Mid-State Health Network

Board of Directors Meeting ~ May 13, 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

   Remind members of the Board Member Conduct Policy – specifically to seek recognition from the chair before making remarks and to limit yourself to two three minute comments on each item.

2. Board Member Ten Year Service Recognition
3. Roll Call
4. **ACTION ITEM:** Approval of the Agenda

   Motion to Approve the Agenda of the May 13, 2025 Meeting of the MSHN Board of Directors

5. Public Comment (3 minutes per speaker)
6. **ACTION ITEM:** FY2024 Audit Presentation (*Page 9*)

   Motion to receive and file the FY2024 Audit Report of Mid-State Health Network completed by Roslund, Prestage and Company.

7. Chief Executive Officer's Report *(Page 24)*
8. Deputy Director's Report *(Page 35)*

   A. Network Adequacy Assessment Presentation

9. Chief Financial Officer's Report

   Financial Statements Review for Period Ended March 31, 2025 *(Page 137)*

   ACTION ITEM: Receive and File the Preliminary Statement of Net Position and Statement of Activities for the Period ended March 31, 2025, as presented

10. **ACTION ITEM:** Contracts for Consideration/Approval *(Page 145)*

    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

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

September 9, 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 03/04/2025 *(Page 147)*

13.2 Receive Board Executive Committee Minutes 04/18/2025 *(Page 152)*

13.3 Receive Policy Committee Meeting Minutes 04/01/2025 *(Page 154)*

13.4 Receive Operations Council Key Decisions 02/25/2025 *(Page 156) and 03/17/2025 (Page 159) and 04/21/2025 (Page 162)*

13.5 Approve the following policies:

13.5.1 Appointed Member Compensation *(Page 164)*

13.5.2 Cash Management *(Page 166)*

13.5.3 Cash Management – Advances *(Page 169)*

13.5.4 Cash Management – Budget & Oversight *(Page 172)*

13.5.5 Cash Management – Cost Settlement *(Page 174)*

13.5.6 Costing Policy *(Page 176)*

13.5.7 Financial Management *(Page 178)*

13.5.8 Fixed Asset Depreciation *(Page 181)*

13.5.9 Food Expense *(Page 183)*

13.5.10 Investment *(Page 185)*

13.5.11 PA2 Fund Use *(Page 188)*

13.5.12 PA2 Interest Allocation *(Page 190)*

13.5.13 Procurement *(Page 191)*

13.5.14 Risk Management – Internal Service Fund *(Page 195)*

13.5.15 SUD Treatment – Income Eligibility & Fees *(Page 197)*

13.5.16 Travel *(Page 199)*

13.5.17 Administrative & Retained Contract Monitoring & Oversight *(Page 202)*

14. Other Business
15. Public Comment (3 minutes per speaker)
16. Adjourn

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POLICIES AND PROCEDURES MANUAL

Chapter:	**General Management**		
Title:	**Board Member Conduct and Board Meetings**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle: Biennial** **Author:** Chief Executive Officer	**Adopted Date: 01.06.2015** **Review Date:** 09.10.2024	**Related Policies:** Compliance & Program Integrity Conflict of Interest Confidentiality and Notice of Privacy

Purpose

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

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

Policy

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

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

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

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

Compliance with Laws, Rules, and Regulations: Board members shall comply with all laws, rules, policies (including Board-approved operational plans, such as but not limited to the Corporate Compliance Plan) and regulations applicable to MSHN.

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

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

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

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

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

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

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

Board Meeting Procedures:

A. MSHN Board meetings shall be conducted in accordance with board bylaws and parliamentary procedures. Specifically, the process of decision and order of procedures shall occur as outlined in the bylaws, applicable policies, or established parliamentary procedures.

B. On matters of general comment or comments of a personal nature, after being recognized by the Chairperson, each Board member may speak on items presently before the Board twice, for up to three (3) minutes each time. The Chairperson may extend an additional (3) minute speaking period at the request of the individual board member or if duly authorized by board action. Any member can make a motion to suspend the rule, which motion must be seconded. If the motion passes, the rule shall be suspended for the duration of consideration of the item before the Board.

C. On matters involving questions about an item presently before the Board, there shall be no limit on board member questions or other inquiry.

D. On matters of debate involving significant differences in views among board members about an item presently before the Board, the Board Chair may designate a timeframe within which the debate is to occur. The Board, by motion duly seconded and adopted, may extend the period for debate. Any member can motion to close debate, which motion must be seconded and is not debatable. If the motion passes, such debate shall terminate.

Applies to:

☐All Mid-State Health Network Staff

☒ Mid-State Health Network Board Members

☒Selected MSHN Staff, as follows: Chief Executive Officer

☐MSHN's CMHSP Participants: ☐Policy Only ☐Policy and Procedure

☐Other: Sub-contract Providers

Definitions:

Boardsmanship: Describes the competencies and skills necessary to be an effective Board member
CEO: Chief Executive Officer
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health and Human Services
PIHP: Pre-Paid Inpatient Health Plan

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

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

Change Log:

Date of Change	Description of Change	Responsible Party
01.06.2015	New	Chief Executive Officer
11.2015	Annual Review	Chief Executive Officer
03.2017	Annual Review	Chief Executive Officer
11.2018	Follow-up Review	Chief Executive Officer
01.2019	Annual Review	Chief Executive Officer
07.2020	Biennial Review	Chief Executive Officer
07.2022	Biennial Review	Chief Executive Officer
07.2024	Biennial Review	Chief Executive Officer

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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	2028
Brodeur	Greg	brodeurgreg@gmail.com		989.413.0621		Shia Health & Wellness	2027
Conley	Patrick	conleypat@gmail.com		585.734.6847		BABHA	2028
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		989.545.9556	989.823.2687	TBHS	2027
Grimshaw	Dan	midstatetitlesvcs@mstsinc.com		989.823.3391	989.823.2653	TBHS	2026
Hanna	Tim	thanna280@gmail.com		517.230.8773		CEI	2028
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
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	2028
Raquepaw	Tracey	tl.raquepaw@icloud.com	raquepawt@michigan.gov	989.737.0971		Saginaw County CMH	2028
Scanlon	Kerin	kscanlon@tm.net		502.594.2325		CMH for Central	2028
Schultz	Lori	ljodas63@gmail.com		616.293.8435		Newaygo County MH	2028
Swartzendruber	Richard	rswartzn@gmail.com		989.269.2928	989.315.1739	HBH	2026
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	

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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

CPS: Children's Protective Services

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)

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

MCO: Managed Care Organization

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

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

MICAS: Michigan Intensive Child and Adolescent Services

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

NAA:: Network Adequacy Assessment

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

OIG: Office of Inspector General

OMT: Opioid Maintenance Treatment - Methadone

OP: Outpatient

OTP: Opioid Treatment Provider (formerly methadone clinic)

OWQP: Only Willing and Qualified Provider

PA: Public Act

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

PAC: Political Action Committee

PCP: Person-Centered Planning

Primary Care Physician

PEO: Professional Employer Organization

PEPM: Per Eligible Per Month (Medicaid funding formula)

PFS: Partnership for Success

PI: Performance Indicator

PIP: Performance Improvement Project

PIHP: Prepaid Inpatient Health Plan

PMV: Performance Measure Validation

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

PRTF: Psychiatric Residential Treatment Facility

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

SUDHH: Substance Use Disorder Health Home

SUD OPB: Substance Use Disorder 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)

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FY2024 FINANCIAL AUDIT REPORT

Background

Pre-Paid Inpatient Health Plans (PIHPs) must have an annual financial review by an independent auditing firm and must comply with the laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not limited to: the Medicaid Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP). The independent auditing firm is retained by and responsible to the Board of Directors. The auditing firm's responsibility is to express an opinion on whether MSHNs financial statements are free from material misstatement.

The Financial Audit was conducted in January 2025 for fiscal year 2024 by Roslund Prestage & Company. The report is due to MDHHS by March 31, 2025.

The opinion rendered by Roslund Prestage & Company, is that MSHNs financial statements present fairly, in all material respects, the respective financial position of the business-type activities, each major fund, and the aggregate remaining fund information of the PIHP, as of September 30, 2024, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Recommended Motion:

The MSHN Board of Directors receives and files the Fiscal Year 2024 Financial Audit of Mid-State Health Network completed by Roslund, Prestage and Company.

Full report in Board Member folders. For those members not present and would like a copy mailed to them, please contact MSHN Executive Support Specialist, Sherry Kletke.

Mid-State Health Network

Financial Statements
September 30, 2024

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

RPC
Roslund Prestage & Company
Certified Public Accountants

Independent Auditor's Report

To the Members of the Board
Mid-State Health Network
Lansing, Michigan

Report on the Audit of the Financial Statements

Opinions

We have audited the accompanying financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Mid-State Health Network (the PIHP), as of and for the year ended September 30, 2024, and the related notes to the financial statements, which collectively comprise the PIHP's basic financial statements as listed in the table of contents.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities, each major fund, and the aggregate remaining fund information of the PIHP, as of September 30, 2024, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the PIHP and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the PIHP's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions.

Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the PIHP's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the PIHP's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated March 24, 2025, on our consideration of the PIHP's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the PIHP's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering PIHP's internal control over financial reporting and compliance.

Sincerely,

Roslund, Prestage & Company, P.C.

Roslund, Prestage & Company, P.C.
Certified Public Accountants

March 24, 2025

Mid-State Health Network
Statement of Net Position
September 30, 2024

	Enterprise	Internal Service	
	Behavioral Health Operating	Medicaid Risk Reserve	Total Proprietary Funds
Current assets			
Cash and cash equivalents - unrestricted	$ 28,978,594	$ -	$ 28,978,594
Cash and cash equivalents - restricted	-	25,992,161	25,992,161
Investments - unrestricted	3,499,661	-	3,499,661
Investments - restricted	-	31,998,687	31,998,687
Due from affiliate partners and other agencies	7,725,078	-	7,725,078
Due from MDHHS	52,712,006	-	52,712,006
Due from other funds	24,882,964	-	24,882,964
Prepaid expenses	290,875	-	290,875
Total current assets	118,089,178	57,990,848	176,080,026
Noncurrent assets			
Capital asset being depreciated, net	37,792	-	37,792
Total noncurrent assets	37,792	-	37,792
Total assets	118,126,970	57,990,848	176,117,818
	PY Total assets		188,686,405
Current liabilities			
Accounts payable	30,424,860	-	30,424,860
Accrued wages and related liabilities	194,150	-	194,150
Due to affiliate partners	28,742,290	-	28,742,290
Due to MDHHS	34,622,455	-	34,622,455
Due to other funds	-	24,882,964	24,882,964
Unearned revenue	6,990,434	-	6,990,434
Compensated absences	453,683	-	453,683
Direct borrowing, due within one year	39,748	-	39,748
Total current liabilities	101,467,620	24,882,964	126,350,584
Total liabilities	101,467,620	24,882,964	126,350,584
	PY Total liabilities		124,112,414
Net position			
Net investment in capital assets	(1,956)	-	(1,956)
Restricted for risk management	-	33,107,884	33,107,884
Restricted local - PBIP	5,535,896	-	5,535,896
Restricted local - CCBHC QBP	5,732,729	-	5,732,729
Unrestricted	5,392,681	-	5,392,681
Total net position	$ 16,659,350	$ 33,107,884	$ 49,767,234
PY Total net position	8,633,574	55,940,417	64,573,991

The notes to the financial statements are an integral part of this statement.

Mid-State Health Network
Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended September 30, 2024

	Enterprise	Internal Service	
	Behavioral Health Operating	Medicaid Risk Reserve	Total Proprietary Funds
Operating revenues			
Medicaid capitation	$ 619,475,191	$ -	$ 619,475,191
Healthy Michigan	97,425,307	-	97,425,307
Autism	62,841,037	-	62,841,037
PA2 revenues	4,205,055	-	4,205,055
DHS incentive	1,529,170	-	1,529,170
CCBHC	88,497,589	-	88,497,589
Behavioral health home	1,618,630	-	1,618,630
Opioid health home	838,304	-	838,304
State and federal grants	13,442,623	-	13,442,623
Incentive payments	16,617,956	-	16,617,956
Contributions - Local match drawdown	1,550,876	-	1,550,876
Total operating revenues	908,041,738	-	908,041,738
		PY Operating revenues	856,635,672
Operating expenses			
Contractual obligations			
Funding for affiliate partners	811,735,067	-	811,735,067
HRA and IPA taxes	41,402,531	-	41,402,531
Local match	1,550,876	-	1,550,876
Total contractual obligations	854,688,474	-	854,688,474
		PY Contractual obligations	784,581,830
Substance use services			
Prevention	5,054,860	-	5,054,860
Outpatient	9,713,667	-	9,713,667
Recovery Support	6,360,447	-	6,360,447
Medication-Assisted Treatment	9,250,997	-	9,250,997
Withdrawal management	3,015,053	-	3,015,053
Residential	20,609,403	-	20,609,403
Opioid health home	720,203	-	720,203
Women's Specialty	5,168,584	-	5,168,584
Other contractual agreements	2,773,026	-	2,773,026
Total substance use services	62,666,240	-	62,666,240
		PY Substance use services	61,180,705
Administrative expense			
Board per diem	26,530	-	26,530
Depreciation	37,792	-	37,792
Dues and memberships	5,890	-	5,890
Insurance	20,068	-	20,068
Professional contracts	772,884	-	772,884
Rent and utilities	5,449	-	5,449
Salaries and fringes	7,204,814	-	7,204,814
Software maintenance	1,016,932	-	1,016,932
Supplies	259,311	-	259,311
Travel and training	107,743	-	107,743
Total administrative expense	9,457,413	-	9,457,413
		PY Administrative expense	8,576,986
Total operating expenses	926,812,127	-	926,812,127
Operating income (loss)	(18,770,389)	-	(18,770,389)

The notes to the financial statements are an integral part of this statement.

Mid-State Health Network
Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended September 30, 2024

	Enterprise	Internal Service	
	Behavioral Health Operating	Medicaid Risk Reserve	Total Proprietary Funds
Non-operating revenues (expenses)			
Interest income	$ 670,669	$ 2,050,431	$ 2,721,100
Interest expense	(1,211)	-	(1,211)
Non-operating income (loss)	669,458	2,050,431	2,719,889
Income before transfers	(18,100,931)	2,050,431	(16,050,500)
Transfers in (out)	24,882,964	(24,882,964)	-
Change in net position	6,782,033	(22,832,533)	(16,050,500)
PY Change in net position	(197,212)	4,328,570	4,131,358
Net position, beginning of year			
Beginning, as previously presented	8,633,574	55,940,417	64,573,991
Adjustment to beginning net position	1,243,743	-	1,243,743
Beginning, as restated	9,877,317	55,940,417	65,817,734
Net position, end of year	$ 16,659,350	$ 33,107,884	$ 49,767,234

The notes to the financial statements are an integral part of this statement.

Fair Value of Investments

The PIHP measures and records its investments using fair value measurement guidelines established by generally accepted accounting principles. These guidelines recognize a three-tiered fair value hierarchy, as follows:

- *Level 1:* Quoted prices for identical investments in active markets;
- *Level 2:* Observable inputs other than quoted market prices; and,
- *Level 3:* Unobservable inputs.

Debt and equity securities classified as Level 1 are valued using prices quoted in active markets for those securities. Debt and equity securities classified in Level 2 are valued using the following approaches: debt securities are normally valued based on price data obtained from observed transactions and market price quotations from broker dealers and/or pricing vendors; equity securities are valued using fair value per share for each fund. Certificates of deposit classified in level 2 are valued using broker quotes that utilize observable market inputs. Securities classified as Level 3 have limited trade information, these securities are priced or using the last trade price or estimated using recent trade prices.

At year-end, the PIHP had the following recurring fair value measurements.

Description	Value as of Sept 30th	Fair Value Measurements Using		
		Level 1	Level 2	Level 3
Debt Securities				
U.S. treasuries	35,498,348	35,498,348	-	-

NOTE 3 - DUE FROM AFFILIATE PARTNERS AND OTHER AGENCIES

Due from affiliate partners and other agencies as of September 30th consists of the following:

Description	Amount
CMHA of Clinton, Eaton, and Ingham Counties	4,718,565
Tuscola Behavioral Health Systems	15,133
LifeWays Community Mental Health Authority	1,450,881
Due from Counties	1,245,754
Other	294,745
Total	7,725,078

NOTE 4 - DUE FROM MDHHS

Due from MDHHS as of September 30th consists of the following:

Description	Amount
CCBHC Payments	18,800,849
FY2024 Withhold Payments	12,448,995
Hospital Rate Adjustment (HRA) Payments	8,768,334
Capitation Payments	7,281,012
DHHS Incentive Payments	773,057
Other MDHHS Contracts	4,639,759
Total	52,712,006

NOTE 5 - INTERFUND RECEIVABLES AND PAYABLES

The amounts of interfund receivable and payable shown on the financial statements as of September 30th, are as follows:

Description	Purpose	Due from Other Funds	Due to Other Funds
Behavioral Health Operating	Cover overspending of Medicaid Managed Care Specialty Services Program Contract	24,882,964	-
Medicaid Risk Reserve		-	24,882,964

The outstanding balances between funds result mainly from the time lag between the dates that 1) interfund goods and services are provided or reimbursable expenditures occur, 2) transactions are recorded in the accounting system and 3) payments between funds are made.

NOTE 6 - CAPITAL ASSETS

A summary of changes in capital assets is as follows:

Description	Beginning Balance	Additions	Disposals	Transfers	Ending Balance
Capital assets being depr/amort					
Computers and software	189,180	-	-	-	189,180
Right to use – Building (MOA Downstairs)	151,169	-	-	-	151,169
Right to use – Building (MOA Upstairs)	52,140	-	(52,140)	-	-
Total capital assets being depr/amort	392,489	-	(52,140)	-	340,349
Accumulated depr/amort					
Computers and software	(189,180)	-	-	-	(189,180)
Right to use – Building (MOA Downstairs)	(75,585)	(37,792)	-	-	(113,377)
Right to use – Building (MOA Upstairs)	(52,140)	-	52,140	-	-
Total accumulated depr/amort	(316,905)	(37,792)	52,140	-	(302,557)
Net capital assets being depr/amort	75,584	(37,792)	-	-	37,792
Net capital assets	75,584	(37,792)	-	-	37,792

NOTE 7 - DUE TO AFFILIATE PARTNERS

Due to affiliate partners as of September 30th consists of the following:

Description	Amount
Bay-Arenac Behavioral Health	5,522,352
Community Mental Health for Central Michigan	6,199,684
Gratiot Integrated Health Network	2,452,790
Huron Behavioral Health	2,578,087
Ionia County Community Mental Health	763,957
Montcalm Care Network	186,056
Newaygo County Mental Health	1,531,762
Saginaw County Mental Health Authority	6,664,133
Shiawassee Health and Wellness	2,843,469
Total	28,742,290

NOTE 16 – ECONOMIC DEPENDENCE

The PIHP receives over 90% of its revenues from the State of Michigan directly from MDHHS.

NOTE 17 – ADJUSTMENTS TO BEGINNING NET POSITION

During the year, a change in estimate resulted in adjustments to beginning net position as follows:

Description	Behavioral Health Operating Fund
Net position - beginning as previously presented	8,633,574
Adjustment related to FY2020 cost settlement	1,263,574
Adjustment related to FY2015 & FY2016 cost settlements	(19,831)
Net position – beginning as restated	9,877,317

NOTE 18 - UPCOMING ACCOUNTING PRONOUNCEMENTS

GASB Statement No. 101, *Compensated Absences*, was issued by the GASB in June 2022 and will be effective for fiscal year 2025. The objective of this Statement is to better meet the information needs of financial statement users by updating the recognition and measurement guidance for compensated absences. That objective is achieved by aligning the recognition and measurement guidance under a unified model and by amending certain previously required disclosures.

This Statement requires that liabilities for compensated absences be recognized for (1) leave that has not been used and (2) leave that has been used but not yet paid in cash or settled through noncash means. A liability should be recognized for leave that has not been used if (a) the leave is attributable to services already rendered, (b) the leave accumulates, and (c) the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means. This Statement requires that a liability for certain types of compensated absences—including parental leave, military leave, and jury duty leave—not be recognized until the leave commences. This Statement also establishes guidance for measuring a liability for leave that has not been used, generally using an employee's pay rate as of the date of the financial statements.

GASB Statement No. 102, *Certain Risk Disclosures*, was issued by the GASB in December of 2023 and will be effective for fiscal year 2025. This Statement requires a government to assess whether a concentration or constraint makes the government vulnerable to the risk of a substantial impact. Additionally, this Statement requires a government to assess whether an event or events associated with a concentration or constraint that could cause the substantial impact have occurred, have begun to occur, or are more likely than not to begin to occur within 12 months of the date the financial statements are issued. If a government determines that those criteria for disclosure have been met for a concentration or constraint, it should disclose information in notes to financial statements in sufficient detail to enable users of financial statements to understand the nature of circumstances disclosed and the government's vulnerability to the risk of substantial impact.

GASB Statement No. 103, *Financial Reporting Model Improvements*, was issued by the GASB in April of 2024 and will be effective for fiscal year 2026. This Statement establishes new accounting and financial reporting requirements—or modifies existing requirements—related to the following:

a. Management's discussion and analysis (MD&A);
    i. Requires that the information presented in MD&A be limited to the related topics discussed in five specific sections:
        1) Overview of the Financial Statements,
        2) Financial Summary,
        3) Detailed Analyses,
        4) Significant Capital Asset and Long-Term Financing Activity,
        5) Currently Known Facts, Decisions, or Conditions;
    ii. Stresses detailed analyses should explain why balances and results of operations changed rather than simply presenting the amounts or percentages by which they changed;
    iii. Removes the requirement for discussion of significant variations between original and final budget amounts and between final budget amounts and actual results;

b. Unusual or infrequent items;
c. Presentation of the proprietary fund statement of revenues, expenses, and changes in fund net position;
    i. Requires that the proprietary fund statement of revenues, expenses, and changes in fund net position continue to distinguish between operating and nonoperating revenues and expenses and clarifies the definition of operating and nonoperating revenues and expenses;
    ii. Requires that a subtotal for *operating income (loss) and noncapital subsidies* be presented before reporting other nonoperating revenues and expenses and defines subsidies;
d. Information about major component units in basic financial statements should be presented separately in the statement of net position and statement of activities unless it reduces the readability of the statements in which case combining statements of should be presented after the fund financial statements;
e. Budgetary comparison information should include variances between original and final budget amounts and variances between final budget and actual amounts with explanations of significant variances required to be presented in the notes to RSI.

Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Members of the Board
Mid-State Health Network
Lansing, Michigan

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Mid-State Health Network (the PIHP), as of and for the year ended September 30, 2024, and the related notes to the financial statements, which collectively comprise the PIHP's basic financial statements, and have issued our report thereon dated March 24, 2025.

Report on Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered the PIHP's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the PIHP's internal control. Accordingly, we do not express an opinion on the effectiveness of the PIHP's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements, on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the PIHP's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or, significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the PIHP's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the PIHP's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the PIHP's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Sincerely,

Roslund, Prestage & Company, P.C.
Certified Public Accountants

March 24, 2025

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

Communication with Those Charged with Governance at the Conclusion of the Audit

To the Members of the Board
Mid-State Health Network
Lansing, Michigan

We have audited the financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Mid-State Health Network (the PIHP), for the year ended September 30, 2024. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, *Government Auditing Standards* and the Uniform Guidance, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you during planning. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Matters

Qualitative Aspects of Accounting Practices
Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the PIHP are described in the notes to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during the year. We noted no transactions entered into by the PIHP during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the PIHP's financial statements were:

> Management's estimate of the payout of employee compensated absences is based on expected payout. We evaluated the key factors and assumptions used to develop the balance of compensated absences in determining that it is reasonable in relation to the financial statements taken as a whole.
>
> Management's estimated lives of capital assets are based on the expected life of the asset. We evaluated the key factors and assumptions used to develop the estimated lives of capital assets in determining that they are reasonable in relation to the financial statements taken as a whole.
>
> Management's estimated incremental borrowing rate used to discount future lease payments under GASB 87 is based on the PIHP's current borrowing rate. We evaluated the key factors and assumptions used to develop the estimated intrinsic borrowing rate in determining that it is reasonable in relation to the financial statements taken as a whole.

The financial statement disclosures are neutral, consistent, and clear.

Difficulties Encountered in Performing the Audit
We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements
Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to each opinion unit's financial statements taken as a whole

Disagreements with Management
For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations
We have requested certain representations from management that are included in the management representation letter.

Management Consultations with Other Independent Accountants
In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the PIHP's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues
We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the PIHP's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters
We applied certain limited procedures to management's discussion and analysis which is required supplementary information (RSI) that supplements the basic financial statements. Our procedures consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We did not audit the RSI and do not express an opinion or provide any assurance on the RSI.

Restriction on Use
This information is intended solely for the information and use of the Board and management of the PIHP and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

Roslund, Prestage & Company, P.C.

Roslund, Prestage & Company, P.C.
Certified Public Accountants

MSHN
Mid-State Health Network

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
March/April 2025

- Faces & Voices of Recovery announced that it will present **Peer 360 Recovery Alliance** with the **Recovery Organization of the Year Award** this year at the 2025 Recovery Leadership Summit. Peer 360 is a regional partner with MSHN. Peer 360 was nominated and selected to receive this national award because of its outstanding advocacy and leadership as a grassroots organization. This award annually recognizes one transformational and exemplary organization whose leadership and advocacy increase the prevalence and quality of long-term recovery from substance use disorder.
- Mid-State Health Network acknowledges with appreciation Deb McPeek-McFadden and David Griesing for ten years of service on the MSHN Board!

PIHP/REGIONAL MATTERS

1. Regional Financial Situation Update:

The MSHN region – for the first time in its history – ended FY 24 with a significant deficit of ~$24M. Despite considerable cost-containment strategies, most of this deficit is accounted for in revenue shortfalls and increased utilization. MSHN's Chief Financial Officer, Leslie Thomas, Deputy Director Amanda Ittner, and I have met with each Community Mental Health Service Program (CMHSP) in our region to identify local cost drivers and to reinforce the contractual requirement that CMHSP Participants operate within the revenue provided by MSHN. Together we identified a few strategies that have the potential for adoption by other CMHSPs in the region to achieve some efficiencies. Nonetheless, there remains a revenue shortage problem, as detailed further below.

Increased Utilization: Many service categories are trending higher – many significantly higher - both in utilization and cost that the Michigan Department of Health and Human Services (MDHHS) actuary has not included in its rate calculations. A few highlights:

- In FY 2020, MSHN served nearly 58,000 residents of the region. During FY 24, approximately 68,000 persons were served.
- **Autism:** FY 24 Expenditures ($73,513,775) were 14% higher ($9,154,604) than FY 23 ($64,359,171)
  - 484,308 more units of service in FY 24 than FY 23
  - 233 more unique individuals served in FY 24 (2,137) than FY 23
  - FY 24 average cost per consumer was $38,361
- **Community Living Supports:** FY 24 Expenditures ($343,906,264) were 11.3% higher ($35,022,596) than FY 23 ($308,883,668)
  - 57,458 more units of service in FY 24 (1,653,520) than FY 23
  - 7 fewer unique individuals served in FY 24 (547) than FY 23
  - FY 24 average cost per consumer was $56,790
- **Psychiatric Inpatient:** FY 24 Expenditures ($58,294,885) were 15.6% higher ($7,864,916) than FY 23 ($50,429,969)
  - 5,587 more units of service in FY 24 (68,089) than FY 23
  - 271 more unique individuals served in FY 24 (5,312) than FY 23
  - FY 24 average cost per consumer was $11,132

Revenue shortfalls:

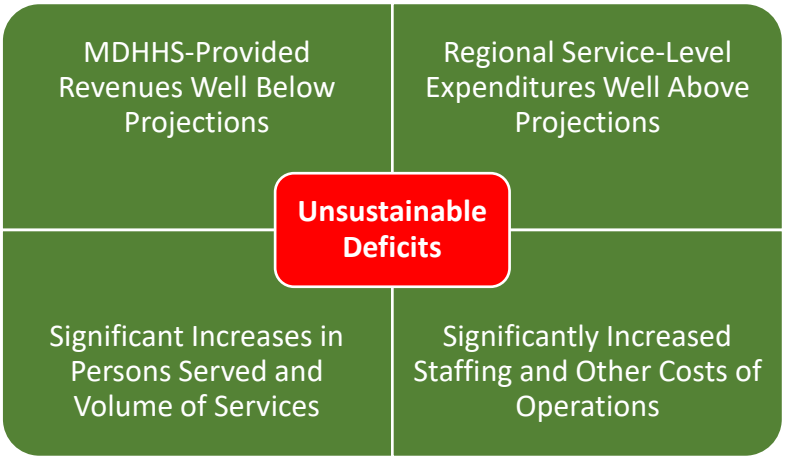
- Between October 2023 and January 2025, the region experienced 75,300 fewer enrollees but its actuary enrollee estimates were based on a significantly higher level of enrollment resulting in significant revenue loss due to lower rates per enrollees, while individuals served continued to increase.
- Based on MDHHS actuarial rate certification for FY 25, MSHN projected revenues totaling about $783M. Actual revenues to date, annualized, show a revenue reduction of about $35M in FY 25 alone (about 5% lower).
- Based on actuarial projections for FY 25, Healthy Michigan Program revenues were projected to increase by more than 20%. Actual revenues are lagging by at least 7-10%.

The following table shows FY 24 revenues compared to FY 23 revenues (the same time period covered by the utilization increases discussion shown above).

Revenues	FY 24[1]	FY 23[2]	Variance	Percent Variance
Medicaid	$619,475,191.	$616,707,578.	$2,767,613.	00.45%
HMP	$97,425,307.	$125,825,551.	$(28,400,244.)	-29.15%
Autism	$62,841,037.	$53,074,371.	$9,766,666.	15.54%
CCBHC	$88,497,589.	$32,414,548.	$56,083,041.	63.37%
All Other	$39,802,614.	$28,613,624.	$11,188,990.	28.11%
TOTAL:	$908,041,738.	$856,635,672.	$51,406,066.	05.66%
Ending ISF	$33,107,884.	$55,940,417.	$(22,832,533.)	-68.96%

Total Revenue increased by $51,406,066 across all fund sources, including restricted activities like Certified Community Behavioral Health Clinic (CCBHC),Substance Use Disorder Health Home (SUD-HH), Behavioral Health Home (BHH), SUD grants, etc.

FY 24 INCREASES IN SERVICE COSTS IN THE ABOVE THREE SERVICE CATETORIES ALONE TOTAL $52,042,116[3]. This is a clear indication that revenues are insufficient to cover service costs.



[1] From FY 24 Financial Audit
[2] From FY 23 Financial Audit
[3] [Autism ($7,864,916.00), Community Living Supports ($35,022,596.00), and Psychiatric Inpatient (9,154,604)]

MSHN has communicated all of these details to MDHHS. MSHN is anticipating a rate adjustment before year end, but MDHHS has not committed to a time frame, nor have they indicated what, if anything, will be included in the rate adjustment if it occurs.

2. **Federal Action Eliminates About $350,000 from MSHN grant:**
Action by the federal government to eliminate American Rescue Plan Act (ARPA) and COVID-19 Block Grants have resulted in the loss of about $350,000 in funding for FY 24. MSHN received a stop work order from MDHHS and in turn issued a stop work order to several providers whose work is in part funded through the ARPA fund source. These funds mostly supported reducing/eliminating health disparities under our Equity Upstream initiative. Statewide, this federal action resulted in the loss of about $58M in funding. A list of grantees and projected balances affected by the federal action is available at this link. There has been a temporary restraining order against the federal action issued by a federal court, but the stop work order remains in effect.

3. **Statewide Pre-paid Inpatient Health Plan (PIHP) Financial Information:**
For context against the MSHN financial information presented above, we provide the following statewide context: For FY 24 (fiscal year ended 09/30/24), 6 of 10 PIHPs ended the year in significant deficits ranging from $8M to $34M. For FY 25, 8 of 10 PIHPs project deficits ranging from $350K to ~$25M. For additional context, it's been reported that Michigan's Medicaid Health Plans fell about $250M short last fiscal year. [All of this clearly indicates that this is, indeed, a revenue problem that can only be "fixed" by MDHHS and the legislature].

4. **Performance Bonus Incentive Earnings:** Mid-State Health Network has again earned the majority of its performance bonus! For FY 24, the earnings total ~$5.1M, was distributed to our CMHSP participants as required in our operating agreement in mid-April. Since 2017, MSHN has earned and distributed ~$37.4M in performance bonus earnings, which become restricted local funds for our CMHSP Participants. MSHN also distributed ~$671,000 in earned interest to its CMHSP Participants in early April. That's good news among all the rest that isn't so positive.

5. **Conflict Free Access and Planning Update:** My previous board reports detail anticipated requirements. It has been over one year since MDHHS announced that it will require system compliance with separating service planning from service delivery. There have been no official communications, policies, contract requirements, or any other form of communication on the status or related requirements of the public behavioral health system since my last report.

6. **Competitive Procurement of PIHPs:**
As you know, on 02/28/25 MDHHS announced its intention to subject PIHPs to a new competitive procurement process. A timeline was not officially provided, but sources indicate that its new system must be in place by 10/01/26 (because that's when the transition to termination contracts expire for the five PIHPs that did not sign FY 25 contracts). It is important to note that even that has not been stated officially, and that there has been no official communications with MSHN or anyone else that we know about on this matter. MSHN Leadership continues to work toward positioning itself for positive and successful participation in the procurement process.

   On 03/25/25, a number of advocate organizations released a Michigan's Medicaid System: Prioritizing Care." The infographic emphasizes people over paperwork, less administration, ending conflicts of interest, and recommending adoption of an Administrative Services Organization (ASO) model.

7. **MSHN Staff Retention Strategy:**

MSHN Compensation Policy and Procedure vests the Chief Executive Officer with the authority and responsibility to administer the MSHN compensation program and to approve any changes, adjustments, or exceptions to established compensation systems. Accordingly, with input from Amanda Ittner from an HR perspective and Leslie Thomas from a Finance viewpoint, I have developed a retention strategy in light of the MDHHS announced plans to competitively procure the PIHP system in Michigan. Our Leadership Team has also endorsed this plan.

NOTE: Specific details will not be provided or disclosed until an actual precipitating event occurs.

Precipitating Events:

Implementation of the retention strategy will coincide with the any of any of the following "precipitating events" effective at the start of the next pay period:

1. An announcement by MDHHS that existing PIHPs, including MSHN, would not be eligible bidders in the announced competitive procurement process, OR
2. Upon notification that the MSHN submission of a bid or other procurement application is not awarded by MDHHS, OR
3. Upon official notification that MSHN must operate under a transition to termination provision to transfer its responsibilities to a successor organization.

Retention Strategy Elements: Eligibility criteria include individuals who are active, full time, non-contract employee whose hire date is before the implementation date.

Retention:
Compensation: upward adjustment payment made quarterly assuming continuing active status during the previous quarter and has not resigned.

- Note that as compensation is adjusted, so too are employer payments to retirement accounts.
- Staggered increases if phased over multiple years such that the longer an individual stays, the higher the adjustment up to specified caps.

Separation: non-disciplinary, non-voluntary separation due to any of the above precipitating events or restructuring in a manner that eliminates positions. Employees who resign or who are terminated for cause would not be eligible for post service benefits. Depending on how long a transition is involved, the longer an employee stays with MSHN, the longer the period over which these elements are provided, up to specified caps.

- Severance
- Cash value for healthcare benefits continuation under COBRA
- Outplacement Services

The MSHN Leadership Team, MSHN Operations Council, and the MSHN Board Executive Committee have all been briefed on this plan per the above.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

8. **Governor Whitmer Signs Executive Directive to Identify Impacts of Federal Medicaid Cuts:**
Under the executive directive, MDHHS must review federal budget proposals and prepare a report quantifying the impact of Congress' proposal within 30 days. The report, drawing from available analyses, should delineate the specific impact of proposed cuts to Medicaid, including:

- The number of Michiganders who would lose health care if the proposed cuts go into effect.
- The effect of the proposed cuts on hospitals, especially in rural and other underserved communities, including reductions in services and closures of facilities
- The impact on timely access to care for Michiganders, such as the creation or expansion of healthcare deserts in areas of the state.
- The ways in which reductions in federal money would impact the state's budget, including the need for cuts to other vital services.

9. **Protect MI Care:**
From Gongwer, 04/23/25: More than 100 Michigan organizations launched Protect MI Care on Wednesday to defend Medicaid.

The coalition in a letter urged Michigan's congressional delegation to reject proposals that would cap, cut or restructure Medicaid. These proposals, including a $880-billion reduction in federal funding over the next decade outlined in the House Budget Resolution, would jeopardize coverage and care for children, seniors, veterans, people with disabilities, and working families.

"Medicaid is a cornerstone of Michigan's health care system and our economy," Monique Stanton, president and CEO of the Michigan League for Public Policy, said in a statement. "Cutting Medicaid would be catastrophic for families across our state and especially harmful to children, older adults, people with disabilities and the caregivers who support them. We formed Protect MI Care to fight for them."

Medicaid covered 45 percent of births in Michigan in 2024, and more than 1 million children received health insurance through the program. The federal government covered approximately 76 percent of Michigan's total Medicaid spending, the coalition said in a press release.

Michigan Health and Hospital Association CEO Brian Peters said Medicaid isn't just a program, "it's the financial lifeline that keeps hospitals, mental health providers and nursing homes open."

"Cuts at this scale would lead to facility closures, creating health care deserts that hurt everyone, regardless of how they're insured," Peters said.

The Protect MI Care Coalition includes groups across every region of the state, including both rural and urban areas, as well as frontline health care workers, educators, faith leaders, and advocates for maternal and child health, behavioral health and disability rights.

RELATED:

The Commonwealth Fund has released a report entitled *How Potential Federal Cuts to Medicaid and SNAP Could Trigger the Loss of a Million-Plus Jobs, Reducing Economic Activity, and Less State*

Revenue that provides a state-by-state analysis of the economic toll of funding cuts discussed by some policymakers. Potential federal budget cuts to Medicaid health coverage and to food benefits through the Supplemental Nutrition Assistance Program (SNAP) could trigger severe economic effects across the United States, including 1 million jobs lost and a $113 billion decline in states' gross domestic products (GDPs), according to a new report from the Commonwealth Fund and the George Washington University Milken Institute School of Public Health. Among the key findings:

- Potential Medicaid cuts would shrink state GDPs by an estimated $95 billion in 2026, eliminate 477,000 jobs, and reduce state and local tax revenues by $7 billion.
- Potential SNAP cuts would reduce state GDPs by an estimated $18 billion in 2026, wipe out 143,000 jobs, and decrease state and local tax revenues by $1.8 billion."

10. KB Lawsuit Update:

The Michigan Department of Health and Human Services (MDHHS) has received preliminary court approval for the settlement of litigation alleging that medically necessary intensive home and community-based services were not timely provided to Medicaid-eligible children and youth as required by Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions. This litigation is known as DD v. MDHHS; formerly known as KB v. MDHHS.

The Class Action Notice, which outlines a summary of the settlement's terms, as well as the full Agreement, can be found on the MDHHS website. Class members include all Medicaid-eligible beneficiaries under the age of 21 in the State of Michigan for whom a licensed practitioner of the healing arts acting within the scope of practice under state law has determined, through an assessment, that intensive home and community-based services are needed to correct or ameliorate their emotional, behavioral, or psychiatric condition.

MDHHS plans to issue definitive policy updates and other guidance to the field, including contractual requirements of PIHPs and updates to the Medicaid Provider Manual in the near future.

FEDERAL/NATIONAL UPDATES AND ACTIVITIES

11. List of All Presidential Executive Orders to Date

The Federal Register maintains a current and running list of all presential executive orders with links to the orders. Follow the link provided and navigate to those of interest.

12. Drastic CMS Reductions Announced in Letter to State Medicaid Directors:

The federal Centers for Medicare and Medicaid Services (CMS) on April 10 sent a letter to State Medicaid Directors "taking action to preserve the core mission of the Medicaid program by putting an end to spending that duplicates resources available through other federal and state programs or isn't directly tied to healthcare services.

- Mounting expenditures, such as covering housekeeping for individuals who are not eligible for Medicaid or high-speed internet for rural healthcare providers, distracts from the core mission of Medicaid, and in some instances, serves as an overly-creative financing mechanism to skirt state budget responsibilities.
- CMS does not intend to approve new or extend existing requests for federal matching funds for state expenditures on these two types of programs — designated state health programs (DSHP) and designated state investment programs (DSIP). DSHPs and DSIPs are state-funded

health programs that, without "creative interpretations" of section 1115 demonstration authority, would not have qualified for federal Medicaid funding.
- DSHPs and DSIPs have grown from approximately $886 million in 2019 to nearly $2.7 billion in eligible expenditures in 2025, representing increasing costs to the federal government without a sustainable state contribution.

As CMS continues to focus on the statutory objectives of the Medicaid program and improving health outcomes for the most vulnerable, the agency is refocusing its resources on Medicaid programmatic goals. To ensure this vital safety net continues to be available in the future, CMS is taking this action to safeguard the financial health of the Medicaid program. While CMS will continue to work with states on innovative state section 1115 demonstrations, those demonstrations should be focused on improving health outcomes of the most vulnerable dependent on Medicaid."

13. **Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Certified Community Behavioral Health Clinics (CCBHCs)**

A leaked, pre-decisional copy of OMB guidance to HHS for the FY26 HHS President's Budget reveals plans for widespread reorganization of HHS and especially for its program and office eliminations, and funding level changes.

The caution at this point is that this initial proposed must be fleshed out and presented in the form of a final FY26 President's Budget. Then the proposals will receive legal and programmatic review by congressional committees of oversight and appropriations before markup by committee, floor action, etc. Some points of note:

- There would no longer be an organization with the content and expanse of the current SAMHSA, as its component offices and programs will be within the proposed office of Administration for Healthy America (AHA).
- Substance Abuse and Mental Health Public Awareness and Support, and the Substance Use and Mental Health Performance and Quality Improvement System are now part of the AHA Section on Policy, Research and Evaluation.
- CCBHC funding is eliminated along with other Substance Use and Prevention initiatives.
- Funding for programs of regional and national significance, including Children's Mental Health Services, Substance Use Prevention, Treatment, and Recovery Services Block Grant, Community Mental Health Services Block Grant are funded.
- Regarding CMS, both the Mental and Behavioral Health Education and Training, and the Workforce Education and Training programs are eliminated.

Some Senate and House Appropriations Committee members sent a letter to the HHS Secretary requesting more detailed explanations.

14. **Federal Poverty Guidelines**

The Kaiser Family Foundation has reported that the federal health and human services office office that sets federal poverty guidelines, which determine whether tens of millions of Americans are eligible for health programs such as Medicaid, food assistance, child care, and other services, is being eliminated. "The small team, with technical data expertise, worked out of HHS' Office of the Assistant Secretary for Planning and Evaluation, or ASPE. The sacking of the office will lead to cuts in assistance to low-income families next year unless the Trump administration restores the positions or moves its duties elsewhere."

15. **Key Facts About Medicaid Integrity (Fraud, Waste, Abuse):**
The Kaiser Family Foundation has published an article entitled *5 Key Facts about Medicaid Program Integrity – Fraud, Waste, Abuse and Improper Payments*. The topic is particularly germane given the President's musing to not touch Medicaid but has been soft on the potential to address the issues of fraud, abuse, etc. in Medicaid. The House Speaker and others in the House have referenced fraud, waste, etc. and could well use that as an argument to "not touch Medicaid itself, but only fraud, abuse, and waste" in the effort to achieve some of the "savings" in the $800+ billion target. The article, after offering a number of relevant definitions, includes the following:

1. "Both the federal government and states are responsible for ensuring program integrity. Program integrity refers to the proper management and functioning of the Medicaid program to ensure it is providing quality and efficient care while using funds–taxpayer dollars–appropriately with minimal waste.
- State Medicaid agencies administer Medicaid on a day-to-day basis and have the primary responsibility for program integrity. Program integrity includes specific, dedicated activities, as well as activities that are built into program functions (e.g., beneficiary and provider enrollment, service delivery, payment). Federal laws and regulations include requirements for states to reduce fraud, waste, and abuse.
- The federal government's responsibility is to provide "effective support and assistance to states to combat provider fraud and abuse." CMS supports states through funding, training, and defining in regulation how states must comply with Medicaid program integrity requirements.

2. There is no comprehensive or reliable measure of fraud in Medicaid. Fraud is not unique to Medicaid. Fraud occurs in Medicaid, Medicare, and private health insurance. Most monetary loss from fraud is by providers. There are no reliable measures of fraud against Medicaid. Department of Justice (DOJ) and Health and Human Services-Office of Inspector General (HHS-OIG) operate a Health Care Fraud and Abuse Control (HCFAC) program, designed to coordinate federal, state, and local health care fraud and abuse law enforcement activities.

3. Improper payments are not a measure of fraud. The Office of Management and Budget (OMB) has identified Medicaid and Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments.
- The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and produces a national improper payment rate, which is not a fraud rate. Improper payments, which are often cited when discussing program integrity, are payments that do not meet CMS program requirements.
- In 2024, Medicaid paid an estimated 94.9% of total outlays *properly*, representing $579.73 billion in proper federal payments. The overall Medicaid *improper* payment rate was 5.1% (or $31.10 billion in federal payments). However, 79.1% of the improper Medicaid payments were the result of insufficient documentation or missing administrative steps.
- Medicaid Paid an Estimated 94.9% of Total Outlays Properly, and Improper Payments are Mostly Due to Insufficient Information

4. HHS and CMS identify key areas of program integrity focus, informed in part by recommendations made by other federal agencies. HHS works with all states to develop strategies to address the root causes of improper payments. States are responsible for implementing, overseeing, and assessing the impact of these strategies and actions.
- Every five years, HHS and CMS must issue a comprehensive Medicaid program integrity plan that outlines the agency's strategy for working with states on program integrity. Historically, program

integrity efforts focused on the recovery of misspent funds, but more recent initiatives move beyond "pay and chase" models to focus more heavily on prevention and early detection of fraud and abuse and other improper payments.
- Independent agencies like Medicaid and CHIP Payment and Access Commission (MACPAC) and Government Accountability Office (GAO) regularly make recommendations to reduce fraud, waste, and abuse in Medicaid.

5. "Fraud, waste, and abuse" are at the forefront of current debates as a basis for making changes in Medicaid and more broadly.
- Medicaid is a very complex program that involves millions of beneficiaries, hundreds of thousands of providers, 51 state agencies (including DC), different delivery systems, complicated eligibility rules, and significant federal and state expenditures—all of which together create vulnerabilities and opportunities for error.

As the budget debate continues, there may be efforts to recast certain Medicaid policy changes such as adding work requirements to Medicaid and restricting the use of provider taxes as addressing fraud, waste, and abuse. There are proponents and opponents of such policies, and these policies may come with tradeoffs (e.g., decreasing federal funding while shifting costs to the states and reducing coverage), but they are not about rooting out fraud in Medicaid."

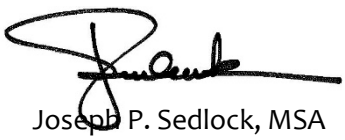
16. **Impacts of Drug Seizures on Opioid Overdose Deaths:**

Summarized from the article (due to subscription requirements) "When Good Intentions Backfire: How Drug Seizures Can Drive Overdose Deaths and What We Can Do Instead." The United States has been in the midst of an overdose crisis for more than a decade, largely due to the proliferation of fentanyl and other potent synthetic opioids. Although fatalities have declined from their 2023 peak of roughly 114,000, drug overdoses still took almost 90,000 lives last year. In an effort to stem the crisis, many U.S. communities from Boston to San Francisco have directed more law-enforcement resources toward breaking up open-air drug markets and deterring public drug use.

However, some research suggests that increased law enforcement activity and the disruption of illicit drug markets caused by drug seizures may have a troubling, yet unintended consequence: more overdose deaths. Rather than relying primarily on crackdowns, cities and states must consider integrated and health-oriented approaches as well.

If you want a copy of the article summarized above, please contact my office.

Submitted By:



Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 05/01/2025

Attachments:

- MSHN Michigan Legislation Tracker (expertly compiled and tracked by Sherry Kletke)

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Mid-State Health Network

Compiled and tracked by Sherry Kletke

Below is a list of Legislative Bills MSHN is currently tracking and their status as of April 25, 2025:

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 4001	Minimum Wage (Roth) Modifies minimum hourly wage rate.	Received in Senate (2/4/2025; To Regulatory Affairs Committee)
HB 4002 (PA 2)	Benefits (DeBoyer) Modifies requirements for an employer to provide earned sick time.	Signed by the Governor (2/21/2025; Presented 2/21/2025; Signed: February 21, 2025, Effective: February 21, 2025; earlier Presented at 1:30 a.m.)
HB 4037	Health Records (Rogers) Establishes certain requirements to operate a health data utility.	Committee Hearing in House Health Policy Committee (3/12/2025)
HB 4253	Accrued Leave (Paiz) Requires an employer to pay to an employee certain types of accrued leave when employment is terminated.	Introduced (3/18/2025; To Economic Competitiveness Committee)
HB 4255	Controlled Substances (Lightner) Modifies penalties for crime of manufacturing, delivering, or possession of with intent to deliver certain controlled substances.	Passed in House (4/23/2025; 66-40; Given Immediate Effect)
HB 4256	Controlled Substances (Bollin) Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver certain controlled substances.	Passed in House (4/23/2025; 65-41; Given Immediate Effect)
HB 4279	National Guard (Greene, J.) Creates Michigan National Guard apprenticeship program.	Committee Hearing in House Families and Veterans Committee (4/22/2025)
HB 4280	Occupations - Social Workers (Edwards) Extends period for renewal for limited licenses for bachelor's social worker and master's social worker.	Introduced (3/20/2025; To Health Policy Committee)
SB 8 (PA 1)	Minimum Wage (Hertel, K.) Modifies minimum hourly wage rate.	Signed by the Governor (2/21/2025; Signed: February 21, 2025, Effective: February 21, 2025)
SB 15	Benefits (Singh) Modifies earned sick time.	Reported in Senate (2/12/2025; Substitute S-1 adopted; By Regulatory Affairs Committee)
SB 207	Veterans (Hertel, K.) Creates Michigan veterans coalition fund.	Introduced (4/16/2025; To Veterans and Emergency Services Committee)
SB 208	Veterans (Hauck) Creates Michigan veterans coalition grant program.	Introduced (4/16/2025; To Veterans and Emergency Services Committee)

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
SB 215	Consumer Protections (Santana) Amends Michigan consumer protection act to enhance protections for individuals applying for veterans benefits.	Introduced (4/17/2025; To Veterans and Emergency Services Committee)
SB 219	Hospitalization (Hertel, K.) Revises person requiring treatment and modifies certain procedures for treatment.	Introduced (4/17/2025; To Health Policy Committee)
SB 220	Hospital Evaluations (Irwin) Expands hospital evaluations for assisted outpatient treatment.	Introduced (4/17/2025; To Health Policy Committee)
SB 221	Mental Capacity (Santana) Provides outpatient treatment for misdemeanor offenders with mental health issues.	Introduced (4/17/2025; To Health Policy Committee)
SB 222	Outpatient Treatment (Wojno) Expands petition for access to assisted outpatient treatment to additional health providers.	Introduced (4/17/2025; To Health Policy Committee)
SB 237	National Guard (Albert) Creates Michigan National Guard apprenticeship program.	Introduced (4/22/2025; To Regulatory Affairs Committee)
SB 239	Vietnam Veterans (Daley) Creates Vietnam veteran era bonus extension act.	Introduced (4/22/2025; To Appropriations Committee)

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Community Mental Health Member Authorities

Bay Arenac Behavioral Health

CMH of Clinton.Eaton.Ingham Counties

CMH for Central Michigan

Gratiot Integrated Health Network

Huron Behavioral Health

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

LifeWays CMH

Montcalm Care Center

Newaygo County Mental Health Center

Saginaw County CMH

Shiawassee Health and Wellness

Tuscola Behavioral Health Systems

Board Officers

Ed Woods
Chairperson

Irene O'Boyle
Vice-Chairperson

Deb McPeek-McFadden
Secretary

REPORT OF THE MSHN DEPUTY DIRECTOR
to the Board of Directors
March / April

Staffing Update

Mid-State Health Network (MSHN) is pleased to announce we have filled the following positions.

- Christina Romero joined MSHN as the Substance Use Disorder (SUD) Care Navigator on April 14th, 2025. Christina comes to MSHN with a master's in social work and has her certification as an advanced alcohol and drug counselor. Her most recent work was with the Judson Center as a program supervisor of the SUD treatment program.
- MarChare Canada joined MSHN as the Treatment Specialist on April 28, 2025, filling the vacancy left by Beth Lafleche's resignation in April. MarChare comes to us with a master's in business administration, bachelor's in social work and is working towards obtaining a license in professional counseling. Her most recent work was with Saginaw County Community Mental Health Authority as a Crisis Intervention Therapist.

SUD Oversight Policy Board Members Receive 10-Year Awards

Mid-State Health Network would like to acknowledge our appreciation to the board members identified below who have been appointed to the Substance Use Disorder Oversight Policy Board serving over 10 years with our agency. MSHN values their commitment and dedication to individuals within their communities, helping to support and ensure appropriate substance use disorder treatment, prevention and recovery services.

- John Hunter – Representing Tuscola County
- Bruce Caswell – Representing Hillsdale County
- Kim Thalison – Representing Eaton County

Annual Disclosure of Ownership, Controlling Interest, and Criminal Convictions

MSHN is contractually responsible for monitoring ownership and controlling interests within its provider network and disclosing criminal convictions of any staff member, director, or manager of MSHN, any individual with beneficial ownership of five percent or more, or an individual with an employment, consulting, or other arrangement with MSHN. Therefore, Board of Directors members must complete an annual disclosure statement that ensures MSHNs compliance with the contractual and federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions.

Included in the Board Members folders is the disclosure form required to be filled out, signed, and returned. For Board Members not in attendance, the form will be emailed/mailed directly to the member. Common questions that arise when completing the form:

- ***Do I have to provide my social security number?*** 42 CFR § 455.104 requires names, address, Date of Birth (DOB), and Social Security numbers in the case of an individual.
- ***How will my information be kept confidential and secure?*** MSHN maintains policies and practices that protect the confidentiality of personal information, including Social Security numbers, obtained from its providers and associates in the course of its regular business functions. MSHN is committed to protecting information about its providers and associates, especially the confidential nature of their personal information. Access to this, and other

confidential documentation, is limited to MSHN staff who need to access information in order to perform their duties, relative to monitoring disclosures.

- ***What does MSHN do with the information it obtains through disclosure statements?*** MSHN is required to ensure it does not have a 'relationship' with an 'excluded' individual and must search the Office of Inspector General's (OIG) exclusions database to ensure that the provider entity, and any individuals with ownership or control interests in the provider entity (direct or indirect ownership of five percent or more or a managing employee), have not been excluded from participating in federal health care programs. MSHN must search the OIG exclusions database monthly to capture exclusions and reinstatements that have occurred since the last search, or at any time new disclosure information is provided. If Board Members have questions about the disclosures or need assistance completing the form, please feel free to reach out to Sherry or myself.

Provider Network Adequacy Assessment (NAA) – FY24

The Code of Federal Regulations (CFR) at 42 CFR Parts 438.68 and 457.1218 charges states holding managed care contracts with the development and implementation of network adequacy standards. Michigan Department of Health and Human Services (MDHHS) developed parameters for Pre-paid Inpatient Health Plans (PIHPs) to ensure compliance with CFR requirements that include time and distance standards as well as Medicaid Enrollee-Provider Ratio standards. MDHHS requires each PIHP to submit plans on how the standards will be effectuated by region. Understanding regional diversity, MDHHS expects to see nuances within the PIHPs to best accommodate the local populations served. PIHPs must consider at least the following parameters for their plans:

1) Maximum time and distance (*NEW this year MDHHS will calculate)*
2) Medicaid to Enrollee Ratios
3) Timely appointments
4) Language, Cultural competence, and Physical accessibility

MSHN delegates Network Management to the Community Mental Health Service Programs (CMHSPs), including assurance of sufficient capacity to meet the community needs. MSHN and the CMSHPs began assessing the adequacy of our regional Network. The NAA plan was updated with FY24 data points, including the state required analysis on the above elements. After a review of the results, MSHN developed a list of recommendations to address identified gaps, areas for improvement and future demand considerations.

