Mid-State Health Network

Board of Directors Meeting ~ March 1, 2022 – 5:00 p.m.

Board Meeting Agenda

THIS MEETING WILL BE HELD AT A PHYSICAL LOCATION WITH APPROPRIATE SOCIAL DISTANCING AND/OR MASKING REQUIREMENTS

Best Western Okemos/East Lansing Hotel & Suites
Stadium Room
2209 University Park Dr.
Okemos, MI 48864

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

1. Call to Order
2. Roll Call
3. **ACTION ITEM:** Approval of the Agenda

   Motion to Approve the Agenda of the March 1, 2022 Meeting of the MSHN Board of Directors
4. Public Comment (3 minutes per speaker)
5. **ACTION ITEM:** FY2022 Quality Assessment and Performance Improvement Program (QAPIP) and the FY2021 Annual Effectiveness Evaluation (*Page 4*)

   MOTION to approve the Quality Assessment and Performance Improvement Program (QAPIP) for October 1, 2021 to September 30, 2022 and the Annual Effectiveness and Evaluation Report for October 1, 2020 to September 30, 2021.
6. **ACTION ITEM:** Provider Staffing Crisis Stabilization Program (*Page 11*)

   MOTION to designate up to $13 million (thirteen million dollars) of FY22 MSHN resources for the purpose of stabilizing and assisting eligible provider organizations contracted within the region in addressing workforce/staffing crises pursuant to regional guidelines established by MSHN.
7. **ACTION ITEM:** FY2021 Board Self-Assessment (*Page 13*)

   MOTION to receive and file the FY2021 Board Self-Assessment report
8. **ACTION ITEM:** Consideration of the MSHN FY22 Budget Amendment *(Page 18)*

   MOTION to approve current year FY22 Budget Amendment as presented
9. Chief Executive Officer's Report *(Page 21)*
10. Deputy Director's Report *(Page 45)*
11. Chief Financial Officer's Report

    Financial Statements Review for Period Ended January 31, 2022 *(Page 59)*

    ACTION ITEM: Receive and File Preliminary Statement of Net Position and Statement of Activities for the Period ended January 31, 2022

MSHN
Mid-State Health Network

Our Mission:

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

Our Vision:

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

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Board of Directors Meeting Materials:
Click **HERE**
or visit MSHN's website at:
https://midstatehealthnetwork.org/stakeholders-resources/board-councils/board-of-directors/fy2022-meetings

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Upcoming FY22 Board Meetings

Board Meetings convene at 5:00pm unless otherwise noted

May 3, 2022
Location to be determined

July 5, 2022
Location to be determined

September 13, 2022
Location to be determined

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

MSHN Medicaid Internal Services Fund (ISF) Analysis is available for Board Member viewing only through the end of the day March 1, 2022 at: https://mshn.box.com/s/wbpbuhlqeru980wj0lj91773fu20fxwp.

12. **ACTION ITEM:** Contracts for Consideration/Approval *(Page 67)*

    The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2022 Contracts, as Presented on the FY 2022 Contract Listing

13. Executive Committee Report

14. Chairperson's Report

15. **ACTION ITEM:** Consent Agenda

    Motion to Approve the documents on the Consent Agenda

    15.1 Approval Board Meeting Minutes 01/11/22. *(Page 70)*
    15.2 Receive Board Executive Committee Minutes 02/18/22. *(Page 75)*
    15.3 Receive Policy Committee Minutes 02/02/22. *(Page 77)*
    15.4 Receive Operations Council Key Decisions 01/24/22. *(Page 80)*
    15.5 Approve the following policies:
    15.5.1 Conflict Free Case Management *(Page 82)*
    15.5.2 Emergency and Post-Stabilization Services *(Page 84)*
    15.5.3 Credentialing/Re-Credentialing *(Page 88)*
    15.5.4 Disclosure of Ownership *(Page 92)*
    15.5.5 Fiscal Year Contract Monitoring *(Page 94)*
    15.5.6 Provider Directory *(Page 97)*
    15.5.7 Provider Network *(Page 99)*
    15.5.8 Provider Network Reciprocity *(Page 103)*
    15.5.9 Substance Use Disorder Direct Service Provider Procurement *(Page 105)*
    15.5.10 Appointed Member Compensation *(Page 107)*

16. Other Business

17. Public Comment (3 minutes per speaker)

18. Adjourn

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FY22 MSHN Board Roster

Last Name	First Name	Email 1	Email 2	Phone 1	Phone 2	Appointing CMHSP	Term Expiration
Anderson	Jim	jdeweya@yahoo.com		989.667.1313	989.327.0734	BABHA	2022
Bohner	Brad	bbohner@tds.net		517.294.0009		LifeWays	2022
Brehler	Joe	jbrehler@sprynet.com		517.882.7491	517.230.5911	CEI	2022
Cadwallender	Bruce	bcadwall@umich.edu		517.703.4223		Shia Health & Wellness	2024
Cierzniewski	Michael	mikecierzniewski@yahoo.com		989.493.6236		Saginaw County CMH	2023
Colton	Craig	johnniec15@hotmail.com		989.912.0312		HBH	2023
DeLaat	Ken	kdelaat1@aol.com		231.414.4173		Newaygo County MH	2023
Griesing	David	davidgriesing@yahoo.com		989.823.2687		TBHS	2024
Grimshaw	Dan	midstatetitlesvcs@mstsinc.com		989.823.3391	989.823.2653	TBHS	2023
Hicks	Tina	tmhicks64@gmail.com		989.576.4169		GIHN	2024
Holman	Dianne	dianne@workingbugs.com		517.303.3631		CEI	2022
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2024
Johnson	Steve	saj1950@comcast.net		231.349.6979		Newaygo County MH	2022
Ladd	Jeanne	stixladd@hotmail.com		989.634.5691		Shia Health & Wellness	2024
Matelski	Rhonda	rhondam2374@gmail.com		989.269.2374		HBH	2023
McFarland	Pat	pjmcfarland52@gmail.com		989.225.2961		BABHA	2023
McPeek-McFadden	Deb	deb2mcmail@yahoo.com		616.794.0752		The Right Door	2024
Nyland	Gretchen	gretchen7080@gmail.com		616.761.3572		The Right Door	2022
O'Boyle	Irene	irene.oboyle@cmich.edu		989.763.2880		GIHN	2023
Peasley	Kurt	peasleyhardware@nethawk.com		989.560.7402	989.268.5202	MCN	2024
Phillips	Joe	joe44phillips@hotmail.com		989.386.9866	989.329.1928	CMH for Central	2022
Raquepaw	Tracey	tl.raquepaw@icloud.com	raquepawt@michigan.gov	989.737.0971		Saginaw County CMH	2022
Scanlon	Kerin	kscanlon@tm.net		502.594.2325		CMH for Central	2022
Woods	Ed	ejw1755@yahoo.com		517.392.8457		LifeWays	2024

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Background:

FY 2022 Quality Assessment and Performance Improvement Program (QAPIP) Plan and FY2021 Annual Effectiveness and Evaluation Report:

To comply with the Michigan Department of Health and Human Services/PIHP Contract, specifically as it relates to the description of the QAPIP and Annual Effectiveness and Evaluation:

> "The PIHP must have a written description of its QAPIP which specifies 1.) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2.) the components and activities of the QAPIP including those as required below; 3.) the role for recipients of service in the QAPIP; and 4.) the mechanisms or procedures to be used for adopting and communicating process and outcome improvement."

And specifically, as it relates to the Governing Body Responsibilities:

> "The QAPIP must be accountable to a Governing Body that is a PIHP Regional Entity. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:
>
> A. Oversight of QAPIP - There is documentation that the Governing Body has approved the overall QAPIP and an annual QI plan.
>
> B. QAPIP progress reports - The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions.
>
> C. Annual QAPIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.
>
> D. The Governing Body submits the written annual report to MDHHS following its review. The report will include a list of the members of the Governing Body."

Please refer to the FY2022 Plan and Executive Summary for an overview and highlights from the full FY 2022 Quality Assessment and Performance Improvement Program (QAPIP) Plan and FY2021 Annual Effectiveness and Evaluation Report.

Recommended Motion:

The MSHN Board of Directors has reviewed and approves the Quality Assessment and Performance Improvement Program (QAPIP) Plan for the period of October 1, 2021– September 30, 2022 and the Annual Effectiveness and Evaluation Report for the period of October 1, 2020 - September 30, 2021.

Mid-State Health Network

Quality Assessment and Performance Improvement Program FY21 Report and FY22 Plan Executive Summary

Mid-State Health Network (MSHN) as the Prepaid Inpatient Health Plan (PIHP) is responsible for monitoring quality improvement through the Quality Assessment and Performance Improvement Program (QAPIP). The scope of MSHN's QAPIP program is inclusive of all CMHSP Participants, the Substance Use Disorder Providers and their respective provider networks, and the Certified Community Behavioral Health Clinics within the MSHN region. The QAPIP is reviewed annually for effectiveness. The review includes the components of the QAPIP, the performance measures, and improvement initiatives, as required based on the MDHHS PIHP contract and the BBA standards. In addition to ensuring the components continue to meet the requirements, each performance measure relevant to the QAPIP is reviewed to determine if the expected outcome has been achieved. Following the review of the Annual QAPIP Report, recommendations are made for the Annual QAPIP Plan. The Board of Directors receives the Annual QAPIP Report and approves the Annual QAPIP Plan for following year. The QAPIP is reviewed and approved by the Quality Improvement Council (QIC), Leadership, Operations Council and MSHN's Board of Directors. The QAPIP Plan, and Report is required to be submitted to MDHHS by February 28th. Due to timing, the Board of Directors will be reviewing the QAPIP Report and Plan, March 1st. Once reviewed and approved by the Board of Directors the plan and report will then be submitted to MDHHS. The measurement period for this annual QAPIP Report is October 1, 2020 through September 30, 2021.

Annual QAPIP Report

The QAPIP Report is the annual effectiveness review of the QAPIP Plan. The QAPIP components as required by MDHHS are reviewed in addition to, strategic tasks and activities as it relates to the QAPIP, and performance measures. Areas that have not met the standard include a goal. Recommendations are developed for areas that may benefit from additional interventions to improve the performance or the quality of a process.

Performance Measures Review

The performance measures include required measures that are reported to MDHHS, and optional measures that MSHN has identified as key priority areas. A status of "met" indicates that performance standard was met for FY21. The following areas were monitored through performance measures:

- Michigan Mission Based Performance Indicator System (MMBPIS)- Met 7 out of 7 measures.
- BH-TEDS Data Quality- Met 1 out of 1 measure.
- Performance Improvement Projects-Recovery Self-Assessment and Diabetes Monitoring, Met 2 out of 2 measures.
- Event Monitoring and Reporting-Met 9 out of 13 measures.
- Behavior Treatment- Met 3 out of 4 measures.
- Stakeholder and Assessment of Member Experiences- Met 7 out of 10 measures.
- Provider Monitoring- Met 1 out of 3 measures.
- Medicaid Event Verification-Met 2 out of 2 measures.
- Priority Measures for Long Term Supports and Services- Met 7 out of 17 measures.
- Performance Based Incentive Payments-Met 7 out of 7 measures.

Those that did not meet the standard were track and trend data with internal standards and/or priority measures as agreed upon by Operations Council. Each measure that has not met the standard will include efforts towards improvement.

FY22 Performance Measures:

In addition to the CCBHC measures currently being developed, new measures for FY22 based on performance in FY21 include the following:

- MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Baseline)
- MSHN's ACT programs will demonstrate an increase in fidelity for average minutes per week per consumer (120 minutes).
- MSHN will demonstrate an increase in compliance with access standards for the priority populations. (Baseline)
- MSHN will demonstrate an improvement with the data quality on the BH-TEDS living arrangements fields. (Baseline)
- MSHN will demonstrate an improvement with the data quality on the BH-TEDS employment fields. 3 categories. (Baseline)
- MSHN will increase access and service utilization for Veterans and Military members. (Baseline)
- MSHN will demonstrate an improvement with the data quality on the BH-TEDS LOCUS fields. (Baseline)
- MSHN will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rules. (Baseline)
- MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years) (Baseline)
- MSHN will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements. (Baseline)

Annual review of the QAPIP Components: MDHHS reviewed the QAPIP Plan and Report, providing feedback to be incorporated into the documents. MSHN developed goals for those areas that have not yet demonstrated compliance or those areas that did not meet the standard through the external review process. Goals and recommendations below include ten areas identified by external reviews as not meeting the standard. Additional recommendations were made in other areas to ensure continued compliance and optimal performance.

Goals/Recommendations:

Organizational Structure and Leadership

Recommendations:

- Development of a process to monitor progress of the quality workplan and performance measures, inclusive of other MSHN departments. Status: Complete
- Utilization of the quarterly report for periodic progress review to the Board of Directors. Status: Completed
- Evaluate and modify time frames for the quality workplan to ensure Board approval is received before 2.28.2022. Status: In Progress/Continue. Quarter 4 data is not fully available until January. The Board of Directors meet every other month. The QAPIP Report and Plan cannot be approved until the March meeting.
- (New) Discontinue the SUD Provider Advisory Council, utilize focused regional SUD Treatment and Recovery workgroups.

- (New) Established a Regional Equity Advisory Committee for Health (REACH), an advisory body comprised of Region 5 stakeholders and community partners, to address MSHN's strategic priority of better equity,

Performance Management

Goals:

- (New) MSHN will demonstrate an increase in compliance with access standards for the priority populations. (In addition to those included in the MMBPIS) (Compliance Review 2021)
- (New) Performance Improvement Projects: 1) The racial or ethnic disparities between the minority penetration rate and the index (white) penetration rate will be reduced or eliminated.
  2) The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergency biopsychosocial assessment will demonstrate an increase.

Recommendations:

- (New) Refer network adequacy issues to the Provider Network Management Committee as it relates to the access indicators.
- (New) MSHN to verify Medicaid eligibility prior to MMBPIS submission to MDHHS (PMV-2021)
- (New) Verification of accurate data entry in REMI for SUD Indicator 4-Follow up within 7 days of Discharge from a Withdrawal Management Unit.

Stakeholder Feedback

Goals:

- MSHN will distribute satisfaction surveys for each representative population served (SUD, MI, SED, IDD inclusive of LTSS) with development of action plan to address areas of dissatisfaction (below 80%) annually. Status: In Progress
- MSHN will demonstrate an 80% rate of satisfaction for each representative population.
  Status: Complete
- (New) MSHN will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule.
- (New) MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years)

Recommendation:

- (New)Develop proposal for the administration of qualitative and quantitative assessment of member experience, and provider satisfaction for the region.

Event Monitoring and Reporting

Goal:

- Will demonstrate a 100% completion rate of Critical Incident/Event Performance Summaries each quarter for CMHSP Participants and SUD Providers. Status: Complete

Recommendations:

- Develop electronic process for sentinel event submissions to MSHN by the Provider Network. Status: Complete
- (New) Develop Dashboard for tracking and monitoring timeliness of submissions.
- (New) Develop oversight process for risk events.

Utilization Management

Goal:

- MSHN will meet or exceed the standard for compliance with the Adverse Benefit Determination notices in accordance with the 42 CFR 438.404.
  Status: In Progress/Continue
- MSHN 's Provider Network will demonstrate full compliance with the timeframes for service authorization decisions in accordance with the MDHHS requirements. (Compliance Review 2021)
  Status: In Progress/Continue

Practice Guidelines

Goal:

- MSHN will demonstrate full compliance with communication of practice guidelines. Status: Complete
- (New) MSHN will demonstrate full compliance with the use of MDHHS required practice guidelines, Inclusion, Consumerism, Personal Care in Non-Specialized Residential Settings, Family Driven and Youth Guided, Employment Works Policy and Practice Guidelines. (MDHHS Evaluation)
- (New) MSHN will demonstrate an increase for individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (MDHHS Waiver Review 2020)
- (New) MSHN will demonstrate an increase in fidelity to the Evidenced Based Practice-Assertive Community Treatment Michigan Field Guide, for average minutes per week per consumer. (MDHHS Evaluation)

Recommendations:

- (New) Identify practice guidelines adopted/required for use in the MSHN region, reviewing guidelines currently in policy and procedure.

Behavior Treatment

Recommendations:

- Develop a goal to address improved compliance with the MDHHS Standards for Behavioral Treatment Committee. Status: Complete
- (New) MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period.

Provider Monitoring

Goal:

- MSHN's Provider Network will demonstrate an increase in compliance with the MDHHS/MSHN staff qualification, credentialing and recredentialing requirements. Status: In Progress/Continue
  Separated the Licensed and non-licensed providers for monitoring.
- (New) MSHN will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy standards. (Compliance Review 2021)
- (New) Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.
- (New) Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.
- (New) MSHN will demonstrate an increase in performance on the External Quality Review-Compliance Review.

External Review/Monitoring
Recommendations:

- Include corrective action/improvement plans resulting from partial compliance to the QAPIP Work Plan. Status: Complete
- Include recommendations in the quality workplan. Status: Complete

Annual QAPIP Plan- Summary of Changes

General Changes: Updated the dates and references to reflect current MDHHS contract requirements.
Updated the section headings and reorganized the content of the document to be consistent with other MSHN Reports.
Incorporated recommendations from MDHHS evaluation of the Plan and Report.
Incorporated the alignment with the Strategic Priorities.
Removed redundant language.

I. **Overview/Mission Statement:** Added the onset of CCBHC Demonstration. Moved the scope to its own section.

II. **Scope of Plan-**Added CCBHC language

III. **Definitions/Acronyms-**Moved the definitions and acronyms to the front of the report. Added additional definitions for terms included in the plan.

IV. **Philosophical Framework**: Incorporated the alignment with Quintuple Aim, Strategic Plan and the MDHHS Comprehensive Quality Strategy.

V. **Organizational Structure and Leadership**:
Structure: No changes
Governance: Added the inclusion of the Quality Manager membership MDHHS QIC and updated the title of the Director of Compliance and Customer Services and Quality to the Chief Compliance and Quality Officer. Added performance improvement projects to areas of feedback from the Medical Director.
Components: Added the inclusion of stakeholder participation in the PIHP Quality Improvement Council and Customer Services Committee. Added committee/council to replace QIC for monitoring key performance indicators. Removed redundant language that is included in other relevant sections to appropriately represent current process.
Communication of Process and Outcomes: Removed language that is included in other sections of the document.
MSHN Provider Network: Changed heading from Council and Committees to MSHN Provider Network. Moved QIC under MSHN Provider Network. Replaced the SUD Provider Advisory Council (SUD-PAC) with the SUD Treatment and Recovery provider work groups. Added the regional committees and councils that are included in the QAPIP.

VI. **Performance Management:** Added a new section with introduction to the definition of performance management; and included the following sections:

Establishing Performance Measures: Reorganized, removed redundant language and described the alignment with the strategic priorities.
Prioritizing Measures: Modified language for the focus areas to be consistent with MDHHS.
Data Collection, Analysis and Reporting: Incorporated the alignment of the Strategic Priorities. Identified basic components of data collection.
Performance Improvement Action Steps: No substantive changes.
Performance Indicators: Included specific reference to MMBPIS as recommended by MDHHS.
Performance Improvement Projects: Included the topics of the performance improvement projects for FY22; PIP 1-The racial or ethnic disparities between the minority penetration rate and the index (white) penetration rate will be reduced or eliminated; PIP 2- The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. Included the Operations Council approval on the PIP Topics.

VII. Stakeholder Experience/Engagement: Identified the specific surveys and/or assessments used to assess member experience.

VIII. Adverse Events: Changed the section heading from Safety and Risk Monitoring**.** Included the event types for required reporting for each population group including SUD provider requirements. Moved Medicaid Event Verification to the Finance Section.

IX. Clinical Quality Standards:
Utilization Management: No changes
Practice Guidelines: No changes
Oversight of Vulnerable People: Added language related to Long Term Supports and Services as required through the PIHP Medicaid Contract.
Cultural Competence: Added language supporting the strategic priority, "better equity."
Autism Benefit: Modified the time for continuing eligibility determinations to every three years to be consistent with the revised requirements.
Behavior Treatment: Removed redundant language to describe the process. Removed the description of the data collection specific to the Waivers that is no longer required or occurring.
Trauma: Added language supporting the strategic priority "better equity".

X. Provider Standards:
Provider Qualifications: Changed heading from Credentialing and Selection to Provider Qualifications as it encompasses both the licensed and non-licensed provider qualifications.
Medicaid Event Verification: Moved from the Safety/Risk Section.
Financial Oversight: Updated the number of standards from 7 to 8.
Provider Monitoring and Follow Up: No changes
External Review: No substantive changes.

XI. QAPIP Priorities FY2022
The QAPIP Priorities and Work Plan: Updated to include specific activities of the QAPIP for FY22 with assigned responsibilities.

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REGIONAL PROVIDER STAFFING CRISIS STABILIZATION PROGRAM - PROPOSAL SUMMARY

Background

The majority of behavioral health providers in Region 5 continue experiencing unprecedented impacts on staffing due to the COVID-19 pandemic. Mid-State Health Network (MSHN) proposes to create a $13M (Thirteen Million Dollars) regional fund to support all in-region behavioral health providers (including substance use disorder prevention, treatment, and recovery providers) in their efforts to address staff recruitment, attraction, commitment (and related onboarding costs), existing workforce retention strategies, temporary staffing costs, and other staffing stabilization crises they face. Resources are intended for funding creative, provider specific solutions that the provider has assessed as having the potential to improve stabilization of their workforce applicants and employees that provide or administer Medicaid-Manual beneficiary supports and services.

This program is intended to commence April 1, 2022, retroactive to 10/01/2021 to include provider-specific, qualified, staffing crisis related expenses already made this fiscal year and future staffing crisis stabilization initiatives as detailed herein. CMHSP Participants in the Mid-State Health Network region are already funded on a sub-capitation basis and are already able to make changes to their own, internal personnel recruiting, retention, compensation, benefit, and other human resources programs. Thus, the exclusive purpose of this fund is to direct funding to the external provider networks that are directly contracted to the CMHSP Participant and/or to MSHN (hereafter, "funding entity"), in alignment with the following criteria.

MSHN considers this initiative an extension of the provider stabilization initiative and as such has determined that it is within the provider stabilization parameters established by the MDHHS and is allowable, if implemented correctly and with fidelity to regional parameters/guidelines.

It is important to note that the funding entities in the region operate within a budget of $10M (ten million dollars) and consider the $3M (three million dollars) remaining balance a regional contingency fund in the event provider applications exceed the $10M base funding commitment.

MSHN, in collaboration with our CMHSP Participants, have developed regional eligibility criteria including the following:

- Eligible organizations are provider organizations that deliver supports and services covered in the Michigan Medicaid Manual that are contracted to a Region 5 CMHSP Participant or to Mid-State Health Network (hereafter, "funding entity") except for psychiatric hospitals or units (which are already supported with HRA funding).
- Provider site(s) to be assisted with funding under this initiative must be physically located with the geographic boundaries of Region 5 (Mid-State Health Network region). Sites outside of the MSHN region, or provider personnel normally working outside the MSHN region, are not eligible for this program. A provider headquartered or operated from another PIHP region with service sites in the MSHN region is eligible for those service sites only.
- Provider sites may have contracts with one or more funding entities. The funding entity with the largest contract (by dollars) is the funding entity for the provider to apply to.
- Provider must develop and submit a brief regionally standardized application that, in the provider's view, addresses in whole or in part its specific difficulties with attracting and retaining qualified and competent staff to deliver Medicaid-funded services and supports to MSHN-covered individuals in Region 5.

MSHN, in collaboration with our CMHSP Participants, has developed regional funding guidelines including the following:

- Applicant Focused Initiatives (defined as incentives for individuals to accept employment and maintain continuous employment with the provider entity incurred (or to be expended) from 10/01/2021 through the end of the support period – 09/30/2022):
    - Applicant financial or benefit incentives or incentive programs, such as signing incentives, part of which is paid at the time of the employment commitment, and part of which is paid after a period of continuous employment which does not extend beyond 09/30/2022.
        - The region recommends that providers/applicants develop policies to require that individuals to whom an incentive is paid repay the incentive if agreed upon terms for receiving the incentive are not met.
    - Advertising and/or marketing costs intended to increase the pool of applicants for available positions in the provider's organization.
    - On-boarding costs or training incentives.
    - Other provider specific ideas focused on increasing qualified applicant availability and ease of onboarding.

- Existing Staff Retention Focused Initiatives (defined as incentives for existing workforce members to maintain continuous employment with the provider entity retroactive to 10/01/2021 and/or through the end of the support period – 09/30/2022):
    - Retention Incentives (a monetary payment, part of which may be paid at the beginning of the funding period as a recognition incentive, and part of which is paid after a period of continuous employment which does not extend beyond 09/30/2022.
    - Temporary compensation adjustments (temporary means not extending beyond 09/30/2022).
    - Shift differentials or premiums (that do not extend beyond 09/30/2022).
    - Additional overtime compensation payments/premium (above required DOL standards).
    - Temporary Staffing Agency arrangements/costs; Hiring of temporary or deployment of existing staff in roles that relieve staff in direct service roles of some or many COVID-related responsibilities.
    - Other provider specific ideas focused on retaining existing personnel.

- MSHN, in collaboration with our CMHSP Participants, has developed regional funding guidelines that exclude the following activities/initiatives:
    - Base compensation adjustments that would have to be sustained after the time period covered by the regional initiative (i.e., beyond 09/30/2022).
    - Bonuses or other incentives for non-service delivery personnel in excess of that which is provided to service delivery personnel.
    - All applicants or existing personnel assisted through this program must be physically working in the MSHN geographic region, thus considerations for applicants or personnel working in a main office or branch location outside of the MSHN region are not eligible.
    - Unreasonable requests, as determined solely by the Funding Entity.

  MSHN, in collaboration with our CMHSP Participants, has developed a regionally standardized application form and process, as well as a regional implementation plan.

  The MSHN Operations Council supports and recommends the adoption of this proposal.

  Recommended Motion:

  Motion to designate up to $13 million (thirteen million dollars) of FY 22 MSHN resources for the purpose of stabilizing and assisting eligible provider organizations contracted within the region in addressing workforce/staffing crises pursuant to regional guidelines established by MSHN.

