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

From the Chief Executive Officer's Desk

Joseph Sedlock

Mid-State Health Network strives to achieve effective collaborations with our provider partners, beneficiaries and their advocates, and the communities we serve. Effective collaboration starts with an idea about the outcome, not necessarily yet in full definition. It requires that everyone is engaged as equals in the search for solutions that either produce the desired outcome(s) or move closer to the desired ends.

Time and time again I have witnessed collaborations that have resulted in outcomes better and beyond those desired at the beginning; over and over better solutions to complex problems have come from the creativity, ingenuity, and commitment of all involved.

Mid-State Health Network has earned a reputation as a strong and effective collaborator. This is because all of our staff are committed to our strategic priorities: better health, better care, better provider systems, better equity, and better value. And all of our staff are committed to being effective partners, effective problem solvers – better collaborators. Most of the time, we do it well; sometimes we miss the mark. Always we will aim to do better – especially in our strategic priority areas.

I am proud of this organization and the reputation we have earned. I am especially proud to work among a group of staff that continually steps up, continually faces difficult challenges, and practices teamwork and collaboration with

such excellence.

Celebrating our collaborations is highlighted in our upcoming update to our Impact Report (expected for release in early August). Within it we highlight strong collaborations in four key areas: People, Partners, Communities, and Employees. We think you'll readily see the results of some of our collaborations over the past couple of years and will join us in celebrating those accomplishments.

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

MSHN Staffing Update

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

- Cari Patrick began employment with MSHN on July 15, 2024, filling the Prevention Specialist role that will become vacant as Kari Gulvas retires in August.
- Rusmira Bektas will begin employment on August 12, 2024, as the Access Administrator and comes to MSHN with many years of experience, most recently from Region 10 Pre-paid Inpatient Health Plan (PIHP) as the Substance Use Disorder (SUD) Director and Harbor Oaks Hospital's SUD Program Director.
- Kate Flavin has been promoted from the SUD Treatment Specialist to the SUD Treatment Administrator, effective July 22, 2024.

MSHN is still looking to fill the Treatment Specialist position and the Access Specialist positions located on MSHN's website at: https://midstatehealthnetwork.org/stakeholders-resources/about-us/Careers.

Center for Medicare and Medicaid Services

On July 16, 2024 Centers for Medicare & Medicaid Services (CMS) released a State Health Official (SHO) letter to provide guidance and expectations for compliance with the Requiring Accurate, Updated, and Searchable Providers Directories requirement under the Consolidated Appropriations Act, 2023, which takes effect July 1, 2025. This SHO letter specifically addresses:

- Changes to Provider Directory data requirements and features resulting from Section 5123 of the CAA, 2023;
- Availability of enhanced federal financial participation (FFP) for Medicaid fee-for-service Provider Directory development and operations;
- Non-Compliance: Corrective action plan requirements for re-approval of Medicaid Systems; and
- Returning to compliance and requesting re-approval of Medicaid Systems.

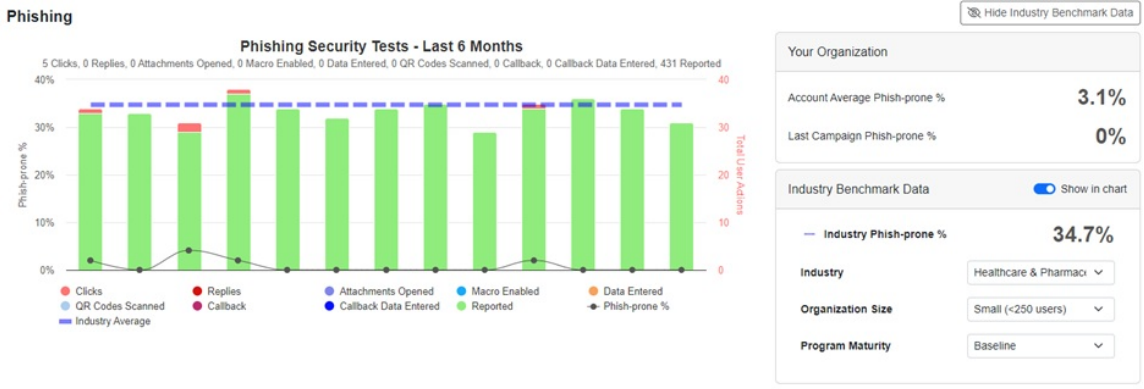
Mid-State Health Network will be working with our Community Mental Health Service Program (CMHSP) Participants to ensure compliance with the new Provider Directory elements that includes new required data elements with the PIHP online provider directory. In addition, Michigan Department of Health and Human Services (MDHHS) has included language in the FY25 contract to strengthen application programming interface (API) requirements to support the direction from CMS stated above.

