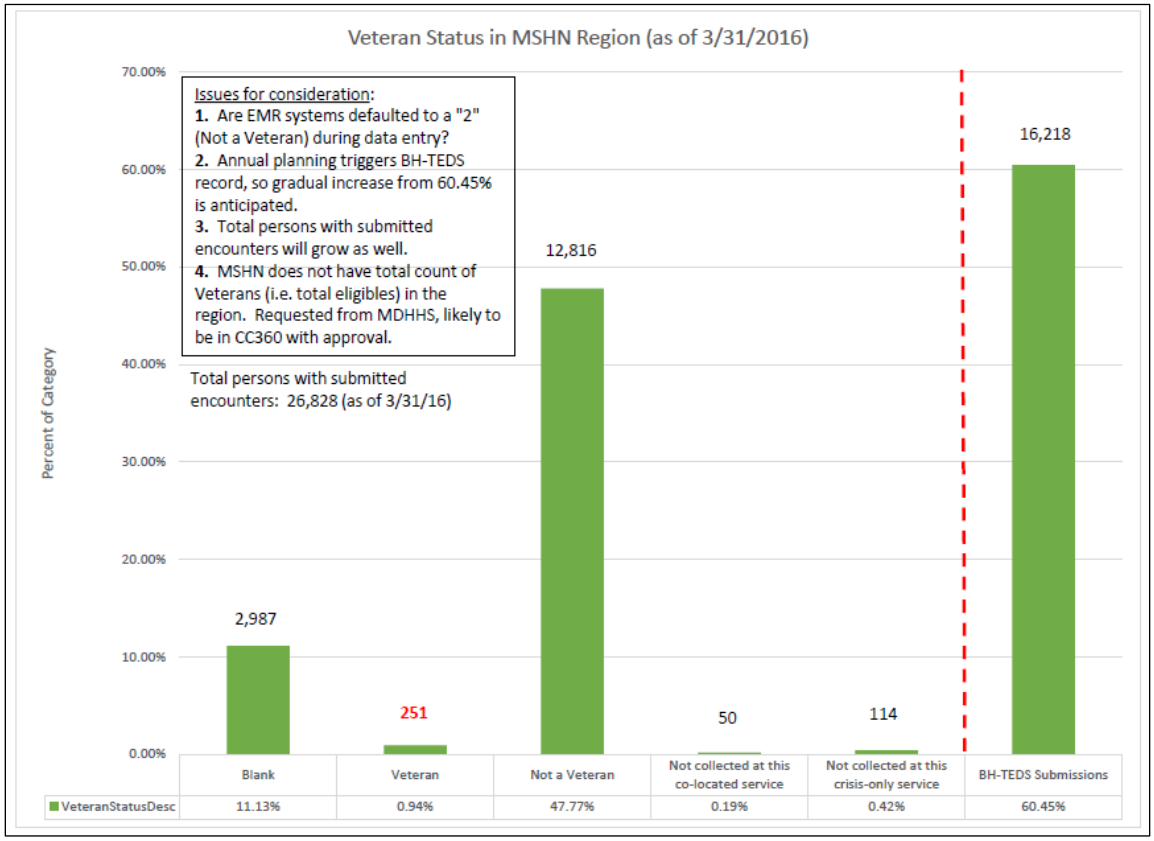
CMHSP Participants and SUD Providers may be the closest available behavioral health service provider in some areas of the region, since CMHSP's are located in each county in the region. Depending upon the level of demand, portions of Huron County to the east, Osceola, Clare, Mecosta and Isabella Counties to the northwest, and Newaygo and Montcalm Counties to the west, could see increases in demand for services. Figure 6 shows the location of Veteran's Administration (VA) Medical Centers and Clinics relative to the MSHN region.

Figure 6: Location of VA Medical Centers and Clinics Relative to MSHN Region



MSHN has begun preliminary analysis of baseline levels of service penetration among the veterans population in the region. Early results, though not yet validated, suggest less than 1% of the individuals receiving behavioral treatment in the region are identified as veterans, as shown in Figure 7.

Figure 7: Veteran Status in MSHN Region



CMHSP's responding to a need for VA services are required to meet the same qualifications as required by Medicare and the service array is primarily psychiatric services and outpatient therapies. Lifeways Community Mental Health operates a clinic in Jackson County which provides behavioral health services to veterans. There is also a clinic in the Lansing area.

The region will continue to monitor the demand for and adequacy of its capacity to serve veterans.

Meeting the needs of enrollees: expected utilization of services

MSHN must maintain a network of providers that is sufficient to meet the needs of the anticipated number of enrollees in the service area[6]. A determination of whether the network of providers is sufficient would typically be made through analysis of the characteristics and health care needs of the populations represented in the region[7]. However, the unique nature of the Medicaid Managed Specialty Supports and Services Program in Michigan complicates the assessment of network sufficiency beyond the scope of a simple analysis of clinical morbidity or prevalence among Medicaid enrollees.

MSHN is required to serve Medicaid beneficiaries in the region who *require* the Medicaid services included under the 1915(b) Specialty Services Waiver; who are *enrolled* in the 1915(c) Habilitation Supports Waiver; who are enrolled in the Autism Benefit; or for whom MSHN has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. The PIHP must also ensure access to public substance use disorder services funded through Medicaid, Public Act 2 and substance use disorder related Block Grants. Furthermore, MSHN is required to limit Medicaid services to those that are *medically necessary* and appropriate, and that conform to accepted standards of care. Services must be provided (i.e., available) in sufficient amount, duration and scope to reasonably achieve the purpose of the service.

Since eligibility and medical necessity for service involves factors beyond the determination of a diagnosis, prevalence may not be best predictor of future demand. Service utilization may serve as a better proxy for consumer demand. Table 20 shows the number of consumers serviced, units provided, and count of services from 10/1/15 through 7/31/16.

Table 20: Service Utilization by CMHSP

CMHSP	Number Served	Units Provided	Count of Services
Bay-Arenac Behavioral Health	4,582	2,772,820	290,308
CMH for Central MI	6,962	10,168,506	885,220
CMHA CEI	6,523	4,790,279	473,470
Gratiot CMH	1,237	415,533	74,269
Huron Behavioral Health	843	457,928	48,826

[6] 42CFR438.207(b)(2) "Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."
[7] 42CFR438.206(b)(ii) "The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the PIHP."

CMHSP	Number Served	Units Provided	Count of Services
The Right Door for Hope, Recovery, and Wellness	1,316	331,509	56,016
Lifeways	5,211	2,489,379	279,050
Montcalm Care Network	1,335	524,215	43,464
Newaygo CMH	1,265	262,298	57,682
Saginaw CMH	4,275	3,317,012	272,196
Shiawassee CMH	1,388	1,347,182	101,564
Tuscola CMH	1,030	445,012	60,631

Table 21 shows the number of consumers served: Home-Based Services (HBS), Targeted Case Management (TCM), and Habilitation Supports Waiver (HSW) from 10/1/15 through 7/31/16.