  J. Sedlock, February 17, 2022

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FY2021 Board of Directors Self-Assessment Report

Background

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

Recommended Motion:

Motion to receive and file the FY2021 MSHN Board of Directors Self-Assessment report.

February 17, 2022

FY 21 Response Rate: 21 respondents - 87.5%

	MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY16-FY21)	Yes					No					Needs Improvement					Unsure				
		16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21
Mission, Vision and Strategic Direction	1. The Board participates in strategic planning	80%	88%	93%	95%	86%	0%	0%	0%	0%	0%	13%	12%	7%	5%	5%	7%	0%	0%	0%	9%
	2. The Board has a clear sense of needs and priorities for the region	67%	59%	77%	82%	71%	7%	1%	0%	5%	5%	13%	35%	23%	5%	14%	7%	1%	0%	8%	10%
	3. MSHN has a clear sense of direction	87%	59%	92%	86%	86%	0%	1%	0%	0%	0%	0%	29%	8%	5%	5%	13%	1%	0%	9%	9%
	4. The Board is advised on national, state and local trends for their effect on behavioral health services	73%	88%	93%	100%	90%	7%	0%	0%	0%	0%	13%	12%	7%	0%	10%	0%	0%	0%	0%	0%
	5. The Board is presented with information about the strengths and weaknesses of MSHN	73%	80%	85%	86%	85%	0%	0%	0%	0%	0%	13%	18%	15%	14%	5%	13%	1%	0%	0%	10%
	6. The Board receives adequate information, analysis, plans, proposals and background materials that enable decision making	80%	71%	100%	86%	95%	0%	1%	0%	0%	0%	20%	24%	0%	9%	5%	0%	0%	0%	5%	0%
	7. MSHN's strategic priorities are clear, specific and measurable	80%	88%	69%	73%	86%	7%	0%	0%	0%	5%	7%	12%	7%	9%	5%	7%	0%	24%	19%	4%
	8. The Board evaluates progress of opportunities for improvement that are identified	87%	88%	69%	77%	67%	0%	0%	0%	5%	5%	0%	12%	0%	5%	19%	13%	0%	0%	13%	9%
	Comments: 1)Some "less than positive" ratings are due to uncertainties caused by the system redesign efforts and not by MSHN or the MSHN Board. 2)I think the Board is very strong in this area. 3)Explore more substance abuse counseling services (not just prevention) for teens. 4)We have a strong staff that believes in Mission, Vision and Strategic Direction. 5)DEI should be part of the mission and vision. 6)The Board is given all the tools necessary to be an active part of the mission, vision and strategic direction. 7)Good focus on current issues during a critical time. 8)We are given information regarding changes that are currently taking place, and some ideas how and when more changes could take place. 9)Measurable need more definition. 10)Excellent job. 11)Keep providing top rate services. 12)Satisfied in this area. 13)The Board is doing a great job! 14)I think all their values are met and above average.																				
CEO/Board Roles & Responsibilities	10. The Board asks "What" and "Why" and Expects the CEO to provide the "How"	93%	80%	93%	86%	90%	7%	0%	0%	5%	5%	0%	18%	7%	9%	5%	0%	1%	0%	0%	0%
	11. There is a mutual respect and open discussion between the Board and the CEO	100%	65%	93%	100%	100%	7%	1%	0%	0%	0%	0%	29%	7%	0%	0%	0%	0%	0%	0%	0%
	12. Board communication to staff and providers is channeled through the CEO	100%	88%	93%	91%	86%	0%	0%	0%	0%	0%	0%	0%	7%	0%	0%	0%	12%	0%	9%	14%
	13. Revisions to all policies are reviewed and approved by the Board	93%	94%	93%	100%	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	7%	6%	7%	0%	5%
	14. The Board receives timely and accurate communication	73%	71%	79%	86%	95%	7%	12%	0%	0%	0%	13%	6%	21%	9%	5%	7%	11%	0%	1%	0%
	Comments: 1)Our Board and CEO communicate very effectively. 2)This is a strength of MSHN. 3)The Board understands their role. The CEO works with each member to respond to special circumstances. 4)CEO upholds his responsibilities so the Board can uphold theirs. 5)Meeting material is provided with plenty of time for analysis. 6)There is such a changing of rules, it takes great difficulty to ascertain what the state/federal want. Joe keeps up updated on changes now and what future looks like. 7)Not sure. 8)CEO and Board work hand in hand, CEO always includes Board before making decisions that impact our PIHP. 9)Satisfied-good job. 10)Great communication between the CEO and Board. 11)Zeo does a wonderful job of keeping the Board informed of all information pertinent. We are very lucky to have him in our Network. He is very approachable and has extremely great communication skills.																				

MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY16-FY21)		Yes					No					Needs Improvement					Unsure				
		16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21
Resource Utilization & Risk Management	16. Board members are advised of key laws, rules and regulations and the implications for MSHN	94%	94%	69%	91%	100%	0%	0%	0%	0%	0%	0%	0%	31%	9%	0%	6%	6%	0%	0%	0%
	17. The Board has established policies, by-laws and operating agreements to reduce the risk of liability for the Board and MSHN	100%	81%	100%	91%	90%	0%	0%	0%	0%	0%	0%	19%	0%	0%	0%	0%	0%	0%	9%	10%
	18. Annually, or more often, the Board establishes priorities for the use of resources	81%	87%	93%	77%	95%	0%	6%	0%	9%	5%	13%	6%	7%	9%	0%	6%	0%	0%	5%	0%
	19. The Board receives routine financial reports including investment and risk management strategies	94%	87%	100%	100%	100%	0%	0%	0%	0%	0%	0%	13%	0%	0%	0%	6%	0%	0%	0%	0%
	20. The Board has an approved compliance plan and receives routine updates of compliance monitoring activities	94%	100%	93%	91%	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	6%	0%	7%	9%	5%
	21. The Board receives regular reports of external quality review, audits and other monitoring activities inclusive of planned corrective action	94%	100%	93%	95%	95%	0%	0%	7%	0%	0%	0%	0%	0%	0%	0%	6%	0%	0%	5%	5%
	Comments: 1)I'm not sure how many Board members read some of these documents, as there are few comments made by Board members. On the other hand, we are given very little time to read the large documents prior to the board discussion period. Executive Summaries are always helpful. 2)Always updated and discussion on this area. 3)Strong Financial staff. 4)MSHN has done a good job of managing taxpayers dollars for the benefit of our consumers. 5)No comment. 6)Key initiatives are in process as we face major challenges in the legislature. 7)The Board provides updates in between meetings as well as in the meeting. 8)Always looking for ways to utilize our resources, and minimize our risk. 9)Satisfied. 10)Good Job!																				
Public Trust	23. The public has opportunities to address concerns to the Board	88%	94%	100%	95%	100%	0%	0%	0%	0%	0%	6%	6%	0%	5%	0%	6%	0%	0%	0%	0%
	24. Public requests for action/change are addressed as appropriate	75%	93%	77%	68%	81%	0%	0%	0%	0%	5%	6%	0%	0%	0%	0%	19%	6%	23%	32%	14%
	25. Board members provide information and support Board positions with the media, key local/ state decision makers and legislators	69%	47%	62%	59%	71%	6%	6%	16%	5%	0%	6%	12%	0%	9%	10%	19%	35%	16%	27%	19%
	26. The Board reviews customer satisfaction feedback and evaluates concerns	67%	73%	93%	59%	57%	6%	0%	0%	0%	5%	6%	0%	0%	14%	19%	19%	27%	7%	27%	19%
	Comments: 1)We receive customer satisfaction feedback, but often spend little time evaluating it. 2)We don't seem to get a lot of public input but when and if we get it is addressed in a professional and timely manner. 3)I get the feeling that some Board members may strike out on their own at times and not always support the Board's position. 4)MSHN has developed a strong public trust due to their fiscal discipline. 5)No Comment. 6)Board is open to community concerns. 7)I have seen very little of public to attend Board meeting. Our web site provides meeting dates and time. Also, news, in our community, and state. 8)Question 25, the Board does support PIHP positions, but most media comments are made thru the CEO or Administration. 9)Unsure about entire category.																				

MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY16-FY21)		Yes					No					Needs Improvement					Unsure				
		16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21
Boardmanship	28. Members refrain from intruding on administrative issues that are the responsibility of the Mid- State Health Network CEO/staff except to monitor results and prohibit methods that conflict with policy	56%	53%	62%	77%	90%	0%	0%	0%	0%	5%	38%	41%	28%	18%	5%	6%	6%	10%	5%	0%
	29. Members do not exercise authority apart from the authorization of the full Board	88%	70%	77%	64%	95%	6%	0%	0%	0%	5%	0%	18%	8%	5%	0%	6%	12%	8%	32%	0%
	30. Members serve the best interest of Mid-State Health Network rather than personal or other professional interests	75%	60%	93%	77%	90%	0%	6%	7%	0%	0%	6%	22%	0%	18%	5%	19%	12%	0%	5%	5%
	31. Members are respectful of one another	88%	94%	100%	100%	95%	0%	0%	0%	0%	0%	12%	6%	0%	0%	5%	0%	0%	0%	0%	0%
	32. I am satisfied with the personal contribution I make to the Board	88%	100%	69%	55%	67%	0%	0%	7%	5%	0%	15%	0%	14%	32%	33%	0%	0%	0%	8%	0%
	Comments: 1)I think the Board tries hard to balance these issues, but sometimes we stray into the "deep end." 2)We hve a very strong Board and function very well in this area. 3)I believe that this has improved over the years and we have strong board that works together well. 4)No comment. 5)Members are encouraged to bring issues forward for discussion. 6)Our Board has ability to have conversations, not yelling. 7)Our Board is comprised of free thinkers, question askers, and concerned people, who always try to put consumers as a first priority. A well rounded group. 8)Board is exceptional--very happy with their performance. 9)There are a few members that seem to push their own interests and harbor biases that can influence board action. 10)I am new to the Board and I'm trying to learn as I go. I do feel I will learn from others.																				
Board Evaluation of Support Staff	34. I am satisfied that meetings are set up efficiently and in a timely manner	94%	88%	100%	100%	100%	0%	0%	0%	0%	0%	0%	6%	0%	0%	0%	6%	6%	0%	0%	0%
	35. I am satisfied that Board Packets are sent in a timely and complete manner and copies are made accessible	100%	82%	100%	86%	95%	0%	0%	0%	9%	0%	0%	18%	0%	5%	0%	0%	0%	0%	0%	5%
	36. Responsiveness to information requested is adequate, of good quality and timely	94%	94%	100%	100%	100%	0%	6%	0%	0%	0%	6%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	37. Board member requests are handled in a polite, friendly and professional manner	100%	88%	100%	100%	95%	0%	6%	0%	0%	0%	0%	6%	0%	0%	0%	0%	0%	0%	0%	5%
	38. Board meeting minutes are accurate and presented in a timely manner	88%	88%	100%	100%	95%	0%	0%	0%	0%	0%	12%	12%	0%	0%	5%	0%	0%	0%	0%	0%
	Comments: 1)I'd like the meeting packet earlier, but am in the minority. 2)Considering the challenges of COVID, an excellent performance. 3)Thanks for a job well done. 4)Sheryl Kletke has been a welcome and strong addition to the team. 5)Staff is reliable and extremely open to answer questions and explain anything asked. 6)Excellent. 7)Really great people. When asked to clarify, or answer a question, they do and if they don't know they get back to us with follow-up. 8)Very satisfied in this area. 9)Great job!																				

MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY16-FY21)		Yes					No					Needs Improvement					Unsure				
		16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21
Visioning	40. My dream for Mid-State Health Network is: 1)To remain in existence, to continue to lead most PIHP's, and to continue to improve services to consumers across the region. 2)To continue to succeed and improve our services to those we are responsible to. 3)To flourish in a public mental health atmosphere. 4)To be able to continue to function as a part of a public mental health system. 5)Make a stronger commitment to develop short term placement facilities for youth with mental illness who are struggling with engagement in their individual treatment plans. Far too often parents and staff jump to the last component of the safety plan, which is to call police. Having law enforcement serve as case managers/therapists four and five times a month is not the best way to handle mental health issues. 6)To be here at this time next year. 7)Prepare to respond to legislation that would allow MSHN to become a SIP. 8)My dream is that MSHN continues to exist and do the good work in our community it has done since it's inception. 9)To continue to be an exemplar within the PIHPs. 10)To continue to have our decisions made by us. continue not to have a private insurance co. 11)I am too new. 12)Continue to be the premier PIHP in MI. Work with the Association and MDHHS in the overall restructuring of CMH system. 13)To continue to be the premier PIHP in the state. Always putting the consumers needs first.Always looking for ways to improve service to the people we serve. 14)To continue as directed. 15)To be the best health network in Michigan and the US. Mid State can do this! It seems like a lot of pressure for me to put on our board, but, I believe we can do it. 16)To continue what they're doing to provide excellent care for the communities.																				
	41. My greatest concern for Mid-State Health Network is: 1)The quality product put forth by the CEO and staff and the CMH's that has allowed us to remain financially healthy and lead most PIHP's in many areas. 2)Political interference and ignorance. 3)The private people who are looking at dollars not citizens of our State. 4)The current political environment. 5)Surviving the current political climate. 6)Legislation by our State Legislature. 7)That the whole system will be taken apart by the state. 8)Health plan take over of the public mental health system. 9)My greatest concern are the Senate bills would pass and consumers ultimately suffer. 10)Impact of legislation forcing dissolution of the PIHP or other dire outcomes. 11)Take over and become private. 12)I am too new. 13)Restructuring of the mental health system. 14)The constant attacks,to try to move Mental Health services out of Public sector,to for profit private sector Health Plans. 15)Uncertainity of future. 16)A few of the members seek to take over the board and seek to undermine what we do. They are entitled to their opinions, but they need to be more polite and keep decorum. 17)State making changes with privatization. 18)With cutbacks and severe staffing issues, the concern for Community Care at risk.																				
	42. With respect to Mid-State Health Network, I am proudest of: 1)The quality product put forth by the CEO and staff and the CMH's that has allowed us to remain financially healthy and lead most PIHP's in many areas. 2)I am part of a Board that I consider the best in the State. 3)Everything we do. 4)The level of competence consistently demonstrated. 5)The dedication of the staff to pursue our mission. 6)Our financial situation compared to the other State regions. 7)The CEO and the staff. 8)The collective work of the board, leadership team, and staff to make MSHN successful. 9)I am the proudest of the responsible spending that is done. 10)Our performance in the areas of effectiveness and fiscal responsibility. 11)Our ability to provide care to those who come to our door. 12)Too new. 13)Our fiscal responsibility and our leadership on the state. 14)Being able to continue to provide services,quality services during pandemic times. 15)Being a member of the finest board of all times. 16)Our overall unity and drive to improve the lives of the network and providers we serve. 17)Great functioning PIHP. 18)R c e o and his wonderful guidance and respect of board members, and his great commitment to our communities.																				
	43. I feel that Mid-State Health Network's greatest opportunity for improvement is: 1)Helping member CMH's move smoothly into CCHBC's and finding ways to increase the resources and treatment for consumers with SUDs. 2)Up in the air as. A result of political interference. 3)I think the whole public mental health system needs more visiblity. Our State needs to hear the good about our Public Mental Health system. So does our citizens. 4)Developing research analysis as to which best practices have adequate, reliable data to support their claims. 5)Increase access for board member conferences and training. 6)N/A 7)Continuing to be strong advocates for the public mental health system. 8)Providing quality care amid all the situations we have been forced to endure in last couple of years. 9)Work with all stakeholders in state wide restructuring. 10)Keep looking for ways to improve. 11)unknown 12)Keep on being a solid network that is transparent with information.																				
	44. Other recommendations/feedback: 1)None 2)None 3)It's a pleasure to work with this great organization. 4)N/A 5)None 6)Continue to provide quality of care and sensitive to staff. 7)Keep up the good work. 8)Keep up the great attitude, service to consumers, financial stability, and w																				

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Background

MSHN periodically updates its regional budget to adjust for revenue and expenditure variations throughout the fiscal year. Typically, a budget amendment is brought forth to the Board for consideration in September. This is a special amendment period due to MSHN receiving the MDHHS rate certification information after the September 2021 board meeting. The revenue increases were significant and some CMHSP spending increased as a result especially around provider stabilization funds. The Fiscal Year (FY) 2022 Budget Amendment has been provided and presented for review and discussion.

Recommended Motion:

Motion to approve the FY 2022 Budget Amendment as presented.

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FISCAL YEAR 2022 AMENDED BUDGET DRAFT

	FY 2022 Original Budget	FY 2022 Amended Budget	FY 2022 Increase (Decrease) from Original Budget	Notes
REVENUES				
Prior Year Savings	$ 51,407,120	$ 51,407,120	$ -	
Medicaid Capitation SP/iSPA MH	387,375,014	419,681,749	32,306,735	Budget based on FY2022 capitation rates received in September 2021 after the original budget was presented; budget amended to include CCBHC supplemental revenue for the demonstration CMHSP sites
Medicaid Capitation SP/iSPA SUD	14,017,949	14,987,375	969,427	
Medicaid Capitation HSW	93,225,446	104,934,440	11,708,994	
Healthy Michigan Plan Capitation MH	62,976,885	68,716,591	5,739,706	
Healthy Michigan Plan Capitation SUD	26,221,167	31,683,904	5,462,737	
Medicaid Autism	55,155,351	51,334,953	(3,820,398)	
Medicaid DHS Incentive Payment	2,530,970	2,530,970	-	
CCBHC Supplemental Payments	-	18,806,293	18,806,293	
Hospital Rate Adjustor	15,773,100	15,773,100	-	
Performance Bonus Incentive Payment	4,792,289	5,185,043	392,754	
Community Grant and Other SUD Grants	15,149,457	15,149,457	-	
PA2 Liquor Tax SUD	4,712,059	4,712,059	-	
Local Match Contribution	3,140,208	2,345,532	(794,676)	
Interest Income	80,000	80,000	-	
Other Grants	235,000	235,000	-	
Other Income	58,800	58,800	-	
TOTAL REVENUE BUDGET	**$ 736,850,813**	**$ 807,622,387**	**$ 70,771,574**	
EXPENDITURES				
ADMINISTRATION:				
Salaries and Wages	$ 5,756,833	$ 5,756,833	$ -	
Employee Benefits	2,082,083	2,082,083	-	
Other Contractual Agreements	504,150	504,150	-	
IS Subscriptions and Maintenance	987,300	987,300	-	
Consulting Services	130,000	130,000	-	
Conference and Training Expense	91,545	91,545	-	
Human Resources Fees	64,540	64,540	-	
Mileage Reimbursement	74,425	74,425	-	
Other Expenses	175,480	175,480	-	
Building Rent	73,879	73,879	-	
Telephone Expense	72,450	72,450	-	
Office Supplies	35,850	35,850	-	
Printing Expense	55,000	55,000	-	
Meeting Expense	44,575	44,575	-	
Liability Insurance	38,445	38,445	-	
Depreciation Expense	50,397	50,397	-	
Audit Services	35,500	35,500	-	
OPB and Council Per Diems	18,060	18,060	-	
Dues and Memberships	6,500	6,500	-	
Legal Services	5,000	5,000	-	
Equipment Rent	5,100	5,100	-	
Internet Services	2,940	2,940	-	
Subtotal Administration	**$ 10,310,053**	**$ 10,310,053**	**$ -**	
Percent Administration Expenses to Total Expenses	1.47%	1.41%		

	FY 2022 Original Budget	FY 2022 Amended Budget	FY 2022 Increase (Decrease) from Original Budget	Notes
CMHSP and SUD EXPENSES and TAXES:				
CMHSP Participant Medicaid	$ 492,816,745	$ 498,127,343	$ 5,310,598	Budget based on CMHSP FY2022 amended expenses; some CCBHC expenses are included in the Medicaid budget due to lack of sufficient data and ongoing CCBHC program development
CMHSP Participant Healthy Michigan Plan	64,334,217	64,985,497	651,280	
CMHSP Participant Medicaid Autism	52,816,366	54,796,759	1,980,393	
CMHSP Participant CCBHC Supplemental	-	18,618,230	18,618,230	
CMHSP Participant Other	5,256,730	5,256,730	-	
SUD Medicaid Contracts	12,300,000	12,300,000	-	
SUD Healthy Michigan Plan Contracts	25,200,000	25,200,000	-	
Community Grant and Other SUD Grants	9,892,900	12,892,900	3,000,000	Budget amended for COVID-19 grant expenses
SUD PA2 Liquor Tax	4,712,059	4,712,059	-	
Hospital Rate Adjustor	15,773,100	15,773,100	-	
Tax Insurance Provider Assessment	5,782,945	5,782,945	-	
Tax Local Match Contribution	3,140,208	2,345,532	(794,676)	
Subtotal CMHSP and SUD Expenses and Taxes	**$ 692,025,271**	**$ 720,791,096**	**$ 28,765,825**	
TOTAL EXPENDITURE BUDGET	**$ 702,335,323**	**$ 731,101,149**	**$ 28,765,825**	
Revenue Over/(Under) Expenditures	**$ 34,515,490**	**$ 76,521,238**	**$ 42,005,748**	

MSHN
Mid-State Health Network

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER TO THE MSHN BOARD OF DIRECTORS
January/February 2022

MSHN delivered 50,000 KN95 masks to CMHSPs in the region on 02/01/2022. We deeply appreciate the assistance of Shiawassee Health and Wellness in logistical support for this personal protection equipment distribution. MSHN anticipates making another request from the State Emergency Operations Center for PPE supplies for our substance abuse prevention, treatment and recovery network.

MSHN would like to congratulate Andy's Place, a permanent supportive housing facility associated with Jackson's Treatment Court, on its receipt of a National Charles L. Edson Tax Credit Excellence Award by the Affordable Housing Tax Credit Coalition. This recognizes Andy's Place for its innovation and impactful use of low-income housing tax credits to strengthen the Jackson community and improve support for special needs populations.

Congratulations also to our partners at Huron Behavioral Health which has received an expedited re-accreditation from the Council on Accreditation.

PIHP/REGIONAL MATTERS

1. COVID-19 MSHN Internal Operations Status:

- MSHNs suite of four offices within the Michigan Optometric Association (MOA) building have been closed since March 16, 2020.
- All MSHN personnel remain engaged in the work of supporting our region, its providers, and beneficiaries. All MSHN personnel are working from remote locations 100% of the time, except for three positions that are office or field based.
- Mid-State Health Network internal operations will continue to be performed and conducted via away from office (remote) work arrangements for an indeterminate period, for all employee classifications unless specific operational or business requirements mandate that a specific employee or group of employees be deployed for in-person work at either the MSHN office location(s) or at provider or community-based site(s). We remain in regular communication directly with MSHN staff and through leadership team members.
- MSHN is engaged in the process of evaluating the conditions for a return to office-based work, continuation of remote-based work, or a hybrid arrangement, based in part on information gathered from an employee and a provider survey of preferences and considerations. Given the current surge/spike, MSHN is projecting that it's plan will be ready for release at the end of March 2022. MSHN intends to give employees and providers several months' notice of any individual, departmental or organizational change in operating posture and parameters.

2. **MSHN Regional Operations Status:**

- CMHSPs: All CMHSPs in the region remain functional and capable of delivering all essential services and supports to beneficiaries, families, and communities. CMHSPs in the region are at various tiers and in various stages of office-based services re-engagement. Most are continuing with a blend of telehealth and in-person services.
- SUD Prevention, Treatment and Recovery Providers: All SUD providers remain functional and capable of delivering all essential services and supports to beneficiaries, families, and communities. In all cases, services and supports that can be delivered telephonically or by means of video or other alternatives to in-person/face-to-face have been developed and deployed (as authorized under State guidance).

3. **Board Member Information Forms:**

MSHN Administration will be distributing via survey monkey a very brief request for background information on board members. We are undertaking this effort to better catalog the background of board members so that we can better consult with members that have specific experience or expertise when needed. The survey is very brief, and we appreciate the time you take to provide this useful background information. We have attempted to isolate areas where MSHN administration anticipates future consultation and we have not tried to capture all background and experience information. However, we encourage you to provide us with any details of your background that you think would be useful for us to know.

4. **Region (and Statewide) Workforce Issues Continue:**

As reported previously, providers across the region (and the State) continue to experience extreme workforce issues impacting services and supports. Please see my September and November 2021, and January 2022 board reports for additional details if needed.

- **UPDATE:** MSHN, supported by the regional Operations Council, is proposing at this board meeting the dedication of resources to support provider staffing crisis responses. The meeting packet contains details of $10M in funding to be made available to SAPTR providers and CMHSP provider networks to fund one-time or short-term staffing crisis-related initiatives (other than base salary increases). This was mentioned in my report and remarks at the January board meeting.

5. **MSHN Legislation Tracking Improvements:**

My office has undertaken an effort to improve tracking of, and communications about, legislative initiatives potentially affecting our responsibilities. Sherry Kletke, MSHN's Executive Assistant, is now responsible for monitoring Michigan legislation initiatives, communicating legislation proposals to various MSHN subject matter experts, and helping with related education and advocacy efforts. In this and all future board reports there will be an attachment summary of Michigan legislative activities being tracked or monitored by MSHN. Sherry has done an excellent job with getting this initiative organized and implemented, for which the leadership team is grateful.

6. **Office Building Update:**

On January 25, Sherry Kletke, our Executive Assistant, arrived for work at our offices and found that some areas of the office had been damaged due to someone seeking something. The portion of the building we occupy had been unoccupied since Wednesday, 01/19, and the cleaning crew was last in on Friday evening, suggesting this occurred over the weekend.

There was minor damage to some locked drawers and our confidential shred bin. There was no damage to entry doors of the building or the suites we occupy, and the MSHN offices were not ransacked. It appears the perpetrator knew where to look for items. Stolen were our master key box, a small portable (empty) document safe, a polycom wireless conference phone unit, a disabled laptop computer, and a large flat screen TV display (from our conference room).

All exterior door locks and all interior suite locks have been changed. A police report has been filed, including notification of the IP address from which the stolen laptop was activated on Sunday, 01/23. No protected information is stored on laptops, so there has been no breach into our systems.