The Board of Directors will receive a summary presentation on the results of the FY24 Network Adequacy Assessment. More detailed information including regional, SUD Provider Network and CMHSP specific results, related to the information above is included and attached. ***FY24 Provider Network Adequacy Assessment***

Balanced Scorecard Measures for FY25

The Balanced Scorecard (BSC) is utilized by our region throughout all the council and committee groups to update the Board of Directors on the status of the strategic objectives included in MSHN's Strategic Plan. The BSC includes key performance indicators for each of the strategic priority areas for Better Health, Better Care, Better Value, Better Provider Systems and Better Equity. In addition, MSHN supports reporting of the specific state and clinic measures related to the Certified Community Behavioral Health Clinics (CCBHC) that apply to four of our CMHSPs, Behavioral Health Home measures that apply to five of our CMHSPs and Opioid Health Homes related to the substance use disorder providers. ***The FY24 Balanced Scorecard is attached*.**

Submitted by:

Amanda L. Ittner
Finalized: 05.01.25

Attached
FY24 Provider Network Adequacy Assessment
FY25 Balanced Scorecard

MSHN

Mid-State Health Network

Assessment of Network Adequacy

2024

Reviewed by MSHN Leadership: March 2025

Reviewed by Provider Network Committee, Customer Service Committee, Clinical Leadership Committee, Regional Consumer Advisory Council, and Quality Improvement Council: March 2025

Approved by MSHN Operations Council: April 2025

Updated Plan Submitted to MDHHS: April 2025

Reviewed by MSHN Board of Directors: May 2025

Contents

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Definitions

The following are definitions for key terms used throughout the assessment of provider network adequacy:

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

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

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

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

Background

As a Pre-Paid Inpatient Health Plan (PIHP), Mid-State Health Network (MSHN) must assure the adequacy of its network to provide access to a defined array of services for specified populations over its targeted geographical area. This document outlines the assessment of such adequacy as performed by MSHN. This assessment of the adequacy of its provider network demonstrates MSHN has the required capacity to serve the expected enrollment in its 21-county service area in accordance with Michigan Department of Health and Human Services (MDHHS) standards for access to care.

MSHN is a free-standing entity, but it was formed on a collaborative basis by twelve Community Mental Health Service Programs (CMHSP Participants). MSHN entered agreements with the CMHSP Participants to deliver Medicaid funded specialty behavioral health services in their local areas, so the twelve CMHSP Participants also comprise MSHN's Provider Network. Each CMHSP Participant in turn directly operates or enters subcontracts for the delivery of services, or some combination thereof. There are twelve CMHSP Participants for the 21 counties, as follows:

Bay-Arenac Behavioral Health (BABH)	LifeWays CMH (LCMHA)
CMH of Clinton-Eaton-Ingham Counties (CEI)	Montcalm Care Network (MCN)
CMH for Central Michigan (CMHCM)	Newaygo County Mental Health (NCMH)
Gratiot Integrated Health Network (GIHN)	Saginaw County CMH Authority (SCCMHA)
Huron Behavioral Health (HBH)	Shiawassee Health & Wellness (SHW)
The Right Door for Hope, Recovery and Wellness (TRD)	Tuscola Behavioral Health Systems (TBHS)

The counties in the MSHN service area include:

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

Scope

Since CMHSP Participants have their own subcontracted and direct operated provider networks, primary responsibility for assessing local need and establishing the scope of non-SUD behavioral health services remains with the CMHSP's. MSHN works with the CMHSP Participants to ensure adequate networks are available and has primary responsibility for SUD service capacity funded under Medicaid, Healthy Michigan, Public Act 2, and related Block Grants.

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

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

The focus of this assessment of provider network adequacy is both MSHN's mental health and substance use disorder provider networks. The scope of services is Medicaid funded specialty behavioral health services, including 1915(b) State Plan and Autism services, the 1915(i) State Plan Amendment (SPA) services, services for adults with developmental disabilities enrolled in the Habilitation Supports Waiver program, and specialty behavioral health (mental health and substance use disorder) services under the Healthy Michigan Plan.

The 1915(c) which now includes waiver programs for children with developmental disabilities and serious emotional disturbance (SED) and 1915(i) services must be Home and Community Based Services (HCBS) compliant. Services included under the 1915(i) include: Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support and Training, Fiscal Intermediary, Housing Assistance, Respite Care, Skill-Building Assistance, Specialized Medical Equipment and Supplies, Supported Integrated Employment and Vehicle Modification. [1]

The scope also includes Block Grant and PA2 funded substance use disorder treatment and prevention programs. Excluded are those services which are exclusively the focus of the CMHSP system through direct contract with MDHHS, such as services financed with General Funds.

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

Consistent with MSHN's strategic priority of "better equity," MSHN now includes within the scope of its Network Adequacy Assessment (NAA) efforts to determine if its provider networks are helping reduce health disparities or if they are reinforcing them. MSHN recognizes, for example, that national studies have identified disparities in Opioid Treatment Providers (OTPs) between White and Black patients in methadone dosing, drug tests and discharges. Therefore, the definition of network adequacy needs to

[1] www.michigan.gov/bhdda

extend beyond the number of providers, levels of care, and distance to any consumer living in Region 5 to include race, ethnicity and potential or actual barriers to equitable access to care. Network adequacy is not race-blind as evidenced, for example, in significant Region 5 disparities between Black and White patients following up after a psychiatric hospitalization (FUH) or between Black and White patients following up after an Emergency Department visit related to a substance misuse issue (FUA). It is within the scope of this NAA to investigate if MSHN's network adequacy includes offering providers who bring cultural competence and/or cultural humility to their interactions with all demographic groups within the region.

COVID-19 Assessment

Fiscal Year 2020 presented unique and unprecedented challenges for Mid-State Health Network (MSHN), Community Mental Health Service Providers (CMHSP), Substance User Disorder (SUD) providers and persons served. The challenges stem from the COVID-19 global pandemic response. For many services, at the onset of the pandemic in Michigan in early 2020, utilization temporarily dropped; for other services, utilization increased. For residentially based services, many providers reduced capacity in order to implement social distancing requirements, resulting in decreased utilization and increased demand. Risks of infection, actual infection, and potential for spread of the virus to their family members have impacted our regional workforce, especially those working in residential settings, making delivery of some required services strained as unprecedented retention, recruitment and replacement of affected workforce members has continued to worsen during the pandemic period.

From 2020 through March 2023, Medicaid enrollment realized significant increases due to the hold on Medicaid redeterminations. As of April 2023, states had up to 2 months to initiate, and 14 months to complete a renewal for all individuals enrolled in Medicaid, the Children's Health Insurance Program, and the Basic Health Program. Therefore, utilization progressively decreased from July 2023 through September 2024.

In relation to COVID-19 impacts specific to Provider Network Adequacy Assessment, MSHN has monitored the count of individuals served (Figure 1-2) and the impact on provider sustainability (Figure 3).

Individuals Served

Figure 1: Individuals Served CMHSP

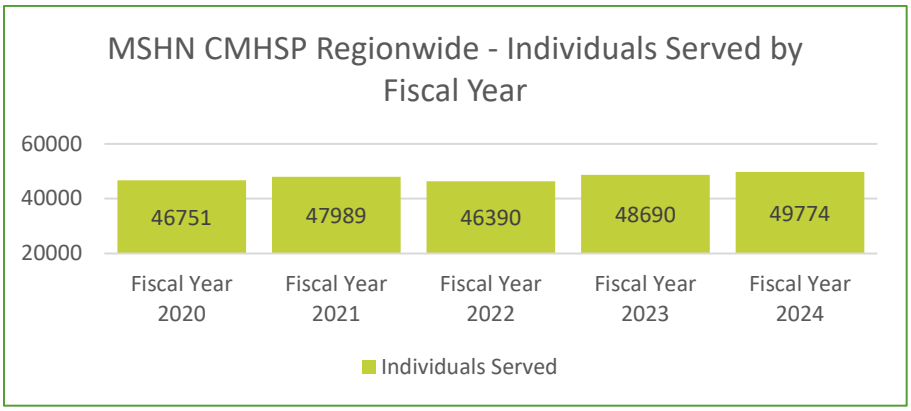


Figure 2: Individuals Served SUD

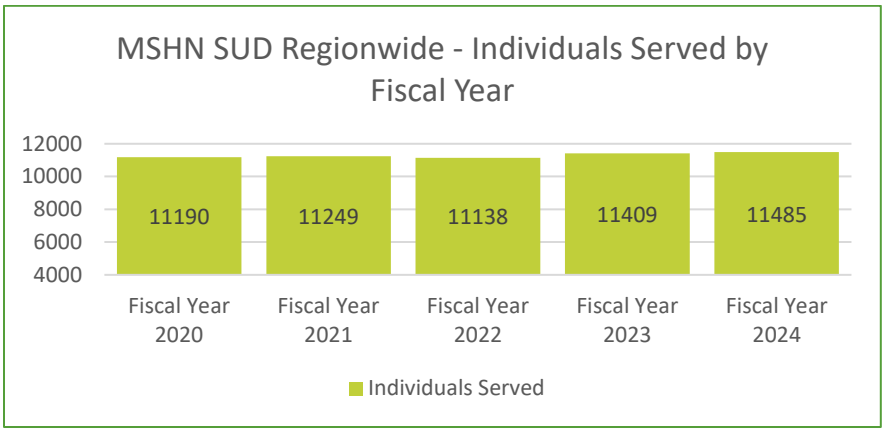


Figure 3: Provider Closures

MSHN PROVIDER CLOSURES THROUGH OCTOBER 30, 2024				
Name of Provider	Date of Closure	Services Provided	Individuals Served	Impact on Network
Newaygo RESA	10.1.23	SUD Prevention	520	No impact. New provider took over these services.
Catholic Charities of Jackson & Lenawee	12.26.23	SUD Outpatient	0	No impact. Provider has not had sufficient staffing for almost a year and been referring to other area providers to support needs.
Saginaw Psychological Services	12.31.24	SUD Outpatient/MAT & Recovery	69	No impact. Numerous providers with similar service contiuum available to absorb individuals in need of services.
Family & Childrens Services of Mid-Michigan	1.31.24	SUD Outpatient	3	No impact. Provider utilization low; existing providers able to support.
Catholic Charities Shiawassee & Genesee	2.29.24	SUD Outpatient	40	No Impact. Another provider in the count absorbed the individuals with services and offers SUD outpatients supports with MOUD.
Sterling Area Health Center	8.16.24	SUD Prevention	375	No impact. New provider taking over the same services.
Michigan Rehabilitation Services	10.1.24	Employment Supports	45	No impact. MRS continues to support individuals with SUD needs without this supplemental funding.
PPPS - Lansing Only	10.2.24	SUD Outpatient	0	No impact. Provider location had not been able to support staff for an extended period of time.

Assessment Updates

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

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

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

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

Meeting the needs of enrollees: expected service provisions

MSHN must maintain a network of providers that is sufficient to meet the needs of the anticipated number of Medicaid beneficiaries in the service area[2]. A determination of whether the network of providers is sufficient would typically be made through analysis of the characteristics and health care needs of the populations represented in the region[3]. However, the unique nature of the Medicaid Managed Specialty Supports and Services Program in Michigan complicates the assessment of network sufficiency beyond the scope of a simple analysis of clinical morbidity or prevalence among Medicaid beneficiaries.

MSHN is required to serve Medicaid beneficiaries in the region who require the Medicaid services included under the 1115 Demonstration Waiver, 1915(i); who are *eligible* for the 1115 Healthy Michigan Plan, the Flint 1115 Waiver or Community Block Grant; who are *enrolled* in the 1915(c) Habilitation Supports Waiver; 1915(c) Children Waivers (SEDW and CWP) who are *enrolled* in program; or for whom MSHN has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. MSHN must also ensure access to public substance use disorder services funded through Medicaid, Public Act 2, and substance use disorder related Block Grants. Furthermore, MSHN is required to limit Medicaid services to those that are *medically necessary* and appropriate, and that conform to accepted standards of care. Services must be provided (i.e., available) in sufficient amount, duration, and scope to reasonably achieve the purpose of the service.

Population Density Standards/Geographic Accessibility: Behavioral and Physical Health and Aging Services Administration (BPHASA) revised its network adequacy standards to address new requirements issued by Centers for Medicare and Medicaid Services (CMS), dated January 30, 2025, which states, at a minimum, each state must set time and distance standards. In January 2025 MDHHS revised the Network Adequacy Standards[4], which removed the requirement for PIHPs to conduct time and distance standards, indicating MDHHS would be completing the analysis for the entire state of Michigan. Therefore, the time and distance standards utilized during this review are based on the 2023 analysis until MSHN has the state results for 2024.

MDHHS has established population density standards for Assertive Community Treatment (ACT), Clubhouses, Crisis Residential, Home-Based Services and Wraparound for children, and Opioid Treatment Programs with additional standards added in 2025 (as informational only) for Intensive Crisis Stabilization Services, Respite Services, Parent Support Partners and Youth Peer Services, which have been incorporated in this assessment.

Appropriateness of the range of services

MSHN must offer an appropriate range of specialty behavioral health services that is adequate for the anticipated number of beneficiaries in the service area.[5] MSHN assesses the "appropriateness" of the

[2] 42CFR438.207(b)(2) "Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."
[3] 42CFR438.206(b)(ii) "The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the PIHP."

[4] https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/BH-DD/Reporting-Requirements/ProcedureMDHHSNetworkAdequacyStandardsMedicaidSpecialityBehavioralHealthServices
[5] 42CFR438.207(b)(1) "Offers an appropriate range of preventative, primary care and specialty services that is adequate for the anticipated number of enrollees in the service area."

range of services by comparing the service array available within the region to the array determined to be appropriate by MDHHS for the target population(s).

The service array is articulated by MDHHS in the *Medicaid Managed Specialty Support and Services Program(s), the Health Michigan Program and Substance Use Disorder Community Grant*. MSHN is contractually obligated by MDHHS to provide the services described in the contract boilerplate and its attachment, for which additional specifications and provider qualifications are articulated for Medicaid funded services in the Michigan Medicaid Provider Manual, Mental Health-Substance Use Disorder section:

- Michigan 1115 Demonstration Project Healthy Michigan Plan (HMP) mental health and substance use disorder services authorized through the Affordable Care Act provisions for Medicaid expansion programs
- Michigan 1915(i) State Plan Amendment (iSPA), formerly (b)(3)
- Michigan 1915(c) Habilitation and Support Waiver (HSW) services; Children's Waiver Program; Children with Serious Emotional Disturbance (SED)
- Autism Benefit (EPSDT)
- SUD services funded by Public Act 2 and Block Grants

Independent CMHSP Network Analysis

MSHN has analyzed the independent CMHSP Provider Network sufficiency to ensure all Medicaid Specialty services are available as determined medically necessary. The following grid depicts the availability of services within each CMHSP network.

* Prevention Direct Service models noted in the graph below: The Michigan Mental Health Code indicates that the public mental health system "may" offer prevention services and does not specify how many or what types of "prevention direct services" must be offered by the PIHPs. Some of these services are also identified in the Medicaid Provider Manual as "…a State Plan EPSDT service when delivered to children birth-21 years." Per MDHHS, they are evaluating the current Medicaid Provider Manual language and considering clarifications to policy requirements for prevention direct services.

Findings: After reviewing the CMHSP services grid below, MSHN finds that each CMHSP meets the expectations to provide services either directly, contracted or through a single case agreement as outlined in the Medicaid Provider Manual and as required by the Network Adequacy Standards.

Future expansion: While noted capacity exists within each CMHSP area, the following CMHs are in the process of a Request for Proposal.

- TBHS: Community Living Supports (CLS), Speech-Language Pathology (SLP), Psychologist for Behavior Treatment Plans (BTP)

Table 1: Mental Health Services Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GIHN	HBH	TRD	LifeWays	MCN	NCMH	SCCMHA	SHW	TBHS
Applied Behavioral Analysis	X	X	X	X	X	X	Contract	X	X	X	X	X
Assertive Community Treatment	X	X	X	X	X	X	Contract	X	X	X	X	X
Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Assistive Technology	Provided on a per request basis.											
Behavior Treatment Review	X	X	X	X	X	X	X	X	X	X	X	X
Child Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Child Therapeutic Foster Care			Grant		Contract		Contract					
Clubhouse Psychosocial Rehabilitation	X	X	X				X	X		X		
Community Living Supports	X	X	X	X	X	X	X	X	X	X	X	X
Community Transition Services *Coordinating when MDHHS is providing	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Intervention	X	X	X	X	X	X	X	X	X	X	X	X
Crisis Residential Services	X	X	X	X	X	X	X	X	X	X	X	X
Drop-In Centers (Peer Operated)		X	X	X	X	X	X		X	X	X	X
Enhanced Medical Equipment & Supplies	X	X	X	X	X	X	X	X	X	X	X	X
Enhanced Pharmacy	X	X	X	X	X	X	X	X	X	X	X	X
Environmental Modifications	Per request											
Family Support and Training	X	X	X	X	X	X	X	X	X	X	X	X
Family Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Fiscal Intermediary Services	X	X	X	X	X	X	X	X	X	X	X	X
Goods & Services	Provided on a per request basis.											
Health Services	X	X	X	X	X	X	X	X	X	X	X	X
Home-Based Services	X	X	X	X	X	X	Contract	X	X	X	X	X
Home-Based Serv. – Infant Mental Health	X	X	X	X	X	X	X	X	X	X	X	X
Housing Assistance	Provided on a per request basis.											
Individual and Group Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Inpatient Psychiatric Hospital Admission	X	X	X	X	X	X	X	X	X	X	X	X
Intensive Crisis Stabilization Services	X	X	X	X	X	X	X	X	X	X	X	X
ICF Facility for IDD												

Medication Administration	X	X	X	X	X	X	X	X	X	X	X	X
Medication Review	X	X	X	X	X	X	X	X	X	X	X	X
Non-Family Training	Per request	X	X	X	Per request	X		X		X	X	X
Nursing Facility Mental Health Monitoring	X	X	X	X	X	X	X	X	X	X	X	X
Occupational Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Out-of-Home Non-Voc Habilitation	X	X	X	X	X	X	X	X	Per request	X	X	X
Outpatient Partial Hospitalization Services	X	X	Contracted	X	X	X	X	X	X	X	X	X
Overnight Health and Safety Support	X	X	X	X	X	X	X	Contracted	X	X	X	X
Peer Specialist Services	X	X	X	X	X	X	X	X	X	X	X	X
Personal Care in Licensed Spec. Residential	X	X	Contracted	X	X	X	X	X	X	X	X	X
Personal Emergency Response	Per request	Per request	X	Per request	Per request	Per request	Per request	Per request	Per request	Per request	X	Per request
Physical Therapy	X	Per request	X	X	X	Single case	X	Single case	X	X	Per request	X
Prevention Direct Service Models	X	X	X		X	X	X	X	X	X	X	X
• Child Care Expulsion Prevention		X	X							X		
• School Success Program *Youth intervention Specialist			X								X	
• Infant Mental Health-Prevention	X	X	X	X	X	X	X	X	X	X	X	X
• Parent Education	X	X	X		X	X	X	X	X	X	X	X
Pre-Vocational Services	X	X	X	SCA	X	X	X	X	Per request	X	X	X
Private Duty Nursing	X	X	X	SCA	X	X	X	X	Per request	X	X	X
Respite Care	X	X	X	X	X	X	X	X	X	X	X	X
Skill Building Assistance	X	X	X	X	X	X	X	X	X	X	X	X
Speech, Hearing and Language Therapy	X	X	X	X	X	X	X	X	X	X	X	X
Supports Coordination	X	X	X	X	X	X	X	X	X	X	X	X
Supported Employment	X	X	X	X	X	X	X	X	X	X	X	X
Targeted Case Management	X	X	X	X	X	X	X	X	X	X	X	X
Telemedicine	X	X	X	X	X	X	X	X	X	X	X	X
Therapeutic Overnight Camp	SCA	Contract	Contract	SCA	Contract	Contract	Contract	SCA		X		Per request
Transportation	X	X	X	X	X	X	X	X	X	X	X	X
Treatment Planning	X	X	X	X	X	X	X	X	X	X	X	X
Wraparound Services	X	X	X	X	X	X	X	X	X	X	X	X

Specialty Services within MSHN

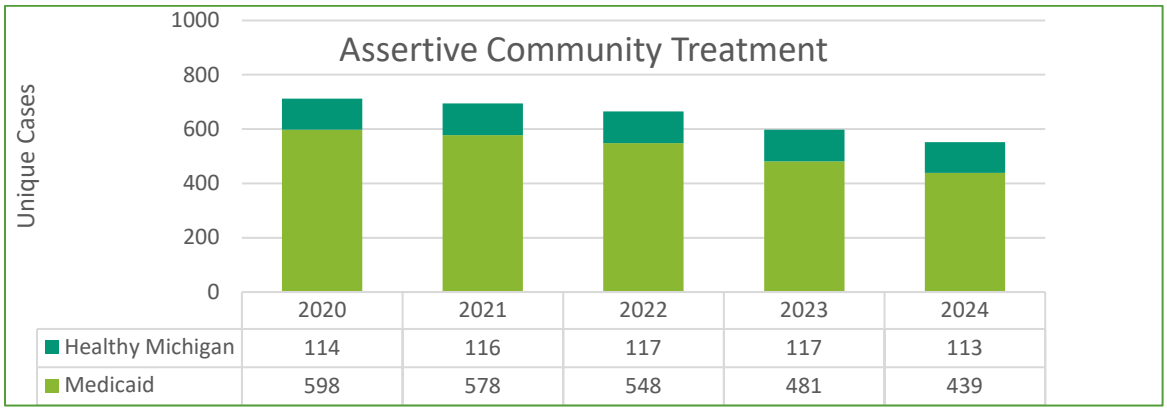
MSHN offers an appropriate array of specialty services provided by the CMHSPs. The following graphs illustrate the number of unique cases served from FY20-FY24 for each specialty service. The information was collected from encounters reported or directly reported figures by the CMHSPs. **Programs below include an analysis where MDHHS has required a specific adequacy standard. For all others, the utilization trends will be combined as part of the analysis to determine adequacy.**

Assertive Community Treatment

Assertive Community Treatment (ACT) is a community-based approach to comprehensive assertive team treatment and support for adults with serious mental illness. It provides continuous team-based care 24 hours a day, 7 days a week. ACT is the most intensive non-residential service in the continuum of care within the service array of the public behavioral health system. **MDHHS has established an adequacy standard for ACT programs (30,000:1 Medicaid Enrollee to Provider Ratio). MSHN's FY24 Ratio: 591,929 Total Medicaid Enrollees to 8 providers however, MSHN has 13 teams. In order to meet the requirement, MSHN would need to have a total of 20 teams in-region. Using Average enrollees per month of 424,977, MSHN's required FY24 Ratio would be 14 (424,977 / 30,000). As of March 2025, MSHN's Average Enrollees = 383,614, therefore, future planning wouldn't require any expansion as MSHN's current provider capacity of 8 with 13 teams would be sufficient.** Four CMHSPs in the MSHN region do not directly provide ACT services; However, they have written agreements in place with other CMHSPs or other subcontractors that provide ACT services to ensure the availability of this evidence-based practice in each of their catchment areas. ACT is but one service that might meet the level of intensity required to address the recipient's care needs. It is often true that individuals who meet the eligibility criteria for ACT often choose other (non-ACT) services or combinations of services more suitable to their individual circumstances. MSHN concluded that as alternatives to ACT, combinations of services and supports that often parallel the services in the ACT service bundle, are available and routinely provided to recipients in the region, including at CMHSPs that do not currently have enrolled ACT Programs and at those that do. MSHN is satisfied that the arrangements in place at the CMHSPs that do not have enrolled ACT programs are adequate to ensure that if/when ACT services are desired by the recipient, they can and will be provided.

MSHN has experienced in parts of its region where, due to staffing shortages, the continued need for an exception to the ACT staffing model. Bay-Arenac Behavioral Health (BABH) and Tuscola Behavioral Health Systems (TBHS) worked with MSHN to ensure that MDHHS received the exceptions requests. BABH has had a master's level position vacant but posted for several months. TBHS will continue to work on improving their ACT staffing levels, which continued to be an issue throughout FY24, to come back into compliance with ACT requirements. Until that time, TBHS will provide enhanced-intensity services to its beneficiaries meeting the ACT criteria. BABH and TBHS continue to post for open positions.

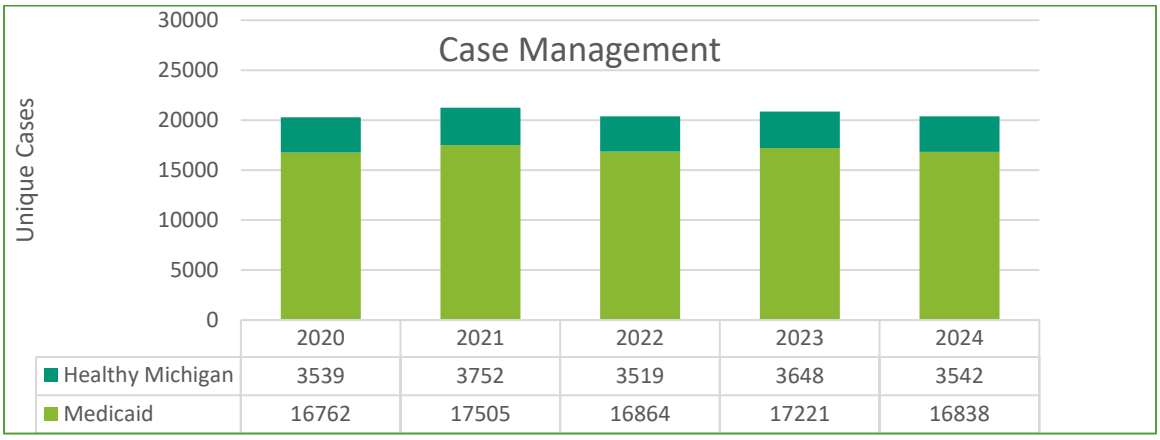
Figure 4. Assertive Community Treatment



Case Management

For the purpose of the assessment, case management refers to supports coordination and targeted case management. These two services are combined in the following graph. Targeted case management helps with obtaining services and supports. Its focus is goal oriented and individualized. Supports coordination works with waiver beneficiaries in home and community-based settings.

Figure 5. Case Management

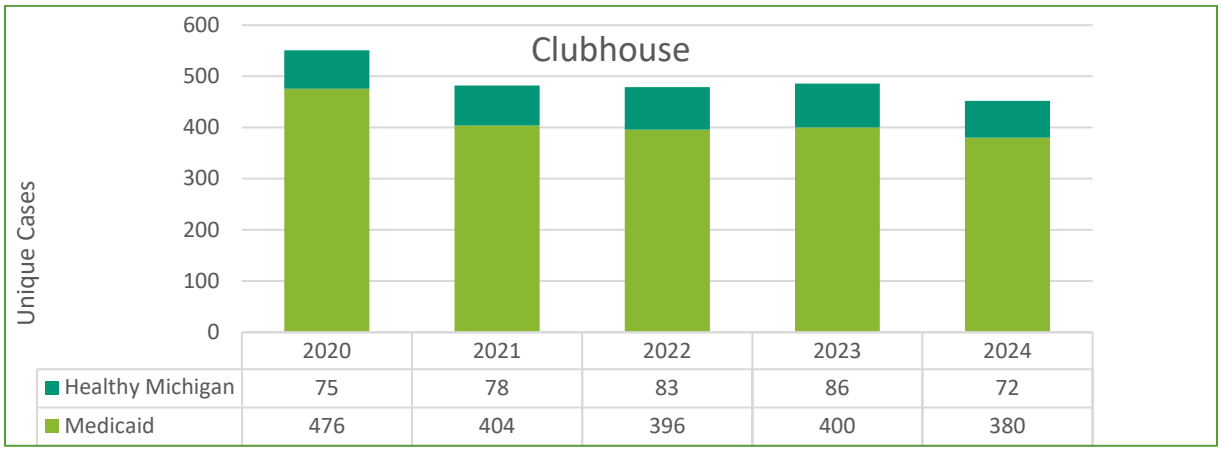


Clubhouse Psychosocial Rehabilitation Programs

A Clubhouse is a community-based program designed to support individuals living with mental illness. Participants work alongside staff to gain skills in employment, education, housing, community inclusion, wellness, community resources, advocacy, and recovery. Clubhouse Psychosocial Rehabilitation Program accreditation by the International Center for Clubhouse Development (ICCD) is required by MDHHS. Additionally, **MDHHS has established an adequacy standard for Clubhouse programs (45,000:1 Medicaid Enrollee to Provider Ratio) which requires 7.3 clubhouse programs in the region, based on the number of *adult* enrollees. Currently, six CMHSPs have accredited clubhouse programs.**

While clubhouse is offered by six of the twelve CMHSPs, one of the six operates a second clubhouse program for a total of seven (Central operates two) in the region. Therefore, **MSHN's FY24 Ratio: 328,455 Adult MH Medicaid Enrollees to 7 Providers. As of March 2025, MSHN's Average Adult MH Enrollees = 237,256 therefore, future planning would only require 5.3.** Alternatively, ten of the twelve CMHSPs offer Drop-In Center activity with four CMHSPs offering both. For those CMHSPs without a clubhouse program (six) drop-in centers are offered.

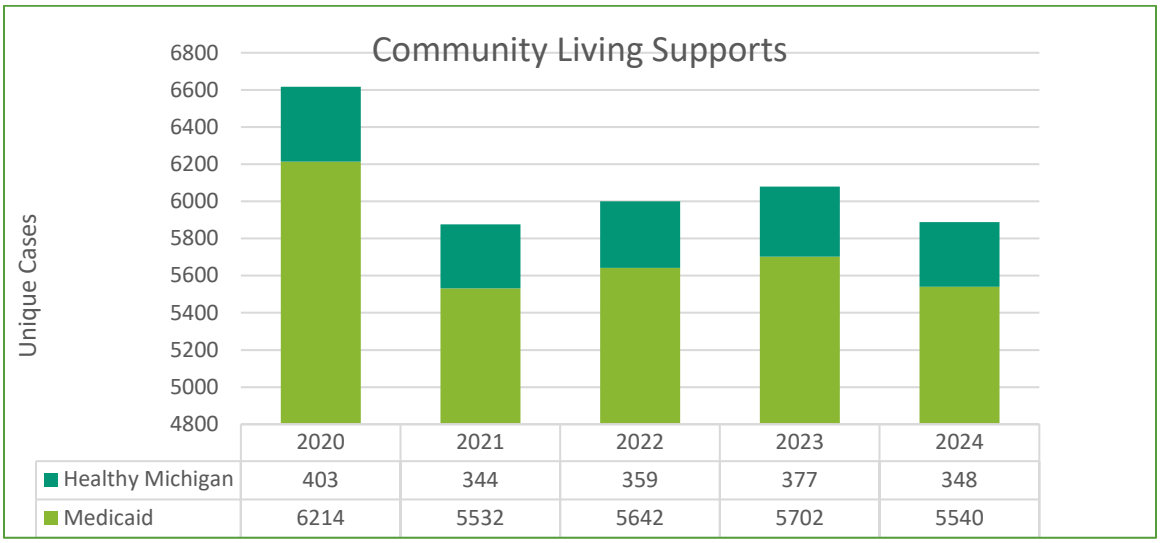
Figure 6. Clubhouse Psychosocial Rehabilitation Programs



Community Living Supports

Community Living Supports (CLS) are designed to increase an individual's independence, productivity, promote inclusion and participation. These services can be provided in a person's home or in a community setting.

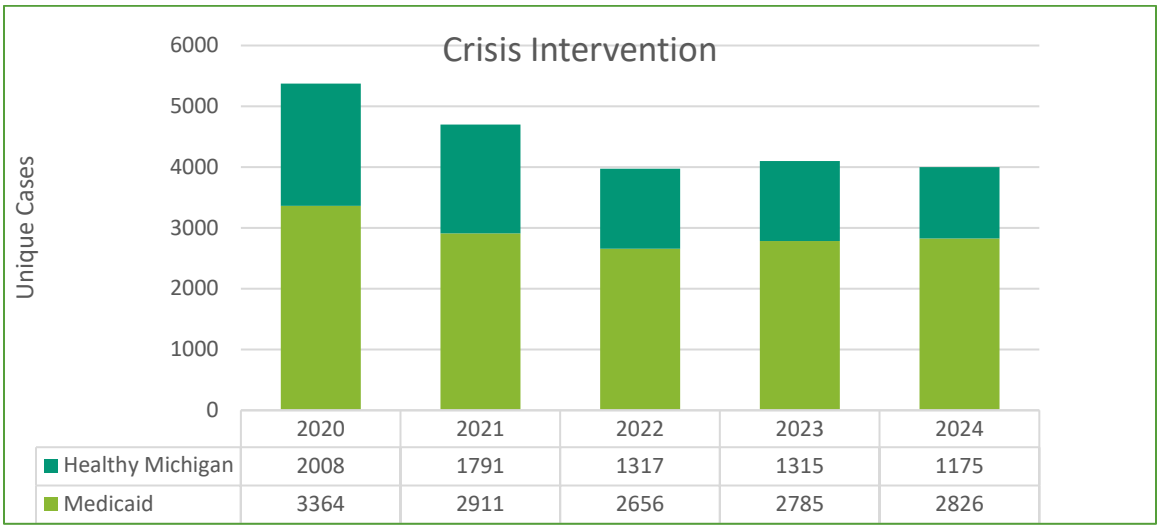
Figure 7. Community Living Supports



Crisis Services: Crisis Intervention

A service for the purpose of addressing problems/issues that may arise during treatment and could result in the beneficiary requiring a higher level of care if intervention is not provided.

Figure 8: Crisis Intervention



Crisis Services: Crisis Residential Services

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay. MDHHS has established an adequacy standard (16 adult beds per 500,000 total population and 8-12 pediatric beds per 500,000 total population). MSHN total population = 1,643,130 (2024 census), so the standard for MSHN is 53 adult beds and 26 pediatric beds (min 8 bed).

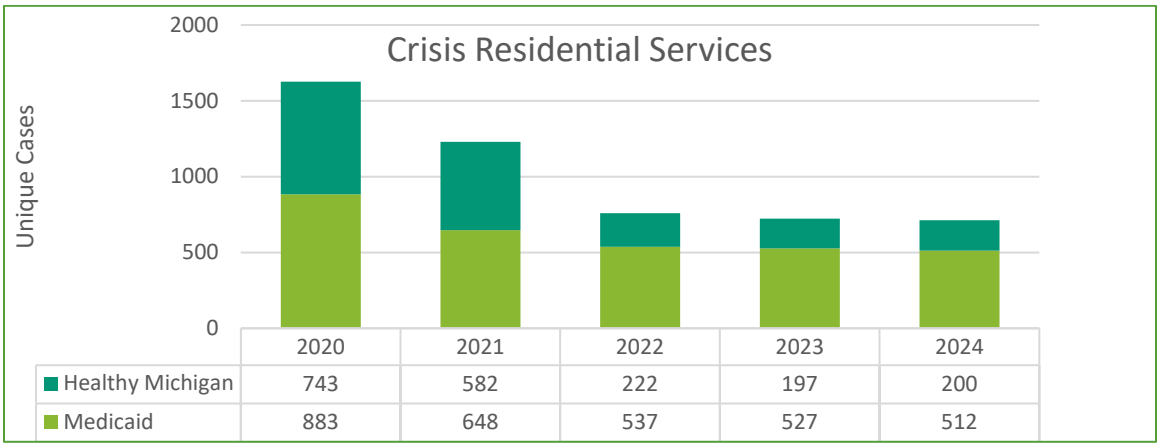
MSHN has an inventory of 16 contracted crisis residential providers, with a total of 88 adult beds and of those 18 beds are designated pediatric. As a result, MSHN considers its adult capacity to be compliant with the published standard but under the standard for pediatric beds.

MSHN collaborated with its partner CMHPs and a crisis residential provider to establish an additional adult Crisis Residential setting within the MSHN region, which was opened in June 2024. This added six crisis beds to the MSHN region. The provider, Healthy Transitions, is located in Alma, Michigan and is operating at 33-66% capacity and will be working to achieve stability in daily census.

Lastly, one of MSHN's CMHSPs (Bay-Arenac) completed development of a six-bed crisis residential setting. This facility was successfully licensed and approved to operate crisis residential services, opening in October 2024. CEI CMH has begun work on a crisis stabilization unit which is underway and will be developed throughout FY25.

Pediatric Crisis Residential Beds: The most significant deficit in the MSHN region is the absence of any in-region crisis residential beds for children and adolescents. Based on information provided through the Crisis Residential Network, this appears to be a statewide issue as there are only approximately six child crisis residential facilities in Michigan out of 20 total crisis residential facilities. In FY24, MSHN contracted with three Pediatric Crisis Residential Settings, including Beacon Crisis Residential Treatment Program at Sandhurst, Hope Network Safehaus, and Samuel's house. Each setting provides services to children and adolescents aged 5-17 SED primary and/or cooccurring. Beacon at Sandhurst services had been designed for children and youth with mental illness, or children with both a mental illness and another concomitant disorder, however, the primary reason for services was due to a mental illness. Beacon Sandhurst closed in early 2025, leading to the current regional deficit for adolescent/youth crisis residential services.

Figure 9: Crisis Residential Services



Crisis Services: Intensive Crisis Stabilization Services (ICSS)

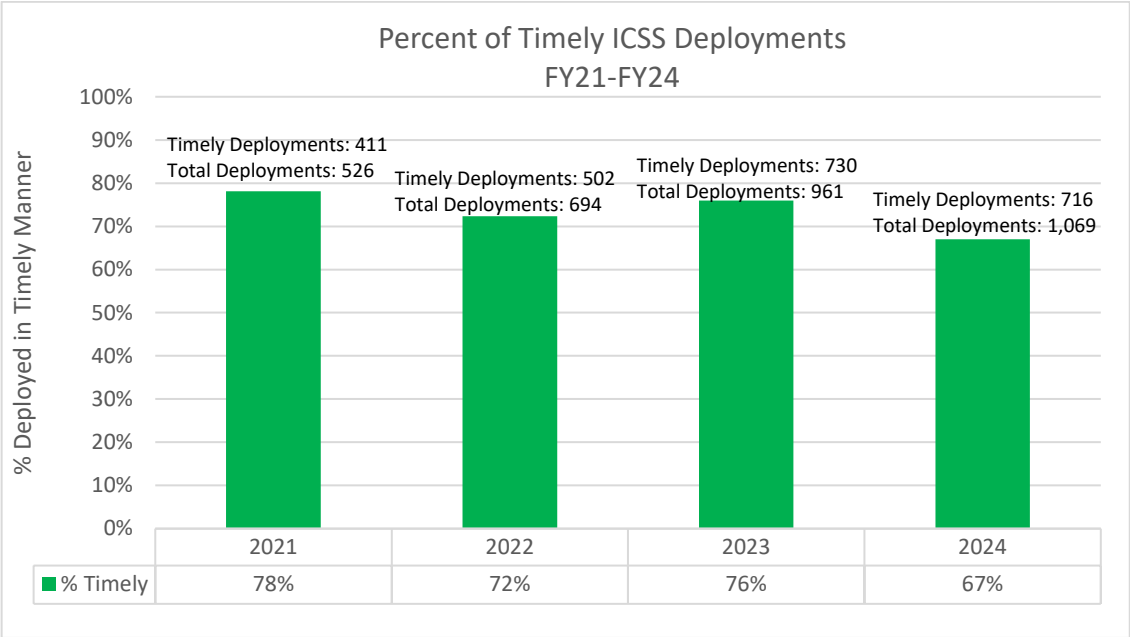
Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term crisis alternative to inpatient psychiatric services. Services may be used to avert psychiatric admission or to shorten the length of an inpatient stay when clinically indicated. Children's ICSS are provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement.

These services must be available to children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD). Encounter data is not available (H2011 TJ, HB, HC and previously S9484). This warrants investigation to ensure accurate reporting.

However, the region's CMHSPs submit annual ICSS data to MSHN on the performance of the program. Since formal data collection began in 2021, total calls received, and total calls deployed increased each fiscal year. Deployments were up 11% in FY24 and have increased 103% since FY21. For deployed calls, the standards are one hour for urban areas and two hours for rural areas. **The MSHN region's mean percentage of meeting the deployment timeframes was 67% for FY24.** The analysis of the data showed that performance varied with CMHSPs contributing slight drops in performance with a few CMHSPs contributing more of a drop, resulting in a drop of 9% in timely deployments. The region's CMHSPs are now sharing quarterly data about timeliness of ICSS deployments to requests in urban and rural settings to continue addressing timeliness of deployments.

MDHHS does not currently have an established adequacy standard, however in FY24, MDHHS added required reporting of monthly average Full-Time Equivalents (FTEs) and number of teams as informational only. MSHN reported 58.7 monthly average FTE's and 21.5 response teams.

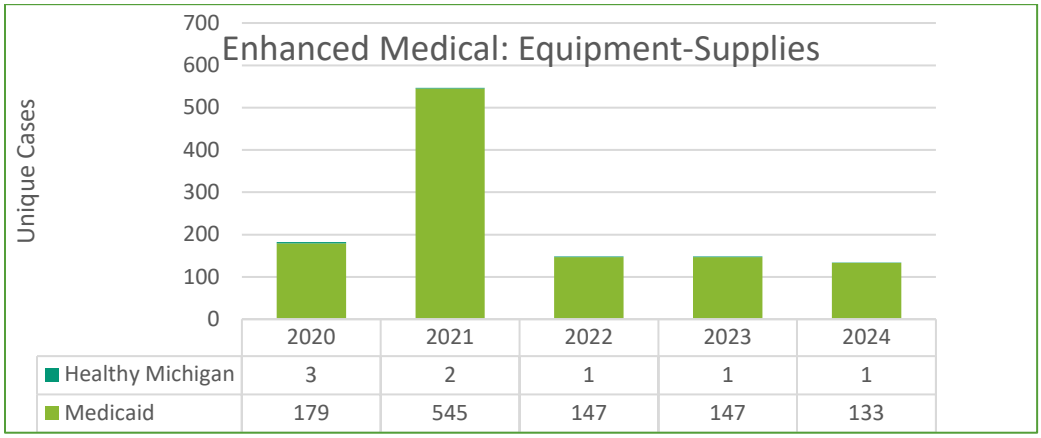
Figure 10: Intensive Crisis Stabilization Services



Enhanced Medical Equipment Supplies

Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances. All enhanced medical equipment and supplies must be specified in the plan of service and must enable the beneficiary to increase the person's abilities to perform activities of daily living; or to perceive, control, or communicate with the environment.

Figure 11: Enhanced Medical Equipment-Supplies

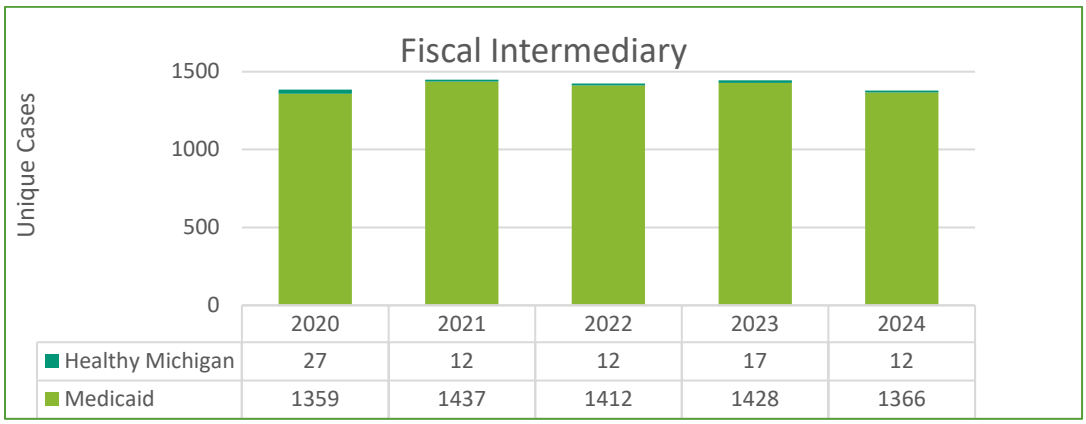


Financial Management Services (FMS)/Fiscal Intermediary (FI)

A financial management service/fiscal intermediary is an organization or individual independent of the CMH system that assists employers to manage the self-directed budgets. The FI acts as the fiscal agent of the CMHSP for the purpose of assuring fiduciary accountability for the funds authorized to purchase specific services identified in the consumer's individual plan of service (IPOS) under a self-directed

arrangement. The self-directed services technical requirement (January 2022) and implementation guideline published January 2022 states that *each CMHSP is required to contract with an FMS provider. Additionally, the PIHP must ensure there are two FMS providers within the region and ensure access to all impaneled FMS providers*[6]. MSHN meets this requirement with each CMHSP having one or more contracts with a FMS provider and the region has a total of 4 FMS providers.

Figure 12: Fiscal Intermediary

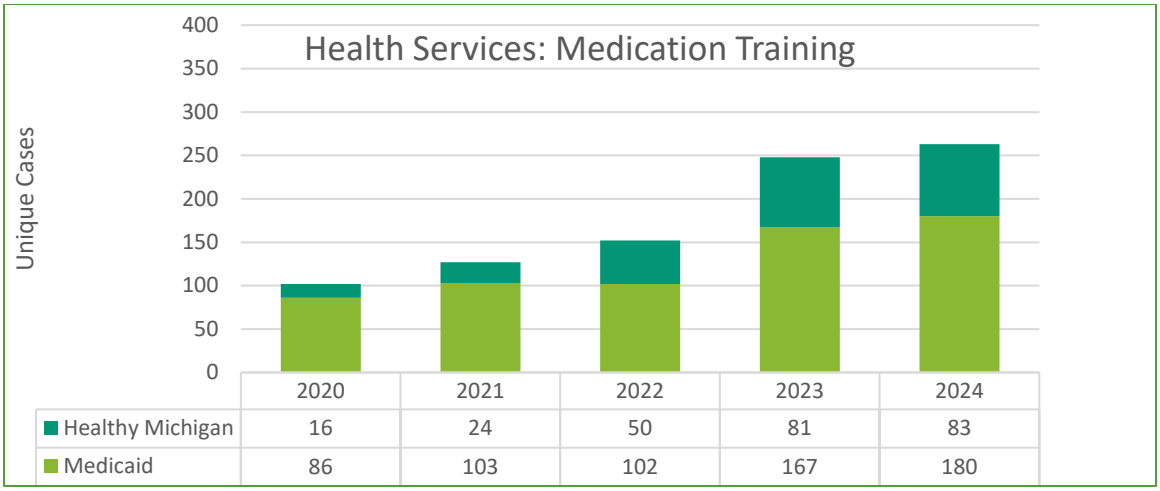


	2020	2021	2022	2023	2024
Healthy Michigan	27	12	12	17	12
Medicaid	1359	1437	1412	1428	1366

Health Services: Medication Training

Medication Training and Support involves face-to-face contact with the person and/or the person's family or nonprofessional caregivers to monitor medication compliance, educate on medication and side effects.

Figure 13: Health Services: Medication Training



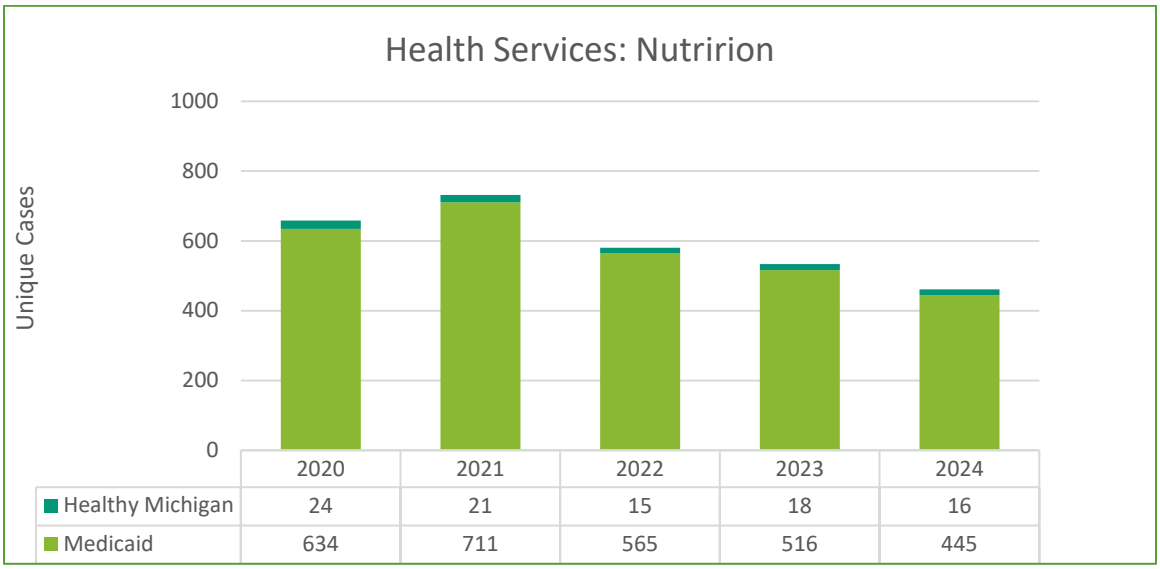
	2020	2021	2022	2023	2024
Healthy Michigan	16	24	50	81	83
Medicaid	86	103	102	167	180

Health Services: Nutrition

Nutrition services include the management and counseling for individuals on special diets for genetic metabolic disorders, prolonged illness, deficiency disorders or other complicated medical problems. Nutritional support through assessment and monitoring of the nutritional status and teaching related to the dietary regimen.

[6] Source: MDHHS Self-Directed Services Technical Requirements and MDHHS Self-Direction Technical Requirement Implementation Guide

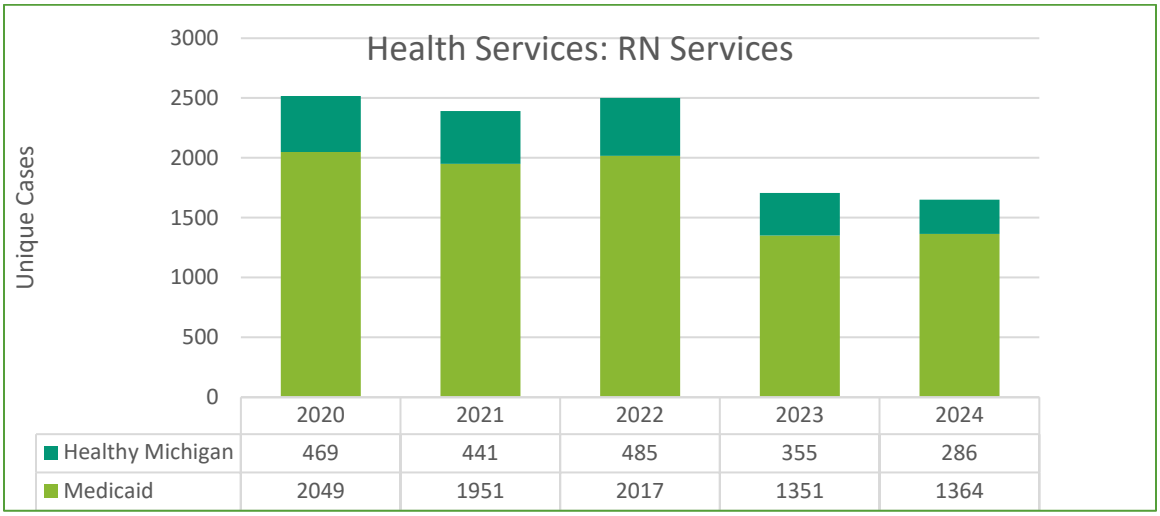
Figure 14: Health Services: Nutrition



Health Services: RN Services

Nursing services are covered on an intermittent basis. These services must be provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN.

Figure 15: Health Services: RN Services



Homebased Services

Homebased services provide assistance to children and their families with multiple service needs. The goals are to meet children's developmental needs, support families, reunite families and prevent out of home placement. MDHHS has an established adequacy standard (2,000:1 Medicaid Enrollee to Provider Ratio). Home-Based services were verified through provider enrollment information to ensure compliance with educational standards of licensure and FTE designations. MSHN complies with the published standard reporting 164.33 FTEs Homebased therapists and staff for FY24. MSHN's FY24 Ratio:

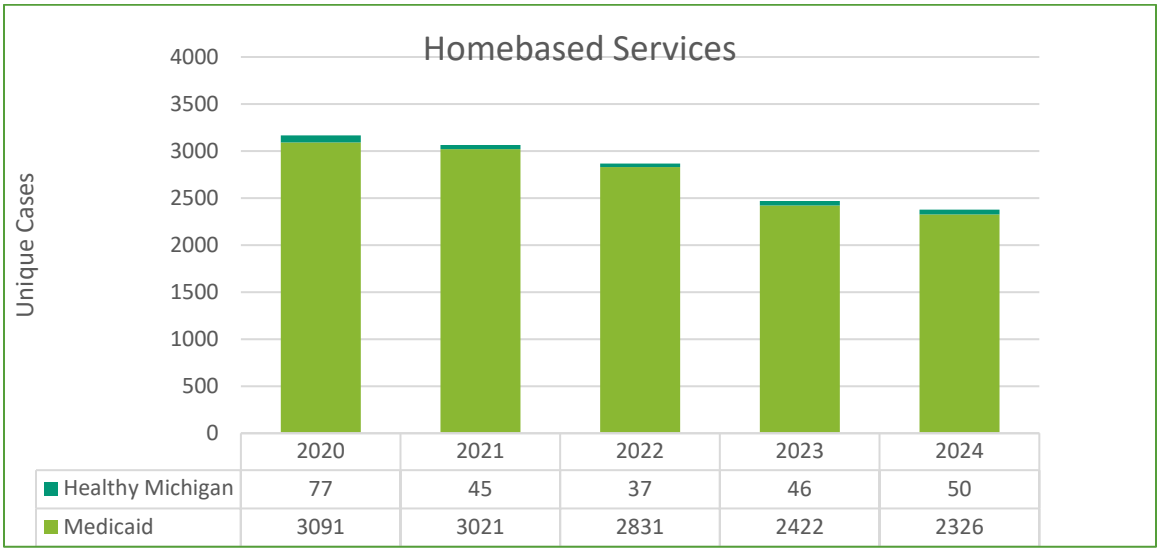
328,455 Total Children Medicaid Enrollees to 164.33, which just meets the required ratio of 164.23 FTEs. As of March 2025, MSHN's Average Children Enrollees = 146,358, therefore, future planning would only require 73.12 FTE's.

In April 2023, the CMHSPs underwent Home-Based program approvals through the MiCAL Customer Relations Management (CRM) system. Each CMH entered their information relative to the characteristics of their programs and MSHN reviewed these elements to ensure consistency with Home-Based program requirements. When complete, each online application was then shared with MDHHS for final review.

The MSHN partner CMHSPs have 13 Home-Based programs (LifeWays CMH operates two Home-Based programs), and of those 13, one (Montcalm) continues under provisional status. Provisional approval is given when a program is not fully meeting all Home-Based program standards, and they are given six months to implement corrective action to bring the program into compliance. MDHHS will then schedule a follow-up meeting to explore progress.

The Right Door (Ionia), LifeWays (New Direction), Montcalm, and Newaygo CMH each received provisional approval, affecting four total programs. Of these four CMHSPs, The Right Door (Ionia), LifeWays (New Direction), and Newaygo all came into compliance. The remaining CMHSP, Montcalm Care Network (Montcalm) remains under provisional status due to short-staffing situation, resulting in caseload ratios exceeding the acceptable standard of 12:1 (or 15:1 if there are families transitioning out of Home-Based services). They have also continued to institute a corrective action plan to ameliorate the deficit through case review and determining whether families are ready for program discharge, posting position availability at multiple sites and with universities, as well as enhanced loan forgiveness, competitive pay, staff support (I.e. culture of support), and internship program development.