Table 21: HBS, TCM, and HSW Service Utilization

CMHSP	HBS Number Served	TCM Number Served	HSW Number Served
Bay-Arenac Behavioral Health	158	1,109	164
CMH for Central MI	408	1,533	513
CMHA CEI	950	2,843	242
Gratiot CMH	127	441	62
Huron Behavioral Health	64	228	49
The Right Door for Hope, Recovery, and Wellness	189	325	46
Lifeways	584	1,691	251
Montcalm Care Network	243	408	35
Newaygo CMH	112	607	24
Saginaw CMH	32	1,800	128
Shiawassee CMH	82	225	70
Tuscola CMH	136	42	66

Consumer satisfaction with services is an important consideration when evaluating the adequacy of a provider network. MSHN conducts an assessment of consumer perception of care for adults with mental illness utilizing Assertive Community Treatment and children with serious emotional disturbance receiving Home Based Services. Although not necessarily representative of all consumer populations, these high need groups have been repeatedly identified by MDHHS as key stakeholders for solicitation of feedback and therefore are used here as proxies for the satisfaction of MSHN recipients of service.

Results of the MSHN 2015 Perception of Care Survey conducted in 2016 are shown in in Figures 8 and 9, in comparison to the results from 2014. The responses to the Access (to services) subscale for Home-Based Services is favorable, with less than 10% of either population expressing concern about access to services. A slightly lower percentage of agreement was reported for Assertive Community Treatment, but still above 85%.

Figure 8: Percent Agree by Subscale, Home-Based Services

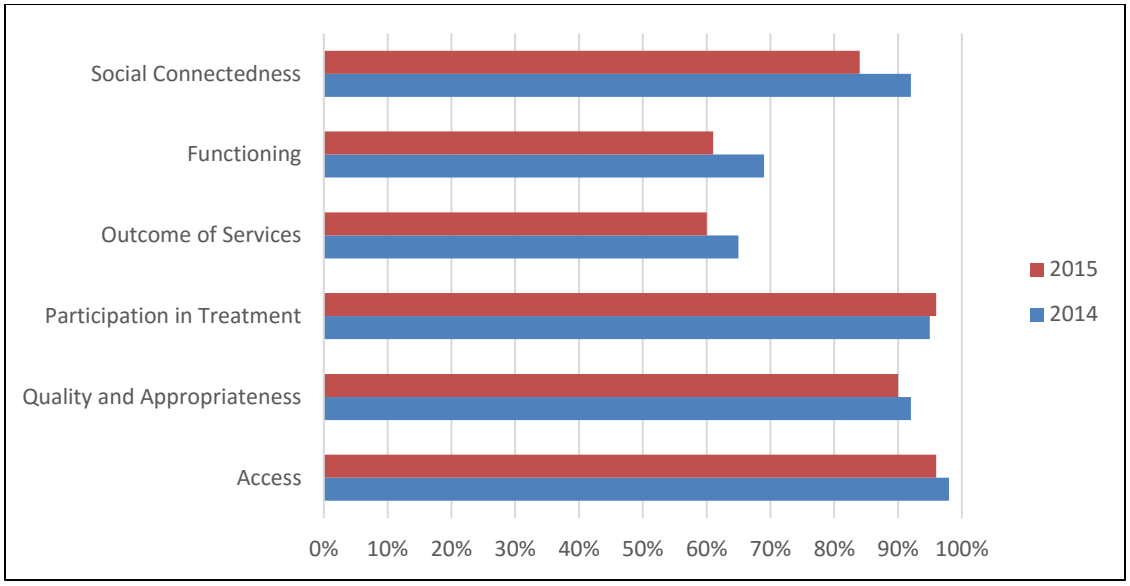
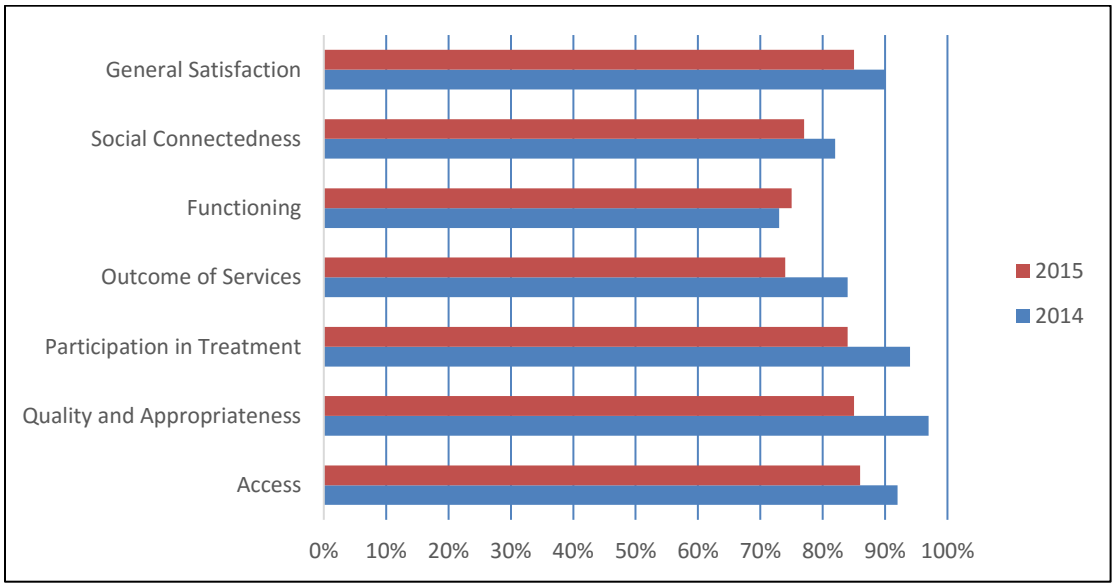


Figure 9: Percent Agree by Subscale, Assertive Community Treatment



The results will be reviewed by the MSHN Quality Improvement Council and the Regional Consumer Advisory Council to determine possible region wide improvement efforts as well as identification of any trends that have occurred from year to year. The results will be compared to national averages as available. The areas of improvement will be targeted towards the domains with the lower average scores (based on the regional average of all scores) and those domains that have shown a decrease from the previous years. Each CMHSP will also review

their local results for areas of improvement at the local level. It is also recommended that those with a low number of returned responses review their process and determine if additional action may need to be taken to impact the response rate. The low number of responses may result in an acceptable threshold based on the standard set or it may result in an unacceptable threshold. The low numbers may also impact the ability for the results to be generalized throughout the population.

Sufficiency of network in number, mix and geographic distribution

MSHN must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area[8]. The effectiveness of the number of providers in the network may be evaluated to a great extent by past performance.

