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Mid-State Health Network gratefully celebrates Deb McPeek-McFadden and David Griesing for ten years of service on the Board of Directors. (Left to Right: Amanda Ittner, MSHN Deputy Director; Deb McPeek-McFadden; David Griesing; Ed Woods, MSHN Board Chairperson; Joe Sedlock, MSHN Chief Executive Officer)

From the Chief Executive Officer's Desk

Joseph Sedlock

While Mid-State Health Network (MSHN) has several questions in to Michigan Department of Health and Human Services (MDHHS) about the proposed bidder qualifications and eligibility requirements, our conclusion (which has been informally confirmed) is that existing Regional Entities operating as Pre-Paid Inpatient Health Plans (PIHPs) are not eligible bidders as they are currently configured. MSHN is seeking official confirmation or clarification from MDHHS. This is not the situation MSHN had been planning for. Nonetheless, MSHN will pursue what it sees as a few long-shot options to successfully participate in the bid process.

This likely means that MSHN will discontinue operations at some future date if it cannot find a viable path to participate in the MDHHS-initiated procurement process. There is nothing imminent about this announcement. MSHN has a FY 25 contract to fulfill and expects a FY 26 contract (although it may contain some additional transitional provisions). MDHHS has announced its intent that new PIHP contracts will be in place for FY 27 by 10/01/2026. This is a very short and potentially unachievable target date in our view.

MSHN intends to carry out its contractual obligations with continued focus on access to and quality of services for beneficiaries, their families, and communities, integrity, compliance with its contract and regulatory requirements, ongoing support to our provider partners across the region, and visibly living our values.

Don't count us out! The paths ahead are likely to ride like some of Michigan's roadways. The MSHN team will seek to minimize negative impacts on the region. We seek your continued partnership, collaboration, and support as we take next steps in this unpredictable and likely chaotic process. We appreciate your ongoing support.

We believe communication is always important, especially under these circumstances, so as questions, concerns, or other issues arise, please connect directly with our office.

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

Managed Care Functions

As a follow up to the Chief Executive Officer's (CEO's) article above regarding the PIHP procurement where MDHHS released the proposed bidder qualifications and eligibility requirements, three high level requirements were included in the qualifications:

1. Operate exclusively as a payor entity, fully independent from provider,
2. Have a non-profit organizing structure, and
3. Have National Committee for Quality Assurance (NCQA) accreditation.

Additional details under number one above regarding the exclusively as a payor entity include the requirements that contractors are expected to provide managed care functions to enrollees. Managed care functions include, but are not limited to, eligibility and coverage verification, utilization management, network development, contracted network provider training, claims processing, activities to improve health care quality, and fraud prevention activities. Contractors may not directly provide or deliver health care services beyond these managed care functions. In addition, contractors may not delegate managed care functions to contracted provider entities.

Mid-State Health Network was formed and operated with a philosophy to delegate managed care functions to the Community Mental Health Service Programs (CMHSPs) where feasible and appropriate, while providing oversight at the PIHP to ensure compliance with state and federal requirements.

MSHN outlines the CMHSPs delegated functions in the PIHP/CMHSP contract delegation grid. The managed care functions include the below areas of which only some functions are retained at the PIHP level.

- **Information Systems and Requirements**: Brochures, handbooks, provider directories, Limited English Proficiency (LEP), annual cost of services, explanation of benefits
- **Customer Services:** Enrollee Rights, Customer Service telephone line, grievances, appeals, Fair Hearings, second opinions
- **Financial Management**: Risk Management Plan and Strategy, encounter and financial reporting, budget management, financial forecasting, payment and claims processing
- **Quality Management:** Quality Assurance and Performance Improvement Program
    - Performance Measures
    - Performance Improvement Projects (PIPs)
    - Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Event Management
    - Behavioral Treatment Review
    - Member Experience with Services (consumer surveys)
    - Practice Guidelines (e.g. Person Centered Plan [PCP], Self Determination)
    - Verification of Services
    - Long-Term Services and Supports (LTSS)
- **Compliance:** Corporate Compliance Plan and effectiveness reporting, compliance investigations, Office of Inspector General reporting, data mining, fraud, waste and abuse detection
- **Provider Network:** Regional Network Adequacy, Network Management, Network Development, Network Oversight, Organizational Credentialing, Individual Credentialing and Network Monitoring
- **Utilization Management:** Utilization Management Plan, Authorizations, Denials, Adverse Benefit Determinations, Adequate and Advance Notice, Retrospective and Prospective Utilization reviews,

