Mid-State Health Network

Board of Directors Meeting ~ November 1, 2022 ~ 5:00 p.m.

Board Meeting Agenda

THIS MEETING WILL BE HELD AT A PHYSICAL LOCATION WITH APPROPRIATE SOCIAL DISTANCING AND/OR MASKING REQUIREMENTS

MyMichigan Medical Center
Wilcox Room
300 E. Warwick Dr.
Alma, MI 48801

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

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

   Motion to Approve the Agenda of the November 1, 2022 Meeting of the MSHN Board of Directors
4. Public Comment (3 minutes per speaker)
5. **ACTION ITEM:** MSHN External Compliance Examination Report Presentation *(Page 7)*

   Motion to receive and file the Report on Compliance of Mid-State Health Network for the year ended September 30, 2021
6. **ACTION ITEM:** MSHN Compliance Plan Update for Approval *(Page 13)*

   Motion to approve the FY2023 MSHN Corporate Compliance Plan and acknowledge receipt of plan
7. Chief Executive Officer's Report *(Page 43)*
8. Deputy Director's Report *(Page 68)*
9. Chief Financial Officer's Report

   Financial Statements Review for Period Ended September 30, 2022 *(Page 84)*

   ACTION ITEM: Receive and File the Preliminary Statement of Net Position and Statement of Activities for the Period ended September 30, 2022, as presented.
10. **ACTION ITEM:** Contracts for Consideration/Approval *(Page 92)*

    The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2023 Contracts, as Presented on the FY 2023 Contract Listing

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/fy2023-meetings

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Upcoming FY23 Board Meetings

(Tentative until Board Approval)
Board Meetings convene at 5:00pm unless otherwise noted

November 1, 2022
MyMichigan Medical Center
300 E. Warwick Dr.
Alma, MI 48801

January 10. 2023
Comfort Inn & Suites Hotel & Conference Center
2424 South Mission Street
Mount Pleasant, MI 48858

March 7, 2023
Best Western/Okemos Conference Center
University Park Drive
Okemos, MI 48864

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

11. Executive Committee Report
12. Chairperson's Report
13. **ACTION ITEM:** Consent Agenda

Motion to Approve the documents on the Consent Agenda

13.1 Approval Board Meeting Minutes 09/13/22 *(Page 98)*
13.2 Approval Public Hearing Meeting Minutes 09/13/22 *(Page 103)*
13.3 Receive SUD Oversight Policy Board Minutes 08/17/22 *(Page 105)*
13.4 Receive Board Executive Committee Minutes 10/21/22 *(Page 110)*
13.5 Receive Policy Committee Minutes 10/04/22 *(Page 112)*
13.6 Receive Operations Council Key Decisions 09/19/22 *(Page 114)* and 10/17/22 *(Page 116)*
13.7 Approve the following policies:
13.7.1 Behavioral Health Recovery Oriented Systems of Care *(Page 118)*
13.7.2 Children's Home and Community Based Services Waiver *(Page 121)*
13.7.3 Community Dependent Living Placement *(Page 125)*
13.7.4 Cultural Competency *(Page 128)*
13.7.5 Emergency Services Poststabilization *(Page 130)*
13.7.6 Evidence-Based Practices *(Page 134)*
13.7.7 Habilitation Supports Waiver *(Page 137)*
13.7.8 Home and Community Based Services Compliance Monitoring *(Page 140)*
13.7.9 Indian Health Services/Tribally-Operated Facility/Urban Indian Clinic Services *(Page 142)*
13.7.10 Inpatient Psychiatric Hospitalization Standards *(Page 144)*
13.7.11 Out-of-State Placements *(Page 148)*
13.7.12 Person/Family Centered Plan of Service *(Page 152)*
13.7.13 Serious Emotional Disturbance Waiver *(Page 155)*
13.7.14 Service Philosophy & Treatment *(Page 158)*
13.7.15 Standardized Assessment *(Page 164)*
13.7.16 SUD Services Medication Assistance Treatment *(Page 166)*
13.7.17 SUD Services Out of Region Coverage *(Page 168)*
13.7.18 SUD Services Women's Specialty Services *(Page 170)*
13.7.19 Support Intensity Scale *(Page 173)*
13.7.20 Supports Intensity Scale Quality Lead *(Page 175)*
13.7.21 Telemedicine *(Page 177)*
13.7.22 Trauma Informed Systems of Care *(Page 179)*

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

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FY23 MSHN Board Roster

Last Name	First Name	Email 1	Email 2	Phone 1	Phone 2	Appointing CMHSP	Term Expiration
Bohner	Brad	bbohner@tds.net		517.294.0009		LifeWays	2025
Brehler	Joe	jbrehler@sprynet.com		517.882.7491	517.230.5911	CEI	2025
Cadwallender	Bruce	bcadwall@umich.edu		517.703.4223		Shia Health & Wellness	2024
Cierzniewski	Michael	mikeciezniewski@yahoo.com		989.493.6236		Saginaw County CMH	2023
DeLaat	Ken	kdelaat1@aol.com		231.414.4173		Newaygo County MH	2023
Griesing	David	davidgriesing@yahoo.com		989.823.2687		TBHS	2024
Grimshaw	Dan	midstatetitlesvcs@mstsinc.com		989.823.3391	989.823.2653	TBHS	2023
Hicks	Tina	tmhicks64@gmail.com		989.576.4169		GIHN	2024
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2024
Ladd	Jeanne	stixladd@hotmail.com		989.634.5691		Shia Health & Wellness	2024
McFarland	Pat	pjmcfarland52@gmail.com		989.225.2961		BABHA	2023
McPeek-McFadden	Deb	deb2mcmail@yahoo.com		616.343.9096	616.794.0752	The Right Door	2024
Mitchell	Ken	kmitchellcc@gmail.com		517.899.5334	989.224.5120	CEI	2025
Nyland	Gretchen	gretchen7080@gmail.com		616.761.3572		The Right Door	2025
O'Boyle	Irene	irene.oboyle@cmich.edu		989.763.2880		GIHN	2023
Peasley	Kurt	peasleyhardware@gmail.com		989.560.7402	989.268.5202	MCN	2024
Phillips	Joe	joe44phillips@hotmail.com		989.386.9866	989.329.1928	CMH for Central	2023
Raquepaw	Tracey	tl.raquepaw@icloud.com	raquepawt@michigan.gov	989.737.0971		Saginaw County CMH	2025
Ryder	Tom	tomryder51@yahoo.com		989.860.8095		BABHA	2025
Scanlon	Kerin	kscanlon@tm.net		502.594.2325		CMH for Central	2025
Swartzendruber	Richard	rswartzn@gmail.com		989.269.2928	989.315.1739	HBH	2023
Twing	Susan	set352@hotmail.com		231.335.9590		Newaygo County MH	2025
Wiltse	Beverly	bevwiltse@gmail.com		989.326.1052		HBH	2023
Woods	Ed	ejw1755@yahoo.com		517.392.8457		LifeWays	2024

Administration:

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

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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 Compliance Officer

Chief Clinical Officer

CFR: Code of Federal Regulations

CFAP: Conflict Free Access and Planning (Replacing CFCM)

CFCM: Conflict Free Case Management

CLS: Community Living Services

CMH or CMHSP: Community Mental Health Service Program

CMHA: Community Mental Health Authority

CMHAM: Community Mental Health Association of Michigan

CMS: Centers for Medicare and Medicaid Services (federal)

COC: Continuum of Care

COD: Co-occurring Disorder

CON: Certificate of Need (Commission) – State

CPA: Certified Public Accountant

CQS: – Comprehensive Quality Strategy

CRU: Crisis Residential Unit

CS: Customer Service

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

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

CW: Children's Waiver

DAB: Disabled and Blind

DEA: Drug Enforcement Agency

DMC: Delegated Managed Care (site visits/reviews)

DRM: Disability Rights Michigan

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

EBP: Evidence-Based Practices

EEO: Equal Employment Opportunity

EMDR: Eye Movement & Desensitization Reprocessing therapy

EPSDT: Early and Periodic Screening, Diagnosis and Treatment

EQI: Encounter Quality Initiative

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

FC: Finance Council

FI: Fiscal Intermediary

FOIA: Freedom of Information Act

FSR: Financial Status Report

FTE: Full-time Equivalent

FQHC: Federally Qualified Health Centers

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

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

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

HB: House Bill

HCBS: Home and Community Based Services

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)

I/DD: Intellectual/Developmental Disabilities

IDDT: Integrated Dual Diagnosis Treatment

IOP: Intensive Outpatient Treatment

ISF: Internal Service Fund

IT/IS: Information Technology/Information Systems

KPI: Key Performance Indicator

LBSW: Licensed Baccalaureate Social Worker

LEP: Limited English Proficiency

LLMSW: Limited Licensed Masters Social Worker

LMSW: Licensed Masters Social Worker

LLPC: Limited Licensed Professional Counselor

LPC: Licensed Professional Counselor

LOCUS: Level of Care Utilization System

LTSS: Long Term Supports and Services

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

MAT: Medication Assisted Treatment (see MOUD)

MCBAP: Michigan Certification Board for Addiction Professionals

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

MCO: Managed Care Organization

MDHHS: Michigan Department of Health and Human Services

MDOC: Michigan Department of Corrections

MEV: Medicaid Event Verification

MHP: Medicaid Health Plan

MI: Mental Illness

Motivational Interviewing

MiHIA: Michigan Health Improvement Alliance

MiHIN: Michigan Health Information Network

MLR: Medical Loss Ratio

MMBPIS: Michigan Mission Based Performance Indicator System

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

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

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

MPHI: Michigan Public Health Institute

MRS: Michigan Rehabilitation Services

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

NAMI: National Association of Mental Illness

NASMHPD: National Association of State Mental Health Program Directors

NCQA: National Committee for Quality Assurance

NCMW: National Council for Mental Wellbeing

NMRE: Northern Michigan Regional Entity (PIHP Region 2)

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)

PA: Public Act

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

PAC: Political Action Committee

PASARR: Pre-Admission Screening and Resident Review

PCP: Person-Centered Planning

Primary Care Physician

PEP: Performance Enhancement Plan

PFS: Partnership for Success

PEO: Professional Employer Organization

PEPM: Per Eligible Per Month (Medicaid funding formula)

PI: Performance Indicator

PIP: Performance Improvement Project

PIHP: Prepaid Inpatient Health Plan

PMV: Performance Measure Validation

PN: Prevention Network

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

PS: Protective Services

PTSD: Post-Traumatic Stress Disorder

QAPIP: Quality Assessment and Performance Improvement Program

QAPI: - Quality Assessment Performance Improvement

QHP: Qualified Health Plan

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

QRT: Quick Response Team

RCAC: Regional Consumer Advisory Council

REMI: MSHN's Regional Electronic Medical Information software

RES: Residential Treatment Services

RFI: Request for Information

RFP: Request for Proposal

RFQ: Request for Quote

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

SIS: Supports Intensity Scale

SMI: Serious Mental Illness

SPMI: Severe & Persistent Mental Illness

SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income (Social Security)

SSN: Social Security Number

SUD: Substance Use Disorder

SUD OPB: Substance Use Disorder Regional Oversight Policy Board

SUGE: Bureau of Substance Use, Gambling and Epidemiology

TANF: Temporary Assistance to Needy Families

UR/UM: Utilization Review or Utilization Management

VA: Veterans Administration

WM: Withdrawal Management (formerly "detox")

WSA: Waiver Support Application

YTD: Year to Date

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

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Background

The Compliance Examination was conducted by Roslund Prestage and Company (RPC) firm for the fiscal year ending September 30, 2021. The intent of the review is for auditors to express an opinion on the PIHP's compliance with the Medicaid Contract. In addition to the tests performed at the PIHP level, the process also includes incorporation of each CMHSP's Compliance Examination results. RPC's auditor presented the report results and allowed questions from board members. MSHN did receive minor findings and implemented corrective action to address issues.

Recommended Motion:

Motion to receive and file the "Report on Compliance" of Mid-State Health Network for the year ended September 30, 2021.

Report on Compliance

Mid-State Health Network

September 30, 2021

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

525 WEST WARWICK DRIVE, SUITE A, ALMA, MICHIGAN 48801

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT ACCOUNTANT'S REPORT ON COMPLIANCE

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

Report On Compliance

We have examined Mid-State Health Network's (the PIHP) compliance with the compliance requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to its Medicaid Contract, General Fund (GF) Contract, Community Mental Health Services (CMHS) Block Grant, and Substance Abuse Prevention and Treatment (SAPT) Block Grant programs for the year ended September 30, 2021.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its Medicaid Contract, GF Contract, CMHS Block Grant, and SAPT Block Grant programs.

Independent Accountants' Responsibility

Our responsibility is to express an opinion on the PIHP's compliance with the Medicaid Contract, GF Contract, CMHS Block Grant, and SAPT Block Grant programs based on our examination of the compliance requirements referred to above.

Our examination of compliance was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the PIHP complied, in all material respects, with the compliance requirements referred to above.

An examination involves performing procedures to obtain evidence about the PIHP's compliance with the specified compliance requirements referred to above. The nature, timing, and extent of the procedures selected depend on our judgement, including an assessment of the risk of material noncompliance, whether due to fraud or error. The nature, timing and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the compliance requirements described in the *Compliance Examination Guidelines* issued by the Michigan Department of Health and Human Services.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to the engagement.

We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion. However, our examination does not provide a legal determination of the PIHP's compliance.

Opinion on Each Program

In our opinion, the PIHP complied, in all material respects, with the specified compliance requirements referred to above that are applicable to its Medicaid Contract, GF Contract, CMHS Block Grant, and SAPT Block Grant programs for the year ended September 30, 2021.

Other Matters

The results of our examination procedures disclosed instances of noncompliance, which are required to be reported in accordance with Compliance Examination Guidelines, and which are described in the accompanying Comments and Recommendations as item 2021-01. Our opinion is not modified with respect to these matters.

Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract, General Fund Contract, and/or Community Mental Health Services Block Grant Program(s):

None

Material noncompliance with the provisions of laws, regulations, or contracts related to the Medicaid Contract, General Fund Contract, and/or Community Mental Health Services Block Grant Program(s):

None

Known fraud affecting the Medicaid Contract, General Fund Contract, and/or Community Mental Health Services Block Grant Program(s):

None

During our compliance audit, we may have become aware of matters that are opportunities for strengthening internal controls, improving compliance and increasing operating efficiency. These comments and recommendations are expected to have an impact greater than $10,000, but not individually or cumulatively be material weaknesses in internal control over the Medicaid Contract, General Fund Contract, and/or Community Mental Health Services Block Grants program(s). Furthermore, we consider these matters to be immaterial deficiencies, not findings. The following comments and recommendations are in regard to those matters.

2021-01 FSR Examination Adjustments

Criteria or specific requirements:
The Contractor must provide the financial reports to the State as listed in the Medicaid Contract. Forms, instructions and other reporting resources are posted to the MDHHS website. (Contract Schedule E)

Condition:
The PIHP is not in compliance with FSR instructions.

Examination adjustments:
Examination adjustments were made to sections of the FSR. See detailed descriptions of these examination adjustments in the Explanation of Examination Adjustments section of this report.

Context and perspective:
The examination adjustments that were made to the PIHP's FSR were the result of adjustments made to participant CMHSPs' examined FSRs and prior year examination adjustments.

Effect:
See detailed descriptions of these examination adjustments in the Explanation of Examination Adjustments section of this report.

Recommendations:
The PIHP should ensure that participant CMHSPs have appropriate controls in place regarding the preparation and review of the Financial Status Report to assure that all amounts are reported in compliance with the reporting instructions.

Views of responsible officials:
Management is in agreement with our recommendation.

Planned corrective action:
Mid-State Health Network will continue to verify reported information with each individual CMHSP prior to submission of the final Financial Status Report.

Responsible party:
Amy Keinath, Finance Manager

Anticipated completion date:
February 28, 2023

Examined Medicaid Contract Settlement Worksheet

An examination adjustment was made to Total Lapse and Total Earned Savings as a result of other examination adjustments.

Row 4.1 (Total Lapse) was decreased from $19,854,623 to $18,716,288; a difference of $(1,138,335)
Row 4.1 (Total Earned Savings) was increased from $33,859,406 to $35,277,939; a difference of $1,418,533
Row 4.2 (Total Earned Savings) was decreased from $16,703,607 to $15,285,074; a difference of $(1,418,533)

An examination adjustment was made to Section 5 in order to agree these amounts to the ending balance from the FY20 Examined FSR.

Row 5a (FY20) was increased from $29,102,684 to $29,301,709; a difference of $199,025
Row 5b (FY20) was increased from $29,102,684 to $29,301,709; a difference of $199,025
Row 5c (FY20) was decreased from $4,004,533 to $2,586,000; a difference of $(1,418,533)
Row 5d (FY20) was decreased from $4,004,533 to $2,586,000; a difference of $(1,418,533)

Examined Financial Status Report – Medicaid

The following examination adjustments were made to agree MSHN's examined FSR to the CMHSPs' examined FSRs.

Row A115 (Newaygo) was decreased from $13,477,243 to $13,396,070; a difference of $(81,173)
Row A202 (Newaygo) was decreased from $13,477,243 to $13,396,070; a difference of $(81,173)

Mid-State Health Network

Background

To comply with the PIHP/MDHHS Services Contract, specifically as it relates to the General Requirement Section: Program Integrity, which includes the following:

"The Contractor must have a program integrity compliance program as defined in 42 CFR 438.608. The program integrity compliance program must include the following:

i. Written policies and procedures that describe how the Contractor will comply with federal and State fraud, waste and abuse standards, and well publicized disciplinary standards for failure to comply.
ii. The designation of a compliance officer who reports directly to the Chief Executive Officer and the Board of Directors, and a compliance committee, accountable to the senior management or Board of Directors, with effective lines of communication to the Contractor's employees.
iii. Effective training and education for the compliance officer, senior management, and the Contractor's employees regarding fraud, waste and abuse, and the federal and State standards and requirements under this Contract. While the compliance officer may provide training to Contractor employees, "effective" training for the compliance officer means it cannot be conducted by the compliance officer himself/herself.
iv. Provisions for internal monitoring and auditing. Audits must include post payment reviews of paid claims to verify that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities, etc.). Acceptable audit methodology examples include:
    1. Record review, including statistically valid random sampling and extrapolation to identify and recover overpayments made to providers
    2. Beneficiary interviews to confirm services rendered
    3. Provider self-audit protocols
    4. The frequency and quantity of audits performed should be dependent on the number of fraud, waste and abuse complaints received as well as high risk activities identified through data mining and analysis of paid claims
v. Provisions for the Contractor's prompt response to detected offenses and for the development of corrective action plans. "Prompt response" is defined as action taken within 15 business days of receipt by the Contractor of the information regarding a potential compliance problem."

The attached 2023 Corporate Compliance Plan was revised through a review by the MSHN Compliance Committee, Regional Compliance Committee and the Operations Council with recommendation for approval to the MSHN Board of Directors. The attached Summary of Recommended Changes to the 2023 Corporate Compliance Plan provides an overview of the recommended revisions to the plan. In addition, the Corporate Compliance Plan as proposed is in compliance with and supports the MSHN Policy: General Management - Compliance and Program Integrity.

Recommended Motion:

The MSHN Board approves the 2023 Corporate Compliance Plan and acknowledges receipt of said plan.

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Summary of Recommended Changes to the 2023 Corporate Compliance Plan

The following is a summary of the recommended changes, per section, to the 2023 Compliance Plan.

KEY: No Revisions = no changes recommended; No Substantive Revisions = only minor additions/deletions not affecting intent

I. OVERVIEW/MISSION STATEMENT

- No Substantive Revisions

II. VALUE STATEMENT

- No Revisions

III. SCOPE OF PLAN

- Revisions include the following
    - Added sanctions and termination as possible action taken to Provider Network for failure to comply with the Compliance Plan

IV. DEFINITIONS

- No Substantive Revisions

V. COMPLIANCE PROGRAM

A. Compliance Policies

- No Revisions

B. Compliance Plan

- No Substantive Revisions

VI. STRUCTURE OF THE COMPLIANCE PROGRAM

A. General Structure

- No Substantive Revisions

B. MSHN Compliance Officer

- No Revisions

C. Regional Compliance Committee

- No Revisions

D. MSHN Corporate Compliance Committee

- No Revisions

VII. COMPLIANCE STANDARDS

A. Standards of Conduct and Ethical Guidelines

- No Revisions

B. Legal and Regulatory Standards

- No Revisions

C. Environmental Standards

- No Revisions

D. Workplace Standards of Conduct

- No Revisions

E. Contractual Relationships

- No Revisions

F. Purchasing and Supplies

- No Revisions

G. Marketing

- No Revisions

H. Financial Systems Reliability and Integrity

- Revisions include the following:
    - Removed references to fraud, abuse and waste and replaced with assuring appropriate documentation is available as needed to support claims payments and cost reimbursements

I. Information Systems Reliability and Integrity

- No Substantive Revisions

J. Confidentiality and Privacy

- No Substantive Revisions

VIII. AREAS OF FOCUS

- No Revisions

IX. TRAINING

A. MSHN Employees and Board Members

- No Substantive Revisions

B. MSHN Provider Network

- No Substantive Revisions

X. COMMUNICATION

- No Revisions

XI. MONITORING AND AUDITING

- No Substantive Revisions

XII. REPORTING AND INVESTIGATIONS

A. Reporting of Suspected Violations and/or Misconduct

- No Substantive Revisions

B. Process for Investigation

- No Revisions

XIII. Corrective Actions and Prevention

- No Revisions

XIV. Submission of Program Integrity Activities

- Revisions include the following:
    - Updated the name of the new quarterly report
    - Removed references to the identification and investigation of fraud, waste and abuse as well as corrective action plans implemented to match the new contract language

XV. References, Legal Authority and Supporting Documents

- Revisions include the following:
    - Updated links to reference materials

ATTACHMENT A

- No Revisions

ATTACHMENT B

- No Revisions

ATTACHMENT C

- Revisions include the following:
  - Added OHH, BHH, CCBHC and 1915i to the area of focus table

ATTACHMENT D

- Revisions include the following:
  - Changes to CMHCM and TBHS Compliance Officers information

ATTACHMENT E

- Revisions include the following:
  - Recommend removing the fraud referral form and replacing with a link

CORPORATE COMPLIANCE PLAN
20233~~2~~

Mid-State Health Network, Corporate Compliance Committee: ~~August 11, 2021~~ August 10, 2022
Mid-State Health Network, Regional Compliance Committee: ~~August 20, 2021~~ August 19, 2022
Mid-State Health Network, Operations Council Approved: ~~September 20, 2021~~ September 19, 2022
Mid-State Health Network PIHP Board Adopted: ~~November 02, 2021~~

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I. OVERVIEW/MISSION STATEMENT

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid-State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of ~~Community~~ Health and Human Services as Region 5, that includes services for behavioral health and substance use disorders. ~~.~~ The CMHSP Participants include Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, The Right Door for Hope, Recovery and Wellness (formerly Ionia County CMH), Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness and Tuscola Behavioral Health Systems. In addition, MSHN ~~As of October 1, 2015,~~ MSHN ~~took over the direct administration of all~~also manages ~~public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers.~~ a network of substance use treatment, recovery and prevention providers.

The mission of Mid-State Health Network is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members.

II. VALUE STATEMENT

MSHN and its provider network are committed to consumers, employees, contractual providers, and the community to ensure business is conducted with integrity, in compliance with the requirements of applicable laws, regulations, contractual obligations, and sound business practices, and with the highest standards of excellence. MSHN has adopted a compliance model that provides for prevention, detection, investigation, and remediation.