Sufficiency of number of providers – access timeliness and inpatient follow-up

MDHHS requires PIHP's to report indicators of access timeliness and inpatient follow-up. Below is a table showing the FY16 YTD performance of the 21 county region :

Table 20: State Performance Indicators for Access Timeliness and Inpatient Follow-Up

	Population	MSHN Score FY16 Q1	MSHN Score FY16 Q2
New persons receiving face to face assessment w/in 14 days of non-emergency assessment (Standard: ≥95%)	MI-Children	99.82%	98.79%
	MI-Adults	99.76%	99.45%
	DD-Children	100.00%	98.44%
	DD-Adults	100.00%	100.00%
	Medicaid SA	98.38%	96.37%
New persons starting on-going service w/in 14 calendar days of a non-emergent assessment (Standard: ≥95%)	MI-Children	96.60%	96.68%
	MI-Adults	99.88%	97.96%
	DD-Children	98.00%	95.74%
	DD-Adults	100.00%	98.11%
	Medicaid SA	100.00%	100.00%
Persons discharged from psychiatric inpatient unit/ substance abuse detox unit seen for follow-up care w/in 7 days (Standard: ≥95%)	Children	97.53%	100.00%
	Adults	98.14%	98.32%

[8] 42CFR438.207(b)(2) "Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."

	Population	MSHN Score FY16 Q1	MSHN Score FY16 Q2
	Medicaid SA	100.00%	100.00%
Persons readmitted to an inpatient psychiatric unit w/in 30 days of discharge	Children	6.31%	11.90%
	Adults	9.35%	8.26%

MSHN's performance is performing above state thresholds.

MSHN has already identified network crisis response capacity and community psychiatric inpatient availability as areas of concern for the region's provider network, although MSHN performs better than state averages relative to inpatient recidivism. Both areas are being addressed by MSHN, which will is expected to help with inpatient recidivism as well.

Sufficiency of number of providers – autism spectrum disorder capacity

CMHSP Participants have found it difficult to secure adequate providers to provide Applied Behavioral Analysis services for children with autism, due to the extensive training requirements for providers and the relative newness of the required credentials in the behavioral health industry and Michigan in particular. Insufficiencies in the quantity of providers who are qualified to provide Autism benefit services, particularly Board Certified Applied Behavioral Analysts (BCBA's) to provide Applied Behavioral Analysis (ABA) services is a challenge in some areas of the provider network, although progress has been made.

MSHN conducted a survey of network capacity in the April of 2015 and again in June of 2016, which yielded the results shown in Table 21.

Table 21: MDHHS Medicaid Autism Spectrum Disorder (ASD) Capacity as of 3/31/16

	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Adequate capacity for diagnostic services of ASD?	2015 –Yes 2016- Yes	2015-Yes 2016-No	2015-Yes 2016-No	2015-Yes 2016-Yes	2015-Yes 2016-Yes	2015-Yes 2016-Yes	2015-Yes 2016-Yes	2015-Yes 2016-Yes	2015-Yes 2016-Yes	2015-Yes 2016-Yes	2015-Yes 2016-No	2015-Yes 2016-Yes
Capacity to assist additional children with diagnostic services for ASD?	2015-No 2016-No	2015-Yes 2016-No	2015-No 2016-No	2015-Yes 2016-No	2015-No 2016-No	2015-Yes 2016-Yes	2015-Yes 2016-Yes	2015-No 2016-Yes	2015-Yes 2016-Yes	2015-No 2016-No	2015-Yes 2016-No	2015-Yes 2016-No
Capacity to provide ABA for additional children in addition to your community?	2015-No 2016-No	2015–Yes 2016-Yes	2015-No 2016-No	2015-No 2016-No	2015-No 2016-No	2015-Yes 2016-Yes	2015-Yes 2016-Yes	2015-Yes 2016-No	2015-Yes 2016-No	2015-No 2016-No	2015-No 2016-No	2015-No 2016-No
Number of BCBA's supervising ABA services	2015 – 3 2016 – 4	2015 - 7 2016 - 12	2015 – 5 2016 - 9	2015 – 2 2016 - 3	2015 – 1 2016 - 1	2015 – 2 2016 - 2	2015 – 2 2016 - 5	2015 – 1 2016 – 2	2015 -1 2016 -1	2015 – 4 2016 -11	2015 – 1 2016 – 1	2015 – 1 2016 - 1
Other qualified professionals supervising ABA services	2015-None 2016-None	2015 - 6 2016- 6	2015 - 4 2016 - 2	2015-None 2016 - 3	2015-None 2016-None	2015-None 2016-None	2015 – 2 2016 - 2	2015-None 2016-None	2015-None 2016-None	2015 – 3 2016 -5	2015-None 2016-None	2015-None 2016-None

	BABH	CEI	CMHCM	GCCMHA	HBH	RDHRW	LCMHA	MCN	NCMH	SCCMHA	SHIACMH	TBHS
Number of ABA aides	2015 - 1 FT/ 8 PT[9] 2016 -7 FT/ 11 PT	2015 - 22 2016 - 92	2015 - 0 FT/ 13 PT 2016 - 18	2015 - 14 FT/ 10 PT 2016 -5 FT/ 13 PT	2015 – 2016 - 11	2015 - 0 FT/ 4 PT 2016 – 4 FT/ 3 PT	2015 - 10 FT/ 3 PT 2016 – 23 FT/ 15 PT	2015 - 1 FT/ 0 PT 2016 – varies	2015 - 0 FT/ 3 PT 2016 – 3 PT	2015 - 6 FT 2016 -60	2015 - 3 FT/ 3 PT 2016 - 11	2015 - 1 FT/ 3 PT 2016 - 2 FT/ 2 PT
As of Mar 31, # of children eligible for the benefit	2015 – 17 2016 - 49	2015 - 65 2016 - 105	2015 – 29 2016 - 40	2015 – 13 2016 – 21	2015 – 0 2016 - 2	2015 – 5 2016 - 13	2015 – 31 2016 - 53	2015 – 2 2016 - 25	2015 – 5 2016 - 9	2015 – 51 2016 -145	2015 – 10 2016 - 15	2015 – 7 2016 - 5
Of those eligible, number receiving ABA services	2015 – 15 2016 - 35	2015 - 60 2016 - 92	2015 – 24 2016 - 33	2015 – 10 2016 – 14	2015 - 0 2016 - 2	2015 – 4 2016 - 5	2015 – 23 2016 - 53	2015 – 2 2016 - 8	2015 – 5 2016 - 6	2015 – 38 2016 - 110	2015 – 8 2016 - 14	2015 – 5 2016 - 3
Do you need assistance acquiring BCBA(s)?	2015 – Yes 2016 - No	2015 – Yes 2016 - Yes	2015 – Yes 2016 - Yes	2015 – No 2016 – No	2015 – No 2016 - No	2015 – No 2016 – No	2015 – No 2016 - Yes	2015 – No 2016 - No	2015 – No 2016 - No	2015 – Yes 2016 - No	2015 – Yes 2016 - Yes	2015 – No 2016 - Yes
Average length of time to start ABA services after referral (after initial contact w/ CMH for ASD services)	2015 - 12 weeks 2016 – 10 weeks	2015 - 30 Days 2016 – 131 days	2015 - 8 weeks 2016 – 2-4 mos	2015 - 3 weeks 2016 – 7.5 weeks	2015 – Unknown 2016 – 30-45 days	2015 - 10 weeks 2016 – 59 days	2015 - 8 weeks 2016 - 30-60 days	2015 – 90 2016 – 30 days (testing)	2015 - 11 weeks 2016 – 75 days	2015 - 45 days 2016 – 45 days	2015 - 6 weeks 2016 – 60-65 days	2015 - 20 weeks 2016 – 90 days

CMHSP Participants continue to address gaps in provider network capacity for autism benefit services.