Under/Over Utilization analysis
- **Information Technology:** Data management and reporting (Behavioral Health Treatment Episode Data Set [BH-TEDS], Level of Care Utilization System [LOCUS], Information Systems Assessments, Health Information Exchange, Data Analytics
- **Population Health:** Coordination with Health Plans, Health Management, Joint Care Planning, Data Validation, Social Determinates of Health, population health analysis
- **Waiver & Program Services:** Enrollment approvals (Habilitation Supports Waiver [HSW], Children's Waiver [CW], Serious Emotional Disturbance [SED], 1915i), Evidence-Based Program Enrollment approvals

The MDHHS bidder requirement to restrict any delegation to the CMHSPs will be another significant change not only for the prospective PIHP but for the CMHSPs as well. MSHN will work with our regional partners to strategize and plan for this large system change.

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

Information Technology

Steve Grulke
Chief Information Officer

Security Information and Event Management (SIEM) system is a critical technology for modern enterprise cybersecurity, providing real-time analysis of security alerts generated by applications and network hardware. SIEM solutions aggregate and correlate data from diverse sources such as firewalls, intrusion detection systems, antivirus software and servers to offer a centralized view of an organization's security posture. By collecting logs and events across the Information Technology environment, SIEM enables early detection of threats, rapid incident response, and compliance with regulatory requirements. Advanced SIEM platforms leverage machine learning and behavioral analytics to identify anomalies and potential breaches that traditional tools might miss. Investing in SIEM enhances risk management by improving visibility into cyber threats, reducing the time to detect and respond to incidents and supporting audit readiness. As cyberattacks grow in sophistication, SIEM is a foundational element in safeguarding organizational assets and maintaining business continuity.

The Mid-State Health Network Information Technology team implemented Huntress, a SIEM platform in March with the help of our managed services provider Providence Consulting. Huntress Managed SIEM provides a turnkey solution to meet Mid-State Health Network's Health Insurance Portability and Accountability Act (HIPAA) obligations by combining automated compliance monitoring and 24/7 expert oversight.

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

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN's Finance Team is beginning preliminary work on the Fiscal Year (FY) 26 budget to be presented during the September 2025 Board of Directors' Meeting. Medicaid revenues associated with Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS-1) will not be included in the FY 26 budget as Michigan Department of Health and Human Services (MDHHS) recently announced the program would move to direct payment system. In other words, CCBHC payments will be sent directly to the CCBHC sites and no longer flow through the Pre-Paid Inpatient Health Plan (PIHP). As a reminder, PPS-1 rates are comprised of capitation and supplemental funding for PIHP historically covered individuals (Severe Mental Illness and Substance Use Disorder). PPS-1 rates are developed from CCBHC cost reports and vary by site. The ratio of capitation and supplemental funding also varies.

In addition, the following items related to contracts are under review by MSHN's internal staff for FY 26:

- Substance Use Disorder (SUD) Provider Manual – The purpose of the manual is to offer information and technical assistance regarding the requirements associated with provider contract roles. It is a comprehensive guidebook touching on all areas of the organization.
- Medicaid Subcontracting Agreement – Guides the contractual relationship between MSHN and the Community Mental Health Service Programs (CMHSPs) in its region. CMHSPs are delegated management functions over their individual provider networks for Behavioral Health services and these agreements are not held at MSHN.
- SUD Contracts - Structures the contractual relationship between MSHN and SUD providers which are managed directly by the PIHP.