7. **Regional Credentialing and Training Flexibilities Request:**

At the request of the Behavioral Health and Developmental Disabilities Administration (BHDDA), the MSHN region submitted the following recommendations for flexibilities to deal with the staffing crisis on February 7, 2022:

Credentials

1. Waive or reduce the one-year experience required for all of the Medicaid Staff Qualifications similar to what was done with the master's level children's credentials (CMHP). This could help with eliminating the administrative burden associated with having supervisors sign off on all billable documents that first year.
2. Please consider these ideas to reduce barriers for individuals to successfully enter the field:
    a. Allow all Continuing Education Units (CEU's) for Medicaid Provider Manual credentials to be completed virtually/online. For example:
        i. Social workers must complete 45 CEUs but only half can be virtual/online. We would advocate that all 45 hours are allowed to be done virtually.
    b. Allow flexibility for all required face-to-face training and supervision requirements to be completed virtually/online.
    c. Fingerprinting and ongoing licensing/registration/certification payments – these out-of-pocket costs are required for clean claims and a fee waiver or reimbursement would assist behavioral health workers across the board.
    d. Payment for internship placement credits - currently interns have to pay to obtain the credits necessary for graduation for their internships – payment would assist marginalized individuals to enter the profession with fewer barriers without having to go further into debt or pay to work.

Trainings

1. Allow substitute trainings for the annual required Assertive Community Treatment (ACT) training. Examples: Motivational Interviewing, Cognitive Behavioral Therapy, Cognitive Enhancement Therapy,

Suicide Risk Assessment, and Crisis Management using online platforms such as Relias Learning to allow for greater flexibility in clinical growth and timing for trainings.

2. Please consider deferring the annual ACT training to every other year in order to bill the ACT code.
3. Please consider a reduction (temporary or ongoing) in the 24 hours of children's required training.
4. Please reduce Child and Adolescent Functional Assessment Scale (CAFAS) reliable trainer and reliable rater training frequencies, specifically:
    a. CAFAS reliable trainer sessions are required every 2 years. For those who have been a trainer for 4 years, please consider deferring the next trainer training for 4 years.
    b. CAFAS. For those who have been a reliable rater for CAFAS for 6 years (done self-train and booster 1 and 2), please consider retraining every 3 years instead of every 2 years.
5. Some EBPs (Evidence-Based Practices) require supervisors to attend trainings with each candidate and then take on a case.
    a. PMTO (Parent Management Training, Oregon Model). Currently one of my supervisors has to attend 8 days of training and then take on one family and provide PMTO treatment. This is very time consuming for supervisors and is challenging when we are dealing with ongoing staffing shortages. Protecting fidelity is important but there should be some flexibility to best meet community needs too.
    b. Other EBPs have requirements that are placed on supervisors for their staff to be allowed to participate in EBPs. Can this be revisited?
6. Please waive the requirement for assessment staff to be at each Trauma Focused Cognitive Behavioral Therapy (TF CBT) initial cohort training when the CMH has already been through intensive TF CBT cohort trainings.
7. Please keep online training for Recipient Rights personnel in place.

Paperwork reduction

1. Allow assessment tool information to satisfy the Personal Care script for T1020 services (Adult Foster Care home). The Supports Intensity Scale (SIS), Psychosocial Assessment, and Daily Living Activities (DLA-20) can show the level of care needs such as level of independence/dependence needs with bathing, grooming, toileting, eating/feeding, dressing, etc. without the need to get a script. This will reduce redundant effort for case holders and doctors.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

8. House Democratic Caucus Listening Tour Report:

In fall of 2021, the Michigan House Democratic Caucus held over 15 mental health listening tour stops throughout Michigan. Please read their paper entitled "Enhancing our Community Mental Health System" which is attached to this board report. I will be participating in a meeting with House Democratic Caucus leadership on 02/18/22 and can provide an update at the March board meeting.

9. Great Lakes Mental Health Technology Transfer Center (MHTTC) Health Equity Resources:

The Great Lakes MHTTC invites everyone to join us in celebrating Black History Month! The Great Lakes MHTTC and our Network partners provide an array of training and technical assistance resources on multiple facets of Black health and wellness. Explore the selected resources listed below and share with your communities.

- Building Health Equity and Inclusion: Black/African American Populations
  This webpage developed by the ATTC Network Office includes a great number of resources and products that explore substance use disorder and mental health treatment and recovery services specialized in Black/African American communities. View the list here.

- Racial Equity and Cultural Diversity
  This webpage includes a compilation of products and resources on cultural responsiveness, racial equity and cultural diversity for the mental health workforce, curated by the MHTTC Cultural Responsiveness Working Group. Visit the webpage here.

- Health Equity and Inclusion
  This webpage includes a compilation of products and resources created to help the substance misuse prevention workforce reduce health disparities, address social determinants of health, and provide prevention services through which all individuals feel acknowledged and respected. Visit the webpage here.

10. MI Kids Now Update:

MDHHS is continuing to work towards resolving the litigation under the KB v. MDHHS lawsuit and is engaged in ongoing negotiations with plaintiff's counsel and recently provided the following update:

- MDHHS has identified the following key goals for the overarching MI Kids Now initiative:
  - Ensure that critical services and supports are available to children, youth, young adults and families in every community. Build on the existing service array to expand access to services, such as mobile intensive crisis stabilization services.
  - Standardize screenings, evaluations, and assessments.
  - Strengthen and expand care coordination (utilizing High Fidelity Wraparound).
  - Ensure individualized plans of care that put the unique needs and strengths of each child, youth, young adult and family first.
  - Increase children, youth, and family engagement in system design
  - Improving monitoring and accountability:
    - Collect and analyze data to (1) determine how well the system is performing and (2) identify areas for improvement.
    - Create a user-friendly dashboard to inform stakeholders about (1) the number of children, youth and young adults being served, (2) the services that they receive, and (3) the outcomes of those services.

- MDHHS has also convened a Leadership Team and several workgroups to assist with the development of the MI Kids Now Initiative. The workgroups are as follows:
  - Service Access, Array, and Care Coordination
  - Screening and Assessment
  - Workforce Development and Training
  - Data Collection and Quality Monitoring
  - Communications

- From November 8 through 17, 2021, MDHHS hosted a series of nine stakeholder engagement feedback forums with behavioral health partners and Michigan families.

- MDHHS is working to include the voices of the stakeholders and families in this initiative. The goal of the sessions was to collect feedback regarding the current state of behavioral health services in Michigan, specifically as it relates to crisis stabilization services, Fidelity Wraparound services, and peer supports.
- The three main themes that emerged from the forums were (1) awareness of services, (2) access and consistency in service development, and (3) resources to support service delivery including funding and workforce.

- The Michigan legislature approved $30 million in General Fund for FY 22 for addressing new commitments under the settlement agreement. MDHHS is working towards implementing proposals to improve children's behavioral health services using the funding, which includes:
  - Expanding access to key home and community-based services such as mobile crisis and intensive crisis stabilization services
  - Investing in workforce development programs such as student loan repayment
  - Establishing additional support for children and youth who are ready to transition back to the community from a state hospital or residential treatment facility
  - Expanding mental health services available through Child and Adolescent Health Centers

11. Michigan Opioid Settlement Updates:

Larry Scott, Director, Office of Recovery Oriented Systems of Care reports as follows:

"As of 1/27/2022, all Michigan Counties and most municipalities, as well as townships, are registered for the Opioid Settlement funding. The state has received the first in a series of multiple settlement payments made by several defendants participating in the Opioid Settlement. As such, there is legislation governing the allocation and expenditure of the settlement funding to the state and subdivisions under development. Given that the subdivisions may receive a considerable amount of resources to address the opioid crisis in the communities you serve, we urge you to collaborate with the respective subdivisions in your regions on strategic planning relative to the Opioid Settlement. Based on the legislation provided, the Department of the Attorney General and the Department of Health and Human Services plan to convene an informational webinar for all the registered subdivision. Following the webinar, there are plans to convene learning communities on the pillars of our State Opioid Strategic Plan, including best practices, for the subdivisions."

12. Michigan Health Integration Updates:

I have been reporting on the Michigan Health Integration Activities and many other BHDDA initiatives. Please see the attached February 2022 update provided by BHDDA on the status of these many initiatives directly related to state Integration Initiatives. Also note that MSHN is directly involved in these initiatives.

13. Michigan Psychiatric Care Improvement Project:

I have been reporting on the Michigan Psychiatric Care Improvement Project and many other BHDDA initiatives. Please see the attached February 2022 update provided by BHDDA on the status of these many initiatives directly related to Psychiatric Care Improvement. Also note that MSHN is directly involved in these initiatives.

14. Arriving Afghan Nationals Statewide Update:

MSHN
Mid-State Health Network

Afghan Arrivals Update: 2/8/2022

Michigan Weekly Afghan Arrivals Status Report

Affiliate/City	*Resettlement County*	*Approved*	*Assured*	*Arrived*	*Proportion Arrived/Assured*
JFS/Ann Arbor		330	290	284	97.9%
	Washtenaw	330		284	
USCRI/Dearborn		300	303	275	90.8%
	Wayne	undetm		275	
	Oakland	undetm		undetm	
	Macomb	undetm		undetm	
Samaritas/Troy		350	334	318	95.2%
	Wayne	undetm		318	
	Oakland	undetm		undetm	
	Macomb	undetm		undetm	
CCSEM/Clinton Twp		50	48	47	97.9%
	Wayne	undetm		47	
	Oakland	undetm		undetm	
	Macomb	undetm		undetm	
Samaritas/Grand Rapids		125	109	109	100.0%
	Kent	125		109	
BCS/Grand Rapids		280	226	220	97.3%
	Kent	undetm		220	
	Muskegon	undetm		undetm	
	Ottawa	undetm		undetm	
Samaritas/Kalamazoo		140	111	96	86.5%
	Kalamazoo	140		96	
BCS/Kalamazoo		50	43	43	100.0%
	Kalamazoo	50		43	
SVCC/Lansing		300	276	247	89.5%
	Ingham	300		247	
Private Sponsorship/Lansing		5	5	0	0.0%

Michigan Weekly Afghan Arrivals Status Report

Affiliate/City	*Resettlement County*	*Approved*	*Assured*	*Arrived*	*Proportion Arrived/Assured*
	Ingham	5		0	
		1930	**1745**	**1639**	**93.9%**

County	*Approved*	*Assured*	*Arrived*	*Proportion Arrived/Approved*
Ingham	305	281	247	81.0%
Kalamazoo	190	154	139	73.2%
Kent/Ottawa/Muskegon	405	335	329	81.2%
Washtenaw	330	290	284	86.1%
Wayne/Oakland/Macomb	700	685	640	91.4%
	1930	*1745*	*1639*	*84.9%*

Approved=National agencies have approved this proposed number of arrivals; Assured=Clients in the process of arriving, or have already arrived in MI; Arrived=Clients are in MI.

FEDERAL/NATIONAL ACTIVITIES

15. Newly Developed SAMHSA Resources :

SAMHSA has "released ongoing resources to help mental health system leaders and providers deliver needed support services and establish integrated programs that continue to build out a robust mental health continuum of care. With the ongoing COVID-19 pandemic, the pre-pandemic rising suicide rates, the opioid crisis and numerous challenges in meeting demands for mental health services across the country, the 2021 Compendium of *Ready to Respond: Mental Health Beyond Crisis and COVID-19*, comes at a critical time. SAMHSA is grateful to the National Association of State Mental Health Program Directors and all the contributors who helped shape this important overview and looks forward to the shared work to ensure the service system is prepared to respond and save lives by serving anyone, at any time, from anywhere across the nation." The compendium is available at this link.

As reflected in the document's table of contents, the following topics are discussed:

- "Ready to Respond: Mental Health Beyond Crisis and COVID-19
- Disaster Behavioral Health Through the Lens of COVID-19
- Suicide Prevention and 988: Before, During and After COVID-19
- Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988
- Strategies and Considerations for Providing a More Equitable Crisis Continuum for People of Color in the United States
- The Effects of COVID-19 on Children, Youth and Families
- Mental Health System Development in Rural and Remote Areas during COVID-19
- Funding Opportunities for Expanding Crisis Stabilization Systems and Services
- Technology's Acceleration in Behavioral Health: COVID, 988, Social Media, Treatment and More

- Using Data to Manage State and Local-level Mental Health Crisis Services"

16. **Bipartisan Policy Center (reported by Captoline Consulting):**

The Bipartisan Policy Center (BPC) has blogged on the topic of *Benefits of Behavioral Health Integration for Primary Care Providers*. The author "points to task force recommendations that would incentivize and better prepare primary care providers to address the behavioral health needs of their patients. Nearly 40% of patients turn to their primary care clinicians for mental health and substance abuse services, yet many of these providers report feeling ill-equipped to handle these needs. In March of 2021, BPC released a task force report (available here) with policy recommendations to provide the supports that primary care clinicians need."

Also: "BPC applauds the U.S. Senate Finance Committee for continuing to work in a bipartisan fashion to address the unmet need for mental health and substance use services across the country. BPC submitted a response to the committee's request for information in November 2021 that included recommendations from our Behavioral Health Integration Task Force's report, Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration. As Republican and Democratic committee leaders begin to develop bipartisan legislation, we look forward to the upcoming hearing on January 26, where U.S. Surgeon General Dr. Vivek Murthy will testify on the mental health challenges facing America's youth."

17. **New Federal Medicaid Option Promotes Enhanced Mental Health and Substance buse Crisis Care:**

(Excerpted from a CMS news release): The Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), is working with states to promote access to Medicaid services for people with mental health and substance use disorder (SUD) crises. Authorized under President Biden's American Rescue Plan (ARP), states have a new option for supporting community-based mobile crisis intervention services for individuals with Medicaid. Mobile crisis intervention services are essential tools to meet people in crisis where they are and rapidly provide critical services to people experiencing mental health or substance use crises by connecting them to a behavioral health specialist 24 hours per day, 365 days a year. This new option will help states integrate these services into their Medicaid programs, a critical component in establishing a sustainable and public health-focused support network.

Submitted by:

Joseph P. Sedlock, MSA
Chief Executive Officer
Mid-State Health Network
Finalized: 02/17/2022

Attachments:

- Legislative Tracking Summary, February 2022
- Enhancing our Community Mental Health System, Michigan House Democratic Caucus, December 2021
- MDHHS Strategic Projects Update, February 2022
- Michigan Psychiatric Care Improvement Project, February 2022

Mid-State Health Network

Compiled and tracked by Sherry Kletke

Below is a list of Legislative Bills MSHN is currently tracking and their status as of February 16, 2022:

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 4059 (PA 111)	Autism Services (Wendzel) Modifies autism evaluation review process requirements for Medicaid benefit eligibility.	Signed by the Governor (11/10/2021; Signed: November 10, 2021, Effective: February 7, 2022)
HB 4075	Parking Spot Signage (LaFave) Modifies signage for parking spaces designated for persons with disabilities.	Received in Senate (10/7/2021; To Health Policy and Human Services Committee)
HB 4076	Accessibility Symbol (LaFave) Modifies symbol of accessibility.	Received in Senate (10/7/2021; To Health Policy and Human Services Committee)
HB 4348	Pharmacy Benefit Managers (Calley) Provides for requirement for pharmacy benefit managers to be licensed in Michigan.	Advanced to Third Reading in Senate (2/15/2022; Earlier committee substitute S-2 adopted.)
HB 5163	MAT Programs (Witwer) Requires certain hospitals to provide emergency-based medication-assisted treatment (MAT) programs and provides for grants from the department of health and human services to implement the MAT programs.	Received in Senate (10/21/2021; To Health Policy and Human Services Committee)
HB 5165	Inpatient Psychiatrics Services (Whiteford) Modifies adult inpatient psychiatric services ability to pay provision.	Received in Senate (2/1/2022; To Health Policy and Human Services Committee)
HB 5353	Mental Health (Whiteford) Provides revisions to the Michigan crisis and access line.	Introduced (9/30/2021; To Health Policy Committee)
HB 5354	Mental Health (Whiteford) Creates the 9-8-8 suicide prevention and mental health crisis hotline fund.	Introduced (9/30/2021; To Health Policy Committee)
HB 5467	Open Meetings (Green) Provides policy related to member participation in virtual committee meetings.	Introduced (10/21/2021; To Local Government and Municipal Finance Committee)
HB 5482	Drug Court (Howell) Modifies eligibility to drug treatment courts.	Introduced (10/27/2021; To Judiciary Committee)
HB 5483	Mental Health Court Participants (LaGrand) Modifies eligibility for mental health court participants.	Introduced (10/27/2021; To Judiciary Committee)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 5484	Drug Court (Yancey) Modifies termination procedure for drug treatment courts.	Introduced (10/27/2021; To Judiciary Committee)
HB 5488	Psychologists (Kahle) Modifies individuals who are authorized to engage in the practice of psychology in this state to include individuals who are authorized to practice under the psychology interjurisdictional compact.	Received in Senate (12/14/2021; To Health Policy and Human Services Committee)
HB 5489	Psychologists (Brabec) Enacts psychology interjurisdictional compact.	Received in Senate (12/14/2021; To Health Policy and Human Services Committee)
HB 5593	Mental Health (Calley) Provides community mental health oversight of competency exams for defendants charged with misdemeanors.	Introduced (12/1/2021; To Health Policy Committee)
HB 5709	Behavioral Health (Anthony) Provides equitable coverage for behavioral health and substance use disorder treatment.	Introduced (2/1/2022; To Insurance Committee)
SB 101	Mental Health (McBroom) Updates provisions within the Mental Health Code by creating standards and licensing requirements for mental health transport for involuntary psych hospitalization.	Reported in Senate (10/7/2021; S-3 substitute adopted; By Health Policy and Human Services Committee)
SB 190	Psychiatric Units (VanderWall) Requires accepting public patients as a condition of licensing for psychiatric hospitals and psychiatric units.	Passed in Senate (3/24/2021; 35-0)
SB 191	Mental Health (VanderWall) Expands the definition of mental health professional to include physician assistants, certified nurse practitioners, and clinical nurse specialists-certified, and allow them to perform certain examinations.	Received in House (4/29/2021; To Health Policy Committee) Passed in Senate (4/29/2021; 35-0)
SB 321	Mental Health (Santana) Provides development or adoption of professional development standards for teachers on mental health first aid.	Passed in Senate (9/29/2021; 36-0)
SB 412	Prescription Drugs (Hertel, C.) Provides exemption of certain prescription drugs from the department of health and human services Medicaid prior authorization process.	Advanced to Third Reading in House (2/15/2022; Committee substitute H-1 adopted)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
SB 435	Public Health Code (MacDonald) Expands to include mental health professionals under the definition of designated professional for the Michigan essential health provider recruitment strategy act.	Reported in House (2/10/2022; Substitute H-1 adopted; By Health Policy Committee)
SB 578	Controlled Substances (Brinks) Allows distribution of opioid antagonists by community-based organizations under a standing order.	Introduced (10/14/2021; To Health Policy Committee) Passed in Senate (10/14/2021; 35-0)
SB 579	MAT Programs (VanderWall) Requires certain hospitals to provide emergency-based medication-assisted treatment (MAT) programs and provides for grants from the department of health and human services to implement the MAT programs.	Introduced (10/14/2021; To Health Policy Committee) Passed in Senate (10/14/2021; 35-0)
SB 597	Behavioral Health Care (Shirkey) Provides specialty integrated plan in behavioral health services.	Reported in Senate (10/26/2021; S-2 substitute adopted; By Government Operations Committee)
SB 598	Mental Health (Bizon) Provides updates regarding the transition from specialty prepaid inpatient health plans to specialty integration plans.	Reported in Senate (10/26/2021; S-2 substitute adopted; By Government Operations Committee)
SB 637 (PA 162)	Mental Health (Chang) Creates community crisis response grant fund and program.	Signed by the Governor (12/27/2021; Signed: December 27, 2021, Effective: December 27, 2021)
SB 638 (PA 163)	Behavioral Health (Outman, R.) Creates behavioral health jail diversion program.	Signed by the Governor (12/27/2021; Signed: December 27, 2021, Effective: December 27, 2021)
SB 705	Open Meetings (Irwin) Provides procedures for electronic meetings of public bodies.	Introduced (10/26/2021; To Local Government Committee)
SB 707	Telehealth Visits (Hollier) Requires reimbursement rate for telehealth visits to be the same as reimbursements for office visits.	Introduced (10/28/2021; To Health Policy and Human Services Committee)
SB 714	Behavioral Health (Shirkey) Provides multidepartment supplemental for behavioral health changes.	Introduced (10/28/2021; To Appropriations Committee)
SB 792	Open Meetings (McMorrow) Modifies circumstances permitting electronic	Introduced (12/14/2021; To Local Government Committee)

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
	attendance of members at meetings of public bodies.	
SB 854	Open Meetings (McCann) Modifies procedures for electronic meetings of public bodies and expand eligibility due to a medical condition.	Introduced (2/1/2022; To Oversight Committee)

ENHANCING OUR

Community Mental Health

SYSTEM

MENTAL HEALTH LISTENING TOUR
MICHIGAN HOUSE DEMOCRATS

Overview

Between September and December 2021, Michigan House Democrats held over 15 Mental Health Listening Tour stops throughout Michigan. The goal of these tours was to facilitate a guided discussion among local mental health practitioners, consumers, and their families on the current state of our Community Mental Health (CMH) system in Michigan. The tour was meant to ensure that any changes to our CMH system were consumer-centered. Consumers and families need to be actively involved in the planning and delivery of services at all levels of the system.

Through these listening tours, we were able to learn about the great work being done locally throughout our CMH system as well as identify areas for improvement. Issues such as access, workforce recruitment and retention, and funding were all common challenges across the state. Michiganders deserve and expect a strong public mental health system. By implementing key policy changes and making targeted investments, Michigan can continue to enhance the system it has built over the past 50 years and create a system that is accessible, person-centered, and community-driven.

Key Takeaways

1. **Keeping Community Mental Health in the Community:** Consumers and mental health practitioners alike support a community-based approach. Most people do not want to see services and decision-making taken out of the local setting. There are countless local partnerships that are working well and should not be disrupted. In fact, many argued that it is through local partnerships that consumers are able to get appropriate services.

2. **Elevating the CCBHC Model:** Certified Community Behavioral Health Clinics (CCBHCs) are a new provider type in Medicaid that must directly provide (or contract to provide) nine types of services. They emphasize 24-hour crisis care and integration with physical health care. CCBHCs are available to any individual in need of care, which is crucial in helping improve access to care for our mild-to-moderate population. Supporting the implementation of CCBHCs in the initial pilot sites (there are currently 36 sites in Michigan) and continuing to scale up statewide is imperative in improving access to care for all Michiganders.

3. **Constant Efforts to Restructure Creates Instability Within the System:** There have been numerous proposals over the years that would drastically alter how behavioral health care is delivered in Michigan. From drastic funding cuts to complete system overhauls, each measure (real or perceived) destabilizes the system and directly impacts consumers, their families, and workforce recruitment and retention.

Albion
Ann Arbor
Battle Creek
Detroit
Grand Rapids
Kalamazoo
Lansing
Livonia
Marquette
Novi
Saginaw
Traverse City (2)
Troy
Warren

15 Listening Tour Sessions

88 Panelists

30+ Hours Spent Listening

38 Survey Responses

450 Attendees

Report prepared by
State Representative Felicia Brabec
101st Legislature • December 2021

Key Takeaways (continued)

4. **Improving Workforce Recruitment and Retention:** The pandemic has only exacerbated already existing workforce issues. Across the state, we are seeing challenges in recruiting and maintaining a qualified workforce. Commonly cited challenges include low wages and benefits, overly burdensome documentation, increased workload, need for child care, lack of training reciprocity, and lack of professionalization of career paths – particularly for our direct care workers.

5. **Adopting a New Funding Strategy:** Over the years, a number of financing decisions have systematically restricted the ability of Michigan's public mental health system to meet the needs of Michiganders. Funding is far below what is needed to meet growing demand. General Fund cuts, the inability of the public system to retain savings, and insufficient Medicaid reimbursement rates are all issues that need to be addressed.

6. **Relieving Administrative Burdens:** In the behavioral health system, there is a tremendous amount of duplication and redundancy in the way the state reviews and audits. There needs to be oversight of the system, but we need to eliminate the duplication and non-value added requirements. These administrative burdens often take away time from helping consumers, and can create significant hurdles for those seeking care.

7. **Addressing Barriers to Access:** There are still barriers to access for consumers for a multitude of reasons. We need to continue to support the work of the system in coordinating the network of services necessary to address the range of social determinants of health: housing, employment, food access, transportation, family support, child care, etc. The shortage of acute and residential psychiatric beds and broadband capacity to access telehealth are also key to addressing access.

8. **Improving Stigma and Public Awareness:** Many people stressed the importance of destigmatization, education, and outreach. More needs to be done to lessen the impact stigma can have on seeking care. Similarly, there needs to be greater clarity in describing available services so that people know where the "front door" is.

MENTAL HEALTH LISTENING TOUR
MICHIGAN HOUSE DEMOCRATS

Conclusion

There are many aspects of the Community Mental Health system that are working well for consumers and should be celebrated. The system has demonstrated strong performance in providing a wide range of services to multiple populations in the community setting. Much of these successes can be attributed to local partnerships, a person-centered approach to care, and the system's proven ability to control costs.

These successes prove the system is working. However, it is equally important for us to recognize areas in which the system can be enhanced. Through thoughtful, responsive legislation, we can work to address barriers to access, issues with workforce recruitment and retention, better address social determinants of health, and improve funding. We can also work to revise departmental policies to reduce duplication and redundancy within the system. There is much work to be done, but we are committed to offering changes in a way that actively involves consumers and their families.

Michigan Integration Efforts

February 2022 Update

Overview

Overview
MDHHS Integration Efforts include four key initiatives: Behavioral Health Homes (BHH), Opioid Health Homes (OHH), Certified Community Behavioral Health Clinics (CCBHC) and Promoting Integration of Primary and Behavioral Health Care (PIPBHC). Each initiative seeks to improve both behavioral and physical health outcomes by emphasizing care coordination, access, and comprehensive care. These programs specifically focus on adults and children with mental health and substance use disorder needs.

Goals

1. Increase access to behavioral health and physical health services.
2. Elevate the role of peer support specialists and community health workers.
3. Improve health outcomes for people who need metal health and/or substance use disorder services.
4. Improve care transitions between primary, specialty, and inpatient settings of care.

