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From the Chief Executive Officer's Desk

Joseph Sedlock

“Harm reduction has its origins in Europe, it is quickly taking hold as a middle-road alternative to the two established traditional approaches favored in this country: the moral model (War on Drugs) and the disease model of addiction. Based on public-health principles and founded by “grassroots” advocacy among drug users themselves, harm reduction offers a pragmatic, yet compassionate set of principles and procedures designed to reduce the harmful consequences of addictive behavior for both drug consumers and for the society in which they live.[1]”

Harm reduction includes public health policies from which evidence based public health strategies are developed to reduce the negative social and/or physical consequences associated with human behaviors, both legal and illegal. There are literally thousands and thousands of examples of harm reduction at work in our daily lives. To name a few: bottle return deposits reduced the public health consequences of littering and waterways contamination; speed limits strongly associated with population density reduced injuries and deaths associated with higher speeds. An example of a harm reduction approach sustained over decades is tobacco use (smoking) reduction.

In the couple of examples I noted above, most people would agree that these strategies actually reduced harm. Applied to a health example, tobacco harm reduction involves providing tobacco users who are unwilling or unable to quit using nicotine products with less harmful nicotine-containing products for continued use. Applied to other forms of substance use and addiction, harm reduction strategies are critical to preventing overdose, the spread of disease, and keeping people as healthy as possible.

According to SAMHSA, “Harm reduction is an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services.”

“A comprehensive prevention strategy, harm reduction is part of the continuum of care. Harm reduction approaches have proven to prevent death, injury, disease, overdose, and substance misuse. Harm reduction is effective in addressing the public health epidemic involving substance use as well as infectious disease and other harms associated with drug use. Specifically, harm reduction services can:

- Connect individuals to overdose education, counseling, and referral to treatment for infectious diseases and substance use disorders.
- Distribute opioid overdose reversal medications (e.g., naloxone) to individuals at risk of overdose, or to those who might respond to an overdose.
- Lessen harms associated with drug use and related behaviors that increase the risk of infectious diseases, including HIV, viral hepatitis, and bacterial and fungal infections.

- Reduce infectious disease transmission among people who use drugs, including those who inject drugs by equipping them with accurate information and facilitating referral to resources.
- Reduce overdose deaths, promote linkages to care, facilitate co-location of services as part of a comprehensive, integrated approach.
- Reduce stigma associated with substance use and co-occurring disorders.
- Promote a philosophy of hope and healing by utilizing those with lived experience of recovery in the management of harm reduction services, and connecting those who have expressed interest to treatment, peer support workers and other recovery support services."

Harm reduction is part of the mission of Mid-State Health Network. There are many more benefits to harm reduction than those listed briefly above, including community benefits such as crime reduction, reduced incarceration (and related costs), safer communities, and so much more.

Join with Mid-State Health Network in welcoming and supporting harm reduction programs around our region. We exist to help people become healthier – which is the whole goal of harm reduction activities. In many cases, these strategies save lives.

[1] Marlatt, G.A. 1996. Harm Reduction: Come as You Are. Addictive Behaviors, Vol 21, No. 6, 779-788.

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

MSHN Reorganization Update

MSHN's Leadership Team has been engaged in organizational planning to carry out current and anticipated future PIHP-level responsibilities. These present and future initiatives include additional responsibilities in establishing and expanding Opioid Health Homes, Behavioral Health Homes, and Certified Community Behavioral Health Clinics and addressing significant increases in both internal and external compliance related activities. To better align the oversight and supervisory responsibilities and to provide an internal promotion pathway, MSHN has created a new "Administrator" scale. With the new changes, MSHN is pleased to announce the following changes.

- Kara Hart has been promoted to Waiver Administrator for Adult Waivers and will oversee the Home and Community Based Services transition compliance and Habilitative Supports Waiver.
- Barb Groom has been promoted to Waiver Administrator for Children Services and will oversee the Children's Waiver, Serious Emotional Disturbance Waiver, and the Applied Behavior Analysis benefit.
- Amy Dillion has been promoted to Compliance Administrator and will oversee regional compliance for both our internal compliance reviews of MSHN's provider network and Michigan Department of Health and Human Services (MDHHS) reviews of the MSHN region, including all waivers, external quality reviews and Medicaid verifications.
- Cammie Myers-Mattice has been promoted to Utilization Management Administrator and will oversee the utilization management for the region, including the substance use disorder provider network authorizations.
- Paul Duff will transfer from the Home and Community Based Waiver Coordinator to the Integrated Healthcare Coordinator, effective January 2, 2023, and will support the implementation efforts related to Behavioral Health Homes.
- Annamarie Macandog will begin employment with MSHN on January 3, 2023, as the Habilitative Supports Waiver (HSW) Coordinator, supporting the region's HSW eligibility and application reviews.