Lastly, Finance staff are currently engaged with Roslund Prestage & Company (RPC) for completion of MSHN's FY 2024 Compliance Examination. These guidelines require that an independent auditor examine compliance issues related to contracts between PIHPs and MDHHS to manage the Concurrent 1915(b)/(c) Medicaid, Healthy Michigan, and the Flint 1115 demonstration. Compliance Examination Guidelines, however, DO NOT replace or remove any other audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. An annual Financial Statement audit is required. Additionally, if a PIHP expends $750,000 or more in federal awards1, the PIHP must obtain a Single Audit. **MSHN has all three audits conducted annually.**

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

Behavioral Health

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

How Medicaid Supports Michigan's Citizens

Medicaid plays a critical role in supporting Michigan's citizens in a multitude of ways. Coverage is especially critical for individuals with low incomes, disabilities, and/or complex health needs. Nationally, Medicaid is the United States' largest provider of health insurance and, in Michigan, covers more than 2.6 million residents (Michigan Department of Health and Human Services, 2025). The state of Michigan's Pre-Paid Inpatient Health Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs) serve and support well over 290,000 Medicaid beneficiaries in ways that help adults and children with mental illness, individuals with intellectual and/or developmental disabilities, persons with a substance use disorder, and anyone experiencing a behavioral health crisis. Services and supports promote community integration, improve quality of life, safeguard individual rights, and are person-centered. Medicaid services save lives and offer dignity and hope to the vulnerable, enabling many to live as independently and fully as possible within their communities.

Through the primary support of Medicaid, the Community Mental Health (CMH) system serves as the front line of behavioral health care for some of the most vulnerable persons in Michigan. Examples of services include case management, psychiatric care, community living supports, peer services, vocational services, residential services, respite, applied behavior analysis (autism), and crisis intervention. The PIHP and CMH systems are committed to ensuring that all individuals have access to quality behavioral health care, especially those individuals that would fall through the cracks of the healthcare system. Without Medicaid to help Michigan's most vulnerable, the consequences of falling through the cracks would be dire, severe, and far-reaching.

Individuals with serious mental illness, intellectual and/or developmental disabilities, and substance use disorders would lose access to critical services. In well over 50 years of behavioral health policy evolution, refinement, and innovation, individuals would be left without the necessary services and supports they have relied upon to live safely and independently in their respective communities. Many individuals with untreated mental health or substance use disorders would be in danger of losing stable housing and could end up in trouble with the law, being jailed or imprisoned. It is also likely that loss of Medicaid coverage would increase the worsening symptoms of an individual's behavioral health disorder, increasing costly visits (and wait times) to emergency rooms, more frequent psychiatric hospitalizations, and higher healthcare costs overall. Stigma, or negative or improper beliefs about a person or their condition, would certainly rise as well, further contributing to the CMH beneficiary's sense of alienation and loneliness, two enemies of well-being and good mental health.

The effect of Medicaid beneficiaries losing their coverage goes well beyond the individual and the legal and healthcare systems, as if those effects were not broad and deep already. The strain on families and caregivers would be untenable, leading to caregiver burnout, financial hardship, loss of productivity, and family breakdown. This "local effect" will drag quality and contentment of life down, leading to greater crises in the community, from abuse to self-harm. The broader community, i.e., towns/cities, counties, states, nationally, would likely see increases in spending on emergency services, law enforcement, and institutional care. You will especially recall that emergency care and law enforcement are already overburdened and spread thin, and we have already found newer ways to involve these two important systems in improving outcomes for persons with severe mental illness, intellectual and/or developmental disabilities, and substance use disorders. Lastly, through the Home and Community-Based Services Rule, institutional care in Michigan has been all but eliminated. Any return to this mode of care would be unjust, illegal, and unethical.