Opportunities for Improvement

1. Improve access to care for all individuals seeking behavioral health services (SMI, SUD, SED, mild to moderate).
2. Identify and attend to social determinants of health needs.
3. Improve care coordination between physical and behavioral health services.

Behavioral Health Homes (BHH)

Overview

- Medicaid Health Homes are an optional State Plan Benefit authorized under section 1945 of the US Social Security Act.
- Behavioral Health Homes provide comprehensive care management and coordination services to Medicaid beneficiaries with select serious mental illness or serious emotional disturbance by attending to a beneficiary's complete health and social needs.
- Providers are required to utilize a multidisciplinary care team comprised of physical and behavioral health expertise to holistically serve enrolled beneficiaries.
- As of October 1, 2020, Behavioral Health Home services are available to beneficiaries in 37 Michigan counties including PIHP regions 1 (upper peninsula), 2 (northern lower Michigan), and 8 (Oakland County)

Current Activities:

- As of January 27, 2022, there are 1048 people enrolled:
    - Age range: 7-84 years old
    - Race: 22% African American, 73% Caucasian, 1% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- The State of Michigan budget allocated funding to expand behavioral health homes into two new PIHP regions. MDHHS is working on policy documents to expand in 2022.
- Regions are continuing to enroll eligible beneficiaries and working to expand health home partners to increase capacity to serve more beneficiaries.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

Certified Community Behavioral Health Clinics (CCBHC)

Overview

- MI has been approved as a Certified Community Behavioral Health Clinic (CCBHC) Demonstration state by CMS. The demonstration will launch in October 2021 with a planned implementation period of two years. 14 sites, including 11 CMHSPs and 3 non-profit behavioral health providers, are eligible to participate in the demonstration. The CCBHC model increases access to a comprehensive array of behavioral health services by serving all individuals with a behavioral health diagnosis, regardless of insurance or ability to pay.
- CCBHCs are required to provide nine core services: crisis mental health services, including 24/7 mobile crisis response; screening, assessment, and diagnosis, including risk assessment; patient-centered treatment planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family supports; and intensive, community-based mental health care for members of the armed forces and veterans.
- CCBHCs must adhere to a rigorous set of certification standards and meet requirements for staffing, governance, care coordination practice, integration of physical and behavioral health care, health technology, and quality metric reporting.
- The CCBHC funding structure, which utilizes a prospective payment system, reflects the actual anticipated costs of expanding service lines and serving a broader population. Individual PPS rates are set for each CCBHC clinic and will address historical financial barriers, supporting sustainability of the model. MDHHS will operationalize the payment via the current PIHP network.

Current Activities

- The CCBHC Demonstration started on October 1, 2021!
- All CCBHCs are provisionally certified and have submitted applications for full certifications. MDHHS staff are reviewing the applications and anticipate full certifications to be issued by March 1.
- The final CCBHC policy (MSA 21-34) and CCBHC Demonstration Handbook can be found on the CCBHC webpage MDHHS - Provider (michigan.gov)
- All technological systems met October 1st start date requirements. As of February 2, 2022, over 13,000 people are assigned to a CCBHC in the WSA. MDHHS is working with PIHPs and CCBHCs to make pertinent updates as needed.
- Final rates and implementation procedures have been submitted to CMS for approval. The Implementation Team has been engaging in ongoing technical assistance with CMS.
- An MDHHS marketing campaign is under development with plans to launch in February. Marketing is intended to increase awareness of the CCBHC model, eligibility, and services among the public and other community providers. Marketing will target the sixteen counties with demonstration sites.

Questions or Comments

- Amy Kanouse (kanousea@michigan.gov)
- Lindsey Naeyaert (naeyaertl@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

Opioid Health Homes (OHH)

Overview

- Medicaid Health Homes are an optional State Plan Amendment under Section 1945 of the Social Security Act.
- Michigan's OHH is comprised of primary care and specialty behavioral health providers, thereby bridging the historically two distinct delivery systems for optimal care integration.
- Michigan's OHH is predicated on multi-disciplinary team-based care comprised of behavioral health professionals, addiction specialists, primary care providers, nurse care managers, and peer recovery coaches/community health workers.
- As of October 1, 2021, OHH services are available to eligible beneficiaries in 48 Michigan counties. Service areas include PIHP region 1, 2, 6,7, 9, 10 and Calhoun and Kalamazoo counties in region 4.

Current Activities

- As of February 1, 2022, 1,970 beneficiaries enrolled in OHH services.
- MDHHS has recently expanded OHH services to an additional nine counties within PIHP region 6, 7, and 10. Existing OHH's are expanding access with new providers and growing services for more beneficiaries.
- MDHHS is working on collaborating with many state agencies such as the Maternal and Infant Health division to ensure OHH beneficiaries have wraparound support services through their recovery journey.

Questions or Comments

- Kelsey Schell (schellk1@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

Promoting Integration of Primary and Behavioral Health Care (PIPBHC)

Overview

- PIPBHC is a five-year Substance Abuse and Mental Health Services (SAMHSA) that seeks to improve the overall wellness and physical health status for adults with SMI or children with an SED. Integrated services must be provided between a community mental health center (CMH) and a federally qualified health center (FQHC).
- Grantees must promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental health and substance use disorders along with co-occurring physical health conditions and chronic diseases.
- MDHHS partnered with providers in three counties:
    - Barry County: Cherry Health and Barry County Community Mental Health to increase BH services
    - Saginaw County: Saginaw County Community Mental Health and Great Lakes Bay Health Centers
    - Shiawassee County: Shiawassee County Community Mental Health and Great Lakes Bay Health Centers to increase primary care

Current Activities

- Grantees are currently working toward integrating their EHR system to Azara DRVS to share patient data

between the CMH and FQHC. This effort should improve care coordination and integration efforts between the physical health and behavioral health providers.

- Shiawassee County is starting to see shared patient data in Azara DRVS. Implementation of the care management module is underway and Saginaw County is continuing to integrate the system into their practice.
- Providers are delivering more in person appointments to enrollees, but telehealth is still offered and preferred by some patients.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

Michigan Psychiatric Care Improvement Project (MPCIP)

February 2022 Update

Overview

Michigan House CARES Task Force and the Michigan Psychiatric Admissions Discussion evolved into the Michigan Psychiatric Care Improvement Project (MPCIP).

Two Part Crisis System

1. Public service for anyone, anytime anywhere: Michigan Crisis and Access Line (MiCAL) per PA 12 of 2020, Mobile crisis*, Crisis Receiving and Stabilization Facilities [1] *

2. More intensive crisis services that are fully integrated with ongoing treatment both at payer and provider level for people with more significant behavioral health and/or substance use disorder issues

Opportunities for improvement

- Increase recovery and resiliency focus throughout entire crisis system,
- Expand array of crisis services
- Utilize data driven needs assessment and performance measures
- Equitable services across the state
- Integrated and coordinated crisis and access system – all partners
- Standardization and alignment of definitions, regulations, and billing codes

MI-SMART (MEDICAL CLEARANCE PROTOCOL)

Overview

- Standardized communication tool between EDs, CMHSPs, & Psychiatric Hospitals to rule out physical conditions when someone in the ED is having a behavioral health emergency and to determine when the person is physically stable enough to transfer if psychiatric hospital care is needed.
- Broad cross-sector implementation workgroup.
- Implementation is voluntary for now.
- Target Date: Soft rollout has started as of August 15, 2020.
- www.mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/

Current Activities:

- Education of key stakeholders statewide; supporting early implementation sites; performance metric development.
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption is occurring.
- Developing a commitment letter for Psych hospitals, CMHSPs, and EDs to sign.
- Partnering with LARA to develop a crosswalk that outlines regulatory practices that MiSMART can help meet.
- Record high COVID numbers in Emergency Departments are impeding progress.
- As of 2/1/22: Adopted/Accepted by: 39 Emergency Departments, 19 Psychiatric Hospitals, 13 CMHSPs. 21 more facilities are in the process of implementing.
- In the past month, MPCIP has started partnering with the Munson Healthcare, McLaren Bay Region, and UP Health System- Marquette.

Michigan Crisis and Access Line (MiCAL)

Legislated through PA 12 of 2020, PA 166 of 2020.

Overview

- Overall Model: One statewide line which links to local services tailored to meet regional and cultural needs.
- It will provide a clear access point to the varied and sometimes confusing array of behavioral health services in Michigan.
- Crisis triage, support, and information and referral services 24/7 via phone, text, and chat

- Predicated on Recovery & Resiliency Principles; caller-defined crisis, holistic, crisis support and triage, trauma informed, collaborative support, least restrictive, and non-judgmental.
- Supports all Michiganders with behavioral health and substance use disorder needs to locate care regardless of severity level or payer type. Warm hand-offs and follow-ups, crisis resolution and/or referral, safety assessments,24/7 warm line, and information and referral offered.
- MiCAL will not prescreen individuals. MiCAL will not directly refer people to psychiatric hospitals or other residential treatment. This will be done through PIHPs, CMHSPs, Emergency Departments, and Crisis Stabilization Units.
- Individual level performance measures.
- Opportunity for systems level change: data source for systems level needs i.e. to be addressed in collaboration with other systems including other crisis lines.
- Common Ground is the MiCAL staffing vendor.
- Target Dates: Pilot start date: Upper Peninsula and Oakland April 2021; Operational Statewide October 2022.
- Integrated with BHDDA Peer/ Recovery Coach Warm line
- Michigan Warmline is active statewide.
- MiCAL Rollout: MiCAL will rollout statewide in two phases.
    - Phase 1 FY 22: Starting in January 2022, MiCAL will rollout statewide one region at a time, providing coverage for 988 and crisis and distress support through the MiCAL number. It will not provide additional regions with CMHSP crisis after hours coverage at this time.
    - Phase 2 FY 23: CMHSP After Hours Crisis Coverage. MiCAL will provide afterhours crisis coverage for CMHSPs who currently contract with a third party for afterhours crisis coverage. Rollout will occur one PIHP at a time.
- Planned Design Activities:
    - Targeted Engagement Discussions to ensure MiCAL meets all Michiganders' needs. This process will pull together providers and people with lived experience for specific population groups to ensure that MiCAL is effectively outreaching and serving them. This will occur through 988 Implementation process.
    - Resources: Developing partnerships and technological integration with 211 and OpenBeds to ensure MiCAL has up to date resource information.
    - Ongoing small improvements to the CRM system.

Current Activities

- Frontline Strong First Responder Crisis support project called Frontline Strong in partnership with Wayne State is in development. Crisis line is estimated to go live in Spring 2022. Staff recruitment is underway.
- MiCAL and the Michigan Warmline staff have had over 41,000 encounters since April 19th (MiCAL go live); mostly calls. Over half the encounters have been on the Warmline.
- Pilot is focused on streamlining and routinizing care coordination process with CMHSPs and ensuring that CRM technology supports these processes.
- Warmline is refining data gathered during the call, i.e. reason for the call and services provided.
- Stakeholder dashboards are being developed.
- Common Ground is hiring staff in preparation for the rollout.
- MiCAL integration with OpenBeds/MiCARE is in progress.
- MiCAL is rolled out in LRE, Region 3. It is rolling out in Region 10 at the end of February.
- MiCAL will roll out in Northern Michigan Regional Entity at the end of March.

BHDDA Customer Relationship Management (CRM) – Internal Business Processes

Overview

- BHDDA will transition its internal business processes to a customer relationship management (CRM) system. The BHDDA CRM is a customized technological platform designed to automate and simplify procedures related to the regulatory relationship between BHDDA and its customers: PIHPs, CMHSPs, CCBHCs, SUD entities, Michiganders, etc.
- The development process includes written documentation of the business process, describing the process and highlighting requirements, and the translation of the business process into technology. All this information is included in the user training.
- Stakeholders for each process are actively engaged throughout the design process and user testing.
- Training materials on the CRM and each of the business processes are housed within the CRM. Training materials include videos and written job aids.
- Virtual, synchronous training and "Learning Lab hours" are held when a business process goes live.
- Statewide business processes: Customer Service Inquiry, Contract Management Processes

Current Activities

- Universal Credentialing (PA 282 of 2020): After initial information gathering through stakeholder meetings, BHDDA is defining overall project scope based on the legislation. MDHHS will reengage stakeholders in the next month or two.
- ASAM Level of Care Certification Development Process is live in Detroit Wayne and the Upper Peninsula.
- CMHSP Certification: This process is almost complete. Design work continues for an upload process for current CMHSP Certification data. Rollout plans and training are being discussed.
- Business Process development is starting on certification for speciality programs: homebased, ACT, intensive crisis stabilization, drop-in centers, clubhouse, therapeutic foster care, crisis residentials, and wrapaound

988 IMPLEMENTATION

Overview

- 988 is the new three digit dialing code for the National Suicide Prevention Lifeline.
- 988 will go live July 16, 2022.
- Michigan completed an extensive 988 Implementation planning process which was funded by Vibrant. An Implementation Plan was developed.
- Stakeholders provided feedback throughout the planning process. Workgroup meetings have focused on topics such as vision, follow up care, resources, marketing, metrics, communications, and funding.
- Marketing will start at the federal level early 2023. We have been asked to wait to market until we receive notice from Vibrant. They will send us marketing materials.
- Over the next several months to a year, Michigan will transition from a regional call coverage system to statewide call coverage through MiCAL except for Network 180 covering Kent County and Macomb CMH covering Macomb County.
- MiCAL will provide statewide text and chat coverage.

Current Activities

- Michigan's Official 988 Plan was submitted to Vibrant and SAMHSA on January 21st.
- MDHHS applied for a 988 Implementation Grant which was submitted January 31st.
- There is ongoing stakeholder advisory engagement through monthly updates.
- Operations workgroup meetings with current NSPL centers to develop common practices around NSPL requirements for things like support callers at imminent risk, active rescues, and follow-up supports.

- Coordination meetings between 911 and 988 have started.

PSYCHIATRIC BED TREATMENT REGISTRY

Overview

- Legislated through PA 658 of 2018, PA12 of 2020, PA 166 of 2020.
- Electronic service registry housing psychiatric beds, crisis residential services, and substance use disorder residential services.
- The Psychiatric Bed Registry is housed in the MiCARE/ OpenBeds platform which is Michigan's behavioral health registry/ referral platform which is operated and funded by LARA.
- MiSMART will eventually house all private and public Behavioral Health Services and will have a public facing portal.
- The Psychiatric Bed Registry Advisory Group's purpose will transition from choosing a platform to supporting successful rollout and maximization of the OpenBeds platform to meet Michigan's needs.
- LARA is rolling out MiCARE regionally with a statewide completion date by early 2022.
- **Target audience:** Psychiatric Hospitals, Emergency Departments, CMHSP staff, PIHP staff.
    - Public and broader stakeholder access through MiCAL.
    - Broad cross-sector Advisory Workgroup.
- **Target Implementation Date:** Implemented statewide by January/ February 2022.

Current Activities

- LARA is in the process of rolling out MiCARE statewide to all the psychiatric hospitals. There are 58 facilities. 70% attended the initial orientation.
- Onboarding date: All Psychiatric Hospitals will fully participate in MiCARE by June 30,2022.
- MDHHS is outreaching to psychiatric facilities for a status on MiCARE implementation.
- Psychiatric Bed Advisory Workgroup is providing feedback on tailoring MiCARE to Michigan, i.e. bed categorization, acuity, the rollout, and referral process.

CRISIS STABILIZATION UNITS

Overview

- PA 402 of 2020 codifies Crisis Stabilization Units (CSUs) in the Mental Health Code. This new statute requires MDHHS to develop, implement, and oversee a certification process for CSUs. The legislation did not appropriate funding.
- MDHHS is contracting with Public Sector Consultants to help develop with the develop of a Michigan Model and certification criteria.
    - MDHHS is convening a cross sector stakeholder group to develop a Michigan model. As a group Stakeholders will review models from other states and from Michigan to make recommendations around a model that will best fit the behavioral health needs of all Michiganders. Stakeholder Workgroup has over 50 members and is inclusive of people with lived experience, Peers, and representatives from diverse disciplines and geographic regions.
- **Timing**: Michigan Model developed by 12/1. Draft Certification rules developed by March 2022, finalized by Sept. 2022

Current Activities

- Michigan CSU Model for adults has been drafted and approved by Workgroup.
- The Michigan Model is being tailored to the needs of Children and Families. Stakeholder meetings will be held in March.

- A small subset of the Stakeholder group is developing draft certification criteria for adults. It will be presented to the larger workgroup in early 2022 for their feedback. There is special attention being paid to congruency with funding requirements, licensing requirements of related services, and accreditation.
- Two meetings were held with rural stakeholders to obtain feedback on the Model and certification rules. One meeting was held with law enforcement and the other with a cross sector of stakeholders.
- PSC 'extensive research on best practices in other states is being incorporated in the model.
- PSC is looking at available statewide data to help determine capacity needs.

MOBILE CRISIS SERVICES

Overview

- Mobile crisis services are one of the three major components that SAMHSA recommends as part of a public crisis services system.
- MDHHS goal is to eventually expand mobile crisis across the state for all populations, taking advantage of the enhanced Medicaid match.
- MDHHS has contracted with PSC/HMA to develop recommendations to expand mobile crisis for adults in Michigan, with special attention on strategies for rural areas.
- There is coordination with the MDHHS staff leading the KB lawsuit around services for children.

Target Date: Spring 2022

Current Activities –

- PSC is doing research on mobile crisis models.
- PSC is coordinating work with the Diversion Council and Wayne State Center for Behavioral Health Justice (CBHJ) who are also focused on looking at adult mobile crisis models.
- PSC will start exploring adult crisis stabilization services offered by CMHSPs in Michigan.
- MDHHS plans to take advantage of the advanced Medicaid match coming in the spring of 2022.
- Wayne State presented research on mobile crisis to the Diversion Council.
- PA 162 and 163 of 2021 set up a Diversion Fund and pilot program for mobile crisis. MDHHS is coordinating internally around implementation plans, prior to stakeholder involvement.

QUESTIONS OR COMMENTS?

- Krista Hausermann (hausermannk@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

MSHN
Mid-State Health Network

Community Mental Health Member Authorities

Bay Arenac Behavioral Health

CMH of Clinton.Eaton.Ingham Counties

CMH for Central Michigan

Gratiot Integrated Health Network

Huron Behavioral Health

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

LifeWays CMH

Montcalm Care Center

Newaygo County Mental Health Center

Saginaw County CMH

Shiawassee Health and Wellness

Tuscola Behavioral Health Systems

Board Officers

Ed Woods
Chairperson

Irene O'Boyle
Vice-Chairperson

Kurt Peasley
Secretary

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

MSHN Staffing Update

Joseph Wager has been promoted to Information Technology Project Manager (the position left vacant from Steve Grulke's promotion to Chief Information Officer), effective February 21, 2022. His current position of Database and Report Coordinator has been posted to the MSHN website under careers. Please join me in congratulating Joe on his new role within MSHN!

A listing of our current vacancies is located on the MSHN website under careers: https://midstatehealthnetwork.org/stakeholders-resources/about-us/Careers.

Health Insurance Update:

MSHN currently provides our employees with two health insurance plan options, Blue Cross Blue Shield PPO $550 Deductible with a 30% coinsurance and a Blue Care Network HMO, $0 deductible with a 10% coinsurance. The health insurance renewals for MSHN's plan year beginning February 2022 realized an above average increase of 10-11% as compared to previous years increases of 3-5%. Since MSHN is limited by Public Act 152, which caps the amount public employers pay toward employee medical benefit plans, any amount over the annual limit must be covered by the employee. The employee premiums would more than double with the renewal plans. Therefore, MSHN obtained quotes for other plans that would reduce the premium cost and was able to add a third plan option for employee selection. In addition to opting to continue with the renewal plans (at the higher premium cost), MSHN added a Blue Care Network HMO $500 deductible plan, with a 20% coinsurance, to the employees at no cost.

Annual Compliance Report

The Compliance Summary Report provides an overview of the activities performed during Fiscal Year 2021 as part of the Compliance Program and identified within the Compliance Plan. Those activities include monitoring and oversight of the provider network completed as part of the internal site reviews, site reviews of the PIHP completed by external agencies; customer service complaints; compliance investigations and compliance related training and review. The report also includes updates on recommendations from FY21 activities as well as new recommendations for FY22 based on the areas of risk identified. The report is developed and monitored throughout the year by Kim Zimmerman, Chief Compliance and Quality Officer, through review and recommendations by the MSHN Internal Compliance Committee as well as the Regional Compliance Committee. Some highlights of the report, include:

- Review process for Home Office/Off Site Office security and privacy of protected health information to ensure compliance with established standards, policies, and procedures.
- Monitor for compliance with rules outlined during the state of emergency and those continued past the state of emergency.
- Research options and determine feasibility for the completion of a compliance risk assessment region wide.

For the full report, ***see the link below: Annual Compliance Summary Report FY21, or to view other compliance activities, see MSHN's website at:*** *https://midstatehealthnetwork.org/consumers-resources/quality-compliance/compliance-reports*

Balanced Scorecard FY21

MSHN departments along with CMHSP and SUD providers have been working to close out the fiscal year and review and report final figures to the Board of Directors. MSHN's approved Balanced Scorecard for FY22, has been finalized for year end and ready for Board review as well as public posting. I'd like to congratulate the region on outstanding performance for fiscal year end September 2021 and the ongoing commitment to quality services, monitoring performance through identified metrics and continuous improvement demonstrated through positive outcomes. While I only highlighted a few metrics below, I encourage all board members to review the full report and join me in recognizing what was and continues to be a challenging year for all, yet our staff and partners continue to support quality services.

					Target Ranges		
Key Performance Indicators	Aligns with	Actual Value (%) as of September 2021	Target Value	Performance Level			
Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth	MSHN Strategic Plan FY19-FY20	+6%	0% Decrease over FY20		1-10% Decrease	11-19% Decrease	20% or more Decrease
The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular screening during the measurement year.	Aligns with strategic plan goal to establish clear criteria and practices that demonstrate improved primary care coordination and with Performance Measure Portfolio	55%	78.5% (2017 National data)		>=78.5%	54.4%-78.4%	<54.4%
Expand SUD stigma reduction community activities.	MSHN WILL SUPPORT AND EXPAND SUD-RELATED STIGMA REDUCTION EFFORTS THROUGH COMMUNITY EDUCATION	166 activities (updated 11/3/21 by SA)	144		>=144	<144 and >72	<=72

For the full report, **see the report attached: *Balanced Scorecard Report FY21 or visit MSHN's website at:*** *https://midstatehealthnetwork.org/stakeholders-resources/about-us/dashboard-information*

Home and Community-Based Services (HCBS) Rule Transition

Provisional Approval Applications and Surveys

As new licensed facilities open and receive licenses and accreditation, MSHN works with CMHSPs to receive provisional approval applications and surveys. This ensures that individuals who are either new waiver recipients or who have moved to a facility licensed after the initial rounds of surveys are still counted and assured freedom from an isolating and/or an institutionalized setting. Under extenuating circumstances, an individualized approval may be granted. MSHN has assumed survey administration from MDHHS, having disbursed surveys in November to providers and case managers per individuals placed under provisional approval between June 2020 and October 2021. 450 surveys were distributed for 224 individuals receiving qualifying HCBS services on November 15th, 2021. Respondents were given until December 13th, 2021, to complete the surveys. Due to changes in service status and participant opt-outs, 417 of the 450 original surveys were expected. Out of 417 anticipated survey returns, 388 were received completed. Of the 417 total anticipated surveys, 209 were mandatory Provider surveys. 204 of these were received completed, giving MSHN a ***98% provider completion rate across the region***.

For the full report, ***see the link below in Behavioral Health Department FY22 Q1 Report.***

Information Technology Report FY22Q1

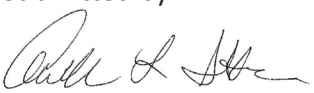
Mid-State Health Network Information Technology team provides services related to technology for the region. This includes assisting and supporting the region in meeting the contractual obligations for MDHHS, supporting the participating CMHSPs and SUD providers through managed care processes, strategic direction for technology initiatives and technical assistance with the MSHN team. This report is developed to:

- **Display statistics** of the MSHN region as it relates to MDHHS reporting.
- **Status projects** as impacting MSHN and the region through this reporting period.
- **Identify future initiatives** for FY22 and beyond.

Information Technology staff work with CMHSPs and SUD providers to submit BH-TEDS and encounters on a weekly and monthly basis. The staff identify any potential concerns or higher than normal error rates and follow-up with providers as needed. The report also includes the volume of files processed, based on consumers and services provided. It also includes the regions completion rate as compared to other PIHPs.

