Mid-State Health Network

Board of Directors Meeting ~ January 7, 2025 ~ 5:00 p.m.

Board Meeting Agenda

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

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

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

   Motion to Approve the Agenda of the January 7, 2025 Meeting of the MSHN Board of Directors
4. Public Comment (3 minutes per speaker)
5. **ACTION ITEM:** FY2025 Quality Assessment and Performance Improvement Program (QAPIP) and the FY2024 Annual Effectiveness Evaluation *(Page 6)*

   Motion to approve the Quality Assessment and Performance Improvement Program (QAPIP) for October 1, 2024 to September 30, 2025 and the Annual Effectiveness and Evaluation Report for October 1, 2023 to September 30, 2024
6. 2025 MSHN By-Laws *(Page 13)*
7. Chief Executive Officer's Report *(Page 25)*
8. Deputy Director's Report *(Page 33)*
9. Chief Financial Officer's Report

   Financial Statements Review for Period Ended November 30, 2024 *(Page 54)*

   ACTION ITEM: Receive and File the Preliminary Statement of Net Position and Statement of Activities for the Period ended November 30, 2024, as presented
10. **ACTION ITEM:** Contracts for Consideration/Approval *(Page 64)*

    The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2025 Contracts, as Presented on the FY 2025 Contract Listing
11. Executive Committee Report
12. Chairperson's Report

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/fy2025-meetings

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Upcoming FY25 Board Meetings

Board Meetings convene at 5:00pm unless otherwise noted

March 4, 2025
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

May 6, 2025
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

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

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

13. **ACTION ITEM:** Consent Agenda

    Motion to Approve the documents on the Consent Agenda

    13.1 Approval Board Meeting Minutes 11/12/2024 *(Page 66)*

    13.2 Receive Board Executive Committee Minutes 12/20/2024 *(Page 71)*

    13.3 Receive Policy Committee Meeting Minutes 12/03/2024 *(Page 73)*

    13.4 Receive Operations Council Key Decisions 11/18/2024 *(Page 74)* and 12/16/24 *(Page 77)*

    13.5 Approve the following policies:

    13.5.1 Certified Community Behavioral Health Clinic Recipient Eligibility *(Page 80)*

    13.5.2 Autism Spectrum Disorder Benefit *(Page 83)*

    13.5.3 Behavioral Health Recovery Oriented Systems of Care *(Page 94)*

    13.5.4 Utilization Management Access System *(Page 97)*

14. Other Business

15. Public Comment (3 minutes per speaker)

16. **ACTION ITEM:** CEO Performance Evaluation Results *(Page 100)*

    Motion to receive and file the 2024 MSHN Chief Executive Officer Performance Evaluation Results

17. Adjourn

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FY25 MSHN Board Roster

Last Name	First Name	Email 1	Email 2	Phone 1	Phone 2	Appointing CMHSP	Term Expiration
Bock	Patty	pjb1873@gmail.com		989.975.1094		HBH	2026
Bohner	Brad	bbohner@tds.net		517.294.0009		LifeWays	2025
Brehler	Joe	jbrehler@sprynet.com		517.230.5911		CEI	2025
Brodeur	Greg	brodeurgreg@gmail.com		989.413.0621		Shia Health & Wellness	2027
DeLaat	Ken	kend@nearnorthnow.com		231.414.4173		Newaygo County MH	2026
Garber	Cindy	cgarber@shiawassee.net		989.627.2035		Shia Health & Wellness	2027
Griesing	David	davidgriesing@yahoo.com		989.823.2687		TBHS	2027
Grimshaw	Dan	midstatetitlesvcs@mstsinc.com		989.823.3391	989.823.2653	TBHS	2026
Hicks	Tina	tinamariemshn@outlook.com		989.576.4169		GIHN	2027
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2027
McFarland	Pat	pjmcfarland52@gmail.com		989.225.2961		BABHA	2026
McPeek-McFadden	Deb	deb2mcmail@yahoo.com		616.794.0752	616.343.9096	The Right Door	2027
O'Boyle	Irene	irene.oboyle@cmich.edu		989.763.2880		GIHN	2026
Palmer	Paul	ppalmer471@ymail.com		517.256.7944		CEI	2025
Pawlak	Bob	bopav@aol.com		989.233.7320		BABHA	2025
Peasley	Kurt	peasleyhardware@gmail.com		989.560.7402	989.268.5202	MCN	2027
Phillips	Joe	joe44phillips@hotmail.com		989.386.9866	989.329.1928	CMH for Central	2026
Purcey	Linda	dpurcey1995@charter.net		616.443.9650		The Right Door	2025
Raquepaw	Tracey	tl.raquepaw@icloud.com	raquepawt@michigan.gov	989.737.0971		Saginaw County CMH	2025
Scanlon	Kerin	kscanlon@tm.net		502.594.2325		CMH for Central	2025
Swartzendruber	Richard	rswartzn@gmail.com		989.269.2928	989.315.1739	HBH	2026
Twing	Susan	set352@hotmail.com		231.335.9590		Newaygo County MH	2025
Williams	Joanie	joanie.williams@leonagroupmw.com		989.860.6230		Saginaw County CMH	2026
Woods	Ed	ejw1755@yahoo.com		517.392.8457		LifeWays	2027

Administration:

Sedlock	Joe	joseph.sedlock@midstatehealthnetwork.org	517.657.3036	989.529.9405	
Ittner	Amanda	amanda.ittner@midstatehealthnetwork.org	517.253.7551	989.670.8147	
Thomas	Leslie	leslie.thomas@midstatehealthnetwork.org	517.253.7546	989.293.8365	
Kletke	Sherry	sheryl.kletke@midstatehealthnetwork.org	517.253.8203	517.285.5320	

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

ACA: Affordable Care Act

ACT: Assertive Community Treatment

ARPA: American Rescue Plan Act (COVID-Related)

ASAM: American Society of Addiction Medicine

ASAM CONTINUUM: Standardized assessment for adults with SUD needs

ASD: Autism Spectrum Disorder

BBA: Balanced Budget Act

BH: Behavioral Health

BHH: Behavioral Health Home

BPHASA – Behavioral and Physical Health and Aging Services Administration

BH-TEDS: Behavioral Health–Treatment Episode Data Set

CC360: CareConnect 360

CCBHC: Certified Community Behavioral Health Center

CAC: Certified Addictions Counselor
Consumer Advisory Council

CEO: Chief Executive Officer

CFO: Chief Financial Officer

CIO: Chief Information Officer

CCO: Chief Clinical Officer

CFR: Code of Federal Regulations

CFAP: Conflict Free Access and Planning (Replacing CFCM)

CLS: Community Living Services

CMH or CMHSP: Community Mental Health Service Program

CMHA: Community Mental Health Authority

CMHAM: Community Mental Health Association of Michigan

CMS: Centers for Medicare and Medicaid Services (federal)

COC: Continuum of Care

COD: Co-occurring Disorder

CON: Certificate of Need (Commission) – State

CPA: Certified Public Accountant

CQS: – Comprehensive Quality Strategy

CRU: Crisis Residential Unit

CS: Customer Service

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

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

CW: Children's Waiver

DAB: Disabled and Blind

DEA: Drug Enforcement Agency

DECA: Devereux Early Childhood Assessment

DMC: Delegated Managed Care (site visits/reviews)

DRM: Disability Rights Michigan

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

D-SNP: Dual Eligible Special Needs Plan

EBP: Evidence-Based Practices

EEO: Equal Employment Opportunity

EMDR: Eye Movement & Desensitization Reprocessing therapy

EPSDT: Early and Periodic Screening, Diagnosis and Treatment

EQI: Encounter Quality Initiative

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

FC: Finance Council

FI: Fiscal Intermediary

FOIA: Freedom of Information Act

FSR: Financial Status Report

FTE: Full-time Equivalent

FQHC: Federally Qualified Health Centers

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

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

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

HB: House Bill

HCBS: Home and Community Based Services

HHP: Health Home Provider

HIPAA: Health Insurance Portability and Accountability Act

HITECH: Health Information Technology for Economic and Clinical Health Act

HMP: Healthy Michigan Program

HMO: Health Maintenance Organization

HRA: Hospital Rate Adjuster

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

HSW: Habilitation Supports Waiver

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

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

ICTS: Intensive Community Transitions Services

I/DD: Intellectual/Developmental Disabilities

IDDT: Integrated Dual Diagnosis Treatment

IOP: Intensive Outpatient Treatment

ISF: Internal Service Fund

IT/IS: Information Technology/Information Systems

KPI: Key Performance Indicator

LBSW: Licensed Baccalaureate Social Worker

LEP: Limited English Proficiency

LLMSW: Limited Licensed Masters Social Worker

LMSW: Licensed Masters Social Worker

LLPC: Limited Licensed Professional Counselor

LPC: Licensed Professional Counselor

LOCUS: Level of Care Utilization System

LTSS: Long Term Supports and Services

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

MAT: Medication Assisted Treatment (see MOUD)

MCBAP: Michigan Certification Board for Addiction Professionals

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MCO: Managed Care Organization

MDHHS: Michigan Department of Health and Human Services

MDOC: Michigan Department of Corrections

MEV: Medicaid Event Verification

MHP: Medicaid Health Plan

MI: Mental Illness

Motivational Interviewing

MichiCANS: Michigan Child and Adolescent Needs and Strengths

MiHIA: Michigan Health Improvement Alliance

MiHIN: Michigan Health Information Network

MLR: Medical Loss Ratio

MMBPIS: Michigan Mission Based Performance Indicator System

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

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

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

MPHI: Michigan Public Health Institute

MRS: Michigan Rehabilitation Services

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

NAMI: National Association of Mental Illness

NASMHPD: National Association of State Mental Health Program Directors

NCQA: National Committee for Quality Assurance

NCMW: National Council for Mental Wellbeing

OC: Operations Council

OHCA: Organized Health Care Arrangement

OHH: Opioid Health Home

OIG: Office of Inspector General

OMT: Opioid Maintenance Treatment - Methadone

OP: Outpatient

OTP: Opioid Treatment Provider (formerly methadone clinic)

PA: Public Act

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

PAC: Political Action Committee

PASARR: Pre-Admission Screening and Resident Review

PCP: Person-Centered Planning

Primary Care Physician

PEP: Performance Enhancement Plan

PFS: Partnership for Success

PEO: Professional Employer Organization

PEPM: Per Eligible Per Month (Medicaid funding formula)

PI: Performance Indicator

PIP: Performance Improvement Project

PIHP: Prepaid Inpatient Health Plan

PMV: Performance Measure Validation

PN: Prevention Network

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

PRTF: Psychiatric Residential Treatment Facility

PS: Protective Services

PTSD: Post-Traumatic Stress Disorder

QAPIP: Quality Assessment and Performance Improvement Program

QAPI: - Quality Assessment Performance Improvement

QHP: Qualified Health Plan

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

QRT: Quick Response Team

RCAC: Regional Consumer Advisory Council

REMI: MSHN's Regional Electronic Medical Information software

RES: Residential Treatment Services

RFI: Request for Information

RFP: Request for Proposal

RFQ: Request for Quote

RHC: Rural Health Clinic

RR: Recipient Rights

RRA: Recipient Rights Advisor

RRO: Recipient Rights Office/Recipient Rights Officer

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

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

SARF: Screening, Assessment, Referral and Follow-up

SCA: Standard Cost Allocation

SDA: State Disability Assistance

SED: Serious Emotional Disturbance

SB: Senate Bill

SIM: State Innovation Model

SMI: Serious Mental Illness

SPMI: Severe & Persistent Mental Illness

SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income (Social Security)

SSN: Social Security Number

SUD: Substance Use Disorder

SUD OPB: Substance Use Disorder Regional Oversight Policy Board

SUGE: Bureau of Substance Use, Gambling and Epidemiology

TANF: Temporary Assistance to Needy Families

THC: Tribal Health Center

UR/UM: Utilization Review or Utilization Management

VA: Veterans Administration

VBP: Value Based Purchasing

WM: Withdrawal Management (formerly "detox")

WSA: Waiver Support Application

WSS: Women's Specialty Services

YTD: Year to Date

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

Background:

FY 2025 Quality Assessment and Performance Improvement Program (QAPIP) Plan and FY2024 Annual Effectiveness and Evaluation Report:

To comply with the Medicaid Managed Specialty Supports and Services 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 FY24-25 QAPIP Plan and Report Executive Summary for an overview and highlights from the full FY2025 QAPIP Plan and the FY2024 QAPIP 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, 2024–September 30, 2025, and the Annual Effectiveness and Evaluation Report for the period of October 1, 2023 - September 30, 2024.

Quality Assessment and Performance Improvement Program
FY24 Report and FY25 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 Community Mental Health Service Participants (CMHSP), the Substance Use Disorder (SUD) Providers and their respective provider networks, the Certified Community Behavioral Health Clinics, Behavioral Health Homes, and SUD Health Homes within the MSHN region. The QAPIP is reviewed annually for effectiveness as required by the Michigan Department of Health and Human Services (MDHHS) PIHP contract and the Balanced Budget Act (BBA). 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 the following year. The QAPIP is reviewed and approved by the Quality Improvement Council (QIC), Leadership, Operations Council and MSHN's Board of Directors. Once reviewed and approved by the Board of Directors the plan and report will then be submitted to MDHHS by the required due date of February 28. The measurement period for the QAPIP Report is October 1, 2023 through September 30, 2024.

Annual QAPIP Report

The QAPIP Report is the annual effectiveness review of the QAPIP Plan. The report includes a review of the required components of the QAPIP description, the tasks associated with improvement activity (workplan), and each performance measure relevant to the QAPIP is reviewed to determine if the expected outcome has been achieved. Areas that do not meet the standard will include a goal and action step for FY25. Areas that have met the standard and are required by MDHHS, will continue to be monitored as appropriate. Recommendations are developed for areas that may benefit from additional interventions to improve the performance or the quality of a process.

Annual Review of the QAPIP Components: MDHHS reviewed the QAPIP Plan and Report, indicating the QAPIP Plan and Report included all required components of the QAPIP description, evaluation, and work plan(page 18-25). Upon MSHN review at the close of FY24, MSHN demonstrated continued compliance with all the required components of the plan.

Annual Review of Performance Measures: Through an evaluation of the effectiveness, the performance measures were reviewed to determine if the action steps identified in the work plan were effective in producing the desired outcome.

MSHN has recommended goals and action steps (workplan) for those areas that did not meet the standard or require action to enhance or further develop the process to ensure effectiveness for FY25.

Performance Measurement

MDHHS Performance Indicators

Goal:

- MSHN will meet or exceed the MMBPIS standards for Indicators as required by MDHHS.

Status:

- MSHN exceeded the State average performance on 12 of the 18 indicators.

Recommendations:

- Continue the use of financial incentives to obtain and retain adequate staffing levels. This will be removed from the QAPIP Workplan. Adequate staffing levels will continue to be monitored through the Network Adequacy Assessment.
- Complete additional data analysis to identify population groups that have a high rate of no shows/cancelations. This includes data collection and analysis of the social determinants of health.
- Increase the use of practices for warm hand offs, staff/peers making direct phone calls to individuals for access and engagement in services and to identify any barriers, utilization of the teachback method to ensure understanding of next steps in treatment.

Performance Based Incentive Payment Measures

Goal:

- MSHN will meet or exceed the measure performance using standardized indicators including those established by MDHHS in the Medicaid contract and analyze causes of negative outliers.

Status:

- Partially Met

Recommendations:

- Identify Causal factors and develop improvement strategies.
- Develop an organizational plan to address disparities for both SUD providers and CMHSP Participants.

Certified Community Behavioral Health Clinics

Goal:

- CCBHC will meet the standard for the CCBHC performance measures.

Status:

- Partially Met

Recommendations:

- MSHN, as the lead entity (LE), will complete the following:
  - Receive CCBHC metrics template quarterly from each clinic quarterly.
  - Review metric templates for completeness and accuracy
  - Ensure improvement strategies are developed based on clinic and LE performance.
  - Establish/develop an efficient method to view performance by clinic, comparing to Michigan CCBHC standards and provide validated detail clinic data as requested to each clinic.

Performance Improvement Projects

PIP #1 Goals/Indicators:

- 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.
- The percentage of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.
- The percentage of new persons who are black or white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

PIP #2: Goals/indicators:

- The percentage of individuals who are black/African American and eligible for Medicaid and have received a PIHP managed service.
- The percentage of individuals who are white and eligible for Medicaid and have received a PIHP managed service.

Status:

- MSHN did not eliminate the disparity between the black or African Americans and the white population groups for CY24Q2. The rate of access to services for Index/White population group demonstrated a downward trend from the baseline year as indicated in the Figure 1 for CY23. The rates in CY24Q2 for both population groups have improved since CY23. The black/African American rate continues to be below the baseline rate, however, did demonstrate a significant increase in CY24Q2.
- Indicator 1 (African American or Black) and Indicator 2 (White) have both rates have increased from previous measurement period (CY24Q2). However, when compared to the baseline year (CY21Q2) both rates have decreased.

Recommendations:

- Complete additional analysis to determine areas of focus. Complete statistical testing to determine significance related to the penetration rate and change over time.

Adverse Event Monitoring and Reporting

Goal:

- MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract and the MDHHS Critical Incident Reporting and Event Notification Policy.

Status:

- MSHN met the standard for four out of six objectives on the work plan.

Recommendations:

- Monitor performance indicators including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence quarterly.
- Increase the rate of critical incidents submitted within the required time frame.
- Increase the rate of remediations completed within the required time frame.
    - Develop training documents and complete training outlining the requirements of reporting critical, sentinel, immediately reportable, and news media events.
    - Validate / reconcile reported data through the CRM.
    - Establish electronic process for submission of sentinel events/ immediate notification, remediation documentation including written analysis for those deaths that occurred within one year of discharge from state operated service. (CRM)
    - Monitor timeliness of submissions and remediation response in the CIRS-CRM through development of dashboard in REMI
    - Track CIRS changes and barriers through the CIRS Process Improvement Report.

Behavior Treatment

Goals:

- MSHN will analyze Behavior Treatment Data where intrusive or restrictive techniques have been approved for use and where physical management or 911 call to law enforcement have been used in an emergency behavioral crisis.
- MSHN will adhere to the MDHHS Technical Requirement for Status: MSHN did not meet the standard for the performance measures, however, there was improvement and no statistically significant negative change.

Status:

- MSHN did not meet each standard.

Recommendations:

- MSHN will reach out to State Workgroup about training opportunities (including Direct Care Workers)

- CMHSPs will share details of their training platforms with others (internal training, contracted trainers, etc.)
- Regional BTR Workgroup will work together to provide/offer training opportunities for those working in direct care roles

Clinical Practice Guidelines

Goal:

- MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period.
- MSHN's ACT programs will demonstrate fidelity for an average of minutes per week per consumer
- MSHN will demonstrate an increase in the implementation of Person-Centered Planning and Documentation in the IPOS. (MDHHS Waiver Review FY22) (Not Met)

Status:

- MSHN did not meet the standards.

Recommendations:

- Monitor utilization summary of the average.
- Recommend improvement strategies where adverse utilization trends are detected.
- Establish a Person-Centered Planning QI Team to review process steps to identify efficiencies.
- Develop report to monitor, analyze, and improve the amount/scope and duration of services received by individuals enrolled in waivers and those not enrolled in waiver programs/services.

Verification of Services -Medicaid Event Verification

Goal:

- Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines.

Status:

- MSHN did meet the performance standard for CMHSPs, but not for SUD providers.

Recommendations:

- Goal: SUD-Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines. 90% Standard
- Goal: CMHSP- Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed. 90% Standard
    - SUD Lunch and Learn which included overview of the MEV SUD Guide,
    - SUD MEV Guide has been added to the website, sent out in the Constant Contact, and linked in the checklist that providers receive prior to the review.
    - Presented to the SUD Residential workgroup and discussed requirements, documentation suggestions, and how to prepare for the review i.e., documentation required.
    - Recommendations to all providers during the review process and within the final reports
    - Created a CMH MEV Guide which has been provided to CMHs via MSHN committees, added to the MSHN website, and linked in the CMH Review checklists.
    - Met with the MSHN Compliance Committee in FY23Q3 to discuss the attribute compliance and make recommendations for improvement.
    - Met with QIC and discussed this specific attribute and provided recommendations for improvement that CMHs could implement.
    - Make recommendations to all CMHs during the review process and within the final reports.

Utilization Management

Goals:

- Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines.
- Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan.
- 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)
- Service Authorizations Denials Report demonstrates 90% or greater compliance with timeframe requirements for service authorization decisions and ABD notices
- Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages

Status:

- MSHN met the standard for three out of the five goals. The goals that were met will be discontinued.

Recommendations:

- MSHN to complete performance summary quarterly reviewing under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees.
- Continued analysis of differences in amount/ duration of services received by individuals enrolled in waivers and non-waiver individuals.
- Develop and monitor reports and identify any areas where improvement is needed.
- Integrate standard assessment tools into REMI- MichiCANS implementation.
- Review tools for determining medical necessity for community living supports; recommend regional best practice.
- Establish process and identify report to monitor aggregate data for assessment of care between care settings.
- Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for community integration and assessment of care between settings.
- Include information in the QAPIP description, workplan, evaluation.
- MSHN clinical team will review community integration during regional site reviews, implementing quality improvement when evidence of community integration is not found, and monitor for effectiveness to ensure community integration is occurring.

Provider Monitoring/External Review

Goal:

- MSHN will monitor the provider network including affiliates or subcontractors to which it has delegated managed care functions, including service and support provision, following up to ensure adherence to the required functions.
- MSHN will demonstrate an increase in compliance with the External Quality Reviews.
- MSHN will demonstrate an increase in compliance with the MDHHS external review standards.
-

Status:

- MSHN partially met the performance standards.

Recommendations:

- MSHN will provide monitoring and oversight to ensure corrective action plans are implemented and effective.

- Region wide quality improvement efforts will be explored to increase efficiencies and improve compliance with standards.
- Review a statistically significant sample prior to submission of those CMHSPs that had findings during the HSAG review.
- Ensure completion of the CMHSP/SUD Provider corrective action plans related to internal review of primary source verification.
- Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.
- Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.

Annual QAPIP Plan- Summary of Changes

General Changes: Updated the dates and references to reflect current MDHHS contract requirements and MSHN policy/procedures updates. Minor changes were made to improve flow of information and areas were removed that were no longer applicable or were redundant.

I. **Overview/Mission Statement:** No substantive changes
II. **Scope of Plan-**No changes
III. **Philosophical Framework**: No substantive changes
IV. **Organizational Structure and Leadership**: Added clarifying language for the CEO role and reorganized this section
V. **Performance Management**: Removed redundant language
VI. **Performance Measurement:** Removed redundant language – Add language for performance based improvement projects
VII. **Stakeholder Experience/Engagement:** Added additional references – added language for long-term supports and services
VIII. **Adverse Events:** Added language to clarify responsibilities and requirements from the MDHHS policy – included clarification of events
IX. **Behavior Treatment**: Updated language to be consistent with MDHHS policy
X. **Clinical Quality Standards**: Removed trauma informed care – this is covered in the clinical practice section.
XI. **Provider Network Oversight**: Updated language to reflect current practices – added annual review of effectiveness for the QAPIP
XII. **QAPIP Priorities FY2024:** Updated the work plan based on the QAPIP Evaluation of Effectiveness.
XIII. **Definitions/Acronyms-** This section was moved to the end of the plan – previously III.

MSHN
Mid-State Health Network

MID-STATE HEALTH NETWORK BYLAWS

ARTICLE I
FORMATION

Preamble. The Entity is formed for the purpose of carrying out the provisions of the Mental Health Code as set forth in these Bylaws and the Operating Agreement, relative to serving as a prepaid inpatient health plan, as defined in 42 CFR 438.2 ("PIHP"), to manage the Medicaid Specialty Support and Services Concurrent 1915(b)/(c) Waiver Programs ("Medicaid"); ensuring a comprehensive array of services and supports as provided in the PIHP Medicaid Contract with MDCH; and exercising the powers and authority set forth in these Bylaws and the Operating Agreement. The Entity's primary mission is to organize its actions in a manner that preserves the local public community mental health safety net, ensure access to Medicaid services for all citizens, and support the delivery of locally accountable health care services by the participating members. ~~If there is any conflict between the Operating Agreement and these Bylaws, the Operating Agreement shall apply.~~ The Operating Agreement is incorporated by reference herein and attached hereto as Attachment 1.

Commented [JS1]: Recommend removal of this sentence as bylaws properly supersede operating agreement as well as reinforced as a CMHSP reserved power any change to the operating agreement per 2.3.2 below.

Commented [TP2R1]: Concur with deletion for reason stated.

Definitions.

The definitions contained in the Operating Agreement shall be incorporated by referenced here.

ARTICLE II
THE CMHSP PARTICIPANTS

2.1 **CMHSP Participants**. The CMHSP Participants of the Entity shall be community mental health services programs, organized and operated as a community mental health authority, county community mental health agency or community mental health organization, whose designated service areas are within the Service Area and who have entered into the Operating Agreement.

2.2 **CMHSP Participant Vote**. The CMHSP Participants of the Entity will each have one (1) vote on those matters reserved to the CMHSP Participants in Section 2.3. The CMHSP Participant's vote shall be conveyed in the form of duly adopted written resolutions of the governing body of each of the CMHSP Participants.

2.3 **CMHSP Participant Reserved Powers.** Each CMHSP Participant shall possess the powers and rights retained and reserved to the CMHSP Participants under these Bylaws which shall include the power to approve the following:

2.3.1 All amendments, restatements or adoption of new bylaws;

2.3.2 The Operating Agreement, any amendment thereto and its termination;

2.3.3 Any proposal of the Entity related to merger, consolidation, joint venture or formation of a new organization;

2.3.4 The termination of the Entity and distribution of assets and liabilities, if any;

2.3.5 The issuance of debt which exceeds certain threshold amounts established for the Entity by the CMHSP Participants in the Operating Agreement;

2.3.6 Secured borrowings and unsecured borrowings in excess of amounts established in the Operating Agreement by the CMHSP Participants; and

2.3.7 The sale, transfer or other disposition of substantially all of the assets of the Entity.

2.4 **New CMHSP Participants**. New CMHSP Participants to the Entity may be added pending written support from the State for purposes of preserving the community mental health system. If addition of these new CMHSP Participants to the Entity is not required by the State, it is seen as within the sole discretion of the existing CMHSP Participants. Thus when not required by the State, the addition of new CMHSP Participants to the Entity requires the approval of two-thirds (2/3) of the governing bodies of the existing CMHSP Participants, conveyed via a duly adopted written resolution of these governing bodies. New CMHSP Participants added to the Entity will be entitled to any membership or governance rights in the same manner as the existing CMHSP Participants. Any new CMHSP Participants added under this section will forward any claims to existing Medicaid risk reserves to the Entity on a pro-rated basis upon date of admission as negotiated with MDCH.