The PIHP and CMHSP systems in Michigan have made significant strides in improvements and outcomes in behavioral and substance use disorder treatment. Improvements include better home-based services, job growth, improved evidence-based practice delivery, greater economic stability, and positive outcomes for Medicaid beneficiaries. These benefits should not be ignored. Even more critically, not heeding the consequences of cutting Medicaid coverage for beneficiaries should be deliberately avoided (Whitmer, 2025). Medicaid does more than directly support beneficiaries; through this support, healthcare systems, families, community organizations, communities, the state, and the nation are all supported. There is not one part of life that Medicaid support does not improve.

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

Population Health and Integrated Care

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

FY26 Certified Community Behavioral Health Clinic (CCBHC) Direct Payment Model

On 5/22/2025, Michigan Department of Health and Human Services (MDHHS) announced a decision to transition to a direct payment model for Certified Community Behavioral Health Clinics (CCBHC) beginning in FY26 for the remainder of the Michigan CCBHC demonstration which is scheduled to end on 9/30/2027. Under this new model, payments will be made directly from MDHHS to CCBHC sites, and all oversight responsibilities will shift to MDHHS. The announcement from MDHHS indicated one reason for the change to a direct payment model is to provide stability for CCBHC operations during the uncertainty of the Pre-paid Inpatient Health Plan (PIHP) procurement process, among other things. MSHN will work closely with its regional CCBHC partners and MDHHS to ensure a smooth transition of PIHP responsibilities for FY26.

FY24 Substance Use Disorder (SUD) Health Home Pay for Performance (P4P)

MSHN was recently notified that the SUD Health Home providers in our region earned the full possible P4P award for FY24 based on meeting or exceeding statewide benchmarks on three performance measures. MSHN would

like to recognize and highlight outstanding regional performance on one metric in particular:

Individuals served by regional SUD Health Home providers had a 95.45% rate of follow up within 7 days following a hospital emergency room visit for alcohol or drug related concerns compared to 24.02% rate of follow up for all Medicaid beneficiaries statewide.

Please join us in congratulating our regional SUD Health Home partners for the fantastic work they are doing to dramatically improve outcomes for individuals they serve. The total P4P award amount of $44,152.36 will be distributed proportionally among the regional SUD Health Home partners based on the number of individuals served by each location throughout FY24.

FY24 Behavioral Health Home Pay for Performance
MSHN also recently received a preliminary P4P award notification for FY24 Behavioral Health Home partners. MSHN Integrated Health and Quality staff members are currently working with MDHHS to validate the accuracy of the P4P performance metric data. Additional information will be shared with regional Behavioral Health Home partners pending final award notification.

Increased Care Coordination for Children/Youth in Foster Care
As board members are aware, one of the region's strategic priorities for FY24-FY26 is improving access to specialty behavioral health services for children and youth involved in the child welfare system. One of the ways MSHN is accomplishing this is through increased care coordination efforts with MDHHS and Medicaid Health Plans for children and youth in foster care. MSHN is piloting a new approach with two health plans in particular, Molina Healthcare and Meridian, by holding separate adult and child/youth care coordination meetings each month. The child/youth care coordination meetings include additional subject matter experts such as child/youth care managers and PIHP Autism and Children's Waiver staff. The primary focus of the child/youth care coordination meetings is to ensure that children and youth in foster care are receiving timely screening and assessment for behavioral needs and are connected to the most appropriate system of care to address their needs. Approximately 12 cases have been reviewed during the initial 3 months of piloting separate child/youth meetings, with additional cases being identified and added each month.

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

Substance Use Disorder Policy, Strategy and Equity

Dani Meier, PhD, LMSW, MA
Chief Clinical Officer

Looking at Costs of the Opioid Overdose Epidemic

Opioid Use Disorder (OUD) affects over 6 million Americans, contributing to an opioid overdose epidemic that ranks among the most deadly and persistent public health crises in U.S. history. Remarkably, this crisis rivals, and in some cases surpasses, the death toll of the COVID-19 pandemic, particularly among young adults aged 18 to 45, for whom overdose has become the leading cause of death (Centers for Disease Control and Prevention [CDC], 2023; National Institute on Drug Abuse [NIDA], 2023).