For the full report, ***see the link below in Information Technology Department FY22 Q1 Report.***

Submitted by:



Amanda L. Ittner
Finalized: 2.17.22

Attached:
Balanced Scorecard FY21

Links to Reports*:*
Annual Compliance Summary Report FY21
Behavioral Health Department Report FY22-Q1
Information Technology Department Report FY22-Q1

MSHN FY21 - Board of Directors and Operations Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2021	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth	MSHN Strategic Plan FY19-FY20	+6%	0% Decrease over FY20		1-10% Decrease	11-19% Decrease	20% or more Decrease
	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular screening during the measurement year.	Aligns with strategic plan goal to establish clear criteria and practices that demonstrate improved primary care coordination and with Performance Measure Portfolio	55%	78.5% (2017 National data)		>=78.5%	54.4%-78.4%	<54.4%
	Expand SUD stigma reduction community activities.	MSHN WILL SUPPORT AND EXPAND SUD-RELATED STIGMA REDUCTION EFFORTS THROUGH COMMUNITY EDUCATION	166 activities (updated 11/3/21 by SA)	144		>=144	<144 and >72	<=72
	Increase health information exchange/record sets	MSHN will improve and standardize processes for exchange of data between MSHN and MHPs; CMHSPs and MSHN. Using REMI, ICDP and CC360 as well as PCP, Hospitals, MHPs.	3	2		3	2	1
	Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use. (NEW)	MDHHS/PIHP Contracted, Integrated Health Performance Bonus Requirements	1	0		0	1	2
BETTER CARE	The percentage of discharges for adults who were hospitalized for treatment of selected mental illness or intentional self harm diagnosis and who had a follow up visit with a mental health provider within 30 days of discharge.(FUH)	Measurement Portfolio NQF 0576; PIHP/MDHHS Contract, 2021 Performance Bonus	75%	58%		>=58%	0	<58%
	Behavior Treatment Plan standards met vs. standards assessed from the delegated managed care reviews.	MDHHS Technical Requirement for Behavior Treatment Plans.	61%	95% or greater		95-100%	90-94%	<90%
	Engagement of AOD Treatment-Percentage who initiated treatment and who had 2 or more additional AOD services or medication treatment within 34 days of the initiation visit.	Aligns with best practices for assisting indiviudals to initiate services and engage in continuation of care.	Engagement: 38.27% (10-1-2020 thru 9-30-2021) (updated 11-3-2021 by TT)	Above Michigan 2020 levels; E: 12.5% (2016)		Increase over National levels	No change from National levels	Drop below National levels
	Integrate standardized assessment tools into REMI	MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region	3	2		3	2	1
	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth	MSHN Strategic Plan FY19-FY20	+6%	0% Decrease over FY20		1-10% Decrease	11-19% Decrease	20% or more Decrease
	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person centered plan	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan; MDHHS Site Review Findings 2019-2020	82%	100%		100%	90%-99%	<90%

MSHN FY21 - Board of Directors and Operations Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2021	Target Value	Performance Level	Target Ranges		
BETTER VALUE	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	96%	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
	MSHN reserves (ISF)	MSHN WILL WORK WITH ITS CMHSPS AND BOARD OF DIRECTORS TO ESTABLISH A RESERVE'S TARGET SUFFICIENT TO MEET FISCAL RISK RELATED TO DELIVERY OF MEDICALLY NECESSARY SERVICES AND TO COVER ITS MDHHS CONTRACTUAL	7.5%	7.5%		> 6%	≥ 5% and 6%	< 5%
	Develop and implement Provider Incentives (VBP, ER FU, Integration)	MSHN will develop methodologies, within established rules, to incentivize providers to cooperate with the PIHP to improve health or other mutually agreeable outcomes	1	2		2	1	0
	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization.	The MDHHS requirement of 95% slot utilization or greater.	94.90%	95% or greater		95-100%	90-94%	<90%
	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages	MSHN Strategic Plan FY19-FY20, Federal Parity Requirements	<1%	<= 5%		<=5%	6%-10%	>=11%
Better Provider Systems	Providers demonstrate increased compliance with the MDHHS/MSHN Credentailing and Staff Qualification requirements. (SUD Network and CMHSP Network)	QAPIP Goal; HSAG and MDHHS reviews	No HSAG Review 2021	80%		>80%	70-79%	<70%
	Managed Care Information Systems (REMI) Enhancements	Provider portal, Patient Portal, ASAM Continuum, Authorization Data, Site Review Module, WSA, Critical Incidents/Grievance and Appeals Module	3	4		3	2	1
	MSHN and its CMHSP participants develop and implement a regional provider application	Reciprocity & Efficiency Standards	75%	100%		100%	70-99%	<70%
	Improve data availability	MSHN FY20-21 Strategic Plan - Staff, Consumers, Providers, and Stakeholders	85%	100%		75%	50%	25%
	CMHSP Participants fully implement Electronic Visit Verifcation in accordance with MDHHS requirements (CMHSP Network)	Committee Goals; Cures Act, CMS	awaiting MDHHS	12		12	8-11	<8

MSHN FY21 - Quality Improvement/Customer Service - Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with		Actual Value (%) as of September 2021	Target Value	Performance Level	Target Ranges		
Better Care	Percent of all Medicaid Children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours	MDHHS PIHP Contract Reporting Requirements		98.32%	95%		95%	94%	<94%
	Percent of all Medicaid Adult beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours	MDHHS PIHP Contract Reporting Requirements		99.17%	95%		95%	94%	<94%
	Percent of child discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days	MDHHS PIHP Contract Reporting Requirements		99.21%	95%		95%	94%	<94%
	Percent of adult discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days	MDHHS PIHP Contract Reporting Requirements		95.97%	95%		95%	94%	<94%
	Percent of discharges from a substance abuse detox unit who are seen for follow up care within seven days.	MDHHS PIHP Contract Reporting Requirements		96.13%	95%		95%	94%	<94%
	Percent of MI and DD children readmitted to an inpatient psychiatric unit within 30 days of discharge	MDHHS PIHP Contract Reporting Requirements		10.14%	0.0%		<=15%	>=15.1%	>=16%
	Percent of MI and DD adults readmitted to an inpatient psychiatric unit within 30 days of discharge	MDHHS PIHP Contract Reporting Requirements		12.05%	0.0%		<=15%	>=15.1%	>=16%
	The percentage of discharges for children who were hospitalized for treatment of selected mental illness or intentional self harm diagnosis and who had a follow up visit with a mental health provider within 30 days of discharge.	Measurement Portfolio NQF 0576; PIHP/MDHHS Contract, 2021 Performance Bonus		89.32%	70%		>=70%		<70%
	The percentage of discharges for adults who were hospitalized for treatment of selected mental illness or intentional self harm diagnosis and who had a follow up visit with a mental health provider within 30 days of discharge.(FUH)	Measurement Portfolio NQF 0576; PIHP/MDHHS Contract, 2021 Performance Bonus		75.34%	58%		>=58%		<58%
	Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children)	MDHHS/PIHP Contracted, Integrated Health Performance Bonus Requirements		0	0		0	1	2
	Increase access and service utilization for Veterans and Military members	MSHN ensures expanded SAPT and CMHSP service access and utilization for veterans and Military Families through implementation of the regional statewide veteran and military member strategic plan		Not avialable yet	Increase over 2020 rate		Increase over 2020 rate	No change from 2020 rate	Drop below 2020 rate
	Percentage of consumers indicating satisfaction with SUD services	MDHHS PIHP Contract: Qualitative and Quantative assessment of member experiencies (QAPIP Technical Requirment)		95%	80%		80%	75%-80%	75%

MSHN FY21 - Quality Improvement/Customer Service - Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with		Actual Value (%) as of September 2021	Target Value	Performance Level	Target Ranges		
	Percentage of consumers indicating satisfaction with mental health services	MDHHS PIHP Contract: Qualitative and Quantative assessment of member experiencies (QAPIP attachment)		85% - MHSIP; 87% - YSS	80%		80%	75%-80%	75%
	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service date and time matching the claim date and time of the service. CMHSP/SUD	MDHHS PIHP Contract: Medicaid Services Verification Technical Requirement		CMHSP: 99.30% SUD: 99.50%	Increase over 2020		95%	90.0%	85%
	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service provided falls within the scope of the service code billed.	MDHHS PIHP Contract: Medicaid Services Verification Technical Requirement		CMHSP: 98.76% SUD: 99.28%	Increase over 2020		95%	90.0%	85%
	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service.	MDHHS PIHP Contract: Grievance and Appeal Technical Requirement		97.28%	95%		95%	91%-94%	90%
	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal.	MDHHS PIHP Contract: Grievance and Appeal Technical Requirement		100%	95%		95%	91%-94%	90%
	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance	MDHHS PIHP Contract: Grievance and Appeal Technical Requirement		95.34%	95%		95%	91%-94%	90%

MSHN FY21 - Provider Network Management Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2021	Target Value	Performance Level	Target Ranges		
Better Provider Systems	Provider surveys demonstrate satsifaction with REMI enhancements - Provider Portal (SUD Network)	Strategic Plan	75%	80%		>80%	70-79%	<70%
	Providers demonstrate increased compliance with the MDHHS/MSHN Credentailing and Staff Qualification requirements. (SUD Network and CMHSP Network)	QAPIP Goal; HSAG and MDHHS reviews	No HSAG Review 2021	80%		>80%	70-79%	<70%
	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN's processes and communications (SUD Network)	Deploy a survey tool to measure participating provider satisfaction and achieve 80% satisfaction with the effectiveness and efficiency of MSHN's processes and communications	79%	80%		>80%	70-79%	<70%
	MSHN and its CMHSP participants develop and implement a regional provider application	Reciprocity & Efficiency Standards	75%	100%		100%	70-99%	<70%
	Autism/ABA provider network will demonstrate satisfaction with regionally organized performance monitoring procedures (CMHSP Network)	Reciprocity & Efficiency Standards	73%	80%		>80%	70-79%	<70%
	CMHSP Participants fully implement Electronic Visit Verifcation in accordance with MDHHS requirements (CMHSP Network)	Committee Goals; Cures Act, CMS	awaiting MDHHS	12		12	8-11	<8
	All CMHSPs will have 100% of applicable trainings vetted in accordance with the training reciprocity plan (CMHSP Network)	Committee Goals; Reciprocity & Efficiency Standards and Training Reciprocity implementation guide	8	12		12	8-11	<8

MSHN FY21 - Clinical Leadership Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2021	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular screening during the measurement year.	Aligns with strategic plan goal to establish clear criteria and practices that demonstrate improved primary care coordination and with Performance Measure Portfolio	54.9%	78.5% (2017 National data)		>=78.5%	54.4%-78.4%	<54.4%
	The percentage of CMHSP completed REMI-documented SUD screenings/referrals will increase regionwide over the previous measurement period.	Aligns with other joint performance metrics (FUA).	0.5%	Increase 10% over previous timeframe.		>=15%	7-14%	<7%
	ADHD medication follow up. This HEDIS measure reports the percentage of children newly prescribed ADHD medication who received at least three follow-up visits.	Aligns with strategic plan goal to establish clear criteria and practices that demonstrate improved primary care coordination and with Performance Measure Portfolio (Monthly)	Initiation: 60.52% ; C & M: 97.12%	Increase over FY 2018 (Initiation 72.86%; C & M 97.25%)		I:74% C&M: 99%	I:70% C&M:95%	I: 65% C&M: 91%
Better Care								
	MSHN's provider network will demonstrate 95% compliance with trauma-competent standard in the site review chart tool.	Aligns with strategic plan goal that region has a trauma competent culture of care.	99.07%	increase over 2016		Increase over 2016	No change from 2016 levels	
	MSHN's CMHSP partners will report completing at least one community education activity on fetal alcohol spectrum disorder (FASD) (Annual).	CLC recommendation.	50.00%	50%		>=50%	25-49%	0-24%
	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization.	The MDHHS requirement of 95% slot utilization or greater.	94.90%	95% or greater		95-100%	90-94%	<90%
	Behavior Treatment Plan standards met vs. standards assessed from the delegated managed care reviews.	MDHHS Technical Requirement for Behavior Treatment Plans.	61.00%	95% or greater		95-100%	90-94%	<90%
	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS.	MSHN FY19-20 Strategic Plan	89.00%	95%		95-100%	90-94%	<90%
BETTER VALUE								
	Continuum of Care - Consumers moving from inpatient psychiatric hospitalization will show in next LOC within 7 days, and 2 additional apts within 30 days of first step-down visit	Aligns with strategic plan goal that MSHN and its CMHSP participants will explore clinical process standardization, especially in the areas of access, emergency services, pre-admission screening, crisis response and inpatient stay management and discharge planning.	I: 38.96%; E: 19.04%	Increase over FY 2019 (I: 38.85%; E: 19.21%)		increase over 2019	No change from 2019 levels	Below 2019 levels

MSHN FY21 - Finance Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2021	Target Value	Performance Level	Target Ranges		
BETTER VALUE	MSHN reserves (ISF)	MSHN WILL WORK WITH ITS CMHSPS AND BOARD OF DIRECTORS TO ESTABLISH A RESERVE'S TARGET SUFFICIENT TO MEET FISCAL RISK RELATED TO DELIVERY OF MEDICALLY NECESSARY SERVICES AND TO COVER ITS MDHHS CONTRACTUAL LIABILITY.	7.5%	7.5%		> 6%	≥ 5% and 6%	< 5%
	Regional Financial Audits indicate unqualified opinion	MSHN WILL REVIEW CMHSP FINANCIAL AUDITS AND COMPLIANCE EXAMINATIONS TO IDENTIFY SIGNIFICANT DEFICIENCIES THAT IMPACT THE REGION.	100.0%	100%		> 92%	< 92% and > 85%	≤ 85%
	No noted significant findings related to regional Compliance Examinations	MSHN WILL REVIEW CMHSP FINANCIAL AUDITS AND COMPLIANCE EXAMINATIONS TO IDENTIFY SIGNIFICANT DEFICIENCIES THAT IMPACT THE REGION.	100.0%	100%		> 92%	< 92% and > 85%	≤ 85%
	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	95.9%	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
	Medical Loss Ratio is within CMS Guidelines	MSHN WILL MAINTAIN A FISCAL DASHBOARD TO REPORT FINANCE COUNCIL'S AGREED UPON METRICS.	90.1%	85%		≥ 90%	> 85% and < 90%	≤ 85%
	Regional revenue is sufficient to meet expenditures (Savings estimate report)	MSHN WILL MONITOR TRENDS IN RATE SETTING TO ENSURE ANTICIPATED REVENUE ARE SUFFICIENT TO MEET BUDGETED EXPENDITURES.	100.0%	100%		<100%	> 100% and <105%	>105%
	Develop and implement Provider Incentives (VBP, ER FU, Integration)	MSHN will develop methodologies, within established rules, to incentivize providers to cooperate with the PIHP to improve health or other mutually agreeable outcomes.	1	2		2	1	0

MSHN FY21 - Clinical SUD - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2021	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	Expand SUD stigma reduction community activities.	MSHN WILL SUPPORT AND EXPAND SUD-RELATED STIGMA REDUCTION EFFORTS THROUGH COMMUNITY EDUCATION	166 activities (updated 11/3/21 by SA)	144		>=144	<144 and >72	<=72
	Increase network capacity for Medication Assisted Treatment	CONTINUE TO ADDRESS NETWORK CAPACITY FOR MEDICATION ASSISTED TREATMENT, INCLUDING AVAILABILITY OF METHADONE, VIVOTROL, AND SUBOXONE AT ALL MAT LOCATIONS. -	MSHN currently has 24 MAT sites. (Update 11-3-21: No new. Saginaw Psychological has requested to add MAT to Midland location. Request is in process.)	Increase contracted MAT locations by 5% over FY20 (ie. 1-2 additional locations)		>5%	No change	<5%
BETTER CARE	Increase percentage of individuals moving from residential level(s) of care who transition to a lower level of care within timeline of initiation (14 days) and engagement (2 or more services within 30 days subsequent to initiation).	Aligns with best practices for assisting indiviudals to initiate services and engage in continuation of care.	Initiation: 40.32% Engagement: 24.73% (10-1-2020 thru 9-30-2021) (updated 11-3-2021 TT)	Increase over MSHN 2020 levels Initiation: 36.81% ; Engagement: 22.30%		Increase over 2020 levels	No change from 2020 levels	Drop below 2020 levels
	Engagement of MAT Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of OUD within 30 days of the initiation visit.	Aligns with best practices for assisting indiviudals to initiate services and engage in continuation of care.	Initiation: 87.06% Engagement: 52.32% (10-1-2020 thru 9-30-2021) (updated 11-3-2021 by TT)	Increase over MSHN 2020 levels (I: 88.69%; E: 54.67%)		Increase over 2020 levels	No change from 2020 levels	Drop below 2020 levels
	Initiation of AOD Treatment.-Percentage who initiated treatment within 14 days of the diagnosis. (Inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, medication treatment).	Aligns with best practices for assisting indiviudals to initiate services and engage in continuation of care.	Initiation: 55.52% (10-1-2020 thru 9-30-2021) (updated 11-3-2021 by TT)***	Above Michigan 2020 levels; I: 40.8%		Increase over National levels	No change from National levels	Drop below National levels
	Engagement of AOD Treatment-Percentage who initiated treatment and who had 2 or more additional AOD services or medication treatment within 34 days of the initiation visit.	Aligns with best practices for assisting indiviudals to initiate services and engage in continuation of care.	Engagement: 38.27% (10-1-2020 thru 9-30-2021) (updated 11-3-2021 by TT)	Above Michigan 2020 levels; E: 12.5% (2016)		Increase over National levels	No change from National levels	Drop below National levels

MSHN FY21 Information Technology Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2021	Target Value	Performance Level	Target Ranges		
Better Value	Unique consumers submitted monthly	Contractual Reporting Oversight	98.4%	85%		86.0%	85.0%	84.0%
	Encounters submitted monthly	Contractual Reporting Oversight	92.1%	85%		86.0%	85.0%	84.0%
	BH-TEDS submitted monthly	Contractual Reporting Oversight	99.6%	85%		86.0%	85.0%	84.0%
	Percentage of encounters with BH-TEDS	Contractual Reporting Oversight	98.9%	95%		95.0%	94.0%	90.0%
Better Care	Integrate standardized assessment tools into REMI	MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region	3	2		3	2	1
Better Health	Increase use cases with MiHIN	Health Information Exchange, including expanded number of use cases with MiHIN, occurs with other healthcare providers to assure appropriate integration and coordination of care	3	1		2	1	0
	Increase health information exchange/record sets	MSHN will improve and standardize processes for exchange of data between MSHN and MHPs; CMHSPs and MSHN. Using REMI, ICDP and CC360 as well as PCP, Hospitals, MHPs.	3	2		3	2	1
Better Workforce	Managed Care Information Systems (REMI) Enhancements	Provider portal, Patient Portal, ASAM Continuum, Authorization Data, Site Review Module, WSA, Critical Incidents/Grievance and Appeals Module	3	4		3	2	1
	Improve data use and quality	MSHN FY20-21 Strategic Plan - Staff, Consumers, Providers, and Stakeholders	75%	100%		75%	50%	25%
	Improve data availability	MSHN FY20-21 Strategic Plan - Staff, Consumers, Providers, and Stakeholders	85%	100%		75%	50%	25%

MSHN FY21 - Utilization Management Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2021	Target Value	Performance Level	Target Ranges		
BETTER CARE	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines.	MSHN Strategic Plan FY19-FY20, MSHN UM Plan	98.50%	100%		96-100%	94-95%	<93%
	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth	MSHN Strategic Plan FY19-FY20	+6%	0% Decrease over FY20		1-10% Decrease	11-19% Decrease	20% or more Decrease
	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person centered plan	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan; MDHHS Site Review Findings 2019-2020	81.5%	100%		100%	90%-99%	<90%
	The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (Plan All Cause Readmissions)	MSHN Strategic Plan FY19-FY20, MSHN UM Plan; Measurement Porfolio NQF 1768	11.59%	<=15%		<=15%	16-25%	>25%
BETTER VALUE	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages	MSHN Strategic Plan FY19-FY20, Federal Parity Requirements	<1%	<= 5%		<=5%	6%-10%	>=11%

MSHN FY21 - Integrated Care - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2021	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	Percent of individuals who receive follow up care within 30 days after an emergency department visit for alcohol or drug use.	MSHN Strategic Plan FY19-20; MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	28%	100%		>=28%	24%-27%	<=23%
	Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use. (NEW)	MDHHS/PIHP Contracted, Integrated Health Performance Bonus Requirements	1	0		0	1	2
BETTER CARE	Percent of care coordination cases that were closed due to successful coordination.	MSHN Strategic Plan FY19-FY20, MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	100%	100%		>=50%	25%-49%	<25%
BETTER VALUE	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP	MSHN Strategic Plan FY19-FY20, MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	75%	100.0%		>=75%	50%-74%	<50%

MSHN
Mid-State Health Network

Background:

In accordance with the MSHN Board of Directors to review financials, at a minimum quarterly, the Preliminary Statement of Net Position and Statement of Activities for the Period Ending January 31, 2022, have been provided and presented for review and discussion.

Recommended Motion:

The MSHN Board of Directors receives and files the Preliminary Statement of Net Position and Statement of Activities for the Period Ending January 31, 2022, as presented.

Mid-State Health Network
Statement of Activities
As of January 31, 2022

Rows Numbers	A	B	C	D	E (C - D)	F (C / B)	
		Budget Annual	Actual Year-to-Date	Budget Year-to-Date	Budget Difference	Actual % of Budget	
		FY 22 Original Bdgt 33.33%		FY 22 Original Bdgt			
1	Revenue:						
2	Grant and Other Funding	$ 293,800	35,997	97,933	(61,937)	12.25 %	1a
3	Medicaid Use of Carry Forward	$ 51,407,120	50,150,952	17,135,707	33,015,246	97.56%	1b
4	Medicaid Capitation	662,068,169	246,886,554	220,689,390	26,197,164	37.29%	1c
5	Local Contribution	3,140,208	563,194	1,046,736	(483,542)	17.93%	1d
6	Interest Income	80,000	15,574	26,666	(11,092)	19.47%	1e
7	Change in Market Value	0	(12,477)	0	(12,477)	0.00%	
8	Non Capitated Revenue	19,861,516	3,462,297	6,620,506	(3,158,208)	17.43%	1f
9	Total Revenue	736,850,813	301,102,091	245,616,938	55,485,154	40.86 %	
10	Expenses:						
11	PIHP Administration Expense:						
12	Compensation and Benefits	7,838,917	1,831,189	2,612,973	(781,783)	23.36 %	
13	Consulting Services	130,000	31,393	43,333	(11,941)	24.15 %	
14	Contracted Services	110,540	19,727	36,847	(17,119)	17.85 %	
15	Other Contractual Agreements	504,150	120,008	168,050	(48,042)	23.80 %	
16	Board Member Per Diems	18,060	4,060	6,020	(1,960)	22.48 %	
17	Meeting and Conference Expense	172,470	23,364	57,490	(34,126)	13.55 %	
18	Liability Insurance	38,445	26,727	12,815	13,912	69.52 %	
19	Facility Costs	154,369	55,412	51,456	3,956	35.90 %	
20	Supplies	305,405	135,673	101,802	33,871	44.42 %	
21	Depreciation	50,397	16,799	16,799	0	33.33 %	
22	Other Expenses	987,300	410,125	329,100	81,025	41.54 %	
23	Subtotal PIHP Administration Expenses	10,310,053	2,674,477	3,436,685	(762,207)	25.94 %	2a
24	CMHSP and Tax Expense:						
25	CMHSP Participant Agreements	612,873,059	221,049,072	204,291,019	16,758,052	36.07 %	1b,1c
26	SUD Provider Agreements	52,104,959	14,907,631	17,368,320	(2,460,689)	28.61 %	1c,1f
27	Benefits Stabilization	2,351,000	783,666	783,667	0	33.33 %	1b
28	Tax - Local Section 928	3,140,208	563,194	1,046,736	(483,542)	17.93 %	1d
29	Taxes- IPA/HRA	21,556,045	7,108,784	7,185,348	(76,565)	32.98 %	2b
30	Subtotal CMHSP and Tax Expenses	692,025,271	244,412,347	230,675,090	13,737,256	35.32 %	
31	Total Expenses	702,335,324	247,086,824	234,111,775	12,975,049	35.18 %	
32	Excess of Revenues over Expenditures	$ 34,515,489	$ 54,015,267	$ 11,505,163			

Mid-State Health Network
Preliminary Statement of Net Position by Fund
As of January 31, 2022

Row Numbers		Column Identifiers A	B	C	D B + C	
1	**Assets**		**Behavioral Health Operating**	**Medicaid Risk Reserve**	**Total Proprietary Funds**	
2	**Cash and Short-term Investments**					
3	Chase Checking Account		74,224,866	0	74,224,866	1a
4	Chase MM Savings		31,820,893	0	31,820,893	
5	Savings ISF Account		0	40,974,561	40,974,561	1b
6	Savings PA2 Account		8,912,541	0	8,912,541	1c
7	Investment ISF Account		0	4,979,853	4,979,853	1b
8	Total Cash and Short-term Investments		$ 114,958,300	$ 45,954,414	$ 160,912,714	
9	**Accounts Receivable**					
10	Due from MDHHS		11,564,895	0	11,564,895	2a
11	Due from CMHSP Participants		11,578,705	0	11,578,705	2b
12	Due from CMHSP - Non-Service Related		26,765	0	26,765	2c
13	Due from Other Governments		8,706	0	8,706	2d
14	Due from Miscellaneous		208,638	0	208,638	2e
15	Due from Other Funds		0	4,190,000	4,190,000	2f
16	Total Accounts Receivable		23,387,709	4,190,000	27,577,709	
17	**Prepaid Expenses**					
18	Prepaid Expense Rent		4,529	0	4,529	2g
19	Prepaid Expense Other		6,534	0	6,534	2h
20	Total Prepaid Expenses		11,063	0	11,063	
21	**Fixed Assets**					
22	Fixed Assets - Vehicles		251,983		251,983	2i
23	Accumulated Depreciation - Vehicles		(92,394)		(92,394)	
24	Total Fixed Assets		159,589	0	159,589	
25	**Total Assets**		**$ 138,516,661**	**$ 50,144,414**	**$ 188,661,075**	
26	**Liabilities and Net Position**					
27	Liabilities					
28	Accounts Payable		$ 11,558,007	$ 0	$ 11,558,007	1a
29	Current Obligations (Due To Partners)					
30	Due to State		42,761,215	0	42,761,215	3a
31	Other Payable		3,735,023	0	3,735,023	3b
32	Due to State HRA Accrual		4,937,400	0	4,937,400	1a, 3c
33	Due to State-IPA Tax		725,640	0	725,640	3d
34	Due to State Local Obligation		(23,189)	0	(23,189)	3e
35	Due to CMHSP Participants		18,523	0	18,523	3f
36	Due to other funds		4,190,000	0	4,190,000	3g
37	Accrued PR Expense Wages		146,787	0	146,787	3h
38	Accrued Benefits PTO Payable		347,825	0	347,825	3i
39	Accrued Benefits Other		41,959	0	41,959	3j
40	Total Current Obligations (Due To Partners)		56,881,183	0	56,881,183	
41	Deferred Revenue		7,913,070	0	7,913,070	1b 1c 2b 3b
42	Total Liabilities		76,352,260	0	76,352,260	
43	Net Position					
44	Unrestricted		62,164,401	0	62,164,401	3k
45	Restricted for Risk Management		0	50,144,414	50,144,414	1b
46	Total Net Position		62,164,401	50,144,414	112,308,815	
47	**Total Liabilities and Net Position**		**$ 138,516,661**	**$ 50,144,414**	**$ 188,661,075**	

Mid-State Health Network
Notes to Financial Statements
For the Four-Month Period Ended,
January 31, 2022

Please note: The Preliminary Statement of Net Position contains Fiscal Year (FY) 2021 cost settlement figures between the PIHP and Michigan Department of Health Human Services (MDHHS) as well as each Community Mental Health Service Program (CMHSP) Participants. CMHSP Cost settlement figures were extracted from MSHN's Financial Status Report (FSR) submitted to MDHHS in November. CMHSP cost settlement activity is generally finalized in May following the fiscal-year end.