ARTICLE III
POWERS

3.1 **Powers**. Except as otherwise stated in these Bylaws, the Entity's powers are limited to the following, all of which are provided under MCL 330.1204b(2):

3.1.1 The power to contract with the State to serve as the Medicaid specialty service prepaid inpatient health plan and as the Department-designated community mental health entity for substance use disorder services ~~coordinating agency~~ for the Service Area including the responsibility and authority to ensure compliance with related federal and State contract requirements;

3.1.2 The power to accept funds, grants, gifts, or services from the federal government or a federal agency, the State or a State department, agency, instrumentality, or political subdivision, or any other governmental unit whether or not that governmental unit participates in the Entity, and from a private or civic source;

Commented [JS3]: Confirm whether all powers listed in 1204(b) are included in these bylaws.

Commented [TP4R3]: The powers expressly stated in MCL 330.1204b(2)(b) - (e) are included. The power expressed in MCL 330.1204b(2)(a) is not stated in the Bylaws, which could be added to state: "The power, privilege or authority that the CMHSP Participants share in common and may exercise separately." Even so, MCL 330.1204b(2)(a) states that this power applies whether or not that power, privilege or authority is specified in the bylaws.

Commented [JS5]: Confirm whether this term exists any longer; information is that is has been replaced by the term "designated community mental health entity" to refer to PIHPs obligations to administer and manage the SUD benefit(s) in the region.

Commented [TP6R5]: Should be revised as set forth to comport with statutory changes.

3.1.3 The power to enter into contracts ~~including without limitation a contract~~ with a CMHSP Participant for any service to be performed for, by, or from the CMHSP Participant;

3.1.4 The power to create a risk pool and take other actions as necessary to reduce the risk that the CMHSP Participants otherwise bear individually;

3.1.5 The power to review, alter and approve annual capital and operating budgets and strategic plans of the Entity; and

3.1.6 The power to appoint and remove the Chief Executive Officer of the Entity.

3.2 **Entity Actions**. The manner by which the Entity's purposes will be accomplished and powers will be exercised shall be through the actions of the CMHSP Participants as provided in Article II and through the actions of the Board as set forth in these Bylaws or as delegated by the Board to officers, committees or other agents.

3.3 **CMHSP Participant Retained Powers**. CMHSP Participants shall retain all powers, rights and authority afforded community mental health services programs, organized and operated as county mental health authorities, agencies or organizations under the Mental Health Code. Only the powers and authority specifically delegated to the Entity under these Bylaws and as further defined under an Operating Agreement to be entered into by the CMHSP Participants are transferred to the Entity.

ARTICLE IV
ENTITY BOARD OF DIRECTORS

4.1 **General Powers**. The business, property, and affairs of the Entity shall be managed by the Board.

4.2 **Number**. There will be twenty-four (24) Entity Board members.

4.3 **Appointment.** The CMHSP Participants shall appoint members of the Entity Board. Each CMHSP Participant will appoint two (2) members to the Entity Board. The appointment becomes effective upon receipt by the Entity Board of a duly adopted written resolution of the CMHSP Participant's governing body.

4.3.1 A Board member shall have his or her primary place of residence in the CMHSP Participant's Service Area;

4.3.2 A Board member shall not be an employee of the Department of Community Health or a community mental health services program;

Commented [JS7]: Confirm whether the phrase "including without limitation" is in 1204(b) and if not, what is the rationale for including it?

Commented [TP8R7]: The phrase is not stated in MCL 330.1204b(2), and may be deleted.

4.3.3 A Board member shall not be a party to a contract with a community mental health program or administering or benefitting financially from a contract with a community mental health services program;

4.3.4 A Board member shall not serve in a policy making position with an agency under contract with a community mental health services program;

4.3.5 At least one (1) board member from each CMHSP Participant shall be a primary consumer or family member of a primary consumer as defined in the Michigan Mental Health Code;

4.3.6 If the Entity is a Department-Designated Community Mental Health Entity, as defined in Section 100a(22) of 2012 P.A. 500, the Board shall also consist of representatives of mental health, developmental or intellectual disabilities and substance use disorder services as required under Section 287 of 2012 P.A. 500; and

4.3.7 Notwithstanding anything to the contrary in these Bylaws, any board member of the CMHSP Participants may also serve on the Entity Board.

4.4 **Term**. The term of office for an Entity Board member shall be three (3) years from May 1st of the year of appointment. The initial Entity Board appointments will be staggered into one (1) year, two (2) year and three (3) year terms.

4.5 **Removal.** At any time a CMHSP Participant may appoint, remove, or replace its appointees to the Entity Board without cause. The removal becomes effective upon receipt by the Entity Board of a duly adopted written resolution of the CMHSP Participant's governing body.

4.6 **Resignation**. An Entity Board member may resign at any time by providing notification to the appointing CMHSP Participant. The resignation will be effective upon receipt of the notice by the CMHSP Participant or at a later time as designated in the notice.

4.7 **Board Vacancies**. A vacancy on the Entity Board may occur through death, removal or resignation of the Board member. A vacancy shall be filled for an unexpired term by the CMHSP Participant in the same manner as the original appointment.

4.8 **Annual Meeting**. An annual meeting of the Entity Board of Directors will be held each year at such time and place as designated by the Board.

4.9 **Regular Meetings**. The Entity Board of Directors will hold regular meetings on at least a quarterly basis at a time and location as determined by the Board. Notice in writing of each meeting shall be given to each Entity Board member by email or U.S. Mail at least five (5) days prior to each meeting and include the date, time and place of

such meeting. Proper notice shall be given to the public pursuant to the Open Meetings Act, 1976 P.A. 267, as amended.

4.10 **Special Meetings**. Special Meetings of the Entity Board of Directors may be held at the discretion of the Chairperson or Vice Chairperson in the Chairperson's absence. Notice in writing of each special meeting shall be given to each Board member by email, fax, or U.S. Mail at least 48 hours prior to each meeting and include the date, time, agenda topics and place of such meeting. The MSHN Executive Assistant shall post at least 18 hours before the special meeting a public notice, as required by 1976 P.A. 267.

4.11 **Waiver of Notice**. The attendance of an Entity Board member at a Board meeting shall constitute a waiver of notice of the meeting, except where a Board member attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully convened. In addition, the Entity Board member may submit a signed waiver of notice that shall constitute a waiver of notice of the meeting.

4.12 **Quorum and Voting**. The presence of thirteen (13) members of the Board of Directors shall constitute a quorum for the transaction of business by the Entity Board. Actions voted on by a majority of Entity Board members present at a meeting where a quorum is present shall constitute authorized actions of the Board, excepting, however, to adopt a budget, to hire/fire/discipline the CEO or to recommend changes to the Bylaws or Operating Agreement, it shall require thirteen (13) votes. Board members are considered present for the purposes of voting (a) if they are physically present during the meeting, or (b) if not physically present due to military duty, or as otherwise permitted under the Open Meetings Act, are present via telephone, teleconference, videoconference, or other similar means, through which all Board members participating can communicate with each other, for the entire duration of the discussion which is the subject of the motion and/or vote, subject to the following requirement:

A. Physical Presence. A Board member may not participate in a Board meeting without being physically present except as specifically permitted under the Open Meetings Act, and then only if a quorum of the Board of Directors is physically present at a duly constituted Board meeting~~A Board member may participate in a Board meeting without being physically present only if a quorum of the Board of Directors is physically present at a duly constituted Board meeting~~.

Commented [JS9]: Recommend revisions to update to current OMA status or for more generic language such as "comply with the OMA"

Commented [TP10R9]: Recommend updating language to comport with current state of the law, with flexibility if further change allows for broader remote participation.

4.13 **Compensation and Expenses.** Entity Board members shall be paid per diem and mileage expenses as fixed by the Entity Board.

4.14 **Conflict of Interest Policy**. The Entity Board of Directors shall adopt and adhere to a conflict of interest policy which shall require, among other things, the disclosure to the Board Chairperson and any committee chairperson any actual or possible conflicts of interest. All Board members will annually disclose any conflicts of interest while serving on the Board.

4.15 **Compliance with Laws**. The Entity and its CMHSP Participants, Board, officers and staff shall fully comply with all applicable laws, regulations and rules, including without limitation 1976 P.A. 267, as amended (the "Open Meetings Act"), ~~and~~ 1976 P.A. 422, as amended (the "Freedom of Information Act"), 1976 P.A. 453, as amended (the "Elliott-Larsen Civil Rights Act"), and 1976 P.A. 220, as amended (the "Persons With Disabilities Civil Rights Act"). The Entity shall develop compliance policies and procedures. In the event that any noncompliance is found, immediate corrective action, as defined in the Operating Agreement, shall be taken by the appropriate source to ensure compliance.

Commented [JS11]: **Consider adding the following:** MSHN and the Counties, as required by law, shall not discriminate against any Board member or applicant for appointment to the Board because of race, color, religion, sex (including gender identity or expression, sexual orientation and pregnancy), genetic information, national origin, age, disability, veteran status, marital status, or any other characteristic protected by law that is unrelated to the individual's ability to perform the duties of a particular job. Breach of this section shall be regarded as a material breach of this Agreement.

Commented [TP12R11]: This language is statutorily mandated for contracts, but is not necessary or appropriate for bylaws. You could add reference to the applicable civil rights laws.

ARTICLE V
COMMITTEES

5.1 **Powers**. The Entity Board of Directors, by resolution adopted by vote of the majority, may designate one (1) or more committees, each committee shall consist of one (1) or more Board members and other appointed members. A committee designated by the Entity Board of Directors will be given proper instructions necessary to discharge the committee's responsibilities. All committees will forward any recommendations to the full Board for consideration.

5.2 **Type of Committees.** All committees authorized by the Entity Board of Directors will be considered Ad Hoc and time-limited to discharge the identified responsibilities. The Chairperson of the Entity Board will designate individual appointments to committees and membership may include any interested individuals considered necessary to fulfill the responsibilities of the committee.

5.3 **Meetings**. Committees shall meet as directed by the Entity Board and meetings shall be governed by the same rules of order and documentation requirements as the Board of Directors. Minutes shall be recorded at each committee meeting and shall be presented to the Entity Board of Directors.

5.4 **Parliamentary Authority**. Robert's Rules of Order, shall govern all questions of procedures which are not otherwise provided by these Bylaws, or by State law.

5.5 **Convening Of Committees And Minutes Requirements.** Meetings of a committee, sub-committee or special committee (hereinafter referred to as "committee") may be convened by its chairperson or by a majority of its members at any time upon reasonable notice to its members (but not less than 48 hours prior notice given to each member by personal delivery, email, mail or fax) and to the chairperson of the Board, provided said notice complies with the requirements of the Open Meetings Act, 1976 P.A. 267. All committee meetings shall be open to the public, with the exception of closed meetings as provided by the Open Meetings Act, 1976 P.A. 267. Each committee shall prepare an agenda.

Minutes shall be kept on file in the office of MSHN. Every committee shall provide an opportunity for the public to be heard at the beginning and end of the agenda.

Members of the public may address the Board or Committee for up to three (3) minutes. Individuals desiring to speak shall be required to identify themselves.

5.6 **Order of Precedence of Motions.** When a motion is seconded and before the Board and/or a Committee, no other motion shall be received except the following:

a. To fix the time to which to adjourn
b. To adjourn
c. For the previous question
d. To lay on the table
e. To postpone indefinitely
f. To postpone to a date certain
g. To refer
h. To amend

These motions shall have precedence in the order as above named.

5.7 **Motions to Adjourn.** A motion to adjourn shall always be in order except while a vote is being taken on any other motion already before the Committee or Board, or when a member has the floor; provided, that there shall be other intervening business or a change in the circumstances between the two motions to adjourn.

5.8 **Motions to Reconsider.** A motion for the reconsideration of any question shall be in order if made on the same day or at the Committee or Board meeting next succeeding that on which the decision proposed to be reconsidered was made; providing, however, that a second reconsideration of any question or a reconsideration at a later date may be had with the consent of two-thirds (2/3) of the members elected and serving, but in such event the moving member shall file written notice of his/her intention to move for a reconsideration in the office of the MSHN at least one day before making such a motion.

5.9 **Reports and Motions Requiring Signatures.** All reports of Committees shall be in writing and the names of the members of such Committees concurring in such reports shall be noted thereon. Every written resolution or motion shall have noted the name of the member or members introducing the same.

~~5.10 **Division of Question.** Upon request by any member, any question before the Committee or Board may be divided and separated into more than one question; provided, however, that such may be done only when the original is of such a nature that upon division, each of the resulting questions is a complete question permitting independent consideration and action.~~

~~5.11 **Appeal From Decision Of Chairperson.** When an appeal is taken from the decision of the Chairperson, the member taking the appeal shall be allowed to state his/her reason for doing so. The question shall be then immediately put in the following form: "Shall the ruling of the Chairperson be sustained?" The question shall be~~

~~determined by a majority vote of the members present, except the Chairperson, upon the request of any member, shall not preside over such a vote.~~

~~5.12 **Motion To Clear The Floor.** If, in the judgment of the Chairperson, there is a confusion of parliamentary procedure existing, the Chairperson shall have the right to request a "motion to clear the floor" which motion, if made and seconded, shall be undebatable, shall take precedence over all other motions, shall be forthwith put by the Chairperson, and, if carried, shall clear the floor completely and with the same effect as if all matters on the floor were withdrawn. The motion to clear the floor shall not be reconsidered; but its passage shall not limit the right of any member to move the reconsideration of any other matter in the same manner as, but for the passage of the motion to clear the floor, would be in accordance with these Rules.~~

Commented [JS13]: Confirm whether these parliamentary provisions are required in the bylaws, recommended, or can be removed.

Commented [TP14R13]: Sections 5.10 - 5.12 are not required, and may be removed. They may not be necessary, as the Bylaws designate Robert's Rules of Order as parliamentary authority in Sec. 5.4. The provisions in Secs. 5.10 and 5.11 are covered by Robert's Rules, but there is additional specificity in Sec. 5.11 as to the Chairperson presiding over an appeal. The provision of Sec. 5.12 may not have a clear parallel in Robert's Rules. Deletion of one or more of these sections is a matter of the Board's discretion.

ARTICLE VI
OFFICERS

6.1 **Officers**. The officers of the Entity shall be elected by the Board of Directors and shall also be members of the Board. The initial officers shall be a Chairperson, Vice Chairperson, and a Secretary. Officers will be annually elected by authorized vote of the Board of Directors. The Entity Board may choose to elect other officers as the Board deems appropriate and necessary to complete the business of the Board. At any given time, either the Chairperson or Vice Chairperson of the Entity Board shall be a primary consumer or family member of a primary consumer as defined in the Michigan Mental Health Code.

6.2 **Appointment.** The election of officers of the Entity will occur during the annual meeting of the Board of Directors. The Entity Board will appoint a nominating committee for the annual meeting for the purpose of recommending officer candidates to the full Board to serve during the next twenty-four (24) month period.

6.3 **Term of Office**. The term of office of all officers will commence upon their election and continue for a two (2) year term without limitation on an officer's possible re-election to office. An officer may resign at any time upon written notice to the Entity Board of Directors. Notice of resignation is effective on receipt or at a time designated in the notice.

6.4 **Vacancies**. A vacancy in any office for any reason may be filled by the Entity Board of Directors. The acting officer shall fill the unexpired term of the vacancy until the next annual meeting of the Entity Board.

6.5 **Removal**. An officer elected by the Entity Board of Directors may be removed from office prior to completion of the annual term with cause by two-thirds (2/3) majority vote of the Entity Board.

6.6 **Chair**. The Chairperson shall preside at all Entity Board meetings. The Chairperson shall have the power to perform duties incident to the office.

6.7 **Vice Chair**. The Vice Chairperson shall have the power to perform duties of the Chair if the Chairperson is absent or unable to perform his or her duties until otherwise directed by the Entity Board.

6.8 **Secretary**. The Secretary shall ensure completion of minutes of the Entity Board meetings, ensure that the notice of meetings is given to Board members as required by law or these Bylaws, ensure the safe storage of Entity records, ensure the maintenance of a register of names and addresses of all Board members and ensure the completion of all required administrative filings as required by the Entity's legal structure, including compliance with the Open Meetings Act.

6.9 **Other Officer Employment and Positions**. An officer of the Board elected by the Board of Directors may concurrently hold another office with a CMHSP Participant's governing body. An officer of the Board may not hold more than one (1) office with the Entity at any time.

ARTICLE VII
STAFF POSITIONS

7.1 **Chief Executive Officer**. The Chief Executive Officer of the Entity will have full managerial and operational authority of the Entity as delegated to that position by the Entity Board of Directors. The Chief Executive Officer will be appointed by the Board of Directors and may be a paid employee of the Entity. The Chief Executive Officer shall have the power to perform duties incident to the office as may be assigned by the Entity Board.

7.2 **Chief Financial Officer**. The Chief Financial Officer of the Entity shall serve as the fiscal officer as defined in MCL 330.1204b. The Chief Financial Officer shall have charge and custody over Entity funds and securities, maintain accurate records of Entity receipts and disbursements, deposit all moneys and securities received by the Entity at such depositories in the Entity's name that may be designated by the Board and perform all duties incident to the office and as assigned by the Chief Executive Officer. The Chief Financial Officer has the responsibilities set forth in MCL 330.1204b and will be responsible for receiving, depositing, investing and disbursing the Entity's funds in the manner authorized by these Bylaws and Board of Directors in accordance with the Entity's Operating Agreement.

7.3 **Other Positions as Approved by the Board**. The Chief Executive Officer will recommend other staff positions for the Entity as necessary to fulfill the managerial responsibilities of the Entity. The Board of Directors will retain the authority to approve or disapprove any positions recommended by the Chief Executive Officer which are not budgeted.

7.4 **Restrictions.** While serving as the Entity's Chief Executive Officer or the Chief Financial Officer (or the Chief Operating Officer or Chief Information Officer if any), those individuals shall not hold any position with any CMHSP Participants.

7.5 **Other Administration Activities**. The Entity Board and/or its designee will, on an ongoing basis, consider possible administrative efficiencies where appropriate.

ARTICLE VIII
REPORTS/CONTRACTS

8.1 **Authority for Entity Documents.** All entity documents (including agreements, insurance and annuity contracts, qualified and nonqualified deferred compensation plans, checks, notes, disbursements, loans and other debt obligations) shall not be signed by any employee, contractual staff, officer, designated agent or attorney-in-fact unless authorized by the Entity Board of Directors, adopted policies and procedures or these Bylaws. When the execution of any contract or other instrument has been authorized by the Board without specification of an executing officer, the Chairperson, Secretary or Chief Executive Officer may execute the same on behalf of the Entity. The Entity Board shall have the authority to designate other officers and agents who will have authority to execute any instrument or document on behalf of the Entity. The entity documents referenced in this section include, but are not limited to, a 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.

8.2 **Financial Accountability**. On an annual basis, after the completion of each fiscal year, the Entity Board will engage an independent public accounting firm to conduct an independent audit of all of the Entity's receipts and disbursements.

8.3 **Reports**. All reports included in these Bylaws or otherwise required by the Board from time to time will be presented to the Board by delivery of same to the Chief Executive Officer, who shall be responsible for distributing such reports to the Board of Directors. Each report will be presented by the Chairperson to the Entity Board of Directors at a meeting of the Board for discussion and approval or other actions as may be required. In addition, the Chief Executive Officer of the Entity on behalf of the Board will provide an annual report of its activities to each CMHSP Participant.

ARTICLE IX
IMMUNITY/LIABILITY/INSURANCE

9.1 **Governmental Immunity**. All the privileges and immunities from liability and exemptions from laws, ordinances, and rules provided under MCL 330.1205(3)(b) of the Mental Health Code to county community mental health services programs and their Board members, officers, and administrators, and county elected officials and employees

of county government are retained by the Entity and the Entity's Board members, officers, agents, and employees, as provided in MCL 330.1204b(4).

9.2 **Liability.** Liability insurance shall be maintained at all times to cover the Board of Directors, the organization, its employees, and its officers. Such coverage shall be in an amount acceptable to the Board.

9.2.1 Each CMHSP Participant and the Regional Entity will obtain its own legal counsel and will bear its own costs including judgments in any litigation which may arise out of its activities to be carried out pursuant to its obligations under these Bylaws or any agreement between the CMHSP Participants or the CMHSP Participants and the Entity. It is specifically understood that no indemnification will be provided in such litigation.

9.3 **Insurance.** The Entity may purchase and maintain insurance on behalf of any person who is or was an Entity Board member, officer, employee or representative of the Entity, against any liability asserted against the person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the Entity would have power to indemnify the person against such liability under these Bylaws or the laws of the State of Michigan.

ARTICLE X
FISCAL YEAR

The fiscal year of the Entity shall be from October 1 through September 30.

ARTICLE XI
AMENDMENTS

Any action by the CMHSP Participants to amend or repeal these Bylaws, or adopt new Bylaws will require approval by two-thirds (2/3) vote of the existing CMHSP Participants in the form of duly adopted written resolutions from their respective governing bodies, to be binding upon the Entity. Notice setting forth the terms of the proposed amendment or repeal shall be given in accordance with any notice requirement for a meeting of the Entity Board of Directors. No amendment to these Bylaws shall be effective until filed as provided in Article XII.

ARTICLE XII
FILING BYLAWS

These Bylaws, including any amendment, shall be effective only after being duly adopted in accordance with MCL 330.1204b(1) and subsequently filed with the clerk of each county in which the CMHSP Participants are located and with the Michigan Secretary of State.

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MSHN
Mid-State Health Network

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
November/December 2024

- MSHN congratulates Bay-Arenac Behavioral Health for establishing an approved crisis residential program in Bay County. Michigan Department of Health and Human Services (MDHHS) provided approval of the program on 11/15/24.
- Community Mental Health (CMH) for Clinton-Eaton-Ingham Counties (CEI) hosted a well-attended "Wall Breaking Celebration" on 11/25/24 to mark the transformation of the former McLaren Greenlawn Campus into a CEI-operated Crisis Care Center for adults, youth, and families facing behavioral health emergencies.
- Substance Abuse and Mental Health Services Administration (SAMHSA) is once again recruiting grant reviewers who have academic qualifications and/or lived experience with mental health or substance use disorders. Interested persons can learn more at this link.
- After decades of service, Michigan Senator Debbie Stabenow has retired from the Senate. Click this link to hear her farewell speech on the US Senate floor on12/05/2024.

PIHP/REGIONAL MATTERS

1. **Legislators Allocate $1M in Opioid Settlement Funds to each Michigan Pre-Paid Inpatient Health Plan (PIHP):**

The state of Michigan has allocated $1,000,000 in Opioid Settlement Funds to each Michigan PIHP. PIHPs have been exempted from some legislative requirements (referred to as Section 250 requirements which would have added several hoops and ongoing requirements tied directly to oversight by the legislature) by the State Budget Office. This appropriation is one-time, and MDHHS has given priority to investments that produce benefits extending beyond the current fiscal year. While it is beyond the scope of my report to detail all of the various provisions, suffice it to say that there are a number of stipulations on the use of funds. Categories for spending include: to support Infrastructure improvements at treatment provider sites, harm reduction-related supplies, engagement with local units of government on opioid use/overdose reductions and use of opioid settlement funds, and several other initiatives. There are a significant number of new requirements for PIHPs to prove and coordinate appropriate use of funds. MSHN is grateful for the allocation of new funding and will work with MDHHS and communities in our region to achieve maximum potential impacts.

2. **Conflict Free Access and Planning (CFAP) Update:**

Please refer to my previous board reports for additional background if needed. As the MSHN Board is aware, Michigan Department of Health and Human Services (MDHHS) has stated its expectation that Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs) will come into compliance with the CFAP requirements (separation of entity conducting service planning from entity responsible for service delivery). Several waiver renewals have been submitted by MDHHS to Centers for Medicare and Medicaid Services (CMS) that include this compliance requirement.

The waiver renewals, which include CFAP-related elements, have not been approved by CMS, which has approved an extension of the current waiver authorities through 03/31/2025. Meanwhile, MDHHS has stated that it is still in detailed discussion with CMS on elements of the waiver renewals, including conflict free access and planning provisions.

MSHN Leadership does not anticipate a public update until at least March 2025.

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

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

Various MSHN-initiated communications to MDHHS occurring over a long period of time have pointed out the unnecessary administrative and legal burdens of prohibiting use of ranges (especially when we are losing so many workforce members for reason of "too much paperwork"). A few examples:

- Under-delivering services (i.e., providing less than the specified number/amount of services) is cause for:
    - Reconvening the entire planning team to insert the correct (or actual) number of services with all of the pre-planning and planning requirements OR
    - Issuing an adverse action notice
- Over-delivering services (i.e., providing more than the specified number/amount of services) is cause for:
    - Reconvening the entire planning team to insert the correct (or actual) number of services with all of the pre-planning and planning requirements OR
    - Findings that the provider did not deliver services according to the plan of service.
- Reconvening planning teams, including persons served and if applicable their guardians and supporters, for a technical change to an amount of something is NOT person-centered.
- Further, the only cited regulation (MPM, Section 1.7, Definition of terms) was as follows: "The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided." In our view, a range IS a number of units between x and y, a minimum and maximum.
- MSHN has also made the point that parity regulations may apply to prevent MDHHS from prohibiting use of ranges in plans of service. An example: "Joe will receive physical therapy between 60 and 90 minutes for up to 12 weeks to alleviate pain association with [insert condition]." Ranges are common in healthcare.

MSHN has again been issued a repeat citation on this topic. A communication from MDHHS states:

> For those CMHSP's who choose not to remediate citations for lack of specific amount, scope (including frequency) and duration within the plans of service, due to their support of MSHN's position on the use of ranges, and for MSHN/Region 5 PIHP, MDHHS is providing this last attempt to secure remediation (both individual and systemic) from MSHN/Region 5, that aligns with MDHHS's requirements for specific amount, scope and duration of services within the plan

of service. Continued refusal to remediate will result in the matter being referred to MDHHS's Program Development, Consultation and Contracts Division for review and appropriate follow up. Failure to remediate will impact financial incentive payments provided to MSHN/Region 5 following completion of the site review process.

MSHN has deliberated internally, with our legal counsel in this matter, and consulted with its regional Operations Council. MSHN will continue to stand behind its position that there are no regulatory requirements mandating a specific/finite number in the place of ranges or that prohibit the use of ranges.

MSHN has communicated the following to MDHHS as our required response on the Corrective Action Plan:

> Mid-State Health Network (MSHN) acknowledges the communication from MDHHS relating to repeat site review citations relating to use of ranges in person-centered plans of service. We understand the MDHHS assertion to be an opinion or interpretation. MSHN can find no rule, regulation, policy, or other regulatory requirement that prohibits the use of ranges to support MDHHS assertions that MSHN is out of compliance with a *standard*. MSHN further asserts that it cannot be out of compliance unless there is a rule, regulation, policy, or other regulatory requirement against which it is being evaluated and held to account. MSHN continues to assert that a reasonable range with a minimum and maximum is a *specific* amount, and notes in particular that beneficiaries and/or their guardians have agreed to reasonable ranges in the person-centered planning process, and that where a beneficiary or guardian does not agree, a finite number is used that is agreeable to the beneficiary.
>
> It is also our position that using reasonable ranges mitigates many issues. To be held to a standard of finite number (amount) for a service(s) results in significantly more administrative burdens, costs, and beneficiary confusion due to increase in advanced/adequate/adverse benefit determination notices sent to beneficiaries when there are fluctuations in service amount and an increase in amended individual plans of service and the number of person-centered planning meetings involving the whole planning team to update that static service amount in their plan when conditions change. Using reasonable ranges is inherently person-centered and advocates for the best interests of the individuals served by the MSHN region.