MSHN identified some weaknesses in network capacity for substance use disorder services, as specified in the aforementioned multi-year strategic plan. Additional detox beds were established in Saginaw county due to lack of capacity to meet current demand and a methadone provider for Suboxone was replaced to maintain current provider volumes.

All CMHSP Participants are required via their contract with MSHN, and indirectly by MSHN's contract with MDHHS, to accept new Medicaid patients[10]. The same requirement applies to SUD Medicaid services.

Sufficiency of mix of providers – IDD, SED

MSHN is required to give priority to individuals with serious mental illness, serious emotional disturbance and developmental disabilities with the most serious forms of illness and those in urgent and emergent situations. Key services for individuals with urgent and emergent needs include inpatient psychiatric care and 24/7 emergency response capacity. Both services are available in all 21 counties in the MSHN region. However, MSHN has noted access to psychiatric inpatient in the region may not be adequate to meet the needs of all consumers (at any given time) for whom a pre-screening has been completed and admission determined to be warranted.

The issues causing this network capacity concern appearance to be the result of a convergence of several factors. Some hospitals are reporting a lack of capacity, but anecdotal evidence

[9] FT is full-time; PT is part-time
[10] 42CFR438.206(b)(iv) "The numbers of network providers who are not accepting new Medicaid patients."

suggests capacity is only a barrier in limited geographic areas or for certain specialty populations. The slackening economy in Michigan in the past several years appears to have triggered restricted staffing in some hospitals, thereby limiting their capacities.

Anecdotal evidence suggests the needs of the patient population have increased due to the growth in opiate and other addictions, married with expanding populations of individuals who were discharged to their home communities during the most recent phase of state center closures and census reductions. The needs of the patient populations are growing ever more complex. Some psychiatric inpatient hospitals have reacted by refusing to admit individuals with significant behavioral challenges or other more intensive/complex symptomatic presentations.

The region has taken action by advocating for regional need at state Certificate of Need (CON) Commission meetings and approaching the MDHHS for assistance. In February, 2016, MSHN entered into an agreement with the Certificate of Need Commission (CON) and the Behavioral Health and Developmental Disabilities Administration (BHDDA) to pilot the collection of psychiatric inpatient denial data in MSHN's 21 county region. The goal of the pilot is to address issues surrounding appropriate and immediate access to inpatient psychiatric care not only with MSHN's region, but around the state, for the state to investigate and resolve patterns of inpatient admission difficulties, and to reduce denials, which should lead to better access for individuals experiencing acute psychiatric distress. All 12 CMHSP's are participating the in the pilot which began on March 1, 2016 and scheduled to end on September 30, 2016. As a result of the data collected, the CON Commission has begun investigating patterns of denials to determine if claims are substantiated, resulting in additional compliance action. MSHN is committed to continuing data collection through FY17 and through conversations with BHDDA and CON, is committed to supporting state-wide expansion efforts.

Between 3/1/16 and 8/31/16, CMHSP's reported 11,108 instances of psychiatric inpatient admission denials for 809 consumers (Table 22). This is an average of 14 denials per consumer, however some consumers were denied as many as 20 times, or more.

Table 22: Denials Reported by CMHSP

Reporting CMHSP	Instances of Denials	Unduplicated Consumer Count
Bay-Arenac CMH	872	84
CEI CMH	4552	195
Central Michigan CMH	246	40
Gratiot CMH	91	19
Huron CMH	328	29
Lifeways	1464	150
Montcalm Care Network	230	25

Reporting CMHSP	Instances of Denials	Unduplicated Consumer Count
Newaygo CMH	106	6
Saginaw CMH	2512	224
Shiawassee CMH	46	4
The Right Door for Hope, Recovery and Wellness	531	21
Tuscola CMH	132	12
Grand Total	**11,108**	**809**
average denials per consumer:	14	

Table 23 represents the number of consumers who are reported as being either an individual with a developmental disability (IDD), an individual with a substance use disorder (SUD), or an individual with autism spectrum disorder (ASD). Of the total number of consumers denied admission, 29% are children/minors and 71% are adults.

Table 23: Population Type

IDD	SUD	ASD
91	138	19
11%	17%	2%

The most common reason for denial reported is At Capacity (75%), with the second most common reason reported being Patient Does Not Fit Milieu and No Call Back/No Response at 5% and 7% respectively (Table 24). All other reasons documented make up just 13% of the denials.