III. SCOPE OF PLAN

The MSHN Compliance Plan encompasses the activities (operational and administrative) of all MSHN board members, employees, and contractual providers. It is the expectation the Provider Network will follow the standards identified in the MSHN Compliance Plan or develop their own Compliance Plan that minimally meets the standards identified in the MSHN Compliance Plan and in accordance with the Code of Federal Regulations, Title 42, Part 438.608: Program Integrity Requirements.

All MSHN board members, employees and contractual providers are required to comply with all applicable laws, rules and regulations including those not specifically addressed in this Compliance Plan.

Failure by MSHN staff to adhere to the requirements in the Compliance Plan could result in disciplinary action, up to and including termination of employment. ~~depending on the seriousness of the offense.~~

Failure by the Provider Network to adhere to the standards within MSHN's Compliance Plan could result in remediation and ~~or further~~ contract ~~action~~ sanctions, up to termination. ~~depending on the seriousness of the offense.~~

Failure by Board Members to adhere to the requirements in the Compliance Plan will be addressed ~~following~~ in accordance with ~~the standards within~~ the MSHN By-Laws.

IV. DEFINITIONS

These terms have the following meaning throughout this Compliance Plan.

1. Abuse: Practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the payor, or in reimbursement for services that are not medically necessary or failure to meet professionally recognized standards for healthcare.

2. Behavioral Health: Refers to individuals with a Mental Health, Intellectual Developmental Disability and/or Substance Use Disorder or children with Serious Emotional Disturbances.

3. CMHSP Participant: Refers to one of the Community Mental Health Services Program (CMHSP) participants in the Mid-State Health Network region.

4. Fraud: An intentional deception or misrepresentation by a person ~~with the knowledge the deception~~ could result in unauthorized benefit to him/herself or some other person. Includes any act that constitutes fraud under applicable Federal or State laws.

5. Subcontractors: Refers to an individual or organization that is directly under contract with a CMHSP or Substance Use Provider to provide services and/or supports.

6. Contractual Provider: Refers to an individual or organization under contract with the MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP participants who hold retained functions contracts.

7. Employee: Refers to an individual who is employed by the MSHN PIHP.

8. Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors.

9. Staff: Refers to an individual directly employed and/or contracted with a Community Mental Health Service Provider and/or Behavioral Health Provider.

10. Waste: Overutilization of services, or other practices that result in unnecessary costs. ~~Generally~~Generally, ~~not~~ considered not caused by criminally negligent actions, but rather the misuse of resources

V. COMPLIANCE PROGRAM

A. Compliance Policies

While the Compliance Plan provides the framework of the Compliance Program, the Compliance Policies provide more specific guidance. Refer to **Attachment A** for a list of the Policy and Procedure categories that are part of the Compliance Program.

B. Compliance Plan

The Compliance Plan is prepared as a good-faith effort to summarize MSHN's rules, policies and procedures. To the extent that the Plan conflicts with, or misstates any applicable law or regulation,

the law takes precedence.

The purpose of the Compliance Plan is to provide the framework for MSHN to comply with applicable laws, regulations and program requirements. The overall key principles of the Compliance Plan are to:

- Minimize organizational risk and improve compliance with billing requirements of ~~Medicare~~, Medicaid, and all other applicable federal health programs.
- Maintain adequate internal controls (paying special attention to identified areas of risk).
- Reduce the possibility of misconduct and violations through prevention and early detection.
- Being proactive in Compliance to reduce exposure to civil and criminal sanctions.
- Encourage the highest level of ethical and legal behavior from all employees, contractual providers, and board members.
- Educate employees, contractual providers, board members and stakeholders of their responsibilities and obligations to comply with applicable local, state, and federal laws and regulations. ~~including credentialing requirements, as well as accreditation standards.~~
- Promote a clear commitment to compliance by taking actions and showing good faith efforts to uphold such laws, regulations, and standards.

The following elements have been identified by the Medicaid Alliance for Program Safeguards and the Office of Inspector General as being essential to an effective compliance program for Managed Care Organizations and Prepaid (Inpatient) Health Plans (PIHP):

- *Standards and procedures* – the organization must have written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards, laws and regulations.
- *High level oversight and delegation of authority* – the PIHP must designate a Compliance Officer and a Compliance Committee.
- *Training* – the PIHP must provide for effective training and education for the Board of Directors, Compliance Officer, and the organization's employees. The PIHP must assure adequate training is provided through the provider network. Training should be provided at hire and annually thereafter.
- *Communication* - Effective lines of communication must be established between the Compliance Officer and the organization's employees.
- *Monitoring and auditing* – The organization must take reasonable steps to achieve compliance with defined standards by utilizing reasonably designed monitoring and auditing systems and practices.
- *Enforcement and disciplinary mechanisms* – Standards must be enforced through well-publicized disciplinary guidelines.
- *Corrective actions and prevention* – After an offense *(non-compliance)* has been detected, the organization must take reasonable steps to respond appropriately and promptly to the offense and to develop corrective action initiatives and performance improvement. This includes follow-up monitoring and review to ensure the performance improvement plan is effective.

VI. STRUCTURE OF THE COMPLIANCE PROGRAM

A. General Structure

- *MSHN Board of Directors*: MSHN's Board of Directors is responsible for the review and

approval of the Compliance Plan and Policies, review of the Annual Compliance Report, and review of matters related to the Compliance Program. The MSHN Board of Directors has the highest level of responsibility for the oversight of the Compliance Program.
    - The Executive Committee of the Board shall review reports annually from the MSHN Compliance Officer (CO)

- *MSHN Corporate Compliance Committee*: The Corporate Compliance Committee provides guidance, supervision, and coordination for compliance efforts at MSHN. MSHN's Corporate Compliance Committee (CCC) is comprised of the MSHN Chief Executive Officer, Deputy Director, Chief Information Officer, Chief Finance Officer, and the Chief Compliance and Quality Officer. The Medical Director and Compliance Counsel will be ad-hoc members of the CCC. In addition, Ex-officio members may be asked to attend as non-voting members to provide consultation on specific areas of expertise.

- *Compliance Officer:* The MSHN Compliance Officer has primary responsibility for ensuring that MSHN maintains a successful Compliance Program. In particular, the Compliance Officer oversees the implementation and effectiveness of the Compliance Plan and Compliance Policies, serves as the Chair of the Regional Compliance Committee and ~~MSHN~~ MSHN Corporate Compliance Committee, provides consultative support to the provider network and has responsibility for the day-to-day operations of the compliance program.

- *Regional Compliance Committee*: The Compliance Committee advises on matters involving compliance with contractual requirements and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608. The committee is comprised of the MSHN Chief Compliance and Quality Officer and the compliance officers of each CMHSP Participant.

- *Operations Council*: The Operations Council reviews reports concerning compliance matters as identified by the Regional Compliance Committee and reported by the MSHN Chief Executive Officer. The Operations Council shall be comprised of the Chief Executive Officers or Executive Directors of each CMHSP Participant and the MSHN Chief Executive Officer .~~who serves as Chair.~~

- See **Attachment B** – MSHN Compliance Process/Governance

B. MSHN Compliance Officer

MSHN designates the Chief Compliance and Quality Officer as the PIHP Compliance Officer, who will be given sufficient authority and control to oversee and monitor the Compliance Program related Policies and Procedures, including but not limited to the following:

- Oversight of internal (PIHP Audits) and external provider network audits (MDHHS Audit and EQR Audit) and monitoring activities outlined in the compliance plan.
- Directs and is accountable for the implementation and enforcement of the Compliance Plan.
- Serves as chair of the MSHN's Corporate Compliance Committee and Regional Compliance Committee
- Provides leadership to MSHN compliance activity and consultative support to CMHSP Participants/SUD Providers.
- Responsible for oversight of MSHN efforts to maintain compliance with federal and state

regulations and contractual obligations.

- Serves as the Privacy Officer for MSHN.
- Ensures that effective systems are in place by which actual or suspected compliance violations are reported in a timely manner to appropriate governing bodies.
- Reviews all reports of actual or suspected compliance violations received by MSHN from any source and ensures that effective investigation and/or other action is taken.
- Completes investigations referred by, and under the direction of, the Office of Inspector General
- Monitors changes in federal and state health care laws and regulations applicable to MSHN operations and disseminate to the region.
- Works collaboratively with other MSHN employees and CMHSP Participants/SUD Providers to ensure that auditing and monitoring protocols are designed to detect and deter potential compliance violations.
- Coordinates compliance training and education efforts for MSHN staff and Board Members
- Ensures that performance improvement plans are adequate to ensure compliance and assures effective implementation of corrective action occurs to reduce risk of future occurrences.
- Prepares and submits the quarterly Office of Inspector General program integrity report
- Prepares and delivers an annual compliance report to the MSHN Board covering the fiscal year, including:
  - A summary of trends in the frequency, nature and severity of substantiated compliance violations;
  - A review of any changes to the Compliance Plan or program; and
  - An objective assessment of the effectiveness of the Compliance Plan and Program.

The authority given to the MSHN Compliance Officer will include the ability to review all documents and other information relevant to compliance activities, including, but not limited to, consumer records, billing records, employee records, and contracts and obligations of MSHN.

Each MSHN CMHSP Participant/SUD Provider shall designate a Compliance Officer who has the authority to perform the duties listed for the MSHN Compliance Officer at their respective organization, as appropriate.

C. Regional Compliance Committee

The MSHN Regional Compliance Committee will consist of the MSHN Chief Compliance and Quality Officer, and the CMHSP Participants' Compliance Officers appointed by MSHN CMHSP Participant's. The Committee will meet at regular intervals and shall be responsible for the following:

- Advising the MSHN Compliance Officer and assisting with the development, implementation, operation, and distribution of the Compliance Plan and supporting MSHN policies and procedures.
- Reviewing and recommending changes/revisions to the Compliance Plan and related policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the Compliance Plan.
- Determining the appropriate strategy/approach to promote compliance with the Compliance Plan and detect potential violations and areas of risk as well as areas of focus.
- Recommending and monitoring the development of internal systems and controls to carry out the Compliance Plan and supporting policies as part of daily operations.

- Reviewing compliance related audit results and corrective action plans, making recommendations when appropriate.

D. MSHN Corporate Compliance Committee

The MSHN Corporate Compliance Committee meets quarterly and its responsibilities include:

- Reviewing the Compliance Plan and related policies to ensure they adequately address legal requirements and address identified risk areas
- Assisting the CO with developing policies and procedures to promote compliance with the Compliance Plan
- Analyze the effectiveness of the compliance program and make recommendations accordingly
- Assisting the CO in identifying potential risk areas and violations
- Advising and assisting the CO with compliance initiatives
- Receiving, interpreting, and acting upon reports and recommendations from the CO
- Providing a forum for the discussion of compliance related issues

VII. COMPLIANCE STANDARDS

MSHN will ensure the development of written policies and procedures, standards, and documentation of practices that govern the PIHP's efforts to identify risk and areas of vulnerabilities and are in compliance with federal regulations and state contract requirements.

A. Standards of Conduct and Ethical Guidelines

MSHN and its Provider Network are committed to conducting the delivery of services and business operations in an honest and lawful manner and consistent with its Vision, Mission, and Values. As such, MSHN minimally establishes the following Standards of Conduct to clearly delineate the philosophy and values concerning compliance with the laws, regulations, contractual obligations, government guidelines and ethical standards applicable to the delivery of behavioral health care.

- Provide through its Provider Network, high quality services consistent with MSHN Vision, Mission, and Values;
- Dedicated to ensuring that equality in voice and governance exists, and that the benefit to the citizens meets Medicaid standards while being provided in ways that reflect the needs and resources of the communities in which each CMHSP Participants/SUD Providers operate;
- Shared operating structure, using a committee-based system that creates many venues, allowing voices from across the region to be heard;
- MSHN operations are for service to the CMHSP Participants/SUD Providers in achieving high levels of regulatory compliance, quality of service, and fiscal integrity;
- MSHN exists to serve in the best interest of and to the benefit of all CMHSP Participants/SUD Providers and their consumers;
- Foster each CMHSP Participants/SUD Providers integration activities and locally driven work.
- Conduct business in an honest, legal and competent manner to prevent fraud, abuse and waste;
- Perform all duties in good faith and refrain from knowingly participating in illegal activities;

- Report any actual or suspected violation of the Compliance Plan, Standards of Conduct, MSHN policies or procedures, contract requirements, state and federal regulations or other conduct that is known or suspected to be illegal;
- Provide accurate information to federal, state, and local authorities and regulatory agencies when applicable;
- Promote confidentiality and safeguard all confidential information according to policy;
- Practice ethical behavior regarding relationships with consumers, payers, and other health care providers;
- Protect through its Provider Network, the integrity of clinical decision-making, basing care on identified medical necessity;
- Seek to continually maintain and improve work-related knowledge, skills, and competence; and
- Actively support a safe work environment, free from harassment of any kind.

These Standards of Conduct provide guidance for MSHN Board members and employees, as well as the provider network in performing daily activities within appropriate ethical and legal standards and establish a workplace culture that promotes prevention, detection, and resolution of instances of conduct that do not conform with applicable laws and regulations. While the above standards are expected to be a framework for compliance, the issues addressed are not exhaustive. Therefore, MSHN Board Members, employees and its provider network staff are responsible for conducting themselves ethically in all aspects of business avoiding even the appearance of impropriety and in accordance with established policies and procedures.

B. Legal and Regulatory Standards

It is the policy of MSHN to ensure compliance with all state and federal regulatory agency standards and applicable laws and regulations including, but not limited to, the following:

State/Federal Laws and Rules

- Michigan Mental Health Code, Public Health Code and Administrative Rules
- Requirements as identified in the MDHHS contract
- Requirements as identified by the Office of Inspector General
- Technical Assistance Advisories, as required
- Medicaid State Plan
- Waiver Applications
- Medical Services Administration (MSA) Policy Bulletins
- Michigan Whistleblowers Act, Act 469 of 1980
- Home and Community Based Final Rules

Federal Medicaid Law, Regulations and Related Items

- Social Security Act of 1964 (Medicare and Medicaid)
- Balanced Budget Act of 1997
- Deficit Reduction Act/Medicaid Integrity Program of 2005
- Anti-kickback Statute
- Code of Federal Regulations
- 42 CFR Part 2 Confidentiality of Alcohol and Drug Use Patient Records
- State Operations Manual
- Letters to State Medicaid Directors
- Technical Assistance Tools
- Quality Improvement Systems for Managed Care (QISMC)
- Guide to Encounter Data Systems
- Office of Management and Budget (OMB) Circulars
- Government Accounting Standards Board (GASB)

- Affordable Care Act

Other Relevant Legislation
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- False Claim Act (Federal and Michigan)
- Provisions from Public Act 368 of 1978 – revised – Article 6 Substance Abuse
- Office of Inspector General Annual Work Plan
- Stark Law
- HITECH Act
- American with Disabilities Act of 1990

C. Environmental Standards

MSHN shall maintain a hazard-free environment in compliance with all environmental laws and regulations. MSHN shall operate with the necessary security systems, permits, approvals and controls. Maintenance of a safe environment is the responsibility of all employees and contractual providers. In order to maintain a safe environment, MSHN shall enforce policies and procedures (as needed) designed to protect consumers, employees, staff, providers, visitors, the environment, and the community.

D. Workplace Standards of Conduct

In order to safeguard the ethical and legal workplace standards of conduct, MSHN shall enforce policies and procedures, per the MSHN Personnel Manual, that address employee behaviors and activities within the workplace setting, including but not limited to the following:

1. Confidentiality: MSHN is committed to protect the privacy of its consumers. MSHN Board members, employees, and contractual providers are to comply with the Michigan Mental Health Code, Section, 330.1748, Code of Federal Regulations (CFR), Title 42 and all other privacy laws as specified under the Confidentiality section of this document.
2. Drug and Alcohol: MSHN is committed to maintain its property and to provide a drug-free work environment that is both safe for our employees and visitors, as well as conducive to efficient and productive work standards.
3. Harassment: MSHN is committed to maintaining a work environment free of harassment for Board members, employees, and contractual providers. MSHN will not tolerate harassment based on sex, race, color, religion, national origin, disability, citizenship, chronological age, sexual orientation, union activity, or any other condition, which adversely affects their work environment.
4. Conflict of Interest: MSHN Board members, employees, and contractual providers shall avoid any action that conflicts with the interest of the organization. All Board members, employees, and contractual providers must disclose any potential conflict of interest situations that may arise or exist in accordance with established policies and procedures.
5. Reporting Suspected Fraud: MSHN Board, employees, and contractual providers shall report any suspected or actual “fraud, abuse or waste” of any funds, including Medicaid funds, to the organization.
6. Solicitation and Acceptance of Gifts: MSHN Board members, employees and contractual providers shall not solicit gifts, gratuities or favors. MSHN Board members, employees and contractual providers will not accept gifts worth more than $25, gratuities or favors of any kind from any individual, consumer, or organization doing business or seeking to do business with MSHN.

7. Workplace Bullying: MSHN defines bullying as “repeated” inappropriate behavior, either direct or indirect, whether verbal, physical, or otherwise, conducted by one or more persons against another or others, at the place of work and/or during the course of employment. Such behavior violates MSHN Code of Ethics, which clearly states that all employees will be treated with dignity and respect.
8. Workplace Violence and Weapons: MSHN takes violence and threats of violence extremely seriously. Any act or threat of violence by or against any employee, customer, supplier, partner, or visitor is strictly prohibited.
9. Political Contributions: MSHN shall not use agency funds or resources to contribute to political campaigns or activities of any political party.

E. Contractual Relationships

MSHN shall ensure that all contractual arrangements with providers are structured in accordance with federal and state laws and regulations and are in the best interest of the organization and the consumers served. In order to ethically and legally meet all standards, MSHN will strictly adhere to the following:

1. MSHN and its Provider Network shall not pay or accept payment of any tangible or intangible kind for referrals. Consumer referrals and intakes will be accepted based on the consumer’s needs, eligibility, and the ability to provide the services needed. No organization, or employee, covered by this plan who is acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of consumers. Similarly, when making consumer referrals to another healthcare provider, MSHN and the Provider Network will not take into account the volume or value of referrals that the provider has made (or may make).
2. The Provider Network shall not enter into financial arrangements with physicians that are designed to provide inappropriate remuneration to the organization in return for the physician’s ability to provide services to federal health care program beneficiaries at MSHN.
3. MSHN does not enter into contractual relationships with individuals or agents/agencies that have been convicted of a criminal offense related to health care or that are listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in federal health care programs. Reasonable and prudent background investigations will be completed prior to entering into contractual relationships with all individuals and agents/agencies.
4. MSHN and its contractual providers, as well as the Provider Network and its contractors, are responsible for properly conducting credentialing and re-credentialing in accordance with State Policy and the MSHN policies and procedures. The Provider Network and contractual providers are responsible for reporting suspected fraud, abuse and licensing violations to MSHN as soon as suspected.
5. The Provider Network and its contractors shall be responsible, and held accountable, to provide accurate and truthful information in connection with treatment of consumers, documentation of services, and submission of claims.

F. Purchasing and Supplies

MSHN shall ensure that all rental, lease, and purchasing agreements are structured in accordance with applicable federal and state self-referral and anti-kickback regulations as well as federal guidelines regarding tax-exempt organizations. All agreements must be commensurate with the fair market value for equipment or space.

All contractor and supplier arrangements shall be managed in a fair and reasonable manner, consistent with all applicable laws and good business practices. Subcontractors, suppliers, and vendors shall be selected based on objective criteria including quality, technical excellence, price, delivery, and adherence to schedules, services and maintenance of adequate sources of supply.

G. Marketing

Marketing and advertising practices are defined as those activities used by MSHN to educate the public, provide information to the community, increase awareness of services, and recruit employees or contractual providers. MSHN will present only truthful, fully informative and non-deceptive information in any materials or announcements.

The federal Anti-Kickback Statute (section 1128B[b] of the Social Security Act) makes it a felony, punishable by criminal penalties, to offer, pay, solicit, or receive "remuneration" as an inducement to generate business compensated by Medicare or Medicaid programs.

H. Financial Systems Reliability and Integrity

MSHN shall ensure integrity of all financial transactions. Transactions shall be executed in accordance with established policies and procedures and with federal and state law and recorded in conformity with generally accepted accounting principles or any other applicable criteria.

MSHN shall develop internal controls and obtain an annual independent audit of financial records and annual compliance examination; shall ensure that reimbursement for services billed is accurate, appropriate, and based on complete claims documentation; and shall maintain accountability of assets. The Federal Civil False Claims Act prohibits the knowing submission of false or fraudulent claims for payment to the federal or state government, the knowing use of a false record or statement to obtain payment on a false or fraudulent claim, or a conspiracy to defraud the federal or state government by having a false or fraudulent claim allowed or paid.

In accord with the 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005) MSHN's fiscal processes shall monitor ~~for actions by~~ contractual providers of Medicaid services to assure appropriate documentation is available as needed to support claims payments and cost reimbursements. ~~prevent fraud, abuse, and waste, or are likely to result in unintended expenditures.~~

I. Information Systems Reliability and Integrity

The MSHN Chief Information Officer shall serve as the Security Officer and shall ensure the reliability and integrity of the information systems utilized to support the effectiveness of the MSHN compliance program, including but not limited to the following:

- Maintaining security, assuring integrity, and protecting consumer confidentiality.
- Controlling access to computerized data.
- Assuring reliability, validity and accuracy of data ~~through periodic auditing processes~~.
- Following procedures that assure confidentiality of electronic information pursuant to HIPAA, the Michigan Mental Health Code and other applicable laws and regulations.

J. Confidentiality and Privacy

The MSHN Chief Compliance and Quality Officer serves as the Privacy Officer. MSHN is committed to protecting the privacy of its consumers and shall strictly govern the disclosure of any information to anyone other than those authorized in compliance with applicable privacy

laws, regulations and contractual requirements. To ensure that all consumer information remains confidential, employees and contractual providers are required to comply with all confidentiality policies and procedures in effect, specifically to include the HIPAA Privacy Regulations, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 C.F.R. Part 2, 45 C.F.R. Part 160 &164 as outlined below:

- MSHN will follow the HIPAA requirements, as well as all applicable federal and state requirements, for the use of protected health data and information.
- MSHN will immediately report to the MDHHS any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements.
- Any breach of protected health information shall result in notification of the affected individuals as well as the HHS Secretary and the media in cases where the breach affects more than 500 individuals.
- Privacy Notice - MSHN will have a notice of privacy practices.
- Authorization - If protected mental health information is shared to an entity outside of MSHN for any purpose other than coordination of care, treatment, or payment of services, a signed authorization will be obtained from the consumer prior to sharing information. If substance use treatment information is being shared, for any purpose, to an entity outside of MSHN, a signed authorization, by the consumer, will be obtained. The Michigan Behavioral Health Consent Form will be utilized for obtaining authorizations.
- MSHN will perform any necessary internal risk analysis or assessments to ensure compliance.
- Physical and electronic safeguards shall be in place for MSHN employees and premises, including, but not limited to, door locks, unique logins and secure passwords, firewall and virus protection, disaster recovery mechanisms, and secure email.
- Business Associate Agreement – MSHN will obtain assurances with all Business Associates that protected health care information shared with them, will be protected and appropriately safeguarded consistent with all applicable State and Federal laws and requirements.
- Qualified Service Organization Agreement (QSOA) - Third-party service providers must become qualified to service Part 2 Programs. This is achieved through the entity entering into a written agreement with the Part 2 Program in which it acknowledges that it is bound by the Part 2 confidentiality regulations and agrees to resist in judicial proceedings any efforts to obtain unauthorized access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment that may come into its possession.

