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From the Chief Executive Officer's Desk

Joseph Sedlock

As has been widely reported, the incoming federal administration has executed a number of Presidential Executive Orders, many of which have the potential to impact Medicaid and healthcare programs. A good summary of all the Presidential executive actions prepared by the Associated Press is available at this link.
Health care related actions included in that summary are listed below (excerpted from the AP Article):

- Repeal Biden directives intended to make it easier to enroll in Medicaid Services, secure insurance coverage under the Affordable Care Act and lower prescription drug costs. The Trump action, however, does not actually repeal the Biden era $35 per month cap on insulin, Medicare's $2,000 annual out-of-pocket cap on prescription drugs or Medicare's ability to negotiate drug pricing. Those policies remain enforced by federal statutes passed by Congress.
- Repeal multiple Biden orders and directives on COVID 19.
- Withdraw the U.S. from the World Health Organization (WHO), direct the White House Office of Management and Budget (OMB) to stop future transfers of U.S. money to WHO and order the Secretary of State to end negotiations on the WHO Pandemic Agreement.
- Order the Secretary of State and OMB Director to identify "credible and transparent United States and international partners" to replace the U.S. relationship with WHO.

The incoming administration also ordered dismantling almost all health equity and diversity related programs, including the following:

- Give executive branch departments and agencies 60 days to eliminate diversity, equity and inclusion (DEI) programs, including all “chief diversity officer” jobs, “equity action plans” and “environmental justice” positions. Require departments and agencies to give the White House Office of Management and Budget an accounting of previous DEI efforts, including names of relevant DEI contractors and DEI grant recipients. Terminate a 60-year-old executive order setting anti-discrimination requirements for government agencies and contractors.
- A separate OMB memo effectively put all federal DEI officers on immediate leave pending their elimination.
- Repeal several Biden-era directives on racial and ethnic equity and LGBTQ rights. They included orders intending to ensure equitable distribution of federal money based on the 2020 census; preventing government discrimination based on gender identity and sexual orientation and specifically encouraging inclusion in school settings; White House educational initiatives for Native Americans, Hispanics and Black Americans; and an order expressly allowing transgender persons to serve in the military.
- Require that the U.S. government recognize two genders only – male and female – on passports, visas, Global Entry cards and all other forms and documents, and in all programs and communications.
- Mandate that all federal civil rights law and labor law be interpreted and enforced with the understanding that "‘sex’ is not a synonym for and does not include the concept of ‘gender identity.’”
- Dissolve the White House Gender Policy Council and repeal Department of Education guidelines on Title IX concerning transgender rights and various documents advising schools on how to support and protect LGBTQ persons.
- Forbid federal money, including grants, from being used to “promote gender ideology” and direct the attorney general and Homeland Security secretary to “ensure that males are not detained in women’s prisons or housed in women’s detention centers."

It is important to emphasize that these orders apply to federal government operations, not to operations of States or state agencies, such as Michigan’s PIHPs and CMHSPs. In May of 2023, the MSHN board adopted an official statement of its values on health equity, diversity, equity, and inclusion. Of particular note, the values expressed in that statement endorsed:

1. We believe all humans are born equal.
2. We believe health is a human right.
3. We believe in health equity, which means that people in Region 5 are provided with the supports they need - individually and as groups - to fully benefit from the public behavioral health supports and services over which MSHN has oversight.
4. We believe that bias, discrimination, and exclusion takes many forms, overt and insidious towards certain populations in our region and in American society.
5. We believe there have been - and continue to be - public policies, community practices, and prevalent biases - explicit and implicit - that disenfranchise some people from full and equitable benefit from participation in community life, including healthcare and in particular behavioral health services and supports that Mid-State Health Network exists to provide.
6. We believe that improving equity and eliminating bias, discrimination and barriers to care will produce benefits to all.