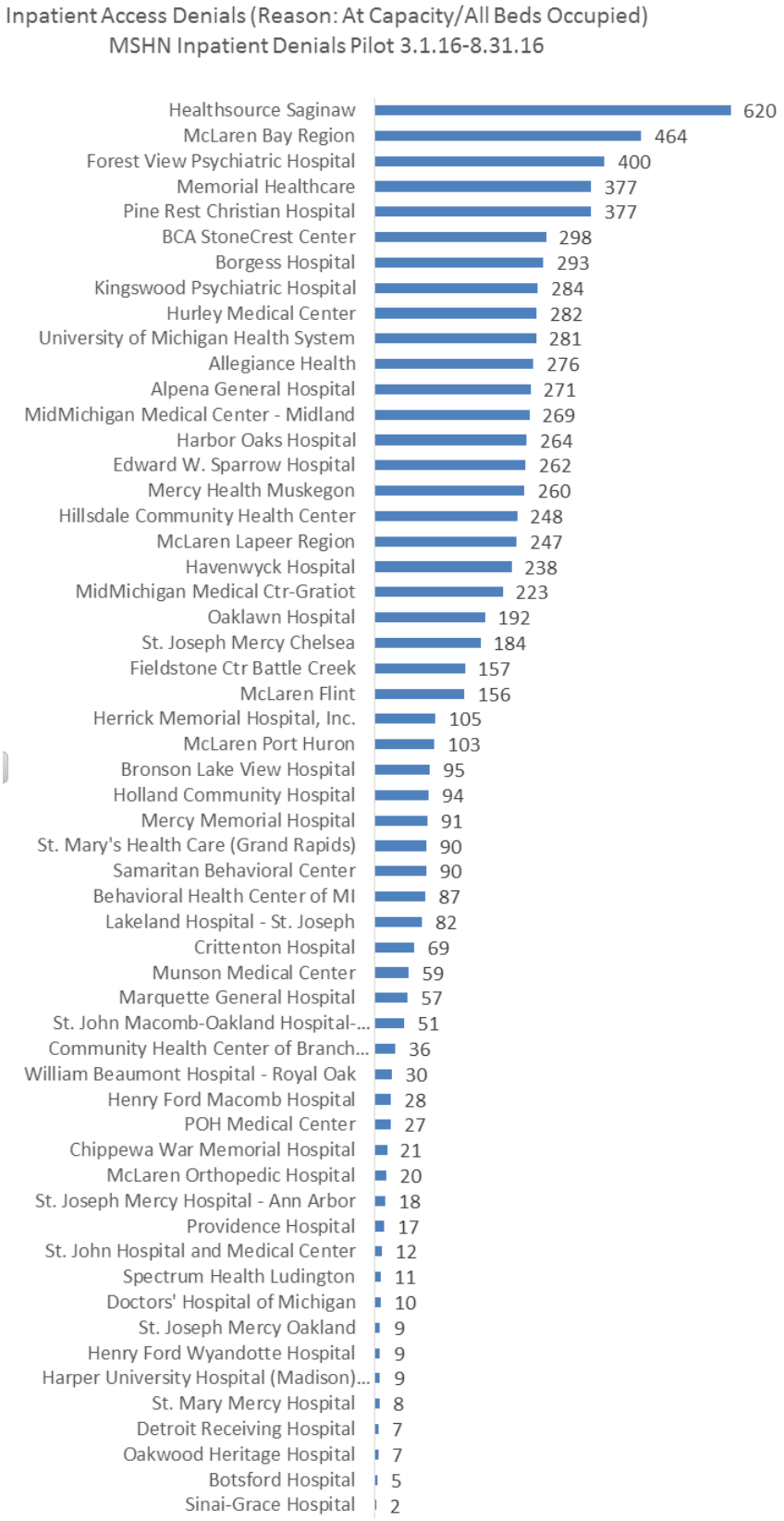
Table 24: Reason for Denial

Reason Reported	Total
Ability to Pay	2
Age	32
At Capacity (All Licensed Beds At The Hospital Are Occupied)	8280
Beds Available But Insufficient Staff	56
Beds Available But No Appropriately Trained Staff	12
Commitment Status	21
Gender	158
Handicap	10
No Call Backs/No Responses	810
Other (Specify)	853
Patient Comorbidities (Specify Medical Illness)	130
Patient Does Not Fit Milieu	540
Payment Rate Issues	10
Religion	1

Reason Reported	Total
Source of Payment	50
Violent/Disruptive behavioral Issues	143
Grand Total	**11,108**

Table 25 shows the total instances of psychiatric inpatient admission denials by hospital for the reason of being at capacity (duplicated count). It is important to note that this does not reflect the final outcome reported.

Table 25: Instances of Denials (Reason: At Capacity/All Beds Occupied) – Duplicated


Inpatient Access Denials (Reason: At Capacity/All Beds Occupied)
MSHN Inpatient Denials Pilot 3.1.16-8.31.16
Healthsource Saginaw 620
McLaren Bay Region 464
Forest View Psychiatric Hospital 400
Memorial Healthcare 377
Pine Rest Christian Hospital 377
BCA StoneCrest Center 298
Borgess Hospital 293
Kingswood Psychiatric Hospital 284
Hurley Medical Center 282
University of Michigan Health System 281
Allegiance Health 276
Alpena General Hospital 271
MidMichigan Medical Center - Midland 269
Harbor Oaks Hospital 264
Edward W. Sparrow Hospital 262
Mercy Health Muskegon 260
Hillsdale Community Health Center 248
McLaren Lapeer Region 247
Havenwyck Hospital 238
MidMichigan Medical Ctr-Gratiot 223
Oaklawn Hospital 192
St. Joseph Mercy Chelsea 184
Fieldstone Ctr Battle Creek 157
McLaren Flint 156
Herrick Memorial Hospital, Inc. 105
McLaren Port Huron 103
Bronson Lake View Hospital 95
Holland Community Hospital 94
Mercy Memorial Hospital 91
St. Mary's Health Care (Grand Rapids) 90
Samaritan Behavioral Center 90
Behavioral Health Center of MI 87
Lakeland Hospital - St. Joseph 82
Crittenton Hospital 69
Munson Medical Center 59
Marquette General Hospital 57
St. John Macomb-Oakland Hospital-... 51
Community Health Center of Branch... 36
William Beaumont Hospital - Royal Oak 30
Henry Ford Macomb Hospital 28
POH Medical Center 27
Chippewa War Memorial Hospital 21
McLaren Orthopedic Hospital 20
St. Joseph Mercy Hospital - Ann Arbor 18
Providence Hospital 17
St. John Hospital and Medical Center 12
Spectrum Health Ludington 11
Doctors' Hospital of Michigan 10
St. Joseph Mercy Oakland 9
Henry Ford Wyandotte Hospital 9
Harper University Hospital (Madison)... 9
St. Mary Mercy Hospital 8
Detroit Receiving Hospital 7
Oakwood Heritage Hospital 7
Botsford Hospital 5
Sinai-Grace Hospital 2

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

Sufficiency of mix of providers - SUD

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

Similarly, MSHN must assure that the twelve CMHSP participants, in addition to network SUD service providers, have adequate capacity and competence to participate in an integrated service access process for individuals seeking treatment for both mental health and substance use disorders. Cross credentialing is a particular area of focus for the region.

Sufficiency of mix of providers – cultural competence

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

Sufficiency of mix of providers – consumer choice

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

Geographic accessibility

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

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

- For office or site-based substance abuse services, the individual's primary service provider (e.g., therapist) must be within 30 miles or 30 minutes of the recipient's residence in urban areas and within 60 miles or 60 minutes in rural areas.[11]

Transportation is a greater challenge for CMHSP Participants given the rural and small/medium city composition of the region. Public transit is limited to city centers and surrounding suburbs in most instances. Delivery of services in non-clinic settings and use of targeted transportation programs helps address any gaps in accessibility for consumers of services.

Substance use disorder providers also continue to add specialized transportation services to meet the needs of MSHN region. One example is added home based services for women with children, which is an enhanced women's specialty service, in order to address geographic limitations/ transportation problems individuals were having in trying to access clinic based services.

Accommodations

All CMHSP Participants offer services in locations with physical access for Medicaid enrollees with disabilities[12]. Delivery of services in home settings as well as telemedicine (now available in selected counties) can offset barriers to physical access where present.

The majority of the CMHSP's in the region are CARF accredited, which requires specific accommodations and accessibility evaluations or plans to ensure services are readily available to individuals with special needs.

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

As of the date of this assessment, none of the populations in the counties in the MSHN region have more than 1% of non-English speaking individuals. However, interpreters/ translators are available at each CMHSP for persons with Limited English Proficiency (individuals who cannot speak, write, read or understand the English language at a level that permits them to interact effectively with health care providers) as required by Executive Order 13166 "Improving Access to Services for Persons with Limited English Proficiency"). This includes the use of sign

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

[12] 42CFR438.206(b)(vi) ". . . considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities."

interpreters for persons with hearing impairments and audio alternatives for people with vision limitations.

Interpreter services, although available across the region in accord with MDHHS standards, are less than adequate for crisis intervention services, where a timely clinical response is critical and wait times for access to an interpreter may delay treatment. The region will monitor the impact of this issue on crisis response capacity.