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

Information Technology

Steve Grulke
Chief Information Officer

Mid-State Health Network employees are provided cybersecurity training on a regular basis. KnowBe4 is the company that produces the activities which come in the form of a short training video and an email phishing test. The video explains one or more aspects of security that an employee needs to be aware of. Typically, it is about an area that is currently being reported as exploited. The phishing test is an email that mimics a situation that has been identified recently by security agencies. Some examples of phishing tactics include a message that attempts to get the user to act quickly so they do not have time to think through their actions and the possibility that it is not legitimate. It sometimes includes attacks on your emotions, like asking for money for a disadvantaged person that needs a costly surgery or medication. Below is a report from the KnowBe4 dashboard regarding the responses from Mid-State Health Network employees.



Two areas to note are: 1) that over the last six months, there were five instances an employee clicked on a phishing test email and 2) MSHN's phish-prone percentage is 3.1% versus the industry average of 34.7%. Even though MSHN is in a better position than many other employers, it only takes one mistake on a real phishing email to cause a major problem. Therefore, MSHN will continue to ensure our employees are trained on cybersecurity and related threats.

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

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN's Finance Team is actively engaged in several activities related to Fiscal Year (FY) 2025.

- MSHN received draft capitation rates from Michigan Department of Health and Human Services (MDHHS) in July. MDHHS has stated final rates will be available mid to late August. Capitation information allows Finance to project the Region's anticipated revenue by Community Mental Health Service Participant (CMHSP) and Substance Use Disorder (SUD). In conjunction with calculating revenue, expense information is also collected and those two components are used to develop a complete FY 2025 budget. Unfortunately, because the rates are in draft format, they are subject to change. In addition, the draft rates do not include key items such as geographic factors and Certified Community Behavioral Health Center - Prospective Payment System (CCBHC-PPS-1). These two items are key when making accurate projections:

    1. Geographic Factors - MDHHS' actuarial contractor assigns a number to each Pre-Paid Inpatient Health Plan (PIHP) based on expenses, urban or rural status, and other financial information. The numbers usually range from .97 to 1.2 for example. PIHPs with a number less than 1 will receive a reduction in base capitation and vice versa for those with numbers greater than 1.
    2. CCBHC PPS-1 rates - CCBHC PPS-1 rates are established for each individual CCBHC, and these numbers vary. PPS-1 rates are calculated based on Cost Reports submitted by each CCBHC site. Typically, MSHN's Severe and Persistent Mental Illness (SPMI)/SUD population's PPS-1 rate is covered with capitation/per eligible per month (PEPM) and supplement CCBHC revenue. Without having CCBHC rates, it is difficult to develop a budget for capitated revenue (Medicaid/Healthy Michigan) the region will receive. Individuals with mild to moderate diagnoses are covered fully with CCBHC supplemental revenue which is fully cost settled by MDHHS.