Preliminary Statement of Net Position:

1. Cash and Short-Term Investments
   a) The Cash Chase Checking and Chase Money Market Savings accounts is the cash available for operations. A portion of cash available for operations will be used to cover accounts payable and taxes.
   b) The Savings Internal Service Fund (ISF) and Investment ISF reflect designated accounts to hold the Medicaid ISF funds separate from all other funding per the MDHHS contract.
   c) The Savings PA2 account holds PA2 funds and is also offset by the Deferred Revenue liability account.
2. Accounts Receivable
   a) Approximately 43% of the balance in Due from MDHHS represents amounts owed to MSHN for October 2021 through January 2022 HRA payments. Roughly 46% of the balance is owed to MSHN for the estimated FY 21 Performance Bonus Incentive Pool (PBIP) funds. The remaining amount in this account stems from Block Grant and other various grants funds owed to MSHN.

CMHSP	Cost Settlement	Payments/Offsets	Total
Bay	1,200,988.76	1,020,840.00	180,148.76
CEI	25,012,373.73	21,260,518.00	3,751,855.73
Central	1,201,002.98	1,020,853.00	180,149.98
Gratiot	1,790,653.20	1,522,055.00	268,598.20
Huron	-	-	-
The Right Door	2,399,076.23	2,039,215.00	359,861.23
Lifeways	4,164,207.21	-	4,164,207.21
Montcalm	3,405,738.03	2,895,000.00	510,738.03
Newaygo	2,226,751.37	1,892,739.00	334,012.37
Saginaw	10,304,265.20	8,758,625.00	1,545,640.20
Shiawassee	1,353,714.72	1,150,658.00	203,056.72
Tuscola	536,243.17	455,807.00	80,436.17
Total	**53,595,014.60**	**42,016,310.00**	**11,578,704.60**

   c) Due from CMHSP – "Non-Service Related" account balance is primarily FY 22's Outstanding CMHSP Relias billing with a small portion owed for MSHN's performance of Supports Intensity Scale (SIS) assessment billed to two CMHs in the region.
   d) Due from Other Governments is the account used to track PA2 billing to the twenty-one counties in MSHN's region. The balance reflects FY 21 quarter four outstanding collections due from one county.

e) Approximately 48% of the balance in Due from Miscellaneous represents amounts owed from providers for Medicaid Event Verification (MEV) findings. The remaining amount represents an advance made to a Substance Abuse and Treatment (SAPT) providers to cover operations.
f) Due from other funds is the account used to manage anticipated ISF transfers. MSHN can retain up to 7.5 % of current FY revenue to manage risk. This amount is in addition to the allowable 7.5% for savings generated when Medicaid and Healthy Michigan revenue exceed expenses.
g) Prepaid Expense Rent balance consists of security deposits for three MSHN office suites.
h) The full balance in Prepaid Expense Other represents payments made in FY 21 for FY 22 Relias training. The Relias contract cycle is November through October. MSHN has a regional contract which includes the CMHSPs, and they are billed directly for their portion of Relias seats.
i) Fixed Asset Vehicle contains the total cost for MSHN's Mobile Unit. The Mobile Unit is utilized to provide Substance Use Disorder services and tele-psychiatry as needed. Amounts in this account are being depreciated.

3. Liabilities
a) Due to State account balance contains the outstanding FY 20 lapse amount which is $2.6 M based on the Compliance Examination. The lapse amount indicates we have a fully funded ISF, and that savings will fall within the second tier (above 5%). Per contractual guidelines MDHHS will receive half of every dollar generated beyond this threshold until the PIHP's total savings reach the 7.5% maximum. In addition, MSHN is projecting an FY 21 $21 M lapse to MDHHS based on the guidelines mentioned directly above. Lastly, MSHN estimates a lapse of approximately $18 M to MDHHS for unspent Direct Care Worker (DCW) premium pay funds.
b) This amount is related to SUD provider payment estimates and is needed to offset the timing of payments.
c) The HRA (Hospital Rate Adjustor) is a pass-through account for dollars sent from MDHHS to cover supplemental payments made to psychiatric hospitals. The HRA payments are intended to incentivize hospitals to have available psychiatric beds as needed. Total HRA payments are calculated based on the number of inpatient hospital services reported.
d) Due to State - IPA Tax contains funds held for tax payments associated with MDHHS Per Eligible Per Month (PEPM) funds. Insurance Plan Assessment taxes are applied to Medicaid and Healthy Michigan eligible.
e) Due to State Local Obligation has a negative balance as MSHN submitted advance payment to MDHHS in November for the first quarter, and one CMHSP payment is still due. In addition, two CMHSPs submitted early payments for the second quarter.
f) Due to CMHSP contains a balance for one FY 21 cost settlement.
g) Due to other funds is the liability account associated with 2f above.
h) Accrued payroll expense wages represent expense incurred in January and paid in February.
i) Accrued Benefits PTO (Paid Time Off) payable is the required liability account set up to reflect paid time off balances for employees.
j) Accrued Benefits Other represents retirement benefits expense incurred in January and paid in February.
k) The Unrestricted Net Position represents the difference between total assets, total liabilities, and the restricted for risk management figure.

Statement of Activities – PLEASE NOTE – Based on discussion during the January 2022 Board of Directors Meeting, MSHN changed the percentage calculation (column F) in the report. Column B above row one, now displays the percent of budget relative to the months presented. Since this is a statement for January 2022, the budget calculation amount is 33.33% which is 4 divided by 12 months. Column F now calculates the actual revenue and expenses compared to the full year budget. Revenue accounts whose Column F percent is higher than 33.33% translates to MSHN receiving more revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 33.33% means MSHN's spending is trending higher than expected.

In addition, Medicaid Carryforward could vary pending FY 21 Cost Settlement activity.

1. Revenue
    a) This account tracks SIS revenue earned from CMHSPs, Veterans Navigator activity and other small grants. Actual revenue is lower than expected due to ongoing pandemic concerns.
    b) Medicaid Use of Carry Forward represents FY 21 savings. Medicaid savings is generated when prior year revenue exceeds expenses for the same period. A small portion of Medicaid Savings is sent to the CMHSPs as Benefit Stabilization for 24/7/365 SUD activities which include access, prevention, and customer services. FY 21 Medicaid Carry Forward must be used as the first revenue source for FY 22.
    c) Medicaid Capitation – Actual is trending higher than budget because MSHN is receiving Certified Community Behavioral Health Center (CCBHC) revenue from MDHHS. This revenue category was not included in the budget presented in September as the program was still in development and the information available was not sufficient for financial forecasting. In addition, there is still a moratorium on Medicaid disenrollments. Medicaid Capitation dollars are disbursed to CMHSPs based on per eligible per month (PEPM) payment files and paid to SUD providers based on service delivery.
    d) Local Contribution is flow-through dollars from CMHSPs to MDHHS. Typically, revenue equals the expense side of this activity under Tax Local Section 928. Local Contributions were scheduled to reduce over the next few fiscal years until completely phased out. FY 2022 amounts owed were nearly $800 k less than FY 21.
    e) Interest income is earned from investments and changes in principle for investments purchased at discounts or premiums. The "change in market value" account records activity related to market fluctuations. Actual interest income is less than anticipated due to ongoing low interest rates and fewer investment opportunities to generate this revenue. In addition, the other portion of interest income is amounts earned from the PA2 and General Savings accounts.
    f) This account tracks non-capitated revenue for SUD services which include Community Grant and PA2 funds. The variance may decrease over time however unspent PA2 dollars remain in the deferred revenue account and Block Grant is received based on actual expenses incurred and billed to MDHHS.
2. Expense
    a) Total PIHP Administration Expense is slightly under budget. The line items with the largest dollar amount variances are Compensation and Benefits and Other Expenses. MSHN's compensation line includes budget amounts for vacant positions and as a result, actual salary expense is lower. Other Expenses actual amount is higher than the budget because MiHIN's (technology provider – data exchange) entire FY 22 invoice was paid in October.
    b) IPA/HRA actual tax expenses are slightly lower than the budget amount however the variance is minimal. IPA estimates are impacted by variability in the number of Medicaid

and Healthy Michigan eligibles. HRA figures will vary throughout the fiscal year based on inpatient psychiatric utilization. (Please see Statement of Net Position 3c and 3d).

MID-STATE HEALTH NETWORK
SCHEDULE OF INTERNAL SERVICE FUND INVESTMENTS
As of January 31, 2022

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY
UNITED STATES TREASURY BILL	912796SP5	4.23.19	4.25.19	10.24.19	no	988,182.64	1,000,000.00	2.365%
UNITED STATES TREASURY BILL	912796SP5	4.23.19	4.25.19	10.24.19			(1,000,000.00)	
FEDERAL HOME LOAN MTG CORP	3137EAEF2	5.2.19	5.3.19	4.20.20	no	624,605.01	630,000.00	2.331%
FEDERAL HOME LOAN MTG CORP	3137EAEF2						(630,000.00)	
UNITED STATES TREASURY BILL	912796RN1	6.7.19	6.10.19	12.5.19	no	1,979,752.50	2,000,000.00	2.068%
UNITED STATES TREASURY BILL	912796RN1						(2,000,000.00)	
UNITED STATES TREASURY BILL	912796TF6	8.14.19	8.15.19	2.13.20	no	2,972,607.48	3,000,000.00	1.823%
UNITED STATES TREASURY BILL	912796TF6						(3,000,000.00)	
UNITED STATES TREASURY BILL	912796TK5	9.12.19	9.12.19	3.12.20	no	991,043.07	1,000,000.00	1.788%
UNITED STATES TREASURY BILL	912796TK5						(1,000,000.00)	
FEDERAL FARM CREDIT BANK	3133ELCD4	12.2.19	12.3.19	6.2.21	yes	2,000,092.22	2,000,000.00	1.660%
FEDERAL FARM CREDIT BANK	3133ELCD4						(2,000,000.00)	
UNITED STATES TREASURY BILL	912796UC1	2.12.20	2.13.20	1.28.21	no	2,959,268.75	3,000,000.00	
UNITED STATES TREASURY BILL	912796UC1						(3,000,000.00)	
UNITED STATES TREASURY BILL	912796C56	1.28.21	1.28.21	7.29.21	no	2,999,590.50	3,000,000.00	0.027%
UNITED STATES TREASURY BILL	912796C56	1.28.21	1.28.21	7.29.21			(3,000,000.00)	
UNITED STATES TREASURY BILL	912796k57	8.2.21	8.3.21	7.14.22		2,998,706.25	2,999,375.49	
UNITED STATES TREASURY BILL	91282CDR9	1.19.22	1.20.22	12.1.23		1,992,391.23	1,991,669.44	
JP MORGAN INVESTMENTS							4,991,044.93	
JP MORGAN CHASE SAVINGS							40,447,262.49	0.050%
							$ 45,438,307.42	

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

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

MSHN
Mid-State Health Network

Background

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

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

Therefore, MSHN presents the attached FY22 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 FY22 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2022 CMHSP CONTRACTS - AMENDED
March 2022

CONTRACTING ENTITY	CMHSP SERVICE AREA	CONTRACT TERM	FY2022 CONTRACT AMOUNT - AMENDED	FY 2021 TOTAL CONTRACT AMOUNT	INCREASE/ (DECREASE)	FY 2022 REVENUE PROJECTION - AMENDED	REVENUE OVER/(UNDER) EXPENSE
PIHP/CMHSP MEDICAID SUBCONTRACTS							
Bay-Arenac Behavioral Health	Bay & Arenac	10.1.21 - 9.30.22	**55,528,976**	50,003,906	5,525,070	54,846,219	(682,757)
CEI Community Mental Health Authority	Clinton, Eaton & Ingham	10.1.21 - 9.30.22	**139,226,737**	122,012,470	17,214,267	160,860,082	21,633,345
Community Mental Health of Central Michigan	Clare, Gladwin, Isabella, Mecosta, Midland, Osceola	10.1.21 - 9.30.22	**121,995,223**	102,589,575	19,405,648	117,731,099	(4,264,124)
Community Mental Health Authority Gratiot County	Gratiot	10.1.21 - 9.30.22	**16,221,051**	15,536,613	684,438	18,274,722	2,053,671
Huron County Community Mental Health Authority	Huron	10.1.21 - 9.30.22	**13,042,479**	11,750,414	1,292,065	11,110,361	(1,932,118)
The Right Door for Hope, Recovery & Wellness	Ionia	10.1.21 - 9.30.22	**17,663,940**	17,232,432	431,508	20,400,797	2,736,857
LifeWays Community Mental Health Authority	Jackson & Hillsdale	10.1.21 - 9.30.22	**84,346,452**	75,648,444	8,698,008	85,302,771	956,319
Montcalm Care Network	Montcalm	10.1.21 - 9.30.22	**22,909,335**	20,363,500	2,545,835	24,195,332	1,285,997
Newaygo County Community Mental Health Authority	Newaygo	10.1.21 - 9.30.22	**16,185,650**	15,455,924	729,726	18,018,349	1,832,699
Saginaw County Community Mental Health Authority	Saginaw	10.1.21 - 9.30.22	**84,584,284**	79,715,558	4,868,726	96,819,248	12,234,964
Shiawassee County Community Mental Health Authority	Shiawassee	10.1.21 - 9.30.22	**22,874,164**	20,593,151	2,281,013	24,703,206	1,829,042
Community Mental Health Authority Tuscola County	Tuscola	10.1.21 - 9.30.22	**23,331,308**	21,176,969	2,154,339	23,331,308	(0)
			617,909,599	552,078,956	65,830,643	655,593,493	37,683,893

MID-STATE HEALTH NETWORK

FISCAL YEAR 2022 NEW AND RENEWING CONTRACTS

March 2022

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	ORIGINAL FY22 CONTRACT AMOUNT	FY22 TOTAL CONTRACT AMOUNT	FY22 INCREASE/ (DECREASE)
PIHP ADMINISTRATIVE FUNCTION CONTRACTS					
MacDonald Garber Broadcasting	Web-based media campaign using My Life My Quit texting quit line for youth ads/images utilizing targeted display and geofencing strategies. (COVID-BG)	3.1.22 - 3.1.23	-	**325,000**	**325,000**
			$ -	**$ 325,000**	**$ 325,000**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT SOR PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL SOR COST REIMBURSEMENT CONTRACT AMOUNT	TOTAL SOR COST REIMBURSEMENT CONTRACT AMOUNT	SOR INCREASE/ (DECREASE)
CONTRACTS LISTED IN THIS SECTION ARE ALL SOR GRANT FUNDED PROGRAMS					
Samaritas	Grant funds to support requirement of GPRA assessment with individuals in services. (Eaton)	2.1.22 - 9.30.22	-	**18,000**	**18,000**
			$ -	**$ 18,000**	**$ 18,000**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL FY22 COST REIMBURSEMENT CONTRACT AMOUNT	FY22 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY22 INCREASE/ (DECREASE)
Boys & Girls Club of Great Lakes Bay Region	Botvin's Life Skills Programming (COVID-BG)	3.1.22 - 9.30.22	114,823	**158,630**	**43,807**
			$ 114,823	**$ 158,630**	**$ 43,807**

Mid-State Health Network (MSHN) Board of Directors Meeting

Tuesday, January 11, 2022

Best Western Okemos/East Lansing

Meeting Minutes

1. Call to Order

Chairperson Ed Woods called this meeting of the Mid-State Health Network Board of Directors to order at 5:07 p.m. Mr. Ed Woods welcomed Board members and expressed his wishes that everyone had a good holiday season. Mr. Ed Woods reminded Board members of the Open Meetings Act change stating members participating on the phone are excluded from both roll call voting or motion voting.

2. Roll Call

Secretary Kurt Peasley provided the roll call for Board Members in attendance.

Board Member(s) Present: Joe Brehler (CEI), Mike Cierzniewski (Saginaw), Craig Colton (Huron), David Griesing (Tuscola), Dan Grimshaw (Tuscola), Tina Hicks (Gratiot), Dianne Holman (CEI), John Johansen (Montcalm), Steve Johnson (Newaygo), Jeanne Ladd (Shiawassee), Pat McFarland (Bay-Arenac), Deb McPeek-McFadden (Ionia), Kurt Peasley (Montcalm), Joe Phillips (CMH for Central Michigan), Tracey Raquepaw (Saginaw), Ed Woods (Lifeways)

Board Member(s) Remote: Jim Anderson (Bay-Arenac), Ken DeLaat (Newaygo), Rhonda Matelski (Huron), Irene O'Boyle (Gratiot), Kerin Scanlon (CMH for Central Michigan)

Board Member(s) Absent: Brad Bohner (LifeWays), Bruce Cadwallender (Shiawassee), Gretchen Nyland (Ionia)

Staff Members Present: Joseph Sedlock (Chief Executive Officer), Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Sherry Kletke (Executive Assistant, remote); Steve Grulke (Chief Information Officer)

3. Approval of Agenda for January 11, 2022

Board approval was requested for the Agenda of the January 11, 2022, Regular Business Meeting.

ON A MOTION PROPERLY MADE AND SUPPORTED, CHAIRPERSON ED WOODS CALLED FOR APPROVAL OF THE AGENDA OF THE JANUARY 11, 2022, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 16-0.

4. Public Comment

There was no public comment.

5. CMHAM Special Assessment

Mr. Joseph Sedlock presented the proposal of the MSHN Executive Committee and request from Community Mental Health Association of Michigan (CMHAM) that MSHN (and all other CMHSPs and PIHPs) make a voluntary payment to CMHAM early in FY2022. The funds received through this special assessment will be used to strengthen public education, advocacy and related to system redesign and public behavioral health system value to communities. This strengthened advocacy capacity is needed now to match the level of threats and opportunities faced by the state's CMHSPs and PIHPs and those whom we serve.

MOTION BY JOE BREHLER, SUPPORTED BY TRACEY RAQUEPAW, FOR A ROLL CALL VOTE TO DIRECT THE MSHN CHIEF EXECUTIVE OFFICER TO PAY A SPECIAL ASSESSMENT OF DUES FOR THE 2022 FISCAL YEAR IN THE SUM OF $20,000 (TWENTY THOUSAND DOLLARS) TO THE COMMUNITY MENTAL HEALTH ASSOCIATION OF MICHIGAN TO ENHANCE THE ASSOCIATION'S PUBLIC EDUCATION AND ADVOCACY ACTIVITIES. VOTING IN FAVOR: JOE BREHLER, MIKE CIERZNIEWSKI, CRAIG COLTON, DAVID GRIESING, TINA HICKS, DIANNE HOLMAN, JOHN JOHANSEN, JEANNE LADD, KURT PEASLEY, JOE PHILLIPS, TRACEY RAQUEPAW, ED WOODS. VOTING IN OPPOSITION: DAN GRIMSHAW, STEVE JOHNSON, DEB McPEEK-McFADDEN, PAT McFARLAND. MOTION CARRIED: 12-4.

6. Chief Executive Officers Report

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

- PIHP/Regional Matters
  - COVID-19 MSHN Internal Operations Status
  - Region (and Statewide) Workforce Issues Continue, and MSHN development of a potential regional approach to supporting providers in addressing the crisis
  - FY2022 Budget Amendment Update – Delay until March 2022
  - MSHN Legislation Tracking Improvements
- State of Michigan/Statewide Activities
  - Michigan Psychiatric Care Improvement Project

- Michigan Health Integration Updates

- Federal/National Activities
  - Surgeon General's Youth Mental Health Advisory

7. Deputy Directors Report

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

- MSHN Staffing Update
- Crisis Residential Development
- Performance Bonus Incentive Report FY21
- Population Health and Integrated Care Update

8. Chief Financial Officers Report

Ms. Leslie Thomas provided an overview of the financial reports included within board meeting packets for the period ended November 30, 2021.

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY JOHN JOHANSEN, TO RECEIVE AND FILE THE PRELIMINARY STATEMENT OF NET POSITION AND PRELIMINARY STATEMENT OF ACTIVITIES FOR THE PERIOD ENDING NOVEMBER 30, 2021, AS PRESENTED. MOTION CARRIED: 16-0.

Ms. Leslie Thomas presented an overview of the FY2021 Block Grant Utilization and Spending. MSHN initiatives to align block grant funded activities with reduced revenues have been successful. The Block Grant updates will no longer be presented.

9. Contracts for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2022 contract listing provided in the meeting packet and requested the board authorize MSHN's CEO to sign and fully execute the contracts listed on the FY2022 contract listing.

MOTION BY DAVID GRIESING, SUPPORTED BY TRACEY RAQUEPAW, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY22 CONTRACT LISTING. MOTION CARRIED: 16-0.

10. Executive Committee Report

Ms. Irene O'Boyle informed the Board members that the FY2021 Board Self-Evaluation will be emailed to members on Wednesday, January 12th, 2022 through Survey Monkey. The evaluation will be open through the end of the day on Tuesday, January 25th, 2022. The Board Self-Evaluation is conducted annually. Ms. O'Boyle encouraged all Board members to participate by completing the evaluation in the timeframe offered.

11. Chairpersons Report

The National Council for Mental Well-Being annual conference is scheduled for April 11-13, 2022 in Washington, D.C. MSHN will sponsor up to 2 Board members to attend. The NATCON22 conference is currently scheduled to be held in-person. Any interested Board member should get in touch with Mr. Joseph Sedlock.

AD-HOC ITEM: MARCH BOARD MEETING VENUE. Concern was raised that the currently slated March Board Meeting venue location may not allow for Board members to feel comfortable in terms of social distancing. The March meeting is slated to be held at the same location as tonight's meeting, that being the Best Western Okemos/East Lansing Stadium Room. The larger space option for March would have some logistical issues to address, such as the audio equipment. Mr. Ed Woods asked the Board to vote on continuing to meet in the current reserved space at the Best Western or switch to the larger space located across the street.

MOTION BY JOHN JOHANSEN, SUPPORTED BY PAT McFARLAND TO STAY IN THE CURRENT RESERVED LOCATION AT THE BEST WESTERN OKEMOS/EAST LANSING STADIUM ROOM WHERE TONIGHT'S MEETING IS BEING HELD. MOTION CARRIED: 16-0.

12. Approval of Consent Agenda

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

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY TINA HICKS, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE NOVEMBER 2, 2021 BOARD OF DIRECTORS MEETING; RECEIVE SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD MINUTES OF JUNE 16, 2021 AND OCTOBER 20, 2021; RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF DECEMBER 17, 2021; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF NOVEMBER 15, 2021 AND DECEMBER 20, 2021. MOTION CARRIED: 16-0.

13. Other Business

Mr. Ed Woods expressed appreciation to Ms. Jeanne Ladd for attending tonight's meeting following her recent procedures.

14. Public Comment

There was no public comment.

15. CEO Performance Evaluation Results

Mr. Joseph Sedlock requested this matter be discussed in closed session.

MOTION BY TINA HICKS, SUPPORTED BY DAN GRIMSHAW, TO ENTER INTO CLOSED SESSION TO ADDRESS THE CEO PERFORMANCE EVALUATION RESULTS. VOTING IN FAVOR: JOE BREHLER, MIKE CIERZNIEWSKI, CRAIG COLTON, DAVID GRIESING, DAN GRIMSHAW, TINA HICKS, DIANNE HOLMAN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, DEB McPEEK-McFADDEN, PAT McFARLAND, KURT PEASLEY, JOE PHILLIPS, TRACEY RAQUEPAW, ED WOODS. VOTING IN OPPOSITION: NONE. MOTION PASSED: 16-0.

MOTION BY PAT McFARLAND, SUPPORTED BY KURT PEASLEY, TO ADJOURN THE CLOSED SESSION AND RECONVENE THE BOARD OF DIRECTORS REGULAR BUSINESS MEETING. MOTION CARRIED: 16-0

MOTION BY TRACEY RAQUEPAW, SUPPORTED BY DEB McPEEK-McFADDEN, TO RECEIVE AND FILE THE 2021 MSHN CHIEF EXECUTIVE OFFICER PERFORMANCE EVALUATION RESULTS. MOTION CARRIED: 16-0

16. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 6:35 p.m.

MSHN
Mid-State Health Network

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

Friday, February 18, 2022 - 9:00 a.m.

ZOOM VIDEO CONFERENCE

Committee Members Present:	Ed Woods, Chairperson; Irene O'Boyle, Vice-Chairperson; Kurt Peasley, Secretary; David Griesing, At Large; Pat McFarland, At Large
Staff Present:	Joseph Sedlock, Chief Executive Officer; Amanda Ittner, Deputy Director
Others Present:	None

1. **Call to order:** Chairperson Woods called this meeting of the Mid-State Health Network Board Executive Committee to order at 9:00 a.m.

2. **Approval of Agenda**: Motion by K. Peasley supported by D. Griesing to approve the agenda for the 02/18/2022 Executive Committee meeting. Motion carried.

3. **Guest Board Member Comments:** None.

4. **Board Matters:**
   - 4.1 **March 2022 Draft Board Meeting Agenda:** The draft March 1, 2022 board meeting agenda was reviewed by the committee. There were no adjustments to the draft agenda. The Committee noted that the agenda presented is draft until finalized by administration.
   - 4.2 **Board Self-Assessment:** Vice-Chairperson O'Boyle reviewed the 2021 Board Self-Assessment, noting areas where there were improvements and areas for continued focus for improvement as well as board member comments. Ms. O'Boyle will review the results with the full board and the document with historical rankings will be included in the March 1, 2022 Board Meeting Packet.
   - 4.3 **Accommodations for Individuals with disabilities:** Mr. Sedlock noted a recent Michigan Attorney General Opinion indicating that persons with disabilities must be provided with reasonable accommodations in order to fulfill their roles as members of public body boards.
   - 4.4 **Board Member Information Form** (Survey Monkey): Mr. Sedlock informed the Committee that MSHN Administration will be distributing via survey monkey a very brief request for background information on board members. MSHN is undertaking this effort to better catalog the background of board members so that we can better consult with members that have specific experience or expertise when needed.
   - 4.5 **Locations for May, July and September board meetings:** Mr. Sedlock reported that due to ongoing COVID pandemic concerns, locations for future board meetings in the current year must be large enough to allow for social distancing. There are no CMHSP locations that can accommodate the group. Mr. Sedlock recommended continuing board meetings at the current location at a hotel in Okemos. The Executive Committee concurred.
   - 4.6 **Other:** none

5. **Administration Matters**
   - 5.1 **Annual Litigation Report Review:** Ms. Ittner reviewed the annual litigation report with the Committee noting that while there are several suits involving CMHSPs in the region, MSHN is not a named party in any known litigation. The report is confidential and is available for viewing only by any MSHN board member.