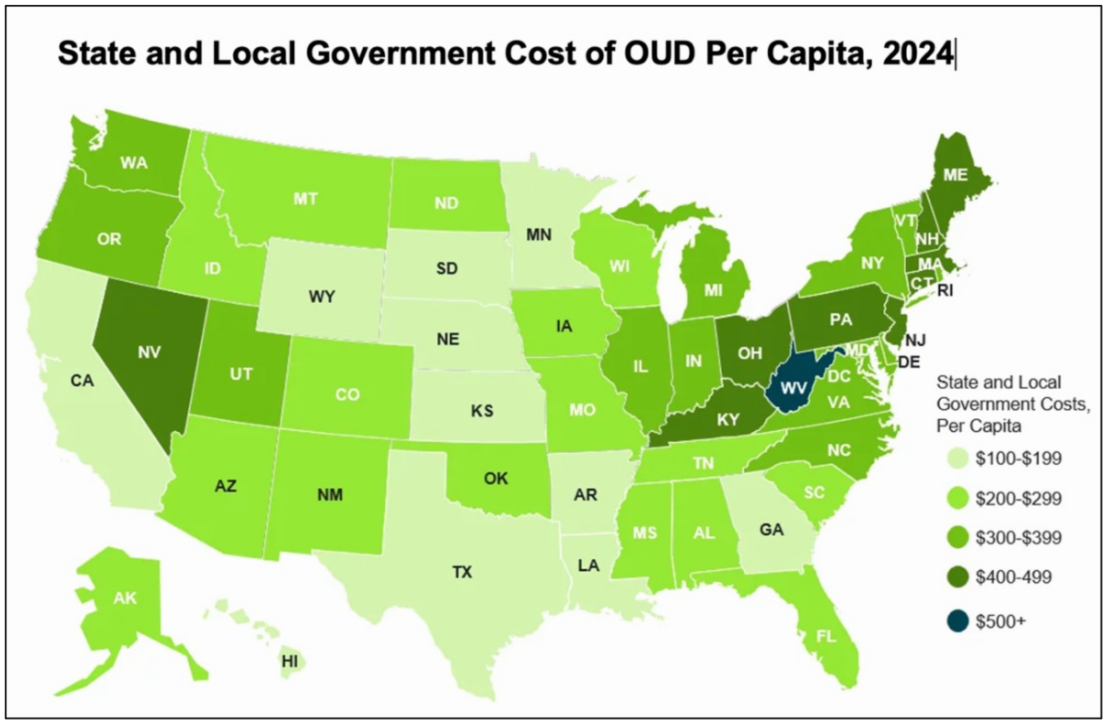
The economic ramifications of this crisis are often overlooked, extending far beyond the immediate health impacts to create significant local and national burdens. Previous attempts to quantify these costs have inadequately captured the full scope of societal and economic challenges associated with OUD, including treatment expenses, hospitalizations, and the involvement of law enforcement and the judicial system. To address this critical gap, Avalere Health conducted a comprehensive analysis of the costs linked to OUD, modeling potential savings derived from effective treatment strategies at both national and state levels.

Avalere Health's findings outline a staggering financial burden tied to OUD in the United States, estimated at approximately $4 trillion in 2023. Although this figure declined to just over $3 trillion in 2024 (due to a decrease in overdose deaths), the economic impact remains severe. On average, the cost per OUD patient amounts to about $695,000 when incorporating the expenses incurred by all stakeholders. Isolating costs specific to OUD cases—excluding the broader patient burden—reveals an expense of approximately $163,000 per case, distributed among both public and private entities. Patients themselves face a burden tied to lost quality of life and shortened lifespans, estimated at roughly $532,000 annually.