Health disparities irrefutably exist in this region of Michigan. Diversity is a goal we are committed to pursue, along with accessibility, inclusion and belongingness with deliberate, planned, and urgent vigor.

As the Chief Executive Officer of this agency, I reiterate this region and this organization’s commitment to these values and the commitments this organization has made to pursue better equity as one of our five Board of Directors strategic priorities.

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

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Organizational Updates

Amanda Ittner, MBA
Deputy Director

MSHN Staffing Update

MSHN is pleased to announce the following staffing changes and new hires effective through February. Please join me in congratulating our staff and welcoming our newest members to the MSHN team.

- Evan Godfrey has accepted the Utilization Management Specialist position effective January 27, 2025. Even previously held the SUD Care Navigator position for MSHN. In preparation for his transition, MSHN has posted the SUD Care Navigator position to our website under careers.
- Elizabeth Philpott joined MSHN as the Integrated Healthcare Administrator on January 13, 2025. Liz came to us with a master’s in social work, certified advanced alcohol and drug counselor and years of experience, most recently working for Calhoun County Community Mental Health Authority as the Director of Certified Community Behavioral Health and Training.

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

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) announced on January 15, 2025, the new Medicaid and Children's Health Insurance Program (CHIP) Core Set Data Dashboard, featuring dynamic displays of performance data on 2023 Child and Adult Core Set measures. It shows detailed information, including state-specific performance and national medians, on each Core Set measure that was reported by at least 25 states and met CMS's standards for data quality. The easy-to-navigate dashboard can be used to better understand the quality of care provided to beneficiaries in Medicaid and CHIP and to identify areas for quality improvement. CMS plans to add more years of Core Set data to the Dashboard in the future.

For more information about the Child and Adult Core Sets, including other data products and releases, please visit the Child Core Set and Adult Core Set pages on Medicaid.gov.

Mid-State Health Network utilized the Child and Adult Core set measures and specifications when reporting to Michigan Department of Health and Human Services. Regional reporting on MSHN Priority Measures includes the national and state medians to allow comparison of performance standards. Priority measures are located on MSHN's website at https://midstatehealthnetwork.org/stakeholders-resources/about-us/dashboard-information/priority-measures.

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

Information Technology

Steve Grulke
Chief Information Officer

Cybersecurity Statistics

The threats in cybersecurity are constantly changing, with new vulnerabilities emerging as quickly as old ones are mitigated. Below are some statistics that were found that show how prevalent this is and how much effort should be extended to avert these threats.

Ransomware

- Despite new technology, ransomware motivated over 72% of cybersecurity attacks in 2023.[1]
- 83% of respondents paid the ransom in the wake of an attack.[3]
- 52% experienced a ransomware attack that significantly impacted business systems and operations.[3]
- 82% of data breaches included cloud-based data, with ransomware at the forefront.[1]
- The average ransom in 2023 was $1.54 million, almost double the 2022 figure.[1]
- Over 72% of businesses worldwide were affected by ransomware attacks as of 2023.[1]
- According to IBM, it takes an average of 49 days to identify a ransomware attack.[1]
- Ransomware-as-a-service (RaaS) is growing, with 67 active RaaS found in the first half of 2022.[1]
- In just the first 6 months of 2023, ransomware extortion totaled $176 million more than in all of 2022.[2]

Phishing

- 96% of phishing attacks are delivered via email.[4]
- IBM reported in 2023 that phishing attacks cost businesses $4.9 million per attack. [1]
- In just November 2022, Google blocked over 231 billion spam and phishing emails.[1]
- More 18-24-year-olds fell for phishing emails than other age groups in 2022.[4]
- 50% of people who fell for a phishing email claimed it was due to tiredness or distraction.[4]

Business Email Compromise (BEC)

- BEC accounts for 19% of data breaches.[4]
- BEC attacks caused $1.8 billion in damages in 2021.[4]
- In 2022, 34% of all attacks were launched as Business Email Compromise (BEC) attacks.[1]
- Gift card requests are the most common way to retrieve funds from an attack (68% of attacks).[4]
- 52% of people fell for phishing links because they believed they were from a senior executive.[4]
- 29% of companies have lost a client in 2022 due to a business email compromise.[4]

Conclusion

The statistics and trends above show a picture of a rapidly evolving cybersecurity landscape, marked by sophisticated threats. As we move into 2025, it's clear that staying informed and proactive in addressing cybersecurity challenges is more critical than ever.