- Contracts - In addition to the SUD contracts, MSHN also works with the CMHSPs on the following Regional ones:

    1. Medicaid Subcontracting Agreement - Contract between MSHN and the CMHSPs for all disbursed payments. In addition to standard boiler plate language, the contract includes a funding exhibit (anticipated revenues) and CMHSP reporting requirements.
    2. Applied Behavioral Analysis (ABA) - CMHSPs use this contract template for their work with Autism Service Providers.
    3. Inpatient - CMHSPs use this contract template with hospitals for individuals receiving Mental Health Inpatient Care.
    4. Financial Management Services (FMS) - The purpose of FMS Providers is to manage an individual budget and make payments as authorized by the person served for individuals assisting in their care. An FMS Provider may also render a variety of supportive services that assist the person in self-directing their care.

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

Behavioral Health

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

Social Work Licensure Compact Gains Ground

The United States continues to struggle through a mental health crisis, including a behavioral health workforce shortage. The workforce shortage is not simply met by increasing the supply of behavioral health providers, and while this is a needed part of the overall strategy to improve and maintain access to care, maldistribution of the workforce is also a key limiting influence (National Center for Workforce Analysis, 2023). This means that the strategies intended to increase the behavioral health workforce must account for meeting the behavioral health needs of individuals in rural and underserved areas as well. In December 2023, over half of the population of the United States was projected to live in a Health Professional Shortage Area (HPSA). In 2021, Michigan was ranked fifth worst in the nation for mental health professional shortages (Slootmaker, 2022). One such strategy to addressing the mental health workforce shortage issue should include the Social Work Licensure Compact ("the compact").

Benefits of the compact include:

- Increased access to care for beneficiaries.
- Streamlined licensing.
- Advancements in telehealth opportunities.
- Enhanced workforce mobility and ability to practice in multiple states.
- Maintain continuity of care.

Official planning for the Social Work Licensure Compact began in October 2021 in partnership with the Council of State Governments (CSG), the Association of Social Work Boards (ASWB), the Clinical Social Work Association (CSWA), and the National Association of Social Workers (NASW) after the United States Department of Defense (DOD) awarded a grant to promote social work interstate licensure portability for military spouses (Interstate Licensure Compact, 2024.). An interstate compact is a legal contract between two or more states that in terms of this compact, would allow social workers to practice in other states beyond the state in which they are licensed. Without licensure in a specific state, a social worker cannot practice; they are limited to practicing in the state where they are licensed. This compact is an effort to promote licensure "portability," that is, the compact would allow a social worker to practice in other states where the compact was in effect.

The planning group set forth in its draft the requirement that there be at least seven participating states to ensure sufficient participation, facilitate multistate practice, and establish governance. On April 12, 2024, the Social Work Licensure Compact officially began when Kansas became the seventh state and passed its own Social Work Interstate Licensing Compact Legislation that officially created a Compact Commission that will now guide and coordinate the compact among the participating states. Currently, there are 25 states that have passed or have pending legislation, which include Missouri, South Dakota, Washington (state), Utah, Kentucky, Virginia, Kansas (these first seven states are the first members to begin the commission), Arizona, Nebraska, South Dakota, Louisiana, Alabama, Pennsylvania, New Jersey, Connecticut, Vermont, New Hampshire, Maine, Georgia, Iowa, Colorado, Minnesota, North Carolina, Ohio, and Tennessee (Compact Map, 2024). There are other states that have house and/or senate bills for legislative consideration. Once legislation is passed and signed into law, states must meet an implementation timeline, attend commission meetings, and participate in establishing a data system for multistate licensure management.

Michigan has also begun pursuit of addressing the Social Work Licensure Compact. The Michigan Chapter of the NASW has been actively discussing the compact with legislative partners to determine a plan for moving forward. The Michigan legislature must enact licensure compact legislation to become a member of this growing group of states. Joining this compact will greatly benefit Michigan and individuals' access to needed mental health services while creating an efficient processing system, protecting public safety, encouraging interstate regulation of social work practice, and strengthening state licensure systems. The compact will ultimately become an important response in the overall strategy to improve Michigan's mental health workforce shortage challenges and simultaneously improve care to its beneficiaries.