MSHN has also requested a meeting with Kristen Jordan and Jackie Sproat, currently scheduled in early January, to restate our positions on this and attempt to resolve. If MDHHS implements the sanctions it has threatened, we intend to pursue an appeal but the contract is not quite clear on whether that is appealable under the Administrative Procedures Act, contract terms, or in any other way.

4. **MSHN By-Laws:**

Most of the following information was previously reported.

Update 12/20/24: ten of twelve CMHSP Participants have adopted the proposed revisions briefly highlighted below. This represents the required 2/3 of the region's CMHSPs, which is required for adoption. The remaining CMHSPs have scheduled board action on the resolution of adoption.

Because the 2/3 majority have adopted approval resolutions, MSHN has updated the bylaws to reflect the changes indicated below and will file updated bylaws with the appropriate state and county entities. A revised copy of the bylaws will be sent to MSHN Board Members when all related matters are finalized.

- Remove sentence indicating if there is any conflict between Operating Agreement and Bylaws, Operating Agreement prevails.
- Remove outdated "coordinating agency" language and replace with "Department-designated community mental health entity" (which is the term used in the public health code).
- Remove "without limitation" within the phrase "The power to enter into contracts with a CMHSP…"
- Adjust very specific quorum and voting language with a more generic statement that requires MSHN Board to abide by the open meetings act as it may exist from time to time.
- Add anti-discrimination language applicable to the Board.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

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

I provided a summary of issues in my September Board Report, an update in my November Board Report, and an email update to board members on 12/10/2024.

As of the date of this report, four PIHPs (Region 10, NorthCare, NMRE, and Southeast Partnership) filed suit against MDHHS in the Michigan Court of Claims. In effect, several pieces of the suit allege that MDHHS is trying to strong-arm and bully the Plaintiff PIHPs, seeks a declaratory judgment to void three provisions in the FY 25 contract: Internal Service Fund-related language, Waskul settlement language, and some CCBHC-related language. The suit includes plaintiff claims that some elements violate federal regulation and/or state law. These four PIHPs also seek a preliminary injunction to stop MDHHS implementation of contract actions – in particular, Substance Use Disorder Health Home (SUDHH) implementation. To my knowledge, those four PIHPs (and the one other that signed a red-lined contract which MDHHS has not countersigned) are operating under the transition requirements language in the contract termination section of the FY 24 contract (the last contract they signed).

MDHHS has 21 Days (excluding weekends/state holidays) to file a written answer (circa January 15, 2025).

6. **Private Foster Care Agencies File Suit Against MDHHS:**

While not directly a PIHP issue, the following selective excerpt (from Gongwer, 12/9/24) may be of interest in light of the item #5 immediately above.

Several private foster care placement, case management and licensing organizations sued the Department of Health and Human Services recently over what they said was a unilateral decision to pay them less than a statutorily mandated per diem rate.

The lawsuit, Michigan Federation for Children and Families v. DHHS (COC Docket No. 24-000195), was filed in the Court of Claims. It alleges that in October, the department imposed a provision in its master agreement to amend placement contracts with a new per diem rate of $53.18, which the plaintiffs argue is far less than what was mandated by the Legislature in the Fiscal year 2024-25 budget.

The approved budget included a per diem rate of $60.20, the lawsuit noted.

"The MDHHS has … acted unilaterally, without authority, and contrary to the Legislature's direction by improperly reducing the amount of compensation it is paying to foster care service providers, and it threatened said providers with contract termination if they refused to accept the lesser pay," the lawsuit said. "The MDHHS has made passing reference to Act 174, Public Acts of Michigan, 2020, (Act 174) as the source of its authority for including incentives in the amended contracts but has failed to respond to the plaintiffs' requests for a substantive explanation of which provision of Act 174 empowers the Agency to pay less than the mandatory per diem rate. Consequently, the plaintiffs are forced to seek judicial relief to prevent the MDHHS from violating state law and exceeding its limited authority..."

…"In an unprecedented attempt to coerce the Plaintiff Providers into capitulation with the illegal amended contracts, in or about the beginning part of October 2024, the plaintiff providers received communication from the MDHHS indicating the agency would potentially remove foster care placement cases from plaintiff providers who refused to sign the amended contracts, which would ultimately lead to contract termination – further jeopardizing the safety and welfare of those served by the plaintiff providers," the lawsuit said.

7. **MDHHS Announced a new "Mental Health Framework":**

On 11/22/24, MDHHS held a meeting with PIHPs to announce a new "Mental Health Framework" initiative that it intends to "go live" 10/01/2025. The overall objective is to provide more enrollee-centered, whole person care. Goals stated by MDHHS are to:

- ensure access to mental health care for all Medicaid Comprehensive Health Care Program (CHCP) enrollees (which is a reference to people enrolled in the Medicaid Health Plans);
- a more coordinated and seamless enrollee experience across the care continuum;
- improved mental health outcomes

Noted by MDHHS as the beginning of a conversation to create the new framework, MSHN anticipates a number of policy changes affecting the Medicaid Health Plans, Pre-Paid Inpatient Health Plans, CMHSPs and medical care providers. There was some emphasis on increased coordination between Medicaid Health Plan (MHP) and PIHP delivery systems and strengthened plan accountability for assigned enrollees.

Key elements described by MDHHS include clear and consistent criteria for mental health coverage responsibility (likely via a new benefit plan MDHHS has called "PIHP +", specifying and holding MHPs responsible for mild/moderate services, standardized assessments between MHP/PIHP systems, and more. MSHN anticipates new network adequacy standards, increased complex care management/joint care planning requirements, and additional MHP/PIHP-level requirements.

There are several problematic elements (such as introducing the concept that MHPs cover psychiatric inpatient hospitalization for people with mild/moderate conditions; MSHN provided input that if a person is mild/moderate, they are no longer mild/moderate at the point they require psychiatric inpatient care) included in the plan, but there are – at least in the initial view – improvements.

MSHN has relayed this information to our regional CMHSP Participants and will keep the region and our MSHN Board of Directors informed as developments continue.

FEDERAL/NATIONAL UPDATES AND ACTIVITIES

8. **Overdose Crisis Community Decision Tool:**

The National Institutes of Health's HEAL Initiative has launched a free, web-based resource that guides community decision-makers in selecting tailored, evidence-based strategies to reduce opioid overdose deaths.

9. **SAMHSA Releases Substance Use Disorder Treatment Month Toolkit:**

SAMHSA has released a toolkit for the first Substance Use Disorder Treatment Month, to be observed January 2025. Treatment Month raises awareness of the benefits and availability of evidence-based treatments for people with a substance use disorder; addresses barriers to treatment, including stigma; and normalizes seeking help.

The toolkit includes information about weekly themes, social media graphics and messaging, a webinar background, and resources that public health organizations, treatment providers, professional associations, and others can use to spread awareness of Treatment Month.

10. **Incoming Federal Administration:**

The Kaiser Family Foundation (KFF) has published an article entitled *Potential Health Policy Administrative Actions in the Second Trump Administration.* "President-elect Trump could exercise executive branch authority through administrative action to quickly move forward on some policy changes without congressional action. This is a quick guide to potential health policy administrative actions under the incoming Trump administration based on campaign positions and statements by President-elect Trump, President Trump's record during his first administration, and expected actions that would reverse or modify regulations or guidance issued by the Biden administration. Note this is not an exhaustive list of possible administrative actions and the guide may be updated as new information becomes available up until his inauguration on January 20, 2025.

Affordable Care Act

- Continue to implement hospital and health plan price transparency requirements.
- Make changes to ACA Marketplace enrollment processes.
- Limit or eliminate funding for Affordable Care Act consumer assistance and outreach programs.
- Require separate payments for abortion coverage in ACA Marketplace plans.
- Approve or reject state waivers.
- Reinstate expansion of short-term, limited-duration health plans (STLDs).
- Reinstate expanded access to association health plans (AHPs).
- Revise guidance implementing section 1557 of the Affordable Care Act (ACA), removing LGBTQ protections.

Abortion

- Direct the FDA to revoke the approval of mifepristone or revert to older dispensing protocols under the REMS.
- Enforce the Comstock Act to ban the distribution of medication abortion pills and other supplies in all states.
- Stop enforcing the Emergency Medical Treatment and Labor Act (EMTALA) for emergency abortion care.

- Rescind HIPAA regulations to safeguard abortion privacy.
- Rescind guidance to retail pharmacies about nondiscrimination obligations.
- Revoke rules authorizing access to abortion care under the Veteran's Administration.
- Revoke support for active military troops and their spouses who seek abortion or fertility care.
- Exclude abortion from the protections of the Pregnant Workers Fairness Act.
- Bar the use of NIH funds for research involving fetal tissue derived from abortions.
- Require separate payments for abortion coverage in ACA Marketplace plans.
- Approve waivers that exclude Planned Parenthood clinics and other providers from the Medicaid program.
- Reinstate Mexico City Policy and potentially expand it further.

Contraception

- Reinstate limitations to the Title X Family Planning Program.
- Overturn recently expanded contraceptive coverage regulations.

Medicaid

- Delay implementation or issue new regulations to undo final regulations streamlining Medicaid enrollment and renewal processes.
- Approve waivers that include work requirements as a condition of Medicaid eligibility, premiums, and other eligibility restrictions.
- Delay implementation or issue new regulations to undo final access and managed care rules.
- Approve waivers that exclude Planned Parenthood clinics and other providers from the Medicaid program.

Immigration and Health

- End the Deferred Action for Childhood Arrivals (DACA) program and associated ACA Marketplace coverage expansion.
- Reinstate changes to public charge policy to include health coverage programs.
- Carry out mass detentions and deportations of millions of immigrants.
- End birthright citizenship for children of some immigrants.
- Reinstate "Remain in Mexico" policy.
- Limit entry of humanitarian migrants.

LGBTQ Health Policy

- Revise guidance implementing section 1557 of the Affordable Care Act (ACA), removing LGBTQ protections.
- Issue executive orders limiting LGBTQ protections, including in health care.
- Limit access to gender affirming care for minors and, potentially, adults.

Racial Health Equity and DEI Initiatives

- Eliminate equity-focused initiatives and issue anti-diversity, equity, and inclusion (DEI) executive orders.

Global Health

- Reinstate Mexico City Policy and potentially expand it further.
- Cease U.S. engagement in pandemic treaty negotiations.
- Halt funding for and withdraw from the World Health Organization (WHO).
- Rejoin Geneva Consensus Declaration on Women's Health and Protection of the Family.
- Invoke the Kemp-Kasten amendment to prevent U.S. funding for UNFPA.

Prescription Drugs

- Reinstate executive order on manufacturing essential medicines in the U.S.

Fentanyl

- Impose tariffs on Mexico, China, and Canada.
- Deploy U.S. military to the southern border to combat drug trafficking.
- Intensify domestic law enforcement efforts related to fentanyl.
- Expand federal coverage for faith-based treatment and flexibilities for protected leave during addiction treatment.

Long-term Care

- Relax regulations governing nursing facilities."

11. **New Paper on the Causes, Impact and Solutions to Mass Violence in the US:**

The National Council Medical Director Institute is excited to introduce an update to the groundbreaking paper Mass Violence in the United States: Definition, Prevalence, Causes, Impacts and Solutions.
This report challenges common misconceptions about the relationship between mental illness and mass violence, offering evidence-based insights into this complex issue. Key takeaways include:

- Mass violence is a serious and growing public health concern in the U.S.
- Most mass violence perpetrators **do not** have major psychiatric disorders.
- The link between mental illness and violence is modest and limited to specific conditions.
- Interventions known to be effective in understanding and preventing mass violence have not yet been widely adopted.
- Establishing multidisciplinary behavioral threat assessment and management teams can help reduce the risk of mass violence.

The paper is an essential resource for mental health professionals and other stakeholders seeking to understand and address mass violence, reduce discrimination against those with mental health conditions and effectively support people who are struggling.
Download the paper now to access the full findings and recommendations, including effective strategies for addressing mass violence, future research needs, and tips for working with the media, courts and law enforcement.

Submitted By:

Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 12/20/2024

Attachments:
None – Pending Legislation not enacted in this legislative session will need to be reintroduced in the next legislature.

MSHN
Mid-State Health Network

REPORT OF THE MSHN DEPUTY DIRECTOR
to the Board of Directors
November/December

Staffing Update

Mid-State Health Network is pleased to announce we have filled the following positions effective in January 2025.

- Kara Laferty transferred from the Database Report Coordinator to the Quality Manager position.
- Stacey Lehman transferred from the Utilization Management Specialist to the Data & Grant Coordinator position.

Please join us in congratulations to staff on their transfers.

MSHN is still looking to fill the **Database and Report Coordinator, Integrated Health Administrator** and **Utilization Management Specialist positions** located on MSHN's website at: https://midstatehealthnetwork.org/stakeholders-resources/about-us/Careers.

Fiscal Year End 2024 Reports Available

Annual Consumers Served Survey Results

The Mid-State Health Network (MSHN) annually administers a survey to individuals served as required by Michigan Department of Health and Human Services (MDHHS). MSHN, in collaboration with the Community Mental Health Services Program (CMHSP) and their contracted providers, and the Substance Use Disorder Treatment Providers utilized the Mental Health Statistics Improvement Program (MHSIP) and the Youth Satisfaction Survey (YSS) survey tool to obtain feedback related to the perception of care for a representative sample of all served within the MSHN region.

Summary of the survey results:

- MSHN performed above the national performance and the 80% standard for the following domains: Access, Participation in Treatment, Appropriateness, General Satisfaction, Cultural Sensitivity.
- Growth areas include the domains that did not meet the 80% standard and/or performed below the National average. These domains include Perception of Social Functioning, Social Connectedness, and Outcomes.
- Distribution methods with the highest rate of return for children and families was phone distribution, and adults was face to face distribution method. The method with the highest increase in utilization and most consistent used was electronic. Phone surveys were the least used method.

Figures 1 & 2 below represent the domain results in comparison to national performance. MSHN's Quality Improvement Council will establish a plan to address any systemic issues including exploration of an electronic process for the entire region, conduct additional analysis to include separation of results by race/ethnicity and gender and finally to review areas below the 80% standard where MSHN's performance decreased from previous years as well as by CMHSP specific results.

Figure 1: Experience of Care Surveys-Children and Family Performance Comparison to National Performance.

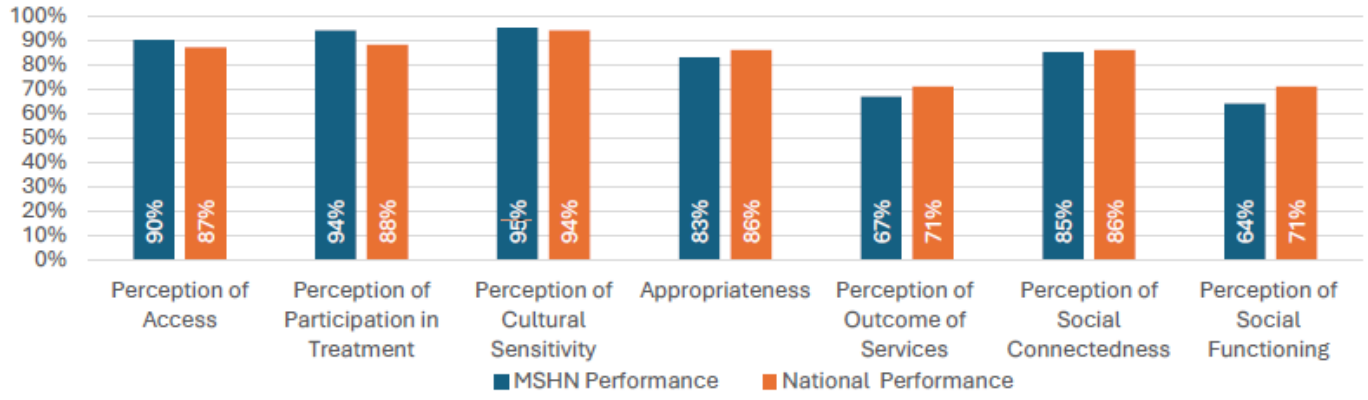
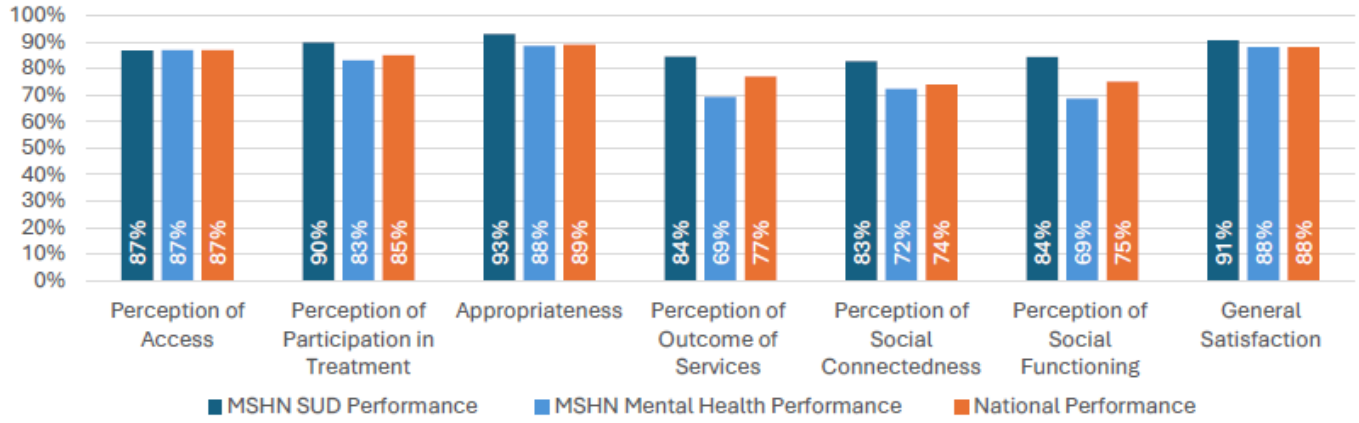


Figure 2: Experience of Care Surveys-Adult Performance Comparison to National Performance.



For more detailed information, see the **Annual Experience of Care** links below.

Population Health Priority Measurement Portfolio

With input from our regional councils and committees, MSHN developed a few years ago a priority measure portfolio based on national healthcare industry standards. MSHN provides reports on these measures both as a region as well as performance of each CMHSP. MSHN councils and committees review status quarterly for ongoing input into performance improvement strategies. In addition, MSHN publishes the priority measures on the MSHN website: Priority Measures - (midstatehealthnetwork.org).

The FY24 year-end report is now available and linked below, **Priority Measures FY24**.

Balanced Scorecard

MSHN departments along with CMHSP and Substance Use Disorder (SUD) providers have been working to close out the fiscal year and review and report final figures to the Board of Directors. The Balanced Scorecard metrics report for FY24 preliminary results are ready for Board review and included as an update on the agency's strategic plan. I'd like to congratulate the region on outstanding performance for fiscal year end September 2024 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 Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level			
BETTER HEALTH	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN Ages 19-64	MDHHS PIHP Contract: Performance Bonus Measure	72%	72%	69%	66%	Baseline year to set benchmark and target		75-100%	66-74%	<65%
	Percent of individuals who receive follow up care within 30 days after an emergency department visit for alcohol or drug use. (FUA)	MSHN Strategic Plan FY19-20; MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	38%	39%	Not Available	Not Available	100%		>=28%	24%-27%	<=23%
	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year. (Rolling 12 months)	Aligns with strategic plan goal improve population health and integrated care activities.	Report being built by MSHN IT	56%	67%	58%	Michigan 2023: 70.31%		Baseline Year		
	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.(FUH)	HEDIS-NCQA	85%	85%	Not Available	Not Available	70%		>=70%	0	<70%

For the full report, see the attached ***FY24 Balanced Scorecard Report.***

Performance Bonus Incentive Pool Report

Per MDHHS requirements, MSHN must submit an annual report on the joint metrics and activities related to integration of behavioral health and physical health. Pre-Paid Inpatient Health Plans (PIHPs) must provide a narrative related to five (5) areas of performance; 1. Comprehensive Care, 2. Patient-Centered, 3. Coordinated Care, 4. Accessible Services, and 5. Quality and Safety. Attached via the link below, includes the report submitted on November 15, 2024. The report provides updates to each one of the identified areas related to MSHN direct provided efforts as well as the integration of services across the region by our affiliate community mental health partners.

MSHN expects to receive 100% of the bonus incentive again this year, estimated at $5million, that will be distributed to our CMHSPs as earned local funds. Highlights from the report include:

- MSHN and its regional partners expanded Certified Community Behavioral Health Clinics (CCBHCs) adding LifeWays CMH to the already participating 3 CMHs (CEI, Saginaw and The Right Door). ***16,502 Medicaid beneficiaries and 3,369 non-Medicaid beneficiaries in the MSHN region were enrolled in CCBHC services by the end of FY24 (as of 9/30/2024).***
- MSHN and its regional partners expanded the Behavioral Health Home (BHH) initiative adding Gratiot Integrated Health Network to the already 5 CMHs (Saginaw, Central, Montcalm, Newaygo and Shiawassee) and served 336 individuals during the first 6 months of the initiative. ***Total FY 24 served was 660, compared to 336 in FY23.***
- MSHN expanded the Opioid Health Home (OHH) initiative adding 4 more locations late in FY24, serving Saginaw, Jackson and Lansing (Victory Clinic Services), Recovery Pathways – Essexville and MidMichigan Community Health Services. ***Total FY 24 served was 397, compared to 234 in FY23.***
- 86% of individuals experienced a reduction in Emergency Department (ED) utilization as compared to the 12-month period prior to being opened for care coordination.
- 630 individuals received screening and follow-up support from Project ASSERT coaches in response to a substance-related hospital ED visit during FY 2024.

For the full report, see the link below: **Performance Bonus Incentive Report FY24**.

Submitted by:

Amanda L. Ittner
Finalized: 12.23.24

Attached:
Balanced Scorecard FY24

Links to Reports:
Adults Mental Health Experience of Care FY24
Adults Substance Use Disorder Experience of Care FY24
Child/Family Experience of Care FY24
Priority Measures FY24
Performance Bonus Incentive Pool FY24

MSHN FY24- Board of Directors and Operations Council - Balanced Scorecard

									Target Ranges		
Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level			
BETTER HEALTH	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN Ages 19-64	MDHHS PIHP Contract: Performance Bonus Measure	72%	72%	69%	66%	Baseline year to set benchmark and target		75-100%	66-74%	<65%
	Percent of individuals who receive follow up care within 30 days after an emergency department visit for alcohol or drug use. (FUA)	MSHN Strategic Plan FY19-20; MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	38%	39%	Not Available	Not Available	100%		>=28%	24%-27%	<=23%
	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year. (Rolling 12 months)	Aligns with strategic plan goal improve population health and integrated care activities.	Report being built by MSHN IT	56%	67%	58%	Michigan 2023: 70.31%		Baseline Year		
	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.(FUH)	HEDIS-NCQA	85%	85%	Not Available	Not Available	70%		>=70%	0	<70%
BETTER CARE	The percentage of Intensive Crisis Stabilization Service calls deployed in a timely manner.	Aligns with annual MDHHS reporting process and improving children/adolescent timely access to care.	91%	89%	91%		>=95%		95-100%	90-94%	<90%
	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 individuals to initiate services and engage in continuation of care.	Initiation: 47.74% (1-1-2023 thru 12-31-2023)	Initiation: 47.54% (3-1-2023 thru 2-29-2024)	Initiation: 47.01% (6-1-2023 thru 5-31-2024)	Initiation: 45.63% (10/1/2023 thru 9/30/2024)	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 individuals to initiate services and engage in continuation of care.	Engagement: 29.75% (1-1-2023 thru 12-31-2023)	Engagement: 29.66% (3-1-2023 thru 2-29-2024)	Engagement: 28.91% (6-1-2023 thru 5-31-2024)	Engagement: 28.43% (10/1/2023 thru 9/30/2024)	Above Michigan 2020 levels; E: 12.5% (2016)		Increase over National levels	No change from National levels	Drop below National 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 individuals to initiate services and engage in continuation of care.	Initiation: 86.80% Engagement: 47.49% (1-1-2023 thru 12-31-2023)	Initiation: 86.11% Engagement: 47.61% (3-1-2023 thru 2-29-2024)	Initiation: 85.75% Engagement: 47.03% (6-1-2023 thru 5-31-2024)	Initiation: 87.34% Engagement: 48.65% (9/1/2023 thru 8/31/2024)	Increase over MSHN 2020 levels (I: 88.69%; E: 54.67%)		Increase over 2020 levels	No change from 2020 levels	Drop below 2020 levels
	Continuum of Care - Consumers moving from inpatient psychiatric hospitalization will show in next LOC within 7 days, and 2 additional appts within 30 days of first step-down visit. (Quarterly)	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: 38.12%; E: 20.46%	I: 38.67%; E: 20.52%	I: 36.47%; E: 19.36%	I: 42.39%; E: 22.64%	Increase over FY 2019 (I: 38.85%; E: 19.21%)		increase over 2019	No change from 2019 levels	Below 2019 levels
	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, MSHN UM Plan; Measurement Portfolio NQF 1768	12.8%	13.0%	13.0%	12.5%	<=15%		<=15%	16-25%	>25%
BETTER VALUE	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	88%	88%	89%	88.6%	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
	MSHN reserves (ISF)	RESERVE'S TARGET SUFFICIENT TO MEET FISCAL RISK RELATED TO DELIVERY OF MEDICALLY NECESSARY SERVICES AND TO COVER ITS MDHHS CONTRACTUAL LIABILITY.	Data not available	Data not available	Data not available	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.	2	2	2	2	2		2	1	0
	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization. (FYTD)	The MDHHS requirement of 95% slot utilization or greater.	94%	96%	96%	96%	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 FY21-22, Federal Parity Requirements	1%	0.08%	0.09%	0.01%	<= 5%		<=5%	6%-10%	>=11%