VIII. AREAS OF FOCUS

The MSHN Compliance Officer under the direction of the MSHN Board of Directors, MSHN Corporate Compliance Committee and the MSHN Regional Compliance Committee, will identify strategic areas of focus developed from a risk analysis that will guide the direction of MSHN compliance activities (**Attachment C**).

IX. TRAINING

A. MSHN Employees and Board Members

All MSHN Employees and Board members shall receive a copy of the MSHN Compliance Plan and training on the MSHN Compliance Plan, Compliance Policies and Standards of Conduct. Additional training may be required for employees involved in specific areas of risk or as new regulations are issued. Records shall be maintained on all formal training and educational activities. The Compliance Officer must receive training by an entity other than himself/herself.

Training is considered a condition of employment and failure to comply will result in disciplinary action up to and including termination.

Training will be provided upon hire for new employees and during orientation for new Board Members. All current staff and Board Members will receive annual training.

The Compliance Officer will provide ongoing information and education on matters related to health care fraud and abuse as disseminated by the Office of Inspector General, Department of Health and Human Services or other regulatory bodies.

It is the responsibility of MSHN staff to obtain training in order to maintain licensure and certifications that are specific totheir job responsibilities.

B. MSHN Provider Network

The MSHN Provider Network Committee will review and recommend a Regional Training Requirement to assure and provide consistent training requirements throughout the provider network. MSHN will monitor the provider network to ensure adherence to the identified training requirements. Where viable, MSHN will offer related compliance training and educational materials to the Provider Network. The Regional Training Requirements ~~is~~ are available on MSHN'swebsite.

X. COMMUNICATION

Open lines of communication between the MSHN Compliance Officer, the CMHSP Participant/SUD Provider Compliance Officer(s) and CMHSP Participant/SUD Provider staff within the region are essential to the successful implementation of the Compliance Plan and the reduction of any potential for fraud or abuse. Methods for maintaining open lines of communication may include, but not be limited to the following:

- There shall be access to the MSHN Compliance Officer for clarification on specific standards, policies, procedures, or other compliance related questions that may arise on a day-to-day basis.
- Access to a dedicated toll-free compliance line.
- Utilization of interpreter as needed/requested.
- Information will be shared regarding the results of internal and external audits, reviews, and site visits, utilization data, performance and quality data, and other information that may facilitate understanding of regulations, and the importance of compliance.
- Information may be communicated through a variety of methods such as formal trainings, e-mails, newsletters, intranet resource pages, or other methods identified that facilitate access to compliance related information as a preventative means to reduce the potential for fraud and abuse.
- Compliance contact information shall be available to stakeholders through a variety of methods such as the MSHN & CMHSP Participants/SUD Provider customer service handbook, websites, posters, and/or other methods (or processes) identified consistent with standards associated with MSHN Policies.

XI. MONITORING AND AUDITING

Monitoring and auditing of MSHN's operations is key to ensuring compliance and adherence to policies and procedures. Monitoring and auditing can also identify areas of potential risk and those areas where additional education and training is required. Results of the below activities will be

communicated through the appropriate council/committee and summarized results will be provided to the Operations Council, ~~MSHN Quality Improvement Council,~~ MSHN Corporate Compliance Committee, MSHN Regional Compliance Committee and MSHN Board of Directors through the Annual Compliance Report.

MSHN shall assure the provision and adequacy of the following monitoring and auditing activities:

Financial and Billing Integrity

- An independent audit of financial records each year;
- An independent compliance examination in accordance with the MDHHS guidelines (if applicable);
- Contractual providers have signed contracts and adhere to the contract requirements;
- Fiscal Monitoring reviews for all SUD providers
- Explanation of benefits (annually to 5% of the consumers receiving services)
- Medicaid Event Verification Site Reviews

Information Systems Reliability and Integrity

- MSHN Information System employees and Provider Network staff monitor the reliability and integrity of the information system and data;
- Assure appropriate security and system backup and recovery processes are inplace to address loss of information and that provide sufficient disaster recovery plans; and
- MSHN employees and Provider Network staff are trained on use of information systems and provided access based on role and job function.

Clinical/Quality of Care

- Performance indicators are monitored and reviewed in an effort to continually improve timeliness and access to services;
- MSHN employees are evaluated in writing on their performance and are provided with detailed job descriptions;
- MSHN employees are hired through a detailed pre-employment screening and hiring process and complete a comprehensive orientation program;
- Assuring qualification and competency of organizational and practitioner credentialing and privileging directly operated by or under sub-contract with the Provider Network;

Consumer Rights and Protections

- Rights complaints and issues are reviewed and investigations are completed as required;
- MSHN shall ensure that the Provider Network has a designated individual (Recipient Rights Officer or Advisor) and that the responsibilities of the Recipient Rights Office are completed in accordance with state and federal requirements.
- Risk events and incident reports are completed, reported and follow up action is taken as needed
- A root cause analysis is completed on each sentinel event reported as defined in MDHHS contract.

Environmental Risks

- Comprehensive maintenance reviews of facilities, equipment, and vehicles are completed as required;
- Emergency drills are conducted and evaluated on a regular basis;
- Accommodations are provided in accordance with the Americans with Disabilities Act (ADA);
- Privacy reviews of facility/office are completed;
- Ensure appropriate environmental licensures; and
- Initial and ongoing education on health, safety, and emergency issues are provided.

Quality and Utilization Reviews

- Review of delegated managed care functions (as identified in the MSHN/CMHSP Medicaid Subcontract);
- Review of SUD Provider Network in accordance with contracted functions
- Review of adherence and compliance with Quality Assessment and Performance Improvement Program (QAPIP) Plan; and
- Review of adherence and compliance with the Utilization Management (UM) Plan.

Additional Internal Monitoring and Auditing Activities

- Assessment of initial capacity and competency to perform delegated PIHP functions;
- Consumer Satisfaction Surveys;
- Review of MSHN contracts for administrative services;
- Contract Expense Monitoring;
- Monitor capacity and demand for services in the PIHP region through the Assuring Network Adequacy Report
- Review of Policies and Procedures for any needed revisions or development of new ones
- Questionnaires to poll staff and the provider network regarding compliance matters including effectiveness of training/education and related policies and procedures
- Exit interviews with departing staff (Issues related to Compliance)

Additional External Monitoring and Auditing Activities:

- External Quality Reviews
- CMS Site Visits
- MDHHS Site Visits
- Accreditation Surveys

XII. REPORTING AND INVESTIGATIONS

MSHN and its Provider Network shall follow established disciplinary guidelines for their respective employees who have failed to comply with the standards of conduct, policies, and procedures, federal and state law, or otherwise engage in wrongdoing. The guidelines shall be consistently enforced at all levels of the organization.

A. Reporting of Suspected Violations and/or Misconduct

MSHN shall maintain a reporting system that provides a clear process and guidelines for reporting potential offenses or issues.

MSHN board members, employees, contractual providers, consumers, and others are to report suspected violations or misconduct to the MSHN Compliance Officer or the appropriate CMHSP Participant/SUD Provider Compliance Officer and/or designee as outlined below. Suspected violations or misconduct may be reported by phone/voicemail, email, in person, or in writing (mail delivery). See **Attachment D** for contact information.

MSHN employees, consumers, contractual providers, and CMHSP Participant/SUD Provider staff who make good faith reports of violations of federal or state law are protected by state and federal whistleblower statutes, which includes protections from disciplinary actions such as demotions, suspension, threats, harassment or other discriminatory actions against the employee by the employer.

Violations Involving Suspected Fraud, Waste or Abuse:

- MSHN board members, employees, contractual providers and the provider network will report all suspected fraud and abuse to the MSHN Compliance Officer. The report will be

submitted in writing utilizing the Office of Inspector General (OIG) Fraud Referral Form (**Attachment E**).

- The MSHN Compliance Officer will complete a preliminary investigation, as needed, to determine if a suspicion of fraud exists.
- If there is suspicion of fraud, the MSHN Compliance Officer will report the suspected fraud and abuse to the MDHHS Office of Inspector General using the OIG Fraud Referral Form.
- The MSHN Compliance Officer will inform the appropriate provider network member when a report is made to the MDHHS Office of Inspector General.
- MSHN will follow the guidance/direction provided by the MDHHS Office of Inspector General regarding investigation and/or other required follow up.
- MSHN and the provider network will cooperate fully with investigations involving the MDHHS Office of Inspector General and/or the Department of Attorney General and adhere to any subsequent legal action that may result from such investigation.

Suspected Violations (NOT Involving Fraud, Waste, or Abuse) and/or Misconduct:

- MSHN employees will report all suspected violations or misconduct (not involving suspected fraud or abuse) directly to the MSHN Compliance Officer for investigation. If the suspected violation involves the MSHN Compliance Officer, the report will be made to the MSHN Chief Executive Officer. Information provided shall at a minimum include the following:
    - Provider Information, if applicable (Name, Address, Phone Number, NPI Number, Email)
    - Complainant Information (Name, Address, Phone Number, NPI number [if applicable], Medicaid ID # [if applicable], Email)
    - Consumer Information, if applicable (Name, Address, Phone Number, Email)
    - Summary of the violation and/or misconduct
    - Date(s) of the violation and/or misconduct
    - Supporting documentation, if any (i.e. claims data, audit findings, etc.)
    - Action, if any, taken prior to submitting the violation
- Any suspected violations regarding the MSHN Chief Executive Officer will be reported to the MSHN Compliance Officer and/or the MSHN Board Chairperson/Executive Committee for investigation.
- CMHSP Participant/SUD Provider staff with firsthand knowledge of activities or omissions that may violate applicable laws and regulations (not involving suspected fraud or abuse) are required to report such wrongdoing to the MSHN Compliance Officer or to the CMHSP Participant/SUD Provider Compliance Officer. The CMHSP Participant/SUD Provider Compliance Officer will review reported violations to determine the need to report to the MSHN Compliance Officer. The review will be based on but not limited to: external party involvement, Medicaid recipient services, practices and/or system-wide process applicability.
- The Provider Network (CEO)/Executive Director(ED) and/or designee, shall inform, in writing, the MSHN Chief Executive Officer (CEO) of any material notice to, inquiry from, or investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory (excluding Recipient Rights related to non-PIHP activities), prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of a recipient of Medicaid services. The Provider Network

CEO/ED shall inform, in writing, the MSHN CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.
- Reports of suspected violations or misconduct may be made on a confidential basis to the extent possible.

B. Process for Investigation

All reports involving suspected fraud, waste and abuse will follow the guidance/direction of the MDHHS Office of Inspector General for any required investigation.

All reports of suspected wrongdoing, not involving fraud or abuse, shall be investigated promptly following the process outlined in the MSHN Compliance Investigation Procedure. "Prompt response" is defined as action taken within 15 business days of receipt by the PIHP of the information regarding a potential compliance problem.

The investigation process and outcome will be documented and will include at a minimum the following (as identified on the required OIG report template):
- Date of Complaint
- Consumer Name (if applicable)
- Provider Name (if applicable)
- Source of the Complaint/Activity (Identify how the report was received such as phone, hotline, anonymous, etc)
- Activity Type (audit, complaint, referral, etc.)
- Medicaid ID# (if applicable)
- Target of Activity (indicate whether the report involves a provider, consumer, etc.)
- Provider Type (Group home, Facility, etc.)
- Time Period Covered (enter a date range that the activity occurred)
- Summary of the Complaint/Activity
- Codes Involved in Complaint/Activity (If Applicable)
- Total Amount Paid Relating to Activity (If Applicable)
- Overpayment Identified (If Applicable)
- Date the Initial Review was Completed (for determining if further action is needed such as reporting to OIG)
- Was Potential Fraud Identified (Yes or No)
- Date Referred to MDHHS OIG (If Applicable)
- Date Final Notice sent to Provider (If Applicable for matters of overpayment, etc.)
- Total Overpayment Amount Identified (If Applicable)
- Total Number of Paid Claims Related to Overpayment (If Applicable)
- Total Collection Amount (If Applicable)
- Date the Complaint was Resolved
- Summary of the Findings

In conducting the investigation, judgment shall be exercised, and consideration shall be given to the scope and materiality consistent with the nature of the concern. Each investigation must be carefully documented to include a report describing the disclosures, the investigative process, the conclusions reached and the recommended corrective action, when such is necessary. No one involved in the process of receiving and investigating reports shall communicate any information about a report or investigation, including the fact that a report has been received or an investigation is ongoing, to anyone within MSHN who is not involved in the investigation process or to anyone outside of MSHN without the prior

approval of the MSHN Compliance Officer. All MSHN employees, Provider Network staff and subcontractors are expected to cooperate fully with investigation efforts.

The MSHN Compliance Officer and the CMHSP Participant/SUD Provider Compliance Officers must report any conflict of interest that may exist when investigating a report of suspected wrongdoing or misconduct. If a conflict of interest does exist, the MSHN Compliance Officer will be responsible for securing an appropriate source to complete the investigation, which may include utilizing the MSHN Compliance Officer, one of the Provider Network Compliance Officers or an external source if necessary.

XIII. Corrective Actions and Prevention

Where an internal investigation substantiates a reported violation, corrective action will be initiated as identified within MSHN policies and procedures and the MSHN subcontracts with the CMHSP Participant/SUD Providers including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, the provision of a corrective action plan from the designated Provider Network member (as necessary) including follow-up monitoring of adequate implementation, and implementing system changes to prevent a similar violation from recurring in the future.

Corrective Action Plans should minimally include the following description:

- How the issue(s) identified will be immediately corrected, or the reason why it cannot be immediately corrected.
- Steps taken to prevent further occurrences
- Process for monitoring to ensure implementation and effectiveness of corrective action plan

Depending on the seriousness of the offense, the resulting action for MSHN staff could include additional training, written reprimand, suspension or termination of employment. The resulting action for the provider network would also depend on the seriousness of the offense and could include additional training, letter of contract non-compliance and termination of contract.

XIV. Submission of Program Integrity Activities

The PIHP, and the provider network will log and track all program integrity activities performed. The provider network will utilize the Quarterly Managed Care Program Integrity Report~~program integrity activities performed~~ template to report quarterly to the PIHP. The PIHP will report the program integrity activities to the MDHHS Office of Inspector General, on a quarterly basis, using the provided template.

The program integrity activities will include, but limited to, the following:

- Tips/Grievances received
- Data mining/Algorithms ~~and analysis of paid claims, including audits performed based on theresults~~
- Audits ~~performed~~
- Overpayments ~~collected~~
- ~~Identification and investigation of fraud, waste and abuse~~
- ~~Corrective action plans implemented~~
- Provider dis-enrollments
- Contract terminations

XV. References, Legal Authority and Supporting Documents

1. Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans, Medicaid Alliance for Program Safeguards, May 2002
~~http://ahca.myflorida.com/medicaid/managed_care/pdf/federal_cms_guidelines_constructing_compliance_program.pdf~~ https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf

2. Anti-kickback Statute (section 1128B[b] of the Social Security Act)
http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm
https://oig.hhs.gov/compliance/safe-harbor-regulations

3. False Claims Act
https://oig.hhs.gov/fraud
http://www.legislature.mi.gov

4. 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005)
http://www.cms.hhs.gov/deficitreductionact

5. Michigan Mental Health Code
~~http://michigan.gov/documents/mentalhealthcode_113313_7.pdf~~
http://www.legislature.mi.gov/(S(ea1olrem4pvgdzylgs0hay4e))/mileg.aspx?page=GetObject&objectname=mcl-Act-258-of-1974

6. Department of Health and Human Services, Office of Inspector General
https://oig.hhs.gov

7. Michigan Public Health Code
http://www.legislature.mi.gov/documents/mcl/pdf/mcl-act-368-of-1978.pdf

8. Code of Federal Regulations (Title 42, Part 2 and Title 45, Part 160 & 164)
http://www.ecfr.gov/cgi-bin/ECFR?page=browse

ATTACHMENT A

MSHN's Policies and Procedures can be found at the following link:

https://midstatehealthnetwork.org/provider-network-resources/provider-requirements/policies-procedures/policies

Policy and Procedure Categories Include:

Compliance

Customer Service

Finance

General Management

Human Resources

Information Technology

Provider Network

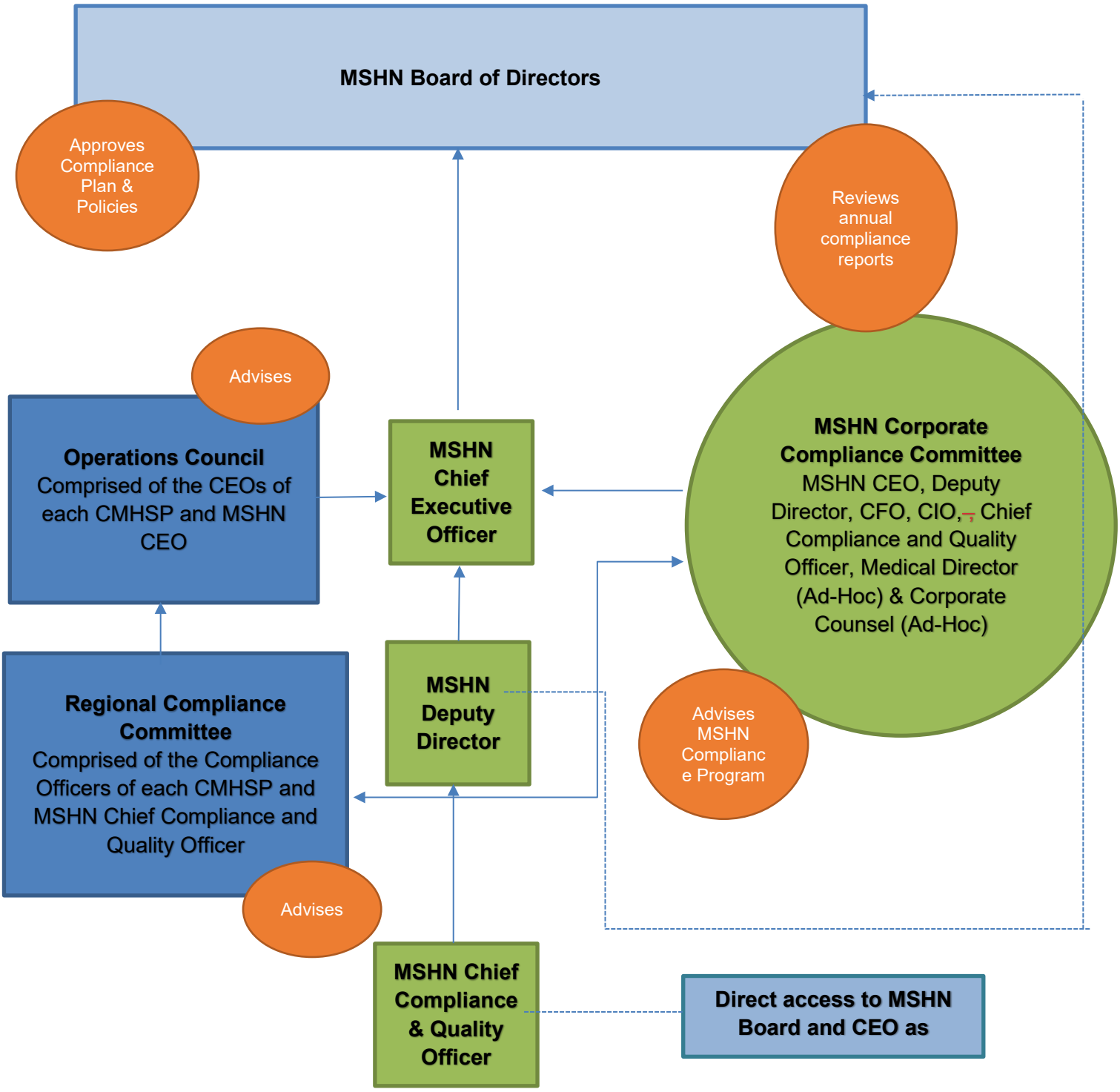
Quality

Service Delivery System

Utilization Management

Attachment B

Mid-State Health Network Compliance Process/Governance



ATTACHMENT C

MSHN Compliance Officer in coordination with the ~~MSHN Quality Improvement Council,~~ MSHN Corporate Compliance Committee and the Regional Compliance Committee shall focus its efforts on overseeing compliance in the below key areas as identified and prioritized:

Area of Focus	Task
Credentialing and Provider Qualifications	Develop processes and monitoring to ensure compliance with state contract requirements
Remote Work Environment	Review process for Home Office/Off Site Office security and privacy of protected health information to ensure compliance with established standards.
Compliance Training Requirements	Develop/review training to promote compliance with state and federal requirements
Waiver/Appendix K Extension	Monitor for Compliance with requirements after termination of PHE and related waiver exemptions
Telehealth Requirements	Monitor for compliance with rules outlined during the state of emergency and those continued past the state of emergency
HCBS Planning and implementation of changes	Review capacity, changes in waiver requirements and implementation to meet compliance
Children's Waiver (CW) and Serious Emotional Disturbance (SED) Waivers Certification Process for B3 Services	Review capacity, changes in waiver certification requirements and implementation to meet compliance
OHH, BHH, CCBHC, 1915i	Ensure new initiatives and PIHP responsibilities meet expected criteria and compliance with requirements.

ATTACHMENT D

MID-STATE HEALTH NETWORK

COMPLIANCE OFFICER CONTACT INFORMATION

PIHP Compliance Officer:

Mid-State Health Network	Kim Zimmerman, 517-657-3018, kim.zimmerman@midstatehealthnetwork.org

CMHSP Compliance Officers (or designee):

Bay Arenac Behavioral Health,	Janis Pinter, 989.895.2760, jpinter@babha.org
CMH for Central Michigan,	~~Bryan Krogman~~Kara Laferty, 989.772.5938~~1380~~, ~~bkrogman~~klaferty@cmhcm.org
Clinton, Eaton, Ingham CMH,	Jessica Scutt, 517.237.7115, compliance@ceicmh.org
Gratiot County CMH,	Pam Fachting, 989.466.4143, pfachting@gihn-mi.gov
Huron Behavioral Health,	Levi Zagorski, 989.269.9293, levi@huroncmh.org
The Right Door,	Susan Richards, 616.527.1790, srichards@rightdoor.org
LifeWays CMH,	Ken Berger, 517.789.2526, ken,berger@LifeWayscmh.org
Montcalm Care Network	Sally Culey, 989.831.7523, sculey@montcalmcare.net
Newaygo CMH,	Andrea Fletcher, 231.689.7542, afletcher@newaygocmh.org
Saginaw County CMH,	Richard Garpiel, 989.797.3539, Rmgarpiel@sccmha.org
Shiawassee County CMH,	Dirk Love, 989.723.0762, dlove@shiabewell.org
Tuscola Behavioral Health Systems	~~Lindsay Harper, 989.672.3014, lharper@tbhs.net~~

A complete listing of SUD Providers, with contact information, is located on the MSHN website at the following link: https://midstatehealthnetwork.org/provider-network-resources/provider-information/directory

MSHN Compliance Line: 1-844-793-1288
MDHHS Medicaid Fraud Hotline: 1.855.MI.FRAUD (643.7283)
HHS/OIG Hotline: 1.800.HHS.TIPS (447.8477)

ATTACHMENT E

Add link to MSHN website for form

MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES
INSPECTOR GENERAL ADMINISTRATION
INTEGRITY DIVISION
MCO – FRAUD REFERRAL

MCO Details:			
MCO Name:		**Date of Referral:**	
Referrer's Name:		**Referrer's Phone:**	
Referrer's Title:		**Referrer's Email:**	
Suspect Provider(s) Details:			
Provider Name:		**Provider Phone #:**	
Provider NPI #:		**Provider Type:**	
Provider Address:		**Provider Email:**	
Facility Owner Name:		**Owner Phone #:**	
Complainant(s) Details:			
Complainant Name:		**Complainant Phone #:**	
Complainant Address:		**Complainant Email:**	
Medicaid ID #:		**DOB:**	
Suspected Fraud Referral Details:			
Summarize the Suspected Fraudulent Activity:			
Estimated Fraud Amount:			
Date(s) of conduct:			
Document the specific laws, rules, regulations, policies, etc. that were violated:			
Supporting Documentation:	*Attach any and all documentation, data, or records obtained, reviewed, or relied on by the auditor leading to the suspicion of fraud including but not limited to:* ⇒ *Beneficiary/patient files and/or relevant medical records* ⇒ *Audit reports and findings* ⇒ *Provider Enrollment Agreements* ⇒ *Relevant fee schedules* ⇒ *Relevant provider policy manual* ⇒ *Provider education letters* ⇒ *Interview transcripts* ⇒ *Encounter claims data*		

	Label attachments 1-10, as applicable. *All submissions must be (1) zipped, encrypted, and sent to MDHHS-OIG@michigan.gov or (2) submitted via the secure File Transfer Protocol (FTP) to the OIG area specific to your MCO.*
Action Taken:	*Document the status of the current audit.* *NOTE – Do not make a fraud complaint if corrective action has been taken against the suspect provider (e.g., recoupment, contract termination, prepayment review, etc.).*
Record Review Results:	
Describe Record Selection Methodology:	*Include sample size and how the sample was selected (e.g., statistical vs nonstatistical, judgmental, etc.)*
Describe Record Review Results:	
Interview Results:	
Summarize Interviews:	*List all communications, chronologically, between the MCO and complainant, member and/or provider concerning the suspected fraud.*
Audit History:	
Document Suspect Provider(s) prior Audit History and Action Taken:	

MSHN
Mid-State Health Network

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
September/October 2022

The "988" National Suicide and Crisis Lifeline" is now live nationwide. Toolkits and other information is available at this link. Increased marketing activities in Michigan are scheduled to take place Winter/Spring 2023.