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

Utilization Management & Care Coordination

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

Health Homes: Early Successes and Future Planning

By way of review, Health Homes are an innovative model of care established by the Centers for Medicare & Medicaid Services (CMS) to provide comprehensive care coordination for Medicaid beneficiaries with chronic physical and behavioral health conditions. The State of Michigan currently offers Behavioral Health Homes and Opioid Health Homes as optional Medicaid State Plan services in select Pre-Paid Inpatient Health Plan (PIHP) regions. Both initiatives were implemented in the MSHN region during FY23. Opioid Health Homes were implemented on 10/1/2022 with one Health Home Partner (HHP), Victory Clinical Services in Saginaw. Behavioral Health Homes were implemented on 5/1/2023 with three HHPs: Saginaw County Community Mental Health Authority, Community Mental Health for Central Michigan, and Montcalm Care Network. Additionally, Newaygo Community Mental Health and Shiawassee Health & Wellness began working toward implementing Behavioral Health Homes but did not begin enrolling beneficiaries during FY23.

Health Home Partners have the opportunity to earn a quality bonus payment by increasing the number of beneficiaries that are enrolled in the health home each quarter during the first year of implementation. Victory Clinical Services in Saginaw served 179 Medicaid beneficiaries through its Opioid Health Home program during the first year of implementation in FY23 and earned the full possible bonus amount totaling **$32,855.34.**

The Behavioral Health Homes in the MSHN region served a total of 556 Medicaid beneficiaries during FY23 and earned the full possible bonus amount totaling **$46,818.95.** The Behavioral Health Home quality bonus payment was distributed to the three HHPs based on the total number of monthly case rate payments each HHP received during the fiscal year. A monthly case rate payment is received for each Medicaid beneficiary who was enrolled in the health home and received at least one health home service during the month.

FY23 Behavioral Health Home Quality Bonus Payment Distribution				
	CMH for Central MI	Montcalm	Saginaw	Total
Monthly Case Rate Payments	51,789	44,613	103,577	199,979
% of Total	25.90%	22.31%	51.79%	100%
QBP amount	$12,124.72	$10,444.79	$24,249.44	$46,818.95

Of note, Michigan Department of Health and Human Services (MDHHS) allows PIHPs to retain up to 5% of the health home quality bonus payments for administrative responsibilities the PIHP performs. MSHN opted to distribute 100% of the FY23 quality bonus payments to its health home partners and did not retain any portion for administrative expenses.

Future Planning
MSHN has continued to work with its regional Community Mental Health partners and Substance Use Disorder providers to expand the presence of health homes in the region during FY24. Gratiot Integrated Health Network and Shiawassee Health & Wellness launched Behavioral Health Homes this fiscal year and have started enrolling beneficiaries. Newaygo Community Mental Health has been working on staffing for is Behavioral Health Home program with plans to begin enrolling beneficiaries before the end of FY24. Victory Clinical Services implemented Opioid Health Homes in two additional locations, Lansing and Jackson, and Recovery Pathways implemented an Opioid Health Home in Bay County during FY24. Additionally, MidMichigan Community Health Services is a Federally Qualified Health Center located in Houghton Lake (Roscommon County) that currently operates an Opioid Health Home program in partnership with Northern Michigan Regional Entity PIHP. MidMichigan Community Health Services currently serves individuals from the MSHN region who live in bordering counties. MSHN recently finalized a contract for Opioid Health Home services with MidMichigan Community Health Services and is looking forward to onboarding them as a Health Home Partner for our region.

MDHHS recently announced that the Opioid Health Home initiative will be expanding in FY25 to serve individuals who are experiencing any of the following: Alcohol Use Disorder, Stimulant Use Disorder, and/or Opioid Use Disorder. The expanded benefit will be renamed Substance Use Disorder (SUD) Health Homes instead of Opioid Health Homes. MSHN will be providing an informational session about SUD Health Homes during the September 19, 2024, SUD Provider meeting for any Community Mental Health and SUD Providers who are interested in learning more about future opportunities to become a SUD Health Home.