MSHN FY24- Board of Directors and Operations Council - Balanced Scorecard

									Target Ranges		
Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level			
	Medical Loss Ratio is within CMS Guidelines	MSHN WILL MAINTAIN A FISCAL DASHBOARD TO REPORT FINANCE COUNCIL'S AGREED UPON METRICS.	Data not available	Data not available	Data not available	96.3%	85%		≥ 90%	> 85% and < 90%	≤ 85%
	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP	MDHHS PIHP Contract: Performance Bonus Incentive Program	77%	83%	71%	86%	100%		>=75%	50%-74%	<50%
BETTER PROVIDER SYSTEMS	Percentage of consumers indicating satisfaction with LTSS (Annual Comprehensive Total)	NCI-Satisfaction Section	Not Applicable	Not Applicable	Not Applicable	85%	>=80%		80%	75%-80%	75%
	Managed Care Information Systems (REMI) Enhancements	Patient Portal, BTPR, Critical incidents, EVV, etc.	2	3	3	4	4		3	2	1
	Determine feasibility of CLS/Specialized Residential servcies regional contract template and monitoring	Strategic Plan - Better Provider Systems	Data not available for Dec and Mar	Data not available for Dec and Mar	Data not available for June	Data not available for September	Not Started		Complete	In Process	Not Started
	Improve data availability (Foster Care/child Welfare, SDoH, Employment & Housing, Autism Reporting, etc.)	MSHN FY24-25 Strategic Plan - MSHN will increase regional use of information technology data systems to support population health management.	33%	75%	90%	90%	100%		75%	50%	25%
BETTER EQUITY	The disparity between the white population and at least one minority who initiated treatment (AOD) within 14 calendar days will be reduced. (IET-Initiation disparity)	MDHHS PIHP Contract: Performance Bonus Incentive Program	Not Available	Not Available	Not Available	Not Available	TBD		TBD	TBD	TBD
	The disparity between the white population and at least one minority group who engaged in treatment (AOD or MAT) within 34 calendar days will be reduced. (IET-Engagement disparity)	MDHHS PIHP Contract: Performance Bonus Incentive Program	Not Available	Not Available	Not Available	Not Available	TBD		TBD	TBD	TBD
	Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities between the white and minority adults and children who receive follow-up care within 30 days following a psychiatric hospitalization (FUH)	MDHHS PIHP Contract: Performance Bonus Incentive Program	1	1	Not Available	Not Available	0		0	1	2
	PIP 1 - The racial disparities between the black/African American population and the white population will be reduced or eliminated without a decline in performance for the white population. (Yes=The disparity is not statistcially lower than the White population and the index rate did not decrease)	EQR-PIP#1 Strategic Plan	No	Not Available	Not Available	Not Available	Yes		Yes	No change	No

MSHN FY24 - Opioid Health Home - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2023	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Performance Level	Target Ranges		
	Please Note: * Indicates Pay for Performance Measure										
BETTER CARE	**Initiation of Alcohol and Other Drug Dependence Treatment within 14 days (IET 14)***	CMS Health Home Core Set (2023)	86.21%	48%	No Value	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	**Engagement of Alcohol and Other Drug Dependence Treatment within 34 days (IET 34)***	CMS Health Home Core Set (2023)	82.76%	30%	No Value	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 7 days (FUA 7)***	CMS Health Home Core Set (2023)	100%	100%	100%	Not Available	Not Available		>58%		<58%
BETTER CARE	**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 30 days (FUA 30)***	CMS Health Home Core Set (2023)	100%	100%	100%	Not Available	Not Available		>58%		<58%
BETTER CARE	**Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries**	CMS	Not Available	Discontinued by MDHHS during FY24	Discontinued by MDHHS during FY24	Discontinued by MDHHS during FY24	Discontinued by MDHHS during FY24				
BETTER HEALTH	Controlling High Blood Pressure (CBP)	CMS Health Home Core Set (2023)	33.3%	57%	56%	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Screening for Depression and Follow-Up Plan (CDF)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available	Not Available	Not Available				
BETTER HEALTH	Colorectal Cancer Screening (COL)	CMS Health Home Core Set (2023)	Not Applicable	30%	No Value	Not Available	Not Available				
BETTER CARE	Follow-Up After Hospitalization for Mental Illness within 7 days (FUH 7)	CMS Health Home Core Set (2023)	100.0%	50%	33%	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Hospitalization for Mental Illness within 30 days (FUH 30)	CMS Health Home Core Set (2023)	100%	100%	100%	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness within 7 days (FUM 7)	CMS Health Home Core Set (2023)	20%	0%	0%	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness within 30 days (FUM 30)	CMS Health Home Core Set (2023)	40%	0%	0%	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available	Not Available	Not Available				
BETTER CARE	Plan All-Cause Readmission Rate (PCR)	CMS Health Home Core Set (2023)	33%	7%	19%	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Prevention Quality Indicator: Chronic Conditions Composite (PQI 92)	CMS Health Home Core Set (2023)	102 per 1,000 beneficiaries	213 per 1,000 beneficiaries	193 per 1,000 beneficiaries	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER EQUITY	Admission to a Facility from the Community (AIF)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available	Not Available	Not Available				
BETTER CARE	Inpatient Utilization (IU)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available	Not Available	Not Available				

MSHN FY24 - Community Certified Behavioral Health Clinic - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns With	CCBHC Program	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER CARE	Follow-Up After Hospitalization for Mental Illness-7 Days (FUH - Adults) MSHN Ages 18-64.	CMS Adult Core Set (2023)	Michigan CCBHC Program	47.6%	46.2%	Not Available	Not Available	58.0%		>58%		<58%
			CEI	42.4%	41.7%	Not Available	57%	58.0%		>58%		<58%
			Lifeways	48.1%	46.8%	Not Available	49%	58.0%		>58%		<58%
			The Right Door	49.0%	43.7%	Not Available	40%	58.0%		>58%		<58%
			SCCMHA	51.3%	48.0%	Not Available	40%	58.0%		>58%		<58%
BETTER CARE	Follow-Up After Hospitalization for Mental Illness-30 days (FUH - Adults) MSHN Ages 18-64.	CMS Adult Core Set (2023)	Michigan CCBHC Program	72.4%	70.4%	Not Available	Not Available	58.0%		>58%		<58%
			CEI	67.7%	64%	70%	73%	58.0%		>58%		<58%
			Lifeways	82.2%	77.3%	79%	77%	58.0%		>58%		<58%
			The Right Door	77.5%	78%	72%	70%	58.0%		>58%		<58%
			SCCMHA	73.1%	71%	60%	64%	58.0%		>58%		<58%
BETTER CARE	Follow-Up After Hospitalization for Mental Illness-7 days (FUH-Child/Adolescents) MSHN. Ages 6-17.	CMS Child Core Set (2023)	Michigan CCBHC Program	60.9%	59%	Not Available	Not Available	70.0%		>70%		<70%
			CEI	71.7%	73%	Not Available	70%	70.0%		>70%		<70%
			Lifeways	64.0%	60%	Not Available	65%	70.0%		>70%		<70%
			The Right Door	73.9%	79%	Not Available	41%	70.0%		>70%		<70%
			SCCMHA	61.9%	53%	Not Available	45%	70.0%		>70%		<70%
BETTER CARE	Follow-Up After Hospitalization for Mental Illness 30 days (FUH-Child/Adolescents) MSHN. Ages 6-17.	CMS Child Core Set (2023)	Michigan CCBHC Program	83.4%	82.1%	Not Available	Not Available	70.0%		>70%		<70%
			CEI	90.8%	92%	85%	70%	70.0%		>70%		<70%
			Lifeways	82.0%	81.4%	94%	94%	70.0%		>70%		<70%
			The Right Door	100.0%	100%	75.0%	68.2%	70.0%		>70%		<70%
			SCCMHA	85.7%	80%	74%	68%	70.0%		>70%		<70%
BETTER HEALTH	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN Ages 19-64	CMS Adult Core Set (2023)	Michigan CCBHC Program	59.3%	57.8%	Not Available	Not Available	58.5%		>58.5%		<58.5%
			CEI	62.0%	61%	68%	60%	58.5%		>58.5%		<58.5%
			Lifeways	68.2%	62.9%	69%	61%	58.5%		>58.5%		<58.5%
			The Right Door	75.7%	78%	71%	71%	58.5%		>58.5%		<58.5%
			SCCMHA	58.1%	56%	60%	59%	58.5%		>58.5%		<58.5%
BETTER CARE	Initiation of Alcohol and Other Drug Dependence Treatment MSHN. Ages 13+	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	41.5%	Not Available	Not Available	l -25%		>25%		<25%
			CEI	52.9%	43%	46%	Not Available	l -25%		>25%		<25%
			Lifeways	Not Available	24.0%	45%	Not Available	l -25%		>25%		<25%
			The Right Door	38.9%	41%	51%	Not Available	l -25%		>25%		<25%
			SCCMHA	50.0%	43%	45%	Not Available	l -25%		>25%		<25%
BETTER CARE	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Child) MSHN Ages 6-17.	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available	23.9%		>23.9%		<23.95%
			CEI	83.14%	84.10%	81.27%	Not Available	23.9%		>23.9%		<23.95%
			Lifeways	26.72%	16.67%	18.67%	Not Available	23.9%		>23.9%		<23.95%
			The Right Door	82.80%	86.61%	90.32%	Not Available	23.9%		>23.9%		<23.95%
			SCCMHA	39.53%	31.61%	50.56%	Not Available	23.9%		>23.9%		<23.95%
BETTER CARE	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Adults) MSHN Ages 18+	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available	12.5%		>12.5%		<12.5%
			CEI	75.68%	75.73%	75.02%	Not Available	12.5%		>12.5%		<12.5%
			Lifeways	43.20%	37.50%	19.32%	Not Available	12.5%		>12.5%		<12.5%
			The Right Door	69.62%	68.57%	63.89%	Not Available	12.5%		>12.5%		<12.5%
			SCCMHA	72.58%	73.85%	75.95%	Not Available	12.5%		>12.5%		<12.5%
	Please Note: The QBP is only pertinent to Medicaid CCBHC costs and beneficiaries.											
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness (FUM-7) Initiation. Ages 6+	CMS Adult Core Set (2023)	Michigan CCBHC Program	57.8%	56.4%	Not Available	Not Available			>previous	no change	<previous
			CEI	45.6%	45%	40%	Not Available			>previous	no change	<previous
			Lifeways	68.0%	69.5%	61%	Not Available			>previous	no change	<previous
			The Right Door	53.7%	60%	55%	Not Available			>previous	no change	<previous
			SCCMHA	53.8%	51%	51%	Not Available			>previous	no change	<previous
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness (FUM-30) Engagement. Ages 6+	CMS Adult Core Set (2023)	Michigan CCBHC Program	74.7%	73.3%	Not Available	Not Available			>previous	no change	<previous
			CEI	65.9%	63%	63%	39%			>previous	no change	<previous
			Lifeways	85.7%	86.4%	85%	62%			>previous	no change	<previous
			The Right Door	75.9%	79%	75%	78%			>previous	no change	<previous
			SCCMHA	73.9%	71%	73%	45%			>previous	no change	<previous
BETTER CARE	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-7) Ages 13+	CMS Adult Core Set (2023)	Michigan CCBHC Program	35.3%	36.1%	Not Available	Not Available			>previous	no change	<previous
			CEI	33.1%	32.4%	Not Available	Not Available			>previous	no change	<previous
			Lifeways	25.7%	27.5%	Not Available	Not Available			>previous	no change	<previous
			The Right Door	38.7%	36.4%	Not Available	Not Available			>previous	no change	<previous
			SCCMHA	46.3%	49.4%	Not Available	Not Available			>previous	no change	<previous

MSHN FY24 - Community Certified Behavioral Health Clinic - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns With	CCBHC Program	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER CARE	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-30) Ages 13+	CMS Adult Core Set (2023)	Michigan CCBHC Program	55.7%	55.0%	Not Available	Not Available			>previous	no change	<previous
			CEI	54.9%	52.2%	Not Available	Not Available			>previous	no change	<previous
			Lifeways	51.4%	47.5%	Not Available	Not Available			>previous	no change	<previous
			The Right Door	58.1%	57.6%	Not Available	Not Available			>previous	no change	<previous
			SCCMHA	65.7%	68.4%	Not Available	Not Available			>previous	no change	<previous
BETTER HEALTH	Plan All-Cause Readmission Rate (PCR-AD)^ Ages 18+	CMS Adult Core Set (2023)	Michigan CCBHC Program	10.0%	10.4%	Not Available	Not Available			<previous	no change	>previous
			CEI	9.5%	10%	12%	14%			<previous	no change	>previous
			Lifeways	9.4%	10.9%	11%	13%			<previous	no change	>previous
			The Right Door	7.6%	9%	7%	9.5			<previous	no change	>previous
			SCCMHA	8.7%	11%	15%	15%			<previous	no change	>previous
BETTER CARE	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD-AD)^ Ages 18-64.	CMS Adult Core Set (2023)	Michigan CCBHC Program	82.3%	Not Available	Not Available	Not Available			>previous	no change	<previous
			CEI	86.3%	86%	78%	77%			>previous	no change	<previous
			Lifeways	82.1%	Not Available	77%	78%			>previous	no change	<previous
			The Right Door	84.6%	93%	78%	77%			>previous	no change	<previous
			SCCMHA	86.2%	83%	80%	78%			>previous	no change	<previous
BETTER CARE	Follow-up care for children prescribed ADHD medication. Initiation Phase (ADD-CH)^ Ages 6-12.	CMS Child Core Set (2021)	Michigan CCBHC Program	61.9%	61.0%	Not Available	Not Available			>previous	no change	<previous
			CEI	56.7%	59%	72%	72.15			>previous	no change	<previous
			Lifeways	80.77%*	74.2%	68%	75%			>previous	no change	<previous
			The Right Door	73.08%*	51.85%*	65%	70%			>previous	no change	<previous
			SCCMHA	57.8%	55%	76%	76%			>previous	no change	<previous
BETTER CARE	Follow-up care for children prescribed ADHD medication. C & M Phase (ADD-CH)^ Ages 6-12.	CMS Child Core Set (2021)	Michigan CCBHC Program	68.1%	67.5%	Not Available	Not Available			>previous	no change	<previous
			CEI	61.1%	65%	92%	96%			>previous	no change	<previous
			Lifeways	84.62%*	68.75%*	100%	97%			>previous	no change	<previous
			The Right Door	77.78%*	66.67%*	100%	98%			>previous	no change	<previous
			SCCMHA	84.62%*	83%	98%	97%			>previous	no change	<previous
BETTER HEALTH	Antidepressant Medication Management Acute Phase (AMM-AD) ^ Ages 18+.	CMS Adult Core Set (2023)	Michigan CCBHC Program	51.8%	52.2%	Not Available	Not Available			>previous	no change	<previous
			CEI	48.6%	49.6%	30%	33%			>previous	no change	<previous
			Lifeways	58.1%	56.2%	30%	32%			>previous	no change	<previous
			The Right Door	59.2%	62%	30%	30%			>previous	no change	<previous
			SCCMHA	46.8%	50.5%	29%	29%			>previous	no change	<previous
BETTER HEALTH	Antidepressant Medication Management Cont. Phase (AMM-AD) ^ Ages 18+.	CMS Adult Core Set (2023)	Michigan CCBHC Program	32.2%	31.6%	Not Available	Not Available			>previous	no change	<previous
			CEI	32.4%	31.0%	33%	35%			>previous	no change	<previous
			Lifeways	36.2%	32.9%	35%	35%			>previous	no change	<previous
			The Right Door	40.0%	39.2%	35%	39%			>previous	no change	<previous
			SCCMHA	25.0%	22.9%	29%	33%			>previous	no change	<previous
BETTER CARE	Engagement of Alcohol and Other Drug Dependence Treatment MSHN. Ages 13+.	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available			>previous	no change	<previous
			CEI	44.6%	35%	39%	Not Available			>previous	no change	<previous
			Lifeways	Not Available	Not Available	33%	Not Available			>previous	no change	<previous
			The Right Door	30.6%	37%	43%	Not Available			>previous	no change	<previous
			SCCMHA	43.1%	35%	33%	Not Available			>previous	no change	<previous
BETTER CARE	Time to Initial Evaluation (I-EVAL): Percent of consumers with an initial evaluation within 10 Business Days. Total (all ages)	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available			>previous	no change	<previous
			CEI	61%	56%	55.91%	Not Available	Increase		>previous	no change	<previous
			Lifeways	80%	82%	76.67%	Not Available	Increase		>previous	no change	<previous
			The Right Door	82%	79%	78.93%	Not Available	Increase		>previous	no change	<previous
			SCCMHA	67%	67%	73.45%	Not Available	Increase		>previous	no change	<previous
BETTER CARE	Time to Initial Evaluation (I-EVAL): Mean Number of Days until Initial Evaluaton	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available			<=10 days		>10 days
			CEI	6	10	11.33	Not Available	<=10 days		<=10 days		>10 days
			Lifeways	8	9	9.96	Not Available	<=10 days		<=10 days		>10 days
			The Right Door	7	8	5.83	Not Available	<=10 days		<=10 days		>10 days
			SCCMHA	13	13	12.29	Not Available	<=10 days		<=10 days		>10 days
BETTER CARE	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available			>previous	no change	<previous
			CEI	4%	4%	4.92%	Not Available	Increase		>previous	no change	<previous
			Lifeways	14.81%	7%	14.02%	Not Available	Increase		>previous	no change	<previous
			The Right Door	30%	29%	26.79%	Not Available	Increase		>previous	no change	<previous
			SCCMHA	33%	33%	37.57%	Not Available	Increase		>previous	no change	<previous
BETTER CARE	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)^ All ages	CMS Child Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available			>previous	no change	<previous
			CEI	1%	2%	1%	42%	Increase		>previous	no change	<previous
			Lifeways	0%	0%	0%	56%	Increase		>previous	no change	<previous

MSHN FY24 - Community Certified Behavioral Health Clinic - Balanced Scorecard

									Target Ranges		
Key Performance Areas	**Key Performance Indicators**	**Aligns With**	**CCBHC Program**	**Actual Value (%) as of December 2023**	**Actual Value (%) as of March 2024**	**Actual Value (%) as of June 2024**	**Actual Value (%) as of September 2024**	**Target Value**	**Performance Level**			
	Activity for Children/Adolescents (WCC-CH) - All ages	(2023)	The Right Door	52%	52%	54%	27.1%	Increase		>previous	no change	<previous
			SCCMHA	57%	61%	72%	53%	Increase		>previous	no change	<previous
BETTER HEALTH	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC) Ages 18 +	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available			>previous	no change	<previous
			CEI	9%	13%	24.11%	Not Available	Increase		>previous	no change	<previous
			Lifeways	72%	82%	67.52%	Not Available	Increase		>previous	no change	<previous
			The Right Door	36%	39%	33.13%	Not Available	Increase		>previous	no change	<previous
			SCCMHA	41%	44%	48.13%	Not Available	Increase		>previous	no change	<previous
BETTER HEALTH	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC) Ages 18 +	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available			>previous	no change	<previous
			CEI	9%	12%	24.27%'	Not Available	Increase		>previous	no change	<previous
			Lifeways	3%	4%	4.32%	Not Available	Increase		>previous	no change	<previous
			The Right Door	68%	69%	67.59%	Not Available	Increase		>previous	no change	<previous
			SCCMHA	68%	70%	67.69%	Not Available	Increase		>previous	no change	<previous
BETTER CARE	Screening for Depression and Follow-Up Plan: Age 12+ (CDF-AD)	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available			>previous	no change	<previous
			CEI	2%	3%	4.44%	Not Available	Increase		>previous	no change	<previous
			Lifeways	48%	34%	49.61%	Not Available	Increase		>previous	no change	<previous
			The Right Door	37%	38%	38.19%	Not Available	Increase		>previous	no change	<previous
			SCCMHA	37%	36%	30.32%	Not Available	Increase		>previous	no change	<previous
BETTER CARE	Depression Remission at Twelve Months (DEP-REM-12) Ages 12+	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available			>previous	no change	<previous
			CEI	1%	1%	0.90%	Not Available	Increase		>previous	no change	<previous
			Lifeways	0%	*	0%	Not Available	Increase		>previous	no change	<previous
			The Right Door	3%	3%	5.71%	Not Available	Increase		>previous	no change	<previous
			SCCMHA	4%	0%	1.83%	Not Available	Increase		>previous	no change	<previous
BETTER PROVIDER SYSTEM	Patient Experience fo Care Survey (PEC) Ages 18+ (annual comprehensive score)	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	80%			Not Available	TBD				
			Lifeways	NA			Not Available	TBD				
			The Right Door	81%			Not Available	TBD				
			SCCMHA	75%			Not Available	TBD				
BETTER PROVIDER SYSTEM	Youth/Family Experience fo Care Survey (Y/FEC) Ages <18 (annual comprehensive score)	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	82%			Not Available	TBD				
			Lifeways	NA			Not Available	TBD				
			The Right Door	78%			Not Available	TBD				
			SCCMHA	84%			Not Available	TBD				

MSHN FY24 - Behavioral Health Home - Balanced Scorecard

									Target Ranges		
Key Performance Areas	**Key Performance Indicators**	**Aligns with**	**Actual Value (%) as of September 2023**	**Actual Value (%) as of December 2023**	**Actual Value (%) as of March 2024**	**Actual Value (%) as of June 2024**	**Actual Value (%) as of September 2024**	**Performance Level**			
	Please Note: * Indicates Pay for Performance Measure		***N=<30**								
BETTER HEALTH	**Controlling High Blood Pressure (CBP)***	CMS Health Home Core Set (2023)	100%*	100%*	50%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER VALUE	**Reduction in Ambulatory Care: Emergency Department (ED) Visits (AMB)***	CMS Health Home Core Set (2023)	Not Available - Discontinued by MDHHS								
BETTER CARE	**Access to Preventive/Ambulatory Health Services (AAP)***	HEDIS NCQA	97.08%	92%	98.12%	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Screening for Depression and Follow-Up Plan (CDF)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available	Not Available	Not Available				
BETTER HEALTH	Colorectal Cancer Screening (COL)	CMS Health Home Core Set (2023)	n=0*	58%	n=0*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 7 days (FUA 7)	CMS Health Home Core Set (2023)	100%*	66.67%*	75%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 30 days (FUA 30)	CMS Health Home Core Set (2023)	100%*	66.67%*	75%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Hospitalization for Mental Illness within 7 days (FUH 7)	CMS Health Home Core Set (2023)	71.43%*	53.33%*	53.85%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Hospitalization for Mental Illness within 30 days (FUH 30)	CMS Health Home Core Set (2023)	100%*	86.67%*	88.46%*	Not Available	Not Available		>58%		<58%
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness within 7 days (FUM 7)	CMS Health Home Core Set (2023)	100%*	45.45%*	56.25%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness within 30 days (FUM 30)	CMS Health Home Core Set (2023)	100%*	72.73%*	75%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Initiation of Alcohol and Other Drug Dependence Treatment within 14 days (IET 14)	CMS Health Home Core Set (2023)	25%*	50%*	37.50%*	Not Available	Not Available		>25%		<25%
BETTER CARE	Engagement of Alcohol and Other Drug Dependence Treatment within 34 days (IET 34)	CMS Health Home Core Set (2023)	0%*	50%*	12.50%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Plan All-Cause Readmission Rate (PCR)	CMS Health Home Core Set (2023)	Not Available	40%*	24%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Prevention Quality Indicator: Chronic Conditions Composite (PQI 92)	CMS Health Home Core Set (2023)	Not Available	62 per 1,000 beneficiaries	81 per 1,000 beneficiaries	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER EQUITY	Admission to a Facility from the Community (AIF)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Inpatient Utilization (IU)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available	Not Available	Not Available		<previous reporting period	no change	>previous reporting period

MSHN FY24 - Quality Improvement Council - Scorecard

Key Performance Areas	Key Performance Indicators	Regulatory Requirement Source	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	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: QAPIP	MMBPIS FY24 Codebook Indicator 1	98.58%	98.63%	98.22%%	Not Available	>=95%		>=95%	94%	<94%
BETTER CARE	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: QAPIP	MMBPIS FY24 Codebook Indicator 1	99.67%	99.33%	99.67%%	Not Available	>=95%		>=95%	94%	<94%
BETTER CARE	The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non emergency request for service. Cumulative	MDHHS PIHP Contract: Michigan Mission Based Performance Indicator System	MMBPIS FY24 Codebook Indicator 2	61.79%	63.16%	64.13%	Not Available	>=62.%		>=62.3%		<62.3%
BETTER CARE	The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. Cumulative	MDHHS PIHP Contract: Michigan Mission Based Performance Indicator System	MMBPIS FY24 Codebook Indicator 3	59.72%	62.55%	64.13%	Not Available	>=72.9%		>=72.9%		<72.90%
BETTER CARE	Percent of child discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days	MDHHS PIHP Contract: QAPIP	MMBPIS FY24 Codebook Indicator 4a	94.67%	96.03%	100.00%	Not Available	>=95%		>=95%	94%	<94%
BETTER CARE	Percent of adult discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days	MDHHS PIHP Contract: QAPIP	MMBPIS FY24 Codebook Indicator 4a	95.20%	95.60%	97.16%%	Not Available	>=95%		>=95%	94%	<94%
BETTER HEALTH	Percent of MI and DD children readmitted to an inpatient psychiatric unit within 30 days of discharge	MDHHS PIHP Contract: QAPIP	MMBPIS FY24 Codebook Indicator 10	9.36%	9.09%	6.38%%	Not Available	<=15%		<=15%	>=15.1%	>=16%
BETTER HEALTH	Percent of MI and DD adults readmitted to an inpatient psychiatric unit within 30 days of discharge	MDHHS PIHP Contract: QAPIP	MMBPIS FY24 Codebook Indicator 10	10.73%	10.84%	12.79%	Not Available	<=15%		<=15%	>=15.1%	>=16%
BETTER PROVIDER SYSTEM	Percentage of adults indicating satisfaction with SUD services. (Annual Comprehenisve Total)	MDHHS PIHP Contract: QAPIP	SAMSHA 2005 MHSIP	Not Applicable	Not Applicable	Not Applicable	87%	>=80%		80%	75%-80%	75%
BETTER PROVIDER SYSTEM	Percentage of children/families indicating satisfaction with mental health services (Annual Comprehensive Total)	MDHHS PIHP Contract: QAPIP	SAMSHA 2005 YSS	Not Applicable	Not Applicable	Not Applicable	82%	>=80%		80%	75%-80%	75%
BETTER PROVIDER SYSTEM	Percentage of adults indicating satisfaction with mental health services (Annual Comprehensive Total)	MDHHS PIHP Contract: QAPIP	SAMSHA 2005 MHSIP	Not Applicable	Not Applicable	Not Applicable	80%	>=80%		80%	75%-80%	75%
BETTER PROVIDER SYSTEM	Percentage of consumers indicating satisfaction with LTSS (Annual Comprehensive Total)	MDHHS PIHP Contract: QAPIP	NCI-Satisfaction Section	Not Applicable	Not Applicable	Not Applicable	85%	>=80%		80%	75%-80%	75%
BETTER EQUITY	PIP 1 - The racial disparities between the black/African American population and the white population will be reduced or eliminated without a decline in performance for the white population. (Yes=The disparity is not statistcially lower than the White population and the index rate did not decrease)	MDHHS PIHP Contract: QAPIP	EQR-PIP#1 Strategic Plan	No	Not Available	Not Available	Not Available	Yes		Yes	No change	No
BETTER EQUITY	PIP 2 - The racial or ethnic disparity between the black/African American minority penetration rate and the index (white) penetration rate will be reduced or eliminated. (Yes=The disparity is not statistically lower than the white population group, and the index rate did not decrease)	MDHHS PIHP Contract: QAPIP	Strategic Plan	No	No	Not Available	Not Available	Yes		Yes	No change	No
BETTER HEALTH	The rate of critical incidents, per 1000 persons served, will demonstrate a decrease from previous measurement period. (CMHSP) (excluding deaths) Cumulative YTD	MDHHS PIHP Contract: QAPIP	MSHN QAPIP	3.393	5.592	8.848	Not Available	FY23 9.550		Decrease	No change	Increase
BETTER HEALTH	The rate, per 1000 persons served, of Unexpected Deaths will demonstrate a decrease from previous measurment period. (CMHSP) Cumulataive YTD	MDHHS PIHP Contract: QAPIP	MSHN QAPIP	0.463	0.281	0.395	Not Available	FY23 1.109		Decrease	No change	Increase
BETTER HEALTH	The percent of emergency intervention per person served will demonstrate a decrease from previous measurement period.	MDHHS PIHP Contract: QAPIP	MSHN QAPIP	0.77%	0.66%	0.74%	Not Available	Decrease previous quarter .77%		Decrease	No change	Increase