These costs associated with OUD vary significantly across states, however. States hit hardest by the crisis, such as West Virginia, Kentucky, Ohio, and New Hampshire, experience the highest local cost burdens, with *per capita* expenditures ranging from $137 to $524. In Michigan, for example, the average annual cost per case of OUD is projected to be $742,799 in 2024, slightly exceeding the national average. This figure accounts for direct medical costs, lost productivity, and strain on local resources. Additionally, private businesses have incurred losses exceeding $467 billion due to decreased productivity and increased healthcare expenses, while government entities—at the state, local, and federal levels—face cumulative burdens exceeding $94 billion (Avalere Health, 2024).

As federal funding to health care and medical research continues to face massive reductions, there is likely to be an increased reliance on the $1.6 billion garnered from opioid settlement funds. These funds present a significant opportunity to invest in prevention, treatment, and recovery services for OUD, which could greatly benefit affected individuals. Research indicates that for every dollar invested in recovery efforts, there may be a return of 10%, redirecting spending toward essential needs rather than addiction-related issues. This insight empowers stakeholders—from local governments to healthcare providers—to implement informed policies and allocate

resources effectively, ultimately maximizing the impact of recovery efforts on public health.



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

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

Substance Abuse and Mental Health Services Administration (SAMHSA) Releases National Guidance to Standardize and Strengthen Specialty Substance Use Disorder (SUD) Treatment Across the U.S.

In January 2025, the Substance Abuse and Mental Health Services Administration (SAMHSA) released the *National Guidance on Essential Specialty Substance Use Disorder (SUD) Care*, a landmark framework aimed at reshaping how the U.S. delivers specialty care for individuals with substance use disorders. The guidance establishes a national benchmark for the services that should be available in specialty SUD treatment settings and is intended to drive equitable access to high-quality, evidence-based care.

A Blueprint for Comprehensive and Equitable SUD Care

This guidance arrives at a critical time. In 2023 alone, over 48 million people aged 12 and older in the U.S. met the criteria for having a substance use disorder, yet only 6.7% received any form of specialty treatment. The new SAMHSA framework addresses this disparity by defining the minimum core services that should be consistently available across the treatment landscape, regardless of location or provider.
Designed for a wide range of stakeholders, including treatment providers, health agencies, payers, policymakers, and individuals seeking care, the guidance supports efforts to close treatment gaps, inform planning, and promote accountability in delivering care that aligns with current clinical best practices.

Core Components of Specialty SUD Treatment
The document outlines seven essential service categories that should be universally accessible at all specialty SUD treatment facilities:

1. **Pharmacotherapy:** Use of FDA-approved medications for treatment and recovery support, including methadone, buprenorphine, and naltrexone for opioid use disorder. Research shows that medication-assisted treatment (MAT) can reduce opioid-related mortality by up to 50%.
2. **Comprehensive Assessment and Pretreatment Services:** Intake Assessments that capture the full clinical picture, including co-occurring mental health conditions, to inform personalized treatment planning.
3. **Withdrawal Management:** Medically supervised detoxification services, essential for managing acute withdrawal and reducing risk of relapse or fatal overdose.
4. **Psychosocial Interventions:** Evidence-based therapies such as cognitive-behavior therapy (CBT), motivational interviewing, and contingency management that are proven to increase treatment retention and abstinence rates.
5. **Recovery Support Services:** Peer recovery coaches, employment assistance, and housing support that address the social determinants of health known to impact recovery success.
6. **Ancillary Services:** Linkages to medical, legal, and social services to ensure a holistic and integrated treatment experience.
7. **Drug Testing and Monitoring:** Routine and random screenings used to support clinical decision-making and

treatment adherence.

Promoting Consistency and Equity

A core goal of the framework is to address significant inconsistencies in the availability and quality of SUD services nationwide. For example, in some states, fewer than 20% of treatment facilities offer MAT despite its established effectiveness. The guidance seeks to eliminate such disparities by promoting a standardized set of services accessible to all, regardless of geography, race, or socioeconomic status.