For additional information about Behavioral Health Homes please contact Paul.Duff@midstatehealthnetwork.org

For additional information about Opioid/SUD Health Homes please contact Katy.Hammack@midstatehealthnetwork.org

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

Substance Use Disorder Policy, Strategy and Equity

Dani Meier, PhD, LMSW, MA
Chief Clinical Officer

Fentanyl: Following the Data

In the last decade, it's common knowledge that the overdose epidemic in the United States has been exacerbated and accelerated by illicit fentanyl entering the drug supply (see chart below). It's regularly mixed with other opioids like heroin or with stimulants like cocaine and methamphetamine, and its presence is often unbeknownst to the user (PMC) resulting in hundreds of overdose deaths every day in this country. The introduction of fentanyl in the illicit opioid drug stream caused what's often called the 3rd wave in the overdose crisis, and it's prevalence in the stimulant drug supply has been dubbed the 4th wave (NIH).

In 2023, the Drug Enforcement Administration (DEA) seized more than 80 million fentanyl-laced pills and nearly 12,000 pounds of fentanyl powder (DEA). So far in 2024, fentanyl seizures represent over 208 million potentially lethal doses (i.e., 2 mgs of fentanyl). These numbers are daunting to say the least.

While MSHN's focus is on prevention, treatment and recovery of substance use disorders, we often partner with law enforcement who address the supply side of illicit drugs. They are clear that resolving this crisis requires data-informed strategies that derive from what's actually happening on the ground, not from misinformation like the narrative Americans often hear: that it's illegal immigrants who are bringing fentanyl into the country.

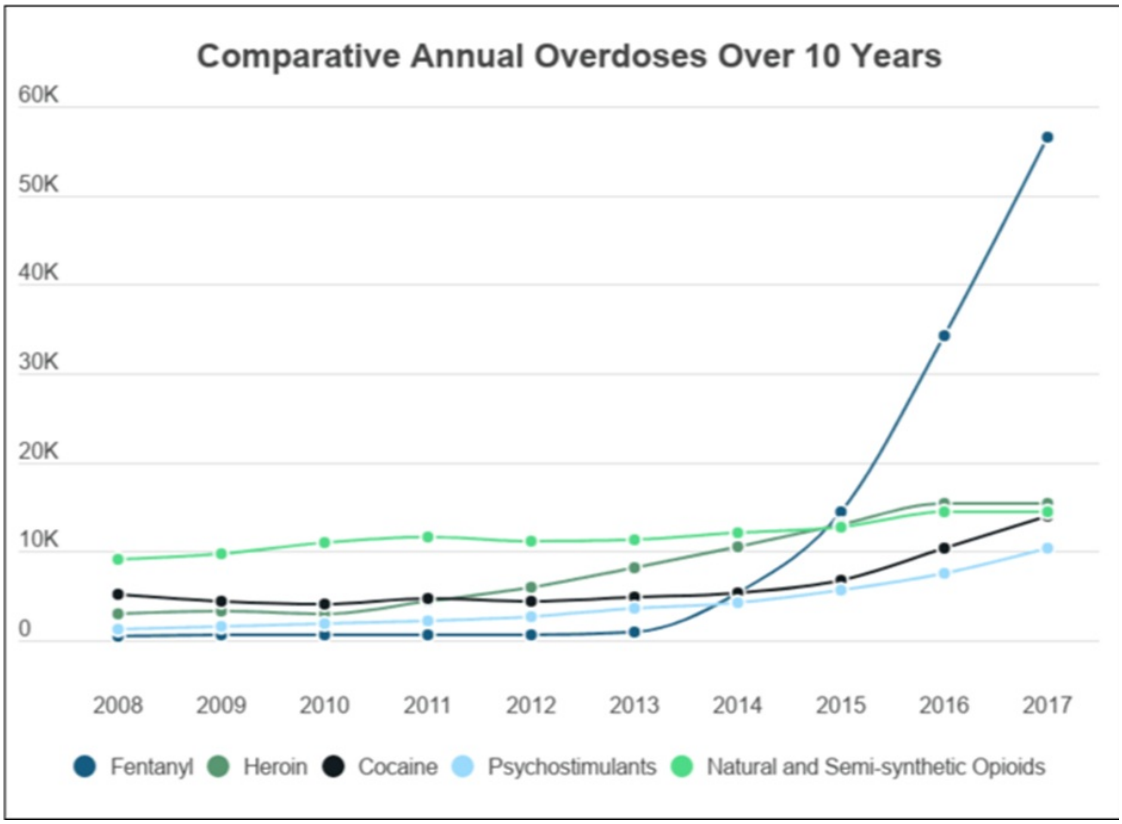
The data shows that the majority of fentanyl is brought into the country by *American citizens* at *legal* Ports of Entry (POEs). This is a stark contrast to the storyline that fentanyl is smuggled by illegal immigrants *between* ports of entry, particularly in areas without fences or other physical barriers. U.S. Customs & Border Control authorities report that close to 90% of fentanyl is seized at *legal* POEs and report that it is smuggled predominantly by U.S. citizens, as well as other travelers who are legally authorized to cross the border (NIF). Almost none is seized from