MSHN FY24 - Customer Service Committee - Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER CARE	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: Appeal and Grievance Resolution Processes Technical Requirement	98.97%	100.00%	98.30%	97.25%	95%		95%	91%-94%	90%
BETTER CARE	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: Appeal and Grievance Resolution Processes Technical Requirement	100%	100%	97.05%	100%	95%		95%	91%-94%	90%

MSHN FY24 - Regional Compliance Committee - Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER CARE	Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines. CMHSP	MSHN QAPIP	Not available	Not available	Not available	Not available	Increase over 2023		Increase	No change	Decrease
BETTER CARE	Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines. SUD	MSHN QAPIP	Not available	Not available	Not available	Not available	Increase over 2023		Increase	No change	Decrease

MSHN FY24 - Provider Network Management Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September	Target Value	Performance Level	Target Ranges		
BETTER PROVIDER SYSTEM	Develop an action plan to address repeat findings related to provider credentialing and recredentialing process requirements through training/technical assistance and monitoring; monitoring and oversight of CMHSPs demonstrate improvement in credentialing and credentialing systems;	HSAG and MDHHS Reviews	25%	50%	75%	100%	90%		>90%	70-89%	<70%
BETTER PROVIDER SYSTEM	Providers demonstrate increased compliance with the MDHHS/MSHN Credentialing and Staff Qualification requirements. (SUD Network and CMHSP Network)	QAPIP Goal; HSAG and MDHHS reviews	25%	50%	75%	100%	90%		>90%	70-89%	<70%
BETTER PROVIDER SYSTEM	Address recommendations from the 2023 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs.	MDHHS Network Adequacy Requirements	25%	50%	100%	100%	100%		>95%	80-94%	<79%
BETTER PROVIDER SYSTEM	Monitor and implement Electronic Visit Verification as required by MDHHS	MDHHS Reviews	Data not available for Dec and Mar	Data not available for Dec and Mar	Go-Live 9.3.24; Data not available for June	Go-Live 9.3.24; Data not available for September	Once Implemented		Complete	In Process	Not Started
BETTER PROVIDER SYSTEM	Advocate for direct support professionals to support provider retention (e.g. wage increase; recognition)	Strategic Plan - Better Provider Systems	25%	50%	75%	100%	100%		>90%	70-89%	<70%
BETTER PROVIDER SYSTEM	Determine feasibility of CLS/Specialized Residential servcies regional contract template and monitoring	Strategic Plan - Better Provider Systems	Data not available for Dec and Mar	Data not available for Dec and Mar	Data not available for June	Data not available for September	Not Started		Complete	In Process	Not Started
BETTER PROVIDER SYSTEM	Develop and implement regionally approved process for credentialing/re-credentialing reciprocity	QAPIP Goal; HSAG and MDHHS reviews	Data not available for Dec and Mar	Data not available for Dec and Mar	100%; Online application available to be shared thoruhout region - as selected by provider	100%; Online application available to be shared throughout region - as selected by provider	In Process		Complete	In Process	Not Started

MSHN FY24- Clinical Leadership Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year. (Rolling 12 months)	Aligns with strategic plan goal improve population health and integrated care activities.	Report being built by MSHN IT	55.56%	66.67%	57.64%	Michigan 2023: 70.31%	TBD			
BETTER HEALTH	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN Ages 19-64	MDHHS PIHP Contract: Performance Bonus Measure	72.20%	71.8%	69.08%	65.87%	Baseline year to set benchmark and target		75-100%	66-74%	<65%
BETTER CARE	The percentage of Intensive Crisis Stabilization Service calls deployed in a timely manner.	Aligns with annual MDHHS reporting process and improving children/adolescent timely access to care.	90.90%	89.40%	91.00%	96.00%	>=95%		95-100%	90-94%	<90%
BETTER VALUE	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization. (FYTD)	The MDHHS requirement of 95% slot utilization or greater.	93.60%	95.5%	95.90%	95.70%	95% or greater		95-100%	90-94%	<90%
BETTER CARE	Behavior Treatment Plan standards met vs. standards assessed from the delegated managed care reviews. (Quarterly)	MDHHS Technical Requirement for Behavior Treatment Plans.	94.00%	Not avail this quarter	50.00%	50.00%	95% or greater		95-100%	90-94%	<90%
BETTER CARE	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Quarterly)	Monthly autism benefit reporting on timeliness.	87.00%	87.0%	88.00%	87.00%	95%		95-100%	90-94%	<90%
BETTER CARE	Percent of individuals enrolled in the 1915(i) State Plan Amendment. (Quarterly)	MDHHS enrollment of persons eligible for the 1915(i) SPA benefit and HCBS Rule.	100.00%	100.0%	100.00%	100.00%	>=95%		95-100%	90-94%	<90%
BETTER CARE	Continuum of Care - Consumers moving from inpatient psychiatric hospitalization will show in next LOC within 7 days, and 2 additional appts within 30 days of first step-down visit. (Quarterly)	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: 38.12%; E: 20.46%	I: 38.67%; E: 20.52%	I: 36.47%; E: 19.36%	I: 42.39%; E: 22.64%	Increase over FY 2019 (I: 38.85%; E: 19.21%)		increase over 2019	No change from 2019 levels	Below 2019 levels
BETTER PROVIDER SYSTEM	MSHN Crisis Residential will be ready for full operation by 4/30/2024. (Cumulative Quarterly).	Aligns with strategic plan to increase access to acute care. Also aligns with MDHHS requirements for network adequacy.	59.00%	86.0%	100.00%	100.00%	25% growth per quarter		25% or greater growth	15%-24% growth	<15% growth

MSHN FY24 - Clinical SUD - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	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	51 activities FY24-Q1	92 activities FY24-Q2	169 activites FY24-Q3	255 activities FY24-Q4	144		>=144	<144 and >72	<=72
BETTER HEALTH	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. -	27 MAT sites	27 MAT sites	27 MAT sites	27 MAT	Increase MAT locations by 5% over FY20 (22)		>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 individuals to initiate services and engage in continuation of care.	Initiation: 71.77% Engagement: 44.06% (1-1-2023 thru 12-31-2023)	Initiation: 70.46% Engagement: 43.95% (2-1-2023 thru 1-31-2024)	Initiation: 68.35% Engagement: 43.60% (6-1-2023 thru 5-31-2024)	Initiation: 74.30% Engagement: 44.18% (8/1/23 thru 7/31/2024)	Increase over MSHN 2020 levels Initiation: 36.81% ; Engagement: 22.30%		Increase over 2020 levels	No change from 2020 levels	Drop below 2020 levels
BETTER CARE	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 individuals to initiate services and engage in continuation of care.	Initiation: 86.80% Engagement: 47.49% (1-1-2023 thru 12-31-2023)	Initiation: 86.11% Engagement: 47.61% (3-1-2023 thru 2-29-2024)	Initiation: 85.75% Engagement: 47.03% (6-1-2023 thru 5-31-2024)	Initiation: 87.34% Engagement: 48.65% (9/1/2023 thru 8/31/2024)	Increase over MSHN 2020 levels (I: 88.69%; E: 54.67%)		Increase over 2020 levels	No change from 2020 levels	Drop below 2020 levels
BETTER CARE	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 individuals to initiate services and engage in continuation of care.	Initiation: 47.74% (1-1-2023 thru 12-31-2023)	Initiation: 47.54% (3-1-2023 thru 2-29-2024)	Initiation: 47.01% (6-1-2023 thru 5-31-2024)	Initiation: 45.63% (10/1/2023 thru 9/30/2024)	Above Michigan 2020 levels; I: 40.8%		Increase over National levels	No change from National levels	Drop below National levels
BETTER CARE	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 individuals to initiate services and engage in continuation of care.	Engagement: 29.75% (1-1-2023 thru 12-31-2023)	Engagement: 29.66% (3-1-2023 thru 2-29-2024)	Engagement: 28.91% (6-1-2023 thru 5-31-2024)	Engagement: 28.43% (10/1/2023 thru 9/30/2024)	Above Michigan 2020 levels; E: 12.5% (2016)		Increase over National levels	No change from National levels	Drop below National levels
BETTER EQUITY	The disparity between the white population and at least one minority who initiated treatment (AOD) within 14 calendar days will be reduced. (IET-Initiation disparity)	MDHHS PIHP Contract: Performance Bonus Incentive Program	Not Available	Not Available	Not Available	Not Available	TBD		TBD	TBD	TBD
BETTER EQUITY	The disparity between the white population and at least one minority group who engaged in treatment (AOD or MAT) within 34 calendar days will be reduced. (IET-Engagement disparity)	MDHHS PIHP Contract: Performance Bonus Incentive Program	Not Available	Not Available	Not Available	Not Available	TBD		TBD	TBD	TBD
BETTER CARE	Percent of discharges from a substance abuse withdrawal management unit who are seen for follow up care within seven days.	MDHHS PIHP Contract: Michigan Mission Based Performance Indicator System Indicator 4b	95%	98%	92%	Not Available	95%		95%	94%	<94%
BETTER CARE	The percentage of individuals identified as a priority popuation who have been screened and referred for services within the required timeframe.	MDHHS PIHP Contract: Access Standards.	34%	61%	88%	89%	>42%		>42%	41-35%	<35%
BETTER CARE	The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders (SUD). (Cumulative)	MDHHS PIHP Contract: Michigan Mission Based Performance Indicator System Indicator 2e	72%	74%	73%	Not Available	>75.3%		>75.5%		<75.5%

MSHN FY24 Information Technology Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of Decemeber 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September	Target Value	Performance Level	Target Ranges		
BETTER VALUE	Unique consumers submitted monthly	Contractual Reporting Oversight	90.7%	92.6%	95.20%	97.0%	85%		86.0%	85.0%	84.0%
BETTER VALUE	Encounters submitted monthly	Contractual Reporting Oversight	91.3%	96.9%	97.26%	97.7%	85%		86.0%	85.0%	84.0%
BETTER VALUE	BH-TEDS submitted monthly	Contractual Reporting Oversight	91.2%	89.1%	88.28%	91.7%	85%		86.0%	85.0%	84.0%
BETTER VALUE	Percentage of encounters with BH-TEDS	Contractual Reporting Oversight	98.5%	99.1%	99.32%	98.7%	95%		95.0%	94.0%	90.0%
BETTER CARE	Integrate MiCANS Assessment Tool into REMI (MDHHS soft start 10/1/2024)	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	0.00%	0.00%	0%	0%	100%		75%	50%	25%
BETTER HEALTH	Increase use cases with MiHIN (e-consents)	MSHN FY24-25 Strategic Plan - MSHN will pursue e-consent management opportunities to improve care coordination between behavioral health, physical health, and SUD systems of care.	1	1	1	1%	2		2	1	0
BETTER HEALTH	Increase health information exchange/record sets OHH and BHH atribution files to ZTS, etc.)	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.	1	2	2	2%	2		2	1	0
BETTER PROVIDER SYSTEM	Managed Care Information Systems (REMI) Enhancements	Patient Portal, BTPR, Critical incidents, EVV, etc.	2	3	3	4	4		3	2	1
BETTER PROVIDER SYSTEM	Improve data use and quality (Race/Ethnicity Startification, Measure Repository, Predictive Modeling, etc.)	MSHN FY24-25 Strategic Plan - Increase overall efficiencies and effectiveness by streamlining and standardizing business tasks and processess as appropriate.	20%	45%	82%	90%	100%		75%	50%	25%
BETTER PROVIDER SYSTEM	Improve data availability (Foster Care/child Welfare, SDoH, Employment & Housing, Autism Reporting, etc.)	MSHN FY24-25 Strategic Plan - MSHN will increase regional use of information technology data systems to support	33%	75%	90%	90%	100%		75%	50%	25%
BETTER PROVIDER SYSTEM	Research change management system applications for use in areas such as contracts, policies, MDHHS guidance, etc.	MSHN FY24-25 Strategic Plan - Provider systems are fragile and stressed due to the magnitude and frequency of change. Invest in improving change management systems at MSHN and across the region.	0%	0%	0%	0%	100%		75%	50%	25%

MSHN FY24 - Integrated Care - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	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. (FUA)	MSHN Strategic Plan FY19-20; MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	38%	39%	Not Available	Not Available	100%		>=28%	24%-27%	<=23%
BETTER HEALTH	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. (FUA	MDHHS/PIHP Contracted, Integrated Health Performance Bonus Requirements	2	2	Not Available	Not Available	0		0	1	2
BETTER CARE	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.(FUH)	HEDIS-NCQA	85.25%	85%	Not Available	Not Available	70%		>=70%		<70%
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)	HEDIS-NCQA	69.34%	68%	Not Available	Not Available	58%		>=58%		<58%
BETTER EQUITY	Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities between the white and minority adults and children who receive follow-up care within 30 days following a psychiatric hospitalization (FUH)	MDHHS PIHP Contract: Performance Bonus Incentive Program	1	1	Not Available	Not Available	0		0	1	2
BETTER EQUITY	Review and research BH-TEDS Housing Data - develop outcomes related to Housing	MDHHS PIHP Contract: Performance Bonus Incentive Program	In Progress	In Progress	Complete	Complete	Complete		Outcome Reporting	Data Valadation	Data Collection
BETTER EQUITY	Review and research BH-TEDS Employment Data - develop outcomes related to Employment	MDHHS PIHP Contract: Performance Bonus Incentive Program	In Progress	In Progress	Complete	Complete	Complete		Outcome Reporting	Data Valadation	Data Collection
BETTER CARE	Percent of care coordination cases that were closed due to successful coordination.	MDHHS PIHP Contract: Performance Bonus Incentive Program	100%	40%	71%	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	MDHHS PIHP Contract: Performance Bonus Incentive Program	76.70%	83.33%	71.43%	85.70%	100.0%		>=75%	50%-74%	<50%

MSHN FY24 - Finance Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER VALUE	MSHN reserves (ISF)	RESERVE'S TARGET SUFFICIENT TO MEET FISCAL RISK RELATED TO DELIVERY OF MEDICALLY NECESSARY SERVICES AND TO COVER ITS MDHHS CONTRACTUAL LIABILITY.	Data not available	Data not available	Data not available	7.5%	7.5%		> 6%	≥ 5% and 6%	< 5%
BETTER VALUE	Regional Financial Audits indicate unqualified opinion	MSHN WILL REVIEW CMHSP FINANCIAL AUDITS AND COMPLIANCE EXAMINATIONS TO IDENTIFY SIGNIFICANT DEFICIENCIES THAT IMPACT THE REGION.	100%	100%	100%	100%	100%		> 92%	< 92% and > 85%	≤ 85%
BETTER VALUE	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.	Data not available	Data not available	100%	100%	100%		> 92%	< 92% and > 85%	≤ 85%
BETTER VALUE	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	88.00%	88%	88.90%	88.6%	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
BETTER VALUE	Medical Loss Ratio is within CMS Guidelines	MSHN WILL MAINTAIN A FISCAL DASHBOARD TO REPORT FINANCE COUNCIL'S AGREED UPON METRICS.	Data not available	Data not available	Data not available	96%	85%		≥ 90%	> 85% and < 90%	≤ 85%
BETTER VALUE	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.	Data not available	Data not available	Data not available	100%	100%		<100%	> 100% and <105%	>105%
BETTER VALUE	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.	2	2	2	2	2		2	1	0

MSHN FY24 - Utilization Management Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	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 UM Plan	Not Available	97.0%	Not Available	97.0%	100%		96-100%	94-95%	<93%
BETTER CARE	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person centered plan	MSHN Strategic Plan , MDHHS State Transition Plan; MDHHS Site Review Findings	72.73%	N/A	N/A	N/A	100%		100%	90%-99%	<90%
BETTER CARE	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, MSHN UM Plan; Measurement Portfolio NQF 1768	12.82%	13.01%	13.01%	12.51%	<=15%		<=15%	16-25%	>25%
BETTER VALUE	Service Authorizations Denials Report demonstrates 90% or greater compliance with timeframe requirements for service authorization decisions and ABD notices	MSHN QAPIP Plan	97.77%	96.60%	98.46%	Not Available	> 90%		>90%	89-80%	<80%
BETTER VALUE	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages	MSHN Strategic Plan FY21-22, Federal Parity Requirements	1.00%	0.08%	0.09%	0.01%	<= 5%		<=5%	6%-10%	>=11%

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 November 30, 2024, 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 November 30, 2024, as presented.

Mid-State Health Network
Statement of Activities
As of November 30, 2024

Rows Numbers		Columns Identifiers A	B	C	D	E (C - D)	F (C / B)	
			Budget Annual	Actual Year-to-Date	Budget Year-to-Date	Budget Difference	Actual % of Budget	
			FY25 Original Budget		FY25 Original Budget			
			16.67%					
1	Revenue:							
2		Grant and Other Funding	$ 280,000	320,583	46,667	273,917	114.49 %	1a
3		Prior FY Medicaid Carryforward	$ 0	0	0	0		1b
4		Medicaid Capitation	904,524,545	141,164,862	150,754,090	(9,589,230)	15.61%	1c
5		Local Contribution	1,550,876	387,719	258,480	129,240	25.00%	1d
6		Interest Income	2,500,000	530,685	416,666	114,019	21.23%	1e
7		Non Capitated Revenue	18,132,736	2,303,161	3,022,123	(718,963)	12.70%	1f
8	Total Revenue		926,988,157	144,707,010	154,498,026	(9,791,017)	15.61 %	
9	Expenses:							
10		PIHP Administration Expense:						
11		Compensation and Benefits	9,181,634	1,332,273	1,530,272	(197,999)	14.51 %	
12		Consulting Services	223,800	21,514	37,300	(15,786)	9.61 %	
13		Contracted Services	126,350	15,126	21,059	(5,933)	11.97 %	
14		Other Contractual Agreements	679,700	52,853	113,283	(60,430)	7.78 %	
15		Board Member Per Diems	20,820	2,170	3,470	(1,300)	10.42 %	
16		Meeting and Conference Expense	214,043	34,500	35,674	(1,174)	16.12 %	
17		Liability Insurance	34,590	24,277	5,765	18,512	70.19 %	
18		Facility Costs	192,636	43,744	32,106	11,638	22.71 %	
19		Supplies	371,650	41,482	61,942	(20,460)	11.16 %	
20		Other Expenses	1,076,330	401,540	179,388	222,152	37.31 %	
21		Subtotal PIHP Administration Expenses	12,121,553	1,969,479	2,020,259	(50,780)	16.25 %	2a
22		CMHSP and Tax Expense:						
23		CMHSP Participant Agreements	822,423,444	125,240,411	137,070,574	(11,830,163)	15.23 %	1b,1c,2b
24		SUD Provider Agreements	67,318,827	10,183,812	11,219,804	(1,035,992)	15.13 %	1c,1f,2c
25		Benefits Stabilization	1,610,000	1,993,334	268,334	1,725,000	123.81 %	1b
26		Tax - Local Section 928	1,550,876	387,719	258,479	129,240	25.00 %	1d
27		Taxes- IPA/HRA	51,290,698	6,744,143	8,548,450	(1,804,307)	13.15 %	2d
28		Subtotal CMHSP and Tax Expenses	944,193,845	144,549,419	157,365,641	(12,816,222)	15.31 %	
29	Total Expenses		956,315,398	146,518,898	159,385,900	(12,867,002)	15.32 %	
30	Excess of Revenues over Expenditures		$ (29,327,241)	$ (1,811,888)	$ (4,887,874)			

Mid-State Health Network
Preliminary Statement of Net Position by Fund
As of November 30, 2024

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		16,275,914	0	16,275,914	1a
4	Chase MM Savings		10,363,713	0	10,363,713	
5	Savings ISF Account		0	30,522,903	30,522,903	1b
6	Savings PA2 Account		3,474,879	0	3,474,879	1c
7	Investment PA2 Account		3,499,843	0	3,499,843	1c
8	Investment ISF Account		0	11,998,230	11,998,230	1b
9	Total Cash and Short-term Investments		$ 33,614,349	$ 42,521,133	$ 76,135,482	
10	**Accounts Receivable**					
11	Due from MDHHS		39,427,211	0	39,427,211	2a
12	Due from CMHSP Participants		243,717	0	243,717	2b
13	Due from CMHSP - Non-Service Related		7,922	0	7,922	2c
14	Due from Other Governments		242,705	0	242,705	2d
15	Due from Miscellaneous		381,177	0	381,177	2e
16	Due from Other Funds		9,438,498	0	9,438,498	2f
17	Total Accounts Receivable		49,741,230	0	49,741,230	
18	**Prepaid Expenses**					
19	Prepaid Expense Rent		4,529	0	4,529	2g
20	Prepaid Expense Other		1,110	0	1,110	2h
21	Total Prepaid Expenses		5,639	0	5,639	
22	**Fixed Assets**					
23	Fixed Assets - Computers		189,180	0	189,180	2i
24	Accumulated Depreciation - Computers		(189,180)	0	(189,180)	
25	Lease Assets		203,309	0	203,309	2j
26	Accumulated Amortization - Lease Asset		(171,816)	0	(171,816)	
27	Total Fixed Assets, Net		31,493	0	31,493	
28	**Total Assets**		**$ 83,392,711**	**$ 42,521,133**	**$ 125,913,844**	
29						
30	**Liabilities and Net Position**					
31	Liabilities					
32	Accounts Payable		$ 5,756,375	$ 0	$ 5,756,375	1a
33	Current Obligations (Due To Partners)					
34	Due to State		32,877,080	0	32,877,080	3a
35	Other Payable		5,627,981	0	5,627,981	3b
36	Due to Hospitals (HRA)		5,845,556	0	5,845,556	1a, 3c
37	Due to State-IPA Tax		898,588	0	898,588	3d
38	Due to CMHSP Participants		14,331,742	0	14,331,742	3e
39	Due to other funds		0	9,438,498	9,438,498	3f
40	Accrued PR Expense Wages		192,087	0	192,087	3g
41	Accrued Benefits PTO Payable		453,683	0	453,683	3h
42	Accrued Benefits Other		56,719	0	56,719	3i
43	Total Current Obligations (Due To Partners)		60,283,436	9,438,498	69,721,934	
44	Lease Liability		33,177	0	33,177	2j
45	Deferred Revenue		6,619,427	0	6,619,427	1b 1c
46	Total Liabilities		72,692,415	9,438,498	82,130,913	
47	Net Position					
48	Unrestricted		10,700,296	0	10,700,296	3j
49	Restricted for Risk Management		0	33,082,635	33,082,635	1b
50	Total Net Position		10,700,296	33,082,635	43,782,931	
51	**Total Liabilities and Net Position**		**$ 83,392,711**	**$ 42,521,133**	**$ 125,913,844**	

Mid-State Health Network
Financial Statement Notes
For the Two-Month Period Ended,
November 30, 2024

Please note: The Preliminary Statement of Net Position contains Fiscal Year (FY) 2024 cost settlement figures between the PIHP and Michigan Department of Health Human Services (MDHHS) as well as each Community Mental Health Service Program (CMHSP) Participants. CMHSP cost settlement figures were extracted from the interim MDHHS Financial Status Report (FSR) submitted in November 2024.

Preliminary Statement of Net Position:

1. Cash and Short-Term Investments
    a) The Cash Chase Checking and Chase Money Market Savings accounts are the cash line items available for operations.
    b) The Savings Internal Service Fund (ISF) and Investment ISF reflect designated accounts to hold the Medicaid ISF funds separate from all other funding per the MDHHS contract. MSHN holds nearly $12 M in the investment account, which is about 36% of the total ISF net position balance (row 49 col C). The investment portfolio has been temporarily reduced and moved to ISF Savings should the Region need to access funds for service delivery and other operational expenses. Internal Service Funds are used to cover the Region's risk exposure. In the event current Fiscal Year revenue is spent and all prior year savings are exhausted, PIHPs can transfer ISF dollars and use them for remaining costs. MSHN has had a fully funded ISF which is 7.5% of Medicaid Revenue for the last several Fiscal Years.
    c) The Savings PA2 account holds PA2 funds and is also offset by the Deferred Revenue liability account and investments exceeding $3.49 M.
2. Accounts Receivable
    a) Approximately 49% of the balance results from Certified Community Behavioral Health Centers' (CCBHC) supplemental funding which covers all mild to moderate recipients. Supplemental funding also covers a portion of the Prospective Payment System (PPS-1) for individuals with Severe Mental Impairments (SMI)/Severe Emotional Disturbance (SED)/Substance Use Disorder (SUD). In addition, more than 31% of the balance is from withholds while October and November Hospital Rate Adjustor (HRA) amounts account for 15% of the total. Lastly, the remaining balance stems from miscellaneous items.
    b) Due From CMHSP Participants reflect FY 2024 projected cost settlement activity. During November, MSHN cost settled with the CMHSPs for 85% of the balance due by either party. Final cost settlements generally occur in May after the fiscal year ends and once Compliance Examination are complete.

CMHSP	Cost Settlement	Payments/Offsets	Total
Tuscola	243,716.65	-	243,716.65

    c) Due from CMHSPs – Non-Service Related – represents one CMHSP's FY 25 Relias balance. Relias is the platform used for regional training.
    d) Amounts in Due From Other Governments represent six counties outstanding FY 24 quarter 4 PA 2 balance. PA 2 dollars are taxes generated from each counties liquor sales.
    e) The balance in Due From Miscellaneous is split between monies owed for Medicaid Event Verification (MEV) findings and cash advances needed to cover operations for a small number of SUD providers.
    f) Due From Other Funds is the account used to manage anticipated ISF transfers. Approximately $25 M is needed to support FY 24 regional expenses in excess of

revenue. This is a small improvement as the board approved FY 24 amended budget projected more than $27 M would be required to support FY 24 regional operations. MDHHS guidance allows PIHPs 7.5% retention of current FY revenue to manage risk. This amount is in addition to the allowable 7.5% for Savings generated when Medicaid and Healthy Michigan revenue exceed expenses.

g) Prepaid Expense Rent balance consists of security deposits for MSHN office suites.
h) Prepaid Expense Other consists of an FY 26 pre-paid Relias balance.
i) Total Fixed Assets - Computers represent the value of MSHN's capital asset net of accumulated depreciation.
j) The Lease Assets category is now displayed as an asset and liability based on a new Governmental Accounting Standards Board (GASB) requirement. The lease assets figure represents FY 2022 – 2025 contract amounts for MSHN's office space.