By understanding these statistics, individuals and organizations can better prepare to navigate the complexities of the digital age, safeguarding their information and systems against the ever-present threat of cybercrime.

MSHN Response

MSHN leadership and the Information technology department are working together to come up with ways to avoid these threats. One way that is being used currently is to utilize a KnowB4 campaign that shows how an insider attack might look. Another way is having an active phishing test that occurs monthly to ensure that staff are diligent in their efforts to avoid falling victim. We are always looking for additional ways to escape these costly mistakes.

Sources:

1. https://www.getastra.com/blog/security-audit/cyber-security-statistics/
2. https://www.cobalt.io/blog/cybersecurity-statistics-2024
3. https://www.splunk.com/en_us/campaigns/ciso-report.html
4. https://www.terranovasecurity.com/blog/cyber-security-statistics

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

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN's Finance Team is working to finalize Fiscal Year (FY) 24 reports during February. The reports include:

- Financial Status Report (FSR) - The report outlines Medicaid and Healthy Michigan Program (HMP) funding received by the Pre-paid Inpatient Health Plan (PIHP) and funding amounts subsequently used for expenses by each Community Mental Health Service Program (CMHSP) and for Substance Use Disorder (SUD) services. The report also shows the amount of savings the region will earn and use in the next fiscal year as well as identifying the maximum Internal Service Funds (ISF) the PIHP can earn. MSHN is projecting a use of its Internal Service Fund (ISF) of more than $25 M which will leave a balance of approximately $32 M for future risk management. To mitigate the risk of fully exhausting the region's ISF, MSHN and the CMHSPs must develop strategies aside from reducing services to align expenses with available revenue. The region as a whole has been responsible for developing cost containment strategies and will periodically monitor the progress towards these goals throughout the fiscal year.
- Encounter Quality Initiative (EQI) - summarizes Medicaid and Healthy Michigan expense totals for MSHN and CMHSPs by common procedural terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS). The report is used by MDHHS for future rate setting purposes. Rate setting is conducted by MDHHS's actuarial firm and dictates the funding amounts associated with Medicaid and HMP enrollees.
- Legislative Report - Specific to Substance Use Disorder (SUD) and include detailed expense information by individual provider. The report illustrates the number of providers supported through all MSHN's SUD funding and specifies the expense related to block grant service categories such as Treatment, Women's Specialty, and Prevention services.
- Medical Loss Ratio (MLR) - Calculates the percentage of revenue spent by the PIHP on claims and quality improvement. The federal threshold is 85% and MSHN has exceeded this number every past reporting cycle for Medicaid and HMP combined and anticipates the same for FY 24. Exceeding 85% is as a positive outcome and illustrates the region is performing well under the 15% allowed for non-claims cost such as administrative expenses.

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

Behavioral Health

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

Conflict Free Access and Planning Update

The Social Security Act, in Section 1915(c), defines and authorizes Medicaid Home and Community Based Services (HCBS). The Michigan Department of Health and Human Services (MDHHS) furnishes HCBS services through the Children's Waiver Program (CWP), the Waiver for Children with Severe Emotional Disturbance (SEDW), and the Habilitation Supports Waiver (HSW). Each C-Waiver permits MDHHS to offer HCBS that assists Medicaid beneficiaries to live in the community, exercise their right to autonomy, inclusion and choice, and to receive improved person-centered approaches to care as opposed to institutional-level care. The 1915(i) state plan HCBS option offers HCBS services through a state plan amendment (SPA).