MSHN staffing will see more changes as we look to backfill some of the positions left vacant by the promotions above and is still actively seeking to fill the SUD Care Navigator (funded and required by MDHHS).

Job Descriptions are located on MSHN's website at: https://midstatehealthnetwork.org/stakeholders-resources/about-us/Careers.

COVID-19: What's Next for 2023?

COVID-19 continues to be designated as a federal public health emergency (PHE). The PHE was extended on October 13, 2022, for 90 days through January 12, 2023. As of December 1, 2022, Michigan has not received notice of the PHE end, which CMS indicated would provide at least 60 days prior. However, many states including Michigan is preparing for the PHE end date. Policies that will change or end a COVID-19 Response policy, will include a 35-day public comment period and issuance of a final bulletin at least 30 days before the effective date of the policy change. MDHHS has developed a specific webpage to assist providers and beneficiaries. https://www.michigan.gov/mdhhs/end-phe.

On November 1, 2022, Michigan Department of Health and Human Services (MDHHS) issued a notice to all providers that some of the flexibilities offered during COVID-19 are being removed as of December 1, 2022.

Provider Enrollment Requirements

MDHHS is electing to no longer use its Section 1135 authority waiving certain provider enrollment requirements and will begin to reinstate these administrative processes consistent with current policy and federal regulations

governing Medicaid program integrity and provider enrollment activities. For providers, the following will be reinstated:

- Community Health Automated Medicaid Processing System (CHAMPS) enrollment revalidations conducted through CHAMPS;
- Site visits for prospective and current providers;
- Fingerprint-based criminal background checks associated with providers in the high-risk level category; and
- Enrollment application fees

Medicaid Enrollees

The authorization of the Families First Coronavirus Response Act (FFCRA) required states to maintain enrollment of nearly all Medicaid enrollees. When the continuous coverage requirement expires, states will have up to 12 months to return to normal eligibility and enrollment operations. MDHHS has been updating and ensuring accurate enrollee contact information. Beneficiaries will be provided with timely and adequate notice of the ending or reduction of any COVID-19 Response service or process. A proposed policy has been distributed indicating MDHHS will resume Medicaid renewals for all programs effective the first month following the end of the PHE. MDHHS will have a 14-month time limit for renewal unwind.

Telemedicine Post COVID

MDHHS has issued a post COVID draft policy bulletin to update program coverage of telemedicine services. The issue and effective date will be reflective of the PHE end date. The policy outlines telemedicine allowances in effect post-federal PHE, including discontinued and adapted temporary bulletins. Clarification of continued use of telemedicine, discontinued use of audio only (with some exceptions) and requirements to bill such are detailed in the draft policy. For Behavioral Health, use of telemedicine must be documented at the convenience of the beneficiary and not the provider. The services and use of telemedicine must be part of the person-centered plan and available as a choice (not a requirement).

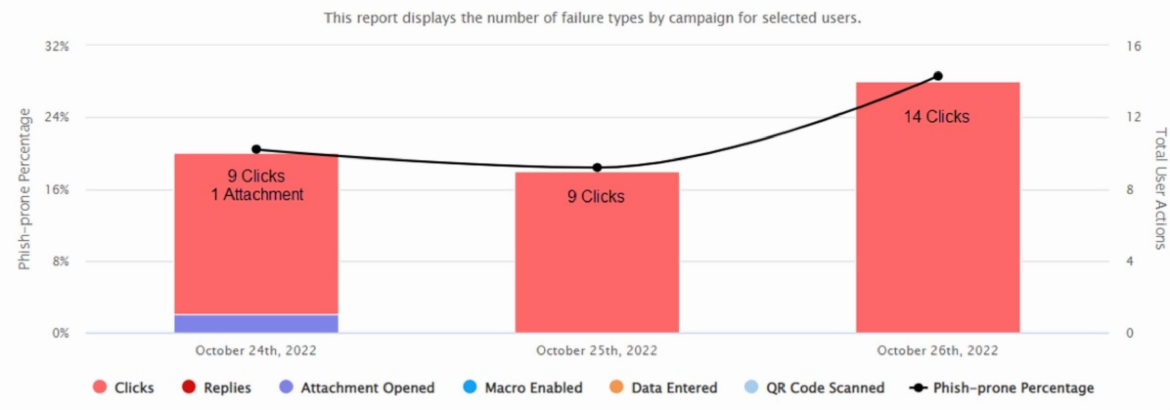
For further information or questions, please contact Amanda at Amanda.Ittner@midstatehealthnetwork.org