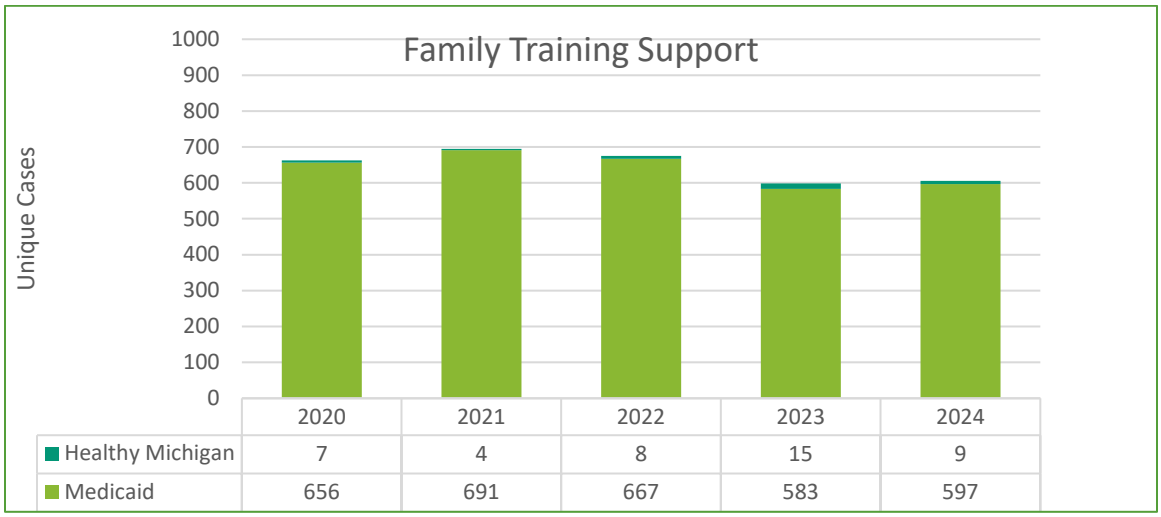
Figure 16: Homebased Services



Homebased Services: Family Training Support

Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance, or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services.

Figure 17: Family Training Support



Homebased Services: Wraparound

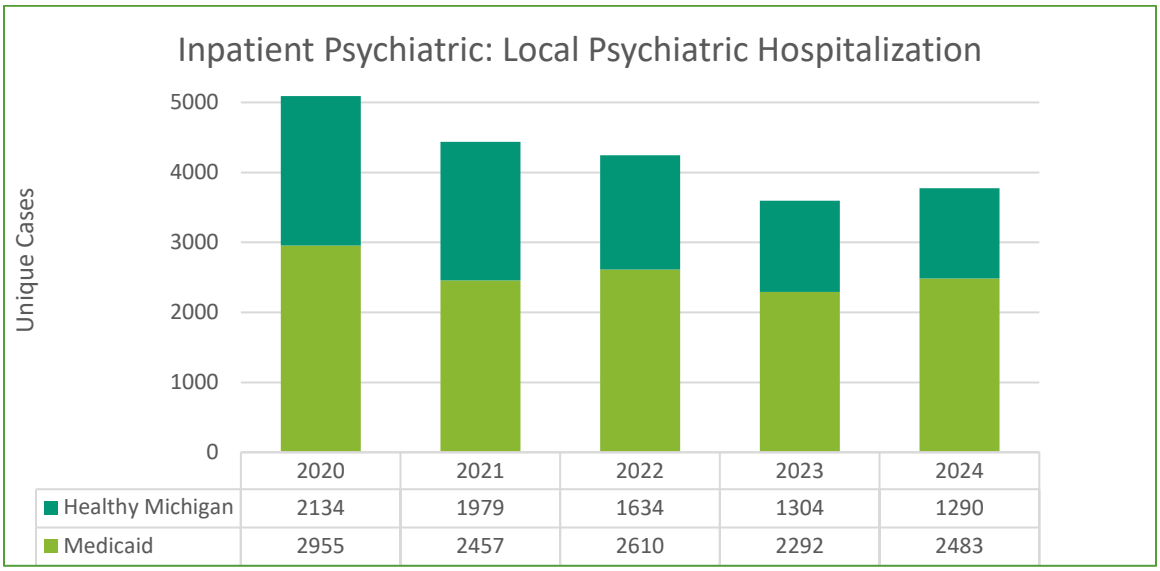
Wraparound services for children and adolescents are highly individualized planning processes facilitated by specialized supports coordinators. **MDHHS has an established adequacy standard (5,000:1 Enrollee to Provider Ratio).** Wraparound services are verified through provider enrollment information to ensure compliance with educational standards of licensure and FTE designations. **MSHN's FY24 Ratio: 328,455 Total Children Medicaid Enrollees to 46.8 FTEs, which DOES NOT meet the required 65.69 FTEs. FY24 Average Children Medicaid Enrollees ratio of 156,101, only requires 31.22 FTEs, indicating MSHN is in compliance with the average. As of March 2025, MSHN's Average Children Enrollees = 146,358, requiring only 29.27 FTEs to meet the standard, indicating continued compliance with the standard.**

Figure 18: Wraparound

Inpatient Psychiatric - Local Psychiatric Hospital

Any community-based hospital that CMHSPs contract with to provide inpatient psychiatric services. Like other PIHPs in the state, MSHN continues to encounter challenges in gaining timely access to psychiatric inpatient and autism services which meet the needs of all clinical populations served.

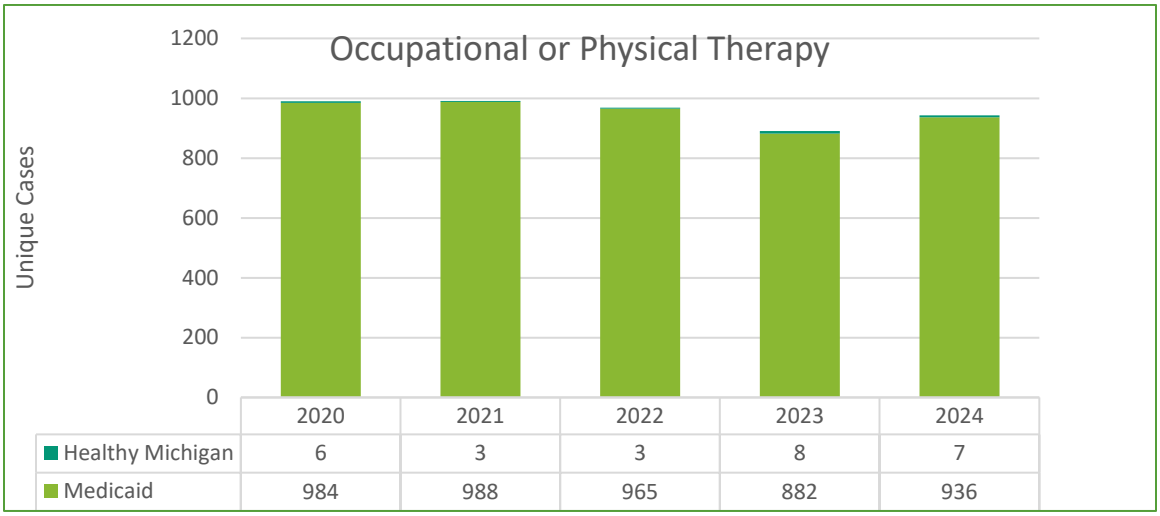
Figure 19: Inpatient Psychiatric: Local Psychiatric Hospitalization



Occupational or Physical Therapy

Occupational and habilitative services are services to help a person keep, learn, or improve skills and functioning for daily living.

Figure 20: Occupational or Physical Therapy

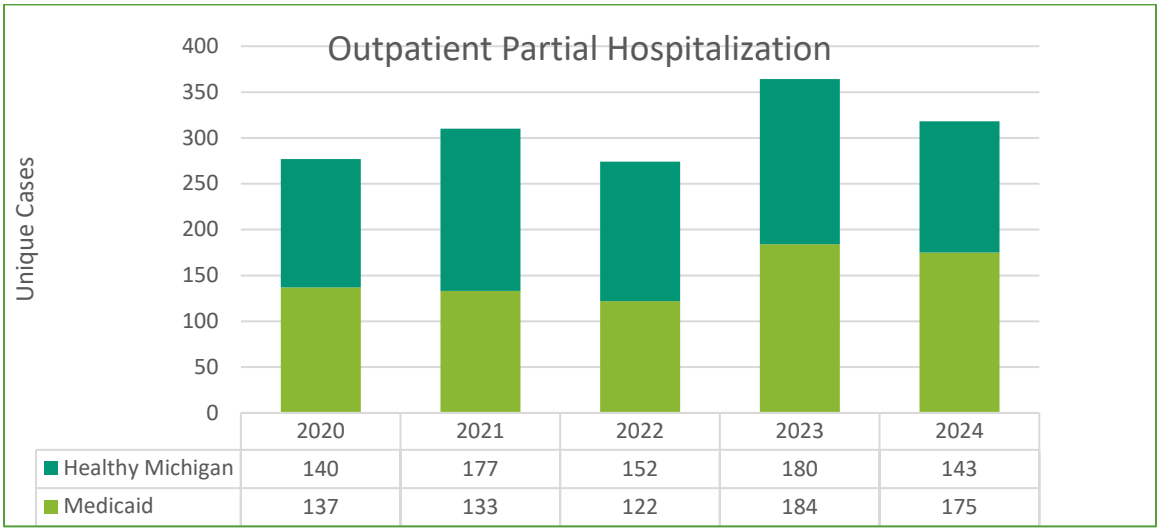


Outpatient Partial Hospitalization

Partial hospitalization is used when an individual does not meet the need for inpatient hospitalization but requires more than traditional outpatient mental health services. Partial hospitalization services may be used to treat an individual with a mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Services are provided more than six hours per day, five days per week. Partial hospitalization utilization went markedly up in 2019 due to the service becoming available to a number of MSHN CMHSPs; however, the increase was primarily attributed to two CMHSP participants utilizing this service. In 2023, increased usage is noted and is tied to a broader use by more of MSHN's CMHSPs. This has been influenced by new partial programs becoming available, using

partial as a means of diversion from inpatient hospitalization when appropriate, and a noted increase in marketing from the partial programs have all contributed to increased use of the service.

Figure 21: Outpatient Partial Hospitalization

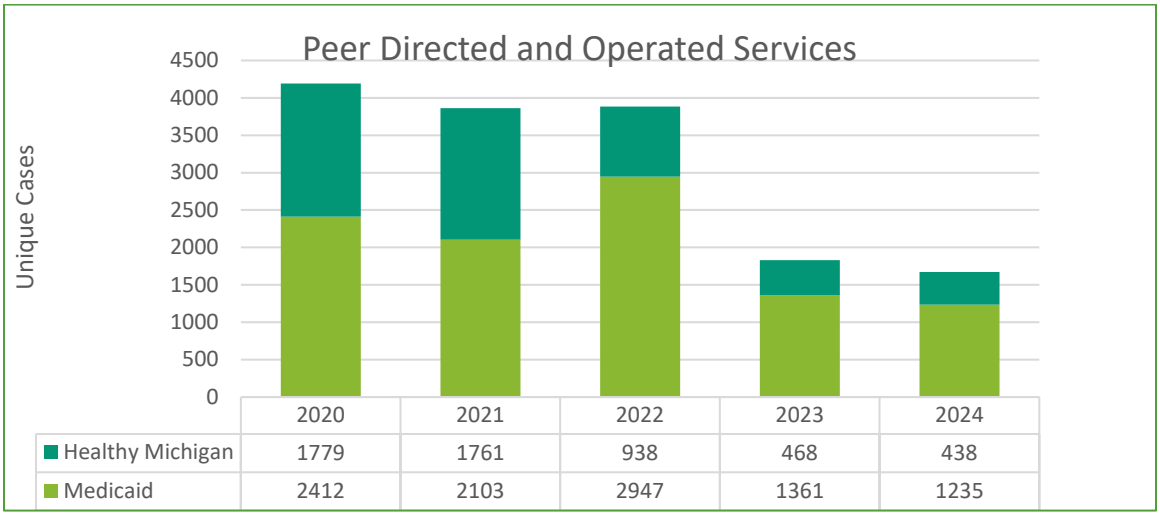


	2020	2021	2022	2023	2024
Healthy Michigan	140	177	152	180	143
Medicaid	137	133	122	184	175

Peer Directed and Operated Support Services

Peer directed services for youth and adults with mental illness and intellectual/developmental disabilities. Peer run drop-in centers are also included.

Figure 22: Peer Directed and Operated Support Services

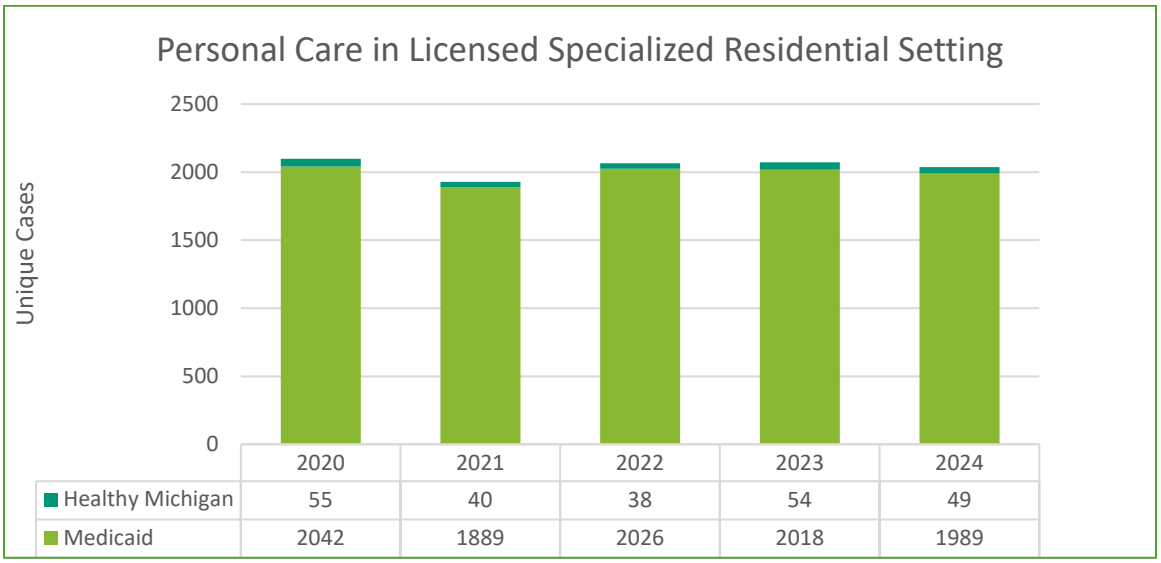


	2020	2021	2022	2023	2024
Healthy Michigan	1779	1761	938	468	438
Medicaid	2412	2103	2947	1361	1235

Personal Care in Licensed Specialized Residential Setting

Services to assist an individual with performing their own personal daily activities. The following are allowable: food preparation, feeding/eating, toileting, bathing, grooming, dressing, transferring, assistance with self-administered medication.

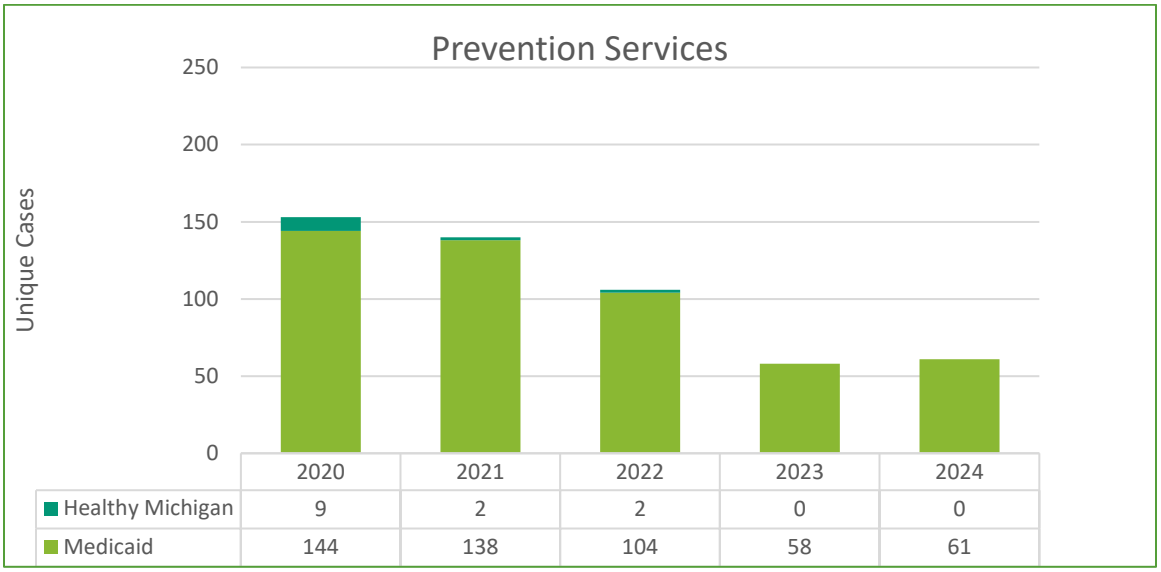
Figure 23: Personal Care in Licensed Specialized Residential Setting



Prevention Services

Services include school success, avoiding childcare expulsion, infant mental health, and parent education. There has been a continued decline in prevention services-direct model since the pandemic. The public mental health system can offer prevention services but there is no direction on how many or what types of services must be offered by the PIHPs. Additionally, some of these services are also identified in the Medicaid Provider Manual as "…a State Plan EPSDT service when delivered to children birth-21 years." In FY24, there was a greater emphasis on connecting youth and families to EPSDT services. The CMHSPs have focused on their specialty services especially due to staffing issues.

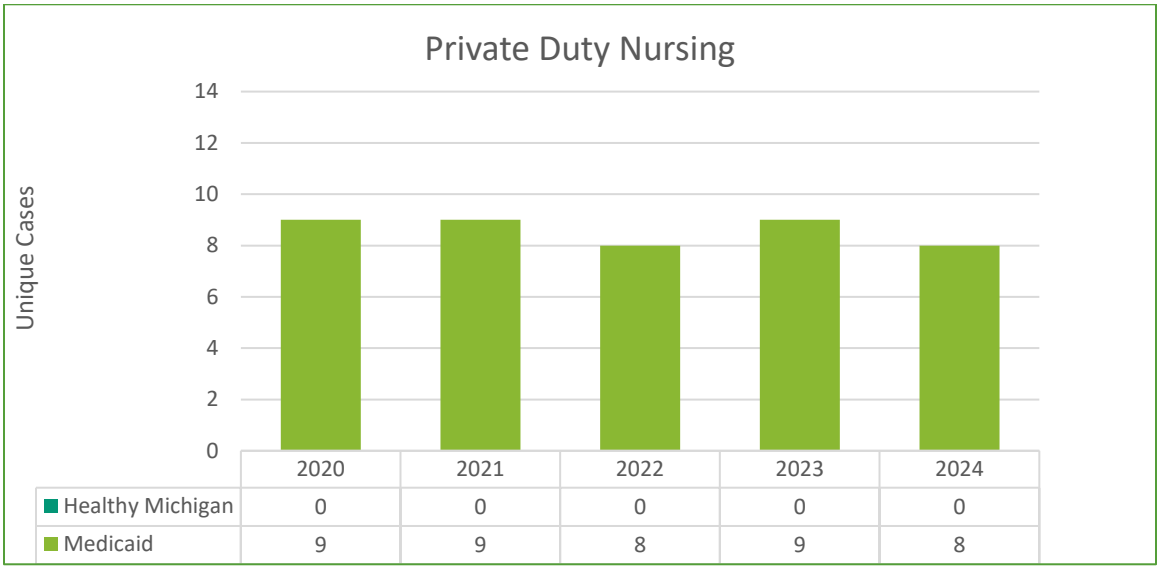
Figure 24: Prevention Services



Private Duty Nursing

Private Duty Nursing is defined as nursing services for beneficiaries who require more individual and continuous care, in contrast to part-time or intermittent care, than is available under the home health benefit.

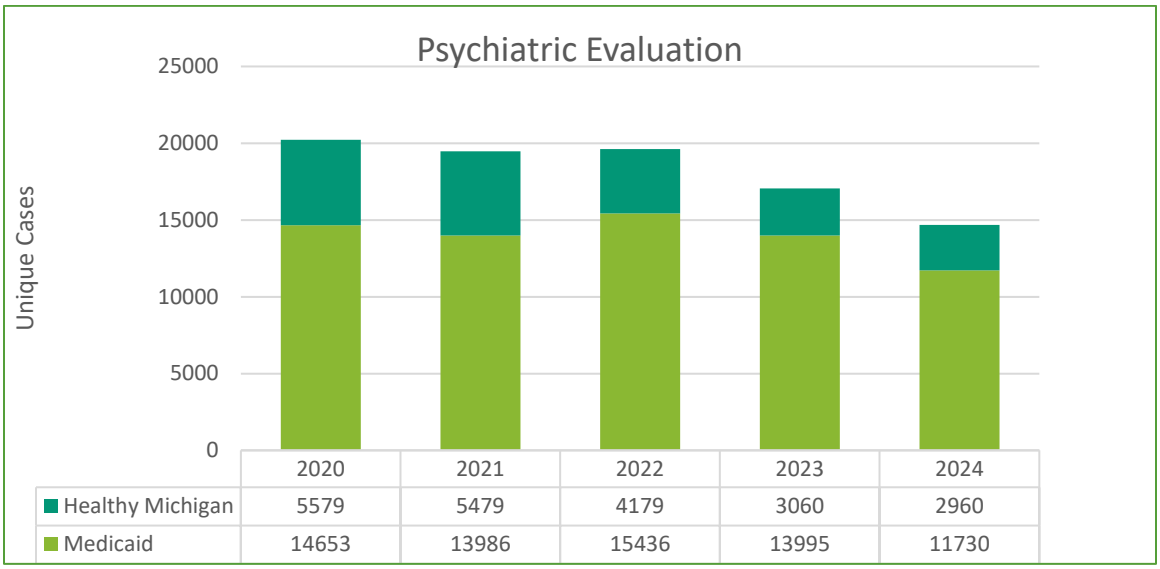
Figure 25: Private Duty Nursing



Psychiatric Evaluation and Medication

A comprehensive evaluation performed face-to-face by a psychiatrist, psychiatric mental health nurse practitioner, or appropriately trained clinical nurse specialist that investigates a beneficiary's clinical status, including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination.

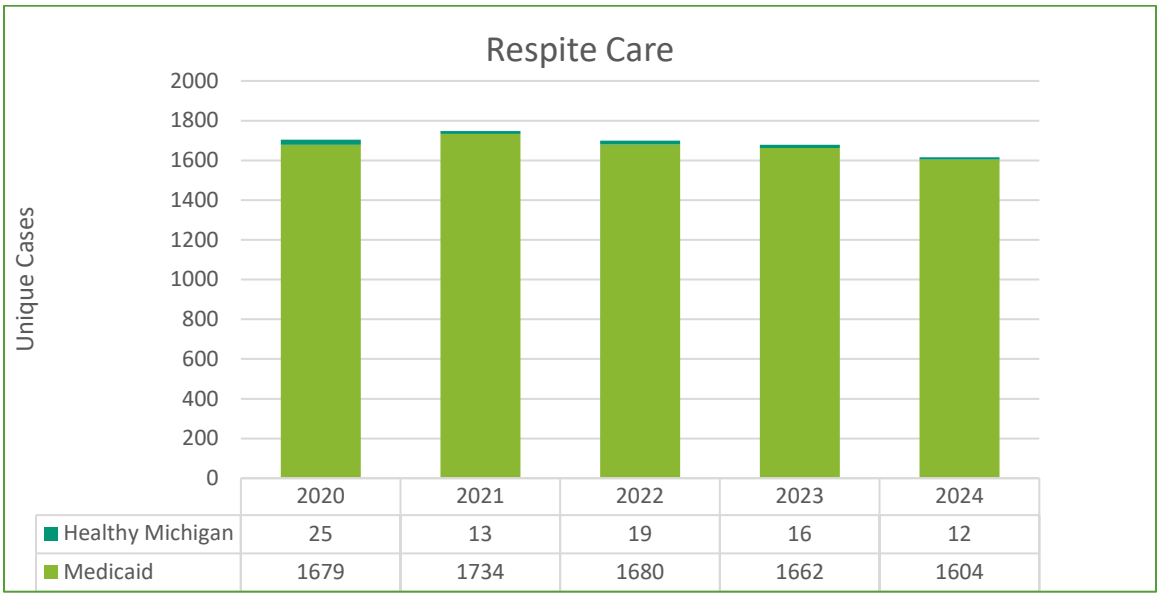
Figure 26: Psychiatric Evaluation



Respite

This includes daily respite care in out-of-home and in-home settings as well as therapeutic camping. **MDHHS does not currently have an established adequacy standard, however in FY24, MDHHS added required reporting of monthly average FTEs for direct care workers and total number of facility-based provider beds as informational only. MSHN reported 217.63 monthly average respite FTEs and 9-12 facility-based respite bed count.**

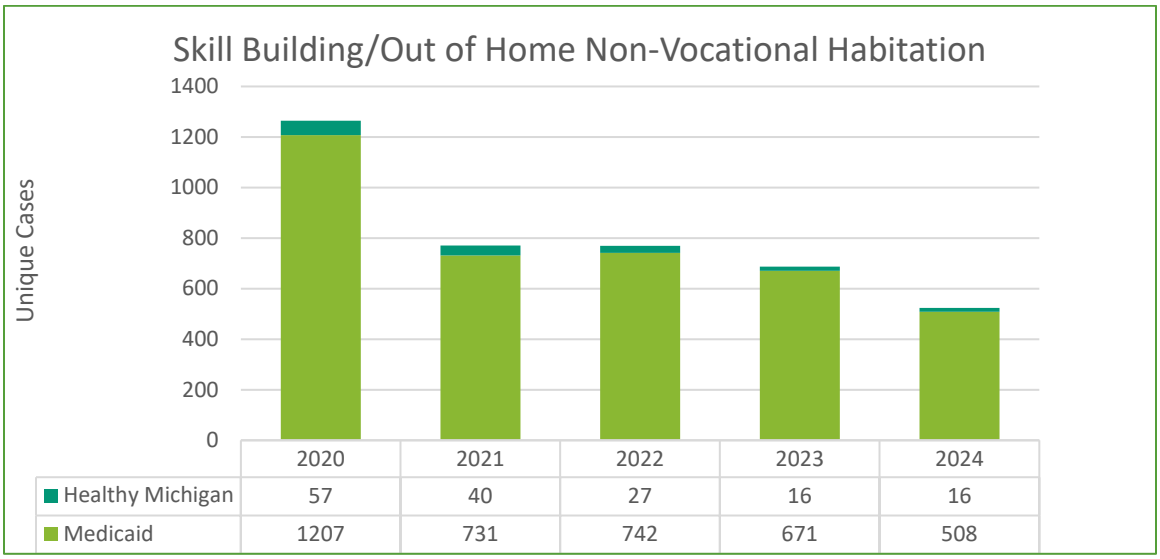
Figure 27: Respite



Skill Building/Out-of-Home Non-Vocational Habilitation

Skill-building assists a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. Since 2019, there has been a dramatic drop in use of skill building/out of home non-vocational habilitation services. This has been due to many different reasons, including HCBS Rule transition, pandemic effects (telehealth and staffing shortages), Medicaid changes relative to skill building being a time-limited service, shifts out of skill building due to medical necessity reviews and advancing to supported/integrated employment, and individual case reviews on whether services were in the community and the type of programming received.

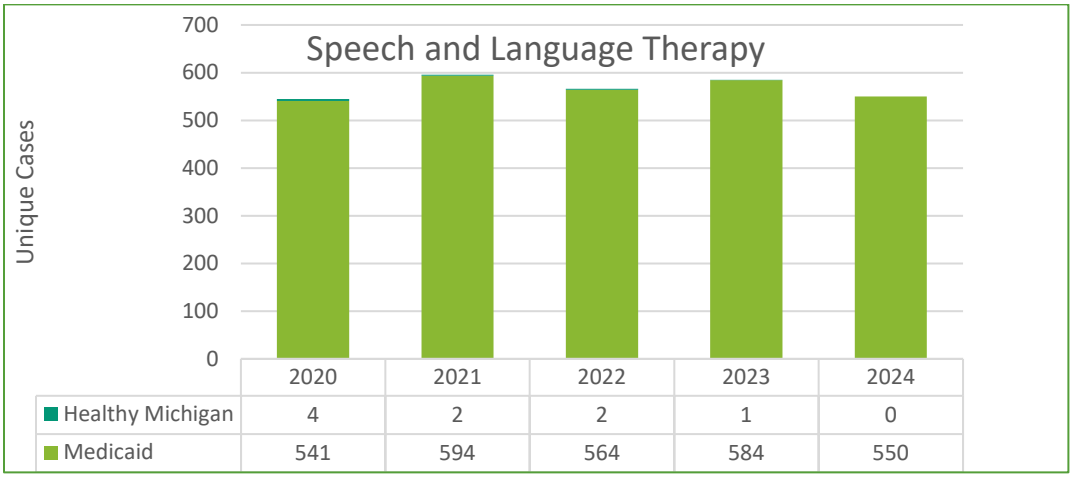
Figure 28: Skill Building/Out of Home Non-Vocational Habilitation



Speech and Language Therapy

Services include: Group therapy provided in a group of two to eight beneficiaries, articulation, language, and rhythm, swallowing dysfunction and/or oral function for feeding, voice therapy, speech, language or hearing therapy, speech reading/aural rehabilitation, esophageal speech training therapy, speech defect corrective therapy, fitting and testing of hearing aids or other communication devices.

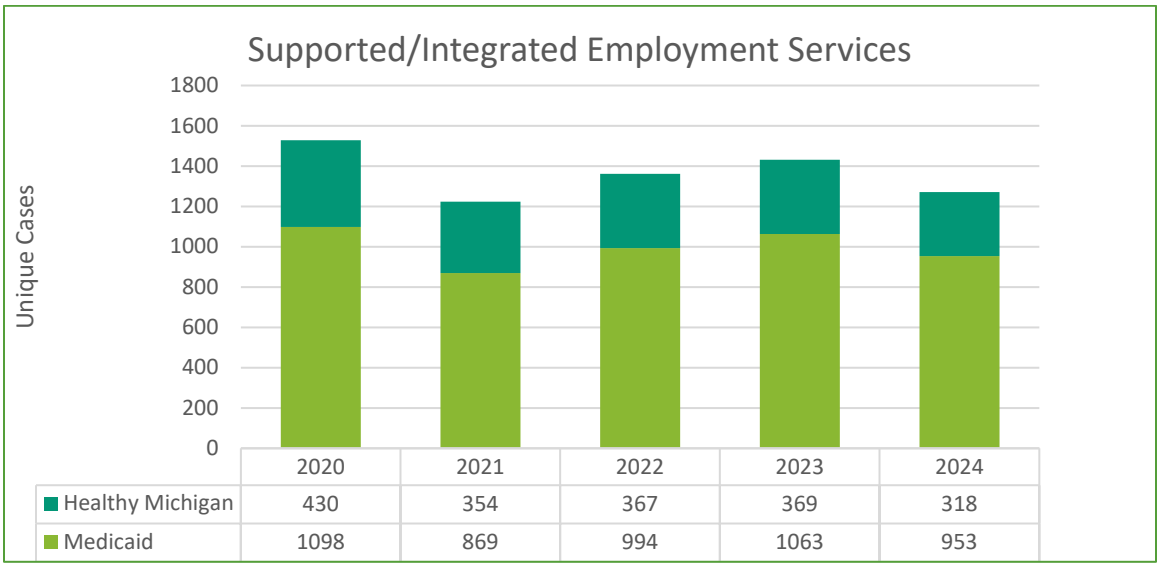
Figure 29: Speech and Language Therapy



Supported Employment Services

Supported employment is the combination of ongoing support services and paid employment that enables an individual to work in the community.

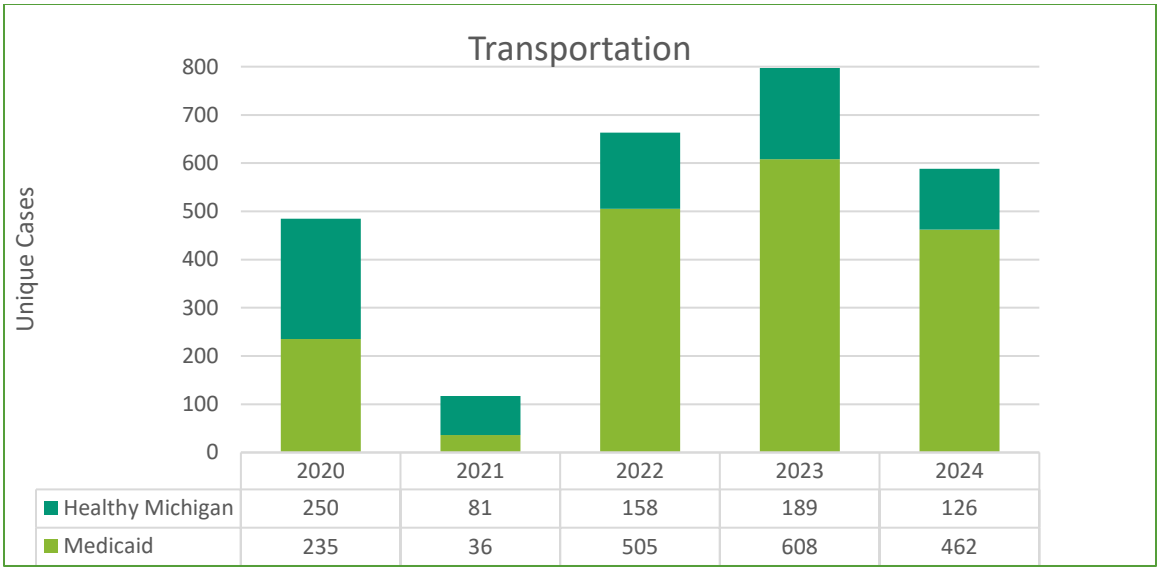
Figure 30: Supported/Integrated Employment Services



Transportation

Transportation is used to transport individuals to/from services other than daytime activity, skill building, clubhouse, supported employment, or community living activities. Transportation has been on the increase since the low point in 2021, principally affected by the pandemic. However, MSHN CMHSPs have been using transportation more. Explanations include where some providers separated transportation out from bundled rates, as well as improved fleet vehicle counts due to beneficiary surveys showing transportation to services as a major barrier to service access.

Figure 31: Transportation

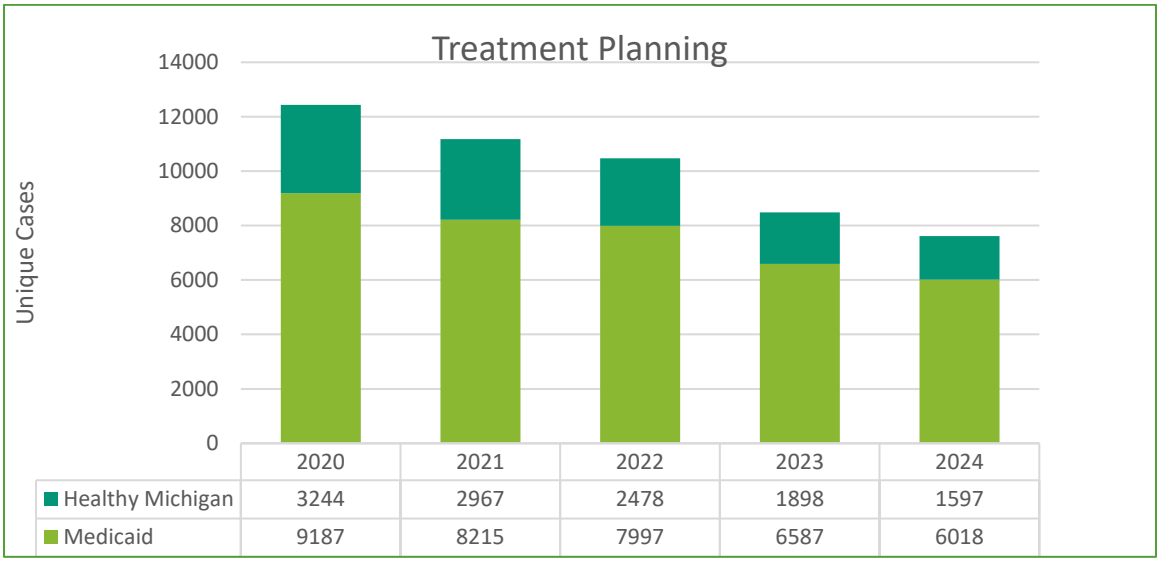


Treatment Planning

Activities associated with developing an individual's plan of service. Also included is writing goals and objectives, measurement and monitoring goals and attending person centered planning meetings. There

has been a progressive decrease in the use of the treatment planning code. The MDHHS EDIT group has clarified use of this code and how reporting has changed and staff often use other codes as required. This has been connected to the use of other codes, such as the T1017 (case management) or home-based, etc. It appears through this transition of code use, the treatment planning code has experienced a drop as services like case management and home-based have increased.

Figure 32: Treatment Planning

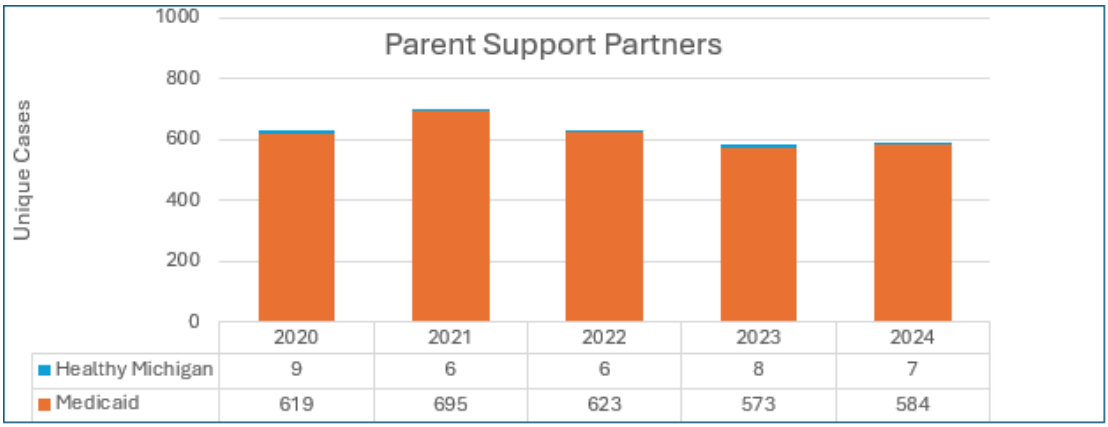


Parent Support Partners

The Parent Support Partner (PSP) Medicaid service is an intervention-based approach to support families whose children receive services through a community mental health service provider.

The purpose of the Parent Support Partner Project or service is to increase family involvement and engagement within the mental health treatment process and to equip parents with the skills necessary to address the challenges of raising a youth with special needs thus improving outcomes for youth with SED, serious emotional disturbance or intellectual/developmental or I/DD, involved with the public mental health system. **MDHHS does not currently have an established adequacy standard, however in FY24, MDHHS added required reporting of monthly average FTEs as informational only. MSHN reported 15.2 monthly average parent support partner FTEs.**

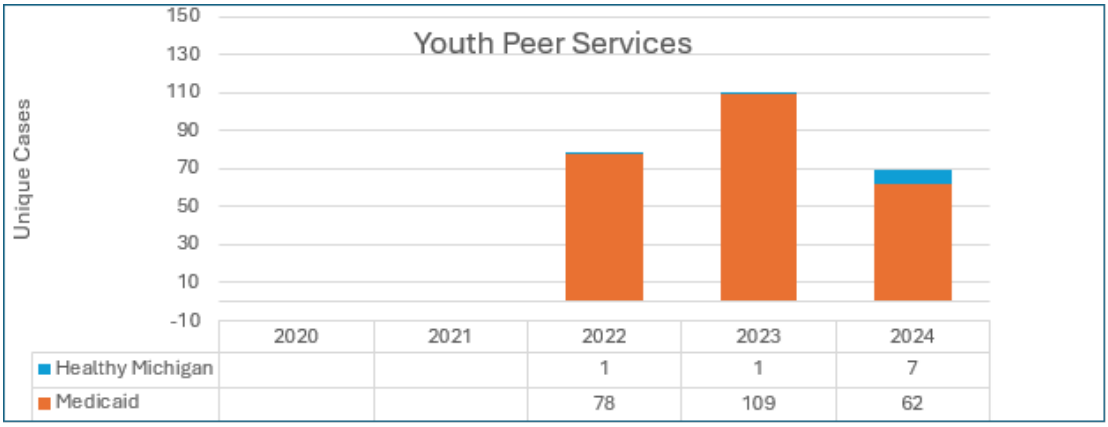
Figure 33: Parent Support Partners



Youth Peer Services

The Youth Peer Support Medicaid Service is designed to support youth with a serious emotional disturbance through shared activities and interventions, supporting youth empowerment, assisting youth in developing skills to improve their overall functioning and quality of life, and, working collaboratively with others involved in delivering the youth's care. **MDHHS does not currently have an established adequacy standard, however in FY24, MDHHS added required reporting of monthly average FTEs as informational only. MSHN reported 5.6 monthly average youth peer supports FTEs.**

Figure 34: Youth Peer Services



Single Case Agreements

During FY24, the CMHSPs contracted out via single case agreements approximately for 211 services down from 526 services in FY23, with the majority of SCA's (60%) for inpatient services. MSHN utilizes the analysis of SCA's to determine adequacy capacity within region. As noted above under crisis services, MSHN is expanding its capacity to address areas of need. There has been a large increase in use of SCAs for inpatient due to hospitals demanding them and refusing to accept the non-contract rate. These are established where there is no existing contract. Another significant contributor to an increase in SCAs includes local hospitals denying admissions requests and the CMHSPs responding by looking to other, further away facilities to ensure proper care availability is covered. There were several meetings scheduled with hospitals to establish contracts which has demonstrated a decrease in the use of SCAs for inpatient in FY24.

Table 2:

Single Case Agreements for FY24

Inpatient	127	60%
Crisis Residential	5	2%
Partial Hosp	15	7%
Other	64	30%
Total	211	100%

Evidence Based Practices – Mental Health

Each CMHSP Participant provides selected specialty services or treatments based upon evidence-based practice models they have adopted in accordance with local needs. Table 3 lists many evidence-based (or best) practices currently offered by CMHSP participants in the region. CMHSPs continue to implement Evidence Based Practices (EBPs).

Table 3: Evidence Based Practices Utilized by CMHSP Participants in the MSHN Region

	Pop.	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Alternative for Families CBT	Families in Danger of Physical Violence										X		
Applied Behavioral Analysis	I/DD-Autism	X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Auricular Acupuncture (NADA Protocol)	Dual SUD/MIA				X						X		
Brief Behavior Activation Therapy	Adults w Depression			X									
Brief Strategic Family Therapy	Families			X	X								
Clubhouse	MIA	X	X	X				X	X		X		
Child Parent Psycho Therapy	Young Children	X	X	X				X	X		X		
Cognitive Behavioral Therapy	All	X	X	X	X	X	X	X	X	X	X	X	X
DASH (Dietary Approaches to Stop Hypertension) Diet	MIA		X						X		X		
Dialectical Behavioral Therapy	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Eye Movement Desensitization	PTSD	X	X		X		X	X	X	X	X	X	X
Family Psychoeducation	Families	X	X	X	X	X	X	X	X		X	X	X
Infant Mental Health	Parents	X	X	X	X	X	X	X	X	X	X	X	X
Integrated Dual-Diagnosed Treatment	Dual SUD/MIA	X	X	X		X	X	X	X	X	X		X
Mobile Urgent Treatment Team	Families	X	X	X	X	X	X		X		X	X	X
Motivational Interviewing	All	X	X	X	X	X	X	x	X	X	X	X	X
Multi-Systemic Therapy	Juvenile offenders			X				X					
Nurturing Parenting Program	Parents			X									
Parent-Child Interaction Therapy	Parents		X	X					X				
Parent Mgt Training – Oregon Model	Parents	X	X	X	X	X	X				X		X
Parent Support Partners	Parent		X	X	X		X	X		X	X	X	X
Parenting Through Change	Parents	X	X	X	X		X		X		X	X	X
Parenting Through Change-R	Parents		X								X		X
Parenting Wisely	Parents							X					

Parenting with Love and Limits	Parents	X											
Peer Mentors	I/DD	X	X									X	
Peer Support Specialists	MIA	X	X	X	X	X	X	X	X	X	X	X	X
Picture Exchange Communication System	I/DD-Autism	X					X				X		X
Positive Living Supports	I/DD	X	X		X	X							
Prolonged Exposure Therapy	Adults w PTSD	X		X	X	X			X			X	
Resource Parent Trauma Training	Parents										X	X	
Schema-Focused Therapy	Couples												
Seeking Safety Trauma Group	SUD & PTSD	X	X	X			X		X		X		X
Self-Management and Recovery Training	MIA, SUD	X											
SOGI Safe	All										X		
Supported Employment	Adults	X	X	X	X	X	X	X	X	X	X	X	X
Transition Independence Process Model (TIP)							X						
Trauma Focused CBT	Children	X	X	X	X	X	X	X	X	X	X	X	X
Trauma Recovery Empowerment Model	Adults			X	X						X		
Whole Health Action Management	Adults		X	X	X				X	X	x		
Wellness Recovery Action Planning	Adults	X	X	X	X			X	X		X		
Wraparound	SED Families	X	X	X	X	X	X	X	X	X	X	X	X
Youth Peer Support			X				X	x		X	X	X	X

Autism Services (EPSDT)

Michigan Medicaid Autism services provides children from birth to 21 years of age who have a medical diagnosis of Autism Spectrum Disorder (ASD) with Applied Behavioral Analysis (ABA) services. Services are contracted or directly delivered by the CMHSP Participants as shown in Table 4.

Table 4: Autism Services Available in the MSHN Provider Network

	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Screening Referral	Performed by pediatrician or family physician as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Service											
Comprehensive Diagnostic Evaluation	X	X	X	X	X	X	X	X	X	X	X	X
Determination of Eligibility	X	X	X	X	X	X	X	X	X	X	X	X
Behavioral Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Behavioral Intervention	X	X	X	X	X	X	X	X	X	X	X	X
Behavioral Observation and Direction	X	X	X	X	X	X	X	X	X	X	X	X

MDHHS expanded eligibility for Autism services to age 21 effective January 2016. Since the MSHN region had encountered difficulties previously in meeting the existing demand for services by children aged 18 months through 5 years, there was concern across the region's CMHSP Participants regarding the adequacy of the network's capacity to absorb such a marked increase in demand for these specialized services with limited qualified professionals in local job markets. MSHN and its CMHSP Participants have been successful in increasing BHT/ABA provider capacity. Table 5 shows the growth in volumes for Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) services as demand has notably

risen for these Medicaid services. As the region continues to work to increase network capacity to address current growth and needs for autism services, there are significant threats to availability of qualified providers of autism services for FY25. Those threats include: Ending of Qualified Behavioral Health Professional (QBHP) allowance 9.30.2025, emphasis on use of Board Certified Behavior Analysts (BCBAs) for writing of behavior treatment plans for all individuals served, proposal to include and allow for Medicaid Autism Services to be provided within the identified school day, and advocacy for removal of the age cap of 21 for autism services.

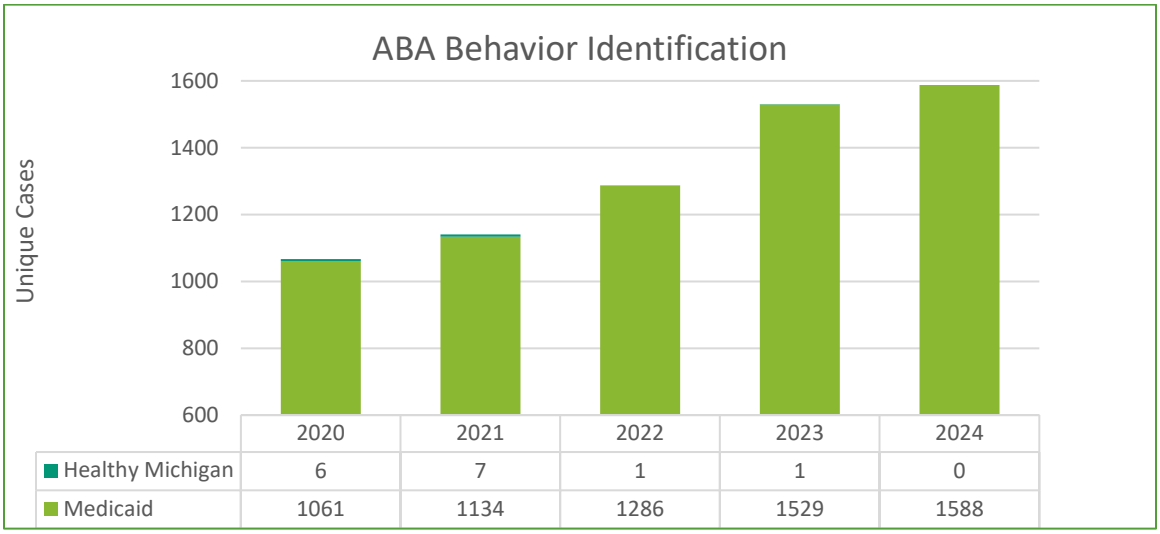
Table 5: Individuals Served by CMHSPs with Autism Spectrum Disorders and ABA Service Utilization

	FY20		FY21		FY22		FY23		FY24	
	ASD diagnosis	Enrolled in the BHT Benefit	ASD diagnosis	Enrolled in the BHT Benefit	ASD diagnosis	Enrolled in the BHT Benefit	ASD diagnosis	Enrolled in the BHT Benefit	ASD diagnosis	Receiving Autism Services
BABH	248	108	290	135	379	146	444	199	515	204
CEI	714	365	862	423	958	444	1,088	471	1,169	510
CMHCM	578	190	685	273	792	336	851	382	915	416
GIHN	122	64	131	67	146	64	151	71	175	71
HBH	47	8	57	14	88	20	100	14	88	15
LCMHA	535	242	604	274	615	252	669	288	718	348
MCN	194	79	239	89	308	111	369	151	394	87
NCMH	97	14	119	14	137	12	132	19	145	27
SCCMHA	566	203	667	239	850	269	862	311	930	311
SHW	122	31	158	57	201	66	222	84	197	97
TBHS	97	37	118	52	157	33	148	58	237	59
TRD	124	30	145	26	170	59	198	37	160	52
MSHN	**3,444**	**1371**	**4075**	**1663**	**4801**	**1812**	**5,234**	**2,085**	**5,643**	**2197**

ABA Behavior Identification

Behavior identification assessment by a qualified provider face to face with the individual and caregiver(s); includes interpretation of results and development of the behavioral plan of care. In 2019, there were additional ABA codes added, so the ABA Behavioral Follow-Up Assessment began to be billed, likely reducing the number of ABA Behavioral Identification Assessment codes.

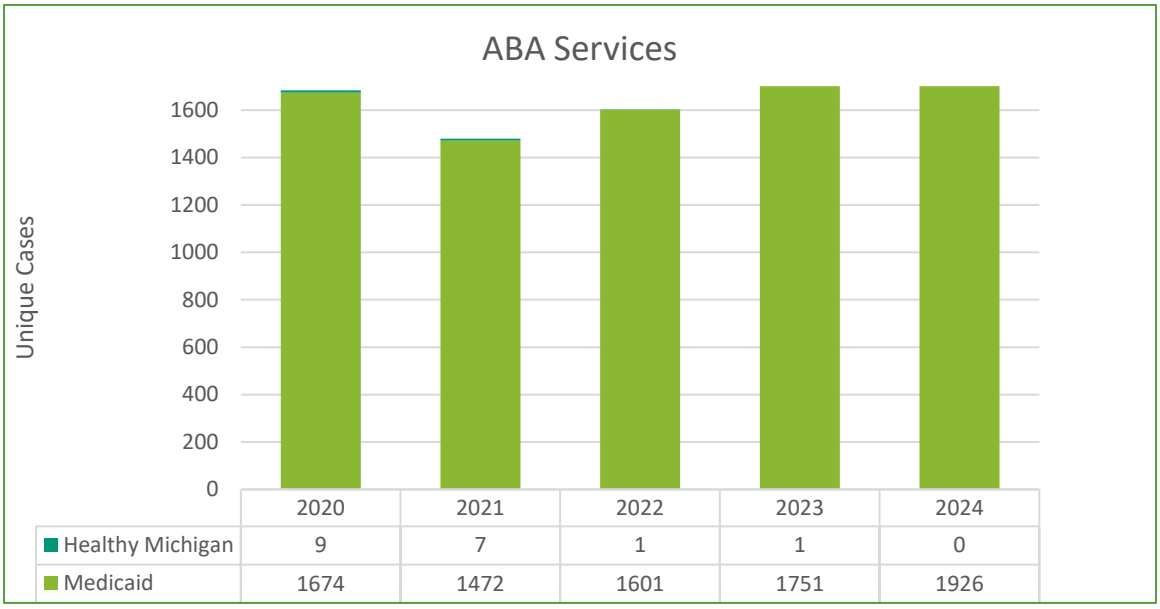
Figure 35: ABA Behavior Identification



Comprehensive Diagnostic Evaluations

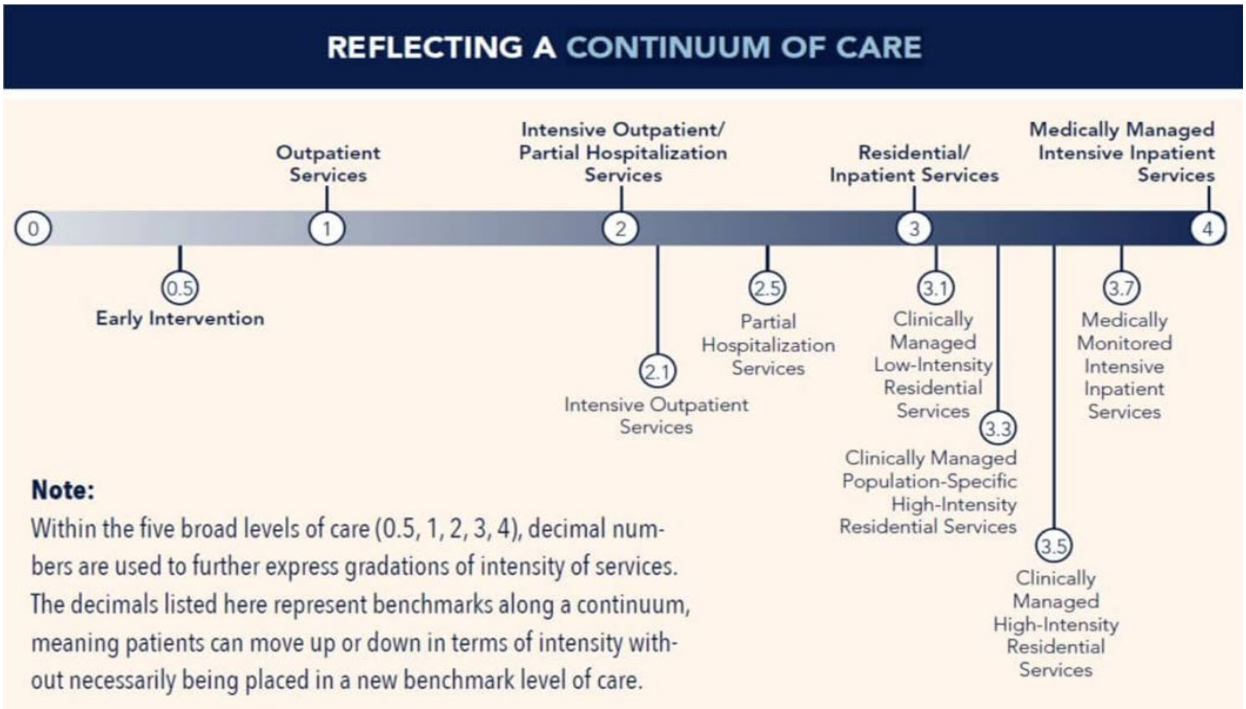
Services include non-medical assessments, psychological testing, and mental health assessments by non-physicians.