The C-Waiver and the 1915(i) SPA applications were submitted by MDHHS to the Centers for Medicare and Medicaid Services (CMS) as a part of the required formal periodic approval process (every five years for the C-Waivers). Conflict free case management, known as conflict free access and planning (CFA&P) in Michigan, is required for HCBS and compels states to establish conflict of interest mitigation processes for services by separating assessment and planning activities from the delivery of HCBS. CFA&P was expected to be featured prominently in the final-approved applications through further definition of the CFA&P rules, requiring that the roles of assessment/planning, and service delivery be separated to mitigate any potential conflicts of interest. The CMS requirement, as driven by the HCBS Final Rule, has been to eliminate any provider self-interest and promote choice and independence for individuals receiving any HCBS service.

As of this writing, the three MDHHS C-Waivers and the 1915(i) SPA application have all been approved by CMS. MDHHS has indicated that it intends to share further guidance in January 2025 on the updates to the approved applications as well as through formal Medicaid Bulletin and Medicaid Provider Manual updates and revisions. For purposes of CFA&P, the major implications in the approved applications are noted below:

- CFA&P requirements have been included in the applications surrounding beneficiary service planning activities and service provision.
- The Only Willing and Qualified Provider (OWQP) introduces language to be developed further around county level exceptions to CFA&P.
- Enhanced requirements relating to the individual and choice of provider and receiving information on all

HCBS services.

- The Community Mental Health Service Program (CMHSP) must arrange themselves in one of two scenarios ***or*** receive an OWQP designation as the third scenario (**SCENARIO 3**).
  - **SCENARIO 1:** The CMHSP contracts out both service planning and direct service functions to providers. The CMHSP must ensure that a member is referred to provider A for service planning and a separate provider B for direct services.
  - **SCENARIO 2:** The CMHSP directly offers both service planning and direct services and contracts with providers for these functions. The CMHSP may continue to provide service planning or direct services to a single member but must ensure a member is referred to a separate provider A to conduct the remaining function.
- The Pre-paid Inpatient Health Plan (PIHP) will be responsible for utilization management (cannot delegate), including authorization of the service plan.
- PIHPs must verify and monitor the adequacy of the separation outlined in the OWQP application.

Next Steps:
Mid-State Health Network (MSHN) anticipates undergoing an intensive regional analysis in coordination with our CMHSP partners to develop an implementation plan in accordance with the requirements outlined in the MDHHS policy guidance forthcoming.

For questions or more information, please contact Todd at Todd.Lewicki@midstatehealthnetwork.org

Utilization Management & Care Coordination

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

FY24 Performance Bonus Incentive Program (PBIP) Summary

Each year MSHN and its Community Mental Health (CMH) partners have the opportunity to earn bonus funds based on achieving certain performance metrics as specified by Michigan Department of Health and Human Services (MDHHS). The full amount of the bonus award each year is distributed to the CMHs as local funding. MSHN recently received the preliminary final scoring for the FY24 Performance Bonus Incentive Program (PBIP) which is summarized here for board members' awareness. Detailed information about each of the performance metrics and scoring is available on the MDHHS website: FY24 PIHP Performance Bonus Incentive Program.

There are 4 performance metrics (highlighted) where the region earned a partial bonus award but not the full possible amount. This was due to disparities between individuals belonging to certain racial/ethnic minority groups compared to White/Caucasian individuals. A detailed analysis will be shared with MSHN regional councils and committees to continue to develop and implement improvement strategies aimed at reducing and eliminating these disparities.

Please note, these results are considered draft. If a Pre-paid Inpatient Health Plan (PIHP) or Medicaid Health Plan (MHP) does not meet the performance requirement for a specific metric the unearned bonus amount is distributed among the PIHPs and MHPs that did meet the performance requirement for that metric. Therefore, the final award amount received by our region may include additional funds that are not represented below.