Information Technology

Steve Grulke
Chief Information Officer

Over the last few months, the Information Technology (IT) staff worked with the Quality Improvement (QI) staff to convert the critical incident reporting from the old Michigan Public Health Institute (MPHI) web services process to the Michigan Department of Health and Human Services (MDHHS) file upload process. This change was initiated and required by MDHHS that included minor changes in what events are required to be reported and additional data fields. This change also required the Community Mental Health Service Providers (CMHSPs) and Substance Use Disorder (SUD) providers to make changes to their internal data collection process and their information management systems in order to follow this new reporting process.

MSHN implemented a new cybersecurity protocol. The process started with a phishing campaign to establish a baseline point (see graph below) which included multiple scam emails being sent to all MSHN employees to test their ability to recognize and report the security concern. Next, everyone was assigned a 15-minute training module to be completed within 3-4 weeks.



Date	Campaign	Delivered	Clicks	Replies	QR Codes Scanned	Attachment Opened
October 2022	3 campaigns	147	32	0	0	1
	Baseline 10/24/2022	49	9	0	0	1
	Baseline 10/25/2022	49	9	0	0	0
	Baseline 10/26/2022	49	14	0	0	0
		147	**32**	**0**	**0**	**1**

On an ongoing monthly basis, staff will be sent phishing tests designed as close to actual phishing attempts known to be used to assess whether they can recognize these attacks and handle them appropriately. If the staff fail on a

test phishing email, they will be assigned additional training to help them correct the behaviors. All of this is designed to build a “healthy paranoia” of email attacks.

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

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN’s Finance Team submitted its FY 22 Interim Financial Status Report (FSR). The report outlines Medicaid and Healthy Michigan Program (HMP) funding received by the Prepaid Inpatient Health Plan (PIHP) and funding amounts subsequently used for expenses by each Community Mental Health Service Program (CMHSP) and for Substance Use Disorder (SUD) services. The report also shows the amount of savings the region will earn and use in the next fiscal year as well as identifying the maximum Internal Service Funds (ISF) the PIHP can earn. MSHN is projecting to fully fund savings and ISF. Unlike many private health insurance plans, including Medicaid Health Plans, MSHN expects to return unused funds attributable to contractual financing calculation guidelines and associated with the Direct Care Worker (DCW) wage increase initiative. Since March 2020, DCW staff have received an enhanced hourly payment for the services they provide. The current DCW rate is an extra $2.35/hour plus 12% to cover provider administration for each hour paid. Beginning in Fiscal Year 23, the DCW wage will no longer be cost settled between the Michigan Department of Health and Human Services (MDHHS) and the PIHP which means the revenue provided for DCW increases will be included in MDHHS’ existing savings formula. Many providers have also benefitted from our general provider stabilization and regional staffing crisis stabilization initiatives.

In addition to FY 22 reporting, MSHN continues its work with the three Certified Community Behavioral Health Clinic (CCBHC*)* sites (CMHSPs in Lansing, Ionia, and Saginaw) in our region. Part of this work also involves PIHPs working with MDHHS on reconciliation processes. If you recall, PIHPs must reimburse CCBHCs a Prospective Payment System (PPS-1) amount for each consumer receiving the daily code (T1040). Working through the interim FSR reporting process, some CCBHC sites reported insufficient PPS-1 revenue to cover program costs. After numerous workgroup discussions with MDHHS, they recently approved PIHPs using capitation revenue for CCBHC sites anticipating cost overruns in Demonstration Year 1 (DY 1) only. MDHHS has also committed to review PPS-1 rates by mid FY 23/DY 2 and make necessary adjustments retro to 10.01.2022 to support CCBHC costs.