In late 2014/early 2015, the Michigan Department of Health and Human Services, in conversation with advocates for individuals who experience deafness or consider themselves hard of hearing, as well as those with co-morbid blindness, determined a need to evaluate regional access, service provision and treatment supports for those who may require specialty behavioral health services. A survey was conducted by MSHN in the winter of 2015, which found the following:

Table 26: Capacity to Serve Individuals w/ Deafness (D), Hard of Hearing (HOH) or Deaf/Blindness

How many DHOH/Deaf Blind consumers is your agency serving?

	Number of DHOH/Deaf Blind consumers
MSHN Total	2288
CMH Average	191

*One CMH stated that they are unable to determine the number of Hard of Hearing consumers.

Would the manner in which your agency provide DHOH services, in general, survive an ADA review (if one existed)?

	Number of CMH
Yes	5
No	0
Unknown	7

Does your agency have American Sign Language interpreters available to support the intake process?

	Number of CMH
Yes	12
No	0
Unknown	0

How many of your DHOH/Deaf Blind consumers depend on friends or family members to provide interpreting services?

	Number of CMH
MSHN Total	34
CMH Average	4

*The average was determined by averaging the response of nine CMHs. Three CMHs stated the data is unknown or unable to be determined. The three CMHs comprises 85% of the MSHN's DHOH/Deaf Blind population.

Who includes the DHOH/Deaf Blind population in cultural competency training?

	Number of CMH
Yes	7
No (not specific)	3
Unknown	2

What type of outreach is your agency doing for the DHOH/Deaf Blind population?

	Number of CMH
Social Media	1
Hospitals	1
Schools	2
Therapists	2
Nothing specific	8
Unknown	0

MSHN requested that CMHSP's and SUD Providers ensure accommodations are available as required for individuals accessing services who experience hearing or vision impairments and also that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services. This is being addressed during site reviews by the MSHN audit team.

NASW-Michigan is providing training to the MSHN region about treating individuals experiencing deafness, deafness and blindness, or are hard of hearing. During FY16 the training will be occurring in Jackson, Ingham and Bay counties.

Public Policy Priorities

In its 2013 Application for Participation for PIHP's, MDHHS identified a series of public policy initiatives which reflected the state's priorities relative to maintaining an adequate provider network capacity for Medicaid beneficiaries. A number of the priorities are addressed here. The following are areas of focus for MSHN dashboard and quality reporting and have been removed from this assessment for the time being:

- Olmstead Compliance – Community Living
  - Individuals Living in Any Licensed Setting
  - Individuals Living in a Licensed Setting Outside of the PIHP Region
  - Individuals Living Independently
- Employment and Community Activities
  - Adults in Employment and Community Activities
  - Competitive Employment

Regional Crisis Response Capacity

MDHHS requires PIHP's to have a crisis response capacity fully available that includes clinical expertise that can be immediately accessed for mental health or behavioral crises. MSHN, along with other PIHP's, has encountered challenges in meeting this requirement. CMHSP's in the region have telephonic response capacity, typically including some type of active monitoring program and the ability to engage in face-to-face crisis contacts if needed. Options for effectively and defensibly expending Medicaid funds to develop and maintain an ongoing residential crisis response capacity is still being addressed by MSHN and the CMHSP Participants.

Previously in this document current barriers to access to inpatient psychiatric care are addressed, which has weakened the region's crisis response capacity. Crisis response remains a priority for the region.

Health and Welfare

MDHHS is seeking greater integration of systems of care to promote healthy behaviors and management of chronic conditions and all aspects of health: physical health, behavioral health, and habilitation. MDHHS expects that MSHN will assure that individuals being served receive appropriate, culturally-relevant and timely healthcare; that medical care providers are knowledgeable in how to approach and treat individuals with mental illness and/or

intellectual/developmental disabilities; and that the PIHPs' provider networks are partners on the health care team for health care planning and monitoring purposes.

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

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

Substance Use Disorder Prevention and Treatment

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

- Prevent the development of new substance use disorders.
- Reduce the harm caused by addiction.
- Help individuals make the transition from brief experiments in recovery initiation to sustained recovery maintenance via diverse holistic services.
- Promote good quality of life and improve community health and wellness.

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

Integration of mental health, substance use disorder and physical health care

MSHN and its CMHSP Participants are currently evaluating the state of integration of mental health, substance use disorder and physical health care publically funded systems of care. MSHN through their FY15 Strategic Plan and the CMHSP Participants identified integration of health care as one of their top priorities. The region adopted a performance improvement

project which addresses diabetes screening for individuals prescribed certain medications which are associated with exacerbation of metabolic disorders or predispositions.

MSHN has obtained access to Medicaid claims data for the region and in 2014 entered into a joint agreement with three other PIHP's for the purchase services from a data analytics vendor. Key measures have been identified for monitoring of the health status and wellness efforts of the region's Medicaid population.

In FY16, MDHHS included contractual requirements regarding PIHP and Medicaid Health Plan Coordination with specific measurements and expectations related to obtaining a performance bonus. MSHN has eight (8) Medicaid Health Plans in the region and has provided health information data regarding our shared population. MSHN along with United Health Care is facilitating state-wide meetings to define a risk stratification process the will prioritize and identify individuals that will receive care coordination. In addition, in FY16 MSHN has developed a data exchange with hospitals in our region to receive admit, discharge and transfer information.

While the PIHP and MHPs work together on the care coordination at the plan level, the CMHSP Participants and the SUD Provider system will see an increase in care management demands at the consumer level. MSHN expects this will increase utilization of CMHPS resources and provider network service.

The following list summarizes CMHSP Participant efforts to increase healthcare integration, as described in their community needs assessment updates:

- BABH
    - Implemented a revised nursing model to expand access to healthcare; embedded questions in social work assessments focused on typical chronic co-morbid conditions to identify consumers for referral to nursing staff for health assessment and enhanced coordination of care with primary care providers
    - Participating in a performance improvement project involving diabetes screening and coordination with primary care physicians
    - Providing funding for the Community Health Assessment
    - Key partner for Saginaw Valley State University and Bay County Health Department HRSA grant to add a behavioral health team to a nurse practitioner primary care clinic
    - Received grant from Blue Cross/Blue Shield Endowment Fund to embed access center clinician in a primary care clinic
    - Working with MDHHS and EHR vendor to explore potential embedding of CC 360
    - Working with Zenith for potential embedding of the Integrated Health Care Platform in EHR, including risk analysis for poor health outcomes
    - Providing wellness classes run by nursing staff
    - Implemented electronic lab ordering and receipt of test results with multiple labs
    - In dialogue with Great Lakes Health Connect for information exchange with regional health center and primary physician clinics