3. Liabilities

a) MSHN estimates FY 2022 and FY 2021 lapses totaling $13.5 M and $19.1 M to MDHHS, respectively. The lapse amounts indicate the ISF was fully funded for both fiscal years, and that savings fell within the second tier (above 5%). Per contractual guidelines MDHHS receives half of every dollar generated beyond this threshold until the PIHP's total savings reach the 7.5% maximum.
b) This amount is related to SUD provider payment estimates and is needed to offset the timing of payments.
c) HRA is a pass-through account for dollars sent from MDHHS to cover supplemental payments made to psychiatric hospitals. HRA payments are intended to encourage hospitals to have psychiatric beds available as needed. Total HRA payments are calculated based on the number of inpatient hospital services reported.
d) Due To State - IPA Tax contains funds held for tax payments associated with MDHHS Per Eligible Per Month (PEPM) funds. Insurance Plan Assessment taxes are applied to Medicaid and Healthy Michigan eligibles.
e) Due To CMHSP represents FY 24 projected cost settlement figures based on the MDHHS Projection FSR. These amounts will be paid during the region's final cost settlements, which generally occur in May or after Compliance Examinations are complete.

CMHSP	Cost Settlement	BHH Settlement	Payments/Offsets	Total
Bay	4,604,484.35	-	3,913,812.00	690,672.35
CEI	2,137,467.22	-	-	2,137,467.22
Central	6,349,417.76	(2,495.84)	5,397,005.00	949,916.92
Gratiot	2,177,990.11	(311.98)	1,851,292.00	326,386.13
Huron	2,615,084.02	-	2,222,821.00	392,263.02
The Right Door	303,129.18	-	-	303,129.18
Lifeways	10,950,503.93	-	8,002,409.00	2,948,094.93
Montcalm	498,751.35	(1,559.90)	423,939.00	73,252.45
Newaygo	1,448,912.85	-	1,231,576.00	217,336.85
Saginaw	6,322,077.53	(173,148.90)	-	6,148,928.63
Shiawassee	980,677.75	(2,807.82)	833,576.00	144,293.93
Total	**38,388,496.05**	**(180,324.44)**	**23,876,430.00**	**14,331,741.61**

f) This liability represents the anticipated remaining ISF transfer that will be made from the Medicaid Risk Reserve fund into Behavioral Health Operations. Please see Statement of Activities 2f for more details.
g) Accrued Payroll Expense Wages represent expenses incurred in November and paid in December.
h) Accrued Benefits PTO (Paid Time Off) is the required liability account set up to reflect paid time off balances for employees.
i) Accrued Benefits Other represents retirement benefit expenses incurred in November and paid in December.

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

Preliminary Statement of Activities – Column F calculates the actual revenue and expenses compared to the full year's original budget. Revenue accounts whose Column F percent is less than 16.67% translate to MSHN receiving less revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 16.67% show MSHN's spending is trending higher than expected.

1. Revenue
    a) This account tracks Veterans Navigator (VN) activity and CMHSP Clubhouse Grant payments used to assist those served with their Medicaid deductibles. In addition, MSHN received a special grant totaling $300k to work with a predictive analytics vendor. The unplanned grant is responsible for the variance in this account.
    b) MSHN is not anticipating an FY 24 carryforward/savings. As a reminder, Medicaid Savings are generated when the prior year revenue exceeds expenses for the same period.
    c) Medicaid Capitation – There is a negative variance in this account which indicates actual FY 25 revenue is lagging behind anticipated amounts. MDHHS FY 25 revenue rates received in late September seemed to indicate MSHN fiscal position would be better than anticipated however other factors such decreasing enrollments and other fiscal withholds impact this line item. The MSHN Region will continue its advocacy efforts with MDHHS around increased revenue rates and closely monitor capitation payments to evaluate if there is movement in a positive direction. Please note, Medicaid Capitation payment files are calculated and disbursed to CMHSPs based on a per eligible per month (PEPM) methodology and paid to SUD providers based on service delivery.
    d) Local Contribution is flow-through dollars from CMHSPs to MDHHS. Typically, revenue equals the expense side of this activity under Tax Local Section 928. Local Contributions were scheduled to reduce over the next few fiscal years until completely phased out. FY 2025 amounts are the same as FY 2024.
    e) Interest income is earned from investments and changes in principle for investments purchased at discounts or premiums.
    f) This account tracks non-capitated revenue for SUD services which include Community Grant and PA2 funds. There is a large variance in this account because the budget amount represents the full MDHHS allocation amount regardless of planned spending.
2. Expense
    a) Total PIHP Administration Expense is slightly under budget. The are two areas with significant variances. Compensation and Benefits is the first and this variance should decrease throughout the fiscal year as budgeted positions are filled. The other line item is Other Expenses. Charges contributing to the Other Expenses' variance are MiHIN (technology - data exchange) and MCHE (technology provider – Level of Care Determination – acute care) as both FY 25 invoices were paid in full in October.
    b) CMHSP participant Agreement shows a large variance when comparing actual to budget. The variance is related to the notes in item 2c above. MSHN funds CMHSPs based on per eligible per month (PEPM) payment files. The files contain CMHSP county codes which designate where the payments should be sent. MSHN sends the full payment less taxes and affiliation fees which support PIHP operations. In addition, benefit stabilization amounts are paid to CMHSP for SUD access activities and assist with cash flow needs. Two CMHSPs have received extra cash flow to cover operational expenditures in excess of their PEPM.
    c) SUD provider payments are less than anticipated and paid based on need. (Please see Statement of Activities 1c and 1f.)
    d) IPA/HRA actual tax expenses are lower than the budget. IPA estimates are impacted by variability in the number of Medicaid and Healthy Michigan eligibles. HRA figures will also vary throughout the fiscal year based on inpatient psychiatric utilization and contribute to the variance. (Please see Statement of Net Position 3c and 3d). Please

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

MID-STATE HEALTH NETWORK
SCHEDULE OF INTERNAL SERVICE FUND INVESTMENTS
As of November 30, 2024

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	91282CDR9	1.19.22	1.20.22	12.1.23		1,992,391.23	2,000,000.00			
UNITED STATES TREASURY BILL	91282CDR9						(2,000,000.00)			
UNITED STATES TREASURY BILL	912797FU6	6.14.23	6.15.23	12.14.23		9,746,615.56	10,000,000.00			
UNITED STATES TREASURY BILL	912797MA2	7.9.24	7.11.24	11.5.24		29,999,379.63	30,505,000.00			
UNITED STATES TREASURY BILL	912797MA2						(30,505,000.00)			
UNITED STATES TREASURY BILL	912797KZ9	8.26.24	8.27.24	11.21.24		1,999,307.58	2,023,000.00			
UNITED STATES TREASURY BILL	912797KZ9						(2,023,000.00)			
UNITED STATES TREASURY BILL	912797NK9	11.4.24	11.5.24	3.4.25		9,999,247.63	9,999,247.63			
UNITED STATES TREASURY BILL	912797KA4	11.19.24	11.21.24	2.20.25		1,998,981.77	1,998,981.77			
JP MORGAN INVESTMENTS							11,998,229.40			11,998,229.40
JP MORGAN CHASE SAVINGS							30,274,463.84	0.020%	248,439.65	30,522,903.49
							$ 42,272,693.24		$ 248,439.65	$ 42,521,132.89

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

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

Chase does not generate statements in months when no investment activity occurs. In these instances, a position report provided by Chase is used to determine the investment principal. In addition, the change in market value is derived from the difference in market value and cost.

MID-STATE HEALTH NETWORK
SCHEDULE OF PA2 SAVINGS INVESTMENTS
As of November 30, 2024

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24		3,499,349.00	3,591,000.00	912797GM3		
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24			(3,591,000.00)			
UNITED STATES TREASURY BILL	912797JZ1	2.7.24	2.8.24	6.4.24		3,499,228.51	3,558,000.00			
UNITED STATES TREASURY BILL	912797JZ1	2.7.24	2.8.24	6.4.24			(3,558,000.00)			
UNITED STATES TREASURY BILL	9127979LK1	6.3.24	6.4.24	10.1.24		3,499,660.72	3,560,000.00			
UNITED STATES TREASURY BILL	9127979LK1						(3,560,000.00)			
UNITED STATES TREASURY BILL	912796ZV4	9.30.24	10.1.24	12.26.24		3,499,843.32	3,499,843.32			
JP MORGAN INVESTMENTS							3,499,843.32			3,499,843.32
JP MORGAN CHASE SAVINGS							3,471,940.13	0.010%	2,938.32	3,474,878.45
							$ 6,971,783.45		$ 2,938.32	$ 6,974,721.77

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

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

Chase does not generate statements in months when no investment activity occurs. In these instances, a position report provided by Chase is used to determine the investment principal. In addition, the change in market value is derived from the difference in market value and cost.

MSHN
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Background

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

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

Therefore, MSHN presents the attached FY25 Contract Listing for Board approval and authorization of the Chief Executive Officer to sign.

Recommended Motion:

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

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

CONTRACTING ENTITY	CMHSP SERVICE AREA	CONTRACT TERM	CURRENT FY25 CONTRACT AMOUNT	FY25 TOTAL CONTRACT AMOUNT	FY25 INCREASE/ (DECREASE)
PIHP/CMHSP MEDICAID SUBCONTRACTS					
CEI Community Mental Health Authority	Clinton, Eaton & Ingham		-	-	-
Clubhouse Spenddown MOU		10.1.24 - 9.30.25	48,805	**60,000**	**11,195**
Community Mental Health of Central Michigan	Clare, Gladwin, Isabella, Mecosta, Midland, Osceola		-	-	-
Clubhouse Spendown MOU		10.1.24 - 9.30.25	56,935	**70,000**	**13,065**
LifeWays	Jackson & Hillsdale		-	-	-
Clubhouse Spendown MOU		10.1.24 - 9.30.25	23,590	**29,000**	**5,410**
Montcalm Care Network	Montcalm		-	-	-
Clubhouse Spendown MOU		10.1.24 - 9.30.25	24,400	**30,000**	**5,600**
Saginaw County Community Mental Health Authority	Saginaw		-	-	-
Clubhouse Spendown MOU		10.1.24 - 9.30.25	16,270	**20,000**	**3,730**
			$ 170,000	**209,000**	**39,000**

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION (Revenue Contract)	CONTRACT TERM	CURRENT FY25 CONTRACT AMOUNT	FY25 TOTAL CONTRACT AMOUNT	FY25 INCREASE/ (DECREASE)
Michigan Department of Health & Human Services (EGrAMS)	Alcohol Use Disorder Treatment	10.1.24 - 9.30.25	$ -	**420,000**	**420,000**
	Clubhouse Engagement	10.1.24 - 9.30.25	$ 170,000	**209,000**	**39,000**
	Healing & Recovery Community Engagement & Infrastucture	10.1.24 - 9.30.25	$ -	**1,000,000**	**1,000,000**
	Prevention	10.1.24 - 9.30.25	$ 2,183,762	**2,190,162**	**6,400**
	Recovery Incentives Infrastructure	10.1.24 - 9.30.25	$ 15,000	**559,680**	**544,680**
			$ 2,368,762	**$ 4,378,842**	**$ 2,010,080**

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, November 12, 2024
MyMichigan Medical Center
Meeting Minutes

1. Call to Order

Chairperson Ed Woods called this meeting of the Mid-State Health Network Board of Directors to order at 5:00 p.m. Mr. Woods reminded members that those participating by phone may not vote on matters before the board and the Board Member Conduct Policy, emphasizing that members seek recognition from the chair and honor time limits. Mr. Woods asked for a moment of silence in respect to the passing of fellow board member, Mr. Bruce Gibb (appointed by Huron Behavioral Health). Mr. Woods announced Mr. Joe Brehler will be retiring at the end of the year, and this is his last meeting. Ms. Amanda Ittner introduced MSHN's newest staff member, Beth LaFleche, Treatment Specialist.

2. Roll Call

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

Board Member(s) Present: Brad Bohner (LifeWays), Joe Brehler (CEI), Greg Brodeur (Shiawassee), Dan Grimshaw (Tuscola), Tina Hicks (Gratiot), John Johansen (Montcalm), Deb McPeek-McFadden (The Right Door), Irene O'Boyle (Gratiot), Paul Palmer (CEI)-joined at 5:14 p.m., Bob Pawlak (BABH), Joe Phillips (CMH for Central Michigan), Linda Purcey (The Right Door), Tracey Raquepaw (Saginaw), Kerin Scanlon (CMH for Central Michigan)-joined at 5:12 p.m., Richard Swartzendruber (Huron), Joanie Williams (Saginaw), and Ed Woods (LifeWays)

Board Member(s) Remote: Kurt Peasley (Montcalm)

Board Member(s) Absent: Ken DeLaat (Newaygo), David Griesing (Tuscola), Pat McFarland (Bay-Arenac), and Susan Twing (Newaygo)

Staff Member(s) Present: Joseph Sedlock (Chief Executive Officer), Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Sherry Kletke (Executive Support Specialist), and Beth LaFleche (Treatment Specialist)

3. Approval of Agenda for November 12, 2024

Board approval was requested for the Agenda of the November 12, 2024, Regular Business Meeting.

MOTION BY TINA HICKS, SUPPORTED BY TRACEY RAQUEPAW, FOR APPROVAL OF THE AGENDA OF NOVEMBER 12, 2024, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 15-0.

4. Public Comment

There was no public comment.

5. MSHN External Compliance Examination Report Presentation

Mr. Derek Miller, Auditor from Roslund, Prestage and Company, presented his report and highlighted key information included in the MSHN Fiscal Year 2023 Compliance Examination conducted by his firm and provided within board member packets. The audit found MSHN complied in all material respects with the specified requirements; that no control deficiencies were found; no material non-compliance with laws, regulations, or contracts were identified; and no fraud was found. Mr. Miller expressed appreciation to Ms. Leslie Thomas and the finance team at MSHN. Mr. Joseph Sedlock acknowledged Mr. Miller and his team for processing the audit every year and Ms. Leslie Thomas and the Finance team for their hard work and diligence to ensure MSHN's financial integrity and compliance on a daily basis and always being prepared not just for audits, but throughout the year.

MOTION BY RICH SWARTZENDRUBER, SUPPORTED BY JOHN JOHANSEN, TO RECEIVE AND FILE THE REPORT ON COMPLIANCE OF MID-STATE HEALTH NETWORK FOR THE YEAR ENDED SEPTMEBER 30, 2023. MOTION CARRIED: 16-0.

6. Chief Executive Officer's Report

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

- Recent MSHN staff accomplishments/recognitions.
- PIHP/Regional Matters
  - Conflict Free Access and Planning (CFAP) Update
  - MSHN Cost Containment Plan – Partial Access Centralization
  - MSHN Bylaws
  - Regional Financial Position
- State of Michigan/Statewide Activities
  - MSHN/MDHHS "Master Contract" for FY25
- Federal/National Activities
  - Food and Drug Administration (FDA) Approves New Medication for Treatment of Schizophrenia
  - Mental Health and Substance Use Parity

7. Deputy Director's Report

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

- Staffing Update
- Michigan Health Endowment Fund Award Notice
- FY25 Software Project Implementation Updates
    - Compliance Software
    - Data Analytics Software
- Health Services Advisory Group (HSAG) – External Quality Reviews Update
    - Performance Measure Validation (PMV) Report
    - Network Adequacy Assessment (NAA) Results
    - Encounter Data Validation
    - Performance Improvement Projects (PIP)
    - Compliance Review

8. Chief Financial Officer's Report

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

MOTION BY TINA HICKS, SUPPORTED BY BRAD BOHNER, TO RECEIVE AND FILE THE PRELIMINARY STATEMENT OF NET POSITION AND PRELIMINARY STATEMENT OF ACTIVITIES FOR THE PERIOD ENDED SEPTEMBER 30, 2024, AS PRESENTED. MOTION CARRIED: 17-0.

9. Contracts for Consideration/Approval

A. FY24 Contract Listing for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2024 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 FY2024 contract listing.

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY TRACEY RAQUEPAW, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY24 CONTRACT LISTING. MOTION CARRIED: 17-0.

B. FY25 Contract Listing for Consideration/Approval

Ms. Leslie Thomas provided an overview of the amended FY2025 contract listing provided in board member folders with the addition of $244,500 designated to Protocol for After

Hours Centralized Access Phone Support and requested the board authorize MSHN's CEO to sign and fully execute the contracts listed on the amended FY2025 contract listing.

MOTION BY BRAD BOHNER, SUPPORTED BY JOANIE WILLIAMS, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE AMENDED FY25 CONTRACT LISTING. MOTION CARRIED: 17-0.

10. Executive Committee Report

Mr. Ed Woods asked Ms. Irene O'Boyle to discuss the CEO performance review process.

Ms. Irene O'Boyle informed board members they will receive the performance evaluation on November 13, 2024, to be completed by Wednesday, November 27, 2024. Reminders will be sent to board members to request they complete the survey before the deadline date. Ms. O'Boyle expressed the importance of completing the survey and a reminder was also noted to board members of their responsibility to complete the evaluation. Results will be compiled and presented to the Executive Committee at the December 2024 meeting and to the full board at the January 2025 board meeting. Mr. Woods expressed his appreciation to Ms. O'Boyle for taking on the role of the Evaluation Chair.

11. Chairperson's Report

Mr. Ed Woods asked for a volunteer for the Policy Committee to replace the vacancy of Ms. Jeanne Ladd who resigned from the board. Ms. Tina Hicks has been appointed to the Policy Committee.

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 BRAD BOHNER, SUPPORTED BY RICH SWARTZENDRUBER, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE SEPTEMBER 10, 2024 BOARD OF DIRECTORS MEETING; APPROVE MINUTES OF THE SEPTEMBER 10, 2024 PUBLIC HEARING; RECEIVE SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD MINUTES OF AUGUST 21, 2024; RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF OCTOBER 18, 2024; RECEIVE POLICY COMMITTEE MEETING MINUTES OF OCTOBER 1, 2024; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF SEPTEMBER 23, 2024 AND OCTOBER 28, 2024; AND TO APPROVE ALL THE FOLLOWING POLICIES: CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES HOME AND COMMUNITY BASE WAIVER, CHILDREN'S HOME AND COMMUNITY BASED SERVICES WAIVER (CWP), COMMUNITY-BASED INDEPENDENT LIVING PLACEMENT, ELECTROCONVULSIVE THERAPY (ECT), EMERGENCY & POST-STABILIZATION SERVICES, EVIDENCE BASED PRACTICES, HABILITATION SUPPORTS WAIVER (HSW), HOME AND COMMUNITY BASED SERVICES COMPLIANCE MONITORING, INDIAN HEALTH SERVICES, INPATIENT PSYCHIATRIC HOSPITALIZATION STANDARDS, OUT OF STATE PLACEMENTS,

STANDARDIZED ASSESSMENT, SUBSTANCE USE DISORDER SERVICES-MEDICATION FOR OPIOID USE DISORDER, SUBSTANCE USE DISORDER SERVICES-OUT OF REGION COVERAGE, SUBSTANCE USE DISORDER SERVICES-TELEMEDICINE, SUBSTANCE USE DISORDER SERVICES-WOMEN'S SPECIALTY SERVICES, TRAUMA-INFORMED SYSTEMS OF CARE, AND PROCUREMENT. MOTION CARRIED: 17-0

13. Other Business

Mr. Ed Woods expressed his appreciation to board members, MSHN staff, Community Mental Health Service Programs, and Substance Use Disorder Providers as the holiday season approaches and wishes everyone Happy Holidays.

14. Public Comment

There was no public comment.

15. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 6:08 p.m.

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

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

Members Absent: David Griesing, Member at Large

Other Board Members Present: None

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

1. **Call to order:** This meeting of the MSHN Board Executive Committee was called to order by Chairperson Woods at 9:03 a.m.

2. **Approval of Agenda**: Motion by K. Peasley supported by D. McPeek-McFadden to approve the agenda as amended to add item 5.5 (MDHHS Use of Ranges Citation). Motion carried.

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

4. **Board Matters**
   - 4.1 Draft January 7, 2025 Governing Board Meeting Agenda: January 2025 Board Meeting Agenda was reviewed noting that the agenda is not final until adopted by the board. J. Sedlock noted that his intention to request a closed session to review his annual performance evaluation with the full board.
   - 4.2 Status Update: CMHSP Participant Adoption of MSHN Revised Bylaws: J. Sedlock reported that as of today, 9 of 12 CMHSPs have adopted resolutions in support of the proposed bylaws changes. The 2/3 majority CMHSP Participant votes required to enact the changes has been achieved. Administration will provide a final copy of the bylaws, which MSHN does not have a vote in changing, to the MSHN Board.
   - 4.3 Annual CEO Performance Review and Succession Plan: I. O'Boyle summarized the 2024 CEO Annual performance review for the Executive Committee. 86% participation rate for board members. I. O'Boyle will provide a similar summary to the MSHN Board at the January meeting. Copies will be distributed and available and recollected after board review/action to avoid distribution concerns of personnel-related documents. Mr. Sedlock's contract is not up for renewal this year.
   - 4.4 New Board Member Appointments: The Executive Committee noted the appointments of Cindy Garber, Shiawassee Health and Wellness and Patty Bock, Huron Behavioral Health. Board orientation for Ms. Bock is scheduled for later today; board orientation for Cindy Garber is still being scheduled.
   - 4.5 May Board Meeting (Conflicts with National Council Conference): As noted, the May board meeting conflicts with the National Council conference. Two MSHN Executives, the MSHN board chair, and potentially other board members will be at the national conference. It should also be noted that the May board meeting is an extended meeting to include a day-long strategic planning event as well as regular board matters. The same venue (Wilcox Room at MyMichigan Medical Center Alma is available on May 13, 2025 beginning at 10:00 a.m. The Executive Committee will recommend rescheduling to MAY 13, 2024 and will also request that any board members requiring overnight accommodations make that need known to MSHN.
   - 4.6 MSHN Sponsorship to Attend NatCon25 (Philadelphia): The Executive Committee supports sponsoring one MSHN Board Member, preferably one who has not been sponsored in the past, to attend the National Conference. MSHN will add this to the Chairperson's report to solicit application by interested board members. If more than one board member expresses interest, a random selection process will be used.
   - 4.7 Other (if any): None

5. Administration Matters

5.1 All Staff Meeting: J. Sedlock informed the Executive Committee that due to requirements to maintain our access centralization staffing at this early and somewhat problematic stage, the December in-person staff meeting will be postponed to a future date when all staff can attend.

5.2 Employee Health Insurance: A. Ittner provided information to the Executive Committee on the employee health insurance increases this year. MSHN offers three plans for employees to choose among, one of which is free. The other two plans require employees to contribute to premiums. Plan renewal increases range from 11-15%. MSHN must comply with the hard cap by law, which places a maximum amount a public employer can contribute to employee health insurance. The 2025 cap only increased by 0.2%. This will mean MSHN must pass along increased premiums to our employees. MSHN sent a survey to staff for input on what is most important to them to help guide plan renewal decisions. Most employees expressed the preference that MSHN stay with current plans offered and some indicated they may consider moving to a lower premium (or free) plan, which is their right during open enrollment in mid-January for the plan year that starts February 1, 2025. MSHN will continue to provide a free insurance option to employees. The two other plans will see significant increases in per-paycheck premiums.

5.3 PIHP/MDHHS Contract Update: A written update is included in J. Sedlock's board report. As of today, four PIHPs have filed suit against the MDHHS; the fifth has not yet filed, but is expected to do so. There remain five PIHPs that have signed FY 25 contracts. To MSHN's knowledge, the five that have not signed a clean version of their contract are continuing operations under the transition clause in the termination section of the last contract they signed. MSHN is not aware of any official action(s) by MDHHS. MDHHS has until mid-January to file a response to the suit in the Michigan Court of Claims. MSHN will update the board when it has benefit of viewing the MDHHS response.

5.4 Conflict Free Access and Planning (CFAP) Update: J. Sedlock and A. Ittner explained that there have been no official updates from MDHHS on this item, but noted that the Centers for Medicare and Medicaid Services (CMS) has approved an extension of all expiring waivers through 03/31/2025. MSHN does not expect an update until near the end of that extension. The new waiver submissions include high level CFAP requirements as previously announced by MDHHS, but no detail and certainly no answers to the questions that have been raised by MSHN and the field. MDHHS has stated that it is still in discussions with CMS on the CFAP requirements in Michigan.

5.5 Repeat Citation for Use of Ranges in Person-Centered Plans: MDHHS has once again cited MSHN for this item in the recent site review report. J. Sedlock provided brief background on the position MSHN has maintained on this matter for at least four years now. J. Sedlock reported that after consultation with our attorneys in this matter and our regional Operations Council, MSHN intends to maintain its position that there is no regulatory requirement prohibiting the use of reasonable ranges (or requiring a finite number) be used in person-centered plans of service. Maintaining this position risks imposition of a financial sanction (failure to earn a portion of the Performance Bonus incentive). J. Sedlock and A. Ittner will meet with MDHHS leadership to explain our position and its rationale in the hopes of achieving mutual understanding and working toward a resolution of the matter. Details will also be provided in J. Sedlock's January board report.

6. **Other**

6.1 Any other business to come before the Executive Committee: J. Sedlock is scheduled for surgery and will be out for at least two weeks (and up to three) beginning January 14,2025. Amanada Ittner will be acting CEO while Mr. Sedlock is on leave.

6.2 Next scheduled Executive Committee Meeting: 02/21/2025, 9:00 a.m.

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

8. **Adjourn**: This meeting of the MSHN Board Executive Committee was adjourned at 9:51 am.

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, DECEMBER 3, 2024 (VIDEO CONFERENCE)

***Members Present**:* Irene O'Boyle, Kurt Peasley, David Griesing, Tina Hicks, and John Johansen-joined at 10:07 a.m.

Members Absent: None

Staff Present: Amanda Ittner (Deputy Director) and Sherry Kletke (Executive Support Specialist)

1. CALL TO ORDER

Mr. David Griesing called the Board Policy Committee meeting to order at 10:02 a.m.

2. APPROVAL OF THE AGENDA

MOTION by Irene O'Boyle, supported by Kurt Peasley, to approve the December 3, 2024, Board Policy Committee Meeting Agenda as presented. Motion Carried: 4-0.

3. POLICIES UNDER DISCUSSION

There were no policies under discussion.

4. POLICIES UNER REVIEW

Mr. David Griesing invited Ms. Amanda Ittner to provide a review of the substantive changes within the policies listed below. Ms. Ittner provided an overview of the substantive changes within the policies.

CHAPTER: POPULATION HEALTH

1. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC RECIPIENT ELIGIBILITY

CHAPTER: SERVICE DELIVERY

1. AUTISM SPECTRUM DISORDER BENEFIT
2. BEHAVIORAL HEALTH RECOVERY ORIENTED SYSTEMS OF CARE

CHAPTER: UTILIZATION MANAGEMENT

1. UTILIZATION MANAGEMENT ACCESS SYSTEM

MOTION by Kurt Peasley, supported by Tina Hicks, to approve and recommend the policies under biennial review as presented. Motion carried: 5-0.

5. NEW BUSINESS

There was no new business.

6. ADJOURN

Mr. David Griesing adjourned the Board Policy Committee Meeting at 10:11 a.m.