PIHP/REGIONAL MATTERS

1. COVID-19 MSHN Internal Operations Status:

- MSHNs suite of four offices within the Michigan Optometric Association (MOA) building, which have been closed since March 16, 2020, will be available for MSHN use beginning January 2, 2023.
- MSHN Leadership finalized a Post-Pandemic Operations Plan in June, 2022. As previously reported, the plan contains general operating principles, a position-by-position analysis with post-pandemic deployment instructions, and a new remote work agreement and related requirements and policies. This plan was developed with significant employee, provider and stakeholder input. MSHN committed to providing its employees at least 60 days' notice of post-pandemic plan implementation.
- After consulting with the MSHN Leadership Team, reviewing recent CDC guidelines and Michigan-specific COVID data, my office provided notice to staff on September 28,2022 that MSHNs post-pandemic operations plan would be implemented December 5, 2022 (with in-person departmental staff meetings for most teams beginning in January 2023).
- Along with MSHN Leadership, I am very proud of our staff and the many adaptations each employee has made throughout the pandemic. We recognize the hardships this has created for our workforce members, provider partners, stakeholders, and others, and we also celebrate the many successes and accomplishments we've made. As we prepare to move in to this next, post-pandemic phase, MSHN will continue to support our employees within the parameters we've established in our plan.

2. Regional Provider Staffing Crisis Stabilization Update:

At its March 2022 meeting, the MSHN Board approved the allocation of up to $13M in MSHN resources for Provider Staffing Crisis Stabilization activities. The program was continued through March 31, 2023 by board action at its September 2022 board meeting. MSHN's regional guidance is located on the MSHN Coronavirus website at this link. MSHN will provide a detailed summary of how these funds have been used in the first approval period (03/22 to 09/22) when final accounting is completed. Meanwhile, I have talked to many provider partners in our region who have expressed their deep gratitude to MSHN for delivering on our commitment to support our providers through COVID and staffing crisis issues.

3. **MSHN Formal Request for Information:**

Multiple provider letters of interest were received in response to the Request for Information (RFI) issued by MSHN for services in Montcalm and Isabella Counties. The next step is for MSHN to issue a request for proposal (RFP) from those interested providers, which is in progress.

4. **MSHN Leadership Team Off-Site Meeting:**

MSHN Leadership Team members conducted a two-day in-person planning session September 14 and 15, 2022. Among the many issues addressed, our priorities were preparedness for post-pandemic operations, consideration of input from staff and stakeholders on how our organization and its leadership can improve, consideration of agency and leadership team culture, functioning and dynamics, known future initiatives including structural and other preparedness considerations, and giving form and structure to our health disparities and diversity, equity, and inclusion work. After 2.5 years of remote operations, this was an important opportunity for the members of leadership to reconnect. The event was important to our roles as the leaders of the organization and the region, and much was accomplished (including a long list of things we need to do).

5. **Mobile Care Unit:**

MSHN purchased and retrofitted a large new van in October 2019 with State Opioid Response (SOR) grant funds. The mobile care unit (MCU) was initially developed to service rural areas primarily in the northern counties of our region. Available "on-board" services included urinalysis screenings, intake and assessment, outpatient therapy, telehealth Medication Assisted Treatment services (with a licensed prescriber), peer support services, overdose education, naloxone distribution and more. MSHN contracted with a licensed SUD provider to operate the MCU. The MCU was temporarily deployed to Charlotte to temporarily bridge a service gap when a then existing treatment provider ceased operations. The COVID pandemic took the MCU off-line from March until August 2020. MSHN made the MCU available to the Michigan Department of Health and Human Services (MDHHS) for COVID testing, which took place 2-3 days/week through September 2020. Services resumed thereafter.

The MSHN MCU model was based primarily on treatment service delivery and some harm reduction activities. Most persons who accessed services via the MCU stated a preference for ongoing services in a "bricks and mortar" location. Many communities also expressed this preference. MSHN's contractor experienced difficulties with finding a place to regularly locate the MCU (i.e., every Tuesday, X location; every Thursday, "Y" location). MSHN staff and our contractor worked tirelessly to establish routine availability of the MCU in community-accessible locations, marketed services and service availability, and in every way they could worked at improving utilization.

Meanwhile, these efforts were frustrated by significant repair requirements. A unit of this type requires a generator to power the interior, which failed and required replacement several times – with weeks of waiting for replacement parts. Support brackets breaking, septic systems failing, improper original equipment installation configurations that required reversal/repair, inoperable wheelchair lift repair, and so, so much more.

Taken together (low utilization, high cost of operation, high cost of maintenance/repair), MSHN made the decision (effective 10/01/2022) to cease current operations and redeploy the MCU. Because this MCU was

purchased with SOR funds, there are limitations on what can be done with it, but one allowable activity is for harm reduction activities. MSHN has notified MDHHS, which supports the redeployment decision, who is considering its options for granting (transferring title) of the MCU to an existing SOR-funded harm reduction provider in our region. MSHN is working with our auditors, attorneys and others so that the disposition decision of this asset is properly handled.

6. **Statewide Consensus Statement of Support for Substance Use Disorder (SUD) Harm Reduction Activities:**

Initiated by Dr. Dani Meier, MSHN's Chief Clinical Officer, all ten of Michigan's Regional Entity/Pre-Paid Inpatient Health Plans have endorsed a consensus statement in support of SUD Harm Reduction Activities. The consensus statement follows:

> Michigan has a comprehensive infrastructure of prevention, treatment and recovery services for people living with a substance use disorder (SUD). Individuals living with a SUD, however, often follow a bumpy road to recovery and sobriety. Social stigma, judgment from others and shame are barriers to individuals seeking treatment. Even after people have engaged in treatment, they can stumble on that road and relapse. Most people living with addictions, however, do recover. A 2017 Harvard study found that while 10% of the U.S. adult population has had a SUD, 9.1% of American adults are in recovery. Despite that, per the CDC, the U.S. exceeded 107,000 drug overdose deaths in 2021 largely related to heroin, methamphetamine and cocaine being laced with synthetic opioids like fentanyl.
>
> Harm reduction is an evidence-based strategy to keep people alive by supporting those struggling with active substance use *wherever they are* in their journey to recovery. If they are still using substances, a harm reduction approach works to lower the chance of overdose or of contracting Human Immunodeficiency Virus (HIV), Hepatitis C (HCV) or other diseases. Harm reduction strategies include distribution of naloxone, the overdose reversal medication that's saved many lives, and Syringe Service Programs (SSPs) which offer education about and connections to treatment pathways as they concurrently safely dispose of used syringes and distribute sterile syringes.
>
> The myth that distributing sterile syringes increases drug use by enabling people to keep using drugs has been thoroughly discredited. In fact, individuals who use syringe service programs are 5 times more likely to engage in treatment and 3 times more likely to quit using drugs than individuals with a SUD that do not use an SSP (per CDC). Syringe Service Programs are not associated with any increase in crime (per NIH) and studies show that for every one dollar spent on harm reduction efforts, $3 is saved in public health costs. Programs have also been shown to result, for example, in a 50% reduction in incidence of HIV and HCV (per NIH). By any measure, Syringe Service Programs are an effective means to save lives and keep people healthy along their journeys to recovery in our communities.
>
> As the Mental Health Code – designated Community Mental Health Entities, Michigan's Prepaid Inpatient Health Plans (PIHPs), the regional entities that oversee the state's public behavioral health system, strongly endorse evidence-based practices like harm reduction. We are working to create a coordinated seamless continuum of care including prevention, harm reduction, treatment, and recovery. Along those lines, 86 SSP sites have been established around the state. We strongly support the work of Michigan's Syringe Service Programs in helping save lives of people who may be struggling with substance misuse or are in the early stages of recovery. We encourage our community partners to do the same.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

7. **1915(i) State Plan Amendment Approved by Centers for Medicare and Medicaid Services:**

Effective 10/01/2022, the federal Centers for Medicare & Medicaid Services (CMS) approved a one year extension of Michigan's 1915(i) state plan amendment. CMS approved Michigan's request for extension in order to allow for the state to have additional time to come into compliance with the eligibility determination requirements for the §1915(i) State Plan benefit for Community Support Services stipulated in the current standard terms and conditions (STCs). This process will transition the needs-based eligibility determination from the Pre-Paid Inpatient Health Plans (PIHPs) to the State of Michigan; requiring the State to evaluate and re-evaluate documentation, to determine whether each enrolled, or potential beneficiary meets the needs-based criteria. MSHN has been involved in and preparing for these changes for a few years. Our efforts are led by Dr. Todd Lewicki, Chief Behavioral Health Officer.

8. **Annual Report on Community Mental Health Service Providers (CMHSPs), PIHPs, and Regional Entities:**

Section 904 of PA 87 of 2021 (The FY 22 Appropriations Act) requires that MDHHS provide a report to the legislature on specific aspects of CMHSP, PIHP, and CMHE (Community Mental Health Entity – a designation under the public health code applicable to PIHPs as regional SUD prevention and treatment coordinators). MDHHS submitted the report for FY 21 earlier this year. The report includes demographics for service recipients, expenditures by service population group, access information (admissions, denials), performance indicator information, administrative expenditures and much more. The report is referred to as the "904 Report" and is available on the MDHHS website. While very detailed and long (288 pages), review of the report can reveal interesting information, and may promote better understanding our public behavioral health system from a larger, statewide, perspective.

9. **Opioid Health Home Begins in the MSHN region:**

The MSHN region kicked off its first Opioid Health Home (OHH) in the Saginaw/Bay/Midland area with our Health Home Partner (HHP) Victory Clinical Services on 10/01/2022. An OHH "provides comprehensive care management and coordination services to Medicaid beneficiaries with an Opioid Use Disorder … and function as the central point of contact for directing patient-centered care across the broader health care system." OHH enrollees will have an interdisciplinary team of providers that includes and elevates the central role of peer recovery coaches to foster engagement and improve overall health.

10. **Behavioral Health Home Coming to the MSHN region, Spring 2023:**

Behavioral Health Homes (BHHs) are similar to Opioid Health Homes described above. MDHHS is expanding the BHH initiative statewide. The MSHN region is scheduled to begin BHH(s) in Spring 2023.

The Behavioral Health Home (BHH) will provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. For enrolled beneficiaries, the BHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model will also elevate 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 Homes receive reimbursement for providing the mandated core services, which are the same as for Opioid Health Homes listed above. NOTE that clinical services are as required in our contract and the Medicaid Provider Manual. In other words, there are no new "services". The Health Home Model adds comprehensive care coordination elements listed under the OHH topic above. Health home partners can be federally qualified health centers, rural health clinics, tribal health centers, clinical practices, or community/behavioral health agencies.

Mid-State Health Network is pleased to report that five of our CMHSP participants have expressed interest in developing BHHs with MSHN. Those CMHSPs are: CMH for Central Michigan, Montcalm Care Network, Newaygo County CMH, Saginaw County CMH, and Shiawassee Health and Wellness.

11. Michigan Health Integration Updates:

I have been reporting on the Michigan Health Integration Activities and many other Behavioral and Physical Health and Aging Services Administration (BPHASA) initiatives. Please see the attached update provided by BPHASA on the status of these many initiatives directly related to State Integration Initiatives. Also note that MSHN is directly involved in these initiatives.

12. Michigan Psychiatric Care Improvement Project:

I have been reporting on the Michigan Psychiatric Care Improvement Project and many other BPHASA initiatives. Please see the attached update provided by BPHASA on the status of these many initiatives directly related to Psychiatric Care Improvement. Also note that MSHN is directly involved in these initiatives.

FEDERAL/NATIONAL ACTIVITIES

13. The Opioid Crisis and Federal Policy Response:

Too lengthy to summarize in this report, the Congressional Budget Office (CBO) has released a report entitled "The Opioid Crisis and Recent Federal Policy Responses." The table of contents notes the scope and content of the report, which is an excellent primer on federal initiatives under the comprehensive addiction and recovery act, 21 Century Cures Act, and the Support for Patients and Communities Act. In this report, the Congressional Budget Office examines the consequences and timeline of the crisis, the contributing factors and federal responses to it, and the effects of the coronavirus pandemic on the crisis.

Summary

- What Are Opioids, and What Is Opioid Use Disorder?
- What Are the Effects of the Opioid Crisis?
- How Has the Crisis Evolved?
- What Factors Have Contributed to the Crisis?
- What Federal Laws Have Been Enacted in Response to the Crisis?
- How Has the Crisis Evolved After Enactment of the Laws and During the Pandemic?

Chapter 1: The Opioid Crisis
- Opioids and Opioid Use Disorder
- Effects of the Opioid Crisis
- Waves of the Opioid Crisis

Chapter 2: Factors Contributing to the Opioid Crisis
- Increased Prescribing of Opioids
- Greater Consumption of Opioids From Illegal Sources
- Increased Demand for Opioids for Self-Medication

Chapter 3: Recent Federal Legislation in Response to the Opioid Crisis
- Types of Responses
- Federal Funding

Chapter 4: The Crisis After Enactment of the Recent Laws and During the Pandemic
- The Opioid Crisis Between the Enactment of the Laws and the Pandemic
- The Opioid Crisis During the Pandemic"

14. Health and Human Services (HHS) Roadmap for Behavioral Health Integration:

Intended to advance President Biden's strategy to address the national mental health crisis, the Assistant Secretary for Planning and Evaluation issued its issue brief on 09/14/2022. According to the report, key points include:

- HHS is committed to providing the full spectrum of integrated, equitable, evidence-based, culturally appropriate, and person-centered behavioral health care to the populations it serves.
- HHS has evaluated key barriers to transforming behavioral health care in line with President Biden's Strategy to Address our National Mental Health Crisis and has identified policy solutions to overcome these barriers.
- HHS will advance the Strengthen System Capacity pillar in the President's national strategy by developing a diverse workforce prepared to practice in integrated settings and investing in infrastructure for integrated care.
- HHS will advance the Connect Americans to Care pillar by leveraging health financing arrangements, including efforts to fully realize the potential of parity.
- HHS will advance the Support Americans by Creating Healthy Environments pillar through investments in behavioral health promotion, upstream prevention, and recovery.

Also of note from the report is the operational definition of integrated care: "…Integrated care has been defined differently in different contexts, but it generally aims to treat the whole person's health care needs in a coordinated way that improves health outcomes. While integration often refers to inclusion of behavioral health services in primary care settings, HHS approaches it more broadly, to also include integration of physical health care into behavioral health settings, and integration of behavioral health care with other specialty areas such as OB/GYN care, as well as in social service and other settings."

The report contains a number of important recommendations to address health equity, eliminate barriers to integration, and support the mental and physical health of Americans

15. **SUD Treatment Admissions in the US – Before and During the COVID 19 Pandemic:**

The Journal of the American Medical Association has published a brief research letter with the following introduction: "The COVID-19 pandemic has led to increases in the number of fatal drug overdoses and self-reported substance use disorder (SUD). Despite these increases, few studies have examined SUD treatment admissions during the pandemic, with studies focusing on state-specific estimates or inferring use through national mobility data. To more comprehensively examine the surge in drug overdose deaths, we quantified changes in national SUD treatment before (2017-2019) and during (2020) the COVID-19 pandemic."

16. **Medicare Updates:**

While not directly related to MSHN operations, often policies implemented in Medicare later impact Medicaid. In addition, there are a large number of dual-covered (Medicare and Medicaid) in public behavioral health services across the region.

CMS has announced that people with Medicare will see lower premiums for Medicare Advantage and Medicare Part D prescription drug plans in 2023. Additionally, thanks to the Inflation Reduction Act, people with Medicare prescription drug coverage will have improved and more affordable benefits, including a $35 cost-sharing limit on a month's supply of each covered insulin product, as well as adult vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP) at no additional cost. Ahead of the upcoming Medicare Open Enrollment beginning October 15 and extending to December 7, CMS is releasing key information, including 2023 premiums and deductibles for Medicare Advantage and Medicare Part D prescription drug plans, to help Medicare enrollees determine the best coverage for their needs.

- The projected average premium for 2023 Medicare Advantage plans is $18 per month, a decline of nearly 8% from the 2022 average premium of $19.52. Medicare Advantage plans will continue to offer a wide range of supplemental benefits in 2023, including eyewear, hearing aids, preventive and comprehensive dental benefits, access to meals (for a limited duration), over-the-counter items, and fitness benefits.

- In addition, more than 1,200 Medicare Advantage plans will participate in the CMS Innovation Center's Medicare Advantage Value-Based Insurance Design (VBID) Model in 2023, which tests the effect of customized benefits that are designed to better manage diseases and meet a wide range of health-related social needs, from food insecurity to social isolation. The benefits under this model are projected to be offered to 6 million people.

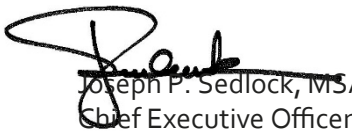
- The VBID Model's Hospice Benefit Component, now in its third year, will also be offered by 119 Medicare Advantage plans in portions of 24 states and U.S. territories, providing enrollees increased access to palliative and integrated hospice care. Medicare Advantage plans participating in the Hospice Benefit Component will implement strategies to advance health equity across all aspects of their participation.

- CMS continues to improve options for enrollees who are dually eligible for Medicare and Medicaid. For example, in 2023, CMS will begin to require all Medicare Advantage dual eligible special needs plans (D-SNPs) to establish enrollee advisory committees and consult with those committees on

various issues, including improving health equity for underserved populations. Additionally, new policies related to cost sharing are estimated to increase payment from MA plans to providers serving dually eligible individuals who incur high costs.

- The average basic monthly premium for standard Part D coverage is projected to be $31.50, compared to $32.08 in 2022. The Medicare Part D program helps people with Medicare pay for both brand-name and generic prescription drugs."

Submitted by:



Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 10/14/2022

Attachments:

- MSHN Michigan Legislative Tracking Summary
- MDHHS Strategic Projects Update
- Michigan Psychiatric Care Improvement Project Update

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 October 19, 2022:

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 4075 (PA 182)	Parking Spot Signage (LaFave) Modifies signage for parking spaces designated for persons with disabilities.	Signed by the Governor (7/25/2022; Signed: July 25, 2022, Effective: October 22, 2022)
HB 4076 (PA 183)	Accessibility Symbol (LaFave) Modifies symbol of accessibility.	Signed by the Governor (7/25/2022; Signed: July 25, 2022, Effective: October 22, 2022)
HB 4414 (PA 214)	Mental Health Transportation (LaFave) Creates standards and licensing requirements for mental health transport for involuntary psych hospitalization.	Signed by the Governor (10/14/2022; Signed: October 14, 2022, Effective: October 14, 2022)
HB 4925	Mental Health (Whiteford) Modifies reference to citizens mental health advisory council to behavioral health oversight council and update.	Committee Hearing in House Health Policy Committee (3/17/2022)
HB 4926	Behavioral Health Care (Hammoud) Expands use of Medicaid funds for behavioral health care services.	Committee Hearing in House Health Policy Committee (3/17/2022)
HB 4927	Mental Health (Green) Eliminates reference to "department-designated community mental health entity" in the public health code.	Committee Hearing in House Health Policy Committee (3/17/2022)
HB 4928	Mental Health (Allor) Eliminates reference to "department-designated community mental health entity" in the Michigan liquor control code of 1998.	Committee Hearing in House Health Policy Committee (3/17/2022)
HB 5163	MAT Programs (Witwer) Requires certain hospitals to provide emergency-based medication-assisted treatment (MAT) programs and provides for grants from the department of health and human services to implement the MAT programs.	Reported in Senate (6/16/2022; S-2 substitute adopted; By Health Policy and Human Services Committee)
HB 5353	Mental Health (Whiteford) Provides revisions to the Michigan crisis and access line.	Introduced (9/30/2021; To Health Policy Committee)
HB 5354	Mental Health (Whiteford) Creates the 9-8-8 suicide prevention and mental health crisis hotline fund.	Introduced (9/30/2021; To Health Policy Committee)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 5462	Medicaid (Outman, P.) Provides impact study related to eligibility for Medicaid program and provides public disclosure related to intentional program violations or fraud cases investigated.	Reported in House (2/22/2022; By Families, Children and Seniors Committee)
HB 5467	Open Meetings (Green) Provides policy related to member participation in virtual committee meetings.	Introduced (10/21/2021; To Local Government and Municipal Finance Committee)
HB 5482	Drug Court (Howell) Modifies eligibility to drug treatment courts.	Committee Hearing in House Judiciary Committee (2/22/2022)
HB 5483	Mental Health Court Participants (LaGrand) Modifies eligibility for mental health court participants.	Committee Hearing in House Judiciary Committee (2/22/2022)
HB 5484	Drug Court (Yancey) Modifies termination procedure for drug treatment courts.	Committee Hearing in House Judiciary Committee (2/22/2022)
HB 5488	Psychologists (Kahle) Modifies individuals who are authorized to engage in the practice of psychology in this state to include individuals who are authorized to practice under the psychology interjurisdictional compact.	Reported in Senate (6/16/2022; By Health Policy and Human Services Committee)
HB 5489	Psychologists (Brabec) Enacts psychology interjurisdictional compact.	Reported in Senate (6/16/2022; By Health Policy and Human Services Committee)
HB 5593	Mental Health (Calley) Provides community mental health oversight of competency exams for defendants charged with misdemeanors.	Introduced (12/1/2021; To Health Policy Committee)
HB 5709	Behavioral Health (Anthony) Provides equitable coverage for behavioral health and substance use disorder treatment.	Introduced (2/1/2022; To Insurance Committee)
HB 5921	FOIA (Johnson, S.) Amends freedom of information act provisions related to civil actions challenging denials of record requests.	Reported in House (6/9/2022; By Oversight Committee)
HB 5922	FOIA (O'Malley) Amends freedom of information act to provide for disclosure of certain FOIA coordinator contact information.	Reported in House (6/9/2022; Substitute H-2 adopted; By Oversight Committee)
HB 5923	FOIA (VanWoerkom) Amends freedom of information act provisions	Reported in House (6/9/2022; Substitute H-1 adopted; By Oversight Committee)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
	related to a public body's response to record requests.	
HB 5924	FOIA (Fink) Amends freedom of information act to prevent certain tactics used to avoid requests for public records.	Reported in House (6/9/2022; Substitute H-1 adopted; By Oversight Committee)
HB 5925	FOIA (Posthumus) Amends freedom of information act provisions related to payment of fees for production of public records.	Committee Hearing in House (6/9/2022; Substitute H-1 adopted; Oversight Committee)
HB 5966	MIcare Act (Rabhi) Creates MIcare act.	Introduced (3/23/2022; To Health Policy Committee)
HB 5968	Opioid Healing And Recovery Fund (Whiteford) Creates Michigan opioid healing and recovery fund.	Received in Senate (5/3/2022; To Health Policy and Human Services Committee)
HB 5969	Opioid Advisory Commission (Whiteford) Creates opioid advisory commission.	Received in Senate (5/3/2022; To Health Policy and Human Services Committee)
HB 5970	Controlled Substances (Morse) Prohibits civil lawsuits related to opioids.	Received in Senate (5/3/2022; To Health Policy and Human Services Committee)
HB 6355	Mental Health (Filler) Requires psychological evaluation on a minor in a hospital emergency room longer than a certain period of time due to a mental health episode.	Committee Hearing in House Health Policy Committee (9/22/2022)
HB 6439	Mental Health Screenings (Hood) Provides mental health screenings for new mothers at various stages of wellness checkups for newborns.	Introduced (10/11/2022; To Health Policy Committee)
SB 14	Controlled Substances (Zorn) Modifies venue under the Michigan Penal Code for prosecution of delivery of a controlled substance causing death.	Reported in House (5/17/2022; By Judiciary Committee)
SB 15	Controlled Substances (Zorn) Modifies jurisdiction under the Code of Criminal Procedure for prosecution for delivery of controlled substance causing death.	Reported in House (5/17/2022; By Judiciary Committee)
SB 101 (PA 146)	Mental Health (McBroom) Creates standards and licensing requirements for mental health transport for involuntary psych hospitalization.	Signed by the Governor (7/19/2022; Signed: July 19, 2022, Effective: October 16, 2022)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
SB 190	Psychiatric Units (VanderWall) Requires accepting public patients as a condition of licensing for psychiatric hospitals and psychiatric units.	Committee Hearing in House Health Policy Committee (6/16/2022)
SB 191	Mental Health (VanderWall) Expands the definition of mental health professional to include physician assistants, certified nurse practitioners, and clinical nurse specialists-certified, and allow them to perform certain examinations.	Received in House (4/29/2021; To Health Policy Committee) Passed in Senate (4/29/2021; 35-0)
SB 321	Mental Health (Santana) Provides development or adoption of professional development standards for teachers on mental health first aid.	Passed in Senate (9/29/2021; 36-0)
SB 578	Controlled Substances (Brinks) Allows distribution of opioid antagonists by community-based organizations under a standing order.	Committee Hearing in House Health Policy Committee (6/30/2022)
SB 579	MAT Programs (VanderWall) Requires certain hospitals to provide emergency-based medication-assisted treatment (MAT) programs and provides for grants from the department of health and human services to implement the MAT programs.	Passed in House (7/1/2022; 98-8, Immediate effect)
SB 597	Behavioral Health Care (Shirkey) Provides specialty integrated plan in behavioral health services.	Advanced to Third Reading in Senate (3/2/2022; Earlier committee substitute S-3 adopted.)
SB 598	Mental Health (Bizon) Provides updates regarding the transition from specialty prepaid inpatient health plans to specialty integration plans.	Advanced to Third Reading in Senate (3/2/2022; Earlier committee substitute S-3 adopted.)
SB 614	Dietitians And Nutritionists (MacDonald) Provides licensure of dietitian nutritionists and nutritionists.	Committee Hearing in Senate Health Policy and Human Services Committee (5/19/2022--Canceled)
SB 705	Open Meetings (Irwin) Provides procedures for electronic meetings of public bodies.	Introduced (10/26/2021; To Local Government Committee)
SB 707	Telehealth Visits (Hollier) Requires reimbursement rate for telehealth visits to be the same as reimbursements for office visits.	Introduced (10/28/2021; To Health Policy and Human Services Committee)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
SB 714	Behavioral Health (Shirkey) Provides multidepartment supplemental for behavioral health changes.	Received in House (6/16/2022; To Appropriations Committee)
SB 792	Open Meetings (McMorrow) Modifies circumstances permitting electronic attendance of members at meetings of public bodies.	Introduced (12/14/2021; To Local Government Committee)
SB 854	Open Meetings (McCann) Modifies procedures for electronic meetings of public bodies and expand eligibility due to a medical condition.	Introduced (2/1/2022; To Oversight Committee)
SB 855	Drug Paraphernalia (Chang) Expands definition of drug paraphernalia to include object designed for the ingestion of nitrous oxide.	Reported in Senate (3/17/2022; By Health Policy and Human Services Committee)
SB 1080	Controlled Substances (McCann) Creates overdose fatality review act.	Committee Hearing in Senate Health Policy and Human Services Committee (9/20/2022)
SB 1170	Controlled Substances (VanderWall) Provides distribution of naloxone under the administration of opioid antagonist act to any individual.	Introduced (9/20/2022; To Health Policy and Human Services Committee)
SB 1171	Controlled Substances (VanderWall) Provides distribution of opioid antagonists by employees and agents of agencies under the administration of opioid antagonists act.	Introduced (9/20/2022; To Health Policy and Human Services Committee)
SB 1172	Peace Officer (Chang) Modifies definition of a peace officer in the mental health code.	Introduced (9/20/2022; To Health Policy and Human Services Committee)
HR 231	Drug Paraphernalia (Slagh) A resolution to oppose the use of federal funds to purchase drug paraphernalia.	Introduced (2/16/2022)
HR 298	Direct Support Professionals Recognition (Kuppa) A resolution to urge Congress to pass legislation to recognize the critical role of direct support professionals.	Introduced (5/17/2022; To Health Policy Committee)

Michigan Integration Efforts

Service Delivery Transformation

October 2022 Update

Overview

Overview
MDHHS Integration Efforts include four key initiatives: Behavioral Health Homes (BHH), Opioid Health Homes (OHH), Certified Community Behavioral Health Clinics (CCBHC) and Promoting Integration of Primary and Behavioral Health Care (PIPBHC). Each initiative seeks to improve both behavioral and physical health outcomes by emphasizing care coordination, access, and comprehensive care. These programs specifically focus on adults and children with mental health and substance use disorder needs.

Goals

1. Increase access to behavioral health and physical health services.
2. Elevate the role of peer support specialists and community health workers.
3. Improve health outcomes for people who need mental health and/or substance use disorder services.
4. Improve care transitions between primary, specialty, and inpatient settings of care.

Opportunities for Improvement

1. Improve access to care for all individuals seeking behavioral health services (SMI, SUD, SED, mild to moderate).
2. Identify and attend to social determinants of health needs.
3. Improve care coordination between physical and behavioral health services.

Service Delivery Transformation Section

- Erin Emerson, Senior Policy Executive
- Lindsey Naeyaert, Section Manager
- Amy Kanouse, Behavioral Health Program Specialist
- Kelsey Schell, Health Home Analyst

Behavioral Health Homes (BHH)

Overview

- Medicaid Health Homes are an optional State Plan Benefit authorized under section 1945 of the US Social Security Act.
- Behavioral Health Homes provide comprehensive care management and coordination services to Medicaid beneficiaries with select serious mental illness or serious emotional disturbance by attending to a beneficiary's complete health and social needs.
- Providers are required to utilize a multidisciplinary care team comprised of physical and behavioral health expertise to holistically serve enrolled beneficiaries.
- Behavioral Health Home services are available to beneficiaries in 42 Michigan counties including PIHP regions 1 (upper peninsula), 2 (northern lower Michigan), 6 (Southeast Michigan), 7 (Wayne County), and 8 (Oakland County).

Current Activities:

- As of October 4, 2022, there are 1,750 people enrolled:
    - Age range: 7-85 years old
    - Race: 24% African American, 71% Caucasian, 2% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- Resources, including the BHH policy, directory, and handbook, are available on the Michigan Behavioral Health Home website. Behavioral Health Home (michigan.gov)
- MDHHS staff will be working to expand the BHH into PIHP Region 5, Mid-State Health Network. Anticipated start date is April 1, 2023.
- MDHHS staff met with each region in July to discuss successes, barriers, and focus for FY23.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)

Certified Community Behavioral Health Clinics (CCBHC)

Overview

- MI has been approved as a Certified Community Behavioral Health Clinic (CCBHC) Demonstration state by CMS. The demonstration launched in October 2021 with a planned implementation period of two years. The Safer Communities Act was signed with provisions for CCBHC Demonstration expansion, extending MI's demonstration until October 2027. 13 sites, including 10 CMHSPs and 3 non-profit behavioral health providers, are participating in the demonstration. The CCBHC model increases access to a comprehensive array of behavioral health services by serving all individuals with a behavioral health diagnosis, regardless of insurance or ability to pay.
- CCBHCs are required to provide nine core services: crisis mental health services, including 24/7 mobile crisis response; screening, assessment, and diagnosis, including risk assessment; patient-centered treatment planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family supports; and intensive, community-based mental health care for members of the armed forces and veterans.
- CCBHCs must adhere to a rigorous set of certification standards and meet requirements for staffing, governance, care coordination practice, integration of physical and behavioral health care, health technology, and quality metric reporting.
- The CCBHC funding structure, which utilizes a prospective payment system, reflects the actual anticipated costs of expanding service lines and serving a broader population. Individual PPS rates are set for each CCBHC clinic and will address historical financial barriers, supporting sustainability of the model. MDHHS will operationalize the payment via the current PIHP network.

Current Activities

- The CCBHC Demonstration wrapped up its first year. As of October 4, 2022, 44,019 Medicaid beneficiaries and 7,407 individuals without Medicaid are assigned in the WSA to the 13 demonstration CCBHC sites. Assignment has increased steadily since the start of the demonstration.
- Virtual DY1 Check-In calls have been completed for all CCBHCs. Together, MDHHS, PIHPs, and CCBHCs reviewed clinical workflows, discussed support needs for DY2, reviewed trending utilization, troubleshooted challenges, and celebrated successes. A training and technical assistance series will take place during DY2 with topics identified as areas of interest during these meetings.
- The MDHHS CCBHC Implementation Team is working to finalize financial reporting requirements for the initial demonstration year and continuing to address additional operational issues that arise as the demonstration moves forward.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)
- Amy Kanouse (kanousea@michigan.gov)

Opioid Health Homes (OHH)

Overview

- Medicaid Health Homes are an optional State Plan Amendment under Section 1945 of the Social Security Act.
- Michigan's OHH is comprised of primary care and specialty behavioral health providers, thereby bridging the historically two distinct delivery systems for optimal care integration.
- Michigan's OHH is predicated on multi-disciplinary team-based care comprised of behavioral health professionals, addiction specialists, primary care providers, nurse care managers, and peer recovery coaches/community health workers.
- As of October 1, 2022, OHH services are available to eligible beneficiaries in 76 Michigan counties. Service areas include PIHP region 1, 2, 4, 5, 6, 7, 8, 9, and 10.

Current Activities

- As of October 1, 2022, 2,555 beneficiaries are enrolled in OHH services.
- With the OHH expansion, LE's have continued to expand OHH services with new Health Home Partners (HHPs). There are currently 38 HHPs contracted to provide services to OHH beneficiaries. Some HHPs are contracting with multiple LEs.
- MDHHS continues to collaborate with many state agencies to ensure OHH beneficiaries have wraparound support services through their recovery journey.

Questions or Comments

- Kelsey Schell (schellk1@michigan.gov)

Promoting Integration of Primary and Behavioral Health Care (PIPBHC)

Overview

- PIPBHC is a five-year Substance Abuse and Mental Health Services (SAMHSA) that seeks to improve the overall wellness and physical health status for adults with SMI or children with an SED. Integrated services must be provided between a community mental health center (CMH) and a federally qualified health center (FQHC).
- Grantees must promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental health and substance use disorders along with co-occurring physical health conditions and chronic diseases.
- MDHHS partnered with providers in three counties:
    - Barry County: Cherry Health and Barry County Community Mental Health to increase BH services
    - Saginaw County: Saginaw County Community Mental Health and Great Lakes Bay Health Centers
    - Shiawassee County: Shiawassee County Community Mental Health and Great Lakes Bay Health Centers to increase primary care

Current Activities

- Grantees are currently working toward integrating their EHR system to Azara DRVS to share patient data

between the CMH and FQHC. This effort should improve care coordination and integration efforts between the physical health and behavioral health providers.

- Shiawassee and Saginaw counties are starting to see shared patient data in Azara DRVS. Both counties are moving to training and adoption. Barry County is working through data validation.
- PIPBHC sites are focused on sustainability and the ways in which integrated care can continue after the end of the grant. The sites are also currently working on completing the annual PIPBHC Integration Self-Assessment Survey to determine how each agency views the current level of integration.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)

Michigan Psychiatric Care Improvement Project (MPCIP)

October 2022 Update

CONTENTS

MPCIP Overview

Michigan House CARES Task Force and the Michigan Psychiatric Admissions Discussion evolved into the Michigan Psychiatric Care Improvement Project (MPCIP).

Two-part Crisis System

1. Public service for anyone, anytime, anywhere: Michigan Crisis and Access Line (MiCAL) per PA 12 of 2020, Mobile Crisis, and Crisis Receiving and Stabilization Facilities.
2. More intensive crisis services that are fully integrated with ongoing treatment both at payer and provider level for people with more significant behavioral health and/or substance use disorder issues through Community Mental Health Service Programs.

Opportunities for Improvement

1. Increase recovery and resiliency focus throughout entire crisis system.
2. Expand array of crisis services.
3. Utilize data driven needs assessment and performance measures.
4. Equitable services across the state.
5. Integrated and coordinated crisis and access system – all partners.
6. Standardization and alignment of definitions, regulations, and billing codes.

988/MiCAL Implementation

The MiCAL, 988, Peer Warmline, and Frontline Strong sections of this report are combined because MiCAL (staffed by Common Ground) answers the calls, texts, and chats to these lines statewide.

Michigan Crisis and Access Line (MiCAL) Overview

- Legislated through PA 12 of 2020 and PA 166 of 2020.
- Based on SAMHSA's Model: One statewide line which links to local services tailored to meet regional and cultural needs and is responsible for answering Michigan 988 calls. MiCAL will provide a clear access point to the varied and sometimes confusing array of behavioral health services in Michigan.
- Supports all Michiganders with behavioral health and substance use disorder needs and locates care, regardless of severity level or payer type. Warm hand-offs and follow-ups, crisis resolution and/or referral, safety assessments, 24/7 warm line, and information or referral offered.
- MiCAL will not replace CMHSP crisis lines. It will not prescreen individuals. MiCAL will not directly refer people to psychiatric hospitals or other residential treatment. This will be done through PIHPs, CMHSPs, Emergency Departments, Mobile Crisis Teams, and Crisis Stabilization Units.
- Piloted in Upper Peninsula and Oakland April 2021; Operational Statewide October 2022.

988 Overview

- **988 went live on July 16, 2022,** as the new three digit dialing code for the National Suicide Prevention Lifeline. It is not a new crisis line. It is managed by Vibrant at the Federal Level.
- **988 Expanded Purpose**: With the addition of 988, the Lifeline is expanding crisis coverage for all behavioral health/emotional crises in addition to people feeling suicidal.

- **988 Implementation Plan**: Michigan's Official 988 Implementation Plan was submitted to Vibrant and SAMHSA on January 21, 2022. It was developed by a cross sector stakeholder group through a Vibrant funded planning process.
- **Michigan Coverage**: As of June 1, 2022, Michigan has active statewide coverage for all 988 calls originating from Michigan counties through MiCAL. Seven counties have primary coverage through Network 180, Gryphon Place, or Macomb CMH.
- **988 Chat and Text**: MiCAL will also be responsible for answering 988 chats and texts.
- Vibrant is contracting with federally funded back up centers to answer call, chat, and text overflow.

Current Activities for 988/MiCAL

- MDHHS received a 2 year SAMHSA 988 Implementation grant mid-April 2022. Key focus areas are (1) adequate statewide coverage, (2) common practices for centers, (3) stakeholder engagement/marketing, (4) stable diversified funding, and (5) 911/988 collaboration.
- **MiCAL Rollout**: MiCAL will rollout statewide in two phases.
    - **Phase 1 FY 22**: January 2022 - MiCAL will rollout statewide one region at a time, providing coverage for 988 and crisis and distress support through the MiCAL number. It will not provide additional regions with CMHSP crisis after hours coverage at this time. MiCAL is rolling out care coordination protocols with publicly funded crisis and access services (CMHSPs, PIHPs, state demo CCBHCs, and CMHSP contract providers).
    - Coordination is in place with services in PIHP geographic regions 1, 2, 3, 4, 5, 6, 7, 8, and 10. It will be coordinated with region 9, all regions, by the end of October. Map of the Prepaid Inpatient Health Plans (michigan.gov).
    - **Phase 2 FY 23**: CMHSP After Hours Crisis Coverage. Afterhours coverage services are currently provided as a pilot in the Upper Peninsula. MiCAL is beginning to plan for Phase 2 FY 23 CMHSP After Hours Crisis Coverage. MiCAL will provide afterhours crisis coverage for CMHSPs who currently contract with a third party for afterhours crisis coverage. Rollout with occur one CMHSP at a time and will start with regions that volunteer participation beginning in January 2023. Afterhours Process Improvement meetings have been occurring throughout September to gather CMHSP and PIHP feedback, and the final meeting will occur on October 4.
- MiCAL integration with OpenBeds/MiCARE is in progress.
- MDHHS created a 988 chat/text implementation plan and submitted it to SAMHSA mid-September 2022.
- **There have been 61,241 MiCAL encounters since go-live on April 19, 2021 (this includes MiCAL number, NSPL, and CMHSP afterhours calls).**
- **988 Center Practices:** Operations workgroup meetings with current 988 centers are focused on developing common practices around Imminent Risk, Active Rescues and Follow Up.
    - Michigan's 988 workgroup is finalizing Michigan's Center Protocol document, which has incorporated Vibrant's requirements and standards and will be utilized and adopted by all of Michigan's 988 call centers as the framework for expected operations.
- **911/988 Collaboration:** State level 911/988 workgroup is meeting at least monthly to develop collaborative practices, with the initial focus on coordinated active rescues.
    - Michigan's 988/911 workgroup finalized the Involuntary Emergency Intervention Workflow. The workflow was created to standardize the way in which staff at all centers are expected to be trained

and handle 988 involuntary emergency intervention processes. It will also be shared with 911 centers as an informational tool.

- **Public Relations**: 988 Implementation is currently focused on ensuring that there is adequate staffing and coordination with 911 and other crisis service providers before openly marketing the 988 number. This was a rollout approach that was recommended by SAMHSA and Vibrant. Targeted marketing will begin early 2023.
    - MDHHS developed a website to share with its stakeholders: 988 Suicide & Crisis Lifeline and Michigan Crisis & Access Line, as well as a MiCAL/988 Quick Facts document for reference.
    - MDHHS has been providing presentations to key stakeholder groups. During the month of October 2022, we will present to TYSP- Emergency Department Community of Practice, Tribal Nations Behavioral Health Meeting, and attending the Blue Cross Blue Shield of MI Healthy Safety Net Symposium.
    - During the planning process, Michigan's 988 Stakeholder group agreed to be active participants in the public awareness/marketing process. As stated earlier, we are reaching back out to this Stakeholder group in early November and December 2022 for their help in developing the comprehensive publicity campaign.
    - Starting in January 2023, MDHHS' public awareness activities will target people most at risk for behavioral health crises and suicide through communication channels via trusted community partners such as community groups, advocacy organizations, and allied professionals. A public awareness/ marketing plan which will identify existing channels such as newsletters, websites, and conferences through which to promote 988. The plan will also provide 988 marketing materials to key stakeholders who can give them to people who might benefit from calling 988.

Stakeholder Participation:

- At this time, we are asking partners to refrain from actively advertising the 988 number, but we have no problem with them sharing the 988 number, general information about 988, and 988 resources.
- We are asking stakeholders to begin replacing the former NSPL number (the 800 number) with 988 and to partner with us in identifying and notifying us of places where the 800 number needs to be replaced.
- Starting in January 2023 partners can openly advertise 988 and utilize SAMHSA's promotional materials.

Current Activities for Michigan Peer Warmline and Frontline Strong Together

- Michigan Peer Warmline is operated under MiCAL by Common Ground. It is statewide. It operates 10 am to 2 am 7 days per week.
- Michigan Peer Warmline is refining data gathered during the call, i.e. reason for the call and services provided.
- **There have been 50,738 Warmline encounters since go-live at the end of April 2021.**
- Frontline Strong First Responder Crisis support project called Frontline Strong Together in partnership with Wayne State is operated under MiCAL by Common Ground and is available statewide 24/7. Common Ground has hired a Project Manager who brings a wealth of first responder, training, and crisis line experience. Frontline Strong Together went live in August 2022.
- **There have been 40 Frontline Strong Together encounters since go-live mid-August 2022.**

Crisis Stabilization Units

Overview

Michigan Public Act (PA) 402 of 2020 added Chapter 9A (Crisis Stabilization Units) to the Mental Health Code, which requires the Michigan Department of Health and Human Services (MDHHS) to develop, implement, and oversee a certification process for CSUs (certification is in lieu of licensure). CSUs are meant to provide a short-term alternative to emergency department and psychiatric inpatient admission for people who can be stabilized through treatment and recovery coaching within 72 hours.

To encourage participation and creation of CSUs, MI Legislature has designated funding in the FY 2023 budget to account for at least 9 CSUs. To develop a model and certification criteria for CSUs in Michigan, MDHHS engaged Public Sector Consultants (PSC) to convene and facilitate an advisory group of stakeholders. The stakeholder workgroup reviewed models from other states and Michigan to make recommendations around a model that will best fit the behavioral health needs of all Michiganders.

Michigan Model developed by 12/1. MDHHS is developing draft certification rules for adult CSUs and will solicit feedback in fall of 2022, with goals of finalizing the criteria during Q1 of 2023. The certification criteria for children CSUs will be developed during FY 2023, with an implementation date in FY 2024.

Current Activities

- Draft CSU Certification standards are being finalized to share with stakeholders for their feedback.
- CSU Certification rules will start the Administrative rules process January 2023.
- A survey was issued to acute and psychiatric hospitals and CMHSPs to assess the existence of any walk-in urgent care or crisis care behavioral health services similar to a CSU such as an EMPATH unit and a psychiatric emergency room. This survey also assesses entities' interest in providing CSU services.
- MDHHS will operate a CSU Community of Practice Pilot which will result in a Best Practice Implementation Handbook and pilot entities receiving CSU certification. Participants are recruited through the CSU survey.
- The Michigan Model has been tailored to include Children and Families. It has been shared for public feedback. Listening sessions with people with lived experience will occur in November and December.