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

Behavioral Health

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

Behavioral Health System Wellness: A Focus on Recovery and Resiliency

As the Michigan behavioral health system addresses the staffing shortage, it is also focusing on the wellness and resilience of its existing workforce. Current research in health policy and systems literature has asked the question of how health systems can become more resilient when faced with the overwhelming effect of the COVID-19 pandemic. The pandemic strained the behavioral health system, advancing the risk of staff burnout and ultimately damaging overall system wellness. The behavioral health system is being called upon to rehabilitate itself from the deleterious effects from the pandemic, and this starts with the ethical imperative of the well-being of its existing and present workforce. The behavioral health system has been devoted to the delivery of quality care to its most vulnerable citizens but also has been affected by difficulties with staffing stability secondary to the pandemic.

The resilience of a healthcare system is the capacity of that system to respond to and recover from a crisis while still maintaining its primary functions (Cannady et al., 2022). According to the work of Kruk et al. (2015), there are five characteristics of resilient healthcare systems: awareness of system strengths and vulnerabilities, diverse health needs are addressed, containment of health threats while continuing to provide care, integration of people and ideas to solve crises, and adaptive and able to improve performance regardless of the presence of a crisis. Having sufficient staffing levels is crucial for system resilience, broadly affecting all five healthcare system resilience factors, and until such time that staffing levels respond noticeably to current efforts, focusing on the wellness of the existing workforce is of immediate importance. Burnout (reduction or absence of wellness) is generally defined as a staff person feeling fatigued and overextended, exhibiting reduced work accomplishments, and possessing negative self-evaluation (Collins & Cassill, 2022). Various studies have reported that from 21% up to 73% of participants have experienced a range of burnout symptoms.

Most professional organization’s set of ethical standards, such as the American Psychological Association, do not specifically address burnout but do strongly imply the need to address it. For example, ethical principles of beneficence and nonmaleficence stress that the health and well-being of staff impacts their ability to provide services. Burnout must be detected and dealt with to ensure adherence to ethical principles as well as to improve staff well-being, who then are more capable and present for the individuals they serve. Therefore, self-care must be present as one such counteractant to burnout. Behavioral health systems improve organizational resilience when workplace support and self-care are active components in organizational and individual behaviors. Mid-State Health Network would like to take the opportunity, during this holiday season of thanks, to recognize with gratitude, its Community Mental Health Service Provider and Substance Use Disorder systems of care for the strength and resilience each brings to communities throughout the region.

References:

- Cannedy, S.; Bergman, A.; Medich, M.; Rose, D.E.; & Stockdale, S.E. (2022). Health system resiliency and the COVID-19 pandemic: A case study of a new nationwide contingency staffing program, *Healthcare 10* (244). doi: https://doi.org/10.3390/healthcare10020244

- Collins, M.H. & Cassill, C.K. (2022). Psychological wellness and self-care: An ethical and professional imperative, *Ethics & Behavior, 32* (7), 634-646, doi: https://doi.org/10.1080/10508422.2021.1971526

- Kruk, M.E.; Myers, M.; Tornorlah V.S.; Dahn, B.T. (2015). What is a Resilient Health System? Lessons from Ebola. *Lancet*, 385, 1910–1912.

For any questions, comments or concerns related to the above and/or MSHN Behavioral Health, please contact Todd at Todd.Lewicki@midstatehealthnetwork.org

Utilization Management & Care Coordination

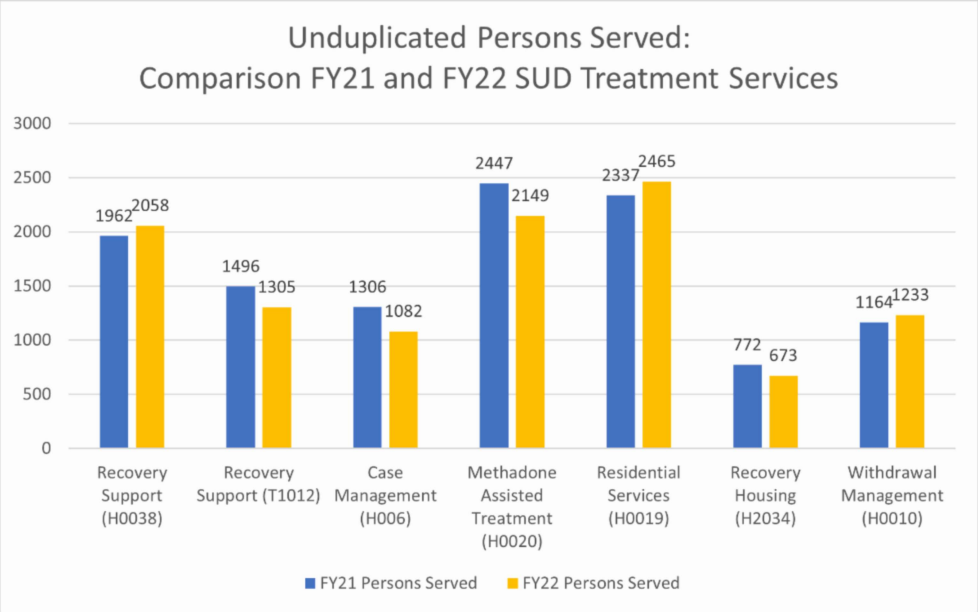
Skye Pletcher-Negrón, LPC, CAADC
Director of Utilization and Care Management