5.2 **MSHN Provider Staffing Crisis Stabilization Proposal:** Mr. Sedlock reviewed the MSHN proposal to provide up $10M (reserve $13M) in FY 22 funding to regional contracted providers located in the MSHN region to assist with staffing crisis stabilization. Full board action will be required to designate funds for this purpose. Mr. Sedlock noted that this proposal is fully supported by the region's CMHSPs. MSHN, along with the Operations Council, has been working out the details, some of which were reviewed with the Committee. Mr. Sedlock answered questions of board members about the proposal. Assuming board approval, MSHN will post regional guidance on the MSHN public-facing website.

5.3 **Office Security Update:** Mr. Sedlock reported to the committee via email when this occurred and reports during this meeting that on January 25, Sherry Kletke, our Executive Assistant, arrived for work at our offices and found that some areas of the office had been damaged due to someone seeking something. There was minor damage to some locked drawers and our confidential shred bin. There was no damage to entry doors of the building or the suites we occupy, and the MSHN offices were not ransacked. It appears the perpetrator knew where to look for items. Stolen items include the master key box, a small portable (empty) document safe, a polycom wireless conference phone unit, a disabled laptop computer, and a large flat screen TV display (from our conference room). Mr. Sedlock noted that the landlord assisted with changing all exterior door locks and all interior suite locks. A police report has been filed, including notification of the IP address from which the stolen laptop was activated on Sunday, 01/23. No protected information is stored on laptops, so there has been no breach into our systems. There has been no update from the police as of this date.

5.4 **Other:** None

6. Other

6.1 **Any other business to come before the Executive Committee:** None

6.2 **Next scheduled Executive Committee Meeting:** 03/18/2022

7. Guest Board Member Comments: None

8. Adjourn: This meeting was adjourned at 9:38 a.m.

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, FEBRUARY 1, 2022 (VIDEO CONFERENCE)

***Members Present**:* Irene O'Boyle, Kurt Peasley, Jim Anderson, Jeanne Ladd, John Johansen

Staff Present: Amanda Ittner (Deputy Director); Sherry Kletke (Executive Assistant)

1. CALL TO ORDER

Mr. John Johansen called the Board Policy Committee meeting to order at 10:00 a.m.

2. APPROVAL OF THE AGENDA

MOTION by Kurt Peasley, supported by Jim Anderson, to approve the February 1, 2022, Board Policy Committee Meeting Agenda, as presented. Motion Carried: 5-0.

3. **POLICIES UNDER DISCUSSION**:

No policies were presented for further discussion.

4. NEW POLICIES

Mr. John Johansen invited Ms. Amanda Ittner to inform members on the new policies being presented. Ms. Ittner provided an overview of the new policies under the Service Delivery chapter. The Service Delivery chapter new policies were developed by the MSHN Clinical Leadership and Utilization Management Committee and were reviewed by the Operations Council in response to a suggestion from an external quality review through the Health Services Advisory Group (HSAG).

CHAPTER: SERVICE DELIVERY

1. CONFLICT FREE CASE MANAGEMENT
2. EMERGENCY AND POST-STABILIZATION SERVICES

MOTION by Jim Anderson, supported by Kurt Peasley, to approve and adopt the new policies as presented. Motion carried: 5-0.

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

5. POLICIES UNDER BIENNIAL REVIEW

Mr. John Johansen invited Ms. Amanda Ittner to inform members on the revisions made to the policies being presented under biennial review. Ms. Ittner provided an overview of the substantive changes within the policies. The Provider Network chapter has been reviewed by the Provider Network Management Committee and the Operations Council.

CHAPTER: PROVIDER NETWORK

1. CREDENTIALING/RE-CREDENTIALING
2. DISCLOSURE OF OWNERSHIP
3. FISCAL YEAR CONTRACT MONITORING
4. PROVIDER DIRECTORY
5. PROVIDER NETWORK
6. PROVIDER NETWORK RECIPROCITY
7. SUBSTANCE USE DISORDER DIRECT SERVICE PROVIDER PROCUREMENT

MOTION by Jeanne Ladd, supported by Jim Anderson, to approve and recommend the policies under biennial review as presented. Motion carried: 5-0.

6. REQUIRED CHANGE POLICY

Mr. John Johansen invited Ms. Amanda Ittner to inform members of the required change policy being presented. Ms. Ittner provided an overview of the substantive changes within the policy to add other members appointed to MSHN committees in addition to Board members to receive compensation. The Chief Financial Officer and the Operations Council have reviewed the required change policy.

CHAPTER: FINANCE

1. APPOINTED MEMBER COMPENSATION

Policy committee members commented their full support in agreement that compensation is a wonderful way to increase consumer involvement and feedback.

MOTION by Irene O'Boyle, supported by Jeanne Ladd, to approve and recommend the required change policy as presented. Motion carried: 5-0.

7. NEW BUSINESS

There was no new business.

8. ADJOURN

Mr. John Johansen adjourned the Board Policy Committee Meeting at 10:13 a.m.

Meeting Minutes respectfully submitted by:
MSHN Executive Assistant

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MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: January 24th, 2022

Members Present: Chris Pinter; Lindsey Hull; Maribeth Leonard; Carol Mills; Sharon Beals; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; John Obermesik; Sandy Lindsey; Sara Lurie

Members Absent:

MSHN Staff Present: Joseph Sedlock; Amanda Ittner; Leslie Thomas

Agenda Item	Action Required				
CONSENT AGENDA	No items for discussion.				
	Approved consent agenda items	By Who	N/A	By When	N/A
MSHN PROVIDER STAFFING CRISIS STABILIZATION SUPPORT PROPOSAL	J. Sedlock reviewed the proposal that includes a regional fund/set aside of $10m with $3m contingency. Two options were presented for rollout; MSHN Managed and CMH Managed. CMHSPs have the availability to conduct and distribute funds within their PEPM. The proposal includes a regional standardization for support of the network. The end of date of which, would be 9.30.22. Other items for consideration: inclusion of payment amount to send to provider; provider application standardization; consideration for provider type; Option 2 agreed upon; revisit eligibility criteria; simple provider application; require incentives tied to length of service, ask provider how much; provider report and track; include reporting on expenditures; differentiating from provider stabilization funds (utilization impacts due to COVID). Excluding CMH direct operations from this. MSHN Board action will be required (March 2022)				
	Ops supported option 2 with CMHSP managed; Sedlock to rewrite proposal based on the agreed upon discussion and will send out for review with a 30min call (to be scheduled) to discuss and finalize.	By Who	J. Sedlock	By When	2.8.22
REGIONAL COVID RELATED UPDATES/PLANNING (IF ANY)	Ordered 50,000 KN95 mask for the region from the State Emergency Operations Center; estimated delivery to Shiawassee 1.25.22 for distribution to the CMHs proportionately to size. Still one time use masks. Expect communication from John at Shiawassee for expected delivery. As soon as Joe has full case counts, he will share the expected amounts. If N95 become available, Joe will try to get those as well.				

Agenda Item	Action Required					
	Discussed remote and onsite operations. Pulled back on large group meetings; based on consumer request regarding telehealth; some CMHs to more remote work; COVID Vaccine Mandate Discussion: LifeWays must comply based on their legal review of the CLIA Waivers Application of CMS mandate: ER's, OBRA, FQHCs					
	Informational	By Who	N/A	By When	N/A	
SYSTEM REDESIGN-ONGOING DIALOG/DISCUSSION/REGIONAL STRATEGIES (IF ANY)	CMHAM indicates nothing new Local updates provided regarding strategies and inclusion of PIHP language by CMHAM					
	Discussion Only	By Who	N/A	By When	N/A	
1003 SUD PROVIDER CAPACITY ACCESS ASSESSMENT	J. Sedlock gave a brief overview of the 1003 Project to increase SUD Provider Capacity/Access. UofM as part of their MDHHS contract will be conducting focus groups. CMHSPs will be asked to have someone participate as part of their role in SUD Access. More information to come. MSHN has requested the questions in advance.					
	Informational	By Who	N/A	By When	N/A	

MID-STATE HEALTH NETWORK
POLICIES MANUAL

Chapter:	Service Delivery System		
Title:	Conflict Free Case Management		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Clinical Leadership and Utilization Management Committee	Adopted Date: Review Date:	Related Policies: Utilization Management Access Person-Centered Planning

Purpose

The Centers for Medicare and Medicaid Services (CMS) Home and Community Based Settings Regulations (known commonly as the HCBS Final Rule) requires that assessment and coordination of services are separate from the delivery of services with the goal of limiting any conscious or unconscious bias that a case manager may have and safeguarding against financial conflicts of interest. The intent is that a single agency is not both assessing what services an individual needs and then providing those services to them as required in conflict-free case management policies in states using Medicaid funds from the Balancing Incentive Program, Community First Choice (1915 k), and 1915(i).

The purpose of this policy is to ensure that Mid-State Health Network (MSHN) and its Community Mental Health Service Program (CMHSP) participants have a consistent definition and operational guidance for the provision of services and supports that are free from conflicts of interest, also referred to as conflict-free case management (CFCM).

Policy

1. MSHN and its CMHSP participants follow established conflict of interest standards for the assessment of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private. At a minimum, the individuals or entities conducting the assessment of functional need and person-centered service plan development process are not:
   a. Related by blood or marriage to the member, or to any paid caregiver of the member.
   b. Financially responsible for the member.
   c. Empowered to make financial or health-related decisions on behalf of the member.
   d. Individuals who would benefit financially from the provision of assessed needs and services.
   e. Providers of HCBS for the member, or those who have an interest in or are employed by a provider of HCBS for the member must not provide case management or develop the person-centered service plan, except when MDHHS demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, MDHHS must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Members must be provided with a clear and accessible alternative dispute resolution process.

2. Administrative and/or structural firewalls should exist between functions, whenever possible:
   a. Assessment & Eligibility/Resource Allocation: This includes the processes for determining eligibility and assigning budgets, hours, or other units of services.
   b. Plan Development: These are the processes that lead to a person-centered plan.
   c. Monitoring & Service Coordination: These are the processes for ensuring that services are delivered according to guidance included in the plan. Activities include coordinating services, monitoring the quality of the services, and monitoring the individual (e.g., watching for changes in needs or preferences).
   d. Direct Supports & Service Delivery: The supports and/or services provided to the individual in accordance with the person-centered plan.
   e. Utilization Management: Utilization management activities are a separate and discrete managed-care function that sit outside of the other processes of assessment/eligibility, plan development, plan

monitoring, and service delivery. Utilization management activities ensure that medical-necessity criteria are met for all services and supports.

3. The CMHSP participants that comprise the MSHN PIHP region are diverse in size, geographic location, rural/urban settings, and resource availability. In instances where complete separation of functions may not be possible CMHSP participants will employ safeguard strategies and robust oversight to limit potential conflicts of interest. Safeguard strategies may include, but are not limited to:
    a. Required training on the principles of conflict-free case management for all case managers and supports coordinators
    b. Use of consumer advocates and independent facilitators in the person-centered planning process
    c. Ensure that all consumers are offered choices of providers at regular intervals (annually, at minimum) and their preference is documented in the plan of service
    d. Random or targeted case reviews should be utilized to determine whether assessment/eligibility determination findings match actual service needs

Applies to

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

Definitions/Acronyms:

CMHSP: Community Mental Health Service Programs
Case Management: Refers to an activity that assists individuals to gain access to needed medical, social, educational, and other services as appropriate to the needs of the individual.
Consumerism: Means active promotion of the interests, service needs, and rights of consumers receiving mental health and/or substance use disorder services.
Customers/Consumers/Members: Refers to those individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.
HCBS: Home and Community Based Services
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan

References/Legal Authority

1. MDHHS Person Centered Planning Policy and Practice Guideline
2. 42 CFR 441.301(c)(1)(vi)
3. 42 CFR 441.555(c)(1-5)
4. 42 CFR 441.730(b)(1-5)
5. The Balancing Incentive Program (BIP) provisions in the Affordable Care Act
6. Final Rule CMS 2249F Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community- Based Services (HCBS) Waivers

Change Log:

Date of Change	Description of Change	Responsible Party
01-2022	New policy	Director of Integrated Care and Utilization Management

MID-STATE HEALTH NETWORK
POLICIES MANUAL

Chapter:	**Service Delivery System**		
Title:	**Emergency & Post-Stabilization Services**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 4	**Review Cycle:** Biennial **Author:** Clinical Leadership and Utilization Management Committee	**Adopted Date:** **Review Date:**	**Related Policies:** Inpatient Psychiatric Hospitalization Standards

Purpose

Federal and State legal authorities require Medicaid managed care entities, including Prepaid Inpatient Health Plans (PIHP), to provide coverage and payment for emergency services and post-stabilization care services. The definition and descriptions of emergency medical conditions, emergency services, and care services focus heavily on physical health and serious bodily impairment. However, the same coverage provisions and requirements for emergency services and post-stabilization care services are still applicable to the PIHP for the scope of services which it is responsible to provide to Medicaid and Healthy Michigan Plan beneficiaries. The purpose of this policy is to provide clarity and definition to the scope of behavioral health and substance use disorder (SUD) emergency services and post-stabilization care services covered by Mid-State Health Network (MSHN) and furnished through its Community Mental Health Service Program (CMHSP) Participants.

Policy

Emergency Medical Condition/Emergency Situation

The definition of emergency medical condition found in 42 CFR 438.114(a) is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

For the purpose of this policy in the context of behavioral health emergencies, MSHN and its CMHSP Participants use the definition of emergency situation found in Section 300.1100(a)(25) of the Michigan Mental Health Code to be synonymous with the Federal definition of emergency medical condition. An emergency situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a minor is experiencing a serious emotional disturbance, and 1 of the following applies:

a. The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally.
b. The individual is unable to provide himself or herself food, clothing, or shelter or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
c. The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

MSHN does not limit what constitutes an emergency situation on the basis of specific diagnoses or symptoms. To assure understanding of the problem from the point of view of the person who is seeking help, methods for determining emergent situations must incorporate consumer or family-defined crisis situations.

Emergency Services

Emergency services are covered inpatient and outpatient services that are as follows:

a. Furnished by a provider that is qualified to furnish these services
b. Needed to evaluate or stabilize an emergency medical condition/emergency situation

MSHN, via delegation to its CMHSP Participants, provides the following types of emergency services described in the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter:

- Crisis Intervention - Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy. Crisis intervention may occur in a variety of settings, including but not limited to the CMHSP offices, hospital emergency department, beneficiary home, schools, jails, and other community settings.
- Inpatient Psychiatric Hospital Pre-Admission Screening - Pre-admission screening to determine if an individual requires psychiatric inpatient hospitalization or whether alternative services are appropriate and available to treat the individual's needs. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Inpatient pre-screening services must be available 24-hours-a-day/7-days-a-week. Pre-admission screenings most often occur in hospital emergency departments although they can take place in other settings such as CMHSP offices, jails, or other community settings.
- Intensive Crisis Stabilization Services - Intensive crisis stabilization services (ICSS) are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated. ICSS may be provided where necessary to alleviate the crisis situation, and to permit the beneficiary to remain in, or return more quickly to, his usual community environment. ICSS can also be used for post-stabilization care once the immediate crisis situation has been addressed. Most ICSS are delivered by a mobile crisis team and typically occur at the beneficiary's home or other community settings where the beneficiary is located.

Coverage and Payment: Emergency Services

The Michigan Mental Health Code 330.1206 (1) (a) requires that all Community Mental Health Service Programs must provide 24/7 crisis emergency service and stabilization for persons experiencing acute emotional, social, or behavioral dysfunctions. These services are funded through the per eligible per month (PEPM) subcapitation payment the CMHSP receives from the PIHP. There is never a cost to the beneficiary for emergency services provided by the PIHP and its CMHSP Participants. No prior authorization is needed.

When necessary, a beneficiary may seek services through the hospital emergency room. Disposition of the psychiatric emergency will be the responsibility of the PIHP (via delegation to its CMHSP Participants). The PIHP is involved in resolving the psychiatric aspect of the emergency situation. Any medical treatment including medical clearance screening, stabilization and emergency physician services needed by the beneficiary while in the emergency room is beyond the contractual requirements of the PIHP (Michigan Medicaid Provider Manual Hospital Chapter, Section 3.14.D Psychiatric Screening and Stabilization Services).

MSHN and its CMHSP Partners adhere to the MDHHS County of Financial Responsibility (COFR) Technical Requirements when a beneficiary requires emergency services from a different PIHP or CMHSP provider outside of the MSHN PIHP region.

Post-stabilization Care Services

Post-stabilization care services means covered services, related to an emergency medical condition/emergency situation that are provided after an individual is stabilized to maintain the stabilized

condition or to improve or resolve the individual's condition. MSHN, via delegation to its CMHSP Participants, provides the following types of post-stabilization care services as described in the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter:

- Inpatient Psychiatric Hospital Admission- Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness/Intensity of Service criteria for admission are based upon the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.
- Crisis Residential – Services are designed for individuals who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/Family Driven, Youth-Guided, and recovery/resiliency-oriented approach. Services must be designed to resolve the immediate crisis and improve the functioning level of the individual to allow them to return to less intensive community living as soon as possible.
- Outpatient Partial Hospitalization – Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the individual does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the individual's present treatment needs. The Severity of Illness/Intensity of Service criteria for admission assume that the individual is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Coverage and Payment: Post-stabilization Care Services

The Michigan Medicaid Provider Manual requires prior authorization for post-stabilization psychiatric services from the PIHP or CMHSP for all Medicaid beneficiaries who reside within the service area covered by the PIHP. The following sections of the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter contain specific prior authorization requirements and provider qualifications for each type of post-stabilization care service:

Section 6.3 - Crisis Residential
Sections 8.1 and 8.2 - Inpatient Psychiatric Hospital Admissions
Section 9.1.A - Intensive Crisis Stabilization Services
Section 10 - Outpatient Partial Hospitalization Services

The MSHN Finance Claims Procedure includes provision for reimbursement of claims for emergency and post-stabilization services provided to beneficiaries of the MSHN region if the provider is not contracted with the PIHP/CMHSP and/or if prior authorization was not obtained but it can be determined that, but for the urgency of the need, the service would have been pre-authorized by MSHN or the CMHSP.

Applies to

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

Definitions/Acronyms:

CMHSP: Community Mental Health Service Programs
Consumers/Beneficiaries: Refers to those individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan

References/Legal Authority

1. Medicaid Managed Specialty Supports and Services MDHHS/PIHP Contract
2. 42 CFR 438.114(a-f)
3. Michigan Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter

Change Log:

Date of Change	Description of Change	Responsible Party
01-2022	New policy	Director of Integrated Care and Utilization Management

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Provider Network Management		
Title:	Provider Network Credentialing/Recredentialing		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 4	**Review Cycle:** Biennial~~Annually~~ **Author:** Provider Network Mgmt. Committee, Chief Executive Officer	**Adopted Date: 04.07.2015** **Review Date:** 11.2021~~03.03.2020~~	**Related Policies:** Provider Network Management Service Provider Reciprocity Personnel Manual

Purpose

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

Policy

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

The policy, and related procedures, applies to Community Mental Health Service Participants (CMHSPs) and their network of providers and Substance Use Disorder Service Providers (SUDSPs) contracted directly with MSHN.

Licensed Independent Practitioners

All credentialing/recredentialing practices shall be conducted in accordance with the MDHHS Credentialing and Recredentialing Process ~~(attachment P.7.1.1)~~ and MSHN *Credentialing Licensed Independent Practitioners procedure*, and at a minimum, require:

- Initial credentialing upon hire or contracting,
- Re-credentialing at least every two years, and
- A process for ongoing monitoring and primary source verification of expired licenses, certifications, and other credentials.

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

Credentialing and recredentialing processes must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state.

Organizational Providers

For organizational providers included in its network, and in accordance with the *Credentialing Organizational Providers procedure*, MSHN and CMHSPs must:

- validate, and re-validate at least every two years, that the organizational provider is licensed or certified as necessary to operate in the State, and has not been excluded from Medicaid or Medicare participation.
- ensure that the contract with any organizational provider requires the organizational provider to credential and re-credential their directly employed and subcontract direct service providers in accordance with the MSHN credentialing/re-credentialing policies and procedures (which must conform to MDHHS's credentialing process).

Monitoring and Oversight of Credentialing and Recredentialing Activities

MSHN provider network credentialing and recredentialing process is delegated ~~to the~~to the CMHSP Participants and Substance Use Disorder Service Providers (SUDSP) under contract with MSHN. Delegation includes compliance with the credentialing and recredentialing policies and procedures, conducting specific credentialing and recredentialing activities for applicable health care providers, and establishing and maintaining credentialing records.

All CMHSPs and SUDSPs under contract with MSHN providing Medicaid, Healthy Michigan, and Substance Use Disorder Community Grant Services shall have policies and procedures for credentialing and recredentialing that are updated as needed (not less than biennially), to meet MDHHS credentialing guidelines, MSHN policy, and any other pertinent regulatory requirements.

The CMHSPs and SUDSPs shall identify a designee with responsibility for the administration and oversight of credentialing and recredentialing activities. The designee shall assure that credentialing and recredentialing decisions are made by the agency's medical director, qualified practitioner, or credentialing committee. The designee shall maintain credentialing and recredentialing source documents of organizational providers and/or licensed independent practitioners who are employed or contracted to provide health care services. Credentialing and recredentialing records are subject to MSHN, state, and Federal audit.

MSHN is responsible for the oversight of any delegated credentialing or recredentialing decisions within its service delivery network and shall review these practices in accordance with the MSHN delegated functions monitoring and oversight policy, procedure, and protocols. Compliance shall be assessed based on MSHN policies and standards in effect at the time of the credentialing or recredentialing decision.

MSHN retains the right to approve the credentialing decisions of a CMHSP or SUDSP or require discontinuation of service by organization providers and/or licensed independent practitioners without the proper credentialing status. Improper or insufficient credentialing practices by CMHSP or SUDSP may be cause for contractual sanction(s) by MSHN, requiring a corrective action plan, and could be cause for contract suspension or termination. In accordance with the Medicaid Event Verification Policy and Procedure, MSHN may recoup funds for any fee-for-service provider for any claims/encounters that are found to be invalid as a result of improper credentialing.

Administration of credentialing/recredentialing activities and oversight is the responsibility of the MSHN Director of Provider Network Management Systems, under the direction of the Provider Credentialing Committee (PCC). The PCC charter details the membership and roles/responsibilities for credentialing activities.

Deemed Status

Organizational Providers or Licensed Independent Practitioners may deliver healthcare services to more than one agency. MSHN, CMHSPs, or SUDSPs may recognize and accept credentialing activities conducted by any other agency in lieu of completing their own credentialing activities. In those instances where a MSHN, CMHSPs, or SUDSPs choose to accept the credentialing decision of another agency, they must maintain copies of the credentialing documents including Primary Source Verification (PSV) and the credentialing decision in their administrative records.

Notification Requirements and Appeal of Adverse Credentialing Decision:
Organizational Providers and Licensed Independent Practitioners shall be notified, in writing, of all credentialing decisions, including credentialing status, effective date, and recredentialing due date. An organizational provider or licensed independent practitioner that is denied credentialing or recredentialing shall be informed of the reasons for the adverse credentialing decision in writing and shall have an appeal process that is available when credentialing or recredentialing is denied, suspended or terminated for any reason other than lack of need. In instances of a conflict of interest, subcontracted providers responsible for credentialing and recredentialing LIPs may utilize the MSHN provider appeal process to ensure a neutral and fair appeal process is available.

If the reason for denial, suspension, or termination is egregious (serious threat to health safety of consumers or staff, represents a substantiated criminal activity, etc.) action shall be taken immediately. In the event of immediate suspension or termination MSHN, CMHSPs, and SUDSPs shall address coordination of care so as to prevent disruption of services.

Record Retention
All credentialing and recredentialing documentation must be retained for each credentialed provider and include:
- Initial credentialing and all subsequent recredentialing applications;
- Information gained through primary source verification; and
- Any other pertinent information used in determining whether or not the provider met credentialing and recredentialing standards

  Records shall be retained in accordance with MSHN Record Retention Policy.

Reporting Requirements
CMHSP Participants and SUDSPs are responsible to report suspected fraud, abuse, and licensing violations to MSHN as soon as it is suspected. If a matter expected to lead to suspension or revocation, is known to be related to fraud, abuse, and/or a licensing violation, reporting shall be conducted in coordination with the MSHN Chief Compliance & Quality Officer~~Director of Compliance, Customer Service and Quality~~ and any regulatory/investigative agency involved. MSHN and the responsible CMHSP or SUDSP shall coordinate immediate verbal (phone) reporting to the Office of the Inspector General (OIG), Licensing and Regulatory Affairs (LARA) and the Division of Program Development, Consultation and Contracts, Behavioral Health and Developmental Disabilities Administration in MDHHS accordingly. Verbal notice shall be followed by written notice of the matter including any relevant supporting documentation. Information shall be submitted via e-mail in an encrypted format and by regular mail if requested. Once a matter has been turned over to the OIG further investigation should be suspended unless approval is granted by the OIG.

The Chief Compliance & Quality Officer~~Director of Compliance, Customer Service and Quality~~ shall maintain records of all credentialing activities reported to MDHHS or the OIG in accordance with MSHN compliance monitoring policies and procedures.