- CEI
  - Have Behavioral Health Consultants (BHC) placed in three Primary Care Practices to review screenings based on the Bright Futures Screening Protocol, and consult with patients and provide brief treatment at the clinic. Additionally, BHCs continue to provide onsite behavioral health interventions, including both brief intervention as well as ongoing treatment.
  - In partnership with Michigan Child Collaborative Care (MC3) offering pediatricians and OB/GYNs psychiatric consultation with University of Michigan psychiatry staff. Currently 75 local providers have been enrolled into MC3, with dozens already utilizing psychiatric consultation.
  - CMHA-CEI's Families Forward Program continues to convene the Action Learning Network (ALN) a consortium of five CMH Children's Services including CEI, Detroit-Wayne, Kalamazoo, Kent and Saginaw. The ALN has completed 4 additional Practice Briefs this year; 2 of which have been disseminated, and 2 more that will be disseminated prior to September 30, 2016. Practice Briefs have focused on the value of integration between the Community Mental Health System and pediatric primary care practices.
- CMHCM
  - Co-locating five therapists
  - Participating in the Michigan Health Improvement Alliance collaborating with other agencies to achieve a community of health excellence
  - Meeting with Great Lakes Health Information Exchange about integrating lab and available physical health data into the EMR
  - Accessing State of Michigan web portal, Care Connect 360 that provides population health and data analytics information was pursued. Work will continue this year on these initiatives.
  - Expanding the co-location in Clare by another 20 hours a week.
  - Meeting with CMU's school of medicine and collaborating on several fronts
  - Medical Director is now adjunct prof at CMU and is teaching with their med students.
  - Having CMU's 3rd and 4th year psych residents with us as a placement site
  - Full-time staff located on site at the new Emergency Department that MidMI Health is building here in Mt. Pleasant
  - Meeting with the Mid-Michigan Regional Medical Center and sharing the CC360 data
  - Strategizing on how to approach the highest ED users.
- GCCMHA
  - Exploring options to locate a clinician in the eastern area of the county; placed a clinician in the Emergency Department of Mid-Michigan Medical Gratiot
  - Pursuing a grant through the health department to bring a Physician Assistant to the CMH site
- HBH
  - Have a co-located primary care provider at the CMH site
  - CMH staff are co-located in the emergency department
  - Psychiatric consultation is provided to primary care sites
  - Providing healthy lifestyle education

  - Integrating wellness and recovery principles into services
- RDHRW
  - The Board of Directors established consumer based outcomes related to wellness: that 85% of all consumers complete an annual visit with an established health care provider in the community; and 85% of all consumers have a wellness goal in their person centered plan.
  - Strategically providing "physician outreach" whereby the psychiatrist, nurses and clinical leaders meet with local primary care providers to educate, provide consultation and address high utilizing patients.
  - Have formal coordination of care agreements with most all Rural Health Clinics in Ionia County; including Sparrow Medical Group Clinic in Ionia and various physician practices.
  - Providing lunches for primary care providers in Ionia County with our Medical Director at least annually
  - Providing the Medical Director's personal cell phone number to community primary care providers for direct consultation
  - In addition to sending medication reviews and evaluation notes, also share lab values with primary care providers
  - Publishing a quarterly newsletter on best practices and coordination of care for primary care providers
  - Establishing physician outreach efforts and outcomes.
  - Consumers seen by the Medication Services team has their BMI, waist circumference, AIMS testing, and lab orders completed
- LCHMA
  - Plan to establish partnerships with primary care and work toward becoming a Certified Community Behavioral Health Clinic
  - Co-Location of the Federally Qualified Health Center on site at the LifeWays building
  - Co-location of access clinicians with in the Federally Qualified Health Center for access screenings and coordination
  - Psychiatric Consultation provided by the CMHP to the Federally Qualified Health Center
  - Participation in our Health Improvement Organization aimed at conducting a community health assessment and developing a community action plan to improve overall health of our community.
  - Providing Wellness Wednesday classes aimed at improving overall health of our consumers.
  - LifeWays is a site for physician interns through our partnership with Henry Ford Allegiance health Residency Program
- MCN
  - Opened Wellness Works in partnership with Dartmouth University, a combination community fitness facility, program location for In-SHAPE and transitional employment work site; Dartmouth is reporting and benchmarking outcomes; MSU Extension provides nutrition classes
  - Operating an embedded primary care practice in partnership with the Mid Michigan Health Dept.; staffed by a physician's assistant

  - Offering outreach screening and eligibility access services at host physical health care providers, including Spectrum Hospital System, Cherry Health Services (an FQHC), and the Mid-MI Health Department
  - Adding a Pediatric Nurse and Children's Case Manager to increase integrated healthcare for children
  - Training Children's staff in health and wellness protocols; targeting obesity and reducing emergency room overuse
  - Co-sponsoring health prevention classes at the Wellness Center with community hospital partners (United Lifestyles) on topics such as Diabetes Education
  - Offering consultation and training to mid-level practitioners on psychiatric conditions and prescribing to increase the Primary Care Community's comfort level in treating persons with mild/moderate mental health conditions; sponsoring education on prescription drug abuse
- NCMH
  - Co-locating clinicians into physical health settings
  - Co-locating a clinician into an OBGYN clinic
  - Participating in a Process Improvement Project to identify individuals who may need a diabetic screening and linking them back to their PCP.
  - Collaborating with a local health care provider and non-profit organization to develop a care model to meet the needs of those with complex mental and/or physical health concerns who are seeking heat/energy assistance.
  - Providing education on MATP to local health providers.
  - Providing multidisciplinary team care as medically necessary to patients with high behavioral and physical health needs
- SCCMHA
  - Co-located primary health services; renovating building in fall of FY 2016 to offer pharmacy, lab and primary care; relocated psychiatry, nursing and enhanced health services a new Wellness Center to optimize provider networking
  - In year 2 of a PBHCI Grant with health integration transformations occurring throughout the service delivery network
  - Implemented a Children's Health Access Program (CHAP) through a grant from the Michigan Health Endowment Fund; provides community health workers in pediatric practices using the Pathways to Better Health model
  - Awarded a SAMHSA expansion grant for behavioral health consultation in primary care
  - Actively utilizing the MSHN Zenith Data Analytics program as well as CC360 to identify at risk groups as well as at risk individuals
  - Added behavioral health services to CMH Medical Services Family Practice Clinic
- SHIACMH
  - Using Care Connect 360 data to demonstrate improvement in both outcome and process measures for one chronic disease identified as a HEDIS measure
  - Continuing to work with the PIHP on the HSAG developed PIP r/t monitoring of A1C for individuals prescribed anti-psychotic medications