Adult Mobile Crisis Intervention Services

Overview

- Mobile crisis services are one of the three major components that SAMHSA recommends as part of a public crisis services system.
- MDHHS goal is to eventually expand mobile crisis across the state for all populations.
- MDHHS has contracted with PSC/HMA to develop recommendations to expand mobile crisis for adults in Michigan, with special attention on strategies for rural areas.
- Per Diversion Fund legislation MDHHS will pursue the advanced Medicaid match and ensure that the model meets requirements.

- There is coordination with the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) and their intensive mobile crisis stabilization services.

Current Activities

- Multiple areas of MDHHS are working on the expansion of mobile crisis services: Diversion Council, BCCHPS, and Bureau of Specialty Behavioral Health Services.
- Internal meetings are occurring to ensure that models for children/families and adults stay aligned whenever possible.
- PA 162 and 163 of 2021 set up a Diversion Fund and pilot program for mobile crisis. MDHHS is coordinating around implementation plans internally, prior to stakeholder involvement.
- Public Sector Consultants has pulled together legislative and funding requirements, recommendations from Wayne State Center for Behavioral Health Justice (CBHJ), and other best practices to develop a draft model for adults. This model will be altered over the next couple of years based on stakeholder feedback from Diversion Fund pilots, CCBHC discussions, and feedback from people with lived experience.

MI-SMART (Medical Clearance Protocol)

Overview

- Standardized communication tool between EDs, CMHSPs, and Psychiatric Hospitals to rule out physical conditions when someone in the Emergency Department (ED) is having a behavioral health emergency and to determine when the person is physically stable enough to transfer if psychiatric hospital care is needed.
- Broad cross-sector implementation workgroup.
- Implementation is voluntary for now.
- **Target Date: Soft rollout has started as of August 15, 2020.**
- www.mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/

Current Activities

- Education of key stakeholders statewide; supporting early implementation sites; performance metric development.
- As of 9/26/22: Adopted/accepted by 54 Emergency Departments, 26 Psychiatric Hospitals, and 14 CMHSPs.
    - 30 more facilities are pursuing the implementing at their facility, including Munson Medical Center, Sparrow Health, and McLaren Bay Region.
    - We are excited to welcome UPHS Marquette and LifeWays as new MI-SMART users!
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption.
- MHA sent communication to members from their small and rural hospitals informing them about the MI-SMART Form. They were sent a link which they can fill out if they are interested in learning more about how to implement the MI-SMART Medical Clearance Process at their facility.
- MHA and MDHHS co-signed a letter encouraging the use of the MI-SMART Medical Clearance Process. This letter was signed by MDHHS Chief Medical Executive Dr. Natasha Bagdasarian and MHA Executive Vice President Laura Appel. MHA distributed the letter to their members in August.
- Provided a presentation on the MI-SMART Medical Clearance Process at the MHA Small and Rural Hospital Council meeting in September.

- Drafting a letter to send to PIHPs/CMSHPs aiming to work regionally to increase adoption of the MI-SMART Form.
- Partnering with LARA to develop a crosswalk that outlines regulatory practices that MI-SMART can help meet.
- Transitioning Medical Clearance Workgroup to an Advisory Group.
- Record high COVID numbers in Emergency Departments are impeding progress.

Psychiatric Bed Treatment Registry

Overview

- Legislated through PA 658 of 2018, PA12 of 2020, PA 166 of 2020.
- Electronic service registry housing psychiatric beds, crisis residential services, and substance use disorder residential services.
- The Psychiatric Bed Registry is housed in the MiCARE/OpenBeds platform, which is Michigan's behavioral health registry/referral platform, operated and funded by LARA.
- MiCARE will eventually house all private and public Behavioral Health Services and will have a public facing portal.
- The Psychiatric Bed Registry Advisory Group's purpose will transition from choosing a platform to supporting successful rollout and maximization of the OpenBeds platform to meet Michigan's needs.
- LARA is rolling out MiCARE regionally with a statewide completion date by the end of 2022.
- Target audience: Psychiatric Hospitals, Emergency Departments, CMHSP staff, PIHP staff.
    - Public and broader stakeholder access through MiCAL.
    - Broad cross-sector Advisory Workgroup.
- Target Implementation Date: Implemented statewide by December 2022.

Current Activities

- LARA is in the process of rolling out MiCARE statewide a PIHP region at a time. The focus is on substance use disorders treatment services. They recently held a meeting to start the rollout process for providers in the remaining PIHP regions. They will reach out shortly to CMHSPs to bring them on as searchers. Please watch for emails.
- All inpatient psychiatric facilities received communication from LARA and MDHHS notifying them that the goal deadline to complete the onboarding into MiCARE (OpenBeds®) was extended to the end of June 2022. MDHHS has been, and will continue, contacting and working with psychiatric facilities. With the support from LARA, all facilities will be onboarded into MiCARE/OpenBeds within the coming months. MDHHS will begin ensuring psychiatric facilities' bed availability is regularly updated.
- Psychiatric hospitals are being encouraged to onboard as they are able. There are 58 facilities. Nearly all psychiatric hospital has attended the initial orientation.
- LARA reached out to all psychiatric hospitals to offer help with onboarding.
- MDHHS sent a survey to all inpatient psychiatric facilities in June. The purpose of the survey was (1) to comply with legislative requirements and (2) to collect information from all psychiatric hospitals for protocol development around the use of the OpenBeds platform. MDHHS received a lot of great responses from the survey and has been meeting one on one with several psychiatric facilities to gain additional feedback.

- MDHHS and LARA, in partnership with Bamboo Health, hosted a demonstration of the OpenBeds platform for all bed searchers in September. This allowed those who have not had a chance to attend a demonstration the opportunity to learn more about the OpenBeds platform.
- MDHHS is in the process of conducting small group listening sessions with representatives from Psychiatric Hospitals, Community Mental Health Services Programs, and Emergency Departments. The goal is to understand partner requirements so that MDHHS could provide technical assistance and support to facilities utilizing OpenBeds and to develop usage protocols for MiCARE. In doing so, MDHHS would like to gain an understanding of how to implement the platform in the most optimal and cost neutral way. Our next listening session will be with representatives from Emergency Departments. If you are interested in attending, please contact us at mpcip-support@mphi.org.
- Psychiatric Bed Advisory Workgroup is providing feedback on tailoring MiCARE to Michigan, i.e., bed categorization, acuity, the rollout, and referral process.

MDHHS Staff Update - Crisis Services & Stabilization Section

Due to a significate reorganization within Michigan Department of Health and Human Services (MDHHS), crisis services that were previously under the Behavioral Health and Developmental Disability Administration (BHDDA) are now part of the new Crisis Services and Stabilization Section in the Bureau of Specialty Behavioral Health Services within the Behavioral and Physical Health and Aging Services Administration (BPHASA).

Questions or Comments

Community Mental Health Association of Michigan distributes this document to its' members.
To be added to the distribution list for this update - please contact MPCIP-support@mphi.org

MiCAL questions or comments - contact MDHHS-BHDDA-MiCAL@michigan.gov
MiCARE/Openbeds platform questions - contact Haley Winans, Specialist, LARA, WinansH@michigan.gov

Krista Hausermann, LMSW, CAADC
MDHHS State Administrative Manager,
Crisis Services and Stabilization Section,
Bureau of Specialty Behavioral Health Services
HausermannK@Michigan.gov

MSHN
Mid-State Health Network

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
•
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REPORT OF THE MSHN DEPUTY DIRECTOR
to the Board of Directors
September/October

MSHN Staffing Update

Tera Harris has accepted the transfer to the SED/Autism Coordinator position, effective November 7, 2022. Tera has been with Mid-State Health Network since January 2020 as the HSW/CWP Coordinator.

In addition, you may have noticed that Sherry Kletke's title has changed from Executive Assistant to Executive Support Specialist. Sherry assumed additional responsibilities that include support for human resources and office operations previously assigned to the Office Assistant.

Please join me in congratulating Tera and Sherry on their expanded roles at MSHN.

Lastly, MSHN met with the Michigan Department of Health and Human Services (MDHHS) on September 1, 2022, regarding the implementation of Behavioral Health Homes (BHH) in our region. Implementation of BHH has been included in our strategic plan for FY23. This initiative was discussed with the Operations Council in September and five Community Mental Health Service Providers (CMHSPs) indicated interest in implementation of BHH in Spring FY23. This volume of interest makes it a priority to post an Integrated Healthcare Coordinator position in addition to the one recently filled by Katy Hammack to support Opioid Health Homes (OHH) and Certified Behavioral Health Clinics (CCBHCs).

Available job positions are located on MSHN's website under careers at: https://midstatehealthnetwork.org/stakeholders-resources/about-us/Careers.

FY22 Balanced Scorecard

MSHN Leadership and the CMHSPs have reviewed the results of the October 1, 2021 – June 30, 2022, Balanced Scorecard (BSC) Measurement Report. The BSC is utilized by our region to monitor progress on key performance indicators. The key performance indicators are selected to support the strategic objectives included in MSHN's Strategic Plan. The BSC has department area individual reports for Better Health, Better Care, Better Value, Better Provider Systems and the newest area of Better Equity. New this fiscal year is the tab to monitor the specific measures related to the Certified Behavioral Health Clinics (CCBHCs) that apply to three of our CMHSPs. Development for performance targets and data validation continues as baseline for the first demonstration year closes out.

See the attached ***FY22Q3 Balanced Scorecard Report for key performance indicator results.***

Performance Measure Validation Report – FY22

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with Pre-paid Inpatient Health Plans (PIHPs), measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of the mandatory external quality review (EQR) activities that MDHHS conducts through a contract with Heath Services Advisory Group (HSAG).

The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state and federal specifications and reporting requirements. The following categories are reviewed by HSAG:

- Data Integration, Data Control, and Performance Indicator Documentation
- Eligibility and Enrollment Data System
- Claims and Encounters
- Behavioral Health Treatment Episode Data Set
- PIHP Oversight of Affiliate Community Mental Health Service Participants

MSHN and our regional partners continue to excel in performance with our reviews, receiving a "met" for all elements and no findings in any areas. HSAG identified some areas of opportunity that will be reviewed with our partners for quality improvement initiatives.

For more information on the performance measure review results, ***see the link below: FY22 Validation of Performance Measures Report.***

Compliance Review Report – FY22

Health Services Advisory Group (HSAG), contracted by the Michigan Department of Health and Human Services (MDHHS) to conduct oversight of the Pre-paid Inpatient Health Plans (known as the External Quality Review), finalized the review of Mid-State Health Network (MSHN) in July and on October 14, 2022, MSHN received the final report. For FY2022, HSAG reviewed the following sections with the results listed below.

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	10	1	0	**91%**
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard X—Subcontractual Relationships and Delegation	5	5	5	0	0	**100%**
Standard XI—Practice Guidelines	7	7	7	0	0	**100%**
Standard XII—Health Information Systems	12	12	11	1	0	**92%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	28	2	0	**93%**
Total	**119**	**119**	**105**	**14**	**0**	**88%**

Overall, MSHN and the CMHSPs policies and procedures were found in compliance with the standards. A significant portion of the elements not met during the review, were related to documentation lacking compliance with the policy. MSHN will be working with the CMHSPs to develop a corrective action plan and to ensure improvement in process and practices. With the low level of compliance in Provider Selection (credentialing) and the Grievance and Appeal section (related to Adverse Benefit Determinations), MSHN staff will be reviewing the need to implement additional oversight measures.

For more information on the compliance review results, ***see the link below: FY22 Compliance Review Report.***

Compliance, Quality and Customer Service Report

The Office of Inspector General (OIG) requires PIHPs to submit quarterly reports that includes all compliance activities related to overpayments, audits, complaints, and referrals, and required data mining reviews. For FY22 Q3, MSHN reported 54 new activities that were initiated region wide, which represented an increase of 20.00% from the prior quarter. However, there were no activities for FY22 Q3 that included suspected fraud, waste or

abuse. Out of the 54 activities, 30 were identified as having an overpayment and requiring a recoupment or correction and 23 of those activities were concluded and closed during the quarter. The 30 activities that were identified as having an overpayment amount totaled $83,735.67 that required recoupment and/or correction. The summary of the findings from these activities included inappropriate credentials/training, lack of documentation to support the claim, and incorrect date and time.

During FY22 Q3, the data mining activities reviewed a comparison for telehealth, face-to-face and overall encounters, and the death data report. Comparison for telehealth, face-to-face, and overall encounters for FY22 Q3 showed a slight decrease in the average total numbers of face-to-face and telehealth contacts for April and May 2022 compared to previous months. This decrease was within an expected range and no further analysis was necessary. A review of the death data report identified 44 unique individuals that included 637 encounters (multiple encounters for same beneficiary).

MSHN's Chief Compliance Officer, Kim Zimmerman, works closely with the regional compliance officers and the OIG to ensure appropriate follow up and corrective action plans.

For more information on the departmental report, ***see the link below: FY22Q3 Compliance, Customer Service and Quality Report.***

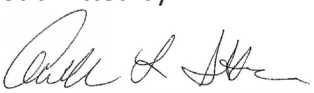
Information Technology Report

The MSHN Information Technology team provides services and supports to the region in meeting the contractual obligations for MDHHS. Each quarter, the Information Technology report includes data for both the CMHSPs and Substance Use Disorder (SUD) providers regarding statistics of encounter processing and treatment episode data sets. MSHN along with CMHSPs review the data to ensure accurate encounter and data submissions to MSHN where it is processed and aggregated/validated and then final submission to MDHHS. The report includes data by each CMHSP, SUD Provider and MSHN as a region compared to other PIHPs.

Data reporting and analytics development continues at MSHN. During FY22 Q3, development updates included: Veteran Penetration Rate, SUD Readmission and Follow-up Rates for Residential, Grievance and Appeals Reports and the Average Time between First Contact and Admission by county/provider. As a reminder, MSHN's website dashboard page includes updates on current statistics: Website dashboard

For more information on the departmental report, ***see the link below: FY22Q3 Information Technology Report.***

Submitted by:



Amanda L. Ittner
Finalized: 10.21.22

Attached:
FY22Q3 Balanced Scorecard Report

Links to Reports:
FY22 Validation of Performance Measures Report
FY22 Compliance Review Report
FY22Q3 Compliance, Customer Service and Quality Report
FY22Q3 Information Technology Report

MSHN FY22 - Board of Directors and Operations Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2022	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth	MSHN Strategic Plan FY19-FY20	+10%	0% Decrease over FY20		1-10% Decrease	11-19% Decrease	20% or more Decrease
	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular screening during the measurement year. (Rolling 12 months)	Aligns with strategic plan goal to establish clear criteria and practices that demonstrate improved primary care coordination and with Performance Measure Portfolio	38%	78.5% (2017 National data)		>=78.5%	54.4%-78.4%	<54.4%
	Expand SUD stigma reduction community activities.	MSHN WILL SUPPORT AND EXPAND SUD-RELATED STIGMA REDUCTION EFFORTS THROUGH COMMUNITY EDUCATION	145 activities	144		>=144	<144 and >72	<=72
	Increase health information exchange/record sets	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.	3	2		3	2	1
	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.	MDHHS/PIHP Contracted, Integrated Health Performance Bonus Requirements	2	0		0	1	2
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)	Measurement Portfolio NQF 0576; PIHP/MDHHS Contract, 2021 Performance Bonus	60%	58%		>=58%	0	<58%
	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)	Measurement Portfolio NQF 0576; PIHP/MDHHS Contract, 2021 Performance Bonus	75%	70%		>=70%	0%	<70%
	Behavior Treatment Plan standards met vs. standards assessed from the delegated managed care reviews. (Quarterly)	MDHHS Technical Requirement for Behavior Treatment Plans.	52%	95% or greater		95-100%	90-94%	<90%
	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: 41.03% *** (7-1-2021 thru 6-30-2022)	Above Michigan 2020 levels; E: 12.5% (2016)		Increase over National levels	No change from National levels	Drop below National levels
	Integrate standardized assessment tools into REMI	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	2	2		3	2	1
	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person centered plan	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan; MDHHS Site Review Findings 2019-2020	85%	100%		100%	90%-99%	<90%

MSHN FY22 - Board of Directors and Operations Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2022	Target Value	Performance Level	Target Ranges		
BETTER VALUE	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	73%	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
	MSHN reserves (ISF)	MSHN WILL WORK WITH ITS CMHSPS AND BOARD OF DIRECTORS TO ESTABLISH A RESERVE'S TARGET SUFFICIENT TO MEET FISCAL RISK RELATED TO DELIVERY OF MEDICALLY NECESSARY SERVICES AND TO COVER ITS MDHHS	7.5%	7.5%		> 6%	≥ 5% and 6%	< 5%
	Develop and implement Provider Incentives (VBP, ER FU, Integration)	MSHN will develop methodologies, within established rules, to incentivize providers to cooperate with the PIHP to improve health or other mutually agreeable outcomes.	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.	93.20%	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%	<= 5%		<=5%	6%-10%	>=11%
Better Provider Systems	Develop crisis residential unit within region	Network Adequacy Assessment Recommendations	In Process	CRU available to Region		Complete	In Process	Not Started
	Managed Care Information Systems (REMI) Enhancements	Provider portal, Patient Portal, ASAM Continuum, CCBHC reporting, LOCUS data transfer, OHH process, etc.	3	4		3	2	1
	Implement and support Provider Stabilization (SUD Only) programs (95% approval)	Strategic Plan - Better Provider Systems	100% for eligible applications	95%		>95%	80-94%	<79%
	Improve data availability	MSHN FY22-23 Strategic Plan - Staff, Consumers, Providers, and Stakeholders	70%	100%		75%	50%	25%
	Implement and support Provider recruitment, incentives and retention programs (Goal of $10m)	Strategic Plan - Better Provider Systems	5.48M	10m		>6m	3-6m	<3m

MSHN FY22 - CCBHC Metrics - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2022	Target Value	Performance Level	Target Ranges		
CCBHC Metrics & Bonus	Follow-Up After Hospitalization for Mental Illness (adult age groups) MSHN	CCBHC Handbook V1.2	67.9%	58.0%		>58	48-57%	<47%
	Follow-Up After Hospitalization for Mental Illness (child/adolescents) MSHN	CCBHC Handbook V1.2	78.3%	70.0%		>70	60-69%	<59%
	Adherence to Antipsychotics for Individuals with Schizophrenia MSHN	CCBHC Handbook V1.2	63.9%	58.5%		>58	48-57%	<47%
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment MSHN	CCBHC Handbook V1.2	I -52.9% / E:-38.2%	I -42.5% / E-18.5%				
	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment MSHN	CCBHC Handbook V1.2	CCBHCs have the assessment - not all the same; manual process in development for box upload/aggregation	12.5%		In development; Waiting on first qu		
	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment MSHN	CCBHC Handbook V1.2	CCBHCs have the assessment - not all the same; manual process in development for box upload/aggregation	23.9%				
	Please note: the QBP is only pertinent to Medicaid CCBHC costs and beneficiaries							
Other PIHP Reporting	Monitor, collect, and report grievance, appeal, and fair hearing information	CCBHC Handbook V1.2	Waiting on MDHHS guidance on changes to templates - PCE revising forms					
	Develop a process to collect CCBHC "encounters" for the non-Medicaid population		In process/validating T1014					
	Note: State Reported Measures will be reported to the PIHP/CCBHC by MDHHS							
e Reported Measures	Housing Status (HOU)	CCBHC Handbook V1.2	In Development in REMI: Awaiting MDHHS Clarification					
	Patient Experience of Care Survey (PEC)	CCBHC Handbook V1.2	Awaiting MDHHS clarification					
	Youth/Family Patient Experience of Care Survey (PEC)	CCBHC Handbook V1.2	Awaiting MDHHS clarification					
	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	CCBHC Handbook V1.2	7 days: 47.7% / 30 days: 71.2%	54%				
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	CCBHC Handbook V1.2	Rely on STATE to Report					

CCBHC State	Plan All-Cause Readmission Rate (PCR-AD)^	CCBHC Handbook V1.2	10.5%					
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD-AD)^	CCBHC Handbook V1.2	83.7%					
	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)^*	CCBHC Handbook V1.2	63.9%					
	Follow-up care for children prescribed ADHD medication (ADD-CH)^	CCBHC Handbook V1.2	I-61.6% / C&M-96.4%					
	Antidepressant Medication Management (AMM-AD) ^	CCBHC Handbook V1.2	I-60.4% / C&M-42.2%					
	Note: CCBHC Reported Measures will be reported by the CCBHC to MDHHS							
CCBHC Reported Measures	**Question to CCBHCs: PIHP responsibility of reporting? PIHP at a minimum must monitoring submission**							
	Time to Initial Evaluation (I-EVAL): Percent of consumers with an initial evaluation within 10 Business Days. Total (all ages)	CCBHC Handbook V1.2	CEI: 62% SCCMH: 52%% The Right Door: 77%					
	Time to Initial Evaluation (I-EVAL): Mean Number of Days until Initial Evaluaton		CEI: SCCMH: 1.86 The Right Door:					
	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	CCBHC Handbook V1.2	CEI: 5% SCCMH: 18% The Right Door: 36%					
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)^	CCBHC Handbook V1.2	CEI: SCCMH: 42% The Right Door: 6%					
	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	CCBHC Handbook V1.2	CEI: SCCMH: 63% The Right Door: 54%					
	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	CCBHC Handbook V1.2	CEI: SCCMH: 29% The Right Door: 32%					
	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)*	CCBHC Handbook V1.2	CEI: SCCMH: 8% The Right Door: 18%					
	Major Depressive Disorder: Suicide Risk Assessment (SRA-A)*	CCBHC Handbook V1.2	CEI: SCCMH: 29% The Right Door: 16%					
	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	CCBHC Handbook V1.2	CEI: SCCMH: 76% The Right Door: 41%					
	Depression Remission at Twelve Months (DEP-REM-12) The Right Door	CCBHC Handbook V1.2	CEI: SCCMH: The Right Door: 3%					

MSHN FY22 - Quality Improvement/Customer Service - Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with		Actual Value (%) as of June 2022	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 Reporting Requirements		98.00%	95%		95%	94%	<94%
	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 Reporting Requirements		98.77%	95%		95%	94%	<94%
	Percent of child discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days	MDHHS PIHP Contract Reporting Requirements		98.97%	95%		95%	94%	<94%
	Percent of adult discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days	MDHHS PIHP Contract Reporting Requirements		95.75%	95%		95%	94%	<94%
	Percent of discharges from a substance abuse detox unit who are seen for follow up care within seven days.	MDHHS PIHP Contract Reporting Requirements		99.37%	95%		95%	94%	<94%
	Percent of MI and DD children readmitted to an inpatient psychiatric unit within 30 days of discharge	MDHHS PIHP Contract Reporting Requirements		5.60%	0.0%		<=15%	>=15.1%	>=16%
	Percent of MI and DD adults readmitted to an inpatient psychiatric unit within 30 days of discharge	MDHHS PIHP Contract Reporting Requirements		10.42%	0.0%		<=15%	>=15.1%	>=16%
	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)	Measurement Portfolio NQF 0576; PIHP/MDHHS Contract, 2021 Performance Bonus		74.69%	70%		>=70%		<70%
	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)	Measurement Portfolio NQF 0576; PIHP/MDHHS Contract, 2021 Performance Bonus		60.11%	58%		>=58%		<58%
	Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children)	MDHHS/PIHP Contracted, Integrated Health Performance Bonus Requirements		0	0		0	1	2
	Increase access and service utilization for Veterans and Military members	MSHN ensures expanded SAPT and CMHSP service access and utilization for veterans and Military Families through implementation of the regional statewide veteran and military member strategic plan		73.3%	Increase over 2021 rate of 75.9%		Increase over 2021 rate	No change from 2021 rate	Drop below 2021 rate
	Percentage of consumers indicating satisfaction with SUD services	MDHHS PIHP Contract: Qualitative and Quantitative assessment of member experiencies (QAPIP Technical Requirement)		95%	80%		80%	75%-80%	75%
	Percentage of consumers indicating satisfaction with mental health services	MDHHS PIHP Contract: Qualitative and Quantitative assessment of member experiences (QAPIP Technical Requirement)		85%-MHSIP 87%- YSS	80%		80%	75%-80%	75%