FY22 Year in Review: Utilization Trends in Substance Use Treatment Services

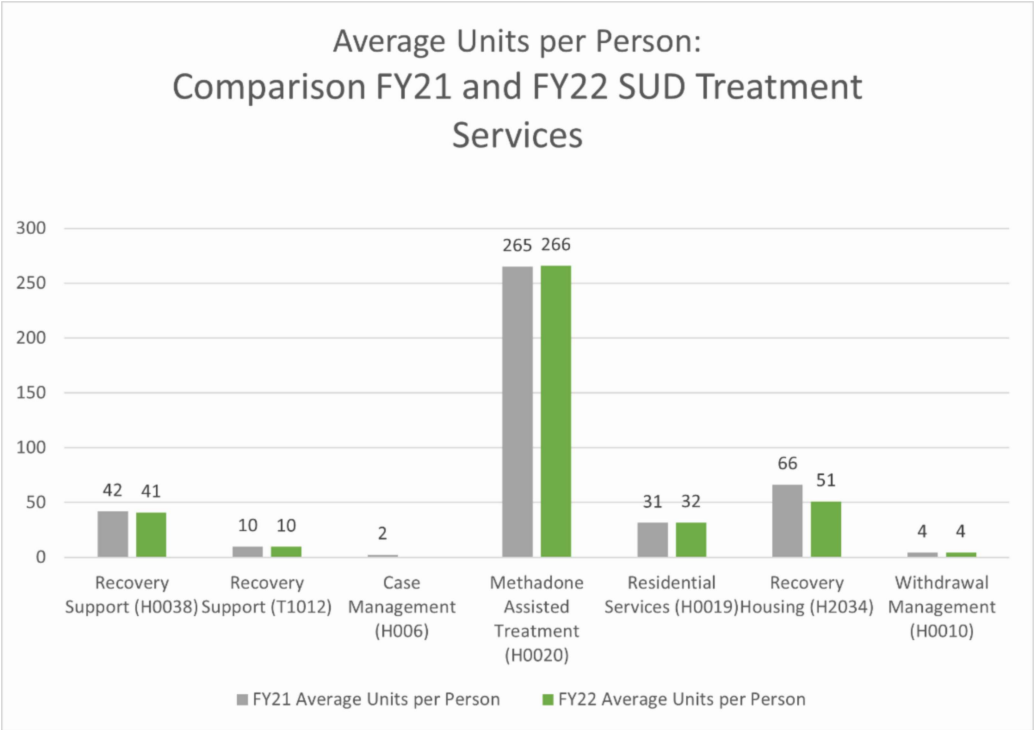
During FY22 there were 11,247 new admissions to MSHN-funded Substance Use Disorder (SUD) treatment services, an increase of 3.2% from FY21 to FY22. The following table represents the total number of admissions to treatment by the county of residence of persons served over the last 2 fiscal years:

County of Residence	FY22 Served	FY21 Served
Arenac	69	62
Clare	278	283
Eaton	548	479
Gratiot	181	179
Huron	113	118
Ionia	236	189
Jackson	1254	1272
Midland	443	446
Newaygo	191	267
Saginaw	1656	1544
Tuscola	208	209
Total Admissions to Treatment	**11,247**	**10,902**

The following chart shows a comparison of the number of unduplicated persons who received SUD treatment and recovery services during FY21 and FY22. (*Please note: This chart depicts the most frequently used SUD treatment services. It is not an exhaustive list of all MSHN-funded SUD services).*