Figure 36: ABA Other Services



Substance Use Disorder Services

Table 11 on page 37 shows the array of services for treatment of substance use disorders and which services are delivered by SUD Providers under the auspices of their contracts with MSHN. MDHHS enrolls providers based upon the intensity of services offered. The intensities correspond to the frequency and duration of services established by the American Society of Addiction Medicine (ASAM) levels of care, as shown below.



Level 0.5: Early Intervention. Professional services for early intervention constitutes a service for specific individuals who, for a known reason, are at risk of developing substance-related problems or for those for whom there is not yet sufficient information to document a substance use disorder.

Level I: Outpatient Treatment. Level I encompasses organized, non-residential services, which may be delivered in a wide variety of settings.

Level II: Intensive Outpatient Treatment/Partial Hospitalization. Level II is an organized outpatient service that delivers treatment services during the day, before or after work or school, in the evening or on weekends.

Level III: Residential/Inpatient Treatment. Level III encompasses organized services staffed by designated addiction treatment and mental health personnel who provide a planned regimen of care in a 24hour live- in- setting.

Level IV: Medically Managed Intensive Inpatient Treatment. Level IV programs provide a planned regimen of 24-hour medically directed evaluation, care and treatment of mental and substance-related disorders in an acute care inpatient setting.

ASAM Level of Care Analysis

Adolescent ASAM Level Detail: 00-17 years-of-age at time of service

Unduplicated count of adolescents served by ASAM Level

Table 6: This displays the unduplicated number of adolescents (00-17) that were served at each ASAM level of care. Note that an individual may be counted in each ASAM level of care within the same fiscal year. Also note that the ASAM levels displayed are the only ASAM levels that services were provided for in the displayed fiscal year, if another ASAM level service was provided it would be displayed; no ASAM levels were excluded from the report, therefore all levels are reported. The displayed ASAM levels do not mean that other ASAM levels are not available to the adolescent population.

Fiscal Year	ASAM Level	Unduplicated Individuals
2021	1.0 Outpatient	37
2021	3.5 Clinically-Managed High Intensity Residential	23
2022	1.0 Outpatient	25
2022	3.5 Clinically-Managed High Intensity Residential	14
2023	1.0 Outpatient	48
2023	3.5 Clinically-Managed High Intensity Residential	11
2024	1.0 Outpatient	77
2024	3.5 Clinically-Managed High Intensity Residential	13

Table 6: Data source – MSHN Encounters; REMI backup ASAM tables

Unduplicated Count of adolescents served

Table 7: This displays the unduplicated number of adolescents (00-17) that were served within each fiscal year. This was calculated by looking at the distinct count of case numbers for individuals under the age of 18 at the time of service that received a service within the respective fiscal year.

Fiscal Year	Unduplicated Individuals
2021	50
2022	34
2023	59
2024	88

Table 7: Data source – MSHN Encounters

Findings: There were no Single Case Agreements (SCA) for an individual under the age of 18 for MSHN during the 2021 - 2024 fiscal years (Data source: Provider Network – Contracts). Though MSHN did not receive any SCA requests for adolescent services, we recognize that several of the counties in the region do not have a provider with services designated for the adolescent population. Per the MDHHS NAA response (November 2022), MSHN is in need of adding the adolescent ASAM levels of care for residential 3.1 and 3.7, as well as 3.2 withdrawal management, to be in compliance. At present, these adolescent ASAM levels of care do not exist within the State of Michigan with existing SUD treatment providers. This is an area that has been discussed with MDHHS-Substance Use, Gambling and Epidemiology (SUGE) and the SUD Directors workgroup. A primary challenge to supporting the adolescent services across the State has been the low level of utilization by this population, which does not translate to sustainability for providers who support the programs. MSHN supported a Request for Proposal (RFP) to add/expand adolescent SUD services across the region in FY24. The RFP included the ASAM LOC's for residential (3.1 and 3.7), withdrawal management (3.2), and outpatient (0.5, 1.0, 2.1). MSHN was successful in identifying one provider to support expanded SUD outpatient services in 7 additional counties.

As an additional note, the area of SUD early intervention services (ASAM 0.5 LOC) is also supported via the regional SUD prevention provider network with a variety of evidence-based curriculums that are provided to schools and communities across the region. The number of adolescents supported with this type of intervention is harder to discern as the Michigan Prevention Data System (MPDS) system is utilized to track this data. In FY24, the MSHN SUD prevention providers supported approximately 8,360 activities in the MSHN region directed toward youth and adolescents ages 0-17 years.

Table 8: Substance Use Disorder Services Available in the MSHN Provider Network - Adolescents

County	Outpatient				Residential				Withdrawal Mgt.	
	0.5	1.0	2.1	2.5	3.1	3.3	3.5	3.7	3.2	3.7
Arenac										
Bay	X	X*								
Clare		X*								
Clinton		X								
Eaton		X*	X							
Gladwin		X*								
Gratiot										
Hillsdale										
Huron	X	X*								
Ingham		X*								
Ionia		X								
Isabella		X*								
Jackson	X	X	X							
Mecosta										
Midland		X*								
Montcalm		X*	X							
Newaygo	X	X								
Osceola										
Saginaw	X	X*								

Shiawassee		X*								
Tuscola	X	X	X							
Out of Network	X	X*	X	X	X		X			
*OP Program offer MAT (Suboxone/Vivitrol)										

Adult ASAM Level Detail: 18+ years-of-age at time of service

Unduplicated count of adults served by ASAM Level

Table 9: This displays the unduplicated number of adults (18+) that were served at each ASAM level. Note that an individual may be counted in each ASAM level within the same fiscal year. Also note that the ASAM levels displayed are the only ASAM levels that services were provided for in the displayed fiscal year, if another ASAM level service was provided it would be displayed; no ASAM levels were excluded from the report.

ASAM Level	Unduplicated Individuals			
	FY 2021	FY 2022	FY 2023	FY 2024
1.0 Outpatient	4375	3926	3908	2763
1.0 Outpatient: Medication Assisted Treatment	3737	3505	3301	2816
2.1 Intensive Outpatient	434	408	469	331
2.5 Partial Hospitalization	43	33	50	36
3.1 Clinically-Managed Low Intensity Residential	573	598	611	479
3.2 Clinically-Managed Withdrawal Management	51	50	64	57
3.3 Clinically-Managed Population Specific	7	3	2	2
3.5 Clinically-Managed High Intensity Residential	2535	2442	2617	2029
3.7 Medically-Monitored Residential	29	24	17	11
3.7 Medically-Monitored Withdrawal Management	167	149	175	133

Table 9: Data source – MSHN Encounters; REMI backup ASAM tables

Adult Single Case Agreements by Fiscal Year

For SUD provider network services, a total of 95 single case agreements (SCA's) were utilized in FY23 and 39 SCA's for FY24.

Table 10:

Fiscal Year	Count of SCA's
2021	8
2022	21
2023	95
2024	39

The breakdown by level of care consists of:

FY22

1.0: 21

Findings: Based on the number of single case agreements (SCA's) in FY22 for 1.0 Outpatient Services, MSHN continued the efforts to expand outpatient capacity within the region as noted in the FY22 Follow up on Recommendations and Updates - 1a.

FY23

1.0: 89 (Bear River)

3.5: 6 (Ascension Eastwood)

Findings: During FY23, MSHN observed an increase in requests for individuals to continue treatment at Bear River Health for services like ASAM 1.0 LOC, that MSHN did not previously contract for with this provider. MSHN has sufficient network adequacy for ASAM 1.0 LOC services within its geographic region as demonstrated by previous time and distance standards study outcomes, so therefore did not support this level of care in the majority of out of region providers. With the occurrence of the increased number of people in services requesting this level of care at Bear River, MSHN has worked with Bear River to expand their contracted services to support ASAM 1.0 LOC options for individuals who wish to relocate and support their pathway to recovery in that local area.

FY24

1.0: 20 (Bear River)

3.7 & 3.5: 4 (Ascension Eastwood)

3.1 & 3.5: 2 (Indiana Center for Recovery)

1.0: 13 (Sunrise Centre)

Findings: During FY24, MSHN observed a decrease in requests for individuals to receive ASAM 1.0 LOC services with Bear River Health. MSHN has sufficient network adequacy for ASAM 1.0 LOC services within its geographic region and worked with Bear River Health on discharge planning practices to ensure that individuals were connected to appropriate services in their home communities upon discharge from Bear River Health residential programs. MSHN observed an increase in requests for individuals to receive ASAM 1.0 LOC services with Sunrise Center. MSHN worked with Sunrise Centre to complete single case agreements for those individuals that requested to relocate to the Alpena area upon completion of residential treatment with Sunrise Centre.

Service Location:

The association of provider sites/services with levels of care will provide a framework for MSHN to understand the range of service options available across the region as it continues to expand its network and ensure access to all levels of care. Substance use disorder covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings, and via telehealth.

Table 11: Substance Use Disorder Services Available in the MSHN Provider Network - Adults

County	Outpatient				Residential				Withdrawal Mgt.		OTP	Women's Specialty Services	Recovery Housing	CCBHC - DCO	SUD - Health Home
	0.5	1.0	2.1	2.5	3.1	3.3	3.5	3.7	3.2	3.7	Level 1	D or E	III or IV	1.0	
Arenac	X	X*													
Bay	X	X*	X									D & E			X
Clare	X	X													
Clinton		X												X	
Eaton	X	X*	X									D		X	
Gladwin	X	X*													
Gratiot		X													
Hillsdale		X*					X					D		X	
Huron	X	X*													
Ingham	X	X*	X		X		X		X	X	X	E	X	X	X
Ionia		X*										D		X*	
Isabella	X	X*	X								X				X
Jackson	X	X*	X				X			X	X	E		X	X
Mecosta	X	X													
Midland	X	X*					X						X		
Montcalm		X*	X									D	X		
Newaygo	X	X*	X									D			
Osceola															
Saginaw	X	X*	X		X		X		X	X	X	D & E	X	X	X
Shiawassee		X*										E			
Tuscola	X	X*	X									D			
Out of Network	X	X*	X	X	X	X	X	X	X	X	X	D	X		X
*OP Program offer MAT (Suboxone/Vivitrol) D = Designated WSS Program E = Enhanced WSS Program															

Medicaid-covered services and supports must be provided, based on medical necessity, to eligible beneficiaries who reside in the region and request services. The Substance Use Disorder services below are authorized through MSHN. Much of the MSHN region is covered relative to the availability of outpatient services that often includes Medication for Opioid Use Disorder (MOUD), formerly referred to as Medication Assisted Treatment or MAT. However, the region continues to expand capacity as distance can be a barrier for consumers in need of services.

Though the opioid overdose epidemic saw declines in overdose rates for White residents of Region 5 in 2023, the death rates for Black men and Native Americans are rising. MSHN's attention to regional capacity persists, therefore, in providing broad access to withdrawal management services, Medication for Opioid Use Disorder (MOUD) including buprenorphine and naltrexone, and MOUD's associated

outpatient treatment and recovery supports. It should be noted that Substance Abuse and Mental Health Services Administration (SAMHSA)'s 42 Code of Federal Regulation (CFR) Part 8 Final Rule in 2024 requires a medication-first approach in which MOUD medications should not be contingent on negative drug screens or engagement in counseling. MSHN is working with its MOUD treatment providers to fully adopt these SAMHSA medications-first principles.

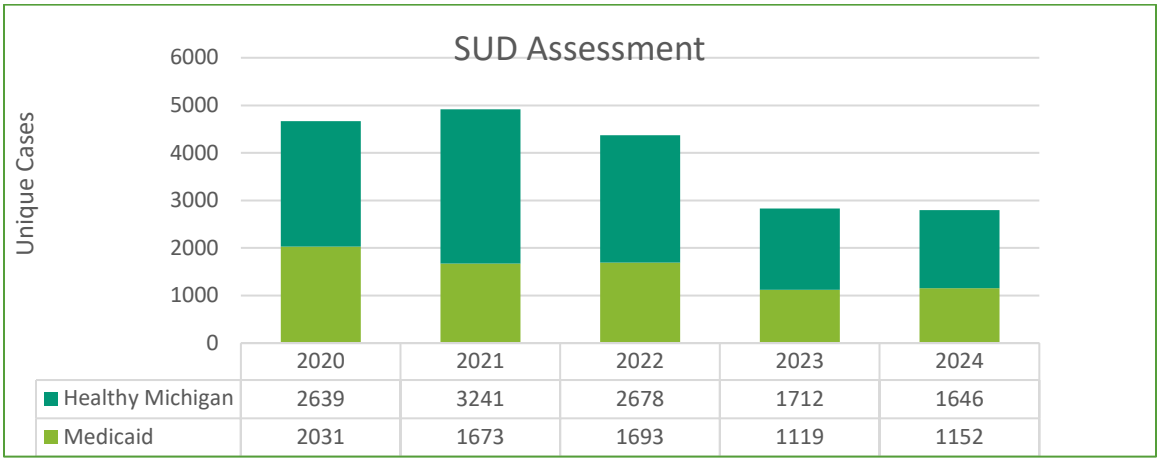
In some categories below, we saw a decline in penetration rates for SUD services across different levels of care which is likely related to the impact of the pandemic. First, the pandemic precipitated more closures of SUD treatment sites than at any time in MSHN's history. This was despite financial stabilization and other supports MSHN offered to keep prevention, treatment, and recovery providers afloat. In most cases, these supports sustained our network, but some providers withdrew from our provider network or closed entirely. Second, even those providers who stayed open have established procedures and reduced their capacity to accommodate social distancing which may not have fully returned to pre-pandemic levels and as COVID resurges along with RSV, Norovirus and other infectious diseases, maintaining safe distancing is likely a good safety measure. Third, existing providers have faced an ongoing struggle to attract, hire, and retain staff at all levels of support. The struggles with staff turnover and workforce deficits were a challenge prior to the pandemic but have escalated since the pandemic with providers communicating staff shortages and protracted searches to find and hire qualified candidates. Lastly, the pandemic disproportionately impacted people of color who already had longstanding mistrust of the medical system. These likely were exacerbated in the wake of disinformation campaigns about vaccines, safe distancing practices, and other evidence-based recommendations. Indeed, overdose death rates have risen most steeply in communities of color in recent years in Region 5, Michigan and the U.S. We've not seen a concomitant association of engagement in SUD services among people of color.

The MSHN region has also seen an expansion of SUD services with its CMHSP partners participating in Certified Community Behavioral Health Clinic (CCBHC) supports and providing individuals with mild to moderate needs with SUD outpatient services. Therefore, a portion of the reduction within SUD service reporting may have transferred to reporting within the CMHSP encounters.

SUD Assessment

Assessment includes an evaluation by a qualified practitioner that investigates clinical status including: presenting problem, history of presenting illness, previous medication history, relevant personal and family history, personal strengths and assets, and mental status examination purposes of determining eligibility for specialty services and supports, and the treatment needs of the beneficiary. The MSHN region saw a continued decline in assessments in FY24 for a variety of reasons. First, in FY23, the PIHPs received guidance from MDHHS that a person in services is only eligible for up to 4 assessments per year. With this guidance, the PIHPs, including MSHN, looked for ways to increase provider collaboration by sharing completed assessments from provider to provider, or utilizing an assessment update, where appropriate, instead of another full biopsychosocial assessment. . This initiative would save the person from having multiple assessments in a short period of time when navigating the SUD provider system on their pathway to recovery. So, while it looks like the number of assessments decreased significantly in the past year, a portion of this decrease was purposeful in how the provider system is approaching collaboration within the provider network by assessment-sharing (with the individuals' served consent). It is also representative of providers updating assessments for people who have left services and returned in short periods of time and updating an assessment versus having a new full assessment. In these instances, the provider has been guided to support the update assessment process with a therapy code (i.e., 908XX) versus the H0001 by MDHHS. An additional factor in reduced assessments is due to provider staff shortages. Many providers have staffing deficits that have not rebounded to pre-pandemic levels which limits those providers' ability to support the same range of services.

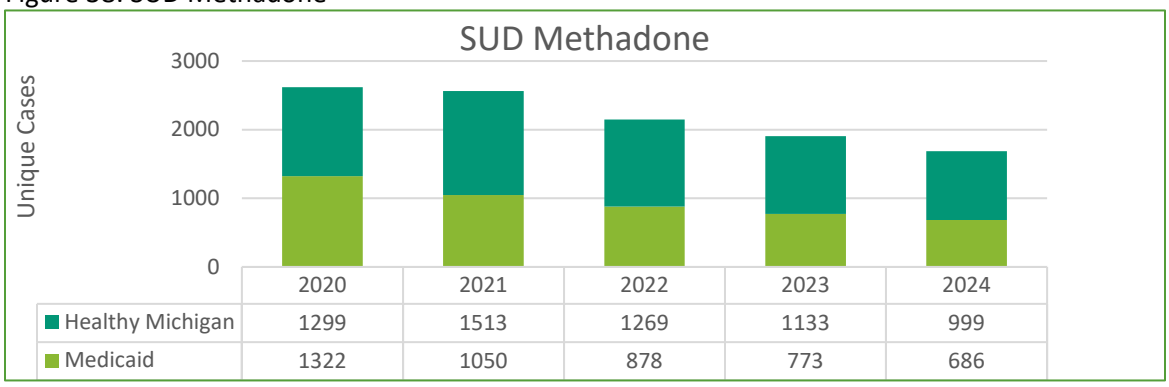
Figure 37: SUD Assessment



SUD Medication for Opioid Use Disorder (MOUD)

MOUD is the standard of care for individuals living with an Opioid Use Disorder and has been demonstrated to decrease overdose deaths and to increase individuals' likelihood of recovery. The Federal Drug Administration (FDA) has approved three medications for this purpose: methadone, buprenorphine (brand name Suboxone), and naltrexone (brand name Vivitrol). Buprenorphine and naltrexone can be prescribed by licensed medical professionals in hospitals, Federally Qualified Health Centers (FQHCs) primary care and/or other healthcare settings. These Office-Based Opioid Treatment (OBOT) settings may or may not be attached to broader SUD outpatient treatment services. Methadone, on the other hand, can only be delivered through licensed Opioid Treatment Providers (OTPs) that are highly regulated by the Drug Enforcement Administration (DEA) and SAMHSA under 42 CFR Part 8.11. Many OTPs also prescribe buprenorphine and naltrexone, but they are primarily focused on the delivery of methadone which requires daily dosing. Determination of which medication is appropriate for each patient should be individualized and guided by medical necessity.

Figure 38: SUD Methadone



SUD MOUD Regional Capacity (OTPs & OBOTs)

MSHN region has seen a decline in individuals seeking methadone services in the last 5 years. This can be attributed to factors like increased isolation during and since the pandemic, mistrust of the medical

system and the burden on work and transportation associated with daily dosing. While methadone treatment has declined, the MSHN region has expanded its MAT options with OBOT providers over that same period of time. At present, Region 5 has 25 locations that support MOUD with SUD outpatient services. **For OTPs that dispense methadone, MDHHS has an established adequacy standard of 35,000:1 Medicaid Enrollee to Provider ratio. MSHN currently contracts with five OTPs in the region that meet this definition.** MSHN has significantly expanded the availability of Medication for Opioid Use Disorder (MOUD) providers in the region, and currently contracts with twenty-five (25) MOUD provider locations and as indicated, five (5) SAMHSA certified OTPs. In addition**, MSHN contracts with four (4) MOUD providers out of its geographic region for services to in-region residents. MSHN has an additional 16 contracted OBOT provider locations in region that have physicians who can prescribe naltrexone and/or buprenorphine. MSHN's Ratio: 591,929 Total Medicaid Enrollees to 21 providers, which is just slightly over the required 20 providers.**

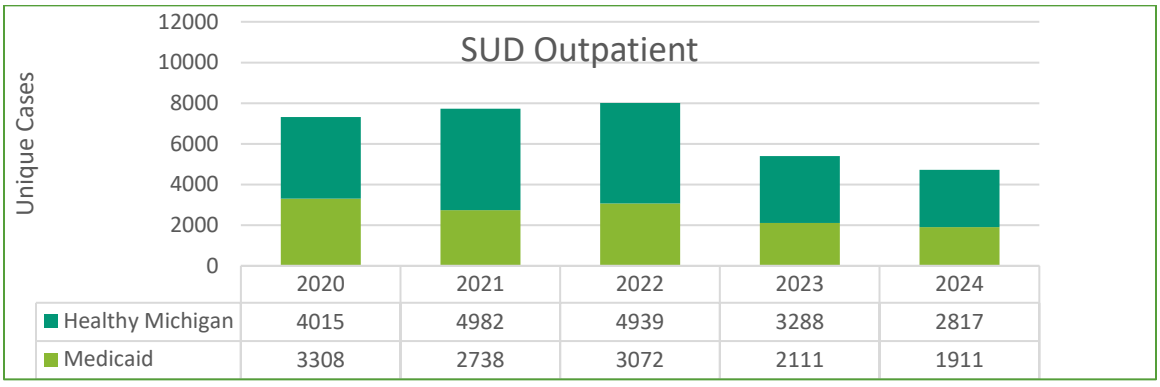
SUD Outpatient

Outpatient treatment is a non-residential treatment service that can take place in an office-based location or a community-based location with appropriately educated/trained/licensed clinical professionals who are educated/trained in providing alcohol and other drug (AOD) treatment... Individual, family, and group therapy, case management, peer supports, and monitoring services may be provided individually or in combination. While the MSHN region shows a continued decrease in outpatient service engagement for FY24, this was also a time period when CMHSPs expanded to support CCBHC and also had contractual Designated Collaborative Organization (DCO) arrangements to support SUD outpatient services in their counties. This was the case for CEI – CMH (supports Clinton, Eaton, and Ingham counties), Lifeways (Jackson and Hillsdale counties), The Right Door (Ionia County), and Saginaw Community Mental Health (Saginaw County).

MSHN performed data analysis to determine if the occurrence of outpatient SUD decreases may be attributed to individuals seeking or obtaining SUD outpatient services through a CCBHC. **The data analysis revealed that 1,383 unique individuals received an outpatient SUD service though a CCBHC (or CCBHC DCO provider) during FY24. This amounts to a combined total of 6,111 unique individuals receiving an outpatient SUD service in FY24 compared to 5,399 unique individuals in FY23, amounting to an 11.7% increase from FY23 to FY24.**

The ongoing staffing crisis also greatly impacted outpatient providers with being able to recruit, hire, and retain sufficient staffing. Many providers had to limit their admissions to their existing capacity until additional staff could be hired, sometimes with long/extended time periods trying to recruit and hire qualified and competent clinicians.

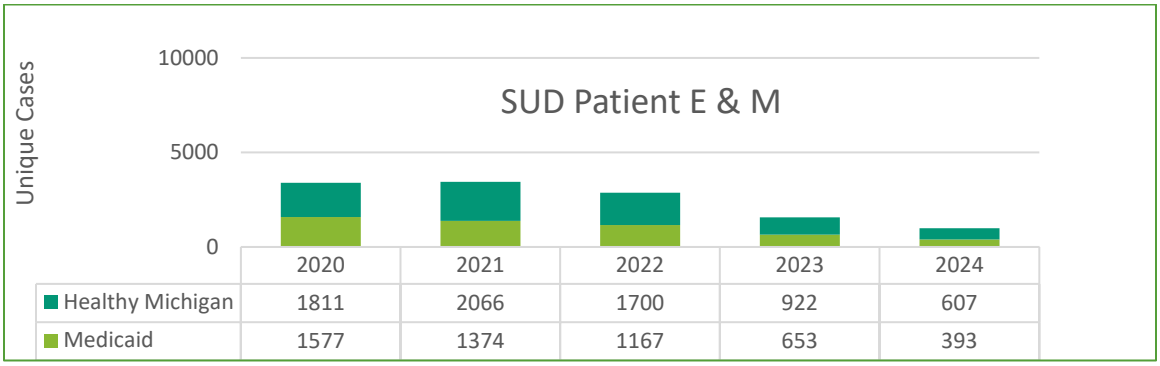
Figure 39: SUD Outpatient



SUD New and Established Patient Evaluation and Management

This includes patient evaluation and medication management by a physician (MD or DO), licensed physician's assistant, or nurse practitioner under their scope of practice.

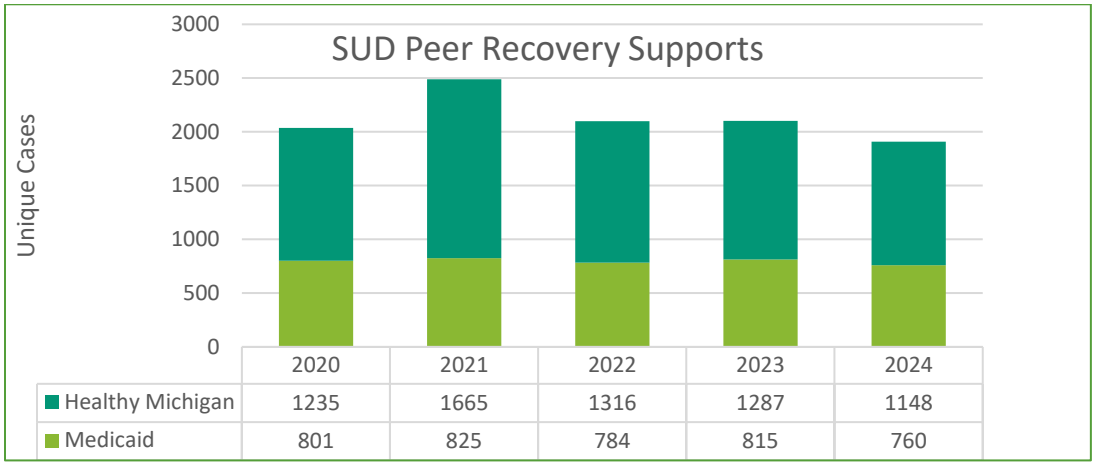
Figure 40: SUD Patient Evaluation and Management



SUD Peer Services/Recovery Supports

Peer Recovery Supports (PRS) are non-clinical services that assist individuals and families to recover from substance use disorders and to maintain their recovery after treatment. They include social support, linkage to, and coordination among, allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. PRS may be provided in conjunction with treatment, or as separate and distinct services, to individuals and families who desire and need them. MSHN supports the SUD network by providing training funds, with over 200 individuals trained to serve as Peer Recovery Coaches, and three Community Recovery Organizations which are a vital part of MSHN's frontline services.

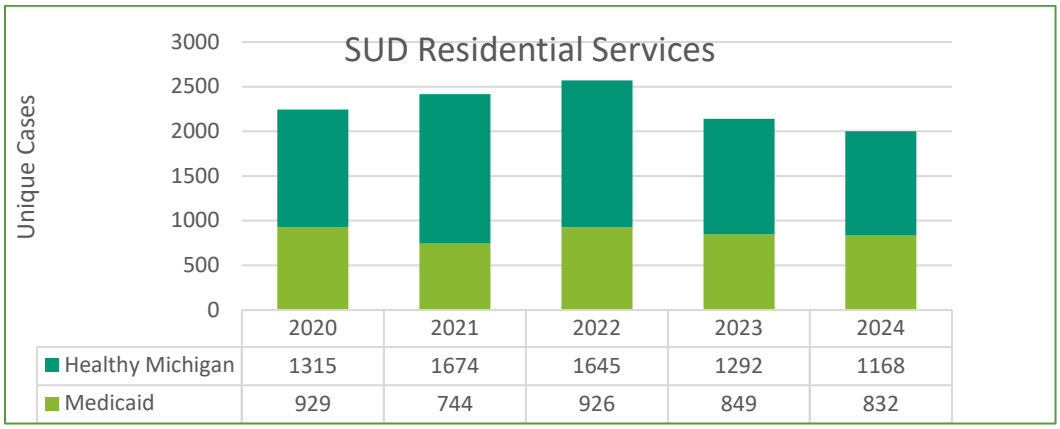
Figure 41: SUD Peer Recovery Supports



SUD Residential Services

Residential Treatment is defined as intensive therapeutic service which includes overnight stay (24-hour setting) and planned therapeutic, rehabilitative, or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from more intensive treatment. The length of stay varies based upon the client's individualized needs.

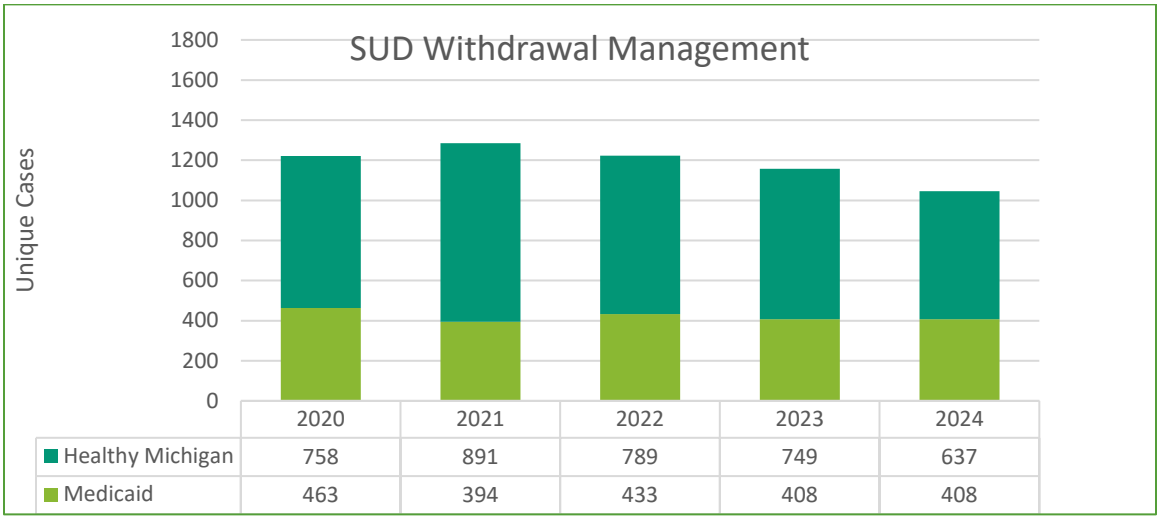
Figure 42: SUD Residential Services



SUD Withdrawal Management

Withdrawal management services provide safe withdrawal from the drug(s) of dependence and consists of three components: evaluation, stabilization, and fostering client readiness for entry into continued treatment. Treatment generally takes place in a residential setting – clinically managed or medically managed.

Figure 43: SUD Withdrawal Management



Evidenced Based Practices - SUD

SUD Providers also utilize evidence-based practices in the context of prevention, treatment, and recovery models. Recovery focused approaches are prevalent, and some providers employ staff trained in motivational interviewing, integrated dual-diagnosis treatment, trauma-informed and other techniques commonly employed by CMHSP's. Table 12 lists evidence-based practices employed by various SUD Providers in the MSHN region:

Table 12: Evidence Based Practices Utilized by SUD Providers in the MSHN Region

*T = Treatment; P = Prevention, R = Recovery & Community Recovery

Focus	Evidenced Based Practices	Focus	Evidenced Based Practices
R	24/7 Dads	T	Nurturing Fathers
P	Above The Influence	P	Nurturing Parenting
P	Active Parenting	P	PALS- Peer Assisted Leaders
T	Acupuncture	P	Photo Voice
T	Adolescent Community Reinforcement Approach	P	Positive Action
P	Alcohol and Tobacco Vendor Education	P	Prescription Disposal/Drug Drop Off Boxes
R	Alcoholics Anonymous	P	Prevention PLUS Wellness
T	Alternative Routes	P	Prime for Life
P/T	Anger Management	P	Program to Encourage Active, Rewarding Lives (PEARL)
T	Art Therapy	T	Progressive Exposure Therapy
P	Be A Star	P	Project Alert
T	Beyond Trauma	P/T	Project ASSERT
P	Big Brothers Big Sisters	P	Project Success
P	Botvin LifeSkills	P	Project Toward No Drug Abuse
P	Breakout	P	QPR Gatekeeper Training for Suicide Prevention
P	Bully Proof	P	Quick Response Team (QRT)
P	Catch My Breath	P	Retailer/Server Education (TIPS)
R	CCAR Peer Recovery Training	P	Safer Smarter Teens
T	Cognitive Behavioral Therapy (CBT)	P	Sanford Harmony SEL
R	Community-Based Support Group	R/T	Screening, Brief Intervention, Referral to Treatment
T/R	Contingency Management (CM)	T/R	Seeking Safety
T	Correctional Therapeutic Community for SUD	R/T	Self-Management and Recovery Training (SMART)
P	Cross Age Mentoring Program	P	SMART Leaders/SMART Moves
T	Dialectical Behavior Therapy (DBT)	R	SMART Recovery
T	Eye Movement Desensitization and Re-Processing (EMDR)	T	Solution Focused Brief Therapy (SFBT)
T	Family Psychoeducation	P	SPORTPLUS Wellness
T	Feedback Informed Treatment	P	Step Bullying Prevention

T	Functional Family Therapy	P	STEP-Teen
T	Helping Women Recover/Helping Men Recover	P/T	Strengthening Families
P	Interactive Journaling	P	Student Assistance Programs
P	INDEPTH	P	Synar Compliance Checks
P	In-School Probation: Early Intervention	P	Systematic Training for Effective Parenting (STEP)
P	It's All About Being A Teen	P	Teen Court
P	JUMP	P	Teen Intervene
P	Letting Go of Anger	T	Thinking for a Change
T	Living in Balance	P	This Is Not About Drugs
T	MATRIX Model	T	Tobacco Cessation
T	Medication Assisted Treatment (MAT)	P	Too Good for Drugs
P	Michigan Model for Health	P	Too Good for Violence
T	Mindfulness	P	Total Trek Quest
T/R	Modified Therapeutic Community (MTC)	T	Trauma Informed CBT
T/R	Moral Recognition Therapy	T	Trauma-Focused Yoga
P	MOST Social Norming Campaign	T	TREM
T	Motivational Enhancement Therapy (MET)	P	Wellness Initiative for Senior Education (WISE)
T/R	Motivational Interviewing	P	Wise Owl
T	M-TREM	P	Youth Empowerment Program
R	Narcotics Anonymous	P	What's Good About Anger
T	Narrative Therapy	P	NOT on Tobacco

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

The adequacy of the numbers and types of providers (in terms of training, experience, and specialization) required to furnish the contracted Medicaid services [7] in the MSHN region can be assessed through review of the direct operated and contracted service provider networks established by the CMHSP Participants. MSHN and its CMHSP Participants have developed regional training requirements, which establish minimum training standards to ensure a base level of competency across the provider network.

Each of the CMHSP participant agencies in the region have extensive experience in the behavioral health care industry, as have many of their contracted service providers. Practitioners and staff employed or contracted by the CMHSPs are properly licensed (by the Michigan Department of Licensing and Regulatory Affairs (LARA) and credentialed in accordance with MDHHS requirements for provider qualifications as defined in the Michigan Medicaid Manual. Disciplines include Licensed/Board Certified Psychiatrists, Licensed Nurse Practitioners, Registered Nurses, Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Full and Limited License Psychologists, Board Certified Behavioral Analysts and Licensed Professional Counselors, among others. Credentialing and re-credentialing procedures, as well

[7] 42CFR438.206(b)(iii) "The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services."

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

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

CMHSPs also employ or contract with individuals who are on their own course of recovery as Peer Specialists, working particularly with people recovering from mental illnesses. Peer Specialists are certified by the state.

Similar credentialing procedures are in place for SUD Providers. Provider agencies must be licensed as Substance Use Disorder Programs by LARA, unless provided by a CMHSP which isn't required to have a LARA license. Individual clinicians, specifically treatment supervisors, specialists, and practitioners, as well as prevention supervisors and professionals, are required to hold certification through the Michigan Certification Board of Addiction Professionals, such as a Certified Advanced Addiction and Drug Counselor (CAADC) and Certified Alcohol and Drug Counselor (CADC). Substance use disorder service provider staff offering prevention services are required to hold certifications as Certified Prevention Specialists (CPS). In addition, MSHN encourages all SUD Recovery Coaches to seek certification through the state's 'Peer Recovery Coach program' if the Coach qualifies under State requirements. This state-offered certification program allows recovery coaches the opportunity upon graduation to pursue other funding sources for reimbursement (ex: Medicaid system). Peer Recovery Coaches (PRC) are also able to become certified through the Connecticut Community for Addiction Recovery (CCAR) curriculum to provide supportive PRC services in the MSHN region.

Trauma Informed Care

The MDHHS Trauma Policy requires PIHPs to ensure their provider networks have the capability to provide trauma informed care (TIC) and treatment when working with individuals with mental illness and/or substance use disorders who have experienced or are experiencing trauma. In addition to requiring the use of trauma screening and assessment tools, the policy mandates the completion of organizational or environmental assessments of service sites for trauma sensitivity. MSHN assesses competency and compliance through annual audits. MSHNs CMHSPs and SUD treatment providers conduct a self-assessment regarding trauma-informed competence and develop goals for their organizations to become more trauma informed in the supports they provide.

Recovery Oriented Systems of Care (SUD)

MSHN maintains a plan for the implementation of Recovery-Oriented Systems of Care (ROSC) which focuses on holistic and integrated services that are person-driven, trauma informed, culturally responsive, ensure continuity of care, and incorporate evidence and strengths-based practices. Across the 21-county region, MSHN supports three regional ROSC groups known as East, West, and South ROSC. Regional ROSC initiatives have focused on reducing the stigma of substance use disorders, sober family events, and working with community partners to assist people on their path to recovery.

Adequacy of Services for Anticipated Enrollees

In addition to ensuring the appropriateness of the range of specialty behavioral health services, MSHN must also determine that services are adequate for the anticipated number of Medicaid Beneficiaries in

the service area.[8] Medicaid enrollment, service penetration rates and community demand are key factors to consider.

Medicaid/Healthy Michigan enrollment

Over the past couple of years, enrollment in Medicaid and Healthy Michigan has shown signs of plateauing, with an increase in enrollees in FY23 & FY24 from Medicaid continuous enrollment. Figures 44 and 45 show the Medicaid and Health Michigan enrollment trends for the mental health and SUD populations.

Figure 44: Total Enrollees vs. Served – MH/SUD and Adult/Child

[8] 42CFR438.207(b)(1) "Offers an appropriate range of preventative, primary care and specialty services that is adequate for the anticipated number of enrollees in the service area."

Figure 44a: Average Enrollees and Individual Served, FY22-FY24

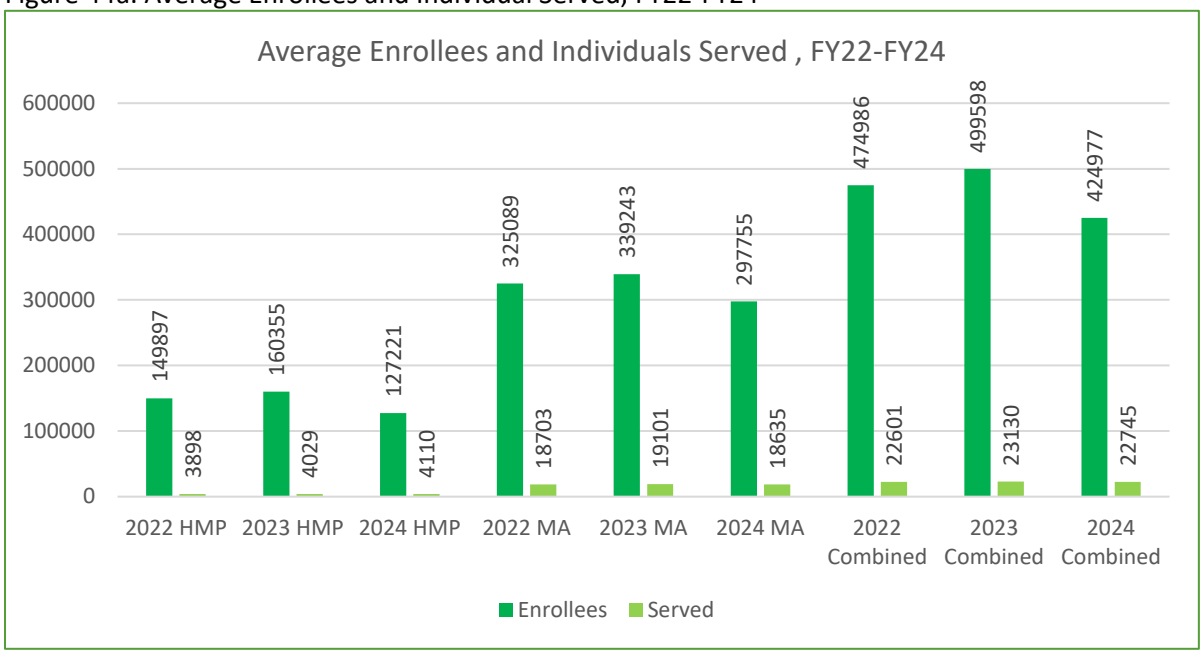
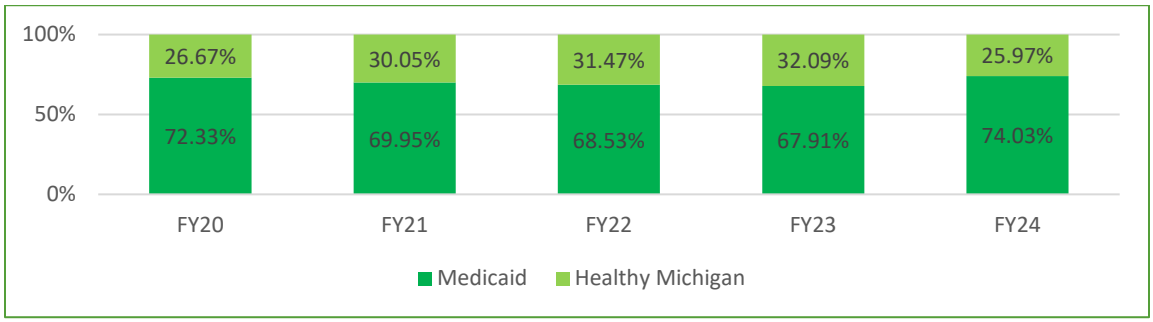


Figure 45: Proportions of Medicaid/HMP Populations



Disenrollments

Effective June 2023, MDHHS began the Medicaid and Healthy Michigan renewals as part of the Public Health Emergency end of continuous enrollment. MSHN has been monitoring the disenrollments to ensure and assist individuals with maintaining coverage where appropriate. Disenrollments may also affect those eligible for services. As of June 2024, MSHN has seen a decline in Medicaid and Healthy Michigan, with 116,701 individuals losing coverage.

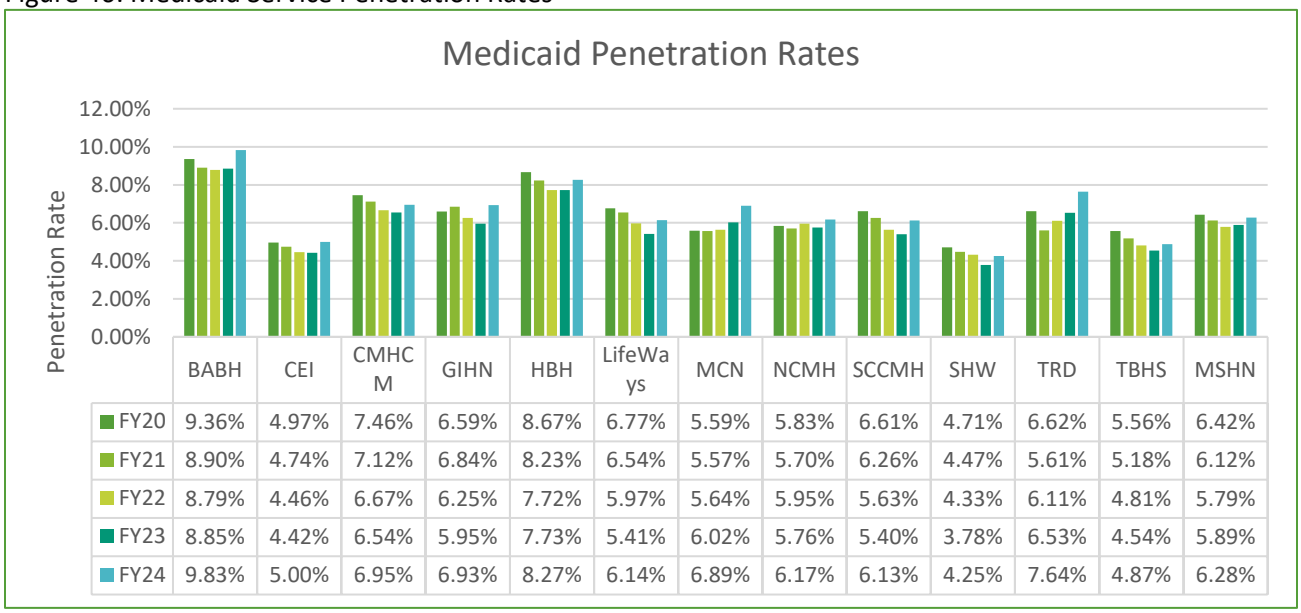
Service Population Penetration Rates

Medicaid enrollees since FY21 have steadily been increasing from the intentional hold on any eligibility loss due to COVID-19. Eligibility reviews began at the end of FY23. The impact for the future will be a continued decrease in Medicaid enrollment. Variability does exist among the CMHSP Participants in the

region relative to population penetration rates, which is reviewed at the executive level by the MSHN Operations Council and is addressed on an ongoing basis by the MSHN Utilization Management Committee. The goal is to determine if the variance is commensurate with community need or if action by the Operations Council is warranted relative to network capacities. Figure 46 and 47 show the Medicaid and Healthy Michigan penetration rate per CMHSP by fiscal year. Figure 48 shows the number of consumers serviced.

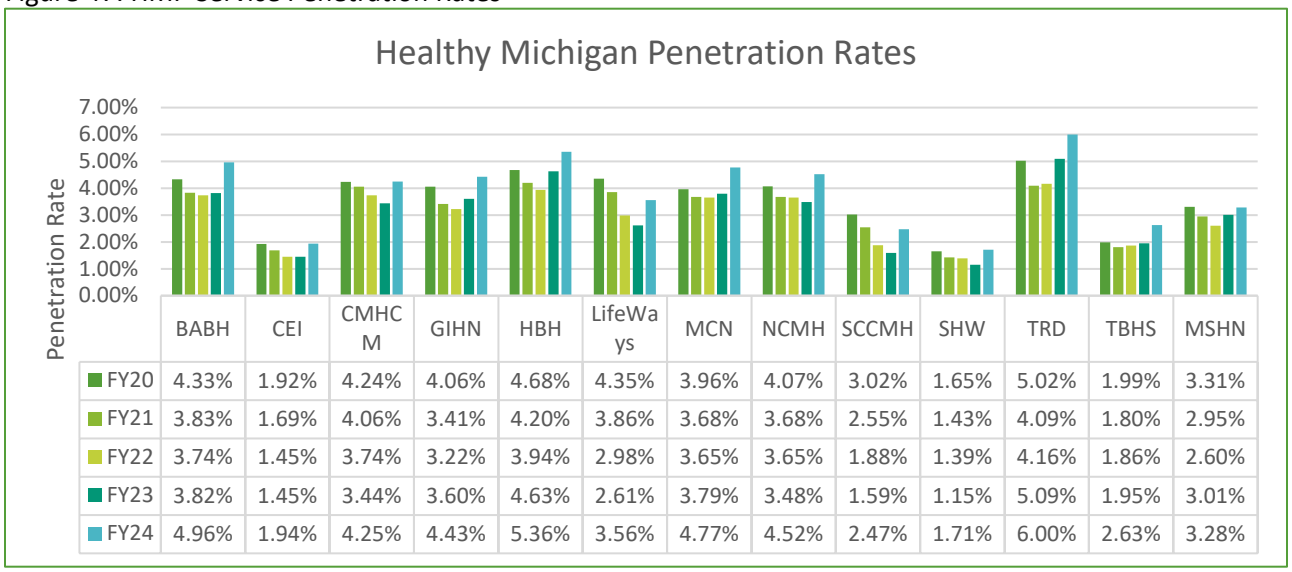
Compared to FY20 (start of COVID-19) CMHSPs have exceeded or almost reached similar Medicaid penetration rates in FY25. As of the end of FY24, (MDHHS Michigan's Mission-Based Performance Indicator System (MMBPIS) PIHP, July 1, 2024 - September 30, 2024)[9] MSHN had the fourth highest penetration rate at 8.53% out of the 10 PIHPs.

Figure 46: Medicaid Service Penetration Rates[9]



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS	MSHN
FY20	9.36%	4.97%	7.46%	6.59%	8.67%	6.77%	5.59%	5.83%	6.61%	4.71%	6.62%	5.56%	6.42%
FY21	8.90%	4.74%	7.12%	6.84%	8.23%	6.54%	5.57%	5.70%	6.26%	4.47%	5.61%	5.18%	6.12%
FY22	8.79%	4.46%	6.67%	6.25%	7.72%	5.97%	5.64%	5.95%	5.63%	4.33%	6.11%	4.81%	5.79%
FY23	8.85%	4.42%	6.54%	5.95%	7.73%	5.41%	6.02%	5.76%	5.40%	3.78%	6.53%	4.54%	5.89%
FY24	9.83%	5.00%	6.95%	6.93%	8.27%	6.14%	6.89%	6.17%	6.13%	4.25%	7.64%	4.87%	6.28%

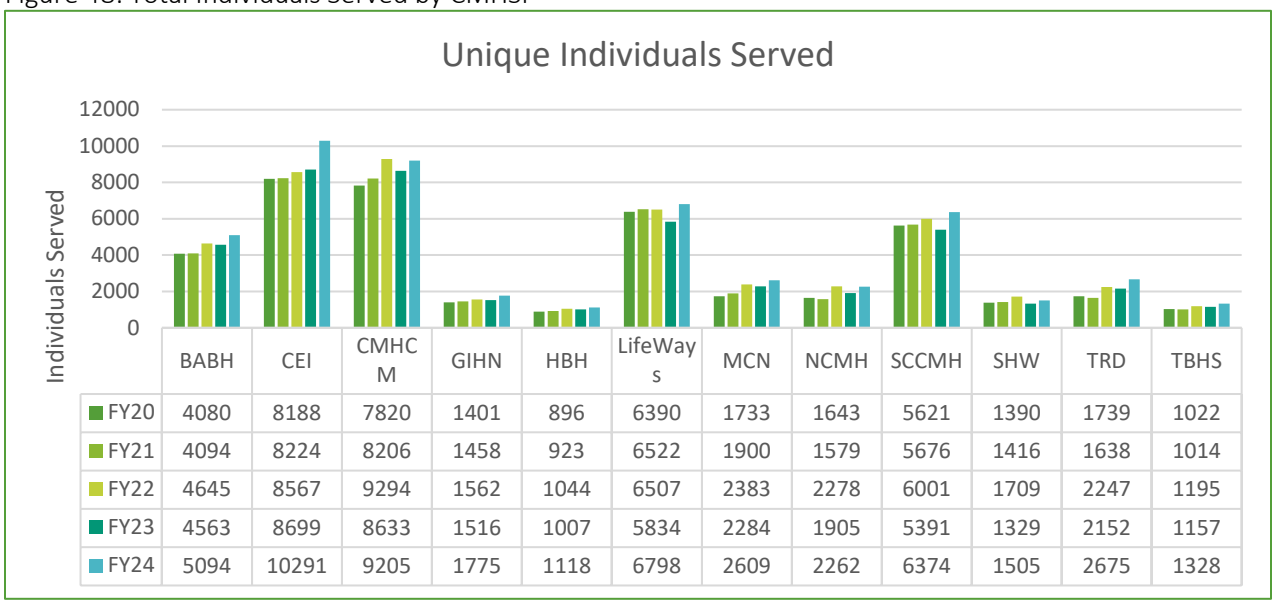
Figure 47: HMP Service Penetration Rates[10]



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS	MSHN
FY20	4.33%	1.92%	4.24%	4.06%	4.68%	4.35%	3.96%	4.07%	3.02%	1.65%	5.02%	1.99%	3.31%
FY21	3.83%	1.69%	4.06%	3.41%	4.20%	3.86%	3.68%	3.68%	2.55%	1.43%	4.09%	1.80%	2.95%
FY22	3.74%	1.45%	3.74%	3.22%	3.94%	2.98%	3.65%	3.65%	1.88%	1.39%	4.16%	1.86%	2.60%
FY23	3.82%	1.45%	3.44%	3.60%	4.63%	2.61%	3.79%	3.48%	1.59%	1.15%	5.09%	1.95%	3.01%
FY24	4.96%	1.94%	4.25%	4.43%	5.36%	3.56%	4.77%	4.52%	2.47%	1.71%	6.00%	2.63%	3.28%

[9] Source: MSHN REMI Penetration Report
[10] Source: MSHN REMI Penetration Report

Figure 48: Total Individuals Served by CMHSP[11]



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS
FY20	4080	8188	7820	1401	896	6390	1733	1643	5621	1390	1739	1022
FY21	4094	8224	8206	1458	923	6522	1900	1579	5676	1416	1638	1014
FY22	4645	8567	9294	1562	1044	6507	2383	2278	6001	1709	2247	1195
FY23	4563	8699	8633	1516	1007	5834	2284	1905	5391	1329	2152	1157
FY24	5094	10291	9205	1775	1118	6798	2609	2262	6374	1505	2675	1328

Community Needs Assessments: Priority Needs and Planned Actions

Each CMHSP is required by MDHHS to complete a Community Needs Assessment each year. The needs assessment addresses service requests and their disposition, the use of service access waiting lists and other community demand information. This assessment informs decision making related to the sufficiency and adequacy of the provider network to address local needs and priorities. In aggregate, the Needs Assessments are also informative regarding regional provider network adequacy. The CMHSP Participants in the MSHN region completed either new community stakeholder surveys to assess community needs this year or provided an update of their last assessment. A regional composite of CMHSP Needs Assessment Priority Needs is shown in Table 13.

[11] Source: MSHN REMI Penetration Report

Table 13: Community Needs Assessment Priorities (Based on the Top Five Priorities per CMHSP Only)[12]

Community Needs	Regional Priority	BABH	CEI	CMHCM	GIHN	HBH	TRD	LCMHA	MCN	NCMH	SCCMHA	SHW	TBHS
Services for Individuals with SUD/ Co-Occurring Disorders	1	1			3	2	1		5	2	2	3	2
Community education, prevention, outreach	5	3	4		4			1	3		2	5	4
Access to Inpatient and/or Residential Placements	10-11	4	2		4/5					4			5
Services for Children	2-3	3				5	3	3					1
Integrated healthcare and health outcomes	2-3	1		1		4							
Ease of access to MH care	4	4	3	5	1	3	4	5		5	1		
Suicide Prevention	6-7	3		2		1	2	4		2	3	2	
Effect of Trauma	6-7	3			2						3		
Staff Recruitment/Retention	8	2	5		5				1	1		1	3
Social Determinants of Health	9	1		3	3	2		2	4				
Affordable and Appropriate Housing; Homelessness	12-13	3	1	4			5			3	4	4	
Services to mild/mod MH needs; uninsured	12-13	4											
Alternatives to Inpatient Psychiatric Services	10-11	3							2				
Youth Suicide	10-11	2					2						
Transportation to MH services	12-13	4											

Across the region, services for individuals with substance *use disorders or co-occurring mental health and SUD disorders* continues to be the number one priority relative to unmet need, both due to increasing rates of occurrence and CMHSP preparations to increased integration of mental health and SUD services. *Community education, prevention, and outreach* and *Services for children* tied for the second priority. The third priority was *integrated healthcare and health outcomes*. *Ease of access to mental health care* was the fourth priority.

Of these top five regional unmet community needs, all are already addressed in this assessment in various ways, with the exception of children's services. Appendix A summarizes CMHSP Participant efforts to expand service capacity for families and children and increase the number accessing services, as described in their community needs assessment updates.

Consumer Satisfaction

Consumer satisfaction with services is a key factor in evaluating the adequacy of a provider network. MSHN conducts an annual assessment of consumer perceptions of care for individuals receiving services funded by the PIHP. This assessment utilizes the Mental Health Statistics Improvement Program (MHSIP) and Youth Satisfaction Survey (YSS) tools depending on the service population. These surveys gather feedback on the quality, availability, and accessibility of care for adults and children receiving long-term

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

support and services for mental illness, developmental disabilities, and/or substance use disorders. Survey results are analyzed both regionally and locally by various service programs. These programs include, but are not limited to, Assertive Community Treatment, Outpatient Therapy, Targeted Case Management/Supports Coordination Services, Home-Based Services, Residential Services, and Withdrawal Management. Surveys are distributed through multiple methods, including mail, phone, electronic platforms, and face-to-face surveying efforts.