Meeting Minutes respectfully submitted by:
MSHN Executive Support Specialist

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

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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 11/18/2024

Members Present: Chris Pinter; Ryan Painter; Maribeth Leonard; Julie Majeske; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; Bryan Krogman; Sandy Lindsey; Sara Lurie
Members Absent: Carol Mills
MSHN Staff Present: Joseph Sedlock; Amanda Ittner

Agenda Item	Action Required				
CONSENT AGENDA	Acknowledged receipt.				
	No items removed from discussion	By Who	N/A	By When	N/A
Regional Financial Position and Cost Containment Strategy	Discussion regarding cost containments strategies regarding scales: GIHN – 4% COLA, not step increase CMHCM – no COLA, health insurance premium reduction for employees, step increases still processed MCN – move to Michigan health insurance pool, eliminated steps, 3.5% at evaluation time moving to measurable outcomes at anniversary, reduced for disciplinary. CEI – next year open for wages/union; January salary study to realign steps BABH opened crisis residential for adults to help reduce high acute cost; reviewed compensation and under Central and Saginaw. Concern any further reduction will impact service delivery Discussed CCBHC funding and planning elements; credentialed staff, community need, FQHCs, projected costs, mild-to-moderate. PPS rate ability to build reserve which allows ability to serve all without Medicaid FMAP future changes a consideration for participation Discussed PIHPs that didn't sign FY25 contract due to ISF disagreement. MSHN is still working/advocating for a future state to retain additional savings. There has been no update on MDHHS position regarding the PIHPs that didn't sign.				
	Discussion and planning only	By Who	N/A	By When	N/A
2024-09 Regional Savings Estimates	Joe reviewed the financials in Leslie's absence. FY24 Interim FSR 18m deficit/use of ISF, 7m in ISF for HMP, 19m due from MDHHS for CCBHCs Question regarding Revenue cash flow advances being considered as add'l revenue and why?				

Agenda Item	Action Required				
	L. Thomas will follow up via email regarding the cash flow question above.	By Who	L. Thomas	By When	11.28.24
REMINDER: CMHSP Participant Board Consideration of Proposed Edits to MSHN Bylaws (5 of 12 received)	CMHs who haven't placed this on their board for approval, request it be done.				
	CMHs who haven't placed this on their board for approval, request it be done.	By Who	CMHs	By When	12.31.24
Update: PIHPs FY25 Contracts	Discussed five PIHPs that didn't sign FY25 contract due to ISF and Waskul disagreement. MSHN is still working/advocating for a future state to retain additional savings. There has been no update on MDHHS position regarding the PIHPs that didn't sign.				
	Update only	By Who	N/A	By When	N/A
Update: MDHHS/PIHP Operations Meetings	No meeting minutes for the last two months due to the October and November meeting being cancelled without explanation by MDHHS.				
	Information Only	By Who	N/A	By When	N/A
Update (if any): Conflict Free Access and Planning	No update on this yet either. Last meeting scheduled for Nov. 1 was cancelled by MDHHS. BABH sent in a letter to identify solution to written response in file from individuals served recognizing no conflict.				
	Information Only	By Who	N/A	By When	N/A
Update: MSHN Partial Access Centralization Update	J. Sedlock reminded Ops continuation of 24/7/365 access supports and that we are still receiving referrals from CMHs that should be completing the screening. Documentation in REMI is required consistent with current contract language. Note that there will be a downward adjustment of the 24/7/365 funding provided to CMHSPs to "right size it" with SUD Outpatient Access due to MSHN centralization of residential, withdrawal management, and recovery housing, at a future date. Ops requested follow up directly with the CEO.				
	MSHN will inform CEOs directly if issues continue at their CMH.	By Who	S. Pletcher	By When	11.20.24
ABA Service Rate Increase	ABA Rate increase memo from MDHHS; notice that BHT-ABA must be paid at no-less-than 16.50 per unit or $66.00 per hour rate effective November 1 being reimbursed by state general fund to the PIHPs. Public comment is due December 17, 2024. *Per Keith White:* To comply with Sec. 924--which is directed towards MDHHS rate setting not PIHP reimbursement--MDHHS directs Milliman to ensure PIHP statewide rates reflect behavioral technician rates of				

Agenda Item	Action Required				
	between $52.35 per hour and not more than $57.35 for autism services. So, consistent with prior year implementation of this boilerplate, the certification report will not include an Autism fee schedule. *From Leslie:* I recommend each CMH send the same comment to MDHHS expressing concerns about the $66/hour rate. In addition, MSHN's feedback to the Department should include concerns about revenue. Some of the messaging from MDHHS suggests revenue for this initiative was included in the rate certification. If that is the case, the region is already overspending for FY 25 and there will be additional ABA expenses which further worsens our fiscal position. Consistent communication with the network providers from the region is recommended, our region is on hold until public comment closes, along with assurance of sufficient funding and will ensure retroactive application as required.				
	MSHN, PIHPs and CMHs will provide the feedback noted above. MSHN to work with CFOs to provide an analysis of increased Autism cost for the region, along with what is paid now. MSHN will provide regional response communication to use with the network.	By Who	All L. Thomas J. Sedlock	By When	12.15.24 11.28.24 11.20.24
Feds investigation of State of Michigan	M. Stillwagon brought up this communication and frustration with how this reflects on PIHP/CMHs. Mellos from the state has brought up issues/concerns regarding the ability to place individuals. This may have been a reason to start the investigation by Disability Rights.				
	Discussion Only	By Who	N/A	By When	N/A

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 12/16/2024

Members Present: Chris Pinter; Ryan Painter; Maribeth Leonard; Carol Mills; Julie Majeske; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; Bryan Krogman; Sara Lurie; Sandy Lindsey

Members Absent:

MSHN Staff Present: Joseph Sedlock; Amanda Ittner; for applicable section Leslie Thomas, Kim Zimmerman, Todd Lewicki

Agenda Item	Action Required				
CONSENT AGENDA	Addition: Minimum Wage and Sick Time Self Determination Arrangements Discussed MDHHS Proposal to add psychiatric inpatient for Mild/Moderate (M2M) to MHP responsibilities (See Consent Agenda, J slide deck): Joe reviewed the high level PIHP+ plan and the feedback MSHN submitted regarding the M2M inpatient, which if inpatient is required then the individual is not considered M2M. MDHHS presented this as an initiative to hold MHPs more accountable for M2M. There is also concern regarding the move of payment for the M2M to the MHPs (enrollment model) and how PIHPs count on funds (eligibility model).				
	No additional questions regarding the consent agenda	By Who	N/A	By When	N/A
REGIONAL FINANCIAL POSITION AND COST CONTAINMENT STRATEGY	L. Thomas reported cost containment strategies have been updated and CMHs reporting expense constraint targets consistent with strategies of about $7m. With new rates we anticipate a deficit of $10m. MSHN updated their strategy with Access information.				
	Update information only	By Who	N/A	By When	N/A
FY24 QAPIP REPORT	K. Zimmerman reviewed the QAPIP report as required to report annually by MDHHS. No questions. Kim identified areas that need improvement and the strategy by MSHN to ensure follow up.				
	Ops council reviewed, acknowledged receipt and recommend Board approval. Next step to present to Board of Directors in January 2025	By Who	K. Zimmerman	By When	1.1.25
FY25 QAPIP PLAN	K. Zimmerman reviewed the QAPIP plan and related updates based on the MDHHS contract.				
	Ops council reviewed, acknowledged receipt and recommend Board approval. Next step to present to Board of Directors in January 2025	By Who	K. Zimmerman	By When	1.1.25
MDHHS SITE REVIEW-USE OF RANGES	J. Sedlock updated the group on the communication from MDHHS regarding repeat findings from the site visit for use of ranges and the MDHHS threat to implement financial sanctions due to several years of repeat citations. MSHN consulted with Health Law Partners and there is a pathway to do a declaratory judgement on this, but our law firm does not advise we pursue it unless we have other objectives. A plan of correction is due by December				

Agenda Item	Action Required				
	20. Then a 90 day follow up will be conducted by MDHHS. MSHN can include that when a plan renews, then the ranges will be eliminated and replaced with exact amount, scope, and duration. There is still a concern regarding new findings if addendums aren't completed in time due to using specific scope instead of ranges. Additional concerns regarding staff resources to implement this CAP. Any funding to support a suit, would need to come from the CMHs local funding. CMHs have protections but PIHPs do not.				
	Operations Council advice is to hold the line on this and submit a CAP that states MSHN will continue to use ranges understanding there will be financial sanctions, and then to deal with (or appeal) whatever sanction is imposed. J. Sedlock will use this input together with input from upper management at MSHN and make a decision on how to proceed..	By Who	J. Sedlock / K. Zimmerman	By When	12.20.24
AUTISM WAITING LIST INQUIRY; WAITING LISTS	T. Lewicki reviewed the report in the packet regarding Autism waitlists and provider capacity. PIHPs cannot have waitlist, however, Autism services are having waitlist and MDHHS is seeking information/requesting information on our regions waitlist. MDHHS indicated the desire to understand the larger implication of provider shortages to support expansion. Some delay could be provider choice as indicated in the notes.				
	Todd's working directly with his team to keep a close on this.	By Who	T. Lewicki	By When	
UPDATE (if any): CONFLICT FREE ACCESS AND PLANNING	MDHHS indicated they are still working on answering questions with CMS. The waivers have been extended until March 31 so anticipation of communication from MDHHS after the new year/February-March.				
	Update only, will keep this item on future agenda	By Who	N/A	By When	N/A
REMINDER: CMHSP PARTICIPANT BOARD CONSIDERATION OF PROPOSED EDITS TO MSHN BYLAWS (8 OF 12 RECEIVED) +2/3 HAVE SUPPORTED – CONSIDERED ADOPTED; MSHN BOARD WILL BE PROVIDED WITH A FINAL COPY; OPS WILL RECEIVE A FINAL COPY	Update only - 8 of 12 received, so enough for 2/3rd to move forward. Would still like documentation from the other CMHs on the status of bylaws. CEI and LifeWays on the Board agenda next week.				
	CMHSPs to report status if they haven't submitted yet.	By Who	CMHs	By When	1.30.25
MINIMUM WAGE & SICK TIME – Self Determination	Standard contract for FMS. Recommend a regional approach to the standardized contract for our providers and implications due to many providers not currently having this benefit as well as the self-determination. PNMC will discuss it as well Wednesday at 10. Finance Council also scheduled a discussion in January on this.				

Agenda Item	Action Required				
	Questions/concerns should be forwarded to Leslie Thomas for PNMC consideration. This topic will be added to the January agenda for an update from PNMC.	By Who	CMHs/L. Thomas	By When	1.8.24
PIHP FY25 Contracts	Discussed the current state of PIHPs that haven't signed the contract (Three have filed suit; two others are considering; five have signed the FY 25 contact). Key issues for the suit include: ISF, CCBHC and Waskul settlement. MSHN repeated and reiterated its positions on these matters, including the potential harm/consequences, and that MSHN does not have a contested legal issue (i.e., the issue at hand is the FY 25 contract and several elements within it; MSHN signed the FY 25 contract, so would not have any standing to join a suit and no local money to do so even if it wanted to/could). Some CMHSP CEOs reiterated that they believed signing the FY 25 contract was a mistake, but also acknowledged the MSHN as a PIHP does not enjoy the same legal status or protections as CMHSPs. MSHN for 10 years has worked hard to position the region as the premiere, go-to PIHP and regional collaboration. Conversation started with ranges, and this might not be the topic to move to suit now but to keep an eye on what is happening with litigation. Foster care placement and related lawsuits are also a concern for future CMH resources. One CMHSP CEO stated that MSHN is not representing the views of the CMHSP and is driving decisions that are opposed. MSHN responded to this concern by stating that all input is being used in the MSHN decision-making processes, which are broader than just Operations Council or individual CMHSP CEO input.				
	Discussion and Information	By Who	N/A	By When	N/A

POLICIES AND PROCEDURE MANUAL

Chapter:	**Population Health~~General Management~~**		
Title:	**CCBHC Recipient Eligibility** Policy		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of ~~3~~2	**Review Cycle:** Biennial **Author:** Chief ~~Behavioral~~ Population Health Officer	**Adopted Date: 05.09.2023** **Review Date: 05.15.2024**	**Related Policies:** CCBHC Recipient Enrollment & Disenrollment Procedure

Purpose

Mid-State Health Network (MSHN) must adhere to the Certified Community Behavioral Health Clinic (CCBHC) contractual and policy requirements with the Michigan Department of Health and Human Services (MDHHS). MSHN shares responsibility for ensuring continued access to CCBHC services and is responsible for meeting minimum requirements and coordinating care for eligible CCBHC recipients.

Policy

~~MSHN Utilization Management (UM) functions are performed in accordance with approved MSHN policies, procedures, and standards. MSHN has delegated determination of CCBHC recipient eligibility to its provider network. This includes monitoring of prospective, concurrent, and retrospective reviews of UM decisions regarding CCBHC eligibility. MSHN provides delegated managed care oversight and monitoring relative to access and eligibility of Medicaid and Non-Medicaid recipients recommended for enrollment in one of its CCBHCs.~~

~~CCBHC Recipient Eligibility:~~

It is the policy of MSHN and its provider network to adhere to the eligibility criteria outlined in the current version of the MDHHS CCBHC Handbook . Any individual with a mental health or substance use disorder (SUD) diagnosis code from the 10th revision of the International Statistical Classification of Disease and Related Health Problems (ICD-10) as cited in Appendix B of the Michigan CCBHC Demonstration Handbook, is eligible for CCBHC services. The mental health or SUD diagnosis does not need to be the primary diagnosis if an individual has more than one diagnosis. Individuals with diagnosis of intellectual/developmental disability are eligible for CCBHC services if a mental illness and/or SUD diagnosis is present as well.

Eligibility review should align with assessment and diagnosis and take place as frequently as clinically appropriate. If an individual continues to have a behavioral health and/or substance use diagnosis, they are eligible for CCBHC services.

MSHN and its regional CCBHC partners will use the MDHHS Waiver Support Application (WSA) to manage individual CCBHC recipient eligibility verification, enrollment, disenrollment, and transfer. Please refer to the MSHN CCBHC Recipient Enrollment & Disenrollment Procedure.

~~CCBHC Enrollment/Disenrollment and Recommendation in the Waiver Support Application (WSA):~~
~~The CCBHC shall be engaged in the following functions related to recipient eligibility:~~

~~1) Recommend MSHN to complete an action on CCBHC recipient assignment.~~
~~2) Adhere to all applicable privacy, consent, and data security statutes.~~
~~3) Practice in accordance with accepted standards and guidelines and comply with all applicable policies published in the Michigan Medicaid Provider Manual.~~

~~4) Utilize the waiver support application (WSA) to develop a recipient roster, review reports, recommend individual assignment to the CCBHC, and view data for assigned recipients.~~

~~5) Attest to diagnostic criteria for recipients.~~
~~6) Recommend recipient disenrollment, as appropriate, to MSHN via the WSA.~~
~~7) Recipients can change CCBHC providers, if feasible. The current CCBHC and the future CCBHC need to coordinate and communicate transition options to the recipient.~~

~~CCBHC Enrollment/Disenrollment and Assignment in the Waiver Support Application (WSA):~~
~~MSHN will use the WSA for CCBHC assignment activities, including assignment management and report generation. Assignment management includes the following:~~

~~1) MSHN shall work with the CCBHCs in its region to assign eligible recipients in the WSA.~~
~~2) Review CCBHC WSA-uploaded information on CCBHC recipients for the Medicaid and non-Medicaid population.~~
~~3) Assign CCBHC recipient to the appropriate CCBHC.~~
~~4) MSHN will engage in oversight and review activity to confirm the presence of appropriate diagnosis/diagnoses as well as consent, as a part of regular delegated managed care activity and utilization management reports.~~
~~5) Disenroll recipient from the WSA, as appropriate.~~
~~6) Facilitate transfer from CCBHC to CCBHC as appropriate.~~

Applies to:

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

Definitions/Acronyms:

Assigned: Medicaid or non-Medicaid CCBHC recipient assigned to a CCBHC in the WSA. This action is completed by the PIHP.
CCBHC: Certified Community Behavioral Health Clinic.
CHAMPS: Community Health Automated Medicaid Processing System
CMHSP: Community Mental Health Service Provider
DCO: Designated Collaborating Organization. An entity not under direct supervision of the CCBHC but is in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC.
Disenrolled: Medicaid or non-Medicaid recipient disenrolled from the CCBHC.
Eligible: Medicaid or non-Medicaid person who is eligible for CCBHC services. These individuals are not yet assigned to a CCBHC in the WSA.
Enrolled: Medicaid beneficiary who is enrolled in the CCBHC benefit plan in CHAMPS.
ICD: International Statistical Classification of Disease
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network.
PIHP: Prepaid Inpatient Health Plan.
Recommended: Medicaid or non-Medicaid eligible recipient recommended by a CCBHC for assignment by the PIHP.
Subcontractors: refers to an individual or organization that is directly under contract with CMHSP and/or MSHN to provide behavioral health services and/or supports.

Provider Network: refers to MSHN CMHSP Participants and SUD providers directly under contract with MSHN to provide/arrange for behavioral health services and/or supports. CCBHC services and supports may be provided through direct operations or through the DCO arrangements.
SUD: Substance Use Disorder
Transfer: an option the recipient can utilize to change CCBHC providers. It is recommended that the recipient establish a lasting relationship with their chosen CCBHC.
UM: Utilization Management
WSA: Wavier Support Application

Related Materials:
N/A

References/Legal Authority:

1. MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program
2. Michigan Medicaid Provider Manual, (current edition).
3. Michigan Certified Community Behavioral Health Clinic (CCBHC) Handbook, Version 1.3

Change Log:

Date of Change	Description of Change	Responsible Party
3/22/2022	New MSHN policy	Director of Utilization and Care Management
5/15/2024	Biennial Review – edited for clarity and removed duplicate content that is contained in the CCBHC Recipient Enrollment & Disenrollment Procedure	Chief Population Health Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Autism Spectrum Disorder Benefit Eligibility**		
Policy: ☑ **Procedure:** ☐ **Page:** 1 of ~~10~~3	**Review Cycle:** Biennial **Author:** Waiver Coordinator and Autism Workgroup	**Adopted Date:** 04.07.2015 **Review Date**: ~~11.10.2020~~02.01.2024	**Related Policies:**

Purpose

To ensure Mid-State Health Network (MSHN) and its Provider Network comply with the requirements for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age with Autism Spectrum Disorder (ASD) under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

Policy

MSHN staff and the MSHN Provider Network shall fully comply with the requirements set forth in the EPSDT benefit and the Michigan Medicaid Manual. This includes, but is not limited to:

- Screening
- Referral
- Diagnostic Evaluation
- Medical Necessity
- Determination of Eligibility
- Reevaluation
- Transfer and Discharge

~~Screening~~

~~The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well-child visit with the child's primary care provider (PCP). EPSDT well-child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well-child evaluation is also designed to rule out medical or behavioral conditions other than ASD and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.~~

~~Referral~~

~~The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the CMHSP directly to arrange for a follow-up evaluation. The PCP must refer the child to the CMHSP in the geographic service area for Medicaid beneficiaries. The CMHSP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each CMHSP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed.~~

~~After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the CMHSP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including~~

BHT) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD that do not meet the eligibility requirements for developmental disabilities by the CMHSP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

While screening for ASD typically occurs during an EPSDT well-child visit with the child's PCP, there is no "wrong door" for a referral for further evaluation of the child. PCP's are responsible for screening the child for ASD and for providing a full medical and physical examination to rule out other medical or behavioral conditions other than ASD. If a beneficiary is self-referred, or is without a PCP, and contacts the PIHP/CMH regarding the need for ASD services, the PIHP/CMH may initiate the eligibility process for services while also making an appropriate referral to the PCP for a further screening and medical/physical examination as needed. Documentation of referrals by the CMH should be recorded in the individuals file.

Comprehensive Diagnostic Evaluations

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment which is provided or supervised by a board certified and licensed behavior analyst (BCBA/LBA) to recommend more specific ASD treatment interventions. The provider who conducts the behavior assessment recommends more specific ASD treatment interventions. These diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes:

- a physician with a specialty in psychiatry or neurology;
- a physician with a sub-specialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline;
- a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
- a psychologist;
- an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health;
- a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
- a masters level, fully licensed clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.

The determination of a diagnosis by a qualified licensed practitioner is accomplished by following best practice standards. The differential diagnosis of ASD and related conditions requires multimodal assessment and integration of clinical information. This is a complex assessment procedure in which clinicians must integrate data from caregiver reports, records (e.g., medical, school, other evaluations), collateral reports (e.g., teachers, other treatment providers), data gathered from utilization of standardized psychological tools (e.g., developmental, cognitive, adaptive assessment), and the observational assessment to determine diagnostic and clinical impressions. The utilization of multiple data modes and sources improves the reliability of ASD diagnosis. No one piece of data determines the ASD diagnosis, and evaluators should consider the accuracy of data and confounding factors that may impact data obtained (e.g., parent who seems to be overly negative about the child, child who was intensely shy during observational assessment). direct observation and utilizing the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2), and by administering a comprehensive clinical interview including a developmental symptom history (medical, behavioral, and social history) such as the Autism Diagnostic Interview-Revised (ADI-R) or clinical equivalent. In addition, a qualified licensed practitioner will rate symptom severity with the Clinical Global Impression Severity Scale. Other tools may be used if the clinician feels it is necessary to determine a diagnosis and medical necessity service recommendations. Other tools may include: cognitive/developmental tests such as the Mullen Scales of Early

~~Learning, Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV), Wechsler Intelligence Scale for Children-IV (WISC-IV), Wechsler Intelligence Scale for Children-V (WISC-V), or Differential Ability Scales-II (DAS-II); adaptive behavior tests such as Vineland Adaptive Behavior Scale-II (VABS-II), Adaptive Behavior Assessment System-III (BHTS-III), or Diagnostic Adaptive Behavior Scale (DABS), and/or; symptom monitoring such as Social Responsiveness Scale-II (SRSII), Aberrant Behavior Checklist, or Social Communication Questionnaire (SCQ).~~

Medical Necessity Criteria

Medical necessity and recommendation for BHT services ~~is~~ shall be determined by a physician, or other licensed practitioner working within their scope of practice under state law. Comprehensive diagnostic reevaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms, and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers.

~~The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas:~~

~~A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by ***all*** of the following:~~

~~1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.~~

~~2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.~~

~~3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.~~

~~B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by ***at least two*** of the following:~~

~~1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).~~

~~2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).~~

~~3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, and/or excessively circumscribed or perseverative interest).~~

~~4. Hyper- or hypo- reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures.~~

Determination of Eligibility for BHT

The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing ~~the ADOS-2 and symptom rating using the Clinical Global Impression Severity Scale~~ valid evaluation tools. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who

have the developmental capacity to clinically participate in the available interventions covered by BHT services. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder, or PDD-NOS should be given the diagnosis of ASD. Children who have marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder.

~~To be eligible for BHT, the~~The following requirements ~~criteria~~ must be met:

1. ~~Child is under 21 years of age.~~
2. ~~Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.~~
3. ~~Child is medically able to benefit from the BHT treatment.~~
4. ~~Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the BHT interventions and that they can be demonstrated beyond the treatment sessions~~ develop, maintain, or restore, to the maximum extent practicable, the functioning of a child with ASD. ~~Measurable variables may include increased social communication~~ skills, ~~increased interactive play/age-appropriate leisure skills, increased reciprocal~~ and functional ~~communication, etc.~~
5. ~~Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individual Education Plan/Individual Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).~~
6. ~~Services are able to be provided in the child's home and community, including centers and clinics.~~
7. ~~Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities or may be masked by learned strategies later in life).~~
8. ~~Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.~~
9. ~~Medical necessity and recommendation for BHT services are determined by a qualified licensed practitioner.~~A ~~qualified licensed practitioner recommends BHT services and the services are medically necessary for the child.~~
10. ~~Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.~~

~~Prior Authorization~~

~~BHT services are authorized for a time period not to exceed 365 days. The 365-day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a qualified licensed practitioner working within their scope of practice under state law.~~

Re-evaluation

Comprehensive diagnostic re-evaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. ~~The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers.~~Please see the Autism Spectrum Disorder Eligibility Procedure for additional steps. ~~An annual re-evaluation occurring within 365 days by a qualified licensed practitioner to assess eligibility criteria must be conducted through direct observation utilizing the ADOS-2 and symptoms rated using the Clinical Global Impression Severity Scale. Additional tools may be used if the clinician feels it is necessary to determine medical necessity and recommended services. Other tools may include cognitive/developmental tests, adaptive behavior tests, and/or symptom monitoring.~~

Transition and Discharge Criteria

The desired BHT goals and outcomes for discharge should be specified at the initiation of services, monitored throughout the duration of service implementation, and refined through the behavioral service level evaluation process. Transition and discharge from all BHT services should generally involve a gradual step-down model and require careful planning. Transition and discharge planning from BHT services should include transition goal(s) within the behavioral plan of care or plan, or written plan, that specifies details of monitoring and follow-up as is appropriate for the individual and the family or authorized representative(s) utilizing the Person-Centered Planning (PCP) process.

~~Discharge from BHT services is determined~~should be reviewed and evaluated ~~by a qualified BHT professional for children who meet any of the below criteria:~~

1. ~~The child has achieved treatment goals and less intensive modes of services are medically necessary and/or appropriate.~~
   ~~The child is either no longer eligible for Medicaid or is no longer a State of Michigan resident.~~
2. ~~The individual, family, or authorized representative(s) is interested in discontinuing services.~~
3. ~~The child has not demonstrated measurable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through a period of six months~~the successive authorization periods~~.~~
4. ~~Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations.~~
5. ~~The child no longer meets the eligibility criteria as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.~~
6. ~~The child and/or parent/guardian is not able to meaningfully participate in the BHT services and does not follow through with treatment recommendations to a degree that compromises the potential effectiveness and outcome of the BHT service.~~

~~BHT Services~~

A. ~~Behavioral Assessment~~

~~A developmentally appropriate applied behavior analysis (ABA) assessment process must identify strengths and weaknesses across domains and potential barriers to progress. The information from this process is the basis for developing the individualized behavioral plan of care with the individual, family, and treatment planning team. Behavioral assessments can include direct observational assessment, record review, rating scales, data collection, functional or adaptive assessments, structured interviews, and analysis by a board certified and licensed behavior analyst (BCBA/LBA). Behavioral assessment tools must describe specific levels of behavior at baseline to inform the individual's response to treatment through ongoing collection, quantification, and analysis of the individual's data on all goals as monitored by a BCBA/LBA.Behavioral assessments must use a validated instrument and can include direct observational assessment, observation, record review, data collection, and analysis by a qualified provider. Examples of behavior assessments include function analysis and functional behavior assessments. The behavioral assessment must include the current level of functioning of the child using a validated data collection method. Behavioral assessments and ongoing measurements of improvement must include behavioral outcome tools. Examples of behavioral outcome tools include Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic Language and Learning Skills revised (ABLLS-R), and Assessment of Functional Living Skills (AFLS).~~

B. ~~Behavioral Intervention~~

~~BHT services include a variety of behavioral interventions, which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence. BHT services are designed to be delivered primarily in the home and in other community settings.~~

~~Behavioral treatment intervention services include, but are not limited to, the following categories of evidence-based interventions:~~

- Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis);
- Adapting environments to promote positive behaviors and learning while discouraging negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports, stimulus fading);
- Applying reinforcement to change behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction);
- Teaching techniques to promote positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting, chaining, imitation);
- Teaching parents/guardians to provide individualized interventions for their child, for the benefit of the child (e.g., parent/guardian implemented/mediated intervention);
- Using typically developing peers (e.g., individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups, peer social interaction training); and
- Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software).