The following chart shows the number of units of service each person received **on average** in FY21 and FY22. Individuals may receive more or less than the average amount depending on their specific needs, however it is important for the MSHN Utilization Management Department to review average trends throughout the region to ensure that services are being delivered consistently and equitably. (*Please note: This chart depicts the most frequently used SUD treatment services. It is not an exhaustive list of all MSHN-funded SUD services).*



The total number of persons receiving SUD treatment and recovery services has remained consistent over the last 2 fiscal years, as well as the average amount of services people receive. The MSHN UM Department will continue to monitor utilization data to better understand the needs of individuals in our region and make recommendations as needed to improve service delivery.

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

Substance Use Disorder Policy, Strategy and Equity

Dr. Dani Meier, PhD, LMSW, MA
Chief Clinical Officer

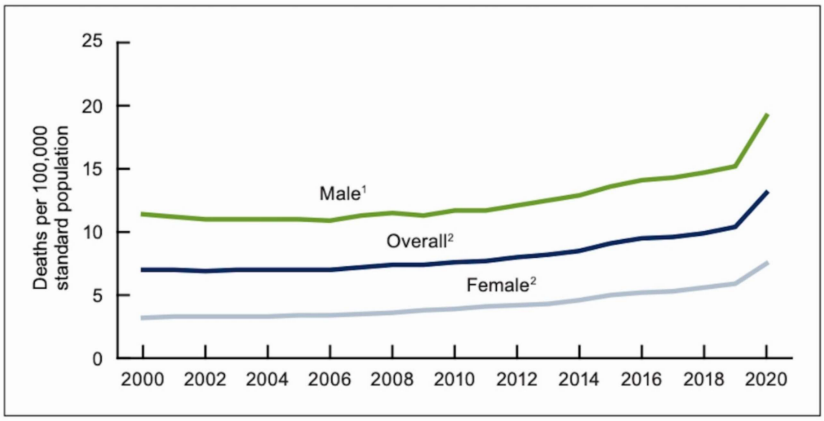
Alcohol Deaths Rising: Awareness During the Holidays

With opioid-related overdose deaths—driven overwhelmingly by fentanyl—topping 109,000 Americans in the last

12 months, it's easy to forget that another dangerous substance is in the refrigerators, wine racks and liquor cabinets of most American households. Alcohol use in the United States increased dramatically in 2019, the first year of the Coronavirus pandemic. This isn't entirely surprising given COVID-related lockdowns, isolation, loss and trauma, but the CDC recently released a report that alcohol-related *deaths* (which have been increasing since 2000) also rose steeply since 2019. While there were differences in death rates based on age and gender, death rates for men were 2 to 4 times higher than for women across all age groups.

Rates of alcohol-induced deaths generally increased from 2000 to 2020 but rose more steeply in recent years.

Age-adjusted rates of alcohol-induced deaths, by sex: United States, 2000–2020



¹Stable trend from 2000 through 2009; significant increasing trend from 2009 through 2020, with different rates of change over time; $p < 0.05$.
²Significant increasing trend from 2000 through 2020, with different rates of change over time; $p < 0.05$.
NOTES: Age-adjusted death rates were calculated using the direct method and the 2000 U.S. standard population. Alcohol-induced deaths include *International Classification of Diseases, 10th Revision* underlying cause-of-death codes E24.4, F10, G31.2, G62.1, G72.1, I42.6, K29.2, K70, K85.2, K86.0, R78.0, X45, X65, and Y15. Alcohol-induced causes exclude unintentional injuries, homicides, and other causes of death from conditions either indirectly or partially related to alcohol use, as well as newborn deaths associated with maternal alcohol use. Access data table for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db448-tables.pdf#1.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Alcohol-related illnesses like liver disease are among the variables which contributed to the U.S. losing ground in life expectancy, declining in 2021 to a national average of 76.1 in 2021. American Indian-Alaskan Native people's life expectancy was the lowest, down to 65.2 in 2021, Black Americans dropped to 70.8, and non-Hispanic whites dropped to 76.4.

Holiday gatherings of friends and family later this month will offer opportunities for laughter and fun, but also for the reemergence of old patterns and conflicts. Moreover, at a time when politics and social issues have divided us more than at any time most of us can remember, dinner conversation can easily get heated. Introducing alcohol—much less a lot of alcohol—into those situations has the capacity to see conflicts escalate quickly. Moreover, aside from the risks associated with holiday revelers driving after drinking, we know that drinking too much is often associated with domestic violence and about 50% of sexual assaults involve alcohol consumption.