Responses to the Perception of Access to Services subscale indicated favorable ratings of 90% for youth and 87% for adults. Additionally, 83% of youth and 88% of adults reported that the services they received were appropriate in addressing their treatment needs. Among individuals receiving services for a substance use disorder, 93% reported services were appropriate for their needs. Overall, general satisfaction remains high, with 88% of adults receiving mental health services and 91% of individuals receiving substance use disorder services reporting positive experiences. While these ratings exceed the satisfaction benchmark of 80%, MSHN remains committed to continuous improvement in consumer satisfaction across the region.

Consumer satisfaction results are reviewed by the MSHN Quality Improvement Council, the MSHN Clinical Leadership Committee, and the Regional Consumer Advisory Council. These groups assess trends and determine whether regional improvement or local efforts are needed. Improvement efforts are prioritized for areas where satisfaction rates fall below 80% or where a significant decline is observed compared to previous survey years. Priority areas are identified based on input from regional councils and committees.

Anticipated changes in Medicaid eligibility or benefits

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

Home and Community Based Services

The Centers for Medicare and Medicaid Services (CMS) released new rules in 2014 for Home and Community-Based Services (HCBS) waivers. In the final rule, CMS has defined home and community-based settings by the presence of opportunities the individual has to make his or her own choices, come and go as they choose, interact in their community, and move freely and access public areas of their home. The changes related to clarification of home and community-based settings will maximize opportunities for participants in HCBS programs to have access to the benefits of community living, receive services in the most integrated setting, and effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.

MSHN has continued to work with its CMHSPs and MDHHS around priority areas, including updating the provider and beneficiary survey processes, provisional meetings, and further defining the IPOS eight elements and the distinctness from behavior treatment plan processes. CMS visited Michigan in July 2024 which resulted in a corrective action plan to address individual provider findings as well as systemic level changes affecting all PIHP regions. MSHN and partner CMHSP staff visit contracted residential and non-residential sites throughout the region to address ongoing HCBS Rule compliance and to ensure that requirements are operationalized.

Sufficiency of Network in Number, Mix and Geographic Distribution

MSHN must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area[13]. The effectiveness of the number of providers in the network may be evaluated by past performance.

Sufficiency of Number of Providers: Access Timeliness and Inpatient Follow-up

In addition to the services for mental health and SUD populations described within this assessment, MSHN is required by MDHHS to maintain a 24-hour access system for all target populations. The region has established a multi-portal access system – a 'no wrong door' approach, with 24/7/365 access for individuals with a primary SUD concern. Beginning on 10/1/2024, MSHN introduced a new partially-centralized access process for individuals seeking withdrawal management, SUD residential treatment, or recovery housing services. Individuals seeking those services can call the MSHN Access Center 24/7/365. MSHN contracts with a professional after-hours behavioral health call center, Protocall, to provide after-hours coverage for the MSHN Access Center. MSHN continues to delegate access responsibilities for all other SUD services to its CMHSP Participants and SUD Providers. CMHSP Participants operate a 24-hour access system, either directly or through a contractual arrangement with other CMHSPs. MSHN, CMHSP Participants and SUD Providers have met the following goals and continue to maintain network capacity to:

Establish, enhance, or expand relationships between the CMHSP and the SUD Provider system within the service area of the CMHSP so that:

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

Engage in community coalitions and other substance use disorder prevention collaborative by:

- Identifying and assigning responsibility for one or more CMHSP-employed individuals to perform the function.
- Identify opportunities where existing mental health prevention efforts can be expanded to integrate and/or support primary SUD prevention.
- With MSHN support general community education and awareness related to behavioral health prevention, access and treatment including outreach (note that a regional goal is to increase the number of persons served, with emphasis on SUD and persons with HMP).

Timely Appointments

MDHHS requires PIHPs to report indicators of access timeliness and outcomes related to inpatient follow-up. MDHHS, in coordination with the PIHPs and CMHSP participants, developed and implemented two new indicators to be reported for FY20Q3. The new indicators do not exclude any individuals and

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

measure the percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service, and 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. The indicators that measure persons being seen for a follow up within 7 days of a discharge from inpatient or detox do not exclude those who chose an appointment outside of the required timeframe or chose not to engage in treatment following a request. MSHN should continue to monitor access to timeliness to treatment. Table 14 shows the recent year-to-year performance of the 21-county region. The indicators highlighted below with the lower percentages is due to not having appointments available due to workforce capacity issues as opposed to lack of providers.

Table 14: State Performance Indicators for Access Timeliness and Inpatient Follow-Up

	Population	MSHN Performance Rate FY21	MSHN Performance Rate FY22	MSHN Performance Rate FY23	MSHN Performance Rate FY24
The percentage of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (Standard: 95%)	MI-Children	99.58%	97.69%	98.52%	98.73%
	MI-Adults	99.22%	98.96%	98.89%	99.44%
The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergent request for service. (Standard: NA)	MI-Children	69.31%	64.26%	59.91%	65.28%
	MI-Adults	63.69%	61.42%	62.76%	66.47%
	DD-Children	65.30%	57.77%	44.54%	50.11%
	DD-Adults	72.74%	67.77%	57.52%	65.99%
	Total	67.39%	62.29%	60.72%	64.97%
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 (Standard: NA).	MI-Children	68.29%	59.24%	58.83%	60.17%
	MI-Adults	72.62%	64.01%	62.17%	65.49%
	DD-Children	78.33%	73.26%	80.64%	80.52%
	DD-Adults	68.01%	65.58%	62.56%	66.46%
	Total	71.34%	63.08%	62.45%	65.00%
The percentage of new persons during quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergent request for services. (SUD Only) (Standard: NA)	Medicaid SUD	83.34%	75.49%	73.66%	73.33%
The percentage of discharges from psychiatric inpatient unit/substance use disorder detox unit seen for follow-up care within 7 days. (Standard: ≥95%)	Children	98.90%	97.44%	97.79%	97.82%
	Adults	97.02%	96.17%	95.76%	96.14%
	Medicaid SUD	96.68%	97.18%	97.46%	93.98%
The percentage of readmissions to an inpatient psychiatric unit within 30 days of discharge. (Standard: <15%)	Children	7.97%	5.50%	8.72%	8.38%
	Adults	12.62%	10.08%	12.36%	11.48%

FY23 Maximum Time and Distance Standards

Understanding the locations of behavioral health providers in relation to the people needing services is the first step in addressing distance challenges associated with network adequacy. **In FY23 MSHN employed the following methodology to understand network adequacy.**

Data from the 2020 Census allows MSHN to estimate the population centers within the region. Population centers are the estimated number of individuals residing within a custom-mile hexagonal boundary. There are thousands of these population centers across MSHN's region. Each population center is assigned to its nearest provider. The nearest provider is determined by finding the provider location with the shortest straight-line distance (in miles) to the population center of interest.

Once all population centers were assigned to their nearest provider, network adequacy was calculated by measuring the proportion of the population centers that fall below a certain acceptable mile-distance threshold. For instance, if the maximum allowable distance to the nearest provider is 30 miles, and 933 out of our estimated 1,000 residents travel less than 30 miles to reach their nearest provider, then 93.3% of the population falls within acceptable coverage. For this example, the county network adequacy is 93.3%.

Figure 49: FY23 Time and Distance Standards for Inpatient Psychiatric Services

Time and Distance Standards for Inpatient Psychiatric Services

Adults

Service	Frontier	Rural	Urban
Inpatient Psychiatric	150 minutes/125 miles	90 minutes/60 miles	30 minutes/30 miles
All Other Select Services	90 minutes/90 miles	60 minutes/60 miles	30 minutes/30 miles

Pediatrics

Service	Frontier	Rural	Urban
Inpatient Psychiatric	330 minutes/355 miles	120 minutes/125 miles	60 minutes/60 miles
All Other Select Services	90 minutes/90 miles	60 minutes/60 miles	30 minutes/30 miles

Figure 50: FY23 Overview of Time and Distance Standards Results

	SUD Outpatient	Outpatient	Homebased	ACT	Clubhouse	Wraparound	Psych Inpatient Children	Psych Inpatient Adults	SUD Residential	SUD Withdrawal Management	Crisis Residential
Rural Stadard	60 min/60 miles	60 min/60 miles	60 min/60 miles	60 min/60 miles	60 min/60 miles	60 min/60 miles	120 min/125 miles	90 min/60 miles	90 min/60 miles	90 min/60 miles	90 min/60 miles
Urban Standard	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	60 min/60 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles
% of Total Population Standard Met	100%	100%	100%	100%	99.63%	99.90%	86.00%	99.00%	94.90%	99.70%	95.19%

Based on the key findings in Figure 50, MSHN focused efforts related to recruitment of providers for SUD residential, psychiatric inpatient for children, and crisis residential. In FY22, MSHN conducted an RFP for a Crisis Residential Unit (CRU) that opened in July 2024. In FY23, MSHN supported an RFP for SUD residential and withdrawal management services, as well as outpatient SUD services (with option of MAT). MSHN identified a provider in FY23 to support the SUD residential and withdrawal management services with focus in Isabella County and has been working on implementation through FY24 and into FY25. At present, the SUD residential facility will be open with capacity up to 75 beds in May of 2025. The SUD withdrawal management program will be implemented after the SUD residential program, with an anticipated implementation in fall of 2025. MSHN also identified providers to support SUD outpatient services during FY23. This included a provider in Montcalm County to support SUD outpatient and MOUD services, as well as another to support SUD outpatient in Isabella County where needs were identified outside of the time and distance standards.

As mentioned earlier, MSHN also supported an RFP for Adolescent Services in FY24 for withdrawal management, residential, and outpatient service expansion for the region. One provider was supported to add SUD outpatient services with MAT to 7 additional counties in the region.

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FY24 Maximum Time and Distance Standards

MDHHS updated the Network Standards related to Time and Distance for FY24. Time/distance standards are now categorized by Large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations (CEAU) MDHHS will utilize PIHPs Provider Directories to calculate compliance with the time and distance standards. The results for FY24 are not available yet and will be utilized for FY25 NAA.

Figure 51: FY24 Time and Distance Standards

Service	CEAU	Rural	Micro	Metro	Large Metro
Inpatient Psychiatric[2]	155 minutes/140 miles	90 minutes/75 miles	100 minutes/75 miles	70 minutes/45 miles	30 minutes/15 miles
All Other Services	118 minutes/105 miles	75 minutes/60 miles	70 minutes/53 miles	45 minutes/30 miles	20 minutes/10 miles

Sufficiency of Number of Providers: HCBS/Independent Assessment

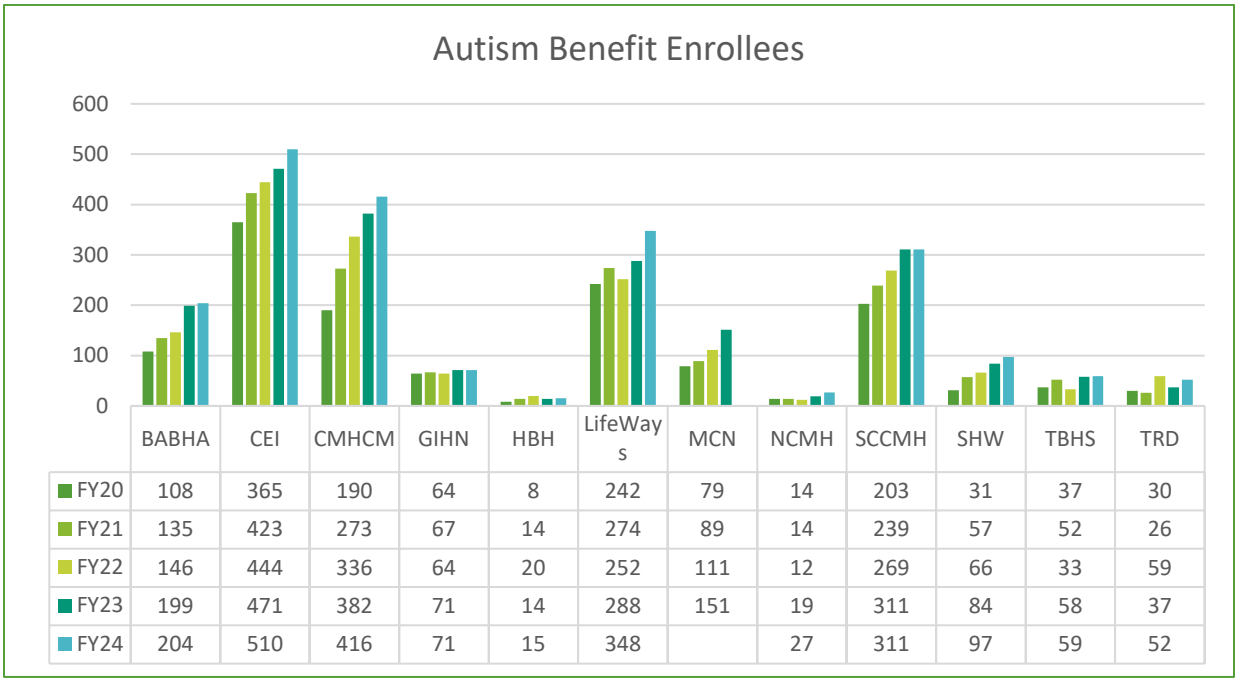
In November 2017, MDHHS released a new Medicaid Provider Manual Home and Community Based Services chapter to address the implementation of the CMS HCBS Final Rule. In its new HCBS guidance, MDHHS instructs that the HCBS Final Rule "provides requirements for independent assessment. This is a face-to-face assessment, conducted by a conflict-free individual or agency. The assessment is based on the individual's needs and strengths and is part of the person-centered planning process." This language highlights the necessity of conflict-free case management and of clinical assessment and person-centered planning free of conflicts of interest. The CMS Federal Rule provides that "the assessor must be independent; that is, free from conflict of interest with regard to providers, to the individual and related parties, and to budgetary concerns." The degree to which this expectation impacts network adequacy will depend on its implementation.

In the late third quarter of FY24, MDHHS submitted for renewal by CMS, its three C-Waiver applications and 1915(i) State Plan Amendment (SPA). These applications were approved by CMS by late first quarter FY25. The applications stipulate the requirements for Conflict Free Access and Planning (CFAP) must separate organizationally who provides the access and planning function and the direct services (an HCBS service) function for individuals who receive home and community-based services. MSHN and its CMHSPs will complete an analysis of situations where the CMHSP provides both functions and to further plan and guide how adherence to CFAP will be reached. The implication for the MSHN region is to ensure that there are a sufficient number of HCBS providers to encourage choice, person-centeredness, and inclusion. MDHHS has identified the Only Willing and Qualified Provider (OWQP) status to address counties that, according to Federal standards, meet rural or critical access area criteria. If a county receives the OWQP designation, the affected CMH can provide both access and planning as well as direct services but must endeavor to bring in providers to address the gap. This planning is anticipated to occur in FY25 and FY26.

Sufficiency of Number of Providers: Autism Spectrum Disorder Capacity

Previous years' assessments found that CMHSP Participants were finding it difficult to secure adequate providers to provide Behavioral Health Treatment/Applied Behavioral Analysis services for individuals with autism, due to the extensive training requirements for providers and the relative newness of the required credentials in the behavioral health industry and Michigan. As discussed previously in this assessment, MSHN and its CMHSP Participants have worked diligently to address the issue of BHT supervisor capacity over the course of the previous year. With the current total of 63 ABA provider contracts (22 shared providers and 41 single CMHSP contracts), the region continues to establish contracts with additional ABA providers since the rate of enrollees has climbed precipitously in many CMHSPs over the past year. Figure 52 shows that most CMHSPs have experienced significant increases in Autism Benefit service enrollment in the past few years.

Figure 52: Autism Benefit Enrollees[14]



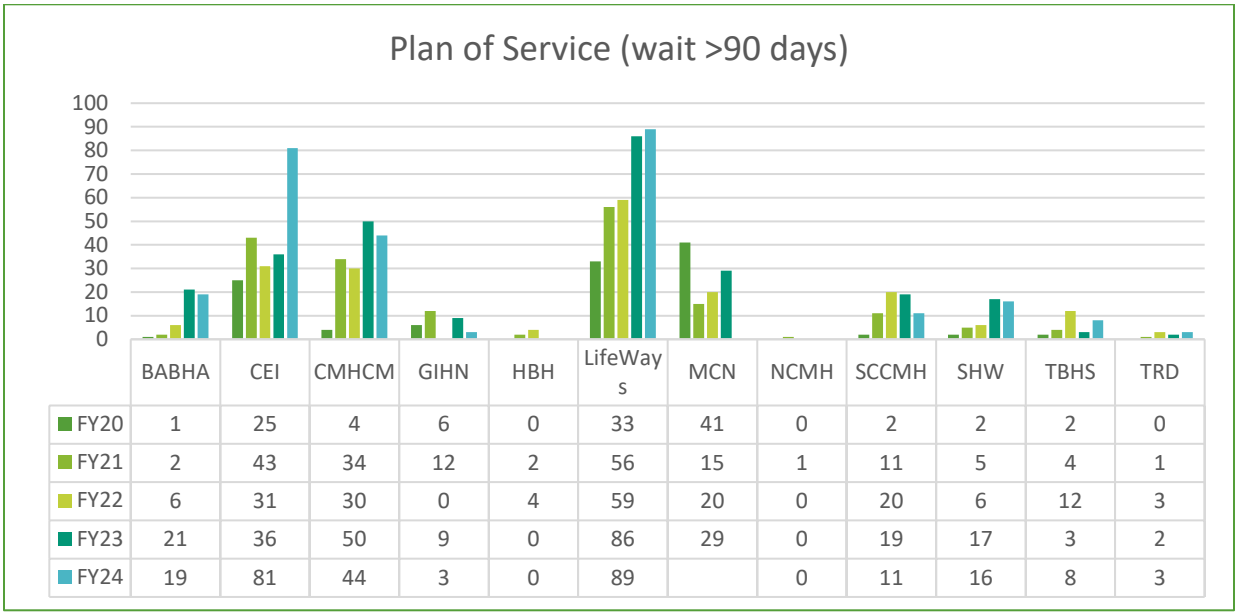
	BABHA	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TBHS	TRD
FY20	108	365	190	64	8	242	79	14	203	31	37	30
FY21	135	423	273	67	14	274	89	14	239	57	52	26
FY22	146	444	336	64	20	252	111	12	269	66	33	59
FY23	199	471	382	71	14	288	151	19	311	84	58	37
FY24	204	510	416	71	15	348		27	311	97	59	52

The issue of the region having an adequate number of ABA contract providers continues to be monitored and addressed. This year, with the elimination of the WSA for autism tracking and monitoring, MSHN has worked with our CMHSPs to develop a new system for oversight outside of the WSA. Within this new system, ABA quality and compliance issues continue to be highlighted in regular monthly reporting and shared with the CMHSPs. MSHN provides monthly notification to each CMHSP with data linked to referral date (date family requested services) to the current number of days pending completion of an initial comprehensive evaluation. MSHN also sends notification monthly to each CMHSP with data referencing all individuals with an Overdue Service Start Date. This measures the time from eligibility determination to start date of ABA services within the new tracking system. For instance, the number of individuals who have been found eligible for Autism Benefit services and are still waiting for a plan of service after 90 days has increased over the past year (see Figure 53), but the number of enrollees in the autism benefit has also risen 11% in FY23. Nonetheless, several new cases each month continue to surpass the 90-day threshold for the start of services. This demonstrates the need for continued efforts to work with ABA

[14] Source: MSHN Autism Report

providers to get assessments completed and individuals into services more quickly. The COVID-19 pandemic also affected the provision of services across our region, including delivery of services via telehealth and an increase in staffing shortages across all service providers. Additionally, families have indicated a desire to wait to start ABA services until a specific provider was available. Some of the identified reasons for a families' request to wait for services with a particular provider have been access to specialty services like SLP/OT, provider location, provider reputation, availability of services outside of school hours, and available transportation. MSHN has provided monthly information to the Autism Workgroup and to the Operations Council quarterly about 90-day benchmarks, with the intention of facilitating internal tracking systems to ensure that individuals are getting into services in a timely fashion. MSHN has worked to streamline and manage compliance issues through the Autism Operations Workgroup, the Regional Standardized ABA contract, and through shared provider performance reviews. CMHSP participants will continue to work within their purviews to address gaps in provider network capacity for autism benefit services.

Figure 53: Individuals Enrolled with an Overdue Service Start Date (Greater than 90 Days from Eligibility)[15]



	BABHA	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TBHS	TRD
FY20	1	25	4	6	0	33	41	0	2	2	2	0
FY21	2	43	34	12	2	56	15	1	11	5	4	1
FY22	6	31	30	0	4	59	20	0	20	6	12	3
FY23	21	36	50	9	0	86	29	0	19	17	3	2
FY24	19	81	44	3	0	89		0	11	16	8	3

Sufficiency of Mix of Providers: Cultural Competence

MSHN requires cultural competence training for staff and its provider network. Out of 1,445 provider listings in the region's Provider Directory, 97.9% indicated Cultural Competency training, which is an increase from 90.9% reported in FY23.

Where MSHN providers are in geographic areas with high concentrations of ethnic or cultural groups, some offer culturally-specific services such as the Latino counseling services available through the CEI provider network. The MSHN Provider Directory indicates where providers specialize in serving distinct ethnic or cultural groups. MSHN recognizes that we do not have sufficient providers with diverse clinical staff that mirror the diversity of communities like Saginaw, Lansing, Jackson and Mt. Pleasant. This is likely a contributing factor in low penetration rates for Black, Hispanic and Native American communities.

[15] Source: MSHN Autism Report

MSHN collects and provides public information via MSHN's website related to the persons served by Race (Figure below). CMHSPs and SUD Providers collect information from individuals served related to specific cultural awareness/needs as identified during person centered planning.

Figure 54: Persons Open by Race FY2024

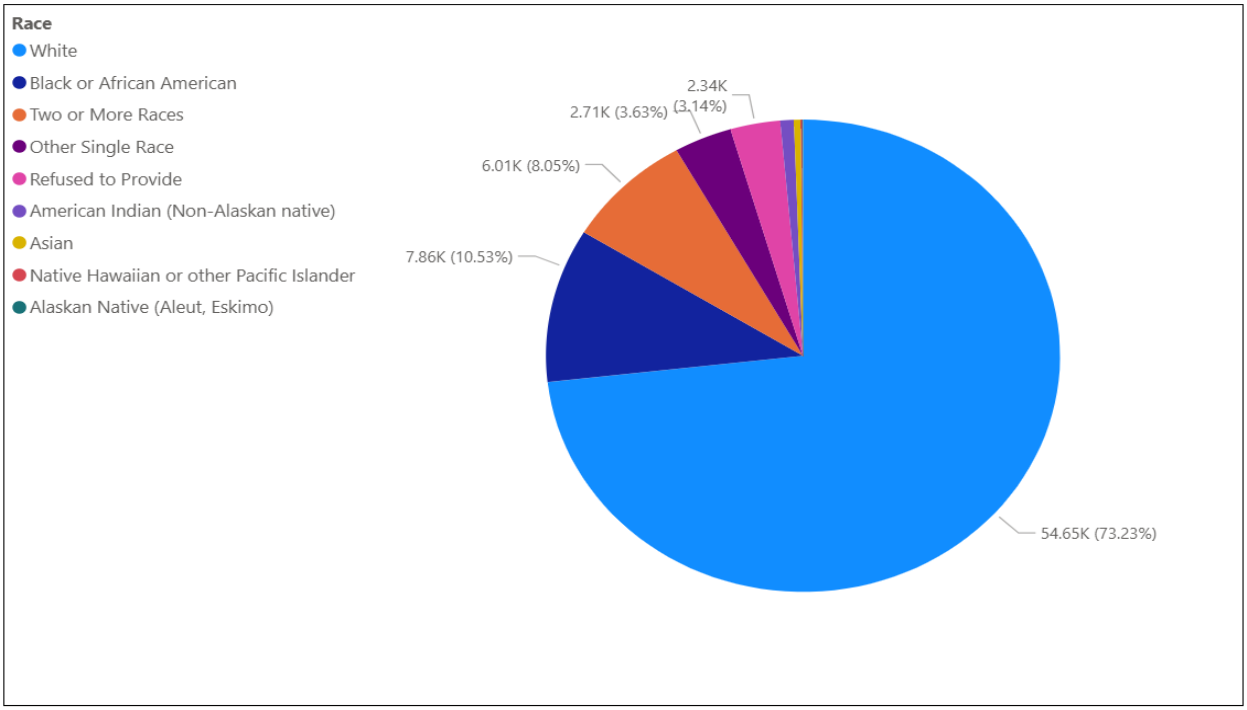


Figure 55: MSHN Regional Penetration Rate by Race/Ethnicity FY2022, 2023 and 2024

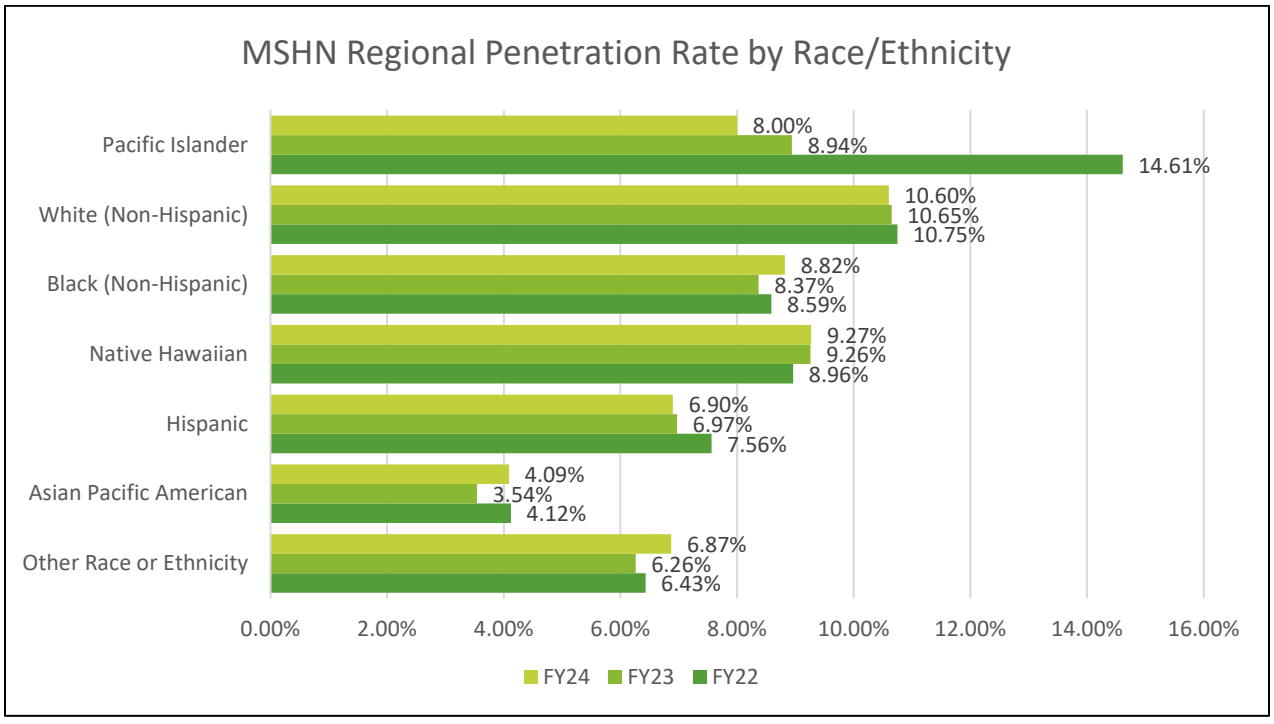
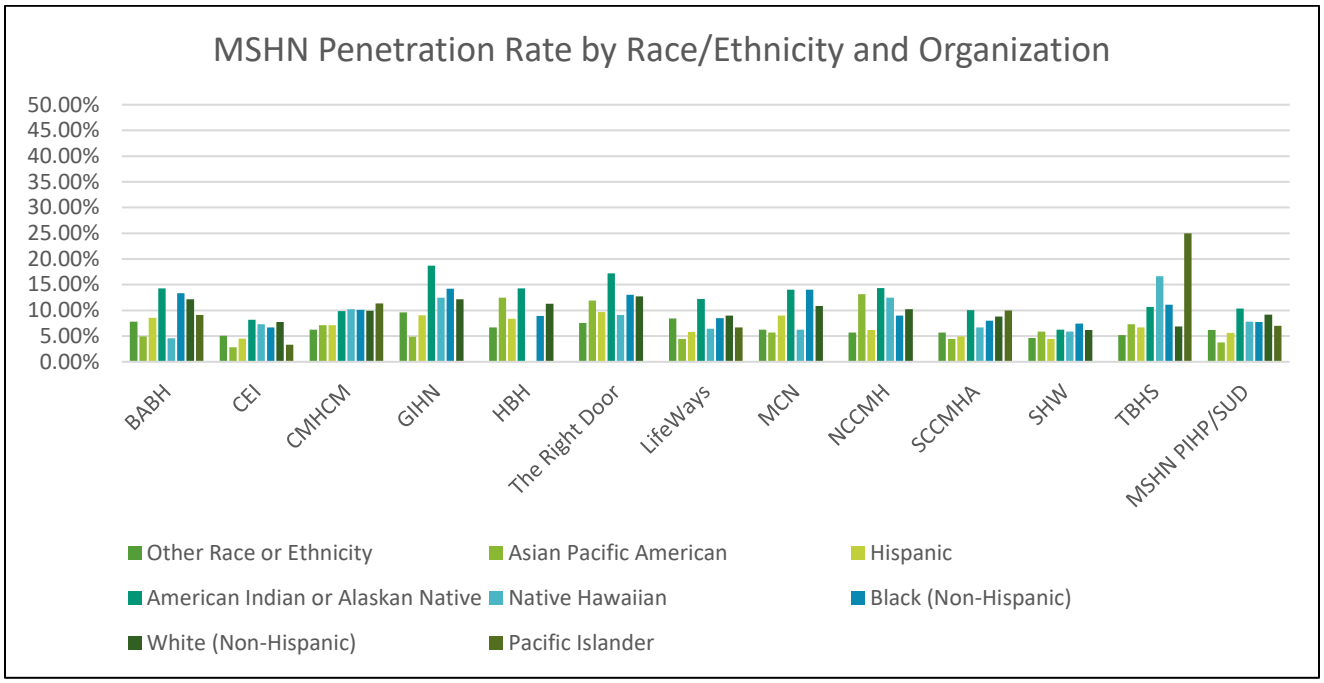


Figure 56: Penetration Rate by Race/Ethnicity FY2024



Sufficiency of Mix of Providers: Diversity, Equity, and Inclusion

Mid-State Health Network is committed to finding intentional ways to achieve better equity in our organization and in our region, to diversify our workforce, stakeholders, and service participants, to grow in our understanding and inclusion of all residents of Region 5, and to eliminate bias, discrimination, and health disparities in the healthcare services we exist to support.

MSHN along with its CMHSP partners have developed plans and policies to address community specific areas of need in ways that reach all populations in our region, so none are excluded. Areas of focus are informed by locally identified needs for improvement, but regional themes that emerged include the below:

- Treatment services for specified target groups based on (age, ethnicity, race, gender, sexual orientation, language, military, religion/spiritual, and socioeconomic)
- Board & Governance
- Clinical Services & Accessibility
- Policy & Procedure Review
- Population Analysis & Trends
- Public Relations / Community Partnerships
- Agency Purpose Statement / Vision
- Quality & Performance Improvement
- Recruitment & Retention & Evaluation
- Social Determinates of Health & Other Health Disparities
- Staffing Analysis (compensation, discipline, etc.)
- Task Force/Workgroup/Workplan
- Training & Engagement Plan

MSHN is in the process of developing a plan to identify gaps and establish regional efforts to reduce health disparities, increase diversity within the network and ensure equitable service delivery across the region.

Sufficiency of Mix of Providers: Consumer Choice

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

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

Substance use disorder providers also continue to add specialized transportation services to meet the needs of MSHN region. One example is added home based services for women with children, which is an enhanced women's specialty service, to address geographic limitations/ transportation problems individuals were having in trying to access clinic-based services. MSHN also supports transportation to and from SUD levels of care for withdrawal management and residential in an attempt to eliminate this as a barrier to treatment for individuals.

In accordance with revisions to the managed care rules, the availability of triage lines or screening systems must also be considered in state provider network adequacy standards. Most of the CMHSPs in the region have used or would use telehealth services for key services which are in short supply, such as psychiatric care. Additionally, the impact of the pandemic has resulted in the temporary expansion of allowable telehealth services. MSHN will continue to monitor telehealth expansion.

All the CMHSPs use emergency services hotlines to receive and triage calls from Medicaid beneficiaries and other members of the community. Some CMHSPs also use telephone based pre-screening programs for determination of medical necessity for psychiatric inpatient care and/or for preliminary eligibility screenings for specialty behavioral health and SUD services.

Accommodations

All CMHSP Participants offer services in locations with physical access for Medicaid beneficiaries with disabilities[16]. Out of 1,430 provider listings in the region's Provider Directory, 94.33% indicated accommodations in accordance with the American Disabilities Act. Delivery of services in home settings as well as telemedicine can offset barriers to physical access where present.

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

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

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

Table 15: Limited English Proficiency

	Languages Spoken									
COUNTY	Arabic	Bengali	English	Spanish	French	Haitian Creole	Russian	Swahili	Vietnamese	Chinese
Arenac			99.80%	0.18%			0.02%			
Bay	0.01%		99.90%	0.12%						
Clare	0.02%		99.79%	0.13%			0.08%			
Clinton	0.20%	0.01%	99.25%	0.56%	0.01%		0.01%		0.01%	0.02%
Eaton	0.16%		97.96%	1.70%	0.06%	0.09%		0.11%	0.02%	0.01%
Gladwin	0.01%		99.53%	0.46%						
Gratiot			99.58%	0.44%						
Hillsdale	0.01%	0.01%	99.75%	0.28%						
Huron	0.03%		99.70%	0.27%			0.01%			0.01%
Ingham	0.77%		97.39%	1.28%	0.06%	0.08%	0.05%	0.48%	0.04%	0.03%
Ionia	0.02%		99.60%	0.40%	0.01%			0.01%		
Isabella	0.02%	0.01%	99.64%	0.37%						0.02%
Jackson	0.01%	0.01%	99.56%	0.42%					0.03%	0.01%
Mecosta	0.01%	0.01%	99.77%	0.20%						0.02%
Midland	0.01%	0.01%	99.59%	0.40%			0.02%		0.01%	
Montcalm			99.62%	0.36%	0.03%	0.02%				
Newaygo	0.01%		99.17%	0.84%		0.01%	0.01%			0.01%
Osceola	0.01%		99.79%	0.20%						0.01%
Saginaw	0.02%		99.52%	0.48%					0.01%	0.01%
Shiawassee		0.01%	99.90%	0.08%	0.01%					0.01%
Tuscola			99.62%	0.38%						

Interpreters and translators are available at each CMHSP for persons with Limited English Proficiency (individuals who cannot speak, write, read, or understand the English language at a level that permits them to interact effectively with health care providers) as required by Executive Order 13166 "Improving Access to Services for Persons with Limited English Proficiency"). This includes the use of sign interpreters for persons with hearing impairments and audio alternatives for people with vision limitations.

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

MSHN requested that CMHSPs and SUD Providers ensure accommodations are available as required for individuals accessing services who experience hearing or vision impairments and that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services. This has been addressed during site reviews by the MSHN audit team. Based on MSHN audits, providers are following these requirements.

As of FY24 assessment, no MSHN county has more than 5% of non-English speaking individuals as identified in the above chart.

FY24 Health Home Expansion

Certified Community Behavioral Health Clinics

The Excellence in Mental Health Act demonstration established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs). CCBHCs provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals and are responsible for directly providing (or contracting with partner organizations to provide) services including:

- 24-hour crisis care
- utilization of evidence-based practices
- access to behavioral health care
- care coordination & integration with physical health care
- provide care regardless of ability to pay or Medicaid

The federal CARES Act of 2020 authorized two additional states—Michigan and Kentucky—to join the demonstration. As a result, MDHHS was approved for a two-year demonstration with an implementation start date of October 1, 2021. In the MSHN region, the following Community Mental Health Service Programs (CMHSP) participate as a CCBHC:

- Community Mental Health Authority of Clinton, Eaton and Ingham
- The Right Door for Hope, Recovery and Wellness (Ionia County)
- Saginaw County Community Mental Health
- LifeWays (Hillsdale, Jackson Counties)

As of September 30, 2024, MSHN enrollment in CCBHCs totaled 19,871 beneficiaries.

The CCBHC model eligibility criteria includes:

- All persons with a mental health and/or substance use disorder (SUD)
- Any person with a mental health or SUD ICD-10 diagnosis code is entitled to receive services through a CCBHC
- Severity of needs do not factor into eligibility (includes the Mild-to-Moderate)
- Individuals with an intellectual/developmental disability diagnosis may eligible provided they also have a mental health or SUD diagnosis
- Do NOT have to be Medicaid Eligible or have an ability to pay

As the demand and services expand across the region, MSHN along with the CCBHCs will continue to monitor sufficient provider capacity.

Opioid Health Home

MSHN successfully implemented the first Opioid Health Home (OHH) in the region during FY23 in partnership with Victory Clinical Services in Saginaw County. MSHN worked with four providers to implement five new OHH locations during FY24. The new OHH locations expanded availability of OHH services to Jackson, Ingham, Isabella, Bay, Clare and surrounding counties. The following Opioid Health Home locations are currently serving residents of the MSHN region (as of 9/30/2024):

- Victory Clinical Services – Saginaw
- Victory Clinical Services – Lansing
- Victory Clinical Services – Jackson
- Recovery Pathways – Bay City/Essexville

- MidMichigan Community Health
- Isabella Citizens for Health

Beginning 10/1/2024, the OHH initiative will become SUD Health Homes and eligibility for services will be expanded to any individuals with an Opioid Use Disorder, Alcohol Use Disorder, -or- Stimulant Use Disorder. MSHN will release a Request for Interest (RFI) during FY25 Q1 to gauge interest in new providers becoming SUD Health Homes to serve the expanded eligible population.

An Opioid Health Home (OHH) is a model of care that provides comprehensive care management and coordination services to Medicaid beneficiaries with an Opioid Use Disorder (OUD). The OHH functions as the central point of contact for directing patient-centered care across the broader health care system. OHH services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. Beneficiaries work with an interdisciplinary team of providers that includes a Health Home Director, Behavioral Health Specialist, Peer Recovery Coach/Community Health Worker/Medical Assistant, Medical Consultant, and Psychiatric Consultant. The OHH model is designed to increase access to health care, reduce unnecessary emergency room visits and unnecessary hospital admissions, increase hospital post-discharge follow up, elevate the role of peer recovery coaches and community health workers in particular to foster empathy, and improve overall health and wellness. Participation is voluntary, and enrolled beneficiaries may opt out at any time.

The Opioid Health Home receives reimbursement for providing the following federally mandated core services:

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community and social support services

As of September 30, 2024, MSHN enrollment in OHH totaled 398 beneficiaries.

Behavioral Health Home

MSHN successfully implemented the first Behavioral Health Homes in the region during FY23 in partnership with CMH for Central MI, Saginaw CMH Authority, Montcalm Care Network, Newaygo CMH, and Shiawassee Health & Wellness. Additionally, Gratiot Integrated Health Network implemented a Behavioral Health Home program during FY24. The Behavioral Health Home (BHH) provides comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. For enrolled beneficiaries, the BHH functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model also elevates the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time.

Behavioral Health Home receives reimbursement for providing the following federally mandated core services:

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Support
6. Referral to Community and Social Service

As of September 30, 2024, MSHN enrollment in BHH totaled 338 beneficiaries.

MSHN will continue to offer support and technical assistance to other regional partners who have indicated potential interest in implementing a BHH during FY25.

Appendix A – CMHSP Delegated Efforts to Expand Service Capacity

BABH

- Continued partnership with the Juvenile Detention Center mental health services for youth and families via Juvenile Liaison position embedded in the local Juvenile Center.
- Expansion of service provider network specific to autism services
- Expansion of ancillary services, Occupation Therapy, Physical Therapy, Speech Language Pathology to meet the needs of toddlers and children receiving ABA services
- Engaging in community outreach with schools, courts, community corrections, and DHS
- Screening children in the Juvenile Court to determine if mental illness exists, to prevent children with mental illness from being involved in the juvenile system.
- Providing school-based outpatient services in Arenac County school district to improve service access for youths and families.
- Collaborating partnership with local DHHS to address t needs of children/families who may be at risk of home removal and/or lack of natural supports due to significant mental health issues.
- Enhancing collaborative partnership with courts, law enforcement, prosecutor, jail, and juvenile center to increase jail diversion activities.
- Conducting EBP survey to focus efforts on increasing availability of multiple EBP's within the BABH provider network.
- Recruitment and retention planning to increase availability of outpatient therapy services and direct care workers.
- Continued collaboration with Arenac County community stakeholders to increase the availability of adequate substance use disorder services in the county.
- Program planning to expand peer support services to include implementation of Parent Support Partner and Youth Peer Mentor.
- Increasing availability of crisis residential services, expected in FY24.

CEI

- Added more staff in assessment units and in case management teams.
- Expanded the afterhours clinic.
- Added more providers for ABA, residential, and CLS/respite.
- Working to add more psychiatry time as well.
- Added more therapists certified in trauma.
- Added prevention therapist.
- Added additional hours in the evening to serve youth and families.
- Created a Clinton Truancy Intervention Program.
- Piloting the Therapeutic Foster Care Oregon (TFCO) program, with four homes in operation
- Developed a mobile crisis team and became certified. It includes mobile Parent Support Partners. Added additional teams and days/hours.
- Added additional Telepsychiatry for youth.
- Added additional Evidenced Based Clinicians in Trauma-Focused Cognitive Behavioral Therapy (TFCBT), Parent Management Training- Oregon model (PMTO) and Dialectical Behavior Therapy (DBT).
- Provided Signs of Suicide follow up with schools and students in collaboration with Eaton Regional Education Service Agency.
- Continuing to work on the "Tri-County Lifesavers" coalition to address Suicide awareness in tri-county area including development of videos designed for parents who need access to emergency psychiatric care or other mental health services for their child.
- Offered Various Youth Mental Health First Aid courses.

- Introducing QPR training opportunities to the community.
- Convened a community group in a local community to address increased suicide rates of your adults from their community.
- Offering Transitional Youth Services.
- Hosted another Children's Mental Health Awareness Event.
- Trained additional staff on Critical Incident Stress Management (CISM), expanded the CISM Team and responded to multiple organization and community events.
- Implemented Care Coordination projects in clinical programs addressing asthma, hypertension, hepatitis, diabetes, and high Emergency Department Utilization.
- The Information Integration Committee developed and refined a Care Coordination Document for improved coordination with primary care physicians and continued to increase the knowledge, understanding, and use of health-related data for care coordination across the organization.
- Worked with Tri-County Crisis Intervention Team Steering Committee to implement additional rounds of 40- hour training sessions for Officers. Over 200 Law Enforcement Officers from across Clinton, Eaton, and Ingham Counties were trained as of 2019.
- Continued to provide and expand various points of entry into services through Primary Care Physicians; Crisis Services and Crisis Response Team and Urgent Care/Emergency Rooms as well as the maintenance of several positions with navigator responsibilities such as the Veterans Navigator, Youth Prevention Therapist, Peer Recovery Coaches and Central Access Staff Outreach.
- Continued expansion of Access Department outreach for assisting consumers with SUD to locate appropriate level of treatment; addition of Recovery Coaches for Admission, Transfer and assisting individuals in their effort to get to treatment programs, working with the local Provider Network on admissions and transfers.
- Continue providing Naloxone Kits at three CMHA-CEI SUD programs and to law enforcement agencies in each county with assistance from the PIHP.
- Participation on the MAT Team with Ingham County Health Department and Ingham County Sheriff Department on bringing MAT services to the jail.
- Partnering with Ingham County Sheriff on the Rapid Response Team to provide immediate access to treatment services to individuals who have experienced a recent drug overdose.
- Provide ongoing follow up to the Sequential Intercept Mapping project held in 2017 resulting in the development of reentry services for each county jail targeting special needs populations.
- Continued collaboration and expansion of work with Lansing Landlords to house consumers with mental illness
- Added additional Applied Behavioral Analysis provider contracts to increase capacity to meet demand.
- Secured a Certified Community Behavioral Health Clinic Expansion Grant to expand care coordination and healthcare integration efforts.
- Continue working with Sparrow Hospital emergency department (ED) to assist in reducing beneficiary time spent in the ED.
- Increased psychiatry staffing for children and adults
- Increased staffing in homebased staff
- Increased staffing in children's crisis services
- Increased staffing and streamlined intake process across all clinical programs
- Added daycare expulsion program
- Added additional providers for CLS/respite services
- Increased nursing staff
- Added an after-hours clinic for mild/moderate population
- Expanded adolescent services

- Summary of gaps in services or need:
- *Feedback from Community Services for Developmentally Disabled (CSDD):*
- Remain unable to keep up with requests for Autism screening due to lack of qualified assessors in the region (positions are funded, unable to hire).
- Despite delays in assessing individuals, we've been able to connect more individuals to Autism services and have adequate provider capacity. But we in turn need more clinicians and support staff to appropriately coordinate and monitor those increased services and compliance with MSHN standards.
- Recognize a need for an increased number of case managers within the Family Support unit (to facilitate the growing demand for intakes and, in part, as tied to the coordination of Autism services).
- Increased capacities (i.e. funding in place) for enhanced children's crisis support, family training, directly supported CLS, etc., but unable able to hire anyone to fill these positions, and in fact are losing staff.
- Recognize a need for more highly specialized, behaviorally oriented, residential care providers in the region. We lack providers who can address acuity needs appropriately, as well as overall demand for this support type in the region.
- *Feedback from Adult Mental Health Services (AMHS):*
- Need to build out adult crisis mobile and secure staffing/therapists. CMHA-CEI is working on a Crisis Services Unit (CSU).
- *Feedback from Quality, Customer Service, and Recipient Rights (QCSRR):*
- Need to focus on timeliness from inquiry to assessment and from assessment to start of service (PIs 2a and 3).
- *Feedback from Families Forward:*
- Need for Mental Health Therapist to provide Evidence Based Treatments, CLS/Respite providers and Psychiatry.

CMHCM

Services for Individuals with SUD/Co-Occuring Disorder (COD)

- We have membership on local opioid fatality review team(s) and other recovery councils.
- We brought MAT providers into all six of our counties; four are co-located onsite
- We implemented process for MAPS use for all prescribers
- We have historically brought in training for staff on MAT, SUD, and COD.
- We have Narcan kits available and are giving them out to consumers who are at high risk of overdose. We also give them to community providers to have on hand (homeless shelter, universities, law enforcement, jails, etc.)
- Narcan vending machines added to multiple CMHCM lobbies.
- We review highest utilizers of emergency and crisis services, many of which are SUD/COD. We use a team approach for best practice and improved outcomes
- We implemented community treatment plans to have a consistent approach from multiple providers.
- We worked with local jails to bring in vivitrol to three of our jails so inmates can start MAT prior to release, with follow up care
- We partnered with a local substance awareness coalition to distribute harm reduction backpacks to inmates being released from jail.

Direct Care Worker Recruitment/Retention

- Executive Director has shared with MDHHS a proposed strategy for improved training and pay opportunities for all Direct Care Workers (DCWs)

- We are exploring ways to improve training access for our DCWs
- We are working on being able to provide de-escalation management training to our provider network
- We have had an expansion in the choice of providers for CLS and Employment Services across our agency.
- We have access to comprehensive employment services for all adult populations.
- We have improved coordination and a cash match increase with Michigan Rehabilitation Services.
- We have a Michigan Rehabilitation Services (MRS) and CMHCM co-location to reduce barriers for individuals served.

Alternatives to inpatient psychiatric services

- We have strengthened our crisis intervention team to maintain our good outcomes with a high diversion rate
- We have contracted with more children and adult Crisis Residential Units (CRUs)
- We used a consulting firm to do a feasibility study on bringing a CRU to our catchment area and did outreach with neighboring CMHSPs for potential partnerships
- We are working with local hospital system on potential arrangements for individuals who need care for symptoms related to SUD
- We established an after-hours contract with a local hospital provider to screen private pay individuals presenting in crisis to ED's for inpatient hospitalization.
- We have identified space in the community where we can see consumers after hours to reduce unnecessary ED visits and for pre-booking jail diversion.

Integrated healthcare and health outcomes

- We have membership on local health and human services councils.
- We have an adult block grant for an integrated health dashboard that shows outcomes and monitors health indicators over time for consumers
- We have provided extensive training for our nurse care managers and case holders on integrated health practices, including case to care management
- We have implemented team huddles and have worked toward caseload alignment within our teams for improved team-based care
- We have utilized health data available from multiple platforms to address consumer needs
- We use ADT data and track it daily for follow-up
- We have done outreach to our primary care practices to strengthen partnerships
- We have a co-located therapist in a local primary care office
- We have strong partnerships with care management with FQHCs in our area
- We have implemented healthy living opportunities in our local clubhouses
- Exploring possibility to become a CCBHC
- CMHCM expanded Behavioral Health Home to additional counties.

Ease of access to MH care

- We continued a partnership with the Juvenile Detention Center mental health services for youth and families via Juvenile Liaison position embedded in the local Juvenile Center.
- We expanded our service provider network specific to Autism services.
- We embedded Jail Diversion Specialists into our local jails.
- We have joined local hostage negotiation teams as mental health experts in two of the counties we provide services in.
- We implemented Same Day Access.

- We have piloted engagement strategies to engage individuals who may need early outreach.
- We have defined which individuals that will be opened using General Funds (GF) when Medicaid is not available
- We have done outreach to local providers, including universities, law enforcement, hospitals, EDs, community colleges to educate them about CMH services
- We piloted the early launch of the Michigan Child and Adolescent Needs and Strengths Tool ahead of full implementation.
- We have increased our marketing efforts
- We have Youth Intervention Specialists work with school districts in 4 of our counties to screen and refer youth with SED to mental health services.
- We have contracts with local school districts in two of our counties to provide school-based therapists within the schools.
- We are part of the Great Start Collaborative and many other collaboratives comprised of community partners that work with families and children.
- We have Infant and Early Childhood Mental Health Consultants in 5 of our counties to provide behavioral consultation with preschools and daycares.
- We have continued efforts to implement Charting the Life Course principles in framework with the individuals we serve.

GIHN

- Co-Located Clinician providing Therapy at Child Advocacy
- Co-located clinician in the court system and jail
- Partnered with law enforcement to implement use of iPad screening capability for officers
- Co-located clinician in the Emergency Department (expanded to 2FTE)
- Member of the Great Start Collaborative
- Health Department co-located in the St. Louis medical clinic providing WIC and immunizations.
- Contract with local Dial A Ride to provide transportation for services
- Trained community members in Adult and Youth Mental Health First Aid.
- Participates in back-to-school events.
- Addition of FASD Screening at Access
- Critical Incident Stress Debriefing Team
- Member of School Safety Alliance
- Increase use of Mobile Children's Crisis through community education
- Collaborate with Gratiot/Isabella RESD and FQHC to utilize 31n funding to increase behavioral health in schools
- Promote and increase consumers served for MAT, and provide Narcan to community
- Support staff SUD training and increase the number of staff with CADC and CAADC
- GIHN Service Committee continue reviewing high crisis and hospitalization service
- Collaborate with Court, Jail etc. for treatment of juvenile and adults in legal system
- Enhance the GIHN Integrated Health Committee activities
- Increased utilization of Wrap Around services through targeted community partner education
- GIHN became a Behavioral Health Home, recently expanded population served to include youth with SED
- Seeking additional Occupational and Speech Therapy providers
- Expanded ABA Provider Network with addition of new provider
- Expanded Community Living Supports service by offering new programs for adults and youth through MMI
- Expanded PERS provider network by offering services through new contract provider, Night Owl

HBH

- Participate in the Great Starts Collaborative; composed of many providers in the community that work with families and children to provide support and education to parents
- Active in community events where outreach to families can occur to assist with education and linkages to needed services or supports to strengthen parenting skills
- Have an active Wraparound program
- Expansion of Autism services and working with contractual provider to increase the timeliness and meet the increased demand for ABA and evaluative services.
- We screen for trauma in each clinical program and have completed an organizational self-assessment on trauma-informed care capabilities.
- Continuing work with MSHN on care coordination for high utilization cases, and have developed clinical tracking projects for persons with diabetes and cardiac issues
- Continuing promotion of staff training in TF-CBT, PMTO, DBT and FPE
- Have a Children's Intensive Mobile Crisis Team available for families
- Participate in on-going meetings with DHHS, court staff, Intermediate School District (ISD), attorneys and Prosecutor staff to improve cross-agency collaboration on shared children/ family cases.
- Staff and community partners have been trained on Trauma Informed Care and screening
- Have an active Wrap-around collaborative
- On-going training for community members on the use/application of Naloxone and distribution of rescue kits
- Trained community partners, and community-at-large members in Youth Mental Health First Aid
- Federally Qualified Health Center co-located at HBH for one-half day per week
- Provision of same day/next day service

LCMHA (LifeWays)

- Increased the availability of BHT services to meet the needs of the Autism expansion
- Has a Prevention & Wellness Program including participation on the Jackson Substance Abuse Prevention Coalition, which includes the Most Teens Don't effort
- Partner in the Intermediate School District Project AWARE, bringing Youth Mental Health First Aid to school staff and establishing mental health supports in into pilot schools; includes a Teen Advisory Team, committed to breaking down the stigma of seeking mental health supports
- Facilitating Youth Mental Health First Aid for the Community-at-large
- Participated in the iChallengeU by South Central Michigan Works where students were tasked with providing strategies to help teens engage in services when needed
- We now offer DBT-A groups two times per week
- Expanded both our jail services to include group work and our MAT services.
- SUD Recovery Incentives Pilot conducted
- Early Psychosis Navigate on Demand pilots running right now.
- Added an infant mental health evaluation initiative to specifically target infant and youth entering services and progressively improve access to care.
- Children's ICSS is operational; adult mobile crisis available in place of ICSS. Was able to add one additional team and expand coverage in FY24. Continued growth through MDHHS Grant opportunity being sought.

MCN

- Expanded Behavioral Health Home to the SED population
- Working to expand EBPs with active efforts to add DBT-Adolescent model and Parenting Through Change.
- Expanded school based mental health professionals with 31 N funding
- In the process of implementing internship programming with GVSU under a HRSA grant to support persons in MSW and NP programs.
- Provided tuition reimbursement and internship place to promote current staff completing Master's and Bachelor's degrees
- Opened one Supported Independence Program (SIP) home and will expand to a second
- Implemented cost containment plans with a focus on improved review of ongoing medical necessity and least restrictive environment for Autism and Specialized AFC placement
- In the process of revamping our Utilization Management Committee and practices
- Added a Parent Support Partner to the service array and will be adding a Family Skills Training position to better address the children's population
- Partnering with the county jail to pilot Medication Assisted Treatment in a jail setting
- Trained local DHHS and juvenile court in Restorative Practices and will be expanding this to the prosecutor's office and school resource officers
- Continued to meet quarterly with Law Enforcement, county judge, and prosecutor's office to improve jail diversion efforts
- Expanded Mobile Crisis hours
- Continuing to create cultural change in the organization through use of Components for Enhancing Clinician Experience and Reducing Trauma (CE-CERT)
- Working with U of M to implement Decipher in our Behavioral Health Home
- Received MHBG funding to support Mobile Crisis, IDDT, and MAT along with Residential Substance Abuse Treatment (RSAT) funding for jail based co-occurring services.
- Continued collaboration meeting with the local DHHS office to actively problem solve services for children at risk of removal from the community or returning home.
- Took over provision of Omnibus Budget Reconciliation Act (OBRA) as a direct run service
- In the process of implementing ICCW including expanding the number of staff who can provide this service
- Added a Waiver Coordinator position to improve identification of person who may qualify and better manage re-certifications
- Partnered with our DHHS Medical Assistance Reimbursement Act (MARA) Worker to better track Medicaid Redetermination and to quickly address any loss of Medicaid

NCMH

- Expansion of service capacity continues to be a focus of Newaygo County Mental Health over the course of this next year. Some of the efforts being put forth to help achieve this include:
  - Leadership team discussion and revamping of the agency's staff recruitment and retention plan.
  - Redevelopment of a new process and programming around interns/internships with the goals of being able to secure master's level interns and recruit them for employment when their internship is complete since adequate staffing is necessary to make any program or service expansion successful.
  - Looking to add additional providers (psychiatrist, MD, PA, NP) who can serve both adults and children.
  - In process of developing policy and procedures to get a Behavioral Health Home approved and running for our agency, which will also require some staffing needs.