In addition to the above listed categories of interventions, covered BHT treatment services may also include any other intervention supported by credible scientific and/or clinical evidence, as appropriate for each individual. Based on the behavioral plan of care which is adjusted over time based on data collected by the qualified provider to maximize the effectiveness of BHT treatment services, the provider selects and adapts one or more of these services, as appropriate for each individual.

C. Behavioral Observation and Direction

Behavioral observation and direction is the clinical direction and oversight provided by a qualified provider to a lower level provider based on the required provider standards and qualifications regarding the provision of services to a child. The qualified provider delivers face-to-face observation and direction to a lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. This service is for the direct benefit of the child and provides a real-time response to the intervention to maximize the benefit for the child. It also informs of any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the behavioral plan of care.

D. Telepractice for BHT Services

All telepractice services must be prior authorized by the Michigan Department of Health and Human Services (MDHHS). Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services. Telepractice must be obtained through real-time interaction between the child's physical location (patient site) and the provider's physical location (provider site). Telepractice services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators, and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients. Qualified providers of behavioral health services are able to arrange telepractice services for the purposes of teaching the parents/guardians to provide individualized interventions to their child and to engage in behavioral health clinical observation and direction. Qualified providers of behavioral health services include Board Certified Behavior Analysts (BCBA), Board Certified Assistant Behavior Analysts (BCaBA), Licensed Psychologists (LP), Limited Licensed Psychologists (LLP), and Qualified Behavioral Health Professionals (QBHP). The provider of the telepractice service is only able to monitor one child/family at a time. The administration of telepractice services are subject to the same provision of services that are provided to a patient in person. Providers of telepractice services must be currently certified by the Behavior Analyst Certification Board (BACB), be a QBHP enrolled in a BACB degree program, be licensed in the State of Michigan as a fully licensed psychologist or be a practitioner who holds a

limited license and is under the direction of a fully licensed psychologist. Providers must ensure the privacy of the child and secure any information shared via telemedicine.

The technology used must meet the requirements of audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter of the Medicaid Provider Manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual.

The patient site may be located within a center, clinic, at the patient's home, or any other established site deemed appropriate by the provider. The room must be free from distractions that would interfere with the telepractice session. A facilitator must be trained in the use of the telepractice technology and be physically present at the patient site during the entire telepractice session to assist the patient at the direction of the qualified provider of behavioral health. Occupational, physical, and speech therapy are not covered under telepractice services. See the telemedicine database for appropriate or allowed telemedicine services that may be covered by the Medicaid Health Plan or by Medicaid Fee-forService.

BHT Service Level

BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within their the individual's community for an appropriate period of time, depending on the needs of the child individual and their parents/guardiansfamily or authorized representative(s). Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the child's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings, or to be provided when the child would typically be in school but for the parent's/guardian's choice to home-school their childresponsibilities of educational or other authorities. Each child's individual's IPOS must specify how identified supports and services will be provided as part of an overall, comprehensive set of supports and services that does not duplicate services that are the responsibility of another entity, such as a private insurance or other funding authority, and do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the individual through a local education agencydocument that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) that are available to the child through a local education agency. The recommended service level, setting(s), and duration will be included in the child's IPOS, with the planning team and the parent(s)/guardian(s) family or authorized representative(s) reviewing the IPOS at regular intervals (minimally every three months)no less than annually and, if indicated, adjusting the service level and setting(s) to meet the child's changing needs. The service level includes the number of hours of intervention provided to the child. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each child individual and should reflect the goals of treatment, specific needs of the childindividual, and response to treatment. It is the responsibility of MSHN's Utilization Management to authorize the level of services prior to the delivery of services.

- Focused Behavioral Intervention: Focused behavioral intervention is provided an average of 5-15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
- Comprehensive Behavioral Intervention: Comprehensive behavioral intervention is provided an average of 16-25 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
-

BHT Service Evaluation

As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement. BCBAs/LBAs and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are

responsible for effectively evaluating the child's response to treatment and skill acquisition. Ongoing determination of the level of service (minimally every six months) requires evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated with the use of reliable and valid assessment instruments (i.e., VB-MAPP, ABLLS-R, AFLS) and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).

BHT Service Provider Qualifications

MSHN and its Provider Network Management shall ensure credentialing of roles and responsibilities of qualified providers. BHT services are highly specialized services that require specific qualified providers that are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services. BHT services must be provided under the direction of a BCBA/LBA, another appropriately qualified LP or LLP, or a Master's prepared QBHP. These services must be provided directly to, or on behalf of, the child by training their parents/guardians, behavior technicians, and BCaBAs to deliver the behavioral interventions. The BCBA/LBA and other qualified providers are also responsible for communicating progress on goals to parents/guardians minimally every three to six months,; clinical skill development and supervision of BCaBA, QBHP, and behavior technicians;, and collaborating with support coordinators/case managers and the parents/guardians on goals and objectives with participation in development of the IPOS that includes the behavioral plan of care.

BHT Supervisors

- Board Certified Behavior Analyst Doctoralrate (BCBA-D/LBA) or Board Certified Behavior Analyst (BCBA/LBA)
    1. Services Provided: Behavioral assessment, behavioral treatmentintervention, and behavioral observation and direction.
    - License/Certification: Current certification as a BCBA through the BACB. The BACB is the national entity accredited by the National Commission for Certifying Agencies (NCCA). Licensed through the Michigan Licensing and Regulatory Authority (LARA).
    i. o Education and Training: Minimum of a master's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.
- Licensed Psychologist (LP or LLP):
    - Must be certified as a BCBA/LBA by September 30, 2020 2025
    2. Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
    i. License/Certification: LP means a doctoral level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements. LLP means a masters level psychologist licensed by the State of Michigan.
    ii. Education and Training: Minimum doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented ABA specific coursework at the graduate level from an accredited university in at least three of the six following areas:
        1. Ethical considerations.
        2. Definitions & characteristics; and principles, processes & concepts of behavior.
        3. Behavioral assessment and selecting interventions outcomes and strategies.
        4. Experimental evaluation of interventions.
        5. Measurement of behavior and developing and interpreting behavioral data.
        6. Behavioral change procedures and systems supports.
    iii. A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA/LBA to discuss the caseload, progress, and treatment of the child with ASD.

3. LLP: Must be certified as a BCBA by September 30, 2020 Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
    i. License/Certification: LLP means a doctoral or master level psychologist licensed by the State of Michigan. Limited psychologist master's limited license is good for one two-year period. Must complete all coursework and experience requirements.
    ii. Education and Training: Minimum of a master's or doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented ABA specific coursework at the graduate level from an accredited university in at least three of the six following areas:
        1. Ethical considerations.
        2. Definitions & characteristics and principles, processes & concepts of behavior.
        3. Behavioral assessment and selecting interventions outcomes and strategies.
        4. Experimental evaluation of interventions.
        5. Measurement of behavior and developing and interpreting behavioral data.
        6. Behavioral change procedures and systems supports.
    o A minimum of one-year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the progress and treatment of the child with ASD.

Board Certified Assistant Behavior Analyst (BCaBA)

1. Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
    i. License/Certification: Current certification as a BCaBA through the BACB. The BACB is the national entity accredited by the NCCA. Licensed through the Michigan Licensing and Regulatory Authority (LARA).
    ii. Education and Training: Minimum of a bachelor's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.
    iii. Other Standard: Works under the supervision of the BCBA.

Qualified Behavioral Health Professional (QBHP):

Must be licensed and certified as a BCBA/LBA by September 30, 2020 2025.

Services Provided: Behavioral assessment, behavioral treatmentintervention, and behavioral observation and direction.

2. o License/Certification: A license or certification is not required but is optional.Must be certified as a BCBA/LBA within two years of successfully completing ABA graduate coursework.
    i. Education and Training: QBHP must meet one of the following state requirements:
        - Must be a physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD.
        - Minimum of a master's degree in a mental health related field or BACB approved degree category from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. Works within their scope of practice, works under the supervision of the a BCBA/LBA, and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented ABA specific coursework at the graduate leveldocumented coursework at the graduate level (i.e., completion of BACB evaluated graduate courses or BACB verified course sequences meeting specific standards toward certification) from an accredited university in at least three of the six following areas:
            1. Ethical considerations.
            2. Definitions & characteristics; and principles, processes & concepts of behavior.

3. Behavioral assessment, and selecting interventions outcomes and strategies.
4. Experimental evaluation of interventions.
5. Measurement of behavior, and developing and interpreting behavioral data.
6. Behavioral change procedures and systems supports.

Behavior Technician or Registered Behavior Technician (RBT)

Services Provided: Behavioral intervention. o

3. License/Certification: A license or certification is not required.

i. Education and Training: Will receive BACB Registered Registered Behavior Technician (RBT) training conducted by a professional experienced in BHT services (BCBA/LBA, BCaBA, LP, LLP, and/or QBHP), but is not required to register with the BACB upon completion in order to furnish services.

ii. Works under the supervision of the BCBA/LBA or other professional (BCaBA, LP, LLP or QBHP) overseeing the behavioral plan of care, with minimally one hour of clinical observation and direction for every 10 hours of direct treatment.

iii. Must be at least 18 years of age; able to practice universal precautions to protect against the transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedure, and to report on activities performed; and be in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien). Must be able to perform and be certified in basic first aid procedures and is trained in the IPOS/behavioral plan of care utilizing the person-centered planning process.

MSHN shall maintain evidence that the child meets needs basedneeds-based criteria for benefit eligibility as evidenced by the above applicable evaluation and outcomes instruments. –MSHN is responsible for a utilization management function in order to ensure sufficient separation of functions and addresses:

1. Conflict of interest;
2. Service authorization;
3. Clinical service provision;
4. Oversight and approval of ABA services;
5. Number and percent of administrative hearings related to utilization management function issues (amount, scope, duration of service;)
6. ABA services during the quarter were within the suggested range for the intensity of service.

Applies to:

☒All Mid-State Health Network Staff ☐Selected MSHN Staff, as follows:

☒MSHN's Affiliates: ☒Policy Only ☐Policy and Procedure

☒Other: Sub-contract Providers

Definitions:

ABA: Applied Behavior Analysis

ABLLS-R: Assessment of Basic Language and Learning Skills-Revised

ADI-R: Autism Diagnostic Interview-Revised

ADOS-2: Autism Diagnostic Observation Schedule-2

ASD: Autism Spectrum Disorder

BCBA: Board Certified Behavior Analyst

BCaBA: Board Certified Assistant Behavior Analyst

BHT: Behavioral Health Treatment

CMS: Centers for Medicare & Medicaid Services

DAS-II: Differential Ability Scales-II

DSM: Diagnostic and Statistical Manual of Mental Disorders
EPSDT: Early Periodic Screening, Diagnosis and Treatment
~~IPOS: Individual Plan of Service~~
~~iSPA: 1915i State Plan Amendment~~
~~LBA: Licensed Behavior Analyst~~LP: ~~Licensed Psychologist~~
~~LLP: Limited Licensed Psychologist~~
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PCP: Person-Centered Planning
Provider Network: The Community Mental Health Services Program (CMHSP) participants that hold a contract with Mid-State Health Network.
~~QBHP: Qualified Behavioral Health Professional~~
~~VABS-2: Vineland Adaptive Behavior Scales-Second Edition~~
~~VB-MAPP: Verbal Behavior Milestones Assessment and Placement Program~~
~~WPPSI-III: Wechsler Preschool and Primary Scale of Intelligence-III~~
~~WPPSI-IV: Wechsler Preschool and Primary Scale of Intelligence-IV~~

Other Related Materials:
N/A

References/Legal Authority:
MDHHS Medicaid Provider Manual
MDHHS Medicaid Managed Specialty Supports & Services Contract
~~Medical Services Administration Bulletin 15-59~~

Change Log:

Date of Change	Description of Change	Responsible Party
10.2014	New Policy	UM & Waiver Coordinator
06.2016	Replaces Original Policy	Waiver Coordinator
01.10.2017	Addition of referrals from outside sources	Waiver Coordinator
11.17.2017	Removed DSM IV language and added language for ABA specific coursework under BHT Supervisor credentialing requirements.	Waiver Coordinator
2.2019	Annual Review	Waiver Coordinator
08.2020	Annual Review	Waiver Coordinator
02.2024	Annual Review	Waiver Coordinator

MSHN
Mid-State Health Network

POLICIES AND PROCEDURES MANUAL

Chapter:	**Service Delivery System**		
Title:	**Behavioral Health Recovery Oriented System of Care**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** ~~SUD Workgroup and HITP Director~~Chief Behavioral Health Officer	**Adopted Date: 1.06.2015** **Review Date:** 11.01.2022	**Related Policies:** Service Philosophy & Treatment

Purpose

To ensure that Mid-State Health Network (MSHN) and its Provider Network develop a holistic and effective behavioral health system that promotes recovery and resilience across its network of care, through adoption of the fifteen guiding principles of a Recovery Oriented System of Care (ROSC) developed by the state of Michigan. Behavioral health systems are inclusive of individuals who encompass one or more of the following disorders:

- Substance use disorders,
- Severe and persistent mental illness,
- Serious emotional disturbances,
- Autism,
- Intellectual/Developmentally disabilities and;
- Co-occurring Disorders.

Policy

MSHN and its Provider Network adopts fifteen ROSC principles to support and guide the development of behavioral health throughout the region as identified below.

A. Adequately and flexibly financed: MSHN's system will be adequately financed to permit access to a full continuum of behavioral health services, ranging from prevention, early intervention, case management, and treatment to continuing care, peer support and recovery support. In addition, MSHN will strive to make funding sufficiently flexible to enable the establishment of a customized array of behavioral health services that can evolve over time to support an individual's and a community's recovery.

B. Inclusion of the voices and experiences of recovering individuals, youth, family, and community members: The voices and experiences of all community stakeholders will contribute to the design and implementation of the system. People in recovery, youth, and family members will be included among decision-makers and have input and/or oversight responsibilities for behavioral health service provision. Recovering individuals, youth, family, and community members will be prominently and authentically represented on behavioral health advisory councils, boards, task forces, and committees.

C. Integrated strength-based services: MSHN's system will coordinate and/or integrate efforts across behavioral health service systems, particularly with primary care services, to achieve an integrated service delivery system that responds effectively to the individual's or the community's unique constellation of strengths, desires, and needs.

D. Outcomes driven: MSHN's system will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration with individuals in recovery, the Provider network and the community. Outcome measures will be diverse and encompass measures of community wellness as well as the long-term global effects of the behavioral health recovery process on the individual, family, and community – not just the remission of biomedical symptoms. Behavioral health outcomes will focus on individual, family, and community indicators of health and wellness, including benchmarks of quality-of-life changes for people in recovery.

E. Family and significant-other involvement: MSHN's system of care will acknowledge the important role that families and significant others can play in promoting wellness for all and recovery for those with behavioral health challenges. They will be incorporated, whenever it is appropriate, into needs-assessment processes, community planning efforts, recovery planning and all support processes. In addition, MSHN's system will identify and coordinate behavioral health services for the family members and significant others of people with substance use disorders.

F. System-wide education and training: MSHN's Provider Network will seek to ensure that concepts of behavioral health prevention, recovery, and wellness are foundational elements of curricula, certification, licensure, accreditation, and testing mechanisms. The workforce requires continuing education, at every level, to reinforce the tenets of ROSC. Education and training commitments are reinforced through policy, practice, and the overall service culture as identified by the state of Michigan.

G. Individualized and comprehensive services across all ages: MSHN's system of care will be individualized, person/family/community-centered, comprehensive, stage-appropriate, and flexible. It will adapt to the needs of individuals and communities, rather than requiring them to adapt to it. Individuals will have access to a menu of stage-appropriate choices that fit their needs throughout the recovery process. The approach to behavioral health care will change from an acute, episode-based model to one that helps people manage their symptoms throughout their lives. Behavioral health treatment and prevention services will be developmentally appropriate, emphasizing strengths, assets, and resiliencies; and engage the multiple systems and settings that have an impact on health and wellness. Behavioral health efforts will be individualized based on the community's needs, resources, and concerns.

H. Commitment to peer support and recovery support services: MSHN's system of care will promote ongoing involvement of peers, through peer support opportunities for youth and families and peer recovery support services for individuals with behavioral health concerns. Individuals with relevant lived experiences will assist in providing these valuable supports and services.

I. Responsive to Cultural Factors, ~~and~~ Personal Belief Systems, and Trauma Sensitive: MSHN's system of care will be culturally sensitive, gender competent, ~~and~~ age appropriate, and trauma sensitive. There will be recognition that beliefs and customs are diverse as well as how a history of trauma~~and~~ can impact the outcomes of behavioral health efforts.

J. Partnership-consultant relationship: MSHN's system will be patterned after a partnership/consultant model that focuses more on collaboration and less on hierarchy. Systems and services will be designed so that individuals, families, and communities feel empowered to direct their own journeys of behavioral health recovery and wellness.

K. Ongoing monitoring and outreach: MSHN's system of care will provide ongoing monitoring and feedback, with assertive outreach efforts to promote continual participation, re-motivation, and re-engagement of individuals and community members in behavioral health services.

L. Research based: MSHN's system will be informed by research. Additional research on individuals in recovery, recovery venues, and the processes of behavioral health recovery (including cultural and spiritual aspects) will be essential to these efforts. Published research related to behavioral health will be supplemented by the individual experiences of people in recovery. Prevention efforts will use the Strategic Prevention Framework and epidemiologically based needs-assessment approaches to identify behavioral health issues and community concerns. Individual, family, and environmental prevention strategies will be data driven.

M. Continuity of care**:** MSHN's system will offer a behavioral health continuum of care that includes prevention, early intervention, treatment, continuing care, and support throughout recovery. Individuals will have a full range of stage-appropriate behavioral health services to choose from at any point in the recovery process with the outcome of improving quality of life. Behavioral health prevention services will involve the development of coordinated community systems that provide ongoing support, rather than isolated, episodic programs.

N. Promote Community Health and Address Environmental Determinants to Health: MSHN's system will strive to promote community health and wellness through strategic behavioral health prevention initiatives that focus on building community strengths in multiple sectors of our communities.

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:
BHS: Behavioral Health Systems: The system is inclusive of individuals who encompass one or more of the following disorders: Substance use, Severe and persistent mental illness, Autism, Serious emotional disturbances, Intellectual/Developmentally disabilities and Co-occurring disorders.
MSHN: Mid-State Health Network
~~HITP: MSHN Health Integration, Treatment and Prevention Director~~
OROSC: Office of Recovery Oriented Systems of Care
Recovery: Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential. (Substance Abuse and Mental Health Services, SAMHSA).
ROSC: Recovery Oriented System of Care; based upon significant input from stakeholders, Michigan defines a ROSC as: *Michigan's recovery-oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life-enhancing recovery and wellness for individuals, families and communities*. Adopted by the ROSC Transformation Steering Committee , September 30, 2010
SAMHSA: Substance Abuse and Mental Health Services Administration
SUD: Substance Use Disorder
Strategic Prevention Framework: The framework establishes the parameters within which a regional prevention plan is established and monitored.
TSC: Transformation Steering Committee – committee working under the direction of OROSC staff. Developed Michigan's ROSC – An Implementation Plan for SUD Service System Transformation.

Other Related Materials:
Michigan's Recovery Oriented System of Care–An Implementation Plan for Substance Use Disorder Service System Transformation:
http://www.michigan.gov/documents/mdch/ROSC_Implementation_Plan_357360_7.pdf
Guiding Principles and Elements of Recovery Oriented Systems: www.samhsa.gov/.../rosc_resource guide

References/Legal Authority:
2013 Application for Participation Region 5 Response:
http://www.midstatehealthnetwork.org/docs/Region5PIHP2013AFP.PDF

Change Log:

Date of Change	Description of Change	Responsible Party
01.06.2015	New Policy	SUD Workgroup and HITP Director
06.2016	Policy reviewed	Clinical Leadership Committee
03.2017	Annual Review	Clinical Leadership Committee/Deputy
02.2018	Annual Review	Clinical Leadership Committee / Chief
03.2019	Annual Review	Chief Clinical Officer
10.2020	Annual Review	Chief Clinical Officer
08.2022	Biennial Review	Chief Clinical Officer
06.2024	Biennial Review	Chief Behavioral Health Officer

POLICIES AND PROCEDURE MANUAL

Chapter	**Utilization Management**		
Title:	**Access System Policy**		
Policy: ☒ **Procedure:**☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Population Health Officer & UM Committee	**Adopted Date: 11.22.2013** **Review Date: 05.07.2024**	**Related Policies:** Service Delivery System: Service Philosophy Utilization Mgmt: Access System Procedure~~Utilization Management~~

Purpose

Mid-State Health Network (MSHN) shall ensure regional access to public behavioral health services in accordance with the Michigan Department of Health & Human Service (MDHHS) contracts, MDHHS Access Standards, MDHHS Medicaid Provider Manual, and Michigan Mental Health Code. The purpose of this policy is to create, implement and maintain access system standards that are uniform throughout the region.~~,~~ MSHN has partially delegated its access system to its Community Mental Health Service Program (CMHSP) Participants and Substance Use Disorder Service Providers (SUDSP). ~~Requests for SUD residential, withdrawal management, and/or recovery housing must be referred to the MSHN Access line at 844-405-3095 as prior authorization is required for those services. MSHN Access staff will complete the screening documents and assist the person in getting connected to a provider.~~ The MSHN provider network shall develop written policies, procedures and plans demonstrating the capability of its access system to comply with those standards and provide for efficient and effective access practices.

Policy

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

- Intellectual/ Developmental Disabilities (IDD),
- Mental Illnesses (MI),
- Serious Emotional Disturbance (SED)
- Substance Use Disorders (SUD), and/or
- Co-occurring Disorders

Additionally, it is the policy of MSHN that the regional access system incorporates a "no wrong door" approach for substance use treatment services. Individuals seeking information, services, and/or supports for substance use treatment needs may contact any CMHSP **or** any SUDSP. Requests for SUD residential, withdrawal management, and/or recovery housing must be warm transferred to the MSHN Access line at 844-405-3095 as prior authorization is required for those services. MSHN Access staff will complete the screening documents and assist the person in getting connected to a provider. ~~Warm transfers to the MSHN Access department should be completed for people seeking SUD residential, withdrawal management, and/or recovery housing services.~~

The access system performs the following key functions:

1. **Welcome** all individuals by demonstrating empathy and providing opportunity for the person presenting to describe situation, problems, and functioning difficulties; exhibiting excellent customer service skills; and working with them in a non-judgmental way.

2. **Screen** individuals who approach the Access System to determine whether they are in crisis and, if so, assure that they receive timely appropriate attention.

3. **Determine** individuals' eligibility for Medicaid specialty services and supports, MIChild, Healthy Michigan Plan, Substance Abuse Block Grant (SABG) or, for those who do not have any of these benefits as a person who is presenting needs for behavioral health services, make them a priority to be served.

4. **Collect** information from individuals for decision-making and reporting purposes.

5. **Refer** individuals in a timely manner to the appropriate behavioral health practitioners for assessment, person-centered planning (PCP), and/or supports and services or, if the individual is not eligible for Prepaid Inpatient Health Plan (PIHP) or CMHSP services, to community resources that may meet their needs.

6. **Inform** individuals about all the available mental health and substance abuse services and providers and their due process rights under Medicaid, MIChild, Healthy Michigan Plan, SABG, and the Michigan Mental Health Code.

7. **Conduct outreach** to under-served and hard-to-reach populations and be accessible to the community-at-large.

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

Definitions:
CMHSP: Community Mental Health Service Program
IDD: Intellectual/Developmental Disabilities
MDHHS: Michigan Department of Health & Human Services
MI: Mental Illnesses
MIChild: a Medicaid health insurance program for uninsured children of Michigan's working families
MSHN: Mid-State Health Network
PCP: Person-Centered Plan
PIHP: Prepaid Inpatient Health Plan
Provider Network: refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements
SABG: Substance Abuse Block Grant
SED: Serious Emotional Disturbance
Staff: refers to an individual directly employed and/or contracted with a CMHSP Participant or SUD providers
SUD: Substance Use Disorder
SUDSP: Substance Use Disorder Service Provider
UMC: Utilization Management Committee

References/Legal Authority:
1. Access System Standards: MDHHS, revised July 29, 2020
2. Appeal and Grievance Resolution Processes Technical Requirement: MDHHS, revised July 29, 2020
3. 42CFR 438.206: Access Standards
4. 42CFR 438.208(c)(4)
5. 42CFR 438.210: Enrollee Rights
6. Michigan Mental Health Code 330.1124: Waiting Lists for Admission
7. Michigan Mental Health Code 330.1208: Individuals to Whom Service is Directed
8. MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disabilities Supports and Serviceschapter
9. Person-Centered Planning Practice Guideline: MDHHS, , revised July 29, 2020

Other References:
MSHN Medicaid Subcontract Agreement Exhibit H: Technical Requirement: CMHSP RESPONSIBILITIES FOR 24/7/365 ACCESS FOR INDIVIDUALS WITH PRIMARY SUBSTANCE USE DISORDERS

Change Log:

Date of Change	Description of Change	Responsible Party
11.22.2013	New Policy	UMC
09.2014	Annual Review and update of definitions and acronyms	MSHN CEO
06.2015/07.2015	Update to integrate with UMP	UMC and MSHN CEO
07.23.2015	Clarify clinical eligibility for SUD, clarify FY15 contract provisions.	UMC
04.26.2016	Differentiated SED from MI, 2015 MDHHS Access Policy, and added assessment tools and reference to HSW and EPSDT policies.	UMC
10.27.2016	Updated the policy to reflect Access Management System changes in FY17 MDHHS/PIHP contract.	UMC
10.26.2017	Updated policy to reflect the PCP policy language around assessment tools and PCP process for authorizing services	UMC
10.26.2018	Annual Review	UMC
02.27.2020	Annual Review- added MDOC priority population requirements for SUD services; added DECA as contractually mandated assessment tool	UMC
02.24.2022	Biennial Review – Updated References/Legal Authorities to current versions; Re-formatted to align with MDHHS Access Standards (Rev. January 2022); Separated content into Access Policy and Access Procedure	UMC
02.22.2024	Biennial Review	UMC
10.01.2024	Updated policy to reflect the FY25 changes in MSHN Access process for SUD withdrawal management, residential, and recovery housing services.-	

MSHN
Mid-State Health Network

MSHN CHIEF EXECUTIVE OFFICER PERFORMANCE EVALUATION RESULTS

Background

The Mid-State Health Network Board of Directors participates in a yearly evaluation of the MSHN Chief Executive Officer (CEO). Board member evaluation results and 360 Leadership Review feedback were compiled, and a draft performance review report was presented to the Evaluation Chair. The Evaluation Chair reviewed the report with the Executive Committee and at the January 7, 2025 board meeting presented the summary to the Board of Directors.

Recommended Motion:

Motion to receive and file the 2024 MSHN Chief Executive Officer Performance Evaluation Results.

January 7, 2025