PIHP-ONLY PERFORMANCE METRICS		
Metric	Total Possible Amount	Earned Amount (Draft)
Implement data driven outcomes measurement to address social determinants of health	$448,407.57	$448,407.57
Adherence to antipsychotic medications for individuals with schizophrenia	$112,101.89	$112,101.89
Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	$280,254.73	$217,975.90
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	$280,254.73	$186,836.49
Increased Participation in Patient Centered Medical Homes Narrative Report	$1,383,973.97	$1,383,973.97
PIHP-MEDICAID HEALTH PLAN JOINT PERFORMANCE METRICS		
Metric	Total Possible Amount	Earned Amount (Draft)
Implementation of Joint Care Management processes	$581,269.07	$581,269.07
Follow-Up After Hospitalization for Mental Illness within 30 days	$332,153.75	$332,153.75
Follow-Up After Hospitalization for Mental Illness within 30 days stratified by race/ethnicity	$332,153.75	$258,341.80
Follow-Up After Emergency Department Visit for Alcohol and Other Drugs within 30 days stratified by race/ethnicity	$415,192.19	$276,794.79
TOTAL	**$4,165,761.65**	**$3,797,855.23**

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

Substance Use Disorder Policy, Strategy and Equity

Dani Meier, PhD, LMSW, MA
Chief Clinical Officer

Peer Recovery Coaches (PRCs) Play a Vital Role in Substance Use Treatment & Recovery

A January 2025 study by the Commonwealth Fund tracked overdose deaths in dozens of countries around the world. It found that since 2020 the United States has had the highest rate of overdose deaths (OD) in the world (324 per million in 2022) with the U.S. territory of Puerto Rico in 2nd place (246 OD deaths per million). This reflects the fragmented approach produced by variations in state and local laws and policies, one expression of which is reflected in the U.S.'s limited access to Medication for Opioid Use Disorder (MOUD) treatment, in which 11% of Americans with Opioid Use Disorder (OUD) received MOUD treatment in 2020, compared to 87% of people with OUD in France and 86% of people with OUD in Norway.

The landscape of substance use disorder (SUD) treatment has evolved in recent years with growing recognition of the importance of harm reduction and of peers with lived experience of addiction guiding people who use drugs (PWUD) to recovery. Peer Recovery Coaches (PRCs) have emerged as essential players in this space, providing mentorship, advocacy, and emotional support to those navigating the challenges of addiction. Unlike most traditional treatment providers—doctors, nurses, social workers and other licensed professionals—PRCs bring firsthand experience with substance misuse and recovery, allowing them to connect with patients on a deeply personal level. This relatability fosters trust, reduces stigma, and enhances engagement, all of which are critical components in sustaining long-term recovery.

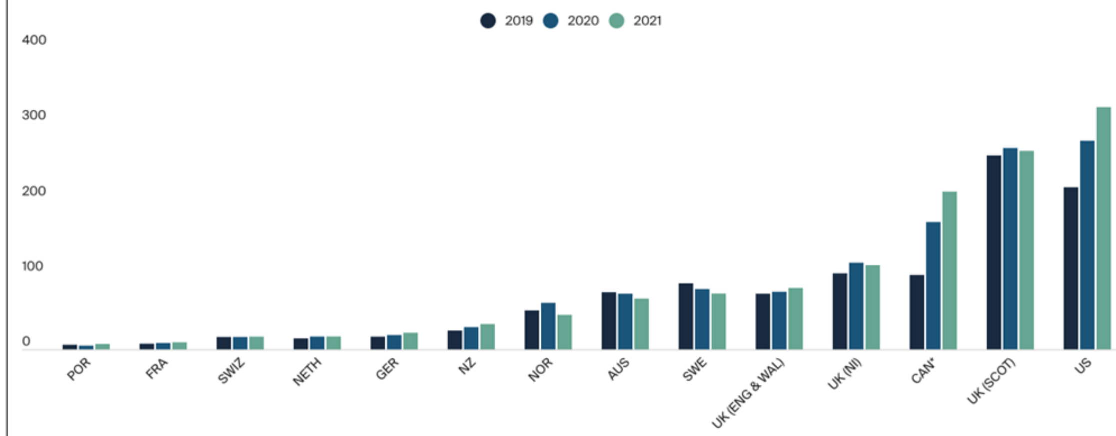
The role of PRCs has become even more crucial as SUD providers (who have always faced financial constraints and workforce shortages), face renewed and drastic cuts under the current leadership in Washington. Since many treatment facilities already struggle to maintain adequate staffing levels, PRCs can help bridge this gap by offering ongoing, non-clinical support that complements professional treatment. PRCs' involvement can reduce the burden on overextended healthcare teams while ensuring that individuals in recovery receive the encouragement and accountability they need. Studies show that peer-led interventions contribute to improved treatment retention, decreased relapse rates, and better overall well-being for those in recovery.