The solution in some cases may be to have alcohol-free holiday celebrations (especially if there are people present who are in recovery). Others may choose to limit the amount that is available on hand for consumption. But ultimately no individual can control the alcohol intake of another adult who can legally purchase as much alcohol as they want. What we all *can* do is be active not silent bystanders. We can look out for each other, our neighbors, friends and family and we can establish a zero-tolerance for behaviors that are aggressive, abusive or violent. With that commitment, we can wish for a peaceful holiday season and a more peaceful year in 2023.

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

Substance Use Disorder Providers and Operations

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

2022 National Stimulant Summit – Current Drug Threats in the United States

The 2022 National Stimulant Summit was held recently on November 2nd thru 4th. MSHN supported the attendance of nineteen (19) Substance Use Disorder (SUD) treatment provider staff to attend the summit and learn the most up to date information on evidence-based practices, promising practices, data on drug trends in the U.S., and hear from some of the nation's top experts related to substance use like Nora Volkov, the Director of the National Institute on Drug Abuse (NIDA).

Stimulants are a class of drugs that speed up messages travelling between the brain and body. They can make a person feel more awake, alert, confident or energetic. Many users of stimulants experience a loss of appetite, increased heart rate, elevated blood pressure and body temperature, interrupted sleep patterns, panic, hallucinations, and irritability. Taking high dosages of stimulants can result in convulsions, seizures, and possibly

even death. Stimulants as a class of substances can include a range of both legal and illegal substances. This includes substances such as methamphetamines, cocaine, and crack as the most used illegal substances. The most common legal substances include caffeine, nicotine, and prescription medications like Ritalin and Adderall that are commonly used to support individuals with attention deficit hyperactivity disorder (ADHD).

A repeated theme of data from the National Stimulant Summit was the drug trends related to the combination of stimulants with opioids (such as fentanyl) having become a driving force in drug overdose deaths within the United States. This trend began in 2015 and has escalated since. The occurrence of the COVID-19 pandemic has also continued to have negative impacts to this problem as illustrated in Chart 1 below. The estimated provisional data for 2021 is indicating the U.S. experienced 107,622 overdose deaths. This would be a 102% increase since 2015: with a 1,073% increase for cocaine with fentanyl deaths, and a 3,704% increase for psychostimulants with fentanyl deaths.

Currently, the rate of overdose deaths that involve stimulants, like cocaine and methamphetamines, have surpassed those caused by prescription opioids (Chart 2). Per the National Institute for Health Care Management (NICMH), in 2020, 68% of deaths involving methamphetamines and cocaine also involved opioids (Chart 3). Overdose death rates also climbed across all ethnic groups, with American Indian or Alaska Natives seeing the highest rates of increase with methamphetamines, and Black and African Americans seeing the highest rates for cocaine (Chart 4). When examining living environment, cocaine death rates were highest in urban areas, whereas methamphetamine deaths were higher in rural areas.