MSHN FY22 - Quality Improvement/Customer Service - Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with		Actual Value (%) as of June 2022	Target Value	Performance Level	Target Ranges		
	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service date and time matching the claim date and time of the service. CMHSP/SUD	MDHHS PIHP Contract: Medicaid Services Verification Technical Requirement		CMHSP: 99.30% SUD: 99.50%	Increase over 2021		95%	90.0%	85%
	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service provided falls within the scope of the service code billed.	MDHHS PIHP Contract: Medicaid Services Verification Technical Requirement		CMHSP: 98.75% SUD: 99.28%	Increase over 2021		95%	90.0%	85%
	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service.	MDHHS PIHP Contract: Grievance and Appeal Technical Requirement		90.71%	95%		95%	91%-94%	90%
	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: Grievance and Appeal Technical Requirement		96.97%	95%		95%	91%-94%	90%
	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: Grievance and Appeal Technical Requirement		97.56%	95%		95%	91%-94%	90%

MSHN FY22 - Provider Network Management Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2022	Target Value	Performance Level	Target Ranges		
Better Provider Systems								
	Provider Directory will encorprate ADA, tag lines and cultural compentency requirements by September 2022.	HSAG Recommendations	100%	100% of elements included		>95%	80-94%	<79%
	Implement and monitor recommendations from FY21 NAA	MDHHS Network Adequacy Requirements	100%	100% Recommendations Implemented		>95%	80-94%	<79%
	Determine feasibility of Independent Facilitation regional contract template and monitoring	Strategic Plan - Better Provider Systems	In Process	Feasiblity Analysis Complete		Complete	In Process	Not Started
	Develop crisis residential unit within region	Network Adequacy Assessment Recommendations	In Process	CRU available to Region		Complete	In Process	Not Started
	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN's processes and communications (SUD Network)	Deploy a survey tool to measure participating provider satisfaction and achieve 80% satisfaction with the effectiveness and efficiency of MSHN's processes and communications	79%	80%		>80%	70-79%	<70%
	Implement and support Provider Stabilization (SUD Only) programs (95% approval)	Strategic Plan - Better Provider Systems	100% for eligible applications	95%		>95%	80-94%	<79%
	Implement and support Provider recruitment, incentives and retention programs (Goal of $10m)	Strategic Plan - Better Provider Systems	5.48M	10m		>6m	3-6m	<3m
	Develop and implement Provider Incentives for FY23 (VBP, ER FU, Integration) - Coordination with Finance Council BSC	Strategic Plan - Better Provider Systems	0	2		2	1	0

MSHN FY22 - Clinical Leadership Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2022 (10/1/2021-06/30/2022) unless noted otherwise	Target Value	Performance Level	Target Ranges		
BETTER HEALTH								
	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular screening during the measurement year. (Rolling 12 months)	Aligns with strategic plan goal to establish clear criteria and practices that demonstrate improved primary care coordination and with Performance Measure Portfolio	38.4%	78.5% (2017 National data)		>=78.5%	54.4%-78.4%	<54.4%
	The percentage of CMHSP completed REMI-documented SUD screenings/referrals will increase regionwide over the previous measurement period.	Aligns with other joint performance metrics (FUA).	10.0%	Increase 10% over previous timeframe.		>=15%	7-14%	<7%
	ADHD medication follow up. This HEDIS measure reports the percentage of children newly prescribed ADHD medication who received at least three follow-up visits. (Rolling 12 months)	Aligns with strategic plan goal to establish clear criteria and practices that demonstrate improved primary care coordination and with Performance Measure Portfolio (Monthly)	Initiation: 54.15% ; C & M: 95.93%	Increase over FY 2018 (Initiation 72.86%; C & M 97.25%)		I:74% C&M: 99%	I:70% C&M:95%	I: 65% C&M: 91%
Better Care								
	MSHN's provider network will demonstrate 95% compliance with trauma-competent standard in the site review chart tool.	Aligns with strategic plan goal that region has a trauma competent culture of care.	100.00%	>95%		95-100%	90-94%	<90%
	MSHN's CMHSP partners will report completing at least one community education activity on fetal alcohol spectrum disorder (FASD) (Annual).	CLC recommendation.	25.00%	50%		>=50%	25-49%	0-24%
	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization. (FYTD)	The MDHHS requirement of 95% slot utilization or greater.	93.20%	95% or greater		95-100%	90-94%	<90%
	Behavior Treatment Plan standards met vs. standards assessed from the delegated managed care reviews. (Quarterly)	MDHHS Technical Requirement for Behavior Treatment Plans.	52.00%	95% or greater		95-100%	90-94%	<90%
	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Quarterly)	Monthly autism benefit reporting on timeliness.	89.00%	95%		95-100%	90-94%	<90%
BETTER VALUE								
	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	Aligns with strategic plan goal that MSHN and its CMHSP participants will explore clinical process standardization, especially in the areas of access, emergency services, pre-admission screening, crisis response and inpatient stay management and discharge planning.	I: 38.41%; E: 20.09%	Increase over FY 2019 (I: 38.85%; E: 19.21%)		increase over 2019	No change from 2019 levels	Below 2019 levels

MSHN FY22 - Clinical SUD - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2022	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	145 activities	144		>=144	<144 and >72	<=72
	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. -	MSHN currently has 25 MAT sites.	Increase contracted MAT locations by 5% over FY20 of 22locations (ie. 1-2 additional locations)		>5%	No change	<5%
BETTER CARE	Increase percentage of individuals moving from residential level(s) of care who transition to a lower level of care within timeline of initiation (14 days) and engagement (2 or more services within 30 days subsequent to initiation).	Aligns with best practices for assisting individuals to initiate services and engage in continuation of care.	Initiation: 61.89% Engagement: 35.59% (7-1-2021 thru 6-30-2022)	Increase over MSHN 2020 levels Initiation: 36.81% ; Engagement: 22.30%		Increase over 2020 levels	No change from 2020 levels	Drop below 2020 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: 88.96% Engagement: 53.95% (7-1-2021 thru 6-30-2022)	Increase over MSHN 2020 levels (I: 88.69%; E: 54.67%)		Increase over 2020 levels	No change from 2020 levels	Drop below 2020 levels
	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: 49.35% *** (7-1-2021 thru 6-30-2022)	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: 41.03% *** (7-1-2021 thru 6-30-2022)	Above Michigan 2020 levels; E: 12.5% (2016)		Increase over National levels	No change from National levels	Drop below National levels

MSHN FY22 Information Technology Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2022	Target Value	Performance Level	Target Ranges		
Better Value	Unique consumers submitted monthly	Contractual Reporting Oversight	97.1%	85%		86.0%	85.0%	84.0%
	Encounters submitted monthly	Contractual Reporting Oversight	86.2%	85%		86.0%	85.0%	84.0%
	BH-TEDS submitted monthly	Contractual Reporting Oversight	87.4%	85%		86.0%	85.0%	84.0%
	Percentage of encounters with BH-TEDS	Contractual Reporting Oversight	99.4%	95%		95.0%	94.0%	90.0%
Better Care								
	Integrate standardized assessment tools into REMI	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	2	2		3	2	1
Better Health								
	Increase use cases with MiHIN	Health Information Exchange, including expanded number of use cases with MiHIN, occurs with other healthcare providers to assure appropriate integration and coordination of care, eg. eConsent, MH ADT and SUD ADT submissions.	1	1		2	1	0
	Increase health information exchange/record sets	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.	3	2		3	2	1
Better Workforce								
	Managed Care Information Systems (REMI) Enhancements	Provider portal, Patient Portal, ASAM Continuum, CCBHC reporting, LOCUS data transfer, OHH process, etc.	3	4		3	2	1
	Improve data use and quality	MSHN FY22-23 Strategic Plan - Staff, Consumers, Providers, and Stakeholders and unenrolled population and Care Alerts.	62%	100%		75%	50%	25%
	Improve data availability	MSHN FY22-23 Strategic Plan - Staff, Consumers, Providers, and Stakeholders	70%	100%		75%	50%	25%

MSHN FY22 - Integrated Care - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2022	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.	MSHN Strategic Plan FY19-20; MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	26%	100%		>=28%	24%-27%	<=23%
	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.	MDHHS/PIHP Contracted, Integrated Health Performance Bonus Requirements	2	0		0	1	2
BETTER CARE	Percent of care coordination cases that were closed due to successful coordination.	MSHN Strategic Plan FY19-FY20, MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	100%	100%		>=50%	25%-49%	<25%
BETTER VALUE	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP	MSHN Strategic Plan FY19-FY20, MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	78%	100.0%		>=75%	50%-74%	<50%

MSHN FY22 - Finance Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2022	Target Value	Performance Level	Target Ranges		
BETTER VALUE	MSHN reserves (ISF)	MSHN WILL WORK WITH ITS CMHSPS AND BOARD OF DIRECTORS TO ESTABLISH A RESERVE'S TARGET SUFFICIENT TO MEET FISCAL RISK RELATED TO DELIVERY OF MEDICALLY NECESSARY SERVICES AND TO COVER ITS MDHHS CONTRACTUAL LIABILITY.	7.5%	7.5%		> 6%	≥ 5% and 6%	< 5%
	Regional Financial Audits indicate unqualified opinion	MSHN WILL REVIEW CMHSP FINANCIAL AUDITS AND COMPLIANCE EXAMINATIONS TO IDENTIFY SIGNIFICANT DEFICIENCIES THAT IMPACT THE REGION.	100.0%	100%		> 92%	< 92% and > 85%	≤ 85%
	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.	100.0%	100%		> 92%	< 92% and > 85%	≤ 85%
	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	73.0%	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
	Medical Loss Ratio is within CMS Guidelines	MSHN WILL MAINTAIN A FISCAL DASHBOARD TO REPORT FINANCE COUNCIL'S AGREED UPON METRICS.	94.49%	85%		≥ 90%	> 85% and < 90%	≤ 85%
	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.	100.0%	100%		<100%	> 100% and <105%	>105%
	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.	0	2		2	1	0

MSHN FY22 - Utilization Management Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2022	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 Strategic Plan FY19-FY20, MSHN UM Plan	97.00%	100%		96-100%	94-95%	<93%
	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth	MSHN Strategic Plan FY19-FY20	+10%	0% Decrease over FY20		1-10% Decrease	11-19% Decrease	20% or more Decrease
	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person centered plan	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan; MDHHS Site Review Findings 2019-2020	85.0%	100%		100%	90%-99%	<90%
	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 FY19-FY20, MSHN UM Plan; Measurement Portfolio NQF 1768	11.61%	<=15%		<=15%	16-25%	>25%
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	1.0%	<= 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 Preliminary Statement of Activities for the Period Ending September 30, 2022, 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 Preliminary Statement of Activities for the Period Ending September 30, 2022, as presented.

Mid-State Health Network
Preliminary Statement of Activities
As of September 30, 2022

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	
			FY22 Amended Bdgt #2		FY22 Amended Bdgt #2			
			100.00%					
1		Revenue:						
2		Grant and Other Funding	$ 935,000	156,909	935,000	(778,091)	16.78 %	1a
3		Medicaid Use of Carry Forward	$ 49,882,291	49,882,291	49,882,291	0	100.00%	1b
4		Medicaid Capitation	760,218,832	665,583,732	760,218,832	(94,635,100)	87.55%	1c
5		Local Contribution	2,345,532	2,345,532	2,345,532	0	100.00%	1d
6		Interest Income	20,000	61,019	20,000	41,019	305.10%	1e
7		Change in Market Value	0	(76,709)	0	(76,710)	0.00%	
8		Non Capitated Revenue	18,857,492	13,860,287	18,857,492	(4,997,205)	73.50%	1f
9		Total Revenue	832,259,147	731,813,061	832,259,147	(100,446,087)	87.93 %	
10		Expenses:						
11		PIHP Administration Expense:						
12		Compensation and Benefits	5,824,835	5,587,192	5,824,835	(237,644)	95.92 %	
13		Consulting Services	122,000	103,651	122,000	(18,349)	84.96 %	
14		Contracted Services	81,095	82,582	81,095	1,487	101.83 %	
15		Other Contractual Agreements	358,000	339,367	358,000	(18,634)	94.80 %	
16		Board Member Per Diems	14,140	13,370	14,140	(770)	94.55 %	
17		Meeting and Conference Expense	81,000	67,097	81,000	(13,903)	82.84 %	
18		Liability Insurance	35,636	35,636	35,636	0	100.00 %	
19		Facility Costs	146,931	147,963	146,931	1,032	100.70 %	
20		Supplies	250,750	235,720	250,750	(15,029)	94.01 %	
21		Depreciation	50,397	50,397	50,397	0	100.00 %	
22		Other Expenses	915,460	868,177	915,460	(47,283)	94.84 %	
23		Subtotal PIHP Administration Expenses	7,880,244	7,531,152	7,880,244	(349,093)	95.57 %	2a
24		CMHSP and Tax Expense:						
25		CMHSP Participant Agreements	669,475,247	643,010,663	669,475,247	(26,464,584)	96.05 %	1b,1c
26		SUD Provider Agreements	50,869,248	49,632,138	50,869,248	(1,237,110)	97.57 %	1c,1f
27		Benefits Stabilization	4,822,063	4,931,059	4,822,063	108,996	102.26 %	1b
28		Tax - Local Section 928	2,345,532	2,345,532	2,345,532	0	100.00 %	1d
29		Taxes- IPA/HRA	23,325,420	22,540,635	23,325,420	(784,784)	96.64 %	2b
30		Subtotal CMHSP and Tax Expenses	750,837,510	722,460,027	750,837,510	(28,377,482)	96.22 %	
31		Transfer to Internal Service Fund	0	1,802,400	0	1,802,400	100.00 %	2c
32		Total Expenses	758,717,754	731,793,579	758,717,754	(26,924,175)	96.45 %	
33		Excess of Revenues over Expenditures	$ 73,541,393	$ 19,482	$ 73,541,393			

Mid-State Health Network
Preliminary Statement of Net Position by Fund
As of September 30, 2022

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		37,686,831	0	37,686,831	1a
4	Chase MM Savings		61,840,263	0	61,840,263	
5	Savings ISF Account		0	38,860,380	38,860,380	1b
6	Savings PA2 Account		8,915,475	0	8,915,475	1c
7	Investment ISF Account		0	11,662,167	11,662,167	1b
8	Total Cash and Short-term Investments		$ 108,442,569	$ 50,522,547	$ 158,965,116	
9	**Accounts Receivable**					
10	Due from MDHHS		11,326,820	0	11,326,820	2a
11	Due from CMHSP Participants		49,325,206	0	49,325,206	2b
12	Due from CMHSP - Non-Service Related		14,700	0	14,700	2c
13	Due from Miscellaneous		198,587	0	198,587	2d
14	Due from Other Funds		0	1,802,400	1,802,400	2e
15	Total Accounts Receivable		60,865,313	1,802,400	62,667,713	
16	**Prepaid Expenses**					
17	Prepaid Expense Insurance		72,190	0	72,190	2f
18	Prepaid Expense Rent		4,529	0	4,529	2g
19	Prepaid Expense Other		158,863	0	158,863	2h
20	Total Prepaid Expenses		235,582	0	235,582	
21	**Fixed Assets**					
22	Fixed Assets - Computers		189,180	0	189,180	2i
23	Accumulated Depreciation - Computers		(189,180)	0	(189,180)	
24	Fixed Assets - Vehicles		251,983		251,983	
25	Accumulated Depreciation - Vehicles		(125,992)		(125,992)	
26	Lease Assets		201,680		201,680	2j
27	Accumulated Amortization - Lease Asset		(72,081)		(72,081)	
28	Total Fixed Assets, Net		255,590	0	255,590	
29	**Total Assets**		**$ 169,799,054**	**$ 52,324,947**	**$ 222,124,001**	
30						
31	**Liabilities and Net Position**					
32	Liabilities					
33	Accounts Payable		$ 14,338,634	$ 0	$ 14,338,634	1a
34	Current Obligations (Due To Partners)					
35	Due to State		68,779,919	0	68,779,919	3a
36	Other Payable		3,647,935	0	3,647,935	3b
37	Due to State HRA Accrual		4,115,804	0	4,115,804	1a, 3c
38	Due to State-IPA Tax		1,592,966	0	1,592,966	3d
39	Due to CMHSP Participants		8,653,344	0	8,653,344	3e
40	Due to other funds		1,802,400	0	1,802,400	3f
41	Accrued PR Expense Wages		78,589	0	78,589	3g
42	Accrued Benefits PTO Payable		388,589	0	388,589	3h
43	Accrued Benefits Other		53,151	0	53,151	3i
44	Total Current Obligations (Due To Partners)		89,112,697	0	89,112,697	
45	Lease Liability		130,521	0	130,521	2j
46	Deferred Revenue		60,661,588	0	60,661,588	1b 1c 2b 3b
47	Total Liabilities		164,243,440	0	164,243,440	
48	Net Position					
49	Unrestricted		5,555,614	0	5,555,614	3j
50	Restricted for Risk Management		0	52,324,947	52,324,947	1b
51	Total Net Position		5,555,614	52,324,947	57,880,561	
52	**Total Liabilities and Net Position**		**$ 169,799,054**	**$ 52,324,947**	**$ 222,124,001**	

Mid-State Health Network
Notes to Financial Statements
For the Twelve-Month Period Ended,
September 30, 2022

Please note: The Preliminary Statement of Net Position contains Fiscal Year (FY) 2022 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 MSHN's July 2022 Savings Estimates. CMHSP cost settlement activity is generally finalized during May following the fiscal year end.

Statement of Net Position:

1. Cash and Short-Term Investments
   a) The Cash Chase Checking and Chase Money Market Savings accounts is the cash available for operations. A portion of cash available for operations will be used to cover accounts payable and taxes.
   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. Please Note: The ISF investment statement has been expanded to show accrued interest and market value figures. The new format shows totals reconciled to figures reported on the Statement of Net Position.
   c) The Savings PA2 account holds PA2 funds and is also offset by the Deferred Revenue liability account.
2. Accounts Receivable
   a) Approximately 50% of the balance in Due from MDHHS represents an amount owed to MSHN for FY 2022 Performance Bonus Incentive Pool (PBIP) funds. In addition, another 36% fourth quarter HRA payments owed to MSHN. Lastly, the remaining amounts in this account stems from Block Grant and other various grants funds owed to MSHN.
   b) Due from CMHSP Participants reflects FY 2022 projected cost settlement activity.

CMHSP	Cost Settlement	Payments/Offsets	Total
CEI	27,605,662.60	-	27,605,662.60
Gratiot	493,792.21	-	493,792.21
The Right Door	2,350,472.51	-	2,350,472.51
Lifeways	416,942.04	-	416,942.04
Montcalm	1,270,674.08	-	1,270,674.08
Newaygo	113,375.17	-	113,375.17
Saginaw	15,590,299.94	-	15,590,299.94
Shiawassee	329,905.33	-	329,905.33
Tuscola	1,154,082.06	-	1,154,082.06
Total	**49,325,205.94**	**-**	**49,325,205.94**

   c) Due from CMHSP – "Non-Service Related" account balance reflects MSHN's performance of Supports Intensity Scale (SIS) assessment billed to two CMHs in the region.
   d) Approximately 37% of the balance in Due from Miscellaneous represents amounts owed from providers for Medicaid Event Verification (MEV) findings. The remaining amount (63%) represents advances made to Substance Use Disorder (SUD) providers to cover operations.

e) Due from other funds is the account used to manage anticipated ISF transfers. MSHN can retain up to 7.5 % 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.
f) Prepaid Insurance holds October 2022 fringe benefits paid in September as well as a payment for MSHN's FY 2023 liability and auto insurance.
g) Prepaid Expense Rent balance consists of security deposits for three MSHN office suites.
h) Approximately $77 k of Prepaid Expense Other is due for MSHN's statewide share of MCG parity software. The other significant portion of this account's balance relates to training paid for MSHN staff and SUD provider network staff.
i) Total Fixed Assets represents the value of MSHN's capital assets net of accumulated depreciation.
j) 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 $48.4 M and $19.1 M to MDHHS, respectively. The lapse amount indicates we have a fully funded ISF, and that savings will fall 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. Further, MSHN owes MDHHS an FY 2020 lapse amount totaling $1.2 M based on Compliance Examination adjustments.
b) This amount is related to SUD provider payment estimates and is needed to offset the timing of payments.
c) The HRA (Hospital Rate Adjustor) is a pass-through account for dollars sent from MDHHS to cover supplemental payments made to psychiatric hospitals. HRA payments are intended to incentivize hospitals to have available psychiatric beds 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 eligible.
e) Due to CMHSPs shows FY 2022 projected cost settlement amounts.

CMHSP	Cost Settlement	Payments/Offsets	Total
Bay	2,277,114.82	-	2,277,114.82
Central	5,093,432.62	-	5,093,432.62
Huron	1,282,796.39	-	1,282,796.39
Total	**8,653,343.83**	**-**	**8,653,343.83**

f) Due to Other Funds is the liability transaction related to Statement of Net Position item 2e.
g) Accrued payroll expense wages represent expense incurred in September and paid in October.
h) Accrued Benefits PTO (Paid Time Off) payable is the required liability account set up to reflect paid time off balances for employees.
i) Accrued Benefits Other represents retirement benefits expense incurred in September and paid in October.
j) The Unrestricted Net Position represents the difference between total assets, total liabilities, and the restricted for risk management figure.

Preliminary Statement of Activities – PLEASE NOTE – Based on discussion during the January 2022 Board of Directors Meeting, MSHN changed the percentage calculation (column F) in the report. Column B above row one, now displays the percent of budget relative to the months presented. Since this is a statement for September 2022, the budget calculation amount is 100% which is 12 divided by 12 months. Column F now calculates the actual revenue and expenses compared to the full year budget. Revenue accounts whose Column F percent is less than 100% translates to MSHN receiving less revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 100% means MSHN's spending is trending higher than expected.

1. Revenue
    a) This account tracks SIS revenue earned from CMHSPs, Veterans Navigator (VN) activity and other small grants. Actual revenue is lower because $771k of the budget stems from Certified Community Behavioral Health Centers (CCBHC) grants from MDHHS to cover non-Medicaid individuals. Typically, an accrual would be entered with an offsetting expense, but the entry did not occur prior to report production. The appropriate revenue amounts will be recorded in FYE 2022 financials. In addition, a small portion of the budget variance results from the VN position not being filled for entire fiscal year.
    b) Medicaid Use of Carry Forward represents FY 2021 savings. Medicaid savings is generated when prior year revenue exceeds expenses for the same period. A small portion of Medicaid Savings is sent to the CMHSPs as funding delegated for SUD activities which include access, prevention, and customer services. FY 2021 Medicaid Carry Forward must be used as the first revenue source for FY 2022.
    c) Medicaid Capitation – The account's variance results from an anticipated surplus of $51 M being moved to deferred revenue on the Preliminary Statement of Net Position. An additional $48M of the surplus will be lapsed to MDHHS (Please see Preliminary Statement of Net position 3a.). Medicaid Capitation dollars are disbursed to CMHSPs based on per eligible per month (PEPM) payment files 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 2022 amounts owed were nearly $800 k less than FY 2021.
    e) Interest income is earned from investments and changes in principle for investments purchased at discounts or premiums. The "change in market value" account records activity related to market fluctuations. Other amounts recorded in interest are those earned from the PA2 and General Savings accounts.
    f) This account tracks non-capitated revenue for SUD services which include Community Grant and PA2 funds. The variance may decrease over time however unspent PA2 dollars remain in the deferred revenue account and Block Grant is received based on actual expenses incurred and billed to MDHHS.
2. Expense
    a) Total PIHP Administration Expense is under budget. The line item with the largest dollar amount variance is Compensation and Benefits. Although the budget amount for this line item was reduced due to vacant positions, actual expense is still slightly lower.
    b) IPA/HRA actual tax expenses are lower than the budget amount. 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).

c) Transfer to ISF reconciles to the notes in the Preliminary Statement of Net Position (2e and 3f).