Beyond direct patient support, PRCs also serve as invaluable assets in navigating the complexities of healthcare and social services. Many individuals with SUD face barriers to housing stability, unemployment, and legal issues, which can lead to relapse and hinder recovery. PRCs can help connect them to community resources, advocate on their behalf, and provide the practical guidance needed to rebuild their lives. This holistic approach strengthens recovery efforts by addressing the social determinants of health that often contribute to addiction.

Financially, integrating PRCs into SUD treatment models can be a cost-effective strategy. Traditional treatment approaches can be expensive, and high relapse rates often result in repeated hospitalizations and emergency care. PRCs help mitigate these costs by promoting sustained engagement in recovery, reducing unnecessary healthcare utilization, and fostering self-sufficiency among those they support. Policymakers and healthcare organizations are increasingly recognizing this value, leading to expanded funding for peer support initiatives and greater integration of PRCs into multidisciplinary care teams.

Barriers exist for PRCs as well, however, particularly if in a PRC's past, they engaged in misdemeanor and/or felony crimes. Most laws broken by PWUD are related to their past drug use and though they may have served their time for past crimes, there are state and federal laws that preclude PRCs who have criminal histories—including for nonviolent crimes—from working in the public SUD treatment realm. MSHN is working with Region 5 community recovery organizations (like Peer360 and Home of New Vision) and our SUD providers [like Mid-Michigan Recovery Services (MMRS)] on advocacy to change restrictive and punitive barriers to PRCs in long-term recovery working in the public system.

The demand for SUD services continues to grow, and PRCs bring a unique blend of empathy, experience, and advocacy that complements clinical care, strengthens recovery outcomes, and alleviates strain on traditional healthcare providers. By expanding the role of PRCs and ensuring they are adequately trained and supported, the healthcare system can better address the complex needs of individuals struggling with addiction, ultimately fostering a more sustainable and person-centered approach to recovery.



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

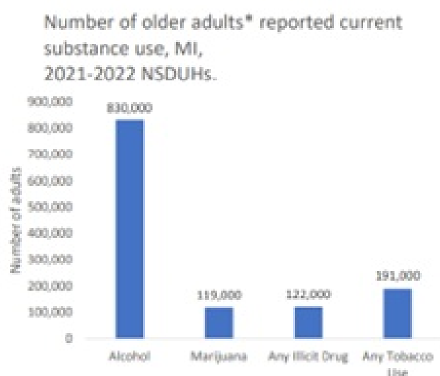
Substance Use Disorder Providers and Operations

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

Substance Misuse in the Older Adult Population

The implementation of the Mid-State Health Network Substance Use Disorder (SUD) 2024-2026 Strategic Plan saw a new focus on preventing and treating Substance Misuse Disorder (SUD) in Michigan's older adult population. The focus is understandable given that nearly one in five Michigan residents are an older adult (aged 65 and older). According to 2021/22 National Survey on Drug Use and Health (NSDUH) data, over 45% of Michigan older adults reported current alcohol use with 10.7% reporting binge alcohol use. In addition to alcohol use, in the same survey, nearly 7% of the older adult population in the state reported marijuana use and 8% reported use of any illicit drug. Sadly, this data can often be overlooked and undertreated by families, professionals, and among older adults themselves.