Additionally, MSHN and its provider network shall maintain written procedures to address:
- Standards and responsible parties for credentialing functions;
- Initial credentialing and recredentialing (including primary source verification and evidence that minimum training requirements are met);
- Temporary and provisional credentialing;
- Suspension and revocation;
- Use of Quality Assessment and Performance Improvement Program information and findings as part of the recredentialing process;
- Background checks;
- Monitoring of credentialing/recredentialing practices including the practices of organizational providers.

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

Definitions:
Credentialing: Confirmation system of the qualification of healthcare providers.
CMHSP: Community Mental Health Services Program
Licensed Independent Practitioner: an individual, as permitted by law and regulation, and also by the organization, to provide care and services without direction or supervision within the scope of the individual's license and consistent with the privileges granted by the organization.
MDHHS: Michigan Department of Health & Human Services
MSHN: Mid-State Health Network: Prepaid Inpatient Health Plan under contract with the MDHHS to provide managed behavioral health services to eligible individuals.
Organizational Providers: Entities that directly employ and/or contract with independent conractors to provide behavioral health/health care services. Examples of organizational providers include but are not limited to: Community Mental Health Services Programs; hospitals; nursing homes; homes for the aged; psychiatric hospitals, units and partial hospitalization programs; substance abuse programs; and home health agencies.
Recredentialing: Process of updating and re-verifying credential information
SUDSP: Substance Use Disorder Service Provider (Treatment, Prevention, and Recovery)

References/Legal Authority:
MSHN Personnel Manual: Credentialing and Recredentialing
MDHHS Contract: Credentialing & Re-credentialing Processes ~~(P.7.1.1)~~; ~~Section 7.1~~ Provider Credentialing;
SUD Policy Manual - Credentialing and Staff Qualification Requirements ~~(PI.B.A)~~
MDHHS Medicaid Provider Manual
42 CFR 438.214
42 CFR 438.12

Attachments:

Change Log:

Date of Change	Description of Change	Responsible Party
03.2015	New policy	PNMC
07.2015	Address compliance requirements with MDHHS Contract attachment– P7.1.1 in accordance with MSHN's	Director of Provider Network Mgmt.
09.2016	Annual Review; Registered Dietitian added to list of professionals requiring credentialing	Director of Provider Network Mgmt.
09.2018	Annual Review	Director of Provider Network Mgmt.
08.2017	Annual Review; update responsible staff title	Director of Provider Network Mgmt.
09.2019	Annual Review – revisions, moved 'A Word About Professional Licensure' to LIP Procedure	Director of Provider Network Management Systems
11.2021	Biennial~~Annual~~ Review – Changed titles as necessary; Removed attachment references to MDHHS contract	Contract Manager

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Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Provider Network Management		
Title:	Disclosure of Ownership, Control, and Criminal Convictions		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial~~Annually~~ **Author:** Director of Provider Network Management Systems	**Adopted Date: 01.05.2016** **Review Date:** 11.2021~~03.03.2020~~ **Revision Eff. Date:**	**Related Policies:** Provider Network Management Provider Credentialing and Re-Credentialing Quality Monitoring and Oversight

Purpose

Federal regulations require PIHP's to disclose information about individuals with ownership or control interests in the PIHP. These regulations also require the PIHP to identify and report any additional ownership or control interests for those individuals in other entities, as well as identify when any of the individuals with ownership or control interests have spousal, parent-child, or sibling relationships with each other.

Policy

Mid-State Health Network (MSHN) and Community Mental Health Service Providers (CMHSP) shall comply with the federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 CFR §455 Subpart B. In addition, MSHN shall ensure that any and all contracts, agreements, purchase orders, or leases to obtain spaces, supplies, equipment, or services provided under the Medicaid agreement require compliance with 42 CFR §455.104-106.

MSHN shall develop procedures to address the following:

- disclosure statement requirements;
- when disclosures are obtained;
- monitoring provider networks;
- reporting with regard to criminal offense;
- delegation and oversight

Applies to:

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

Definitions

CMHSP: Community Mental Health Services Program
MDHHS BHDDA: Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration
MSHN: Mid-State Health Network

References/Legal Authority

42CFR §455 Subpart B
42CFR §455.104-106
The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s)
Social Security Act, Sections 1128(a) and 1128(b)(1)(2), or (3)

Attachments

MSHN Ownership and Disclosure Form

Change Log

Date of Change	Description of Change	Responsible Party
07.2015	New policy	Director of Provider Network Management Svcs
11.2017	Annual Review, No Revisions	Director of Provider Network Management Svcs
10. 2018	Annual Review, No Revisions	Director of Provider Network Management Svcs
09.2019	Annual Review, No Revisions	Director of Provider Network Management
11.2021	Biennial~~Annual~~ Review – No Changes	Contract Manager

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Provider Network Management**		
Title:	**Fiscal Year Contract Monitoring (Amounts vs. Expenses)**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** ~~Biennial~~**~~Annually~~** **Author:** Contract ~~Specialist~~Manager/Finance	**Adopted Date:** **09.01.2020** **Review Date:** **11.2021**	**Related Policies:** Procurement Administrative & Retained PIHP Function Contract Monitoring and Oversight

Purpose

The purpose of this policy is to outline general guidelines for administrative contracts for the purposes of approval, execution, and expense monitoring.

Policy

All contracts and agreements that need to be executed by the MSHN CEO shall be routed through the Contract ~~Specialist~~Manager for review, tracking, and to obtain CEO signature. In accordance with the *Protocol for Use of Signature Stamp*, the Contract ~~Specialist~~Manager is authorized to sign contracts or agreements using the CEO signature under specific conditions – See Attachment A.

Contract listings shall only come from the Assigned Leadership member to the Contract ~~Specialist~~Manager in accordance with the Administrative Contract Monitoring Procedure.

BAA/QSOAs issued to vendors where no formal contract or agreement is established shall be reissued to the vendor and updated at least every three years. Vendor issued BAA/QSOAs shall be reviewed and approved by the MSHN Privacy Officer and Security Officer to ensure all requirements are met.

Contract Maximum expense monitoring report shall be issued to Leadership on a bi-monthly basis and shall identify contracts that have a balance of less than 25% remaining.

Applies to:

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

Definitions:

Agreements: Non-financial arrangements such as Data Use Agreements, Medicaid Health Plan Agreements.
Business Associate Agreement (BAA): The most common agreement between a Covered Entity and its third-party service provider is the BAA. BAA is more common terminology to healthcare providers than the term QSOA simply because a vast majority of Covered Entities do not qualify as Part 2 Programs, and therefore, Covered Entities are using BAAs much more frequently than QSOAs. There are certain required elements of a BAA such as 1) establish permitted and required uses and disclosures of PHI by the Business Associate; 2) provide that the Business Associate will not use or further disclose the information other than as permitted by the BAA or as otherwise required by law; and 3) require the Business Associate to implement appropriate safeguards to prevent unauthorized use or disclosure of PHI.

Qualified Service Organization (QSO): Third-party service providers must become qualified to service Part 2 Programs. This is achieved through the entity entering into a written agreement with the Part 2 Program in which it acknowledges that it is bound by the Part 2 confidentiality regulations and agrees to resist in judicial proceedings any efforts to obtain unauthorized access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment that may come into its possession

QSOA: Qualified Service Organization Agreement
MSHN: Mid-State Health Network
CEO: Chief Executive Officer

References/Legal Authority:

Health Insurance Portability and Accountability Act and 42 CFR PART 2

MDHHS Contract, ~~37.0~~ Provider Procurement

Change Log

Date of Change	Description of Change	Responsible Party
6.2020	New Policy	Contract ~~Specialist~~Manager/Finance Manager
11.2021	Biennial~~Annual~~ Review – Updated titles as necessary	Contract Manager

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Attachment A

Protocol for Use of Signature Stamp

July 08, 2019

Purpose: The purpose of providing a signature stamp and/or electronic image of signature is to expedite approved contract processing time, reduce supply consumption, and enhance efficiency.

The signature stamp or electronic image of signature belonging to the Chief Executive Officer may be used by the MSHN Contracts ~~Specialist~~Manager under the following conditions:

- The signature may be applied electronically or via stamp on all contracts approved by the Mid-State Health Network Board of Directors.
    - A log of stamp/image use (Date, Contract (or Document) Name) is to be maintained by the contract manager and must be provided on request.
- Contracts that are within the signature authority of the CEO but not on a board approval list must be presented for manual signature and the stamp/image may NOT be used.
- The signature or image may NOT be applied to non-contract documents, letters, emails, checks, bills, any banking instrument, or any other agreement not specifically authorized in this protocol.
- When not in use, the signature stamp must be kept in a secure location inaccessible to others.
- Appropriate steps should be taken to safeguard the electronic image of signature. Specifically, the image should only be applied to PDFs of documents authorized for signature and never distributed as part of a non-PDF document.

_____	_____
Contract ~~Specialist~~Manager	Chief Executive Officer
_____	_____
Date	Date

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POLICIES AND PROCEDURE MANUAL

Chapter:	Provider Network Management		
Title:	**Provider Network Directory – Information Requirements**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial~~Annually~~ **Author:** Director of Provider Network Management Systems	**Adopted Date: 07.10.2018** **Review Date:** 11.2021~~03.03.2020~~ **Revision Eff. Date:**	**Related Policies:**

Purpose

Mid-State Health Network (MSHN) and the Community Mental Health Service Provider (CMHSP) Participants shall maintain a current directory of its provider network and comply with the requirements of the Medicaid Managed Care Rule, 438.10(h) Information Requirements – Information for Potential Enrollees – Provider Directory.

Policy

1. MSHN and the CMHSPs shall make available the following information for potential enrollees in paper form upon request and electronic form:
   a. The provider's name as well as any group affiliation.
   b. Street address(es).
   c. Telephone number(s).
   d. Website URL, as appropriate.
   e. Specialty, as appropriate.
   f. Whether the provider will accept new enrollees.
   g. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
   h. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.
2. The provider directory must include the information in paragraph (1) of this section for each of the following provider types:
   a. Physicians, including specialists;
   b. Hospitals;
   c. Pharmacies;
   d. Behavioral health providers; and
   e. LTSS providers, as appropriate.
3. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than thirty (30) calendar days after MSHN receives updated provider information.
4. Provider directories must be made available on the MSHN's website in a machine-readable file and format.
5. Each CMHSP shall designate staff member(s) responsible for supporting Information Requirements and the related Provider Network Directory – Information Requirements procedure.

Applies to:

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

Definitions:
CMHSP: Community Mental Health Service Programs
LTSS: Long Term Services and Supports
MSHN: Mid-State Health Network
URL: Uniform Resource Locator; the generic term for all types of names and addresses that refer to objects on the World Wide Web

Other Related Materials:
N/A

References/Legal Authority:
- Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program
- Managed Care Rule, 438.10(h) Information Requirements – Information for Potential Enrollees – Provider Directory, effective 7.1.17

Change Log:

Date of Change	Description of Change	Responsible Party
04.2018	New Policy	Director of Provider Network Mgmt. Systems
09.2018	Annual Review	Director of Provider Network Mgmt. Systems
9.2019	Annual Review – no change	Director of Provider Network Management
11.2021	Biennial~~Annual~~ Review – No Changes	Contract Manager

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POLICIES AND PROCEDURES MANUAL

Chapter:	**Provider Network Management**		
Section:	**Provider Network Management**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 4	**Review Cycle:** Biennial **Author:** Provider Network Management Committee	**Adopted Date: 12.03.2013** **Review Date:** 12~~09~~.22~~14~~.21 **Revision Eff. Date:**	**Related Policies:** SUD Direct Service Provider Procurement MSHN Procurement Policy

Purpose

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

Policy

A. Network Monitoring and Oversight

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

2. MSHN will monitor CMHSP Participants/SUDSPs at least annually in order to assure the safety, protection, and welfare of consumers/service recipients and to assure compliance with MSHN Policies and all applicable laws and contractual obligations. Such monitoring shall include, but not be limited to, Medicaid claims verification, provider training and credentialing, clinical documentation review, utilization management, and the review of customer services, person-centered planning, and quality assurance activities. Annually, MSHN will additionally conduct formal Risk Assessment for each SUDSP provider, which summarizes risk information not fully captured in the site review process. Risk level will be considered during the following times:

   A. Organizational provider recredentialing (biennially) and will be used to determine ongoing participation in the network.
   B. When SUDSP seeks contract expansion (i.e., new site or new services).
   C. When SUDSP requests additional cost reimbursement funding (lesser of 50% increase in annual allocation or total cost reimbursement over $100,000 at the discretion of the MSHN Chief Financial Officer).

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

B. Network Adequacy/Sufficiency

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

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

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

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

C. MSHN shall monitor and maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract for all eligible persons including those with limited English proficiency or physical or mental disabilities. MSHN will ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

D. CMHSP Service Delivery System

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

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

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

E. SUDSP Service Delivery System

1. Development and management of the SUDSP service delivery system is a retained function of the PIHP. MSHN impanels SUDSPs in accordance with the MSHN SUD Direct Service Provider Procurement Policy. Contracts executed between MSHN and SUDSPs shall be consistent in terms of provider expectations, though documents may differ among SUDSPs.

2. MSHN shall require each SUDSP to have written policies and procedures and to maintain evidence of compliance with network development standards that meet state and federal requirement. This includes:
   i. Provider orientation and training for specific service delivery needs that meet requirements and conform with applicable best practices, and methods to identify new workforce training needs.
   ii. Verification of provider qualifications and credentials required for service delivery responsibilities.
   iii. An assigned individual who is responsible to maintain compliance and consistency with standards and requirements in this area.
   iv. Compliance with State and Federal Procurement Guidelines.

F. Provider Qualifications and Credentialing

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

G. Conflict of Interest

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

H. Payment Liability

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

Applies to:

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

Definitions/Acronyms:

CMHSP: Community Mental Health Service Programs
MDHHS: Michigan Department Health and Human Services
MSHN: Mid-State Health Network, the Prepaid Inpatient Health Plan
SUDSP: Substance Use Disorder Service Provider

Related Procedures

N/A

Monitoring and Review Completed By:

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

References/Legal Authority

- BBA 438.214(b)(2) Provider Selection
- Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program (which includes the Credentialing/Re-Credentialing policy~~attachment P.7.1.1~~)
- Medicaid Provider Manual
- Federal Procurement Guidelines (The Office of Federal Procurement Policy (OFPP) - Office of Management and Budget)
- MSHN Procurement Policy
- MSHN SUD Direct Service Provider Procurement Policy
- Provider Risk Assessment Profile

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New Policy	Provider Network Mgmt Committee
12.2014	Annual Review	Provider Network Mgmt Committee
03.2016	Annual Review and Revisions	Provider Network Mgmt Committee
08.24.2017	Annual Review and Revisions	Provider Network Mgmt Committee
09.2018	Annual Review, No Revisions	Provider Network Mgmt Committee
09.2019	Annual Review	Director of Provider Network Mangement
03.2020	Risk Assessment for SUDSPs	Director of Provider Network Management
12.2021	Added annual requirement to forward NAA to MDHHS	Provider Network Mgmt Committee

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POLICIES AND PROCEDURES MANUAL

Chapter:	**Provider Network Management**		
Title:	**Service Provider Reciprocity**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial~~Annually~~ **Author:** MSHN Provider Network Management Committee	**Adopted Date: 01.06.2015** **Review Date:** 11.2021~~03.03.2020~~ **Revision Eff. Date:**	**Related Policies:** Provider Network Management

Purpose

To provide a framework for the MSHN commitment to service providers in all key aspects of provider network management and relations, which seeks to promote reasonable levels of reciprocity and efficiencies wherever feasible to reduce duplication of resources and expedite provider related processes in accordance with the MDHHS/PIHP Specialty Mental Health and Substance Use Disorder Services and Supports Network Management Reciprocity & Efficiency Policy.

Policy

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

A. MSHN will provide regional leadership in the development of region-wide common practices, documents and processes ~~where ever~~wherever feasible.
B. Each CMHSP Participant will have demonstrated reciprocity practices that facilitate provider efficiency and/or expedition of provider consideration relative to credentialing, monitoring and training.
C. MSHN CMHSP Participants will readily share and accept documents and records within MSHN and with other PIHPs in order to engender provider reciprocity, including provider contracting/procurement, provider monitoring, credentialing and recredentialing records, transcripts and/or training protocols/curriculums.
D. CMHSP Participants of MSHN will seek to promote both simplification and readily available access for service providers regarding needed information, reporting conditions and overall communications.
E. While it is understood that each CMHSP Participant may have unique approaches or procedures, common policies and simplification efforts to support common provider experience across the region will be pursued.
F. MSHN CMHSP Participants will support the ability of partner training/continuing education leaders, whenever feasible to 1) collaborate on resources, 2) share teaching curriculums/protocols, 3) facilitate mutual programs, 4) share mutual training resources, and 5) allow for attendance access upon request in MSHN CMHSP Participant programs on a reciprocal basis.
G. CMHSP Participants will implement regionally approved reciprocity protocols including standard contract templates and regional monitoring standards.
H. This policy applies to all CMHSP Participants who are involved in provider processes in the MSHN region.

Applies to:

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

Definitions:
CMHSP: Community Mental Health Service Program Participant
MSHN: Mid-State Health Network
PIHP: Pre-Paid Inpatient Health Plan
PNMC: Provider Network Management Committee

Other Related Materials:
N/A

References/Legal Authority:
MDHHS PIHP Specialty Mental Health and Substance Use Disorder Services and Supports Network Management Reciprocity & Efficiency Policy

Change Log:

Date of Change	Description of Change	Responsible Party
11.22.2014	New policy	G. Reed
01.2016	Annual Review	Provider Network Management Committee
09.28.2016	Annual Review	Provider Network Management Committee
08.2017	Annual Review; updated legal reference, expanded on activities for which reciprocity shall be pursued	Director, Provider Network Mgmt. Systems
09.2018	Annual Review	Director, Provider Network Mgmt. Systems
09.2019	Annual Review – added use of regionally approved protocols/templates	Directory Provider Network Mangement
11.2021	Biennial~~Annual~~ Review – No Changes	Contract Manager

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Provider Network Management**		
Title:	**Substance Use Disorder Service Provider Procurement**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial~~Annually~~ **Author:** Director of Provider Network Management Systems, Contract Manager	**Adopted Date: 01.06.2016** **Review Date:** 11.2021~~01.12.2020~~	**Related Policies:** Provider Network Policy Provider Network Credentialing and Re-credentialing Policy

Purpose

This policy is intended to provide guidance to Mid-State Health Network (MSHN) staff involved with Substance Use Disorder provider network panel procurement and contracting.

Policy

It is MSHN's objective to acquire needed services and supports at fair and economical prices, with appropriate attention to quality of care and maintenance of existing-care relationships and service networks currently used by service recipients.

MSHN maintains a managed open Substance Use Disorder provider panel of organizational providers and/or provider network entities that are:

- Qualified: with appropriate credentials, license(s), accreditation, quality review, and meet pre- contract and ongoing site review standard(s),
- Willing: to accept contract terms, price and performance expectations, oversight activities, etc.
- Able: with a history of providing same or like services at a satisfactory level; qualified staff; satisfied fund sources,
- Competent: with administrative, clinical, billing, financial and other systems to support/produce desired outcomes,
- Needed: there exists in the MSHN region or parts of the region a documented need for the services/supports offered by the provider and sufficient projected beneficiary/service volume to justify empaneling a provider, and
- On file with MSHN after having submitted a completed Provider Network Application and Ownership & Controlling Interested Disclosure Statement.

MSHN conducts a periodic assessment of its provider network adequacy to identify underserved locales and underserved populations within the MSHN Region. As a result of the assessment, MSHN may, in its sole discretion, using any legitimate means including by way of competitive or non-competitive solicitation, empanel Licensed Independent Practitioners to provide specialized services or to improve access to services in underserved areas thus increasing consumer choice.

MSHN may, at its sole discretion, periodically review, revise, renew or update its provider network. MSHN may use a formal Request for Proposals (RFP) for provider services in circumstances where gaps exist, expansion is desirable, or service capacity is low, or for any other reason in the interests of MSHN. MSHN, in its sole discretion, may restrict or otherwise limit the number of providers that can participate in its provider network in any portion of or for all of its region. Factors that are considered in these circumstances include, but are not limited to, level(s) of utilization of the same or similar services in the geographic or sub-geographic area to be served, consumer choice considerations, quality, cost, pricing, provider saturation, other market factors or other programmatic considerations. For some market factors, such as but not limited to service cost comparison, a periodic Request for Quote (RFQ) process, annual planning process, or similar processes may be utilized when MSHN would like to obtain new or updated information.

MSHN's procurement processes shall reflect applicable State and local laws and regulations, provided that the procurements conform to applicable Federal law and the standards identified in 45 CFR 92.36.

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

Definitions:
Managed Open Provider Panel: Status by which MSHN, in its sole discretion, may contract with a qualified, willing, able, and competent provider or provider entity without going through a formal RFP process, depending upon the needs of the region or a specific sub-geographical part of the region, service demand, service utilization and other market and programmatic factors identified in this policy.
Request for Proposal (RFP): A solicitation, often made through a bidding process, by an agency or company interested in procurement of a commodity, service or valuable asset, to potential suppliers to submit business proposals.
Request for Quote (RFQ): A solicitation in which an agency or company seeks outside providers or vendors to provide a cost quote for the completion of a particular project, service, or program. An RFQ is more likely to occur in situations where products and services are standardized, since this allows the soliciting agency to compare the different bids easily.
SUDSP: Substance Use Disorder Service Provider: Agency that provides prevention, early intervention, outpatient, withdrawal management, residential, recovery housing, or medication assisted treatment services.
MSHN: Mid-State Health Network

Other Related Materials:
Procurement through Request for Proposal Procedure Procurement Technical Requirements ~~P37.0.1~~

References/Legal Authority:
45 CFR 92.36

Change Log:

Date of Change	Description of Change	Responsible Party
11.2015	New Policy	Director of Provider Network Mgmt. Systems
08.2017	Annual Review/Update Language	Director of Provider Network Mgmt. Systems
10.2018	Annual Review	Director of Provider Network Management
01.2020	Annual Review	Director of Provider Network Management
09.2020	Review to included Needed Requirement	Chief Executive Officer
11.2021	Biennial~~Annual~~ Review – Removed attachment reference to MDHHS contract	Contract Manager

POLICIES AND PROCEDURE MANUAL

Chapter:	**Finance**		
Title:	**~~Board~~ Appointed Member Compensation**		
Policy ☒ **Procedure**☐ **Page:** 1 of 2	**Review Cycle:** ~~Annually~~Biennial **Author:** Chief Financial Officer	**Adopted Date: 02.04.2014** **Review Date:** 05.04.2021 **Revision Eff. Date:**	**Related Policies:** Travel

Purpose:
To establish mechanisms regarding all per diem payments and expense reimbursements made to Board members and others including appointed consumer representatives for Mid-State Health Network (MSHN) related work.

Policy:

A. The amount of compensation paid to Board member and non-Board members (as defined by the Operating Agreement) shall be established by the Board through this policy.

B. Board members shall not receive more than one per diem per day regardless of the number of meetings attended. No Board member will be compensated by MSHN if also compensated by a CMHSP for the same meeting.

C. Board members shall receive a per diem of $70 for Board meetings, Standing Committees, and Ad Hoc Committee meetings. In order for Board members to be eligible to receive per diem compensation for these meetings, they must be appointed to such a committee by the Executive Committee of the Board of Directors or Board Chairperson, as per the by-laws of the organization. The minutes for each meeting shall provide documentation that the Board member~~s~~ did in fact participate in the meeting for which he/she is being compensated. Participation can be in person, by phone or by video conference.

D. Board members shall be eligible to receive a per diem for ad hoc Board work sessions as called by the Board Chairperson and for attendance at MSHN committees (made up of representatives from the Board of Directors, consumers, Board members of the Affiliation CMHSPs, advocates, staff, labor, and/or other stakeholders) when the Board members have been appointed to these committees by the Executive Committee or the Board Chairperson. An attendance sheet will provide documentation of attendance. When attendance at MSHN committees to which a Board member has been appointed requires travel outside of the Board member's county of residence, the Board member can receive mileage reimbursement for travel to the meeting. The reimbursement will be at the rate as established by the Board for all MSHN employees and paid in accordance with MSHN Travel Policy.

E. Board members, representing MSHN are eligible to receive a per diem and reimbursement for all conference related expenditures (conference registration, lodging, meals, and travel) for up to two statewide Community Mental Health Association of Michigan (CMHAM) conferences and one National Conference per year. These conferences must be those (typically held in the winter, spring, and fall of each year) during which a CMHAM Member Assembly or Executive Board meeting is held. Reimbursement will be paid in accordance with MSHN Travel Policy.

F. Attendance at other events in support of MSHN, such as: community dialogues, educational offerings, town hall meetings, retirement / recognition events, and program visits are not eligible for per diem compensation.

G. There shall be no monthly or yearly cap on the number of meetings for which Board members may receive compensation.

H. Non-Board members and/or alternates who are appointed to participate as members of a Board committee shall be paid the same per diem, as Board members, for meetings and Board

meetings attended. Non-Board appointed members shall not receive more than one per diem per day.

~~H.~~I. Consumer representatives approved to participate on MSHN council and committees to represent the consumer voice, shall be paid the same per diem as board members.

~~I.~~J. Board members and appointees to committees of the Board of Mid-State Health Network who are paid on a per diem basis are considered employees of Mid-State Health Network for income tax withholding purposes only, per Internal Revenue Code (IRC) 3401 (c) and the regulations there under, and not for any other purpose, including but not limited to conflict of interest.

Applies to:

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

Definitions:

Attendance: Board meeting attendance eligible for a per diem includes in person, by phone and via electronic medium.
CMHAM: Community Mental Health Association of Michigan (formerly MACMHB)
CMHSP: Community Mental Health Service Program
MSHN: Mid-State Health Network

References/Legal Authority:

IRC 3401 (c) and the regulations there under

Change Log:

Date of Change	Description of Change	Responsible Party
02.04.2014	New policy	Chief Financial Officer
11.06.2015	Policy update	Chief Financial Officer
05.24.2017	Policy update	Chief Financial Officer
03.2018	Policy update	Chief Financial Officer
03.2019	Policy update	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2022	Addition of Consumer Representatives	Chief Financial Officer