A Call to Action

SAMHSA encourages all stakeholders to use this guidance to assess current service offerings, identify gaps, and implement targeted improvements. Adoption of these standards is expected to enhance care quality, increase treatment engagement, and ultimately improve outcomes for millions of Americans struggling with addiction.

Conclusion

The *National Guidance on Essential Specialty Substance Use Disorder (SUD) Care* is a transformative step toward achieving a unified and equitable addiction treatment system in the United States. By emphasizing evidence-based care, person-centered practices, and recovery-focused outcomes, SAMHSA offers a practical roadmap for bridging gaps and building a stronger, more compassionate behavioral health infrastructure.

To access the full document, visit: National Guidance on Essential Specialty Substance Use Disorder (SUD) Care

For source information or questions, please contact Trisha at Trisha.Thrush@midstatehealthnetwork.org

Quality, Compliance & Customer Service

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

Annual Review of the Quality Assessment and Performance Improvement Program

The Quality Assessment and Performance Improvement Program (QAPIP) consists of a plan/description and review of effectiveness of the Pre-paid Inpatient Health Plan (PIHP) activities in accordance with the Michigan Department of Health and Human Services (MDHHS) QAPIP Technical Requirement included in the Medicaid Contract. The purpose is to have a quality improvement program that is accountable to the Governing Body that monitors, evaluates and is focused on improving performance as it relates to care. This is completed through various measures for effectiveness, efficiency, and outcomes.

MDHHS began requiring the PIHPs to submit the QAPIP and annual evaluation for review beginning in Fiscal Year 2021. Per Title 42 of the Code of Federal Regulations (CFR) §438.330(e), a State must review, at least annually, the impact and effectiveness of the QAPIP of each PIHP.

The annual QAPIP submission for each PIHP includes the following:

- QAPIP evaluation of the previous year
- QAPIP description of the current year
- QAPIP work plan for the current year based on the evaluation of the previous year

The standards state that the QAPIP must be accountable to a Governing Body that is a PIHP Regional Entity. The responsibilities of the Governing Body include monitoring, evaluating, and making improvements to care through oversight and approval of the QAPIP annually; routinely receiving and reviewing written progress reports describing performance improvement projects undertaken, the actions taken, and the results of those actions; formal reviews on a periodic basis (but no less frequently than annually) of written reports on the operation of the QAPIP; and submission of a written annual report to MDHHS.

MDHHS utilizes a checklist to facilitate the annual review of each PIHP's QAPIP. The checklist contains the primary activities identified in the Quality Assessment and Performance Improvement Program.

Those primary activities include the following:

- Performance Measures
- Performance Improvement Projects (PIPs)
- Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Event Management
- Behavioral Treatment Review
- Member Experience with Services
- Practice Guidelines
- Credentialing and Re-Credentialing
- Verification of Services
- Utilization Management
- Provider Network
- Long-Term Services and Supports (LTSS)

The MSHN QAPIP plan includes a description of each activity and quality initiative, including a performance goal(s) and/or objective(s) for each area in the QAPIP work plan. The QAPIP evaluation/report includes an annual analysis of the progress of each quality initiative or activity in the QAPIP plan and workplan. The MDHHS reviews how each PIHP uses the annual evaluation/report results to support the creation of goals and objectives for the upcoming QAPIP plan.

In addition to the checklist, MDHHS requires the submission of the governing body form. This form requires identifying the governing body members, the dates the governing body approved the annual QAPIP plan, and dates of routine reports provided to the governing body regarding the QAPIP.

The Fiscal Year 2025 QAPIP review by MDHHS indicated that no follow up action was required and there were no recommendations.

MSHN will continue to utilize feedback provided by MDHHS to enhance our QAPIP and quality improvement efforts as well as feedback from Regional Councils/Committees, stakeholders, MSHN staff, consumers, external reviews, etc.

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

Our Mission:

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

Our Vision:

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

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