migrants who are seeking asylum.

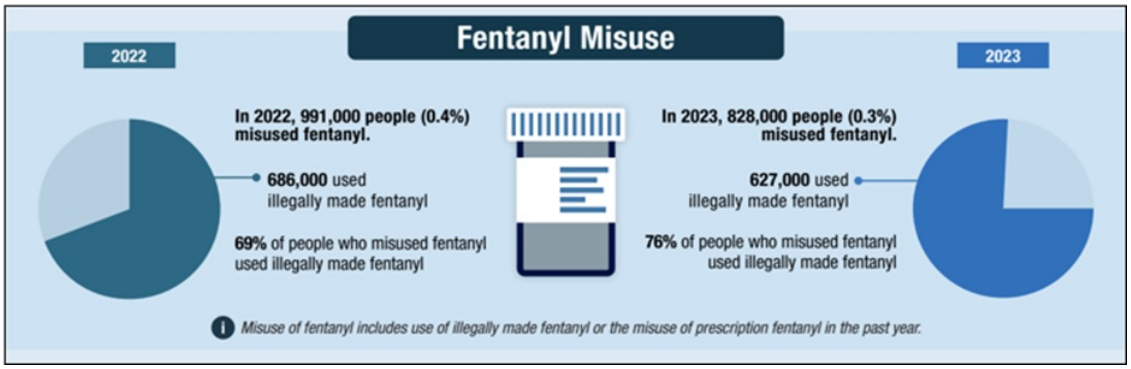
MSHN is working diligently to reduce overdose deaths and we know that overdose death rates are high in populations of color like the Hispanic/Latine population, many of whom are legal residents or U.S. citizens who contribute much to the communities where they reside. The death toll for Hispanic Americans has risen faster than for non-Hispanic Americans, tripling from 2010 to 2021 (NIH) and it continues to rise. Attributing the influx of fentanyl to illegal or undocumented migrants compounds the problem by perpetuating harmful stereotypes, discrimination and stigmatization of migrant communities who are actively contributing members of communities across our region (NPR).

In Michigan, overdose deaths have declined from a high of 3,096 in 2021 to 2,820 last year, an important sign that we're making progress. Among those 2,820 overdose deaths in 2023, however, were 140 Hispanic Michiganders. Those are lives that might have been saved had stigma and distracting misinformation not been contributing variables.

Legitimate concerns about immigration policy in the U.S. needn't be conflated with life and death issues like the fentanyl crisis, as it detracts from the real sources of the problem and can stigmatize already underserved populations in our state and in our region. By understanding the facts and working together to combat the fentanyl overdose epidemic in our country, stakeholders and community partners from law enforcement as well as SUD prevention, treatment and recovery providers can continue to reduce the death toll of fentanyl in Michigan.