- Looking into running more groups for clients around anger management (emotional/behavioral regulation), etc. and the possibility of opening these up to court ordered individuals or those on probation (non-Medicaid individuals included).

SCCMHA

- Implementation of Mental Health First Aid throughout the community and continued promotion for participation of all community members in the identification of persons who may require mental health services.
- Currently offering Mental Health First Aid trainings monthly both Youth and Adult. Offer Mental Health First Aid training to Law Enforcement and Fire and Rescue personnel.
- Continue to participate in collaborative projects such as the MiHIA regional Opioid Taskforce, the regional Neonatal Abstinence Syndrome project and PA2 prevention project for distribution of Naloxone.
- Working with local resources to improve admission referral acceptance and to diversify crisis response options.
- Expand current Mobile Response and Stabilization Services to extend hours of service.
- Working with the Saginaw Police Department to roll out our crisis connect program.
- SCCMHA continues to educate and review behavioral assessments and intervention process through the new Quality Improvement (QI) workgroup.
- Working with consumer stakeholders in focused access assessment and quality improvement projects.
- SCCMHA provides transportation to and from mental health appointments. However public transportation for all other daily life activities remains limited in this county. We will work with Alignment Saginaw, the Saginaw Human Services Collaborative body to explore ways to improve access to transportation.
- Initiated a work group to impact the boarding of consumers in hospitals by working with two area hospitals to improve consumer wait time for hospital admissions.
- Data from our newly created Access and Stabilization for Children team (ASC), revealed significant increase in family engagement in services.
- Movement to value-based purchasing for supported employment.
- We continue to provide respite services to support families.
- Participation in Child Parent Psychotherapy (CPP) training cohort. This is an intervention model for children ages 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including Post-Traumatic Stress Disorder (PTSD).
- We added Eye Movement Desensitization as an evidence-based practice.
- Improve our presence in Saginaw Community Schools to assist youth with mental health concerns with Co-located therapists.
- Participated in CCBHC expansion grant.
- Currently participating in CCBHC demonstration grant with MSHN.
- Continue to have a co located primary healthcare clinic.
- Have co located laboratory services to accommodate transportation barriers for persons served.
- Have hired a Veterans Navigator.
- We have a Hispanic Outreach Worker to bridge the gap to services.
- Saginaw CMH became a Behavioral Health Home.
- Early Childhood Court Program Implementation partnering with local DHHS and Family Court.
- Peer from the Women of Color
- Ongoing TFCBT Training Cohort participation for children's clinical therapists
- Addition of a contracted BCBA to assist with Autism program/service management.

SHW

- Engaging in community outreach with schools, courts, community corrections, and DHS
- Participating in the Great Start collaborative and health and human services coalition
- Board representative for Child Advocacy Center
- Partnership with Shiawassee Community Health Center (Patient-Centered Medical Home) providing integrated health care in both the primary care setting and behavioral health setting
- Same-day Access
- Added Telehealth services
- Added ABA contract provider
- Partnership with DHS in providing continuing education for foster parents
- Partnership with the ISD and other community agencies in providing trauma-focused care
- Co-located early childhood staff with ISD, DHS, public health, early on
- Added Mobile crisis teams for adults and youth
- CISM team available to primary and secondary schools if needed
- Increased the availability of BHT services to meet the needs of the Autism expansion
- Robust respite program for children
- Participating in TF-CBT
- Efforts to expand service capacity for families and children to increase the number accessing services, as identified in the community needs assessment
- SHW became a Behavioral Health Home
- Under collaboration of the COSSUP grant and local law enforcement, added a Quick Response team and LEAD team to increase diversion rates of individuals with co-occurring disorders
- Increase preventative efforts including providing mental health first aid and Narcan distribution kits.
- Participating in the Ce-Cert cohort through the Children's trauma initiative to help with staff secondary traumatic stress and burn out, to increase staff retention and wellness.
- Development of the Wellness Experience training series for Clinical Staff, to provide them with support and resources.
- Eligibility training offered to community partners to help gain understanding about SHW and eligibility for CMH services.
- Enrollment of approximately 10 non- licensed clinical staff to the crisis professionals training offered through the partnership of Wayne State and MDHHS.

TRD

- Have two full-time School Outreach Workers to increase the collaboration and referral rate from schools
- Partnered with Ionia Schools and have one master’s level staff providing social work services to three Ionia elementary schools and Ionia Middle School.
- Participate in Great Start Collaborative in Ionia County in the executive meeting and on the full board meeting.
- Participate in School Readiness Advisory Council.
- We are providing ABA services to Montcalm Care Network.
- The Right Door has three homegrown BCBAs and have two BCBAs that came to us with their credentials. We have one person in BCBA in training.
- Providing screening at the courthouse to juvenile offenders.
- Child psychiatrist provides consultation to primary care providers and provides his personal cell phone number.
- Are a licensed child-placing agency.

- Provide treatment foster care.
- We have staff trained in and providing TF-CBT, Nurturing Parenting, Parenting Through Change and Love and Logic. PMTO and TRAILS provided in schools through School Outreach and School-based social workers. Child-Parent psychotherapy cohort certification.
- We are an active participant in the Children's Advocacy Center for Montcalm/Ionia Counties.
- Extensive collaboration with DHHS to provide coordination of care for children aging out of the Foster Care system.
- Directly providing Children's Mobile Crisis for Ionia County.
- Participate in ICAN (Ionia County Council for the Prevention of Child Abuse). Parent partner available to families being served.
- Provide outreach at numerous housing complexes in Ionia County.
- Participate with the Ionia County Substance Abuse Coalition.
- Executive committee member of the Ionia County Community Collaborative – the social services collaborative expanding service understanding and referrals.
- Became a provisionally certified CCBHC and expanded service providers in outpatient therapy, access, added care coordinators, nursing staff and peers.
- Hold monthly meetings with local DHHS Partners
- Hold monthly meetings with Ionia ISD and Local school administrators.
- Participate in school safety committee
- Hosted a booth for kid's day at Ionia County Fair – Kids yoga and coping mechanism card handout
- Participate in Family Support and Wellness Committee
- Participate in local interagency coordinating council
- Provide Youth Peer Services
- Expanded number of intake clinicians to prepare for CCBHC expansion
- Expanded number of outpatient clinicians to prepare for CCBHC expansion
- Mental Health First Aid- two staff providing this training.
- Parent support partner providing services.
- Outreach at community events to families.
- Jail Diversion clinician and groups provided at the Jail.
- Med Services expanded through CCBHC.

TBHS

- Participate in Great Start Collaborative as well as subcommittees providing education, support and services to children and families.
- Participate in a court collaboration process which primarily focuses on multi-agency involvement in providing services to children and families.
- Participating in multiple EBPs such as PMTO, PTC, TF-CBT.
- Active in community events where outreach to families occurs.
- Provide ongoing presentations and education as requested by community agencies (local hospitals, DHHS, courts, etc.).
- Active in Child Death Review Board to evaluate service delivery as well as services offered, gaps, etc. to assist in preventing county wide child deaths.
- Have staff trained in Mental Health First Aid Youth
- Continued services with the Parent Support Partner to work with parents.
- Continued services with Youth Peer Support.
- Continued Intensive Crisis Stabilization Services for Children.
- Additional staff have been trained in various Evidence-Based Practices for children.

- TBHS participates in case consultation meetings with Tuscola Probation every six weeks as it relates to coordinating treatment and care for children.
- TBHS continues with the contracts with the five ABA providers, with two clinic-based and three home/community-based providers.
- Began providing Wrap-Around services within TBHS.
- Treatment participation in the Juvenile Mental Health Court.
- Infant Mental Health staff participate in the Maternal Infant Health Program quarterly meetings for ongoing collaboration.
- Began to have collaborative meetings with Tuscola MDHHS and TBHS staff to foster working relationships.

FY24 Recommendations & Status Update

1) MSHN's Home Based Services FY24 Ratio: 575,706 Total MH Medicaid Enrollees to 151.85, which is under the required ratio of 283.78 FTEs. Conduct additional analysis to determine appropriate home-based service demand and deficit areas in the region. (MSHN Lead: Chief Behavioral Health Officer)
    a. Status Update: The Medicaid enrollees total is calculated with *all ages,* meaning that the ratio noted above will continue to make the MSHN ratio of FTEs appears to be inadequate. The eligibles should be calculated against youth eligibles who are the subjects of home-based services. The CMHSPs all meet programmatic FTE requirements which exception of one which is actively recruiting to fill an open position and therefore address the issue. If the eligibles to FTE ratio were calculated against youth eligibles, the MSHN region would meet this requirement.
2) MSHN's Wraparound FY24 Ratio: 575,706 Total MH Medicaid Enrollees to 34.3 FTEs, which DOES NOT meet the required 113.51. Conduct additional analysis to determine appropriate wraparound demand and deficit areas in the region. (MSHN Lead: Chief Behavioral Health Officer)
    a. Status Update: Note that wraparound services were originally part of the Serious Emotional Disturbance Waiver (SEDW) and when the Intensive Care Coordination with Wraparound policy took effect on 10/2/2024, wraparound was transitioned to the state plan under the Intensive Care Coordination with Wraparound (ICCW). ICCW wraparound is now programmatically one FTE care coordinator per 10-12 families.
3) MSHN will continue to work with our CMHSPs on building appropriate network capacity to serve all individuals eligible for autism specific services within a timely manner (focus on LifeWays and CMHCM regions). (MSHN Lead: Chief Behavioral Health Officer)
    a. Status Update:
        i. Evaluate current numbers served per MSHN CMHSP and impact relative to current capacity: completed
        ii. Create plan for underserved counties through the Regional Autism Workgroup: In progress. MSHN has been in contact with both ABA providers and Qualified Licensed Practitioners (QLPs) who are interested in increasing capacity throughout our region. MSHN has shared information and provided introductions to CMHSPs for consideration.
        iii. MSHN to implement plan to build network capacity: In progress.
        iv. Threats to network capacity: Ending of QBHP allowance 9.30.2025, emphasis on use of BCBAs for writing of behavior treatment plans for all individuals served, proposal to include and allow for Medicaid Autism services to be provided within the identified school day, and advocacy for removal of the age cap of 21 for autism services.
4) MSHN will continue to work with MDHHS to increase pediatric bed availability statewide. (MSHN Lead: Chief Behavioral Health Officer)
    a. Status Update: The Chief Behavioral Health Officer of MSHN is participating in a state workgroup in April 2025 to address pediatric bed availability. The Clinical Leadership Committee will also be discussing the issue and providing input.
5) MSHN will continue to work with in-region and participate in state-wide efforts to address the workforce shortage and increase timelines to services. (MSHN Lead: Chief Behavioral Health Officer)
    a. Status Update: MSHN has facilitated the use of MDHHS programs relating to tuition coverage and internship programs. Relationships with universities have also been

established to encourage interns and facilitate completion of master's degrees. Partnerships are also shared with the MSHN CMHSPs to further leverage opportunities.

6) MSHN will continue to evaluate, coordinate, and implement changes specific to the new ASAM Criteria 4th edition and ensure training opportunities for the network. (MSHN Lead: Director of SUD Systems & Operations)
    a. Status Update: MSHN will be supporting 10-13 ASAM Criteria 4th edition trainings in FY24 to ensure SUD treatment provider capacity is available for implementation of the new criteria by 10-1-2025 as indicated by MDHHS as the target deadline. These trainings will offer both in-person (3) and virtual (10) formats. MSHN will be providing attendees who successfully complete the training with an ASAM Criteria 4th edition manual and a $100 per diem to the provider for the clinician's time away from billable services. Each ASAM Criteria training can support 40 individuals. Therefore the 10-13 trainings will be able to support 400 – 520 individuals within our contracted SUD provider network system. MDHHS is also offering 10 ASAM Criteria 4th edition trainings to assist with statewide training on this initiative in FY24.
    b. MSHN will also be evaluating and coordinating implementation changes specific to the ASAM Criteria 4th edition within our internal processes and procedures. The opportunity to begin this process to date, has been influenced by the lack of finalized SUD Treatment Policies with the updated ASAM Criteria information being finalized for distribution and details to the field by MDHHS.
7) MSHN will continue to look for opportunities to increase provider capacity to serve adolescents in need of SUD services. (MSHN Lead: Director of SUD Systems & Operations)
    a. Status Update: MSHN supported an RFP for adolescent services in FY24 with implementation into FY25. MSHN received two submissions from providers for SUD adolescent services and successfully contracted with one provider to expand outpatient services with MOUD availability. MSHN is currently working with the provider to implement the services in Arenac, Bay, Gladwin, Isabella, Midland, Saginaw, and Shiawassee counties. In regard to residential and withdrawal management SUD services for adolescents, MSHN continues to discuss and attempt to problem solve with other PIHPs and MDHHS-SUGE. In January 2025, after a few months of discussing the ongoing struggles to maintain SUD adolescent services in the State, especially with residential and Withdrawal Management Level of Care (WM LOC)'s, MDHHS indicated they would be willing to consider a proposal from the SUD Director group about ways to address and support sustainability for this area. MSHN is leading this effort along with participation from four (4) other PIHP regions. Plan to submit a proposal to address multiple adolescent pathways of services to MDHHS in FY25 for consideration of funding.
8) Continue to expand the number of Certified Community Behavioral Health Clinics (CCBHCs), Behavioral Health Homes (BHH), and Opioid Health Homes (OHH) in the region. (MSHN Lead: Chief Population & Health Officer)
    a. Status Update: The Michigan CCBHC demonstration pilot launched on October 1, 2021. Three CMHSPs in the MSHN region participated in the first cohort of the CCBHC demonstration pilot, including Community Mental Health Authority of Clinton, Eaton, Ingham Counties (CEI CMH), Saginaw County Community Mental Health Authority, and The Right Door for Hope, Recovery and Wellness in Ionia County. LifeWays joined the CCBHC demonstration pilot on October 1, 2023, extending CCBHC services to Jackson and Hilldale counties. There were 21,457 individuals enrolled in CCBHC services in the MSHN region as of 12/31/2024.

The Behavioral Health Home (BHH) initiative launched in the MSHN region on May 01, 2023. In the MSHN region there are currently five (5) CMHSPs participating in the BHH initiative including Saginaw County Community Mental Health Authority, Montcalm Care Network, Shiawassee Health & Wellness, Community Mental Health for Central Michigan, and Gratiot Integrated Health Network. There were 338 individuals enrolled in BHH services in the MSHN region as of 12/31/2024.

The Opioid Health Home (OHH) initiative launched in the MSHN region on October 1, 2022, with Victory Clinical Services in Saginaw as the sole OHH provider in the MSHN region during FY23. During FY24, five (5) additional locations received approval and certification from MSHN and MDHHS including Victory Clinic Services in Jackson, Victory Clinic Services in Lansing, Recovery Pathways in Bay City, MidMichigan Community Health Services in Houghton Lake, and Isabella Citizens for Health. MSHN released a Request for Interest (RFI) during Q1 of FY25 to gauge provider interest in becoming SUD Health Home (SUDHH) certified to serve the expanded eligible population. MSHN will be working with three (3) providers to expand SUDHH services to five (5) new locations throughout FY25. There were 466 individuals enrolled in SUDHH services in the MSHN region as of 12/31/2024.

9) MSHN will continue to work with MDHHS to increase children psychiatric capacity as well as conduct feasibility for out of state psychiatric services. (MSHN Lead: Chief Population & Health Officer and Chief Behavioral Health Officer)
    a. Status Update: Work has been done in establishing relationships with new psychiatric hospitals opening in Michigan. There has also been work to facilitate the use of adolescent Intensive Outpatient Program (IOP) for behavioral health.

FY25 Recommendations:

1. MSHN will continue to work with our CMHSPs on building appropriate network capacity to serve all individuals eligible for autism specific services within a timely manner (focus on LifeWays and CMHCM regions). (MSHN Lead: Chief Behavioral Health Officer)

2. For children's waiver programs, MSHN will continue to work to increase network provider capacity including but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite. (MSHN Lead: Chief Behavioral Health Officer)

3. MSHN will support implementation of ASAM Criteria 4th edition standards and updated MDHHS SUD Treatment Policies with the SUD provider network. (MSHN Lead: Director of SUD Operations)

4. MSHN will continue to problem solve and consult on opportunities to expand capacity for adolescent SUD services within the region, and the State. This especially includes SUD residential and withdrawal management services. (MSHN Lead: Director of SUD Operations)

5. MSHN will continue to support the expansion of SUD and Behavioral Health Home providers to benefit beneficiaries across the region. (MSHN Lead: Chief Population Health Officer)

6. MSHN will evaluate and address the absence of pediatric crisis residential within the region and seek to increase bed availability. (MSHN Lead: Chief Behavioral Health Officer)

MSHN FY25- Board of Directors and Operations Council - Balanced Scorecard

									Target Ranges		
Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	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	67%	Data Not Yet Available	0%	0%	>=75%		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)	MDHHS PIHP Contract: Performance Bonus Incentive Program	39%	Not Available	Not Available	Not Available	>=28%		>=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.	71%	Data Not Yet Available	0%	0%	Michigan 2023: 70.31%		70-100%	60-69%	<59%
	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	87%	Not Available	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.	95%	94%	0%	0%	>=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: 46.04% (10-1-23 thru 9-30-2024)	Initiation: 47.29% (1-1-24 thru 12-31-24)	0	0	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: 28.65% (10-1-23 thru 9-30-2024)	Engagement: 30.30% (1-1-24 thru 12-31-24)	0	0	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: 89.11% Engagement: 48.93% (10-1-23 thru 9-30-2024)	Initiation: 88.77% Engagement: 55.96% (1-1-24 thru 12-31-24)	0	0	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: 41.63%; E: 23.60%	Data Not Yet Available	0	0	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	13.2%	Not Available	Not Available	Not Available	<=15%		<=15%	16-25%	>25%
BETTER VALUE	MSHN Administrative Budget Performance actual to budget (%)	MSHN's BOARD APPROVED BUDGET	97%	97%	0%	0.0%	≥ 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.	4%	4%	0%	0.0%	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	0	0	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.	97%	Data Not Yet Available	0%	0%	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%	Not Available	Not Available	<= 5%		<=5%	6%-10%	>=11%

MSHN FY25- Board of Directors and Operations Council - Balanced Scorecard

									Target Ranges		
Key Performance Areas	**Key Performance Indicators**	**Aligns with**	**Actual Value (%) as of December 2024**	**Actual Value (%) as of March 2025**	**Actual Value (%) as of June 2025**	**Actual Value (%) as of September 2025**	**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	0	0.0%	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	65%	Not Available	Not Available	Not Available	100%		>=75%	50%-74%	<50%
BETTER PROVIDER SYSTEMS	Percentage of consumers indicating satisfaction with LTSS (Annual Comprehensive Total)	NCI-Satisfaction Section	Not Applicable			Not Available	>=80%		80%	75%-80%	75%
	Managed Care Information Systems (REMI) Enhancements	Patient Portal, BTPR, Critical incidents, EVV, etc.	1	Data not available yet	0	0	4		3	2	1
	Develop regionally standardized boilerplate and statement of work for: CLS / Specialized Residential Services	Strategic Plan - Better Provider Systems	Data not available for Dec and Mar	Data not available for Dec and Mar	0	0	Complete		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.	71%	Data not available yet	0%	0%	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	Black: 34.73% White: 38.90%	Data not available yet	0	0	Michigan FY 2023 Black: 35.65% White: 36.90%		Significant Decrease from FY 23 levels	No Significant Change in Disparity	Significant Increase from FY 23 levels
	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	Black: 10.15% White: 14.60%	Data not available yet	0	0	MSHN FY 2023 Black: 10.85% White: 13.81%		Significant Decrease from FY 23 levels	No Significant Change in Disparity	Significant Increase from FY 23 levels
	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	Not Available	Not Available	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 statistically lower than the White population and the index rate did not decrease)	EQR-PIP#1 Strategic Plan	No	No	Not Available	Not Available	Yes		Yes	No change	No

MSHN FY25 -Substance Use Disorder Health Home - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns With	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	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)	N=0*	N=0*	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)	N=0*	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)	100.00%*	95.45%*	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)	100.00%*	100.00%*	Not Available	Not Available		>58%		<58%
BETTER CARE	**Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries**	CMS	Not Available - Discountined by MDHHS							
BETTER HEALTH	Controlling High Blood Pressure (CBP)	CMS Health Home Core Set (2023)	66.67%*	71.43%*	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)	2.44%%	1.61%	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Colorectal Cancer Screening (COL)	CMS Health Home Core Set (2023)	N=0*	33.33%*	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)	0.00%*	50.00%*	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)	75.00%*	87.50%*	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)	0.00%*	0.00%*	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)	0.00%*	0.00%*	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				
BETTER CARE	Plan All-Cause Readmission Rate (PCR)	CMS Health Home Core Set (2023)	6.67%	19.35%	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)	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				
BETTER CARE	Inpatient Utilization (IU)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available	Not Available				

MSHN FY25 - Community Certified Behavioral Health Clinic - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns With	CCBHC Program	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	Target Value	Performance Level	Target Ranges		
CCBHC Reported Measures												
An asterisk (*) denotes a metric that is also a Quality Bonus Payment Measure. Please Note: The QBP is only pertinent to Medicaid CCBHC costs and beneficiaries.												
BETTER CARE	**1. Time to Services (I-SERV) ***	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration				
			CEI	Not Available	Not Available	Not Available	Not Available					
			Lifeways	Not Available	Not Available	Not Available	Not Available					
			The Right Door	Not Available	Not Available	Not Available	Not Available					
			SCCMHA	Not Available	Not Available	Not Available	Not Available					
BETTER CARE	**2. Depression Remission at Six Months (DEP-REM-6) * Ages 12+**	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	0.60%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			Lifeways	0.00%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			The Right Door	2.88%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			SCCMHA	3.85%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
BETTER HEALTH	3.A Preventive Care and Screening: Unhealthy Alcohol Use: Systematic Screening (ASC) Ages 18 +	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	8.55%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			Lifeways	3.29%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			The Right Door	67.87%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			SCCMHA	67.52%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
BETTER HEALTH	3.B Preventive Care and Screening: Unhealthy Alcohol Use: Brief Counseling (ASC) Ages 18 +	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	Not Available	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			Lifeways	Not Available	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			The Right Door	Not Available	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			SCCMHA	Not Available	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
BETTER HEALTH	4. Screening for Social Drivers of Health (SDOH) Ages 18+	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	Not Available	Not Available	Not Available	Not Available	Increase				
			Lifeways	Not Available	Not Available	Not Available	Not Available	Increase				
			The Right Door	Not Available	Not Available	Not Available	Not Available	Increase				
			SCCMHA	Not Available	Not Available	Not Available	Not Available	Increase				
BETTER CARE	5. Screening for Clinical Depression and Follow-Up Plan (CDF-AD) Ages 18+	CMS Adult Core Set (2023)	Michigan CCBHC Program	3.97%	3.89%	Not Available	Not Available	Decrease		>previous	no change	<previous
			CEI	0.97%	1.52%	Not Available	Not Available	Increase		>previous	no change	<previous
			Lifeways	1.23%	1.66%	Not Available	Not Available	Increase		>previous	no change	<previous
			The Right Door	5.62%	4.40%	Not Available	Not Available	Decrease		>previous	no change	<previous
			SCCMHA	5.13%	4.17%	Not Available	Not Available	Decrease		>previous	no change	<previous
BETTER CARE	6. Screening for Clinical Depression and Follow-Up Plan (CDF-CH) Ages 12-17	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	5.60%	Not Available	Not Available			>previous	no change	<previous
			CEI	Not Available	0.28%	Not Available	Not Available			>previous	no change	<previous
			Lifeways	Not Available	0%	Not Available	Not Available			>previous	no change	<previous
			The Right Door	Not Available	0%	Not Available	Not Available			>previous	no change	<previous
			SCCMHA	Not Available	4.06%	Not Available	Not Available			>previous	no change	<previous
BETTER HEALTH	7.A Preventive Care & Screening: Tobacco Use: Screening (TSC) Ages 18 +	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	8.61%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			Lifeways	71.74%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			The Right Door	35.85%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			SCCMHA	40.65%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
BETTER HEALTH	7.B Preventive Care & Screening: Tobacco Use: Cessation Intervention (TSC) Ages 18 +	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	Not Available	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			Lifeways	Not Available	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			The Right Door	Not Available	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
			SCCMHA	Not Available	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous
BETTER CARE	**8. 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					
			CEI	75.68%	Not Available	Not Available	Not Available	73.0%		>73%	no change	<73%
			Lifeways	43.20%	Not Available	Not Available	Not Available	73.0%		>73%	no change	<73%
			The Right Door	69.62%	Not Available	Not Available	Not Available	73.0%		>73%	no change	<73%
			SCCMHA	72.58%	Not Available	Not Available	Not Available	73.0%		>73%	no change	<73%
BETTER CARE	**9. 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					
			CEI	83.14%	Not Available	Not Available	Not Available	57.0%		>57%	no change	<57%
			Lifeways	26.72%	Not Available	Not Available	Not Available	57.0%		>57%	no change	<57%
			The Right Door	82.80%	Not Available	Not Available	Not Available	57.0%		>57%	no change	<57%
			SCCMHA	39.53%	Not Available	Not Available	Not Available	57.0%		>57%	no change	<57%
BETTER PROVIDER SYSTEM	10. Patient Experience of Care Survey (PEC) (Annual comprehensive score) Ages 18+	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	80.00%	Not Available	Not Available	Not Available	TBD				
			Lifeways	NA	Not Available	Not Available	Not Available	TBD				
			The Right Door	81.00%	Not Available	Not Available	Not Available	TBD				
			SCCMHA	75.00%	Not Available	Not Available	Not Available	TBD				
BETTER PROVIDER SYSTEM	11. Youth/Family Experience of Care Survey (Y/FEC) (Annual comprehensive score) Ages <18	SAMHSA Metrics and Quality	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	82.00%	Not Available	Not Available	Not Available	TBD				
			Lifeways	NA	Not Available	Not Available	Not Available	TBD				

	Ages 3-18	Measures (2016)	The Right Door	78.00%	Not Available	Not Available	Not Available	TBD						
			SCCMHA	84.00%	Not Available	Not Available	Not Available	TBD						
State Reported Measures														
Note: State Reported Measures will be reported to the PIHP/CCBHC by MDHHS														
BETTER CARE	12.A Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH) Initiation Phase Ages 6-12	CMS Child Core Set (2021)	Michigan CCBHC Program	68.12%	Not Available	Not Available	Not Available							
			CEI	61.11%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous		
			Lifeways	84.62%*	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous		
			The Right Door	77.78%*	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous		
			SCCMHA	84.62%*	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous		
BETTER CARE	12.B Follow-up care for children prescribed ADHD medication (ADD-CH) Continuation and Maintenance Phase Ages 6-12	CMS Child Core Set (2021)	Michigan CCBHC Program	68.12%	Not Available	Not Available	Not Available							
			CEI	61.11%	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous		
			Lifeways	84.62%*	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous		
			The Right Door	77.78%*	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous		
			SCCMHA	84.62%*	Not Available	Not Available	Not Available	Increase		>previous	no change	<previous		
BETTER HEALTH	13.A Antidepressant Medication Management Acute Phase (AMM-AD) Ages 18+	CMS Adult Core Set (2023)	Michigan CCBHC Program	51.75%	50.77%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			CEI	48.90%	50.00%	Not Available	Not Available	Increase		>previous	no change	<previous		
			Lifeways	49.72%	49.33%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			The Right Door	66.91%	68.00%	Not Available	Not Available	Increase		>previous	no change	<previous		
			SCCMHA	48.50%	45.67%	Not Available	Not Available	Decrease		>previous	no change	<previous		
BETTER HEALTH	13.B Antidepressant Medication Management Continuation Phase (AMM-AD) Ages 18+	CMS Adult Core Set (2023)	Michigan CCBHC Program	30.27%	29.69%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			CEI	31.05%	28.32%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			Lifeways	28.25%	30.04%	Not Available	Not Available	Increase		>previous	no change	<previous		
			The Right Door	40.44%	40.00%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			SCCMHA	23.61%	26.77%	Not Available	Not Available	Increase		>previous	no change	<previous		
BETTER CARE	14.A Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 30 days (FUA-AD) Ages 18+	CMS Adult Core Set (2023)	Michigan CCBHC Program	55.71%	55.37%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			CEI	52.60%	50.38%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			Lifeways	58.75%	55.81%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			The Right Door	65.52%	50.00%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			SCCMHA	68.75%	60.40%	Not Available	Not Available	Decrease		>previous	no change	<previous		
BETTER CARE	14.B Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 7 days (FUA-AD) Ages 18+	CMS Adult Core Set (2023)	Michigan CCBHC Program	36.83%	36.38%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			CEI	31.14%	30.68%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			Lifeways	37.50%	33.72%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			The Right Door	41.38%	20.83%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			SCCMHA	51.79%	44.97%	Not Available	Not Available	Decrease		>previous	no change	<previous		
BETTER CARE	15.A Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 30 days (FUA-CH) Ages 6-17	CMS Adult Core Set (2023)	Michigan CCBHC Program	36.83%	50.00%	Not Available	Not Available	Increase		>previous	no change	<previous		
			CEI	31.14%	25.00%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			Lifeways	37.50%	75.00%	Not Available	Not Available	Increase		>previous	no change	<previous		
			The Right Door	41.38%	66.67%	Not Available	Not Available	Increase		>previous	no change	<previous		
			SCCMHA	51.79%	50.00%	Not Available	Not Available	Decrease		>previous	no change	<previous		
BETTER CARE	15.B Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 7 days (FUA-CH) Ages 6-17	CMS Adult Core Set (2023)	Michigan CCBHC Program	38.84%	31.25%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			CEI	37.50%	12.50%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			Lifeways	40.00%	50.00%	Not Available	Not Available	Increase		>previous	no change	<previous		
			The Right Door	66.67%	66.67%	Not Available	Not Available	No Change		>previous	no change	<previous		
			SCCMHA	28.57%	30.00%	Not Available	Not Available	Increase		>previous	no change	<previous		
BETTER CARE	**16.A Follow-Up After Hospitalization for Mental Illness within 30 days (FUH-AD) * Ages 18+**	CMS Adult Core Set (2023)	Michigan CCBHC Program	69.71%	69.25%	Not Available	Not Available	75.0%		>75%		<58%		
			CEI	64.65%	62.84%	Not Available	Not Available	75.0%		>75%		<58%		
			Lifeways	73.31%	72.68%	Not Available	Not Available	75.0%		>75%		<58%		
			The Right Door	79.55%	81.40%	Not Available	Not Available	75.0%		>75%		<58%		
			SCCMHA	72.49%	73.26%	Not Available	Not Available	75.0%		>75%		<58%		
BETTER CARE	**16.B Follow-Up After Hospitalization for Mental Illness within 7 days (FUH-AD) * Ages 18+**	CMS Adult Core Set (2023)	Michigan CCBHC Program	45.70%	45.69%	Not Available	Not Available	48.0%		>48%		<58%		
			CEI	43.57%	44.33%	Not Available	Not Available	48.0%		>48%		<58%		
			Lifeways	43.40%	42.90%	Not Available	Not Available	48.0%		>48%		<58%		
			The Right Door	46.59%	48.84%	Not Available	Not Available	48.0%		>48%		<58%		
			SCCMHA	47.13%	47.16%	Not Available	Not Available	48.0%		>48%		<58%		
BETTER CARE	**17.A Follow-Up After Hospitalization for Mental Illness within 30 days (FUH-CH) * Ages 6-17 (Child/Adolescent)**	CMS Child Core Set (2023)	Michigan CCBHC Program	81.70%	82.50%	Not Available	Not Available	88.0%		>88%		<88%		
			CEI	89.09%	87.97%	Not Available	Not Available	88.0%		>88%		<88%		
			Lifeways	79.17%	81.01%	Not Available	Not Available	88.0%		>88%		<88%		
			The Right Door	88.24%	88.89%	Not Available	Not Available	88.0%		>88%		<88%		
			SCCMHA	76.53%	75.00%	Not Available	Not Available	88.0%		>88%		<88%		
BETTER CARE	**17.B Follow-Up After Hospitalization for Mental Illness within 7 days (FUH-CH) * Ages 6-17 (Child/Adolescent)**	CMS Child Core Set (2023)	Michigan CCBHC Program	60.13%	60.54%	Not Available	Not Available	60.0%		>60%		<60%		
			CEI	67.27%	67.72%	Not Available	Not Available	60.0%		>60%		<60%		
			Lifeways	55.56%	59.49%	Not Available	Not Available	60.0%		>60%		<60%		
			The Right Door	76.47%	61.11%	Not Available	Not Available	60.0%		>60%		<60%		
			SCCMHA	48.98%	50.00%	Not Available	Not Available	60.0%		>60%		<60%		
BETTER CARE	18.A Follow-Up After Emergency Department Visit for Mental Illness within 30 days (FUM-AD) Ages 18+	CMS Adult Core Set (2023)	Michigan CCBHC Program	65.56%	65.14%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			CEI	52.46%	51.84%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			Lifeways	85.86%	83.16%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			The Right Door	73.53%	81.08%	Not Available	Not Available	Increase		>previous	no change	<previous		
			SCCMHA	67.48%	66.67%	Not Available	Not Available	Decrease		>previous	no change	<previous		
BETTER CARE	18.B Follow-Up After Emergency Department Visit for Mental Illness within 7 days (FUM-AD)	CMS Adult Core Set (2023)	Michigan CCBHC Program	46.39%	46.34%	Not Available	Not Available	Decrease		>previous	no change	<previous		
			CEI	32.75%	33.82%	Not Available	Not Available	Increase		>previous	no change	<previous		
			Lifeways	68.59%	70.53%	Not Available	Not Available	Increase		>previous	no change	<previous		

	Ages 18+	(2023)	The Right Door	50.00%	56.76%	Not Available	Not Available	Increase		>previous	no change	<previous
			SCCMHA	46.34%	44.07%	Not Available	Not Available	Decrease		>previous	no change	<previous
BETTER CARE	19.A Follow-Up After Emergency Department Visit for Mental Illness within 30 days (FUM-CH) Ages 6-17	CMS Adult Core Set (2023)	Michigan CCBHC Program	86.87%	85.30%	Not Available	Not Available	Decrease		>previous	no change	<previous
			CEI	75.69%	73.02%	Not Available	Not Available	Decrease		>previous	no change	<previous
			Lifeways	94.59%	91.67%	Not Available	Not Available	Decrease		>previous	no change	<previous
			The Right Door	94.44%	94.44%	Not Available	Not Available	No Change		>previous	no change	<previous
			SCCMHA	71.77%	71.03%	Not Available	Not Available	Decrease		>previous	no change	<previous
BETTER CARE	19.B Follow-Up After Emergency Department Visit for Mental Illness within 7 days (FUM-CH) Ages 6-17	CMS Adult Core Set (2023)	Michigan CCBHC Program	71.41%	68.38%	Not Available	Not Available	Decrease		>previous	no change	<previous
			CEI	55.56%	53.17%	Not Available	Not Available	Decrease		>previous	no change	<previous
			Lifeways	78.38%	76.19%	Not Available	Not Available	Decrease		>previous	no change	<previous
			The Right Door	77.78%	72.22%	Not Available	Not Available	Decrease		>previous	no change	<previous
			SCCMHA	49.19%	48.28%	Not Available	Not Available	Decrease		>previous	no change	<previous
BETTER CARE	20.A Hemoglobin A1C Control for Patients with Diabetes was controlled (<8.0%) (HBD-AD)	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration				
			CEI	24.50%	Not Available	Not Available	Not Available			>previous	no change	<previous
			Lifeways	15.83%	Not Available	Not Available	Not Available			>previous	no change	<previous
			The Right Door	26.39%	Not Available	Not Available	Not Available			>previous	no change	<previous
			SCCMHA	30.24%	Not Available	Not Available	Not Available			>previous	no change	<previous
BETTER CARE	20.B Hemoglobin A1C Control for Patients with Diabetes was poorly controlled (>9.0) (HBD-AD)	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration				
			CEI	12.18%	Not Available	Not Available	Not Available			>previous	no change	<previous
			Lifeways	5.07%	Not Available	Not Available	Not Available			>previous	no change	<previous
			The Right Door	17.18%	Not Available	Not Available	Not Available			>previous	no change	<previous
			SCCMHA	10.74%	Not Available	Not Available	Not Available			>previous	no change	<previous
BETTER CARE	**21.A Initiation of Alcohol and Other Drug Dependence Treatment (IET-AD) *** **Ages 13+**	CMS Adult Core Set (2023)	Michigan CCBHC Program	41.36%	40.30%	Not Available	Not Available	41%		>41%		<41%
			CEI	44.24%	44.05%	Not Available	Not Available	41%		>41%		<41%
			Lifeways	31.56%	31.30%	Not Available	Not Available	41%		>41%		<41%
			The Right Door	42.86%	46.30%	Not Available	Not Available	41%		>41%		<41%
			SCCMHA	43.45%	43.30%	Not Available	Not Available	41%		>41%		<41%
BETTER CARE	**21.B Engagement of Alcohol and Other Drug Dependence Treatment MSHN (IET-AD) *** **Ages 13+**	CMS Adult Core Set (2023)	Michigan CCBHC Program	13.83%	13.67%	Not Available	Not Available	14%		>14%		<14%
			CEI	18.13%	18.17%	Not Available	Not Available	14%		>14%		<14%
			Lifeways	10.03%	9.42%	Not Available	Not Available	14%		>14%		<14%
			The Right Door	18.25%	21.30%	Not Available	Not Available	14%		>14%		<14%
			SCCMHA	13.45%	16.20%	Not Available	Not Available	14%		>14%		<14%
BETTER CARE	22.A Use of Pharmacotherapy for Opioid Use Disorder - any medication (OUD-AD) Ages 18-64	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			Lifeways	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			The Right Door	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			SCCMHA	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
BETTER CARE	22.B Use of Pharmacotherapy for Opioid Use Disorder-buprenorphine (OUD-AD) Ages 18-64	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			Lifeways	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			The Right Door	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			SCCMHA	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
BETTER CARE	22.C Use of Pharmacotherapy for Opioid Use Disorder - naltrexone (OUD-AD) Ages 18-64	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			Lifeways	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			The Right Door	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			SCCMHA	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
BETTER CARE	22.D Use of Pharmacotherapy for Opioid Use Disorder - long-action, injectable naltrexone (OUD-AD) Ages 18-64	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			Lifeways	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			The Right Door	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			SCCMHA	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
BETTER CARE	22.E Use of Pharmacotherapy for Opioid Use Disorder - methadone (OUD-AD) Ages 18-64	CMS Adult Core Set (2023)	Michigan CCBHC Program	Not Available	Not Available	Not Available	Not Available					
			CEI	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			Lifeways	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			The Right Door	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
			SCCMHA	Not Available	Not Available	Not Available	Not Available	10%		>10%		<10%
BETTER HEALTH	**23. Plan All-Cause Readmission Rate (PCR-AD) *** **Ages 18+**	CMS Adult Core Set (2023)	Michigan CCBHC Program	10.53%	10.94%	Not Available	Not Available	10%		>10%		<10%
			CEI	11.18%	10.82%	Not Available	Not Available	10%		>10%		<10%
			Lifeways	9.83%	9.76%	Not Available	Not Available	10%		>10%		<10%
			The Right Door	7.50%	9.16%	Not Available	Not Available	10%		>10%		<10%
			SCCMHA	13.59%	14.32%	Not Available	Not Available	10%		>10%		<10%
BETTER HEALTH	24. Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN Ages 19-64	CMS Adult Core Set (2023)	Michigan CCBHC Program	57.13%	55.93%	Not Available	Not Available	58.5%		>58.5%		<58.5%
			CEI	61.05%	56.29%	Not Available	Not Available	58.5%		>58.5%		<58.5%
			Lifeways	56.90%	56.40%	Not Available	Not Available	58.5%		>58.5%		<58.5%
			The Right Door	79.17%	76.00%	Not Available	Not Available	58.5%		>58.5%		<58.5%
			SCCMHA	57.73%	56.08%	Not Available	Not Available	58.5%		>58.5%		<58.5%
BETTER CARE	25. Child and Adolescent Well-Care Visits (WCV-CH)	CMS Child Core Set (2021)	Michigan CCBHC Program	52.53%	52.60%	Not Available	Not Available	Increase		>previous	no change	<previous
			CEI	47.68%	47.58%	Not Available	Not Available	Decrease		>previous	no change	<previous
			Lifeways	58.40%	56.65%	Not Available	Not Available	Decrease		>previous	no change	<previous
			The Right Door	52.91%	52.24%	Not Available	Not Available	Decrease		>previous	no change	<previous
			SCCMHA	54.83%	53.39%	Not Available	Not Available	Decrease		>previous	no change	<previous

MSHN FY25 - Behavioral Health Home - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	Performance Level	Target Ranges		
	Please Note: * Indicates Pay for Performance Measure									
BETTER HEALTH	**Increase in Controlling High Blood Pressure (CBP)***	CMS Health Home Core Set (2023)	64.86%	65.38%*	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	98.92%	100.00%	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)	10.71%*	13.04%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Colorectal Cancer Screening (COL)	CMS Health Home Core Set (2023)	0.00%*	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)	75.00%*	50.00%*	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)	75.00%*	50.00%*	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)	44.12%	38.89%	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)	88.24%	88.89%	Not Available	Not Available		>58%		<58%
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness within 7 days (FUM-7) Age 6 and over	CMS Health Home Core Set (2023)	61.90%*	73.68%*	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) Age 6 and over	CMS Health Home Core Set (2023)	80.95%*	84.21%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment within 14 days (IET-14) Only MSHN Claims	CMS Health Home Core Set (2023)	42.86%*	38.89%*	Not Available	Not Available		>25%		<25%
BETTER CARE	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment within 34 days (IET-34) Only MSHN Claims	CMS Health Home Core Set (2023)	14.29%*	11.11%*	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)	N=0*	N=0*	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)	18.75%	12.50%	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)	62 per 1,000 beneficiaries	90 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		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Inpatient Utilization (IU)	CMS Health Home Core Set (2023)	10 per 1,000 beneficiaries	10 per 1,000 beneficiaries	Not Available	Not Available		<previous reporting period	no change	>previous reporting period

MSHN FY25 - Quality Improvement Council - Scorecard

Key Performance Areas	Key Performance Indicators	Regulatory Requirement Source	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	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%	98.09%	Not Available	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%	99.70%	Not Available	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 Populations)	MDHHS PIHP Contract: Michigan Mission Based Performance Indicator System	MMBPIS FY24 Codebook Indicator 2	61.79%	58.29%	Not Available	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 Populations)	MDHHS PIHP Contract: Michigan Mission Based Performance Indicator System	MMBPIS FY24 Codebook Indicator 3	59.72%	61.76%	Not Available	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%	95.48%	Not Available	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%	95.61%	Not Available	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%	8.56%	Not Available	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%	10.12%	Not Available	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 Available	>=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 Available	>=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 Available	>=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 Available	>=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 statistically lower than the White population and the index rate did not decrease)	MDHHS PIHP Contract: QAPIP	EQR-PIP#1 Strategic Plan	No	No	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	3.106	2.598	Not Available	Not Available	FY24 14.685		Decrease	No change	Increase
BETTER HEALTH	The rate, per 1000 persons served, of Unexpected Deaths will demonstrate a decrease from previous measurment period (CMHSP - Cumulative YTD)	MDHHS PIHP Contract: QAPIP	MSHN QAPIP	0.400	0.344	Not Available	Not Available	FY24 .623		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%	Not Available	Not Available	Not Available	Decrease previous quarter .77%		Decrease	No change	Increase

MSHN FY25 - Customer Service Committee - Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	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	98.55%	Data Not Yet Available	-	-	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%	Data Not Yet Available	-	-	95%		95%	91%-94%	90%

MSHN FY25 - Regional Compliance Committee - Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	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	91.60%	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	85.65%	Not available	Not available	Not available	Increase over 2023		Increase	No change	Decrease

MSHN FY25- Clinical Leadership Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	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.	71.43%	Data Not Yet Available			Michigan 2023: 70.31%		70-100%	60-69%	<59%
BETTER HEALTH	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN Ages 19-64	MDHHS PIHP Contract: Performance Bonus Measure	66.97%	Data Not Yet Available			>=75%		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.	94.70%	94.30%			>=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.	97.40%	Data Not Yet Available			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.	Under review due to annual MDDHS review	Under review due to annual MDDHS review			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%	Data Not Yet Available			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: 41.63%; E: 23.60%	Data Not Yet Available			Increase over FY 2019 (I: 38.85%; E: 19.21%)		increase over 2019	No change from 2019 levels	Below 2019 levels

MSHN FY25 - Provider Network Management Committee - Balanced Scorecard

									Target Ranges		
Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	Target Value	Performance Level			
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; Advance use of MDHHS mandated CRM credentialing function	HSAG and MDHHS Reviews	25%	50%			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%			90%		>90%	70-89%	<70%
BETTER PROVIDER SYSTEM	Address recommendations from the 2024 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%		>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			Complete		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%			100%		>90%	70-89%	<70%
BETTER PROVIDER SYSTEM	Develop regionally standardized boilerplate and statement of work for: CLS / Specialized Residential Services	Strategic Plan - Better Provider Systems	Data not available for Dec and Mar	Data not available for Dec and Mar			Complete		Complete	In Process	Not Started
BETTER PROVIDER SYSTEM	Develop and implement regionally approved process for credentialing/re-credentialing reciprocity; Use of MDHHS mandated CRM Credentilaing function	QAPIP Goal; HSAG and MDHHS reviews	CRM required as of 10.1.24; Data not available for Dec and Mar	CRM required as of 10.1.24; Data not available for Dec and Mar			Complete		Complete	In Process	Not Started

MSHN FY25 - Clinical SUD - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	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	Q1 data will be available after Q2 when MPDS is fully operational	Q2 data will be available when MPDS is fully operational			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			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.	Initation: 72.66% Engagement: 41.80% (10-1-23 thru 9-30-2024)	Initiation: 71.81% Engagement: 44.02% (1-1-24 thru 12-31-24)			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: 89.11% Engagement: 48.93% (10-1-23 thru 9-30-2024)	Initiation: 88.77% Engagement: 55.96% (1-1-24 thru 12-31-24)			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: 46.04% (10-1-23 thru 9-30-2024)	Initiation: 47.29% (1-1-24 thru 12-31-24)			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: 28.65% (10-1-23 thru 9-30-2024)	Engagement: 30.30% (1-1-24 thru 12-31-24)			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	Black: 34.73% White: 38.90%	Data not available yet			Michigan FY 2023 Black: 35.65% White: 36.90%		Significant Decrease from FY 23 levels	No Significant Change in Disparity from FY 23 levels	Significant Increase from FY 23 levels
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	Black: 10.15% White: 14.60%	Data not available yet			MSHN FY 2023 Black: 10.85% White: 13.81%		Significant Decrease from FY 23 levels	No Significant Change in Disparity from FY 23 levels	Significant Increase from FY 23 levels
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	90.95%	95.27%			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.	81.00%	Data not available yet			>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	73.43%	MDHHS Calculated Data for FY25Q1 not yet available			>75.3%		>75.5%		<75.5%

MSHN FY25 Information Technology Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September	Target Value	Performance Level	Target Ranges		
BETTER VALUE	Unique consumers submitted monthly	Contractual Reporting Oversight	95.3%	Data not available yet			85%		86.0%	85.0%	84.0%
BETTER VALUE	Encounters submitted monthly	Contractual Reporting Oversight	90.0%	Data not available yet			85%		86.0%	85.0%	84.0%
BETTER VALUE	BH-TEDS submitted monthly	Contractual Reporting Oversight	85.0%	Data not available yet			85%		86.0%	85.0%	84.0%
BETTER VALUE	Percentage of encounters with BH-TEDS	Contractual Reporting Oversight	98.7%	Data not available yet			95%		95.0%	94.0%	90.0%
BETTER CARE	Implementation of Vital Data Predictive Modeling Grant Project	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	50.0%	Data not available yet			100%		75%	50%	25%
BETTER HEALTH	Complete RFP and selection of regional Data Analytics Platform	MSHN FY24-25 Strategic Plan - Increase regional use of information technology data systems to support population health management.	25.0%	Data not available yet			100%		75%	50%	25%
BETTER HEALTH	Increase health information exchange/record sets (OHH and BHH atribution files to ZTS, CMHSP autism data, 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	Data not available yet			2		2	1	0
BETTER PROVIDER SYSTEM	Managed Care Information Systems (REMI) Enhancements	Patient Portal, BTPR, Critical incidents, EVV, etc.	1	Data not available yet			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.	55.0%	Data not available yet			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	70.6%	Data not available yet			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%	Data not available yet			100%		75%	50%	25%

MSHN FY25 - Integrated Care - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	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)	MDHHS PIHP Contract: Performance Bonus Incentive Program	39%	Not Available	Not Available	Not Available	>=28%		>=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	Not Available	Not Available	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	86.60%	Not Available	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	68.91%	Not Available	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	Not Available	Not Available	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	Not Available	Not Available	Not Available	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	Not Available	Not Available	Not Available	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	81%	Not Available	Not Available	Not Available	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	64.71%	Not Available	Not Available	Not Available	100.0%		>=75%	50%-74%	<50%

MSHN FY25 - Finance Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	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.	4.3%	4.3%			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	Data not available	Data not available			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%		> 92%	< 92% and > 85%	≤ 85%
BETTER VALUE	MSHN Administrative Budget Performance actual to budget (%)	MSHN's BOARD APPROVED BUDGET	97.40%	97.40%			≥ 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			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			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	1	0

MSHN FY25 - Utilization Management Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2024	Actual Value (%) as of March 2025	Actual Value (%) as of June 2025	Actual Value (%) as of September 2025	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	Not Available	Not Available	Not Available	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	65.00%	68.0%	Not Available	Not Available	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	13.24%	Not Available	Not Available	Not Available	<=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	95.20%	Not Available	Not Available	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%	Not Available	Not Available	<= 5%		<=5%	6%-10%	>=11%

MSHN
Mid-State Health Network

Background:

In accordance with the MSHN Board of Directors to review financials, at a minimum quarterly, the Preliminary Statement of Net Position and Statement of Activities for the Period Ending March 31, 2025, 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 March 31, 2025, as presented.

Mid-State Health Network
Statement of Activities
As of March 31, 2025

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			
			50.00%					
1	Revenue:							
2	Grant and Other Funding		$ 280,000	449,956	140,000	309,956	160.70 %	1a
3	Prior FY Medicaid Carryforward		$ 0	0	0	0		1b
4	Medicaid Capitation		904,524,545	433,540,516	452,262,272	(18,721,757)	47.93%	1c
5	Local Contribution		1,550,876	775,438	775,438	0	50.00%	1d
6	Interest Income		2,500,000	699,152	1,250,000	(550,847)	27.97%	1e
7	Non Capitated Revenue		18,132,736	7,252,863	9,066,368	(1,813,505)	40.00%	1f
8	Total Revenue		926,988,157	442,717,925	463,494,078	(20,776,153)	47.76 %	
9	Expenses:							
10	PIHP Administration Expense:							
11	Compensation and Benefits		9,181,634	3,940,499	4,590,817	(650,318)	42.92 %	
12	Consulting Services		223,800	46,447	111,900	(65,453)	20.75 %	
13	Contracted Services		126,350	50,710	63,175	(12,465)	40.13 %	
14	Other Contractual Agreements		679,700	269,125	339,850	(70,725)	39.59 %	
15	Board Member Per Diems		20,820	5,670	10,410	(4,740)	27.23 %	
16	Meeting and Conference Expense		214,043	60,918	107,021	(46,104)	28.46 %	
17	Liability Insurance		34,590	32,369	17,295	15,074	93.58 %	
18	Facility Costs		192,636	96,789	96,318	472	50.24 %	
19	Supplies		371,650	82,842	185,826	(102,984)	22.29 %	
20	Other Expenses		1,076,330	814,909	538,165	276,744	75.71 %	
21	Subtotal PIHP Administration Expenses		12,121,553	5,400,278	6,060,777	(660,499)	44.55 %	2a
22	CMHSP and Tax Expense:							
23	CMHSP Participant Agreements		822,423,444	385,618,903	411,211,721	(25,592,819)	46.89 %	1b,1c,2b
24	SUD Provider Agreements		67,318,827	29,245,890	33,659,414	(4,413,523)	43.44 %	1c,1f,2c
25	Benefits Stabilization		1,610,000	4,330,000	805,000	3,525,000	268.94 %	1b
26	Tax - Local Section 928		1,550,876	775,438	775,438	0	50.00 %	1d
27	Taxes- IPA/HRA		51,290,698	21,008,709	25,645,349	(4,636,640)	40.96 %	2d
28	Subtotal CMHSP and Tax Expenses		944,193,845	440,978,940	472,096,922	(31,117,982)	46.70 %	
29	Total Expenses		956,315,398	446,379,218	478,157,699	(31,778,481)	46.68 %	
30	Excess of Revenues over Expenditures		$ (29,327,241)	$ (3,661,293)	$ (14,663,621)			

Mid-State Health Network
Preliminary Statement of Net Position by Fund
As of March 31, 2025

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		14,910,697	0	14,910,697	1a
4	Chase MM Savings		10,364,396	0	10,364,396	
5	Savings ISF Account		0	30,689,232	30,689,232	1b
6	Savings PA2 Account		3,512,591	0	3,512,591	1c
7	Investment PA2 Account		3,499,403	0	3,499,403	1c
8	Investment ISF Account		0	11,999,685	11,999,685	1b
9	Total Cash and Short-term Investments		$ 32,287,087	$ 42,688,917	$ 74,976,004	
10	**Accounts Receivable**					
11	Due from MDHHS		50,938,433	0	50,938,433	2a
12	Due from CMHSP Participants		4,733,698	0	4,733,698	2b
13	Due from Miscellaneous		361,199	0	361,199	2c
14	Due from Other Funds		8,882,964	0	8,882,964	2d
15	Total Accounts Receivable		64,916,294	0	64,916,294	
16	**Prepaid Expenses**					
17	Prepaid Expense Rent		4,529	0	4,529	2e
18	Prepaid Expense Other		12,262	0	12,262	2f
19	Total Prepaid Expenses		16,791	0	16,791	
20	**Fixed Assets**					
21	Fixed Assets - Computers		189,180	0	189,180	2g
22	Accumulated Depreciation - Computers		(189,180)	0	(189,180)	
23	Lease Assets		151,169	0	151,169	2h
24	Accumulated Amortization - Lease Asset		(132,273)	0	(132,273)	
25	Total Fixed Assets, Net		18,896	0	18,896	
26	**Total Assets**		**$ 97,239,068**	**$ 42,688,917**	**$ 139,927,985**	
27						
28	**Liabilities and Net Position**					
29	Liabilities					
30	Accounts Payable		$ 6,519,114	$ 0	$ 6,519,114	1a
31	Current Obligations (Due To Partners)					
32	Due to State		32,877,080	0	32,877,080	3a
33	Other Payable		5,189,676	0	5,189,676	3b
34	Due to Hospitals (HRA)		17,536,668	0	17,536,668	1a, 3c
35	Due to State-IPA Tax		1,736,020	0	1,736,020	3d
36	Due to CMHSP Participants		15,149,617	0	15,149,617	3e
37	Due to other funds		0	8,882,964	8,882,964	3f
38	Accrued PR Expense Wages		133,639	0	133,639	3g
39	Accrued Benefits PTO Payable		453,683	0	453,683	3h
40	Accrued Benefits Other		80,517	0	80,517	3i
41	Total Current Obligations (Due To Partners)		73,156,900	8,882,964	82,039,864	
42	Lease Liability		19,970	0	19,970	2h
43	Deferred Revenue		5,243,096	0	5,243,096	1b 1c
44	Total Liabilities		84,939,080	8,882,964	93,822,044	
45	Net Position					
46	Unrestricted		12,299,988	0	12,299,988	3j
47	Restricted for Risk Management		0	33,805,953	33,805,953	1b
48	Total Net Position		12,299,988	33,805,953	46,105,941	
49	**Total Liabilities and Net Position**		**$ 97,239,068**	**$ 42,688,917**	**$ 139,927,985**	

Mid-State Health Network
Financial Statement Notes
For the Six-Month Period Ended,
March 31, 2025

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 final MDHHS Financial Status Report (FSR) submitted in February 2025. The Statement of Net Position will be final after MSHN's Compliance Examination is completed as the report will also include CMHSP adjustments.