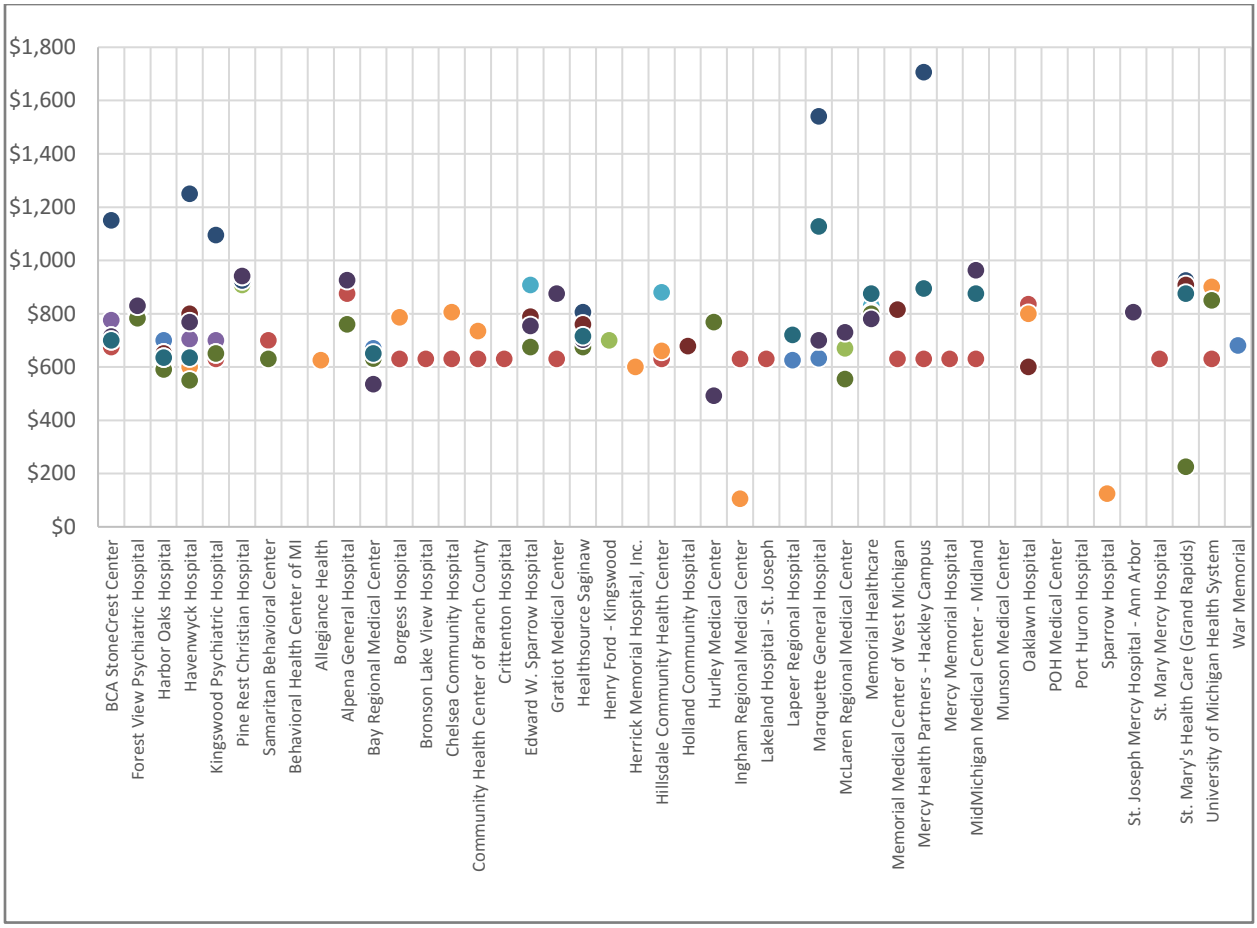
  - Collaborating with local hospital and EMR vendor to support HL7 electronic transfer/upload capabilities for all laboratory and test results; functionality is currently in place with Quest Labs
  - Nurse or Medical Assistant performs a brief assessment (including vitals) for all newly enrolled consumers and those coming in for medication reviews
  - Nursing supervisor/medical staff provide "brown bad" trainings to case holders related to physical health and integration
  - Strong partnership with Shiawassee Community Health Center (patient-centered medical home), who is co-located in the CMHSP, and provides primary care on site to just under one-hundred shared consumers
  - Participating in workgroup through Great Start , which is looking at partnering with OB/GYNs and pediatricians to do maternal screening
  - CMHSP Medical Director provides ongoing psychiatric consultation with Shiawassee Community Health Center (patient-centered medical home)
  - Nursing staff is partnering with Drop-in Center staff and doing wellness classes
  - Social worker co-located at Shiawassee Community Health Center, and becoming trained in smoking cessation and will ultimately offer groups at both the FQHC and CMHSP
- TBHS
  - Have an integrated primary health and behavioral care clinic on site
  - Have staff trained as a behavioral health consultant
  - Sponsored wellness initiatives for service recipients aimed at improving overall health via grant funding
  - Plan to include additional healthcare providers onsite, behavioral healthcare consultation services at primary healthcare locations, and expanded health related initiatives

Economies of scale in purchasing or rate setting

MSHN will explore economies of scale in purchasing, rate setting, regional capacity development and other efficiencies across the provider network. One initiative is already in process; specifically an analysis of inpatient rates for purposes of identifying opportunities for better value through collaborative rate setting.

Figure 10 shows the results of an inpatient rate survey initially conducted in 2014 and repeated in 2015 by MSHN and the CMHSP Participants:

Figure 10: FY 16 MSHN Inpatient Rate Assessment



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

Recommendations/Conclusions

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

1. Continue to seek guidance from MDHHS for Medicaid Expansion program (HMP) enrollees requiring concurrent mental health and SUD services
2. Continue to support provider network capacity to offer key evidence based programs, such as recovery and trauma informed programming, including ROSC.
3. Determine next steps relative to inpatient admission refusals and additional regional crisis response/ inpatient alternative capacity options, particularly for individuals with intellectual and developmental disabilities (such as Autism) exhibiting behavioral challenges.
4. Continue to monitor and expand regional autism service capacity and utilization to ensure sufficient network capacity to meet consumer demand, particularly for the expansion of eligible consumers from age 6 to age 21.
5. Continue to assess and address the integration of mental health, substance use disorder and physical health care.
6. Once the system changes expected as a consequence of the HCBS Final Rule are more understood, develop a plan of action to alter provider capacity for residential, employment and other community living related services, as necessary at a population (versus individual) level.
7. Continue to address reciprocity between CMHSP Participants relative to requirements applied to sub-contracted service providers.
8. Continue to address network capacity for detox services and medication assisted treatment, including availability of Methadone, Vivotrol, and Suboxone at all MAT locations; Continue to address CMHSPs becoming Narcan kit distribution sites.
9. Discuss opportunities if any for regional action to address CMHSP identified issues with services for children.
10. Continue to monitor the demand for and adequacy of its capacity to serve veterans.
11. Evaluate status of regional capacity for 24/7/365 access for SUD.
12. Continue to implement marketing plan to increase service penetration rates for HMP.
13. Continue to monitor legislative change and financial resources for the implementation of PA 200 for those with substance use disorders.
14. Evaluation the status of compliance with the enhanced requirements for trauma informed and sensitive treatment, including any changes that may be needed in provider network specializations.
15. Monitor the impact of wait times for interpreter relative to crisis response capacity, for potential future action.
16. Address delays in completion of Support Intensity Scale (SIS) assessments for individuals with developmental disabilities.

Background:

Pursuant to MSHN Board policy, "Monitoring Chief Executive Officer Performance," the attached summary evaluation report of performance, strengths, weaknesses and goals is presented for Board consideration and approval.

Recommended Motion:

The MSHN Board receives and files the 2015-2016 Chief Executive Officer (CEO) Evaluation Summary, and supports feedback and recommendations contained therein.