(NCDAS)



(NSDUH)

For references or more information, please contact Dani at Dani.Meier@midstatehealthnetwork.org

Substance Use Disorder Providers and Operations

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

Women's Specialty Services

In substance use treatment services, there is no one size fits all, especially when considering factors related to gender specific dynamics such as biological responses to substances and the impacts of trauma on addiction. Previous research has shown stronger associations between trauma and substance use in women than in men, which is due to more exposure to high-impact traumatic events and repeated interpersonal trauma among women, including sexual or physical assaults, intimate partner violence, or rape.

According to study findings by the Research Society on Alcoholism (2022), an increased risk of personal histories of trauma combined with a greater vulnerability to alcohol-related deficits in the brain appear to work together to lead to more severe alcohol use disorders (AUDs) in women compared with men.

"I think it is really important for people to understand that addiction is a brain disease, and the reasons behind initiating and maintaining a relationship with alcohol isn't simply about poor choices," said Milky Kohno, PhD, an assistant professor at Oregon Health and Science University and a health research scientist at VA Portland (Psych Congress Network, 7-13-2022). "This study highlights biological and behavioral variables that influence disease severity."

"We found that women with an AUD who experienced more trauma [as a young person] exhibited higher levels of inflammation, while the opposite was true for men with an AUD," said Dr Kohno. "Trauma and stress can also affect the functioning of the emotional centers of the brain, which leads to impairments in emotion regulation. Alcohol does similar things, and coupled with a history of trauma, these biological adaptations are further compromised and can confer greater risk for relapse ."

In FY23, individuals seeking substance use disorder (SUD) treatment services in the MSHN region indicated their primary substance of concern at admission was alcohol (40%), cocaine/meth (29%), heroin/synthetic opioids (26%) and marijuana (4%). The primary substance indicated at admission can further be broken down by gender to the following:

Primary Substance	Female	Male	All
Alcohol	31.94%	44.39%	40%
Cocaine/Meth	33.25%	25.49%	29%
Heroin/Synthetic Opioids	29.20%	23.93%	26%
Marijuana	4.34%	3.69%	4%

In Michigan, the SUD treatment system is fortunate to have a resource known as Women's Specialty Services (WSS), that is available to support the unique needs of women who have challenges with addiction. The Michigan Department of Health and Human Services provides guidance for WSS through their Treatment Policy #12.

To support successful recovery for women, the WSS requires that the service delivery system integrates substance use disorder treatment, mental health services, recovery supports and, frequently, treatment for past traumatic events. When it is left to the woman seeking treatment to integrate these services, an unnecessary burden is placed on her and her potential for recovery. To meet the specific needs of women, successful programs begin with an understanding of the emotional growth of women.

The relationship theories for women suggest that the best context for stimulating emotional growth comes from an immersion in empathic, mutual relationships. The strongest impetus for women seeking treatment is problems in their relationships, especially with their children. A woman's self-esteem is often based on her ability to nurture relationships. Her motivation and willingness to continue treatment is likely to be fueled by her desire to become a better mother, partner, daughter, etc. Programs that meet the needs of women acknowledge this desire to preserve relationships as strength to be built upon, rather than as resistance to treatment. When a program operates from this theoretical point of view, the characteristics of the clinical treatment program, and its objectives and measures of success are defined very differently from those of traditional treatment programs.

Within the MSHN region there are 28 Women's Specialty Services (WSS) locations that are ready and available to support SUD needs for women.

The MSHN SUD Clinical Team also acknowledges the need for ongoing evaluation and training of the regions available resources to support trauma informed care. SUD treatment and recovery housing providers are required to complete a Trauma Informed Organizational Survey every 3 years and support annual goals related to becoming more trauma informed/inclusive.