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 28% 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.
    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 36% 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 24% of the balance results from withholds while October through March Hospital Rate Adjustor (HRA) amounts account for 34% of the total. Lastly, the remaining balance stems from miscellaneous items.
    b) Due From CMHSP Participants reflect FY 2024 cost settlement activity. Final cost settlements generally occur in May after the fiscal year ends and once Compliance Examination are complete.

CMHSP	Cost Settlement	Payments/Offsets	Total
CEI	4,718,564.99	-	4,718,564.99
Tuscola	15,133.46	-	15,133.46
Total	**4,733,698.45**	**-**	**4,733,698.45**

    c) The balance in Due From Miscellaneous is split 37% and 63% (respectively) for Medicaid Event Verification (MEV) findings and cash advances needed to cover operations for a small number of SUD providers.
    d) Due From Other Funds is the account used to manage anticipated ISF transfers. Approximately $24.9 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.
    e) Prepaid Expense Rent balance consists of security deposits for MSHN office suites.

f) Prepaid Expense Other consists primarily of an advance payment for MSHN's filing platform Box with a small portion relating to FY 26's Relias balance.
g) Total Fixed Assets - Computers represent the value of MSHN's capital asset net of accumulated depreciation.
h) 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 cost settlement figures based on the MDHHS Final 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	5,522,352.18	-	3,913,812.00	1,608,540.18
Central	6,202,179.56	(2,495.84)	5,397,005.00	802,678.72
Gratiot	2,453,101.64	(311.98)	1,851,292.00	601,497.66
Huron	2,578,086.91	-	2,222,821.00	355,265.91
The Right Door	763,957.29	-	-	763,957.29
Lifeways	10,283,756.93	-	8,002,409.00	2,281,347.93
Montcalm	187,616.19	(1,559.90)	423,939.00	(237,882.71)
Newaygo	1,531,762.19	-	1,231,576.00	300,186.19
Saginaw	6,837,281.68	(173,148.90)	-	6,664,132.78
Shiawassee	2,679,927.43	163,541.14	833,576.00	2,009,892.57
Total	**39,040,022.00**	**(13,975.48)**	**23,876,430.00**	**15,149,616.52**

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 2d for more details.
g) Accrued Payroll Expense Wages represent expenses incurred in March and paid in April.
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 March and paid in April.
j) The Unrestricted Net Position represents the difference between total assets, total liabilities, and the restricted for risk management figure.

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 50% translate to MSHN receiving less revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 50% 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 will not have 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. The amount earned is lower than budget as the investment totals have been reduced to ensure sufficient cash on hand for ongoing operations. (Please see Statement of Net Position 1b.)
    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 1c 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 March 31, 2025

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	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	10,143,000.00			
UNITED STATES TREASURY BILL	912797NK9						(10,143,000.00)			
UNITED STATES TREASURY BILL	912797KA4	11.19.24	11.21.24	2.20.25		1,998,981.77	2,021,000.00			
UNITED STATES TREASURY BILL	912797KA4						(2,021,000.00)			
UNITED STATES TREASURY BILL	912797NM5	2.18.25	2.20.25	5.22.25		1,999,952.41	1,999,952.41			
UNITED STATES TREASURY BILL	912797PU5	3.3.25	3.4.25	7.1.25		9,999,732.77	9,999,732.77			
JP MORGAN INVESTMENTS							11,999,685.18			11,999,685.18
JP MORGAN CHASE SAVINGS							30,438,778.66	0.020%	250,453.17	30,689,231.83
							$ 42,438,463.84		$ 250,453.17	$ 42,688,917.01

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 March 31, 2025

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	9127979LK1	6.3.24	6.4.24	10.1.24		3,499,660.72	3,560,000.00			
UNITED STATES TREASURY BILL	9127979LK1	6.3.24	6.4.24	10.1.24			(3,560,000.00)			
UNITED STATES TREASURY BILL	912796ZV4	9.30.24	10.1.24	12.26.24		3,499,843.32	3,537,000.00			
UNITED STATES TREASURY BILL	912796ZV4	9.30.24	10.1.24	12.26.24			(3,537,000.00)			
UNITED STATES TREASURY BILL	912797PA9	12.23.24	12.26.24	4.22.25		3,499,402.50	3,499,402.50			
JP MORGAN INVESTMENTS							3,499,402.50			3,499,402.50
JP MORGAN CHASE SAVINGS							3,509,537.63	0.010%	3,053.75	3,512,591.38
							$ 7,008,940.13		$ 3,053.75	$ 7,011,993.88

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
Mid-State Health Network

Background

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

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

Therefore, MSHN presents the attached 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
May 2025

CONTRACTING ENTITY	PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY25 COST REIMBURSEMENT CONTRACT AMOUNT	FY25 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY25 INCREASE/ (DECREASE)
PIHP ADMINISTRATIVE FUNCTION CONTRACTS					
Kelly Services, Inc.	Temporary Staffing	5.1.25 - 9.30.25	90,000	**140,000**	**50,000**
Wakely Consulting Group	Internal Service Fund Analysis	5.1.25 - 9.30.25	$ 30,000	**$ 60,000**	**30,000**
			$ 30,000	**$ 60,000**	**$ 30,000**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY25 COST REIMBURSEMENT CONTRACT AMOUNT	FY25 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY25 INCREASE/ (DECREASE)
Peer 360	African American Outreach in Saginaw County for groups, events, harm reduction (PA2; Saginaw)	4.1.25 - 9.30.25	1,308,700	**1,358,091**	**49,391**
Randy's House	Montcalm County Drop-In Center Funding Support	4.1.25 - 9.30.25	89,654	**138,417**	**48,763**
Ten16	Harm Reduction Supplies & Materials, Lock Boxes, Deterra Bags; Staff Certifications/Trainings, & Grief Support Groups	4.1.25 - 9.30.25	1,068,375	**1,133,673**	**65,298**
			$ 2,466,729	**$ 2,630,181**	**$ 163,452**

CONTRACTING ENTITY	SUD PROVIDERS FFS PROGRAM DESCRIPTION	CONTRACT TERM			
Lifeways	Substance Use Disorder - Opioid Health Home	5.1.25 - 9.30.25	-	-	-
Sacred Heart	Substance Use Disorder - Opioid Health Home	5.1.25 - 9.30.25	-	-	-
Recovery Pathways	Substance Use Disorder - Opioid Health Home	5.1.25 - 9.30.25	-	-	-
			$ -	$ -	$ -

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	Medicaid Managed Specialty Supports and Services Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs (FY25) - Amendment 2	10.1.24 - 9.30.25	-	-	-
			$ -	$ -	$ -

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, March 4, 2025
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 unless absent due to military duty, disability, or health-related condition and the Board Member Conduct Policy, emphasizing that members seek recognition from the chair and honor time limits. Mr. Woods expressed gratitude to all MSHN staff and their ongoing commitment, especially during the very volatile environment occurring in the past few months. Ms. Amanda Ittner introduced MSHN's newest staff members: Rusmira Bektas, Access Administrator; Eric Turner, Access Specialist; Marc Irish, Access Specialist; Sarah Winchell-Gurski, Access Specialist, and Liz Philpott, Integrated Health Administrator.

2. Roll Call

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

Board Member(s) Present: Patty Bock (Huron), Greg Brodeur (Shiawassee), Cindy Garber (Shiawassee), Tina Hicks (Gratiot), John Johansen (Montcalm), Deb McPeek-McFadden (The Right Door), Paul Palmer (CEI), 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 5:17 p.m., Richard Swartzendruber (Huron), Joanie Williams (Saginaw)-joined at 5:06 p.m., and Ed Woods (LifeWays)

Board Member(s) Remote: Ken DeLaat (Newaygo)-Newaygo, MI, David Griesing (Tuscola)-Vassar, MI, Dan Grimshaw (Tuscola)-Vassar, MI-joined at 5:11 p.m., Irene O'Boyle (Gratiot)-Zapata, TX, Kurt Peasley (Montcalm)-Covington, LA, and Susan Twing (Newaygo)-White Cloud, MI

Board Member(s) Absent: Brad Bohner (LifeWays) and Pat McFarland (BABH)

Staff Member(s) Present: Joseph Sedlock (Chief Executive Officer), Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Sherry Kletke (Executive Support Specialist), Kim Zimmerman (Chief Compliance and Quality Officer), Dr. Todd Lewicki (Chief Behavioral Health Officer), Skye

Pletcher (Chief Population Health Officer), Rusmira Bektas (Access Administrator), Eric Turner (Access Specialist), Marc Irish (Access Specialist), Sarah Winchell-Gurski (Access Specialist), and Liz Philpott (Integrated Health Administrator)

3. Approval of Agenda for March 4, 2025

Board approval was requested for the Agenda of the March 4, 2025, Regular Business Meeting.

MOTION BY PAUL PALMER, SUPPORTED BY GREG BRODEUR, FOR APPROVAL OF THE AGENDA OF MARCH 4, 2025 WITH THE ADDITION OF MDHHS ANNOUNCEMENT OF PIHP RE-BID, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 14-0.

4. Public Comment

There was no public comment.

5. Michigan Department of Health and Human Services Announcement of Prepaid Inpatient Health Plan Re-Bid

The Michigan Department of Health and Human Services (MDHHS) published a press release on Friday, February 28, 2025, announcing a competitive procurement of all 10 Prepaid Inpatient Health Plans (PIHPs) in Michigan. Administration distributed the press release along with some initial information obtained to the, Board of Directors, Substance Use Disorder (SUD) Oversight Policy Board, Operations Council , SUD Provider Network, MSHN staff, and called together a last minute all-staff meeting the same day. Provider network communication occurred as well. MSHN Administration has created a list of criteria to consider for current projects and to assist with organizational priorities through FY26. Mr. Joe Sedlock emphasized that MSHN will continue providing quality supports and services and comply with current PIHP/MDHHS contract provisions. MSHN administration requests a formal statement of support from the board to position the organization to be a successful contender for the upcoming procurement understanding the parameters for the bid proposal are unknown at this time and that any elements requiring board approval will be presented at a later date.

MSHN administration recommends cancelling the all-day Strategic Planning meeting set for May 13, 2025 and to extend the current Strategic Plan for up to two years. There were no objections to these actions.

MOTION BY JOHN JOHANSEN, SUPPORTED BY TINA HICKS, FOR SUPPORTING THE MSHN LEADERSHIP TEAM TO UNDERTAKE EXPLORATORY ACTIVITIES THAT WILL LEAD TO POSITIONING MSHN AND/OR THE REGION TO BE A SUCCESSFUL POTENTIAL BIDDER FOR THE UPCOMING PROCUREMENT OF THE PIHP SYSTEM. MOTION CARRIED: 15-0.

6. Conflict Free Access and Planning Update

Dr. Todd Lewicki provided a presentation to board members with an update on the latest information regarding Conflict Free Access and Planning included in the board meeting packet. Mr. Sedlock acknowledged Dr. Lewicki for staying well-versed with the progress of this initiative.

7. FY2025 Quality Assessment and Performance Improvement Program (QAPIP) and the FY2024 Annual Effectiveness Evaluation

Ms. Kim Zimmerman presented an overview of the FY2025 Corporate Compliance Plan and the FY2024 Compliance Report included within the board meeting packet and recommended for board approval. Mr. Sedlock acknowledged Ms. Zimmerman and her team for their work on the multitude of compliance requirements.

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY RICHARD SWARTZENDRUBER, TO ACKNOWLEDGE RECEIPT OF AND APPROVE THE MSHN FY2025 CORPORATE COMPLIANCE PLAN AND THE FY2024 ANNUAL COMPLIANCE SUMMARY REPORT. MOTION CARRIED: 15-0.

8. FY2024 Board Self-Assessment

Ms. Irene O'Boyle summarized the FY2024 Board Self-Assessment results along with the summary report that can be found in the board meeting packet. The board self-assessment trending report from FY2020-FY2024 was also included in the board meeting packet. It should be noted that only twelve (12) of the currently seated twenty-three (23) members completed the evaluation. Mr. Ed Woods expressed his appreciation to Ms. O'Boyle for taking the lead on the Board Self-Assessment project.

MOTION BY TRACEY RAQUEPAW , SUPPORTED BY PAUL PALMER, TO RECEIVE AND FILE THE FY2024 BOARD SELF-ASSESSMENT REPORT. MOTION CARRIED: 15-0.

9. Chief Executive Officer's Report

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

- PIHP/Regional Matters
  - MDHHS Site Review – Repeat Citation for Use of Ranges in Plans of Service (all available avenues for appeal have been exhausted and the MSHN region will now comply).
- State of Michigan/Statewide Activities – See written report for details.
  - MSHN/MDHHS "Master Contract" for FY25

- MDHHS Announces "Reconfiguration" of MDHHS/PIHP CEO Meetings and MDHHS/PIHP Contract Meetings

10. Deputy Director's Report

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

- Health Insurance Update
- Earned Sick Time Act
- Regional Consumer Advisory Council
- Information Technology Report FY24Q4

11. Chief Financial Officer's Report

Ms. Leslie Thomas provided an overview of the FY2025 Financial Analysis and financial statements included within board meeting packets for the period ended January 31, 2025.

MOTION BY PAUL PALMER, SUPPORTED BY JOHN JOHANSEN, TO RECEIVE AND FILE THE PRELIMINARY STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDED JANUARY 31, 2025, AS PRESENTED. MOTION CARRIED: 15-0.

Mr. Bob Pawlak left the meeting at 6:46 p.m.

12. Contracts for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2025 contract listing provided in board meeting packet and requested the board authorize MSHN's CEO to sign and fully execute the contracts listed on the FY2025 contract listing.

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY PAUL PALMER, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY25 CONTRACT LISTING. MOTION CARRIED: 14-0.

13. Executive Committee Report

Mr. Ed Woods informed board members the Executive Committee met on February 21, 2025, and the material reviewed has been discussed earlier in this meeting and the notes from the meeting are found under the Consent Agenda item.

14. Chairperson's Report

Mr. Ed Woods thanked Ms. Leslie Thomas for including the financial analysis in her financials report to assist board members with understanding the shared risk arrangement contractual relationship with MDHHS.

15. 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 TINA HICKS, SUPPORTED BY RICH SWARTZENDRUBER, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE JANUARY 7, 2025 BOARD OF DIRECTORS MEETING; RECEIVE SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD MEETING MINUTES OF OCTOBER 16, 2024, RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF FEBRUARY 21, 2025; RECEIVE POLICY COMMITTEE MEETING MINUTES OF FEBRUARY 4, 2025; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF JANUARY 27, 2025; AND TO APPROVE ALL THE FOLLOWING POLICIES: ASSESSMENT OF MEMBER EXPERIENCES, BEHAVIOR TREATMENT PLANS, CRITICAL INCIDENTS, EXTERNAL QUALITY REVIEW, INCIDENT REVIEW FOR SUBSTANCE USE DISORDER PROVIDERS, MEDICATION EVENT VERIFICATION, MICHIGAN MISSION BASED PERFORMANCE INDICATOR SYSTEM, MONITORING AND OVERSIGHT, PERFORMANCE IMPROVEMENT, QUALITY MANAGEMENT, REGIONAL PROVIDER MONITORING AND OVERSIGHT, RESEARCH, SENTINEL EVENTS, CULTURAL COMPETENCY, ARTIFICIAL INTELLIGENCE, AND DOCUMENT SHARING. MOTION CARRIED: 14-0

16. Other Business

There was no other business.

17. Public Comment

There was no public comment.

18. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 7:11 p.m.

MSHN
Mid-State Health Network

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

Friday, April 18, 2025 - 9:00 a.m.

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

Members Absent: Ed Woods, Chairperson

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

Others Present:

1. **Call to order:** Vice-Chairperson O'Boyle called this meeting of the MSHN Board Executive Committee to order at 9:01 a.m.

2. **Adjustments to and Approval of Agenda**: Motion by D. Griesing supported by K. Peasley to approve the agenda for this meeting as presented. Motion carried.

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

4. **Board Matters**
   - 4.1 Draft May 13, 2025 Governing Board Meeting Agenda: The draft agenda was reviewed noting that the agenda is not official until adopted by the Board of Directors at its meeting. Of note, the FY 24 financial audit report will be presented by Roslund, Prestage and Company at the meeting. Motion by K. Peasley, supported by D. Griesing to approve the draft May 13 board meeting agenda. Motion carried.
   - 4.2 Board Member "BoardWorks" Standings: Vice Chairperson O'Boyle reviewed the importance of all CMHSP and MSHN Board Members in achieving full certification through the Community Mental Health Association of Michigan "BoardWorks" program. For MSHN Board Members, 12 of 24 board members have completed BoardWorks and are certified. 8 board members are in the process of training, and 3 board members have not taken any modules (there is one current vacancy). The Executive Committee encourages full certification for all board members.
   - 4.3 Other (if any): Mr. Sedlock announced that Ms. Susan Twing's term expired on April 30, 2025. Newaygo County Community Mental Health has appointed Ms. Lori Schultz to her seat. Ms. McPeek-McFadden reported that Linda Pursey was reappointed by The Right Door for Hope Recovery and Wellness.

5. **Administration Matters**
   - 5.1 PIHP/MDHHS Contract and Lawsuit Update: Mr. Sedlock stated that there has been no official communications about the contract or the litigation involving four other PIHPs. Earlier in the year, the litigating PIHPs amended their original complaint, and late last month MDHHS filed its response. In effect, there has been no change in the MDHHS position as detailed in the response to the amended complaint by the Michigan Office of the Attorney General. Assuming there are no further amended filings, the next step is likely to be either a judicial order setting a hearing date or dismissing the suit.
   - 5.2 MSHN Financial Status/Advocacy: Mr. Sedlock stated that a significant deficit is still projected at FY 25 year end (09/30/25), although the deficit has improved somewhat. Leslie Thomas, MSHN Chief Financial Officer, Amanda Ittner, MSHN Deputy Director, and Mr. Sedlock have met with all CMHSPs in the region to better understand the drivers involved in local financial performance and to reinforce the expectation that all CMHSP Participants in the MSHN region operate within the per eligible per month capitation provided by MSHN. These same executives have met with MDHHS and have provided detailed information about the financial status of the MSHN region, noting that the deficits from FY 24 and projected for FY 25 are largely driven by inadequate revenue and increased demand and service costs,

especially in autism services, community living supports, and psychiatric inpatient care. Mr. Sedlock stated that the region is undertaking a collective impact initiative to educate the administration and legislature and to promote allocations to address the issues. Ms. Ittner indicated that Alan Bolter will be assisting the region with logistics relating to legislative actions. Ms. Ittner is leading a regional effort to examine the autism benefit and make improvements in how we manage demand and utilization. Mr. Sedlock noted that 6 PIHPs had significant deficits in FY 24 and 8 PIHPs are projecting significant deficits of at least $59M in FY 25. This underscores the assertion that MDHHS-provided revenue is inadequate. MSHN anticipates a "mid-year" rate adjustment, the size of which is unknown.

5.3 MDHHS Competitive Procurement of PIHPs: Administration reports that there have been no official communications from MDHHS relative to the competitive procurement of PIHPs. A. Ittner reported that MSHN is evaluating pursing accreditation to better position MSHN as a successful bidder. MSHN is also engaged in regional dialog and is engaging with other potential partners and stakeholders to best position the organization to meet bidder qualifications and cover potential contingencies, which are as yet unknown. Mr. Sedlock emphasized the absolute requirement that MSHN continue to carry out its contractual requirements and regional obligations with excellence no matter the external environment. This requires that MSHN retain existing personnel to do so. To maximize the potential for retaining its workforce while faced with the higher potential for employees to leave the organization in search of more stable employment, along with the related inability to recruit replacement employees if/when those vacancies occur, Ms. Thomas, Ms. Ittner, and Mr. Sedlock developed a MSHN Staff Retention Plan emphasizing that nothing will be implemented unless one (or more) of the contingent precipitating events occurs [Either 1) An announcement by MDHHS that existing PIHPs, including MSHN, would not be eligible bidders in the announced competitive procurement process, OR 2) Upon notification that the MSHN submission of a bid or other procurement application is not awarded by MDHHS, OR 3) Upon official notification that MSHN must operate under a transition to termination provision to transfer its responsibilities to a successor organization). The strategy is fully supported by the leadership team. MSHN policies vest the authority and responsibility for compensation with the Chief Executive Officer.

5.4 Conflict Free Access and Planning Update: There have been no official MDHHS communications on the timeframe, requirements, or answers to questions relating to the implementation of Conflict Free Access and Planning. Ms. Ittner noted that CMS has approved State of Michigan waivers which include the same very high level requirements to separate service planning from service delivery. MSHN continues to work with its regional partners to prepare for an eventual implementation of these federal requirements as interpreted by the State of Michigan and approved by the Centers for Medicare and Medicaid Services.

5.5 Other (if any): None

6. Other

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

6.2 Reminder: May 13, 2025 all-day Board Strategic Planning has been cancelled.

6.3 Next scheduled Executive Committee Meeting: 06/20/2025, 9:00 a.m.

7. Guest MSHN Board Member Comments: None

8. Adjourn: This meeting of the MSHN Board Executive Committee was adjourned 9:30 a.m.

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, APRIL 1, 2025 (VIDEO CONFERENCE)

Members Present: John Johansen, Irene O'Boyle, Kurt Peasley, and David Griesing

Members Absent: Tina Hicks

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

1. CALL TO ORDER

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

2. APPROVAL OF THE AGENDA

MOTION by David Griesing, supported by Kurt Peasley, to approve the April 1, 2025, 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. John Johansen 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. The Finance chapter was reviewed by the Chief Financial Officer and the Finance Council. The Administrative and Retained PIHP Functions Contract Monitoring and Oversight policy was reviewed by the Chief Financial Officer and will be moved to the Provider Network Management chapter.

CHAPTER: FINANCE

1. APPOINTED MEMBER COMPENSATION
2. CASH MANAGEMENT
3. CASH MANAGEMENT-ADVANCES
4. CASH MANAGEMENT-BUDGET & OVERSIGHT
5. CASH MANAGEMENT-COST SETTLEMENT
6. COSTING POLICY
7. FINANCIAL MANAGEMENT
8. FIXED ASSET DEPRECIATION
9. FOOD EXPENSE
10. INVESTMENT

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

11. PA2 FUND USE
12. PA2 INTEREST ALLOCATION
13. PROCUREMENT
14. RISK MANAGEMENT-INTERNAL SERVICE FUND
15. SUD TREATMENT-INCOME ELIGIBILITY & FEES
16. TRAVEL

CHAPTER: QUALITY

1. ADMINISTRATIVE & RETAINED CONTRACT MONITORING & OVERSIGHT

MOTION by Irene O'Boyle, supported by David Griesing, to approve and recommend the policies under biennial review as presented. Motion carried: 4-0.

5. NEW BUSINESS

There was no new business.

6. ADJOURN

Mr. John Johansen adjourned the Board Policy Committee Meeting at 10:07 a.m.

Meeting Minutes respectfully submitted by:
MSHN Executive Support Specialist

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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 02/25/2025

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

Members Absent:

MSHN Staff Present: Joseph Sedlock; Amanda Ittner; For relevant items: Leslie Thomas; Kim Zimmerman; Todd Lewicki

Agenda Item	Action Required				
CONSENT AGENDA	No items pulled for discussion				
	Acknowledged Receipt	By Who	N/A	By When	N/A
REGIONAL SAVINGS ESTIMATES AS OF 12/31/2024 • **WAKELY ENGAGEMENT UPDATE** • **ENROLLMENT IRREGULARITIES IMPACTS ON MSHN REVENUES** • **IMPACTS OF MEDICAID ASSET LIMIT CHANGES ON ENROLLMENT/ELIGIBILITY**	Wakely: All 10 PIHPs are sending year-end financial results and EQI, to allow Wakely to conduct a rate setting analysis to compare with Millimen calculations. Follow up to ensure correct rate setting/implications and/or to propose alternate (more advantageous) actuarial methods. L. Thomas reviewed the savings estimates, noting 6 CMHs that didn't submit financials, so MSHN utilized the budget. MSHN needs updated/accurate/timely financial information on which to base regional financial reports and decisions – please reinforce this with your CFOs and help to ensure submissions as requested. Summary: • Expected to use about 24m in ISF, with 8m remaining in ISF. If these projected deficits hold, MSHN will not be able to meet its risk corridor obligations under 110% of revenue in FY 26. • Medicaid Revenue is almost $24M under against what was budgeted to start this fiscal year • HMP Revenue is about $8.4M less that was budgeted to start the fiscal year. • CMHSP Expenses are about $14M (Medicaid), $5.5M (HMP). And $4.4M (Autism) under what was budgeted to start the fiscal year. Discussed impact of eligibility specialist to assist with application and appropriate placement of eligibility type (DAB, TANF) All PIHPs are experiencing similar deficits/revenue issues due varying degrees a reduced revenue MSHN will be scheduling time with each CMH to discuss utilization, trends, revenue and any surplus/deficit, cost containment plans. Any public advocacy/input to push MDHHS to address the state issue? Sedlock reports working with Association, PIHP CFOs, etc. and CMHs should work locally. Discussed setting up joint meetings with legislation, working with Alan to coordinate time for a Lansing day, future legislative brunch, or individual local meetings.				

Agenda Item	Action Required				
	CMHSPs to reinforce submission of actual results to PIHP. MSHN will follow up with the association to detail strategy for individual meetings, collective meetings, and potentially a regional legislative event. MSHN will compile a list of representatives for each county in the region for distribution and schedule legislative discussions	By Who	CMHSP CEOs J. Sedlock MSHN/J. Sedlock	By When	ASAP 3.15.25 3/20/25
REGIONAL APPROACH TO ABA TECH RATE IMPLEMENTATION	L. Thomas collected impact on the region estimating $7m dollars. We have been on hold until the revenue has been received. DCW premium pay is not added to the $66/hr. pay for ABA. Regional discussion and support to not re adjudicate claims, but concerns with this approach is that the add 'l cost may not be included in the rate setting (which would be unacceptable).				
	Discuss this item next month for implications as funds have not been included in the rates yet and have not been included in the contract yet. J. Sedlock will draft a regional response for distribution	By Who	J. Sedlock	By When	3.15.25
FY 25 DRAFT COMPLIANCE PLAN	K. Zimmerman reviewed the changes in the compliance plan.				
	Support to present and recommend adoption to the MSHN Board of Directors	By Who	K. Zimmerman	By When	3.7.25
CMS VISIT/CAP	S. Lindsey requested clarification on PIHP plan of correction given the CMS visit didn't include any MSHN providers. Policy and procedures will be updated on elements included, then distributed to CMHs for their local updates. Training to be completed by MSU for providers/CMHs to attend as a required training. CSM training has 3 modules; self-guided then trainer modules (PIHP will be trainer for first year, then handed off to CMH). MDHHS has yet to distribute the training modules. PIHPs to be in compliance 6months after distribution.				
	CMHs will be informed as updates are received.	By Who	T. Lewicki	By When	3.15.25
MENTAL HEALTH FRAMEWORK	Discussed the meeting held last week regarding the proposed changes to Mental Health Framework. Workgroup (4 from MSHN) attending a meeting with Association and MDHHS to discuss, not scheduled yet.				
	MSHN will keep item on future agenda for updates	By Who	A.Ittner	By When	3.15.25
CCBHC RURAL PROPOSAL	MDHHS had worked with CMHA and their rural caucus to coordinate a brief listening session on February 20, regarding proposed rural flexibility for future expansion. The idea was to run some of these flexibility by a few CMHSPs to get their feedback on whether the changes would assuage some of their concerns with becoming				

Agenda Item	Action Required				
	CCBHCs. MDHHS has a tight turnaround to make a decision about a potential expansion, so we expedited this particular conversation recognizing that we will be soliciting feedback from others if we move forward. PIHPs were not involved in this.				
	Discussed if more CMHs should be joining. MDHHS will be communicating out to the field	By Who	N/A	By When	N/A
EARNED SICK TIME/MINIMUM WAGE	There has been no discussion regarding rate increases for minimum wage/earned sick time. SD budgets will need to be adjusted to ensure compliance, estimated at 1.4m				
	Nothing further noted for follow up	By Who	N/A	By When	N/A
UPDATE: MDHHS SITE REVIEW-USE OF RANGES	No update as waiting on MDHHS to indicate they have discussed internally and ready to schedule follow up meeting.				
	Update only	By Who	N/A	By When	N/A
UPDATE: LITIGATION/PIHPs FY25 CONTRACT	MDHHS submitted their response by February 7 to the litigation as required by the Court of Claims. The response was sent out to the region.				
	No further updates	By Who	N/A	By When	N/A
UPDATE: CONFLICT FREE ACCESS AND PLANNING	MSHN will be required to implement federal/state policy now that waivers have been approved. Discussed the Only Willing Qualified Provider and Rural definitions. C. Mills discussed possible lawsuits with MDHHS. Group discussed not proceeding with planning until policy and contract requirements come out by MDHHS including answers to submitted questions to include set of codes, CCBHC and UM by PIHP.				
	Discussion only	By Who	N/A	By When	N/A
SCHEDULING: MAY STRATEGIC PLANNING MEETING v. DIRECTOR'S FORUM	Directors Forum – Crystal Mtn conflict with Operations Council. May 14th at 9:00 am to noon – location to be determined.				
	J. Sedlock will send out a revised calendar invite when location has been secured	By Who	J. Sedlock	By When	3.15.25

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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 03/17/2025

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

Agenda Item	Action Required				
CONSENT AGENDA	No items removed for discussion				
	Received and acknowledged	By Who	N/A	By When	N/A
ALAN BOLTER, REGIONAL COLLECTIVE IMPACT ADVOCACY	Alan Bolter sent out the list of legislators broken down by PIHP/CMH. Alan suggested identifying key folks to target discussion. House: Bierlein (Bay, Saginaw and Region10) Schuette (Midland), Lansing, O'Neil, Tim Kelly, Green Senate: Anthony, Singh, Hauck Suggest CMHSPs arrange for County Boards of Commissioners to send resolutions to their legislators (Alan will attempt to secure a sample resolution for us to build on). Setting up meetings with key legislators and try to paint a picture of the revenue shortfalls, and then what's happening in their local community. MSHN will create a one-page with regional financial information and distribute it for CMH use in local meetings and local board resolutions.				
	J. Sedlock will send out one-page information	By Who	J. Sedlock	By When	3.31.25
PIHP REBID – EARLY/INITIAL DISCUSSION **1. Project/Initiative/Operational Suspension, Continuation Completion Decision Criteria (Draft)** **2. Positioning for Successful Procurement Participation?** **a. Board Support for exploratory activities** **b. Review existing MSHN Policy (General Mgmt: CMHSP**	CMHs reviewed the projects and operations evaluation criteria drafted by MSHN and supports the criteria within. Group discussed the Strategic planning and regional project status. Discussion regarding the topics identified, including possible scenarios and requirements that could be included in the upcoming PIHP procurement. Operations Council acknowledged all of the unknowns and discussed several possible configurations MDHHS may pursue. Operations Council sees no current need to revisit our General Management Policy on CMHSP application/assignment to this region – at least not until additional procurement parameters are known. All acknowledged that the formation of the regional entity is by the constituent CMHSPs and that any changes to the composition of MSHN/Region 5 would require changes to the bylaws and operating agreements. There is openness to doing this if it will preserve the core of this region and to continue MSHN's operations.				

Agenda Item	Action Required				
application/assignment to MSHN region) **c. Regional Entity foundations (Operating Agreement, Bylaws); potential MHC change(s)** **d. Potential for changes to delegation of managed care functions** **e. Potential for changes to governance structure**	There was broad acknowledgement that MDHHS may require significant changes to what is/is not delegated, potential to change governance requirements, potential to consolidate to fewer PIHPs, and other considerations. While details are not known, the Operations Council supports MSHN pursuing and positioning itself to be a successful participant and bidder in the procurement process. As details emerge, further dialog will be needed in order to make the most informed decisions moving forward.				
	The topic will be ongoing agenda item for update, discussion and planning, including a list of regional project status.	By Who	N/A	By When	N/A
SCHEDULING: May Ops Council Meeting (Keep as in-person? Videoconference?)	Group supported a move to virtual due to other conferences in May.				
	Joe will revise the invite to include virtual	By Who	J. Sedlock	By When	4.15.25
LLBSW Pre-Admission Screenings	M. Stillwagon requested feedback on the memo regarding the limit of qualifications for credentialing of LLBSW. A memo came out in October to expend it until the end of March. C. Mills requested the option to grandfather but was denied by MDHHS this week. Per MDHHS: • While LLBSW's cannot provide the screens, there are at least a couple of different ways that a LLBSW and a licensed at least Master's level clinician can complete the preadmission screens. At least Masters' level staff are required because LBSWs per their license aren't allowed to diagnose, and the PAR requires a diagnosis.				
	Discussion and planning	By Who	N/A	By When	N/A
FINANCIAL UPDATE	S. Lurie requested an update on the regional financial position. Financial position hasn't changed. Joe, Leslie and Amanda meeting with CMHs through March to discuss. We've requested updates on cost containment plans. MSHN meeting with MDHHS this week; will distribute slide deck after the meeting. MSHN will provide an update in April. We will also have the service use analysis including a comparison from the previous year. PIHP CFO's gathering information statewide to submit to MDHHS prior to May recertification.				

Agenda Item	Action Required				
	All information has been submitted to Wakely, including 2yrs of EQI and FSRs. 4 of 5 PIHPs (so far) are in the same financial position as MSHN.				
	Distribute MDHHS slide deck	By Who	J. Sedlock	By When	03/31/2025

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 04/21/2025

Members Present: Maribeth Leonard; Carol Mills; Julie Majeske; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; Sandy Lindsey; David Lowe, Jeff Labun, Bryan Krogman, Sara Lurie, Ryan Painter, Chris Pinter (11:57)
Members Absent: Cassie Watson
MSHN Staff Present: Joseph Sedlock; Amanda Ittner; For applicable areas Leslie Thomas and Skye Pletcher

Agenda Item	Action Required				
CONSENT AGENDA	No items removed for discussion				
	Acknowledge receipt	By Who	N/A	By When	N/A
SERVICE USE ANALYSIS REPORTS	L. Thomas reviewed the service use analysis and the EQI comparison that includes year by year comparison for Autism, CLS and psychiatric inpatient. The information was reviewed in detail with the Finance Council, which recommended splitting out specialized residential from CLS and adding length of stay for inpatient. CMHs to review outliers and use the report to identify areas that may need to be reviewed in more detail to bring in line with average. LifeWays looking at elements by service code that can be shared. CMHSPs asked to respond to LifeWays request for rates. Discussed inpatient regional contract that previously led to higher regional rates. Decision by CMHs to support regional negotiation with inpatient contracts.				
	J. Sedlock will follow up with Ops Council on appointees for the regional inpatient workgroup for FY26 contracts in May. L. Thomas will publish a final report that will be on the Ops agenda next month.	By Who	J. Sedlock L. Thomas	By When	4.30.25 5.15.25
CLS HISTORICAL UTILIZATION REPORT	S. Pletcher reviewed the CLS utilization report that included analysis by CMH from 2020 through 2024. The Utilization Management Committee reviewed the results and requested pre-COVID data. UMC will be looking at the medical necessity tools utilized.				
	Informational only	By Who	N/A	By When	N/A
AUTISM & CLS COST DRIVERS	T. Lewicki reviewed the Autism and CLS drivers report.				

Agenda Item	Action Required				
	Todd is drafting Autism MDHHS policy recommendations to assist with managing the benefit and will be brought to the May Operations Council meeting for review and feedback. PIHP leads are also reviewing the Autism recommendations this week.				
	Informational only	By Who	N/A	By When	N/A
FY24 NETWORK ADEQUACY ASSESSMENT PRESENTATION AND REPORT	A.Ittner reviewed the FY24 NAA presentation and report. The MDHHS reporting is due April 30. MSHN staff working with CMHs to ensure accuracy of data in the provider listing, which will be used by MDHHS to calculate time and distance standards.				
	Discussion and informational only	By Who	N/A	By When	N/A
PIHP REBID-MSHN STAFF RETENTION PLAN	J. Sedlock reported MSHN hasn't heard any updates directly from MDHHS yet on the PIHP procurement. Developed a retention plan for the "event" MSHN is in a transition to termination. While MSHN will work to retain its personnel, CMHSPs support being successful and will support MSHN if/when the time comes to loss of personnel at the MSHN level. MSHN has been preparing as much as we can without the bid specs. We have had some discussions with PIHPs. Discussed the Mental Health Framework and how that may tie with the PIHP procurement.				
	Discussion only	By Who	N/A	By When	N/A
SAGINAW 'HANDS OFF' MEDICAID EVENT	S. Lindsey provided information regarding "Hands Off Medicaid" event being planned at SVSU's Curtiss Hall for either May 6 or May 7 (6-8 pm). While many are involved in planning, this event was sparked by the "Hands Off" marches that took place nationwide earlier this month and is also being coordinated with Indivisible. The event is also being coordinated with Michigan federal legislative offices and there is a plan to livestream the event (with or without video participant interaction).				
	Sandy will share the information via email and any CMH wanting to add a logo, should send it to her asap.	By Who	CMHSPs	By When	ASAP

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Finance**		
Title:	**Appointed Member Compensation**		
Policy ☒ **Procedure**☐ **Page:** 1 of 2	**Review Cycle: Biennial** **Author:** Chief Financial Officer	**Adopted Date: 02.04.2014** **Review Date:** 03.07.2023 **Revision Eff. Date:**	**Related Policies:** Travel

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

Policy:

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

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

C. Board members shall receive a per diem of $70 for Board meetings, Standing Committees, and Ad Hoc Committee meetings. In order for Board members to be eligible to receive per diem compensation for these meetings, they must be appointed to such a committee by the Executive Committee of the Board of Directors or Board Chairperson, as per the by-laws of the organization. The minutes for each meeting shall provide documentation that the Board members did in fact participate in the meeting for which he/she is being compensated. Participation can be in person, by phone or by video conference. For Board members who attend in-person, a folder containing travel and attendance information will be available to be turned in at the end of meeting to the Executive Support Specialist.

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

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

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

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

H. Non-Board members and/or alternates who are appointed to participate as members of a Board Committee shall be paid the same per diem, as Board members, for meetings and Board meetings attended. Non-Board appointed members shall not receive more than one per diem per day.

I. Consumer representatives, volunteers, and ad hoc members as deemed appropriate by MSHN's Chief Executive Officer (CEO) approved to participate on MSHN council and committees to represent the consumer voice, shall be paid the same per diem as board members.

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

Applies to:

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

Definitions:

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

References/Legal Authority:

IRC 3401 (c) and the regulations there under

Change Log:

Date of Change	Description of Change	Responsible Party
02.04.2014	New policy	Chief Financial Officer
11.06.2015	Policy update	Chief Financial Officer
05.24.2017	Policy update	Chief Financial Officer
03.2018	Policy update	Chief Financial Officer
03.2019	Policy update	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2022	Addition of Consumer Representatives	Chief Financial Officer
12.2024	Biennial Review	Chief Financial Officer

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POLICIES AND PROCEDURES MANUAL

Chapter:	**Finance**		
Section:	**Cash Management**		
Policy: ☐ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Finance Council	**Adopted Date: 11.22.2013** **Review Date:** 05.09.2023 **Revision Eff. Date:**	**Related Policies:** Financial Management

Purpose

To ensure the appropriate control of cash disbursements on behalf of Mid-State Health Network (MSHN).

Policy

It is the policy of MSHN that cash disbursements are made with good internal controls and in accordance with generally accepted accounting principles (GAAP).

A. All disbursements of the Entity's funds are made by check, electronic funds transfer, or purchasing card, and are recorded in such a manner as to clearly show to which budget category they are charged.
B. The Entity disburses funds through either the accounts payable system, or electronic funds transfer.
C. Checks issued through the accounts payable system shall be signed by the Chief Executive Officer and the Deputy Director. Signature plates or electronic signatures may be utilized.
D. Electronic funds transfer (EFT) and checks are processed through the payables system.
E. Purchasing Cards may be issued to permanent employees to be used for MSHN expenditures only.
F. The purchasing card is the property of MSHN and shall not be used for personal purchases. Cards used for personal purchases, or any other misuse must be reported to the Chief Financial Officer and Deputy Director immediately.
    1. Restrictions by individual will be maintained by the Deputy Director limiting the dollar limit per cycle, dollar limit per transaction, number of transactions allowed per day, and number of transactions allowed per cycle.
    2. Purchasing card users shall be required to sign a Purchasing Card Holder Agreement (*see Exhibit A*) before obtaining card which in part states that "misuse or fraudulent use of the card may result in disciplinary actions and may be grounds for dismissal".
    3. Financial Manager shall forward monthly purchasing card statements to purchaser's Chief or Director in reporting line for review and sign off. Chief or Director should ensure supporting documentation is submitted by the purchaser prior to sign off.

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:

EFT: Electronic Funds Transfer; the transfer of money from one account to another, either within a single financial institution or across multiple institutions, through computer-based systems
GAAP: Generally Accepted Accounting Principles; a collection of commonly followed accounting rules and standards for financial reporting
MSHN: Mid-State Health Network

Other Related Materials
Audit Procedure

References/Legal Authority
N/A

Change Log:

Date of Change	Description of Change	Responsible Party
11.2013	Policy Update	Chief Financial Officer
10.05.2015	Policy Update	Chief Financial Officer
03.20.2017	Policy Update	Chief Financial Officer
3.2018	Annual Review	Chief Financial Officer
03.2019	Policy Update	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Policy Update	Chief Financial Officer
12.2024	Biennial Review	Chief Financial Officer

Exhibit A – Purchasing Card Holder Agreement:

MID-STATE HEALTH NETWORK (MSHN)
PURCHASING CARD HOLDER AGREEMENT

Participating Employee
Acknowledgment of Responsibilities

By participating in MSHN Purchasing Card Program as a Cardholder, you assume responsibilities pertaining to the operation and administration of the Purchasing Card Program. These responsibilities include, but are not limited to, the following:

MSHN Purchasing Card is to be used for business expenditures only. MSHN Purchasing Card may not be used for personal purposes.

The Purchasing Card will be issued in the name of the employee. By accepting the Card, the employee assumes responsibility for the Card and will be responsible for all charges made with the Card. The Card is not transferable and may not be used by anyone other than the Cardholder.

MSHN Purchasing Card must be maintained with the highest level of security. If the Card is lost or stolen, or if the Cardholder suspects the Card of Account Number to have been compromised, the Cardholder agrees to immediately notify JP Morgan Chase at 1-800-316-6056, and the MSHN Chief Finance Officer.

All charges will be billed to and paid directly by MSHN. On a bi- monthly basis, the Cardholder will receive a statement listing all activity associated with the Card. This activity will include purchases and credits made during the reporting period. While the Cardholder will not be responsible for making payments, the Cardholder will be responsible for the verification and reconciliation of all Account activity within **seven (7)** days of receiving the statement.

Cardholders' accounts may be subject to periodic internal control reviews and audits designed to protect the interests of MSHN. By accepting the Card, the Cardholder agrees to comply with these reviews and audits. The Cardholder may be asked to produce the Card to validate its existence and will be required to produce statements and receipts to verity appropriate use.

Parameters and procedures related to the Purchasing Card Program may be updated or changed at any time. MSHN will promptly notify all Cardholders of these changes. The Cardholder agrees to and will be responsible for the execution of and compliance with any program changes.

The Cardholder agrees to surrender and cease use of their Card upon termination of employment whether for retirement, voluntary separation, lay off, resignation, or dismissal. In the event of transfer within MSHN, the card may be canceled or modified to reflect that change. The Cardholder may also be asked to surrender the Card at any time deemed necessary by management.

MSHN reserves the sole and absolute discretion to deny the issuance of a Purchasing Card to any employee.

Misuse or fraudulent use of the Card may result in disciplinary actions and may be grounds for dismissal.

By signing below, I acknowledge that I have read and agree to the terms and conditions of this document. I certify that, as a participating Cardholder of MSHN, I understand and assume the responsibilities listed above.

Employee signature	Title
Name (Print)	Date

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POLICIES MANUAL

Chapter:	**Finance**		
Title:	**Cash Management - Advances**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle: Biennial** **Author:** Chief Financial Officer Chief Executive Officer	**Adopted Date: 07.05.2016** **Review Date:** 05.09.2023 **Revision Eff. Date:**	**Related Policies:** Financial Management

Purpose

To establish consistent guidelines related to unplanned requests for funds from Community Mental Health Service Programs (CMHSP) Participants and the Substance Use Disorder Provider Network (SUDPN).

Policy

It is the policy of Mid-State Health Network (MSHN) that approval of accelerated payments or cash advance disbursements are made with good internal controls and in accordance with generally accepted accounting principles (GAAP). MSHN will consider requests for advance disbursements (accelerated payments or cash advances), as defined in this policy, within the cash flow requirements of MSHN.

1. **Definitions – Applicable to CMHSP Participants**
   a) ***Accelerated Payment*** Definition: An *accelerated payment* is defined as funds requested by a CMHSP Participant and distributed prior to MSHN's receipt of Medicaid, Healthy Michigan Plan, Habilitation Supports Waiver or Autism capitation payments from Michigan Department of Health and Human Services (MDHHS). Typically, this payment is due to the CMHSP, it is simply being requested that MSHN provide the funds on an accelerated basis, which means prior to receipt of said funds by MSHN. These are typically very short-term arrangements covering a time period of several days to several weeks; these arrangements may span across to monthly reporting periods, but never beyond.
   b) ***Cash Advance*** Definition: A *cash advance* is a disbursement of funds, requested by the CMHSP, to manage short-term cash flow problems. A cash advance is for funds above budgeted current fiscal year disbursements to the CMHSP taking into consideration Medicaid and Healthy Michigan savings for benefit stabilization. Cash advances do not increase the CMHSPs current fiscal year budget nor does a cash advance carry over from one fiscal year to another.
   c) ***Interim Payment*** definition: An *interim payment* is the initial 85% of the current year budgeted Medicaid/Healthy Michigan Program payment sent to CMHSP participants upon MSHN's receipt of funds from MDHHS. The interim payment allows CMHSP participants to receive the majority of their anticipated Per Eligible Per Month (PEPM) immediately upon receipt by MSHN. The remaining budgeted disbursement (up to 15%) due to the CMHSP is made after eligibility file process completion and is typically made within three-to-five business days of the initial interim payment.
2. **Request Process**: While MSHN reserves the right to request additional documentation/information of justification, requests for consideration under this policy must:
   a) Be submitted in writing to the MSHN Chief Financial Officer and
   b) Include supporting information and documentation.
3. **Approval – CMHSP Participants:**
   a) MSHN will consider all requests for accelerated payments or cash advances from CMHSP participants. MSHN will assess regional cash requirements, MSHN cash requirements, bank balances, projected expense payments and all other related factors in making a determination of whether MSHN can support the CMHSP request. MSHN reserves the right, in its sole discretion, to approve, deny, modify or otherwise make decisions based on all available information in the best interests of the region.
   b) The CMHSP will be notified of the decision of MSHN as soon as possible but not later than 30 days after satisfactory submission of all information needed to make a decision.
   c) Approved cash advances will be paid within CMHSP's specified "need by" date if possible or as soon as MSHN can process said request.

4. **Repayment – CMHSP Participants**
    a) An accelerated payment made by MSHN to a CMHSP will be repaid by withholding the funds from the next scheduled interim payment due to the CMHSP once funds are received by MSHN from MDHHS. These are typically very short-term arrangements covering a time period of several days to several weeks; these arrangements may span across to monthly reporting periods but never beyond.
    b) A cash advance may be repaid to MSHN by the CMHSP on a mutually agreeable time frame, which is as short in duration as possible, provided that all repayments must occur on or before September 30 of the fiscal year within which the advance was approved and made. CMHSPs unable to meet the repayment requirements will have their organization's outstanding cash advance balance funds deducted from the last PEPM payments ~~of the fiscal year to meet the fiscal year-end deadline net of any amounts due to CMHSP from MSHN.~~or will have the cash advance amount deducted from anticipated fiscal year-end cost settlement due to the CMHSP.
5. **Definition – Applicable to SUDPN (Fee for Services/Cost Reimbursement Arrangements)**
Cash Advance Definition: A *cash advance* is defined as a request for funds from contracted providers that is financed on a fee-for-service or cost reimbursement basis where service provision has not yet occurred.
    a) Cash Advance Requests must:
        i. Be submitted in writing to the MSHN CFO and
        ii. Include supporting information on MSHN's clinical criteria practice model form
6. **Approval – SUDPN (Fee for Services/Cost Reimbursement Arrangements)**
MSHN will consider all requests for cash advances from MSHN contractors financed on a fee for service or cost reimbursement basis. MSHN will assess regional cash requirements, MSHN cash requirements, bank balances, projected expense payments and all other related factors in making a determination of whether MSHN can support the request. MSHN reserves the right, in its sole discretion, to approve, deny, modify or otherwise make decisions based on all available information in the best interests of the region.
    a) The contractor will be notified of the decision of MSHN as soon as possible but not later than 30 days after satisfactory submission of all information needed to make a decision.
    b) Approved advances will be paid within the specified "need by" date if possible or as soon as MSHN can process said request.
7. **Repayment – SUDPN (Fee for Services/Cost Reimbursement Arrangements)**
Repayments must be made within 60 days unless another mutually agreed upon time frame exists. All repayments must be made by September 30 of the fiscal year in which the advance was approved and made net of balances due to SUDPN, if any. Repayments may also be deducted from future payments to the contractor, in order to secure the repayment balance due.

General: A cash advance should be considered a rare exception and other revenue sources to cover cash flow issues should be pursued.

All payments must comply with Office of Management and Budget (OMB) 2 CRF 200.305 which requires minimum time elapsing between the transfer of funds from MSHN to the CMHSP participant or the SUDPN vendor. MSHN payment methods consist of Automated Clearing House (ACH), bank wire, or check.

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:
ACH: Automated Clearing House; system that accomplishes electronic money transfers
CFO: Chief Financial Officer
CMHSP: Community Mental Health Service Program
GAAP: Generally Accepted Accounting Principles; A collection of commonly followed accounting rules and standards for financial reporting
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
OMB: Office of Management and Budget
PEPM: Per Eligible Per Month
SUDPN: Substance Use Disorder Provider Network

Other Related Materials:
Clinical Criteria Practice Model

References/Legal Authority:
N/A

Change Log:

Date of Change	Description of Change	Responsible Party
12.11.2015	New Policy	Chief Financial Officer
05.31.2016	Annual Review	Chief Financial Officer
06.20.2016	Revised, Endorsed by Operations Council	Chief Executive Officer
03.2017	Auditor recommended change	Chief Financial Officer
03.2018	Annual Review	Chief Financial Officer
03.2019	Annual Review	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
12.2024	Policy Update	Chief Financial Officer

POLICIES AND PROCEDURES MANUAL

Chapter:	Finance		
Title:	Cash Management – Budget and Oversight Policy		
Policy: ☒ Procedure: ☐ Page: 1 of 2	**Review Cycle:** Biennial **Author:** Chief Financial Officer, Finance Council	**Adopted Date: 09.12.2017** **Review Date: 05.09.2023** **Revision Eff. Date:**	**Related Policies:** Financial Management

Purpose

To establish consistent guidelines for Community Mental Health Service Programs (CMHSP) Participants related to Medicaid including Autism and Healthy Michigan Plan (HMP) budgeting and projected cost overruns.

Policy

Mid-State Health Network (MSHN) and all CMHSPs in the region are expected to operate within a contractually established per eligible per month (PEPM) payment beginning Fiscal Year (FY) 2020. This policy outlines region-wide fiscal responsibilities and available remedies and actions when anticipated or actual expenditures exceed PEPM revenue.

MSHN Responsibilities

- Provide CMHSPs with projected revenue obtained from actuarial data and other relevant reports versus actual amounts received annually for budgeting purposes and throughout the fiscal year as rebasing occurs.
- MSHN distributes revenue pursuant to the specifications in the MSHN Operating Agreement, or as otherwise adopted from time to time.
- As it is contractually required to do, MSHN will ~~cost settle as defined in current policy to the allowable expenses and is required to~~ cover allowable CMHSP expenses totaling more than the PEPM
- MSHN will allow redirection of funding to cover shortfalls/overages between Healthy Michigan and Medicaid expenditures above straight capitation.
- After MSHN's Board of Directors approve the next fiscal year's budget, MSHN will request written cost containment plans from CMHSPs with expenditures projecting to exceed Medicaid and HMP PEPM revenue by more than one (1) percent of total combined revenue. MSHN will operate under a cost containment plan based on the same CMHSP criteria outlined directly above. MSHN will monitor quarterly projections and provide reports to the Finance and Operations Councils. MSHN may request an interim cost containment plan from a CMHSP with projected expenditures exceeding Medicaid and HMP revenue by more than (1) percent of total combined revenue. MSHN will operate under a cost containment plan based on the same CMHSP criteria outlined directly above.
- MSHN may elect to waive cost containment plans when the Internal Service Fund (ISF) is fully funded and the anticipated Savings is above the 5% MDHHS threshold or other circumstances warrant such an action. CMHSPs projected to overspend will be reviewed on a ~~case by case~~case-by-case basis. A MSHN cost containment plan may be waived based on the criteria outlined directly above.

CMHSP Responsibilities

- CMHSPs will provide Medicaid and HMP budgets less than or equal to projected Medicaid and HMP revenue and establish mechanisms internally to contain expenses within the capitation provided by MSHN (unless approved by MSHN based on potential MDHHS revenue adjustments). If budgeted expenses exceed revenue, then CMSHPs will submit a balanced budget using all funding sources, with an indication of the amount of anticipated redirect.
- CMHSPs must cooperate with and implement necessary actions and strategies that contain Medicaid and HMP costs within available revenues. The cost containment plan must identify savings targets in dollars to be achieved by specified dates. The strategy must be sufficiently detailed to ensure cost containment strategies do not adversely impact or reduce medically necessary services.
- CMHSPs may redirect funding in excess of their PEPM based on the approved spending plan.
- CMHSPs anticipating spending in excess of PEPM for both Medicaid and HMP may receive an apportioned benefit stabilization payment based on available funding.

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 Programs
HMP: Healthy Michigan Plan
ISF: Internal Service Fund
MSHN: Mid-State Health Network
PEPM: Per Eligible Per Month

Other Related Materials:

References/Legal Authority:
N/A

Change Log:

Date of Change	Description of Change	Responsible Party
06.23.2017	New Policy	Chief Financial Officer
03.2018	Policy Update	Chief Financial Officer
12.19.2018	Policy Update	Chief Financial Officer
11.14.2019	Policy Update	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Policy Update	Chief Financial Officer
12.2024	Policy Update	Chief Financial Officer

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POLICIES AND PROCEDURES MANUAL

Chapter:	**Finance**		
Title:	**Cash Management – Cost Settlement**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle: Biennial** **Author:** Chief Financial Officer & Finance Council	**Adopted Date: 05.03.16** **Review Date:** 05.09.2023 **Revision Eff. Date:**	**Related Policies:** Financial Management

Purpose

To ensure Mid-State Health Network (MSHN) complies with Michigan Department of Health and Human Services' (MDHHS) contract, the Operating Agreement, and the Medicaid Subcontract Agreement related to cost settlement funds.

Policy

It is the policy of MSHN to establish a consistent practice for cost settlement activities that are in accordance with good internal controls and generally accepted accounting principles (GAAP).