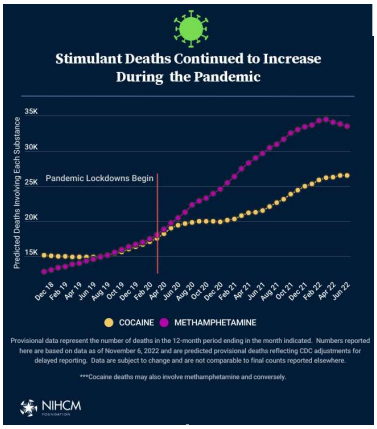


Chart 1

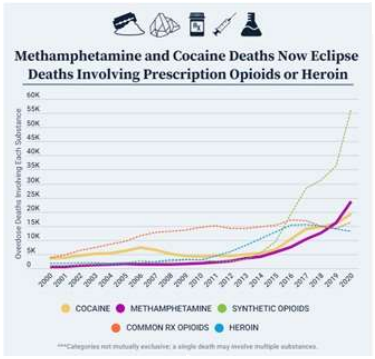


Chart 2

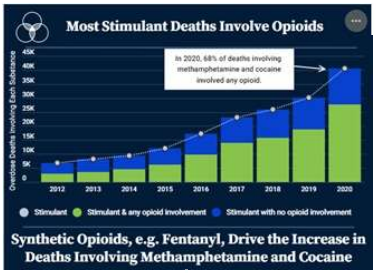


Chart 3

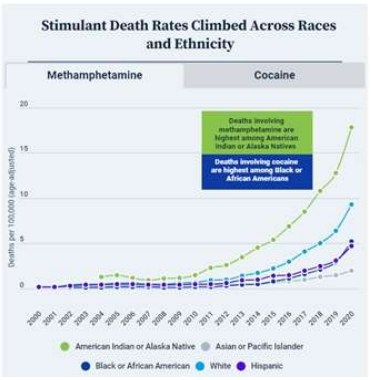


Chart 4

As MSHN moves forward, the SUD clinical team will continue to monitor these drug trends and threats within our 21-county region and look for opportunities to support evidence-based practices within SUD prevention, treatment, and recovery to assist individuals with Stimulant Use Disorders on their pathways to recovery.

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

Quality, Compliance & Customer Service

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

Program Integrity Contract Requirements

The requirements for a compliance program are identified in the 42 Code of Federal Regulations (CFR) 438.608 and state that the Pre-Paid Inpatient Health Plan (PIHP) must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.

A compliance program must include, at a minimum, the following elements:

- Written policies, procedures and standards of conduct that articulate the organizations commitment to comply with all applicable requirements and standards under the contract.
- The designation of a Compliance Officer responsible for developing and implementing policies, procedures and practices designed to ensure compliance with requirements.
- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance

with the requirements under the contract.
- A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract.
- Effective lines of communication between the compliance officer and the organization's employees.
- Enforcement of standards through well-publicized disciplinary guidelines.
- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

Mid-State Health Networks (MSHNs) compliance program incorporates all of these elements through the Compliance Plan, policies, procedures, internal compliance committee, regional compliance committee, and the designation of a compliance officer.

The Michigan Department of Health and Human Services (MDHHS) - Office of Inspector General (OIG) is responsible for providing oversight for the program integrity activities completed by the PIHP and its subcontractors.

The MDHHS-OIG has included the addition of the following elements to the program integrity section in Contract Change Notice 8 of the MDHHS/PIHP Contract.

- If a credible allegation of fraud exists and includes an overpayment of $5,000 or greater is identified, the case must be referred to the OIG. Prior to this change, all credible allegations of any dollar amount were required to be reported to the OIG.
- After reporting a potential credible allegation of fraud, the Contractor shall not take any of the following actions unless otherwise instructed by OIG:
    - Contact the subject of the referral about any matters related to the referral.
    - Enter into or attempt to negotiate any settlement or agreement regarding the referral with the subject of the referral; or
    - Accept any monetary or other thing of valuable consideration offered by the subject of the referral in connection with the findings/overpayment.
- If the State makes a recovery from an investigation and/or corresponding legal action where the Contractor has sustained a documented loss, the State shall not be obligated to repay any monies recovered to Contractor.
- The Contractor must include any improper payments identified and amounts adjusted in encounter data and/or overpayments recovered by the Contractor during the course of its program integrity activities. This report also includes a list of the individual encounters corrected. To ensure accuracy of reported adjustments, Contractor must:
    - Purchase at minimum one (1) license for MDHHS-OIG's case management software. This license will be utilized to upload report submissions to the case management system and to check the completeness and accuracy of report submissions.
    - For medical equipment, supplies, or prescription provided, adjust any encounter for an enrollee to zero dollars paid. If the encounter with a dollar amount cannot be adjusted to zero dollars paid, then the encounters with dollars paid must be voided and resubmitted with zero dollars paid.
    - Specify if overpayment amounts were determined via sample and extrapolation or claim-based review. In instances where extrapolation occurs, Contractor may elect to correct claims, and thus encounters, as they see fit.
    - Report only corrected encounters associated with post payment evaluations that resulted in a determined overpayment amount.

The addition of these new requirements, except for reporting overpayments of $5,000 or greater, will require additional time and resources to track and provide the required data. The OIG is also requiring the use of a new Program Integrity Quarterly Report Template that includes additional data elements to be reported and tracked until all activities such as voiding of claims and recoupment of overpayments are complete.

For more information on the new requirements, please contact Kim Zimmerman.

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

Our Mission:

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

Our Vision:

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