Alcohol Use and Other Substance Use Among Older Adults*



- According to combined 2021 and 2022 National Survey on Drug Use and Health (NSDUH) data, nearly 830,000 (45.7%) older adults*in Michigan reported current alcohol use.
  - 194,000 (10.7%) reported binge alcohol use.
  - 53,000 (2.9%) reported heavy alcohol use.

MSHN demonstrates its commitment to the prevention and treatment of older adult SUD in many ways. Recently, through the training and promotion of the prevention provider network in evidence based older adult programming like the Wellness Initiative for Older Adults (WISE). Developed by the New Jersey Prevention Network, the WISE program is designed to help older adults celebrate healthy aging and avoid substance misuse. The curriculum is delivered over 6 lessons, and the hour-long lessons include detailed information on the following topics:

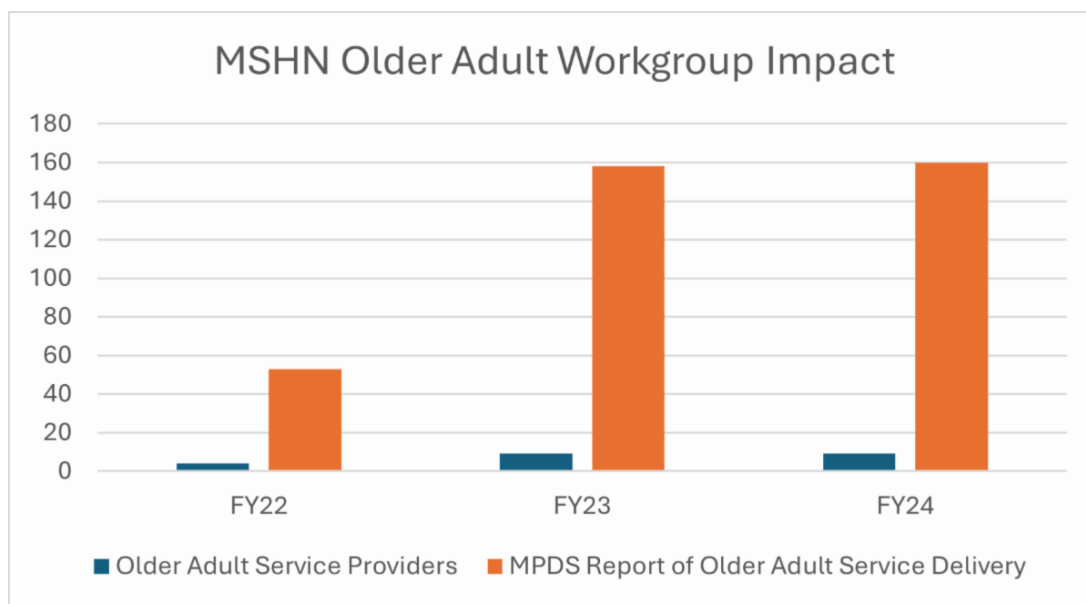
- Understanding the Changes Associated with Aging
- Aging Sensitivity
- Valuing Cultural & Generational Diversity
- Medication and the Older Adult
- Substance Misuse, Addiction, and Older Adults
- An Enhanced Quality of Life

In July of last year, MSHN hosted a training course for contracted prevention providers with 13 individuals successfully trained in the WISE curriculum. Throughout the remainder of FY24 those individuals who received the

training went on to deliver the lessons to over 300 participants within the MSHN catchment area. Some key findings from the National Council on Aging in the evaluation process of the WISE program include increased knowledge around the aging process, recognizing the early signs and symptoms of depression, and participants are more likely to see improved behaviors around lifestyle choices and healthcare empowerment.