MSHN will perform annual preliminary cost settlement activities after the interim Financial Status Report (FSR) report is submitted to MDHHS. Community Mental Health Service Program (CMHSP) Participants are expected to provide preliminary cost settlement figures to the Prepaid Inpatient Health Plan (PIHP) and return 85% of the anticipated lapse to the PIHP within 15 days of the agency's FSR submission to MSHN unless both parties agree to an alternative arrangement. MSHN will make preliminary cost settlement payments of 85% for CMHSPs whose funding does not cover expected expenditures as soon as sufficient funding is available (either through savings or receipt of unexpended funds)

CMHSP's should submit to MSHN final fiscal audits within 6 months after the close of the fiscal year in question by their independent auditor or firm. Final cost settlement activities will generally occur in April or May following the fiscal year. This allows time for completion of MSHN's and its CMHSPs' Compliance Examinations which may impact cost settlement figures. These activities include development of a cost settlement spreadsheet containing detailed amounts and account information as well as a formal Cost Settlement and Contract Reconciliation letter from MSHN to each CMHSP's Chief Executive Officer (CEO). Remaining cost settlement funds are due within 30 days of the cost settlement letter referred to above.

Exceptions to the cost settlement description above may occur when special MDHHS funding is due to cover specific programs. Certified Community Behavioral Health Centers (CCBHC) supplemental funding is one example.

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:

CEO: Chief Executive Officer
CMHSP: Community Mental Health Service Program
FSR: Financial Status Report

GAAP: Generally Accepted Accounting Principles: A collection of commonly followed accounting rules and standards for financial reporting
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Pre-paid Inpatient Health Plan

Other Related Materials
N/A

References/Legal Authority
MDHHS Contract
Operating Agreement
Medicaid Subcontract Agreement

Change Log:

Date of Change	Description of Change	Responsible Party
12.11.2015	New Policy	Chief Financial Officer
03.20.2017	Annual Review	Chief Financial Officer
03.2018	Annual Review	Chief Financial Officer
03.2019	Annual Review	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
12.2024	Policy Update	Chief Financial Officer

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POLICY & PROCEDURE MANUAL

Chapter:	Finance		
Title:	Costing Policy		
Policy: ☐ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Financial Officer and Finance Council	Adopted Date: 11.04.2014 Review Date: 05.09.2023 Revision Eff. Date:	Related Policies: Financial Management

Purpose:

The Mid-State Health Network (MSHN) costing policy is established to:

- Define responsibility for a unit costing system;
- Define the responsibility for comparison of member Community Mental Health Service Program (CMHSP) rates with other Prepaid Inpatient Health Plan (PIHP) rates within the state; and
- Define the responsibility for regular review of unit cost data to ensure that unit costs are reasonable and customary.

Policy:

A. Each Community Mental Health Services Program Participant (CMHSP) will calculate unit costs on an annual basis:
   1. Unit costs will be calculated using full accrual accounting and encounter data services
   2. Unit costs will be calculated based on total costs, which are reflective of staff time, associated with services provided, less any delegated Pre-Paid Inpatient Health Plan (PIHP) administrative cost allocation.

B. Each CMHSP will incorporate unit costs into Encounter Quality Initiative (EQI) reports:
   1. Each CMHSP will submit EQI reports to the PIHP based on the schedule identified in the Michigan Department of Health and Human Services (MDHHS) contract; and
   2. The PIHP will compile data into one PIHP report for submission to MDHHS.
   3. Beginning in Fiscal Year (FY) 2022, CMHSPs will incorporate as applicable Independent Rate Model (IRM) and Standard Cost Allocation (SCA) MDHHS guidelines into costing and unit rate methodology.

C. PIHP will compare regional rates to rates throughout the state on an annual basis:
   1. Annual submission by MDHHS of EQI data by region will be reviewed by PIHP if available to determine codes where the MSHN region is a cost outlier.
   2. For those codes where the MSHN region is a cost outlier:
      a. PIHP will determine, from EQI reports, which CMHSP(s) within the region is an outlier; and
      b. Request from outlier CMHSP(s) steps that will be taken to bring costs within range; or
      c. Request from outlier CMHSP(s) reasons for which their program cannot or should not be modified, including an analysis of a wide range of data (program model, business model, clinical model, other client services, geographic disparities, and/or productivity issues). PIHP may determine outliers not needing review if the regional costs of such services are not material.

D. PIHP will provide opportunities to learn from others by providing comparison data of PIHPs across the state and comparison data of CMHSPs within the region.

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
EQI: Encounter Quality Initiative
IRM: Independent Rate Model
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Pre-paid Inpatient Health Plan
SCA: Standard Cost Allocation
UNC: Unit Net Cost

References/Legal Authority

Michigan Department of Health and Human Services Contract for 1115 Behavioral Health Demonstration Waiver Program, the Health Michigan Plan and relevant approved Waivers (Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), Serious Emotional Disturbance (SED))

Change Log:

Date of Change	Description of Change	Responsible Party
06.24.2014	New policy	Chief Financial Officer
10.05.2015	Policy update	Chief Financial Officer
03.20.17	Policy update	Chief Financial Officer
03.2018	Policy update	Chief Financial Officer
03.2019	Annual Review	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
12.2024	Biennial Review	Chief Financial Officer

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POLICIES AND PROCEDURES MANUAL

Chapter:	**Finance**		
Title	**Financial Management**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle: Biennial** **Author:** Chief Financial Officer	**Adopted Date: 11.22.2013** **Review Date: 05.09.2023**	**Related Policies:** Cash Management

Purpose

To ensure that MSHN maintains an accurate and consistent financial system, financial data reporting, and risk management program. Supporting procedures will address the details of each responsibility stated. Where applicable, each Community Mental Health Services Program (CMHSP) Participant shall adopt policies and/or procedures that meet, at a minimum, the requirements stated in this policy.

Policy

Mid-State Health Network (MSHN), a regional entity operating as the Prepaid Inpatient Health Plan (PIHP), shall ensure accurate and consistent financial systems, financial data reporting and risk management. All MSHN financial practices shall comply with requirements established by federal and state laws and contracts (including, but not limited to, the Medicaid, Substance Use Disorder, and grant contracts approved by the board), and the Medicaid Provider Manual.

Budgeting – General Accounting and Financial Reporting

A. MSHN shall develop the necessary infrastructure and procedures to ensure that the organization meets all budgeting, accounting, and financial reporting requirements imposed by federal and state laws and contracts (including but not limited to the Medicaid, Substance Use Disorder, and grant contracts approved by the Board), along with the Medicaid Provider Manual.
B. MSHN shall prepare, at a minimum, quarterly financial statements for board review that accurately report the financial position of the PIHP.
C. MSHN shall ensure that all contracts and operating agreements with CMHSP Participants and/or subcontractors include requirements necessary to support the budgeting, accounting, and financial reporting infrastructure and procedures developed. At a minimum, these requirements will include references to applicable laws, contracts, and sections of the Medicaid Provider Manual, and will indicate the required information and timelines for reporting to MSHN.

Revenue Analyses

A. MSHN shall develop procedures to analyze and project revenues/funding received through federal, state, and local contracts, and agreements. These procedures shall be adequate to ensure that all revenues due to the PIHP are recorded properly and timely, that errors or exclusions are identified, and all reasonable and appropriate steps are taken to correct them.
B. MSHN shall ensure that all contracts and operating agreements with CMHSP Participants and/or other subcontractors include requirements necessary to support the revenue analysis procedures developed.

Expense Monitoring and Management

A. MSHN shall assure and CMHSPs shall develop procedures to monitor expenses to ensure they are reasonable and necessary to meet the needs of the programs and consumers for which MSHN and CMHSP participants are responsible. All expenses, including those incurred by MSHN, must meet federal, state and local requirements, including, but not limited to, Office of Management and Budget Circular 2 CFR 200 Subpart E Cost Principles, applicable federal and state laws and contracts, and other policies and restrictions imposed by the MSHN Board of Directors.
B. MSHN shall ensure that all contracts and operating agreements with CMHSP Participants and/or other subcontractors include requirements necessary to support the expense monitoring and management procedures developed. At a minimum, these requirements will include provisions for MSHN monitoring of the CMHSP Participants and/or subcontractors, available sanctions to MSHN for inappropriate or

undocumented expenses, and an appeals process. All expense monitoring requirements will be uniformly applied to all MSHN CMHSP Participants.

Service Unit and Recipient-Centered Cost Analyses, and Rate-Setting

A. MSHN shall develop procedures to analyze costs and rates at a level meaningful to the service unit being provided and the recipient of the service. At a minimum, MSHN will perform biennial market rate analysis studies by comparing other PIHP rates, Medicaid Health Plan fee schedules, and commercial insurance reimbursement amounts for like services. MSHN will also consider historical provider arrangements meeting specified costing requirements to ensure best value for all services.

B. MSHN shall ensure that all contracts and operating agreements with CMHSP Participants and/or other subcontractors include requirements necessary to support the cost analysis and rate setting process. At a minimum, these requirements shall include the specific information and timeline for reporting to MSHN. All cost analysis and rate setting procedures will be uniformly applied to all MSHN CMHSP participants.

Risk Analyses, Risk Modeling and Underwriting

A. MSHN shall develop a risk management plan that addresses the various risks involved with managing services to eligible consumers as determined by federal and state laws and contracts.

B. MSHN shall ensure that all contracts and operating agreements with CMHSP Participants and/or other subcontractors include requirements necessary to support the risk analysis procedures developed. At a minimum, these requirements shall indicate the extent that CMHSP Participants and/or subcontractors hold risk related to the populations they serve, and any financial incentives or terms related to the transfer of risk.

Insurance, Re-insurance, and Management of Risk Pools

A. MSHN shall develop procedures to determine the need for, and to participate in insurance, re-insurance, and risk pools sufficient to mitigate risk, in accordance with the Medicaid Contract, Governmental Accounting Standards Board (GASB) Statement 10 (as amended) and generally accepted accounting principles. MSHN may purchase insurance or self-insure against losses and future funding shortfalls.

B. MSHN shall ensure that all contracts and operating agreements with CMHSP Participants and/or other subcontractors include requirements necessary to support the insurance, re- insurance and management of risk pools.

Supervision of Audit and Financial Consulting Relationships

A. MSHN shall develop procedures adequate to ensure supervision of audit/monitoring and financial consulting relationships in the event that these functions are not performed by employees of MSHN.

B. MSHN shall ensure that all contracts and operating agreements with CMHSP Participants and/or other subcontractors include requirements necessary to support the supervision of the audit and financial consulting relationships procedures developed. At a minimum, these requirements shall include the expected interactions/relationship between the audit, financial consultants, and the CMHSP/subcontractor.

Claims Adjudication and Payment

A. MSHN shall develop procedures adequate to ensure that claims adjudication and payment are complete, accurate and timely.

1. CMHSP Participants and subcontractors may be contracted on a basis not conducive to claims adjudication and payment (i.e. sub-capitation or net-cost arrangements). When this occurs, the procedures shall include the mechanisms necessary to initiate payment under these arrangements, and a process by which claims will be captured and associated with the payments. This may require individual or aggregate reporting of activity over the course of a fiscal year.

B. To the extent that claims adjudication and payment functions are delegated to CMHSP Participants and/or subcontractors, the procedures shall include how these functions will be monitored at the CMHSP or subcontractor to ensure compliance with requirements of federal and state laws and contracts, and the Medicaid Provider Manual.

C. MSHN shall ensure that all contracts and operating agreements with CMHSP Participants and/or other subcontractors include requirements necessary to support the claims adjudication and payment procedures developed. At a minimum, the contract shall specify the required information, and timeframes for reporting to MSHN, and in the case of delegation, shall indicate the claims adjudication and payment functions that are being delegated to the CMHSP Participant or subcontractor.

Audits

A. MSHN shall develop procedures to adequately accommodate audits of the PIHP to ensure completion in accordance with federal and state laws and contracts. These audits may include, but are not limited to, audits performed by the State of Michigan Office of Inspector General, the Michigan Department of Health and Human Services, other federal and state departments and agencies, and independent auditors.
B. The Chief Financial Officer (CFO) of MSHN shall prepare an annual financial report in accordance with accounting principles generally accepted in the United States of America. These financial statements shall be subjected to an audit in accordance with generally accepted government auditing standards issued by the U.S. Government Accountability Office. The financial statements, with the audit opinion and any additional letters of comments and recommendations (the reporting package), shall be completed in sufficient time to be delivered to all federal, state and local agencies in accordance with agreed timelines, but no later than six months after the end of the fiscal year. The reporting package will be presented to the MSHN Board and remitted to the CMHSP Participants at the next meeting following completion.
C. MSHN shall ensure that all contracts and operating agreements with CMHSPs and/or other subcontractors include requirements necessary to support the audit procedures developed. At a minimum, the requirements shall include the specific information to be provided and timelines for reporting to MSHN.

Applies to:

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

Definitions:

CFO: Chief Financial Officer
CMHSP: Community Mental Health Service Program
GASB: Governmental Accounting Standards Board
MDHHS: Michigan Department of Health & Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan

Other Related Materials:

Audit Procedure
Capitation Payments and Budget Development Procedure Claims Procedure
Investment Policy Procedure Costing Procedure
Risk Management Procedure MSHN Compliance Plan

References/Legal Authority:

N/A

Change Log:

Date of Change	Description of Change	Responsible Party
11.2013	New Policy	Chief Financial Officer
11.2014	Policy Update	Chief Financial Officer
11.2015	Annual Review	Chief Financial Officer
03.2017	Policy Update	Chief Financial Officer
03.2018	Annual Review	Chief Financial Officer
03.2019	Annual Review	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
01.2025	Biennial Review	Chief Financial Officer

Chapter:	Finance		
Title:	Fixed Asset Depreciation		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Financial Officer	Adopted Date: 03.03.2020 Review Date: 05.09.2023 Revision Eff. Date:	Related Policies:

Purpose

The purpose of this policy is to ensure Mid-State Health Network (MSHN) follows regulatory requirements when accounting for fixed assets and recording depreciation.

Policy

It is the policy of MSHN to record depreciation expense as outline in Governmental Accounting Standards Board (GASB) 34 and in accordance with the below Fixed Asset Depreciation Schedule.

- All equipment purchased with agency funds is the property of ~~the MSHN~~MSHN.
- A fixed asset inventory record will be maintained for any item purchased or donated with an original cost, or if donated an assessed value at the time of acquisition, of ~~$5,000~~$10,000 or greater.
- Limited personal use of MSHN equipment is subject to guidelines approved by the Chief Executive Officer
- Depreciation will be expensed in accordance with GASB 34 and other pertinent accounting standards for all Fixed Assets.
- MSHN will dispose of all items of equipment that is no longer useful to the Prepaid Inpatient Health Plan's (PIHP's) operations. Methods of disposal may include trade-in, transfer to another governmental agency, or other methods that are consistent with agency values. Items of equipment that are no longer in usable condition will be scrapped. MSHN will ensure all Protected Health Information (PHI) is removed prior to disposal and follow Michigan Department of Health and Human Services (MDHHS) contractual guidelines related to equipment disposition.

Fixed Asset Depreciation Schedule:

- Computer Equipment and Software: 3 years
- Vehicles: 5 years
- Office Equipment and Furniture: 5 years
- Building Improvements: 20 years
- Buildings: 30 years

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:

Equipment: Durable items having a useful life of more than one year.

Fixed Assets: Durable items costing ~~$5,000~~$10,000 or more, having a useful life of more than one year, and are depreciated.

GASB: Governmental Accounting Standards

MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PHI: Private Health Information
PIHP: Pre-paid Inpatient Health Plan

Other Related Materials:
N/A

References/Legal Authority:
National Council of Governmental Accounting
Audits of State and Local Governmental Units issued by the American Institute of Certified Public Accountants in 1989
2 CFR Section 200
Governmental Accounting Standard Bulletin (GASB) 34
Michigan Department of Health and Human Services Contract for 1115 Behavioral Health Demonstration Waiver Program, the Health Michigan Plan and relevant approved Waivers (Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), Serious Emotional Disturbance (SED))

Change Log:

Date of Change	Description of Change	Responsible Party
12.04.2019	New Policy	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
12.2024	Policy Update	Chief Financial Officer

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POLICIES AND PROCEDURES MANUAL

Chapter:	**Finance**		
Title:	**Food Purchases**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Financial Officer	**Adopted Date: 03.05.2019** **Review Date: 05.09.2023**	**Related Policies:** Financial Management

Purpose

The purpose of this policy is to establish consistent guidelines for the purchase of food for internal and external meetings.

Policy

During the process of conducting official business, Mid-State Health Network (MSHN) staff may purchase food for internal and external meetings.

Please Note: This policy does not supersede food purchases occurring during conference attendance and travel. Purchases in this category should follow MSHN's travel reimbursement policy.

Internal Meetings

An internal meeting is defined as a gathering primarily of MSHN staff. The purchase of food for such meetings are generally specific to mandatory annual trainings. Food purchases must be reasonable in nature based on guidelines in 2 Code of Federal Regulations (CFR) 200 Subpart E. Food purchases for internal meetings other than those defined for training must be approved in advance by MSHN's Chief Executive Officer (CEO) or Deputy Director (DD).

External Meetings

An external meeting is defined as a gathering primarily of Community Mental Health Service Program (CMHSP) Participants, Board of Directors, and/or Stakeholders with MSHN staff for the purpose of official business. Examples of external meetings as defined in this section include but are not limited to MSHN Board of Directors, Operations Council, Oversight Policy Board (OPB) meetings, as well as meetings of business partners, providers, legislators, state or local officials for business purposes. The purchase of food for such meetings must be reasonable in nature based on guidelines in 2 CFR 200 Subpart E.

Reasonable in Nature

MSHN deems purchases reasonable in nature to include prepared sandwiches, pre-ordered meals, snacks, non-alcoholic beverages, and other miscellaneous food items.

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:

CEO: Chief Executive Officer
CFR: Code of Federal Regulations
CMHSP: Community Mental Health Service Program
DD: Deputy Director
MSHN: Mid-State Health Network
OPB: Oversight Policy Advisory Board

Other Related Materials:
N/A

References/Legal Authority:
2 CFR 200 Subpart E

Change Log:

Date of Change	Description of Change	Responsible Party
11.26.2018	New Policy	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
12.2024	Biennial Review	Chief Financial Officer

MSHN
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POLICIES AND PROCEDURE MANUAL

Chapter:	**Finance**		
Section:	**Investment**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle: Biennial** **Author**: Chief Financial Officer	**Adopted Date: 02.04.2014** **Review Date:** 05.09.2023	**Related Policies:** Financial Management

Purpose:
To provide investment parameters for Mid-State Health Network's (MSHN) Chief Financial Officer (CFO) and banking institutions performing investment transaction. The primary objectives, in priority order, of MSHN investment activities shall be:

1. Safety – Safety of principal is the foremost objective of the investment program. Investments shall be undertaken in a manner that seeks to insure the preservation of capital in the overall portfolio.
2. Diversification – The investments shall be diversified by security type and institution with the objective that potential losses on individual securities not exceed the income generated from the remainder of the portfolio.
3. Liquidity – The investment portfolio shall remain sufficiently liquid to meet all operating requirements that may be reasonably anticipated.
4. Return on Investment – The investment portfolio shall be designed with the objective of obtaining a reasonable market rate of return throughout budgetary and economic cycles, taking into consideration the investment risk, legal constraints and the cash flow characteristics of the portfolio.

Policy:
It is the policy of MSHN to invest its funds in a manner that provides the highest investment return, with maximum security, while meeting the daily cash flow needs of the entity and in compliance with all regulatory requirements governing the investment of public funds.

Prudence: The standard of prudence to be used by investment officials shall be the "prudent person" standard and shall be applied in the context of managing an overall portfolio. Investment officers acting in accordance with written procedures and this investment policy and exercising due diligence shall be relieved of personal responsibility for an individual security's credit risk or market price changes, provided deviations from expectations are reported in a timely fashion and the liquidity and the sale of securities are carried out in accordance with the terms of this policy. Investments shall be made with judgment and care, under circumstances then prevailing, which persons of prudence, discretion, and intelligence exercise in the management of their own affairs, not for speculation, but for investment, considering the probable safety of their capital as well as the probable income to be derived.

Ethics and Conflicts of Interest: Officers, employees and agents, including but not limited to, investment managers, involved in the investment process shall refrain from personal business activity that conflicts with the proper execution of the investment program, or impairs their ability to make impartial investment decisions. They shall disclose any material financial interests that could be related to the performance of MSHN's investment portfolio. They shall also comply with all applicable Federal and State laws governing ethics and conflict of interest.

Delegation of Authority: The responsibility for the investment policy is hereby delegated to the Chief Executive Officer (CEO) and the CFO who shall establish a written procedure and internal controls for the operation of the investment program consistent with this investment policy. Procedures should include references to safekeeping, delivery vs. payment, investment accounting, collateral/depository agreements and banking service contracts. No person may engage in an investment transaction except as provided under the terms of this policy and the procedures established by MSHN. The CFO is delegated as the Investment Officer.

Authorized Investments: The Investment Officer is limited to investments authorized by Act 20 PA of 1943, as amended, and may invest in the following:

1. Bonds, securities and other obligations of the United States or an agency or instrumentality of the United States.
2. Certificates of deposit, savings accounts, deposit accounts, or depository receipts of a financial institution, but only if the financial institution complies with subsection (2) of Act 20 PA of 1943, as amended.
3. Commercial paper rated at the time of purchase within the two highest classifications established by not less than two standard rating services and that matures not more than 270 days after the date of purchase.
4. Repurchase agreements consisting of instruments listed in subdivision (a) of Act 20 PA of 1943, as amended.
5. Bankers' acceptances of United States banks.
6. Obligations of this state or any of its political subdivisions that at the time of purchase are rated as investment grade by not less than one standard rating service.
7. Mutual funds registered under the investment company act of 1940, title one of chapter 686, 54 Stat. 789, 15 U.S.C. 80a-1 to 80a-4 to 80a-64, with the authority to purchase only investment vehicles that are legal for direct investment by a public corporation.
8. Obligations described in subdivisions listed above if purchased through an interlocal agreement under the urban cooperation act of 1967, 1967 (Ex Sess) PA 7, MCL 124.501 to 124.512.
9. Investment pools organized under the surplus funds investment pool act, 1982 PA 367, MCL 129.111 to 129.118.
10. The investment pools organized under the local government investment pool act, 1985 PA 121, MCL 129.141. to 129.150.

Safekeeping and Custody: All security transactions, including collateral for repurchase agreements and financial institution deposits, entered into by MSHN shall be on a cash (or delivery vs. payment) basis. Securities may be held by a designated third-party custodian and evidenced by safekeeping receipts as determined by the Investment Officer. All financial institutions and broker/dealers who desire to become qualified for investment transactions must supply the following as appropriate:

1. Audited financial statements
2. Proof of National Association of Securities Dealers (NASD) certification
3. Proof of state registration
4. Completed broker/dealer questions
5. Certification of having read and understood and agreeing to comply with the MSHN Investment policy, (See Attachment #1)

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:
CEO: Chief Executive Officer
CFO: Chief Financial Officer
CMHSP: Community Mental Health Service Program
MSHN: Mid-State Health Network
NASD: National Association of Securities Dealers
PIHP: Pre-paid Inpatient Health Plan
Prudent Person Rule: A standard that requires that a fiduciary entrusted with funds for investment may invest such funds only in Securities that any reasonable individual interested in receiving a good return of income while preserving his or her capital would purchase.

References/Legal Authority
Act 20 PA of 1943, as amended

Change Log:

Date of Change	Description of Change	Responsible Party
02.04.2014	New policy	Chief Financial Officer
11.06.15	Policy update	Chief Financial Officer
03.20.17	Policy update	Chief Financial Officer
03.2018	Annual Review	Chief Financial Officer
03.2019	Annual Review	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
12.2024	Biennial Review	Chief Financial Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Finance**		
Title:	**Use of Public Act 2 Dollars**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Executive Officer Chief Financial Officer	**Adopted Date: 01.05.2016** **Review Date:** 05.09.2023	**Related Policies:** Financial Management

Purpose

Per Public Act 206 of 1893, Section 24e, Paragraph 11, as amended, Mid-State Health Network (MSHN) receives liquor tax funds, also known as PA2 funds, from each of the counties in the region. The funds are for local use in treatment, intervention and prevention of substance use disorder (SUD) services. This policy stipulates the authority for and the approved use of PA2 funds.

Policy

Pursuant to and in accordance with MCL 211.24e, MSHN shall receive, administer and use PA2 funds in accordance with the law and at the direction of the Substance Use Disorder (SUD) Oversight Policy Advisory Board (OPB). PA2 funds shall be accounted for by county of origin and shall be used exclusively in the county from which they were derived. PA2 fund balances must be accounted for by each county and planned use must occur in the county of origin. Interest income from PA2 funds is considered local income and, at the direction of the SUD OPB, must be used to support SUD treatment, intervention and prevention activities or the related proportionate share of administrative costs.

> *MCL 211.24e: (11) If the sum of a county's operating property tax levy for the ensuing fiscal year plus the county's distribution to be received pursuant to section 10 of the state convention facility development act, 1985 PA 106, MCL 207.630, exceeds the product of the county's taxable value for the ensuing fiscal year times the greater of the county's base tax rate or concluding fiscal year's operating millage rate, then an amount equal to the lesser of 50% of the excess or 50% of the state convention facility development act distribution shall be used for substance abuse treatment programs within the county. The proceeds received by the taxing unit shall be distributed to the coordinating agency designated for that county pursuant to section 6226 of the public health code, 1978 PA 368, MCL 333.6226, and used only for substance abuse prevention and treatment programs in the county from which the proceeds originated.*

At least annually the SUD OPB shall approve a plan and budget for the use of PA2 funds. The plan and budget shall include the amount of planned funding to be expended; the intended purpose for SUD treatment, intervention or prevention; and the identified primary contractor(s). The MSHN Chief Financial Officer (CFO) shall prepare and provide the SUD OPB with a bi-monthly report of PA2 funds received and disbursed.

Applies to:

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

Definitions:

CFO: Chief Financial Officer
MSHN: Mid-State Health Network
OPB: Oversight Policy Advisory Board
PA2 Funds: Public Act 2 Liquor Tax Funds
SUD: Substance Use Disorder

Other Related Materials:
N/A

References/Legal Authority:
Public Act 206 of 1893, Section 24e, Paragraph 11, as amended; MCL 211.24e
Michigan Department of Health and Human Services Contract for 1115 Behavioral Health Demonstration Waiver Program, the Health Michigan Plan and relevant approved Waivers (Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), Serious Emotional Disturbance (SED))

Change Log:

Date of Change	Description of Change	Responsible Party
TBD	New Policy	Chief Executive Officer
11.06.15	Update Policy – Original not Board approved	Chief Financial Officer
03.20.17	Policy Update	Chief Financial Officer
03.2018	Policy Update	Chief Financial Officer
03.2019	Annual Review	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
12.2024	Biennial Review	Chief Financial Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	Finance		
Title:	**Public Act 2 Dollars Interest Allocation**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 1	**Review Cycle:** Biennial **Author:** Chief Financial Officer	**Adopted Date: 09.06.2016** **Review Date:** 05.09.2023	**Related Policies:** Financial Management Use of Public Act 2 Dollars

Purpose

Per Public Act 206 of 1893, Section 24e, Paragraph 11, as amended, Mid-State Health Network (MSHN) receives liquor tax funds, also known as PA2 funds, from each of the counties in the region. The funds are for the expressed purpose of local use in treatment, intervention and prevention of substance use disorder (SUD) services. Interest earned on PA2 funds will be allocated to each county within MSHN's region.

Policy

It is the policy of Mid-State Health Network that interest earned on PA2 funds during the fiscal year will be determined annually at September 30. MSHN earns interest on all revenue sources including, Medicaid, Healthy Michigan, Block Grant, and PA2. Interest attributable to PA2 will be allocated to each county proportionately based on fiscal year end balances. A financial report by county will be presented to the Substance Use Disorder Oversight Policy Board (OPB) designating the revenues received, disbursements made, and interest earned.

Applies to:

☒All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☐ MSHN's Affiliates: ☐ Policy Only ☐ Policy and Procedure
☒Other: MSHN SUD Oversight Policy Advisory Board

Definitions:

CFO: Chief Financial Officer
MSHN: Mid-State Health Network
OPB: Oversight Policy Board
PA2 Funds: Public Act 2 Liquor Tax Funds
SUD: Substance Use Disorder

References/Legal Authority:

Public Act 206 of 1893, Section 24e, Paragraph 11, as amended; MCL 211.24e
Michigan Department of Health and Human Services Contract for
1115 Behavioral Health Demonstration Waiver Program, the Health Michigan Plan and relevant approved Waivers (Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), Serious Emotional Disturbance (SED))

Change Log:

Date of Change	Description of Change	Responsible Party
08.08.2016	New Policy	Chief Financial Officer
03.20.17	Annual Review	Chief Financial Officer
03.2018	Policy Update	Chief Financial Officer
03.2019	Policy Update	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
12.2024	Biennial Review	Chief Financial Officer

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POLICIES AND PROCEDURES MANUAL

Chapter:	Finance		
Section:	**Procurement Policy**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 4	**Review Cycle:** Biennial **Author:** Chief Financial Officer	**Adopted Date: 09.02.2014** **Review Date:** 11.12.2024	**Related Policies:** Financial Management Cash Management

Purpose

To provide guidance to Mid-State Health Network (MSHN) staff involved in purchasing goods and services to assure:

A. That the MSHN obtains the best possible price and terms for all goods and services;
B. That a wide range of qualified vendors are notified of impending purchases;
C. That specifications are not so needlessly complex or restrictive that they would exclude qualified vendors; and
D. That staff are encouraged to exercise discretion in the purchasing process.

Policy

A. Oversight and Supervision of the Purchasing Process Shall be as Follows:
   1. **$0.00 -- $1,999**: Purchase of goods or services valued within this range may be purchased without written cost quotations or proposals. The responsible staff person shall solicit verbal quotations and submit to the Chief-level administrative officer in their reporting line. If approved by the Chief, documentation should be sent to the Chief Financial Officer (CFO) who will authorize the purchase to be made from the vendor best able to provide necessary goods or services based upon price, availability of goods, and delivery schedule.
   2. **$2,000 -- $24,999**: Purchase of goods or services valued within this range shall be preceded by the solicitation of written cost proposals (or estimates), submitted to the Chief-level administrative officer in their reporting line, and if approved, sent to the Chief Financial Officer. The Chief Financial Officer shall develop a written recommendation based on written documentation and present to the Chief Executive Officer (CEO) for approval. The reasons for all purchases made where the low-cost proposal is not accepted shall be clearly documented. Approved purchases shall be made from the vendor best able to provide the necessary goods or services with price being the primary consideration. The Chief Financial Officer will forward all pertinent documentation for inclusion in the accounts payable file.
   3. **$25,000 and higher (annually for multi-year agreements)**: Purchase of goods or services valued within this range shall be preceded by the solicitation of cost proposals as described in the Procedure: Procurement through formal procurement process (such as, but not necessarily limited to requests for quote, requests for information, or requests for proposals). Agency procedures for these processes shall be followed as noted in the Substance Use Disorder (SUD) Direct Service Procurement Policy and Procurement Through Request For Proposal Procedure The purchase shall be made from the vendor best able to provide the necessary goods or services with price being the primary consideration. The Chief-level Administrative Officer responsible for the purchase shall send all pertinent documentation and recommendations to the Chief Financial Officer. The Chief Financial Officer shall develop a written recommendation based on written documentation and present to the Chief Executive Officer for approval. The reasons for all purchases made where the low-cost proposal is not accepted shall be clearly documented. Once approved by the CEO, the Chief Financial Officer, with assistance from the Chief-level administrative officer responsible for the purchase, will prepare a Board Background and Motion (BB&M) containing sufficient background information and underlying rationale to support the purchase recommendation to the Board of Directors.

Items or services previously approved by the Board shall be brought back to the Board for review and approval if there is a dollar amount variance from the original BB&M of more than $10,000. This scenario generally applies to multi-year contracts in which an expanded scope of work is identified.

MSHN's CEO has the authority to approve contract amendments of less than $25,000 without additional board action.

Exceptions:

1. Properties/facilities and maintenance purchases shall be bid out when the annualized or per item cost/value exceeds $10,000.
2. Computer Hardware and Software: The purchase of computer items or services valued less than $5,000 shall not be subject to this policy / procedure. The purchase may be approved when, in the judgment of the Chief Information Officer (CIO), the purchase is made from the vendor best able to provide necessary goods or services based upon price, availability of goods, and delivery schedule. The Chief Financial Officer must approve the purchase or purchase arrangement.
3. Computer Services: The purchase of computer services valued less than $20,000 may be approved by the Chief Information Officer after consultation with the Chief Financial Officer, when the provider of that service has already been selected to provide similar services within the previous 24 months via a documented bid or cost comparison process. Such approval may be made when, in the judgment of the CIO, the vendor continues to be best able to provide necessary services based upon price, performance and schedule.
4. Computer Hardware and Software and Employee/Physician Insurances: Purchases of $25,000 and higher may not be required to adhere to formal procurement process if the responsible Administrative Officer determines a solicitation of cost proposals is more appropriate.
5. Clinical services and/or supports including Substance Use Disorder (SUD) services are excluded from this policy as these procurements are governed by MSHN's SUD Direct Service Procurement Policy.
6. The services sought are professional services of limited quantity or short duration (e.g. Psychological testing);
7. Through the person-centered planning process, the consumer has chosen a qualified non-network provider as his/her provider of choice.
8. Where, for purposes of continuity of care, an existing qualified network provider or provider panel may be selected to provide a service.

Exclusions:

1. The purchase of food and consumable supplies.
2. Goods or service contracts entered under, or based upon, the State of Michigan MI Deal program, US Federal Government's General Services Administration (GSA) program(s), or other non-State of Michigan or non-Federal Government grants.

B. Staff shall obtain cost proposals from qualified vendors for goods and services specified in this policy. Proposals may be obtained by means of direct solicitation or by advertising through professional periodicals, or otherwise appropriate publications with the express purpose of notifying a wide range of vendors. The use of direct solicitation or published advertisements to affect an efficient and expeditious vendor response shall be left to the discretion of the Chief-level administrative officer with responsibility for department making the purchase, in consultation with the Chief Financial Officer if/as needed. Generally, the receipt of at least three cost proposals shall be required prior to authorizing a purchase, however, the receipt of fewer proposals shall be acceptable, provided that a reasonable staff effort and solicitation process is documented and approved by the Chief Financial Officer.

C. MSHNs finance department may maintain a list of qualified vendors for solicitation purposes for routine or regular purchases. This list may be developed from a variety of sources, including vendor requests, professional or trade organizations, and past MSHN experience. The qualification of vendors may include verifying appropriate insurances, licensure, past performance based upon written recommendations and comments from previous customers, and the vendor's size and experience relative to MSHN's project and needs.

D. When used, MSHN Chief-level administrative officer shall develop specifications for cost proposals that are sufficiently complete so that all vendors provide quotations that are comparable. Specifications shall not be designed to favor a particular brand or type of product, or to exclude a particular vendor, without good cause. Good cause for narrow or restrictive specifications may include, but is not limited to, compatibility with existing systems or equipment, particular or specific needs of MSHN that few vendors are capable of fulfilling, professional or technical judgment of MSHN staff, and previous MSHN experience with vendors of products. The reasons for restrictive or narrow specifications must be clearly defined and filed with all other cost and proposal documents. Staff may be authorized make purchases without obtaining cost proposals, if only one vendor or product exists, or if proposals for identified products were received within the past twelve (12) months. The Chief Financial Officer shall approve all written specifications prior to release.

E. Staff shall maintain records sufficient to detail the significant history of a procurement decision. These records shall include, but are not limited to, information pertinent to the rationale for the method of provider selection or rejection and the basis for the cost or price. The files shall be maintained with MSHN's Finance department.

F. It is the responsibility of the Chief-level administrative officer to confirm with the Chief Financial Officer or designee that funds have been allocated and are available prior to the purchase.

G. All audits required by MSHN shall be obtained by direct solicitation or by advertising, which shall adhere to the principles stated herein. The length of the initial audit period shall not exceed three years. The CFO shall approve the audit specifications and proposal process. All responses to audit cost proposals shall be reviewed and approved by the Chief Executive officer and by the Board of Directors. MSHN may authorize staff to extend audit services beyond the original audit period without soliciting additional cost proposals, provided that any extensions do not exceed three (3) years. The cost for any extension may be negotiated at the time the extension is authorized.

H. Sole Source Exceptions: Under certain circumstances, the agency may contract with vendors or providers through single-source procurement without executing a competitive bid process. These circumstances may include any one or more of the following:

1. The goods or services are available only from a single source;
2. There is an urgent or emergent need for the goods or service;
3. After solicitation through a number of sources, there is a lack of qualified provider candidates;
4. The goods or services sought are unique or highly specialized;
5. The services sought are professional services of limited quantity or short duration (e.g. Psychological testing);
6. Through the person-centered planning process, the consumer has chosen a qualified non-network provider as his/her provider of choice.
7. Resource outputs associated with potential gain of multi-source procurement are considered excessive, unreasonable, or cost prohibitive.

Single Source exceptions must be documented in writing and filed with the provider contract file (or accounts payable files) prior to execution of contract or expenditures of funds to complete the purchase.

I. For the purchases funded with federal funds, the MSHN shall be in compliance with requirements of the Davis-Bacon Act, the Copeland "Anti-Kickback" Act, and the Contract Work Hours and Safety Standards Act.

J. MSHN funds may not be utilized for the purchase of alcohol or tobacco products.

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:
Administrative Officer: MSHN officer of administrative services (Chief Executive Officer, Deputy Directory, Chief Financial Officer, Chief Information Officer, Chief Clinical Officer)
BB&M: Board of Directors' Background and Motion
CEO: Chief Executive Officer
CFO: Chief Financial Officer
CIO: Chief Information Officer
CMHSP: Community Mental Health Service Program
GSA: General Services Administration; The executive agency responsible for supervising and directing the disposal of surplus personal property
MI Deal: Extended purchasing program which allows Michigan local units of government to use state contracts to buy goods and services
MSHN: Mid-State Health Network
RFP: Request for Proposal
SUD: Substance Use Disorder

References/Legal Authority
2 CFR 200; Subpart D; Sections 318 through 326
Michigan Department of Health and Human Services Contract for Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program, and Substance Use Disorder Community Grant Programs – Procurement Technical Requirement

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Financial Officer
11.2015	Annual Review	Chief Financial Officer
03.20.17	Policy Update	Chief Financial Officer
03.2018	Annual Review	Chief Financial Officer
03.2019	Policy Update	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
06.2022	Policy Update	Chief Executive Officer
01.2023	Biennial Review	Chief Financial Officer
05.2023	Policy Update	Chief Financial Officer
09.2024	Policy Update	Chief Financial Officer
12.2024	Policy Update	Chief Financial Officer

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POLICIES AND PROCEDURES MANUAL

Chapter:	Finance		
Title:	Risk Management – Internal Service Fund		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Financial Officer	**Adopted Date:** 07.01.2014 **Review Date:** 05.09.2023	**Related Policies:** Financial Management Investments

Purpose

Mid-State Health Network (MSHN) will establish an internal service fund (ISF) as a method for securing funds as part of the region-wide strategy for managing Medicaid risk exposure under the Michigan Department of Health and Human Services (MDHHS)/Prepaid Inpatient Health Plan (PIHP) Medicaid Managed Specialty Supports and Services Contract. The funding of the ISF will be maintained at a level that sufficiently covers the projected overall risk of the Pre- Paid Inpatient Health Plan (PIHP), yet ensures maximum funds are directed to consumer services.

Policy

A. As an integral part of risk management planning, the PIHP shall determine the necessity and the optimal funding amounts for an ISF, with the input and analysis provided by the MSHN Finance Council.

B. The ISF shall be maintained by the PIHP in accordance with the MSHN Investment Policy and in compliance with MDHHS/PIHP Services and Supports Contract with the Michigan Department of Health and Human Services consistent with the following criteria:

1. Contributions to the ISF shall retain their character as state funds in accordance with the Mental Health Code. ~~Beginning Fiscal Year 2017,~~ MDHHS allows Medicaid and Healthy Michigan Plan (HMP) reserves to ~~may~~ be used interchangeably to cover cost overruns in both funding stream. The use of funds to cover cost overruns assumes the funding stream in question exhausted its reserves prior to the redirection.
2. Funds used to finance the ISF shall not be used as local funds or used to match federal cost sharing.
3. ISF funds will be invested in accordance with the MSHN Investment Policy.
4. Interest earnings from the investment of ISF funds shall be used to fund the risk reserve and shall be maintained in the fund.

C. MSHN shall determine at least semi-annually the optimum ISF funding level using the following criteria:

1. The expected risk based on historical costs experience or reasonable cost assumptions.
2. The funds contributed to the ISF determined in compliance with reserve requirements as defined by Generally Accepted Accounting Principles (GAAP) and applicable federal and state provisions, as stated in the MDHHS Services and Supports Contract.
3. Charges allocated to the various programs/cost categories based on the relative proportion of the total contractual obligation.

D. MSHN shall review the costs charged against the ISF using the following criteria:

1. Costs are restricted to the defined purpose of the ISF and no expenses can be charged to these funds
2. The proper share of the risk corridor is charged to the ISF

E. MSHN shall review the total funding level of the ISF to ensure that:

1. If the ISF becomes over-funded, it shall be reduced within one fiscal year through the abatement of current charges.
2. If abatements are inadequate to reduce the ISF to the appropriate level, it shall be reduced through refunds in accordance with Office of Management and Budget (OMB) Circular 2 Code of Federal Regulations (CFR) 200 Subpart E Cost Principles.
3. Upon dissolution of the ISF, any funds remaining in the ISF after all of its claims and related

liabilities have been liquidated shall be refunded pursuant to OMB Circular 2 CFR 200 Subpart E Cost Principles

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:
GAAP: Generally Accepted Accounting Principles
ISF: Internal Service Fund; Risk reserve fund that can be used by the PIHP to cover Medicaid and Healthy Michigan Plan risk corridor financing, if necessary, per the shared risk contract with MDHHS
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
OMB: Office of Management and Budget
PIHP: Pre-paid Inpatient Health Plan

Other Related Materials
MSHN Investment Policy

References/Legal Authority
The following federal and state statues, contracts, and technical specifications establish the standards for Mid-State Health Network's Risk Management – ISF procedure.

A. The Balance Budget Act of 1997
B. OMB Circular 2 CFR 200 Subpart E Cost Principles
C. Mental Health Code
D. Michigan Department of Health and Human Services Contract for 1115 Behavioral Health Demonstration Waiver Program, the Health Michigan Plan and relevant approved Waivers (Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), Serious Emotional Disturbance (SED))
E. Generally Accepted Accounting Principles

Change Log:

Date of Change	Description of Change	Responsible Party
04.01.2014	New policy	Chief Compliance Officer
07.07.2015	Annual Review	Chief Financial Officer
07.05.2016	Annual Review	Chief Financial Officer
03.20.2017	Policy Update	Chief Financial Officer
03.2018	Policy Update	Chief Financial Officer
03.2019	Policy Update	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
12.2024	Policy Update	Chief Financial Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Finance**		
Title:	**Substance Use Disorder Treatment – Income Eligibility & Fees**		
Policy: X **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Financial Officer and Finance Manager	**Adopted Date: 11.2015** **Review Date:** 05.09.2023	**Related Policies:** Financial Management

Purpose:
Per contractual requirements with the Michigan Department of Health & Human Services (MDHHS) Mid-State Health Network (MSHN) is required to establish and maintain an income eligibility policy and procedure. The policy is intended to assure compliance with contractual obligations.

Policy:
MSHN requires use of a standardized income eligibility fee policy and procedure for all substance use disorder (SUD) treatment services. This policy is applicable to all treatment service modalities.

General Information:
Application of First and Third-Party Fees: The contract provisions with respect to the collection and reporting of first and third-party fees earned by a SUD Provider will be the first source of funding for the consumer. If benefits are exhausted or if the person needs a service not covered by that third party insurance, community block grant funds may be applied. It will be the SUD Provider's responsibility to develop and maintain policies and procedures regarding the collection and reporting of consumer fees and accounts receivable.

Consumer Eligibility: The income eligibility scale shall use a consumer's current annualized household income and the family size to determine the consumer's financial eligibility for a SUD treatment benefit from MSHN. Household income would include the income of the consumer's spouse, if living in the same home. It would also include the income of a significant other, if that consumer is cohabitating with the consumer and is engaged in the consumer's treatment process. Income would be excluded for estranged or separated spouses, for parents of any college-age consumer or adults living with parents if the parents only provide room and board. Income would also be excluded for adult children living at home if the parent is in treatment. Consumers whose family income falls at or below the guidelines identified in the attached "Income Eligibility for MSHN Benefits are eligible for a benefit subsidy as identified. Exceptions for income requirements may be made for consumer safety issues, continuity of care issues, and other items as reviewed and approved by MSHN staff. All exclusions should be documented in the consumer chart. The provider retains the authority to grant waivers to this policies and related procedures. If a waiver of income eligibility and fees is granted it shall be documented in the fee section of the consumer record.

- Income Verification: An Income Verification/Fee Agreement is to be completed at admission for each MSHN consumer that is funded through Community Block Grant dollars and signed by the consumer. In addition, proof of income must be documented in the consumer file (i.e., current pay stub, latest income tax return). Income should represent only legally obtained income. Annual gross income can be used, however, the most recent ninety (90) day period prior to admission should be reviewed to include any changes in employment.

Failure to secure and retain these items in the consumer's file will be grounds for non-reimbursement of services. If a consumer reports no income but is physically able to work, employment should be addressed as a treatment issue in the consumer's treatment plan.

An individual will not be denied service because of an inability to pay for services.

Non-allowable uses Block Grant:

- Inpatient hospital services except under conditions specified in federal law
- Cash payments to intended recipients of services
- Purchase, improve, or build (as applicable):
  - Land
  - Buildings and other facilities
  - Major medical equipment
- Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of funds
- Pay the salary of an individual in excess of Level I of the Federal Executive Schedule

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:

MDHHS: Michigan Department of Health & Human Services
MSHN: Mid-State Health Network
SUD: Substance Use Disorder

Other Related Materials:

- Financial Eligibility Worksheet
- MSHN Eligibility Procedure w. Attachment A (Income Verification Agreement)
- Financial Eligibility & Waiver Worksheet

References/Legal Authority:

- Michigan Mental Health Code
- Michigan Department of Health and Human Services Contract for Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program, and Substance Use Disorder Community Grant Programs

Change Log:

Date of Change	Description of Change	Responsible Party
08.2015	New Policy	Finance Manager
06.16.16	Policy Update	Chief Financial Officer
03.20.17	Policy Update	Chief Financial Officer
03.2018	Policy Update	Chief Financial Officer
03.2019	Policy Update	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
12.2024	Biennial Review	Chief Financial Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	Finance		
Section:	Travel		
Policy: ☒ Procedure: ☐ Page: 1 of 3	Review Cycle: Biennial Author: Chief Financial Officer	Adopted Date: 02.04.2014 Review Date: 09.10.2024	Related Policies: Financial Management

Purpose

Mid-State Health Network (MSHN) recognizes that employees, students, volunteers and Board members may be required to travel on behalf of MSHN. It is the intent of MSHN to provide for the reasonable expenses associated with that travel.

Policy

It is the policy of Mid-State Health Network (MSHN) that all reasonable expenses for official travel will be reimbursed in accordance with State and Federal laws and the guidelines set forth below. It is recognized that exceptions are on occasion, necessary. Such exceptions shall be approved, in advance, when possible, by the Chief Executive Officer (CEO).

A. All employees are required to drive their own automobile in the course of their employment. Employees will be reimbursed at Internal Revenue Service (IRS) Mileage Rate. Mileage will generally be computed from the employee's "official station" (OS) if within the State of Michigan and shall be based on Google Maps calculations. If the OS is outside of the State of Michigan, the MSHN Office is designated as the OS for purposes of calculating business mileage. Employees will not be reimbursed for mileage to MSHN's office or other company designated locations for internal meetings, internal trainings, or other MSHN office-based activities[1]. The OS of a Board member or volunteer is determined to be their home (provided it is in the State of Michigan) and reimbursement shall be calculated from that starting location.

B. Should employees/Board members/volunteers attend pre-authorized meetings, conference, conventions, or seminars on behalf of MSHN, the following shall apply:

1. Travel by private automobile shall be reimbursed at the IRS mileage rate.
2. Any business travel outside of the State of Michigan requires prior CEO or Deputy Director approval. Travel within the State of Michigan for paid conferences, conventions, or seminars must be approved by the Director or Chief within the employees' reporting line. Administrators may approve travel vouchers. If travel is by common carrier, commercial fare will be reimbursed if receipts have been retained and submitted with the expense report. Travel reimbursement must be reasonable. One element of reasonableness is comparison of the approximate travel reimbursement against the approximate cost of available alternate means of transportation.
3. Reimbursement for meals plus tip will be allowed while traveling out-of-town to/ from or at the place of any meeting, conference, seminar, or convention not to exceed the daily amount established by the US General Services Administration (GSA) ~~Internal Revenue Service (IRS)~~. Employees will be reimbursed the lessor of receipt total or per diem (including tips and taxes) when itemized receipts are submitted. Employees will be reimbursed for half the per diem when there is no receipt or the receipt is not itemized. Meals for internal departmental meetings are not covered unless prior approval is given by the CEO. Such allowance shall be on a "per meal" basis and are not to exceed three in one day. Detailed receipts

[1] Travel to/from the official station of the employee to the Lansing, Michigan area for official business not conducted at the MSHN offices (including but not limited to provider site visits, board meetings, events involving the State of Michigan or other stakeholders, and trainings) will be paid per the terms of this policy.

are required to be reimbursed (Credit slips not detailing items purchased are not acceptable). Claims for reimbursement of conference expenses (other than mileage and meals) must be supported with adequate documentation (receipts) for reimbursement to be made. Documentation must include proof of payment: detailed credit card statement; original receipt from conference stating amount paid; or copy of personal check with registration documentation.

4. Tolls and telephone expenses will be reimbursed when it is necessary as part of the trip on behalf of MSHN; taxi fare (or available alternatives, such as Lyft or Uber) is reimbursable only if the trip was made for business purposes.
5. Parking fees during the conference, convention, seminar, or meeting will be reimbursed if receipts are retained and submitted with the expense report.

C. Lodging costs and incidental expenses for overnight stays are permitted for external conferences and trainings that are at least two consecutive days. Expense reports shall be submitted to the Chief Financial Officer (CFO) for payment after the appropriate Supervisor approvals and following the convention, conference, seminar, or meeting attended by the employee. A short explanation of each expense must accompany the expense report, along with receipts.

D. Expense Not Reimbursed: MSHN does not reimburse expenses which are not pertinent to required travel unless specific advanced approval has been obtained in writing from the CEO and may include but is not limited to.

1. Expenses associated with the spouse or family member who may be travelling with the MSHN representative.
2. Expenses associated with speeding or parking violations.
3. Alcoholic beverages.
4. State tax (where MSHN is exempt from tax)

E. Expense submitted greater than 60 days: All reimbursement requests must be submitted within 60 days of the travel expense being incurred. Per the IRS Publication 463, "Travel, Entertainment, Gift, and Car Expenses," employees must adequately account to MSHN for travel expenses within a reasonable period of time or the amount may become taxable. A reasonable period of time is defined as adequately accounting for your expenses within 60 days of them being incurred. Any reimbursement requests submitted after 60 days require approval of the Chief Executive Officer.

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:

CEO: Chief Executive Officer
CFO: Chief Financial Officer
CMHSP: Community Mental Health Service Program
GSA: US General Services Administration
IRS: Internal Revenue Service
MSHN: Mid-State Health Network
Official Station (OS): An employee's "official station" is deemed their home address (as noted in most recent Remote Agreement) in the State of Michigan unless otherwise mandated by the CEO Employees with official residences in other States will not be reimbursed for expenses associated with travel to and from Michigan. All other guidelines in this policy apply for expense reimbursement. Some employees, with variable assignments, may have a daily OS assignment, which is defined based on their established work schedule. For the purpose of this policy, the OS for Board members or volunteers is the address provided on their employment forms (or home).

References/Legal Authority
IRS Mileage Rates: http://www.irs.gov/Tax-Professionals/Standard-Mileage-Rates

Change Log:

Date of Change	Description of Change	Responsible Party
02.04.2014	New policy	Chief Financial Officer
11.06.2015	Policy update	Chief Financial Officer
03.20.17	Policy update	Chief Financial Officer
03.2018	Policy update	Chief Financial Officer
03.2019	Annual Review	Chief Financial Officer
02.2020	Added Lansing Area Lodging	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Policy Update	Chief Financial Officer
05.2024	Policy Update	Chief Executive Officer
12.2024	Policy Update	Chief Financial Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	~~Quality~~Provider Network Management		
Title:	**Administrative & Retained PIHP Functions Contract Monitoring and Oversight**		
Policy: ☑ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle: Biennial** **Author:** Chief ~~Compliance~~ Financial Officer	**Adopted Date: 12.08.2020** **Review Date:** 01.12.2021 **Revision Eff. Date:**	**Related Policies:** Quality Management

Purpose

This policy is intended to establish guidelines, as the Pre-Paid Inpatient Health Plan (PIHP), for the development and implementation of the Mid-State Health Network (MSHN). To ensure compliance with federal and state regulations, and to establish standardized processes for conducting a review of performance contracts.

Policy

MSHN shall create, implement and maintain a published process to monitor and evaluate its administrative and retained PIHP function contracts to ensure compliance with federal and state regulations and to ensure compliance with the contracted scope of work.

A. MSHN shall conduct a full monitoring and evaluation process of administrative and retained PIHP function contracts at least annually prior to the expiration (or renewal) of the contract. This process will consist of utilizing a uniform contract assessment template to evaluate compliance with contractual requirements and deliverables identified in the scope of work.
B. The contract assessment process shall consist of the following components:
    1. ***Deliverables in the Contract Scope of Work****:* Identified elements for each component evaluated as follows ~~based on~~: ~~exceeds expectations, meets contract requirements, partial met contract requirements, unmet contract deliverables.~~ Met, Exceeded, Partially Met, Unmet.
    2. ***Customer Service/Satisfaction****:* Includes contractor performance with the Provider Network, MSHN staff and MSHN Councils and Committees.
    3. ***Contract Performance Strengths****:* Includes identification of strengths related to contract performance.
    4. ***Contract Performance Opportunities****:* Includes opportunities for improvement in current performance, consideration for future growth, and requests related to new requirements.
    5. ***Value (Price/ROI)****:* Includes an assessment based on contractor's deliverables, scope of work, contract price to determine value.
    6. ***Recommendations***: Includes recommendation to renew contract, terminate ~~or let expire.~~, and any related change in contract terms such as price, deliverables, etc.
C. Overall responsibility for the contract monitoring evaluation process shall rest with the MSHN contract designee identified in the contract.
D. Input and feedback regarding the assessment shall be obtained from related parties as appropriate. (e.g. Provider Network, MSHN staff, MSHN Councils)
E. The contractor shall be given the opportunity to complete a self-assessment utilizing the MSHN performance contract assessment template.
F. The MSHN contract designee shall discuss concerns ~~and review the completed performance assessment with~~ with the contractor to provide an opportunity for collaborative review and feedback.
G. The completed assessment with the appropriate recommendation shall be forwarded to the Contract Specialist and if appropriate, for addition to the Board of Directors contract list. The Contract Specialist must report any components of this policy not completed to the Chief Financial Officer, Chief Executive Officer, or Deputy Director for follow-up and resolution. ~~MSHN Chief Executive Officer and MSHN Chief Financial Officer for consideration in future contracting.~~
H. Final contract evaluation shall be maintained in the provider's contract file.

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
MDHHS: Michigan Department of Health and Human Services
PIHP: Prepaid Inpatient Health Plan
Provider Network: refers to a CMHSP Participant that is directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through CMHSP subcontractors.

Other Related Materials
~~Performance Contract Assessment~~ Administrative Contract Template

References/Legal Authority
N/A

Change Log:

Date of Change	Description of Change	Responsible Party
01.26.2015	New Policy	Chief Compliance Officer
03.2016	Annual Review	Quality, Compliance and Customer Service Director
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service and Quality
03.2019	Annual Review	Quality Manager
10.2020	Biennial Review	Quality Manager
1.22.25	Updated Policy	Chief Financial Officer