The SUD Clinical team has also invested in a variety of training opportunities to support providers in becoming more trauma informed including hosting evidence-based practices with renowned authors of trauma materials. In May 2024, MSHN hosted a Beyond Trauma training with Stephanie Covington, which was attended by 170 participants. In August 2024, MSHN will also be hosting a Seeking Safety Training with Lisa Najavits for 300 participants.

For references or more information, please contact Trisha at Trisha.Thrush@midstatehealthnetwork.org

Quality, Compliance & Customer Service

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

Revised Delegated Managed Care Review Process

The Mid-State Health Network (MSHN) Delegated Managed Care (DMC) review process was revised to increase efficiency, reduce redundancies and address feedback and concerns received from the Community Mental Health Service Participants (CMHSPs). The DMC review includes evaluating provider compliance with delegated functions, clinical performance and documentation, contract requirements and the Medicaid Event Verification (MEV) review. The MEV is a review of a sample of claims to verify them against established attributes developed by the State. MSHN developed a DMC review cycle that spans over 3 years, versus the previous 2-year cycle, that includes consolidating MSHN reviews with external reviews (when possible).

The feedback received from the CMHSPs was obtained via surveys, discussions, and the Quality Improvement Council. The following identifies the feedback from the CMHSPs as well as how MSHN is addressing the concerns.

CMHSP Feedback: There is duplication across reviews. MSHN reviews waiver charts and policies one year, the Michigan Department of Health and Human Services (MDHHS) reviews the same policies the next year. This causes the CMHSP to have several corrective action plans at once for the same findings. Additionally, there is a follow-up corrective action plan implementation review by MSHN and then an additional one completed by MDHHS.

> MSHN Solution: MSHN now conducts the waiver review at the same time as the MDHHS waiver review and utilizes the MDHHS record sample to eliminate duplication and administrative burden. MSHN also will coordinate a corrective action plan with the CMHSPs for the findings from the MSHN review and the MDHHS review to eliminate the need for CMHSPs to submit two separate corrective action plans for similar findings.

CMHSP Feedback: The size of the MSHN review is overwhelming leading to many staff from the CMHSP having to devote both time and resources to providing documentation for the reviews and making themselves available to answer questions. The MDHHS review also contains a large number of standards that take many staff hours to provide information and supply requested documentation. In addition, the findings are viewed as having minimal impact on quality and the recommendations provided are getting lost in the volume of standards being reviewed.

> MSHN Solution: The new review cycle will be more manageable by spreading out the review process over 3 years. This process will also allow for more MSHN/CMHSP reviewer discussion, interaction and understanding of the findings and expectations of the recommendations.

CMHSP Feedback: Can MSHN have a depository for current documents such as policies, procedures, forms, and handbooks, etc., that the CMHSP regularly submits so that this is not requested each time a review is completed?

> MSHN Solution: MSHN is establishing a policy/procedure attestation process that will require additional review only if there has been a change since the previous review. For documents such as annual compliance plans, Utilization Management (UM) plans, Quality Assessment Performance Improvement Plan (QAPIP), etc. MSHN will develop a process that will accommodate this request.

As part of the feedback process, the CMHSPs were clear that anything MSHN can do to reduce the scope of auditing, or audit less frequently, would assist with the administrative burden that is caused by the reviews. While MSHN is required to monitor programs and delegated functions, there is some flexibility in the process. By establishing a 3-year cycle, this is creating a less burdensome process for CMHSPs by spreading out the standards being reviewed over a 3-year period and combining our reviews, when possible, with external reviews.

MSHN began implementing this process during Fiscal Year 2024 and coordinated the review with the MDHHS waiver review. Going forward, MSHN will utilize the fiscal year time frame for the scope of the audit, rather than the calendar year. This will allow consistency in providing summary information on the DMC reviews as part of our fiscal year reports.

MSHN will be evaluating this process and getting feedback from the provider network to determine if the new process is meeting the intended purpose of decreasing administrative burden, decreasing duplication of reviews, while maintaining compliance with State, Federal and contract requirements.

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

Our Mission:

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

Our Vision:

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

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