Another way MSHN has committed to addressing SUD in older adults is through the implementation of an Older Adult Workgroup. Currently the group consists of MSHN prevention and community network providers, meets bi-monthly, and works to accomplish the MSHN SUD 2024-2026 strategic plan goal of increasing access to prevention services for the state's older adult population. Since its implementation in FY23 the workgroup has identified risk and protective factors that impact SUD in older adults across the state, identified barriers to service delivery, and improved collaboration across various state and local agencies.

The impact this group has had on delivery of prevention services to Michigan's older adults is noted when comparing FY22 to FY23 Michigan Prevention Data System (MPDS) data. For example, the year prior to the initiation of the workgroup (FY22) there were 4 contracted providers who identified delivering 53 unique services to an older adult population. By comparison, in FY23 and FY24 there were more than double the number of contracted providers and triple the number of activities.



MSHN will continue these efforts and more to improve the quality and quantity of service delivery needed to prevent substance misuse in Michigan's older adult population.

MSHNs SUD Strategic Plan for FY24-26 can be found on the MSHN websitehere.

For any questions related to MSHN's Older Adult Prevention efforts, please contact Cari Patrick at Cari.Patrick@midstatehealthnetwork.org.

For source information or questions, please contact Trisha at Trisha.Thrush@midstatehealthnetwork.org

Quality, Compliance & Customer Service

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

C-Suites Under Scrutiny

"The Justice Department will continue to pursue individuals — including C-suite executives — who commit health care fraud." This statement comes from the Principal Deputy Assistant Attorney General Brian M. Boynton, head of the Justice Department's Civil Division. The C-Suite positions include individuals such as Chief Executive Officers (CEOs), Chief Financial Officers (CFOs), Chief Operating Officers (COOs), Chief Compliance Officers (CCOs), Chair of the Board, etc. It is becoming more common that settlements imposed by the Department of Justice (DOJ) include settlement payments directly from the C-Suite staff.

The C-Suite positions have come under scrutiny in healthcare cases when evidence shows they were involved in the decision-making process that led to illegal or non-compliant activity. This includes being complicit in the activity.

Some of the reasons that have led to financial settlements include, but not limited to, violations of the Anti-kickback statute, submitting improper or false claims, submitting codes for services that do not meet requirements, improper renumeration to providers, inflated reimbursements, and misrepresentation on the scope of the provider network.

The DOJ refers to this as 'individual accountability.' Several memoranda from the DOJ leadership have emphasized the importance of evaluating individual accountability in their corporate wrongdoing investigations. The intent is to use accountability to deter future illegal activity and promote the public's confidence in our justice system. In addition, the DOJ is looking for an organization's compliance programs to hold executives accountable

internally as appropriate. When assessing a compliance program, the DOJ has offered the following questions in determining its effectiveness:

- How does the company incentivize compliance and ethical behavior?
- What percentage of executive compensation is structured to encourage enduring ethical business objectives?
- Does the company have policies or procedures in place to recoup compensation that would not have been achieved but for misconduct attributable directly or indirectly to the executive or employee?
- What policies and practices does the company have in place to put employees on notice that they will not benefit from any potential fruits of misconduct?

MSHN has policies, procedures and a compliance plan in place that protect against illegal and non-compliant activities. The C-Suite staff and providers are required to participate in annual compliance training and comply with the standards identified within the MSHN compliance plan, policies and procedures. When suspected fraud, waste, or abuse is detected, it is required to be reported to the Chief Compliance and Quality Officer. An investigation is completed for all reported activity and appropriate action is taken that can include a corrective action plan, training, voiding of claims, recoupment of funds, and if necessary, termination of contract or employment.

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

Our Mission:

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

Our Vision:

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

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

Mid-State Health Network | 530 W. Ionia Street | Lansing, MI 48933 US

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