MID-STATE HEALTH NETWORK
SCHEDULE OF INTERNAL SERVICE FUND INVESTMENTS
As of September 30, 2022

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Change in market value	Chase Savings Interest	Interest - Accrued	Total Chase Balance
UNITED STATES TREASURY BILL	912796k57	8.2.21	8.3.21	7.14.22		2,998,706.25	3,000,000.00					
UNITED STATES TREASURY BILL	912796k57	8.2.21	8.3.21	7.14.22			(3,000,000.00)					
UNITED STATES TREASURY BILL	91282CDR9	1.19.22	1.20.22	12.1.23		1,992,391.23	1,994,555.63		(79,946.25)		3,750.00	
UNITED STATES TREASURY BILL	912796X53	7.8.22	7.11.22	6.15.23		9,740,570.83	9,740,570.83		3,236.77			
JP MORGAN INVESTMENTS							11,735,126.46		(76,709.48)		3,750.00	11,662,166.98
JP MORGAN CHASE SAVINGS							38,652,080.81	0.050%		208,299.09		38,860,379.90
							$ 50,387,207.27		$ (76,709.48)	$ 208,299.09	$ 3,750.00	$ 50,522,546.88

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 FY23 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 FY23 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2023 NEW AND RENEWING CONTRACTS
November 2022

CONTRACTING ENTITY	CMHSP SERVICE AREA	CONTRACT TERM	CURRENT FY23 CONTRACT AMOUNT	FY23 TOTAL CONTRACT AMOUNT	FY23 INCREASE/ (DECREASE)
PIHP/CMHSP MEDICAID SUBCONTRACTS					
CEI Community Mental Health Authority	Clubhouse Spenddown (MOU) - Clinton, Eaton & Ingham	10.1.22 - 9.30.23	-	**60,000**	**60,000**
Community Mental Health of Central Michigan	Clubhouse Spenddown (MOU) - Clare, Gladwin, Isabella, Mecosta, Midland, Osceola	10.1.22 - 9.30.23	-	**80,000**	**80,000**
LifeWays Community Mental Health Authority	Clubhouse Spenddown (MOU) - Jackson & Hillsdale	10.1.22 - 9.30.23	-	**18,000**	**18,000**
Montcalm Care Network	Clubhouse Spenddown (MOU) - Montcalm	10.1.22 - 9.30.23	-	**12,000**	**12,000**
			$ -	**$ 170,000**	**$ 170,000**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT SOR PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY23 SOR COST REIMBURSEMENT CONTRACT AMOUNT	TOTAL FY23 SOR COST REIMBURSEMENT CONTRACT AMOUNT	FY23 SOR INCREASE/ (DECREASE)
CONTRACTS LISTED IN THIS SECTION ARE ALL SOR GRANT FUNDED PROGRAMS					
Catholic Charities of Shiawassee & Genesee County	Coalition minigrant for OEND and harm reduction acitivites and supplies (Shiawassee)	10.1.22 - 9.30.23	-	**18,000**	**18,000**
CMH for CEI	GPRA (Ingham)	10.1.22 - 9.30.23	130,480	**135,430**	**4,950**
Eaton Regional Education Service Agency (RESA)	Coalition minigrant for OEND and harm reduction acitivites and supplies (Clinton, Eaton, Ingham)	10.1.22 - 9.30.23	-	**87,000**	**87,000**
Family Services & Children's Aid	Narcan Vending Machine - Px (Jackson)	10.1.22 - 9.30.23	-	**5,650**	**5,650**
First Ward Community Center	Coalition minigrant for OEND and harm reduction acitivites and supplies (Saginaw)	10.1.22 - 9.30.23	-	**33,000**	**33,000**
Gratiot County Child Advocacy Association	Coalition minigrant for OEND and harm reduction acitivites and supplies - Px (Gratiot)	10.1.22 - 9.30.23	-	**15,000**	**15,000**
Gratiot County Child Advocacy Association	Narcan Vending Machine - Px (Gratiot)	10.1.22 - 9.30.23	-	**6,000**	**6,000**
Huron County Health Dept.	Coalition minigrant for OEND and harm reduction acitivites and supplies (Huron)	10.1.22 - 9.30.23	-	**12,000**	**12,000**
Ionia Public Health Dept.	Coalition minigrant for OEND and harm reduction acitivites and supplies (Ionia)	10.1.22 - 9.30.23	6,000	**18,000**	**12,000**
Lifeways CMH	Coalition minigrant for OEND and harm reduction acitivites and supplies (Hillsdale)	10.1.22 - 9.30.23	-	**15,000**	**15,000**
List Psychological Services	Coalition minigrant for OEND and harm reduction acitivites and supplies (Tuscola)	10.1.22 - 9.30.23	-	**16,000**	**16,000**
McLaren Bay Region (Neighborhood Resource Center)	Coalition minigrant for OEND and harm reduction acitivites and supplies (Bay)	10.1.22 - 9.30.23	-	**26,000**	**26,000**
Mid-Michigan District Health Dept.	Coalition minigrant for OEND and harm reduction acitivites and supplies (Montcalm)	10.1.22 - 9.30.23	-	**18,000**	**18,000**
Mid-Michigan Recovery Services	Narcan Vending Machine - Px (Ingham)	10.1.22 - 9.30.23	-	**6,000**	**6,000**
Newaygo Regional Education Service Agency (RESA)	Coalition minigrant for OEND and harm reduction acitivites and supplies (Newaygo)	10.1.22 - 9.30.23	-	**15,000**	**15,000**
Recovery Pathways	GPRA	10.1.22 - 9.30.23	-	**4,680**	**4,680**
Samaritas	GPRA (Eaton)	10.1.22 - 9.30.23	-	**17,280**	**17,280**
Sterling Area Health Center	Coalition minigrant for OEND and harm reduction acitivites and supplies (Arenac)	10.1.22 - 9.30.23	-	**12,000**	**12,000**
Ten Sixteen Recovery Network	Coalition minigrant for OEND and harm reduction acitivites and supplies (Clare, Gladwin, Isabella, Mecosta, Osceola)	10.1.22 - 9.30.23	-	**75,000**	**75,000**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT SOR PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY23 SOR COST REIMBURSEMENT CONTRACT AMOUNT	TOTAL FY23 SOR COST REIMBURSEMENT CONTRACT AMOUNT	FY23 SOR INCREASE/ (DECREASE)
CONTRACTS LISTED IN THIS SECTION ARE ALL SOR GRANT FUNDED PROGRAMS					
The Legacy Center	Coalition minigrant for OEND and harm reduction acitivites and supplies (Midland)	10.1.22 - 9.30.23	-	**24,000**	**24,000**
W.A. Foote Memorial Hospital (dba Henry Ford Allegiance Health)	Coalition minigrant for OEND and harm reduction acitivites and supplies (Jackson)	10.1.22 - 9.30.23	-	**22,000**	**22,000**
			$ 136,480	**$ 581,040**	**$ 444,560**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY23 COST REIMBURSEMENT CONTRACT AMOUNT	FY23 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY23 INCREASE/ (DECREASE)
Arbor Circle	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	438,937	**443,437**	**4,500**
Arbor Circle	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	438,937	**447,502**	**8,565**
Boys & Girls Club of Great Lakes Bay Region	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	217,615	**226,504**	**8,889**
Catholic Charities Jackson, Lenawee & Hillsdale Counties	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	-	**4,500**	**4,500**
Catholic Charities of Jackson, Lenawee & Hillsdale Counties	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**3,880**	**3,880**
Catholic Charities of Shiawassee & Genesee County	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**18,276**	**18,276**
Catholic Charities of Shiawassee & Genesee County	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	138,416	**145,396**	**6,980**
CMH for CEI	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	780,480	**787,230**	**6,750**
CMH for CEI	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	780,480	**783,811**	**3,331**
Cristo Rey Counseling	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	206,228	**210,728**	**4,500**
Cristo Rey Counseling Services	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	206,228	**214,876**	**8,648**
DOT Caring	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	-	**4,500**	**4,500**
Eaton Regional Education Service Agency (RESA)	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	607,283	**613,223**	**5,940**
Eaton RESA	Funding DYTUR and Tobacco Coalition services (PA2; Eaton)	10.1.22 - 9.30.23	607,283	**617,153**	**9,870**
Family & Children's Service of Mid-Michigan	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	-	**2,250**	**2,250**
Family Services & Children's Aid	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	131,831	**136,331**	**4,500**
Family Services & Children's Aid	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	131,831	**167,136**	**35,305**
First Ward Community Center	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	276,428	**282,325**	**5,897**
Gratiot County Child Advocacy Association	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	183,329	**194,873**	**11,544**
Home of New Vision	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	375,000	**377,490**	**2,490**
Huron County Health Dept.	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	179,970	**183,613**	**3,643**
Ingham County, on behalf of the Ingham County Health Department	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	104,311	**106,038**	**1,727**
Ionia Public Health Dept.	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	152,701	**154,548**	**1,847**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY23 COST REIMBURSEMENT CONTRACT AMOUNT	FY23 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY23 INCREASE/ (DECREASE)
Lifeways CMH	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	-	**4,500**	**4,500**
Lifeways CMH	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	90,289	**92,589**	**2,300**
LIST Psychological	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	-	**2,250**	**2,250**
List Psychological Services	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**51,211**	**51,211**
McCullough Vargas & Associates	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	-	**2,250**	**2,250**
McLaren Bay Region (Neighborhood Resource Center)	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	125,758	**127,746**	**1,988**
Michigan Therapeutic Consultants	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**2,510**	**2,510**
Mid-Michigan District Health Department	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	269,605	**270,654**	**1,049**
Mid-Michigan Recovery Services	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	152,729	**157,229**	**4,500**
Mid-Michigan Recovery Services (f.k.a.NCALRA)	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	152,729	**154,729**	**2,000**
Peer360	Recovery Community Organization (ARPA)	10.1.22 - 9.30.23	913,450	**921,950**	**8,500**
Pinnacle Recovery Services	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**13,100**	**13,100**
Prevention Network	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	20,689	**22,327**	**1,638**
Randy's House	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**16,694**	**16,694**
Recovery Pathways	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	221,858	**228,608**	**6,750**
Recovery Pathways	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	221,858	**226,742**	**4,884**
Sacred Heart Rehabilitation	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	-	**4,500**	**4,500**
Sacred Heart Rehabilitation	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**8,457**	**8,457**
Saginaw Odyssey House	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	-	**4,500**	**4,500**
Saginaw Odyssey House, Inc.	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**10,940**	**10,940**
Saginaw Psychological	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	39,600	**46,350**	**6,750**
Saginaw Psychological Services	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	39,600	**59,497**	**19,897**
Samaritas	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	10,313	**14,813**	**4,500**
Samaritas	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	10,313	**19,253**	**8,940**
Sterling Area Health Center	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	144,011	**149,940**	**5,929**
Ten Sixteen Recovery Network	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	629,225	**666,125**	**36,900**
Ten16 Recovery Network	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	629,225	**638,225**	**9,000**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY23 COST REIMBURSEMENT CONTRACT AMOUNT	FY23 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY23 INCREASE/ (DECREASE)
The Legacy Center	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	155,335	**156,926**	**1,591**
Victory Clinical Services - Lansing	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	-	**9,000**	**9,000**
Victory Clinical Services III - Jackson	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	-	**4,500**	**4,500**
Victory Clinical Services III - Jackson	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**7,349**	**7,349**
Victory Clinical Services IV - Saginaw	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	24,750	**36,000**	**11,250**
Victory Clinical Services IV - Saginaw	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**7,349**	**7,349**
Victory Clinical Services Lansing	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**6,899**	**6,899**
WAI-IAM (Rise Transitional Housing)	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	-	**18,248**	**18,248**
Wedgwood Christian Services	EMDR Training Reimbursement (COVID-BG)	10.1.22 - 2.28.23	76,183	**80,683**	**4,500**
Wellness Inx	Telehealth Technology Improvements (COVID-BG)	10.1.22 - 3.1.23	299,980	**306,932**	**6,952**
			$ 10,184,788	**$ 10,677,194**	**$ 492,406**

MID-STATE HEALTH NETWORK
FISCAL YEAR 2022 NEW AND RENEWING CONTRACTS
November 2022

CONTRACTING ENTITY	CMHSP SERVICE AREA	CONTRACT TERM	CURRENT FY22 CONTRACT AMOUNT	FY22 TOTAL CONTRACT AMOUNT	FY22 INCREASE/ (DECREASE)
PIHP/CMHSP MEDICAID SUBCONTRACTS					
CEI Community Mental Health Authority	Clinton, Eaton & Ingham				
CCBHC GF Amendment (FY22)		**10.1.21 - 9.30.22**	-	**893,343**	**893,343**
The Right Door for Hope, Recovery & Wellness	Ionia				
CCBHC GF Amendment (FY22)		**10.1.21 - 9.30.22**	-	**262,985**	**262,985**
Saginaw County Community Mental Health Authority	Saginaw				
CCBHC GF Amendment (FY22)		**10.1.21 - 9.30.22**	-	**31,014**	**31,014**
			$ -	**$ 1,187,342**	**$ 1,187,342**

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, September 13, 2022
Okemos Conference 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 5:22 p.m. following the Public Hearing on the FY 23 budget.

2. Roll Call

Secretary Kurt Peasley provided the roll call for Board Members in attendance.

Board Member(s) Present: Brad Bohner (LifeWays), Bruce Cadwallender (Shiawassee), Ken DeLaat (Newaygo), David Griesing (Tuscola), Dan Grimshaw (Tuscola), John Johansen (Montcalm), Jeanne Ladd (Shiawassee), Pat McFarland (Bay-Arenac), Ken Mitchell (CEI), Gretchen Nyland (Ionia), Irene O'Boyle (Gratiot), Kurt Peasley (Montcalm), Tracey Raquepaw (Saginaw), Tom Ryder (Bay-Arenac), Kerin Scanlon (CMH for Central Michigan), Richard Swartzendruber (Huron), Susan Twing (Newaygo), Beverly Wiltse (Huron), and Ed Woods (LifeWays)

Board Member(s) Remote: Tina Hicks (Gratiot) and Deb McPeek-McFadden (Ionia)- joined at 5:28 p.m.

Board Member(s) Absent: Joe Brehler (CEI), Mike Cierzniewski (Saginaw), and Joe Phillips (CMH for Central Michigan)

Staff Member(s) Present: Joseph Sedlock (Chief Executive Officer), Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Sherry Kletke (Executive Assistant), and Dalontrius McDaniel (HCBS Waiver Coordinator)

Staff Member(s) Remote: None

Members of Public Remote: Bryan Krogman (CEO-CMHCM)

3. Approval of Agenda for September 13, 2022

Board approval was requested for the Agenda of the September 13, 2022, Regular Business Meeting.

MOTION BY JEANNE LADD, SUPPORTED BY DAVID GRIESING, FOR APPROVAL OF THE AGENDA OF THE SEPTEMBER 13, 2022, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 19-0.

4. Public Comment

An opportunity for public comment was provided. There was no public comment.

5. Chief Executive Officer's Report

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

- PIHP/Regional Matters
  - MDHHS SUD Treatment Department name change from Office of Recovery Oriented Systems of Care to the Bureau of Substance Use, Gambling and Epidemiology (SUGE)
  - COVID-19 MSHN internal operations status including finalization of the MSHN post-pandemic operations plan
  - Regional Provider Staffing Crisis Stabilization Update
  - Direct Care Worker (DCW) Premium Pay Continuation
  - MSHN Regional Provider Network Stabilization Plan
  - MSHN Formal Request for Information
  - MDHHS Directs and Funds New PIHP-Level Complex Care Manager Position
  - MDHHS/MSHN Contract Change Notice
- State of Michigan/Statewide Activities
  - Opioid Health Home Coming to the MSHN region
  - Behavioral Health Home Coming to the MSHN region

6. Regional Provider Staffing Crisis Stabilization Program-Proposal for Continuation of Initiative Initially MSHN Board-Approved in March 2022

MOTION BY KURT PEASLEY, SUPPORTED BY JOHN JOHANSEN, TO DESIGNATE UP TO $5 MILLION (FIVE MILLION DOLLARS) OF FY23 MSHN RESOURCES FOR THE PURPOSE OF STABILIZING AND ASSISTING ELIGIBLE PROVIDER ORGANIZATIONS CONTRACTED WITHIN THE REGION IN ADDRESSING WORKFORCE/STAFFING CRISES PURSUANT TO REGIONAL GUIDELINES ESTABLISHED BY MSHN, THROUGH, MARCH 31, 2023, AS PRESENTED. MOTION CARRIED: 19-0.

7. Deputy Director's Report

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

- MSHN Staffing Update- Dalontrius McDaniel was hired on June 20, 2022 as a HCBS Waiver Coordinator and was introduced to the MSHN Board. Brie Elsasser has been hired as the State Plan Coordinator to support the 1915(i) waivers and will join the MSHN team on September 19, 2022. Katy Hammack accepted the transfer to the Integrated Healthcare Coordinator position effective September 5. 2022. This position was created to support healthcare coordination initiatives associated with Opioid Health Homes (OHHs), Behavioral Health Homes (BHHs) and Certified Community Behavioral Health Centers (CCBHCs).
- Health Services Advisory Group (HSAG) External Quality Review
- MDHHS Site Review
- Utilization Management Department Update

Mr. Ed Woods expressed appreciation for MSHNs support to the CMHSPs in the region during the quality and site reviews.

8. Chief Financial Officer's Report

A. Consideration of MSHN Fiscal Year 2022 Budget Amendment

Ms. Leslie Thomas provided an overview and information on the Fiscal Year 2022 Budget Amendment Two and recommended board approval as presented.

MOTION BY KURT PEASLEY, SUPPORTED BY DAN GRIMSHAW, FOR APPROVAL OF THE MSHN FISCAL YEAR 2022 BUDGET AMENDMENT TWO, AS PRESENTED. MOTION CARRIED: 19-0.

B. Consideration of MSHN Regional Budget for Fiscal Year 2023

Board approval was requested for the MSHN Fiscal Year 2023 Budget as presented during the Public Hearing.

MOTION BY DAVID GRIESING, SUPPORTED BY BEV WILTSE, FOR APPROVAL OF THE MSHN FISCAL YEAR 2023 BUDGET, AS PRESENTED DURING THE PUBLIC HEARING. MOTION CARRIED: 19-0.

C. Financial Statements Review for Period Ended July 31, 2022

Ms. Leslie Thomas provided an overview of the financial reports included within board meeting packets for the period ended July 31, 2022.

MOTION BY TRACEY RAQUEPAW, SUPPORTED BY KURT PEASLEY, TO RECEIVE AND FILE THE STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDING JULY 31, 2022, AS PRESENTED. MOTION CARRIED: 19-0.

9. Contracts for Consideration/Approval

A. FY22 Contract Listing for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2022 contract listing provided in the meeting packet. Ms. Thomas noted an error in the start dates listed in some contracts (listed as 10/01/2022 and should have been 10/01/2021) and requested the board authorize MSHN's CEO to sign and fully execute the contracts listed on the FY2022 contract listing.

MOTION BY BRAD BOHNER, SUPPORTED BY GRETCHEN NYLAND, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY22 CONTRACT LISTING. MOTION CARRIED: 19-0.

B. FY23 Contract Listing for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2023 contract listing provided in the meeting packet and requested the board authorize MSHN's CEO to sign and fully execute the contracts listed on the FY2023 contract listing.

MOTION BY RICH SWARTZENDRUBER, SUPPORTED BY DAVID GRIESING, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY23 CONTRACT LISTING. MOTION CARRIED: 19-0.

10. Executive Committee Report

Mr. Ed Woods provided an overview from the August 2022 Executive Committee meeting, highlighting the following:

- The annual CEO performance review process will formally begin at the next Board of Directors meeting in November. Ms. Irene O'Boyle will serve as the Evaluation Chair.
- Executive Committee Meeting calendar for FY2023 with consensus approval to meet every other month in the even numbered months opposite the months of the Board of Directors meetings.
- MSHN Leadership will participate in a two-day planning session to address critical internal issues and planning for the upcoming fiscal year. A portion of the meeting will be conducted by an external facilitator.
- DEI Workgroup
- Post-Covid operations

11. Chairpersons Report

Mr. Ed Woods asked members to review the FY2023 meeting calendar, highlighting upcoming meetings are scheduled at different locations than where recent meetings

have taken place. If anyone has questions or requires accommodations, please reach out to Ms. Sherry Kletke.

12. Fiscal Year 2023 Board Meeting Calendar

Board approval was requested for the Fiscal Year 2023 Board Meeting Calendar as presented.

MOTION BY KURT PEASLEY, SUPPORTED BY JOHN JOHANSEN, TO ADOPT THE FISCAL YEAR 2023 MSHN BOARD OF DIRECTORS MEETING CALENDAR, AS PRESENTED. MOTION CARRIED: 19-0.

13. 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 JOHN JOHANSEN, SUPPORTED BY JEANNE LADD, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE JULY 5, 2022 BOARD OF DIRECTORS MEETING; RECEIVE SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD MINUTES OF JUNE 15, 2022; RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF AUGUST 19, 2022; RECEIVE POLICY COMMITTEE MINUTES OF AUGUST 2, 2022; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF JULY 18, 2022 AND AUGUST 15, 2022; AND TO APPROVE ALL OF THE FOLLOWING POLICIES: PROCUREMENT; APPOINTED COUNCILS, COMMITTEES AND WORKGROUPS; BOARD GOVERNANCE; BOARD MEMBER CONDUCT AND MEETINGS; BOARD MEMBER DEVELOPMENT; BY-LAWS; CMHSP APPLICATION; CONFLICT OF INTEREST; CONSENT AGENDA; DELEGATION CEO; FOIA; GENERAL MANAGEMENT; LEGLISLATIVE AND PUBLIC BODY ADVOCACY; MONITORING CEO PERFORMANCE; NEW BOARD MEMBER ORIENTATION; OFFICE CLOSURE POLICY; POLICY AND PROCEDURE DEVELOPMENT AND APPROVAL; POPULATION HELATH INTEGRATED CARE; SUD DIRECT SERVICE PROCUREMENT. MOTION CARRIED: 19-0.

14. Other Business

A newer board member expressed his appreciation for all everyone is doing and is grateful that when someone has a question, other members and/or MSHN staff have the answers.

A board member commented the staff at MSHN makes being a board member way easier than other boards participated in.

15. Public Comment

There was no public comment.

16. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 6:21 p.m.

Mid-State Health Network (MSHN) Board of Directors Public Hearing

Tuesday, September 13, 2022

Okemos Conference Center

Meeting Minutes

1. **Call to Order**

   Chairperson Ed Woods called this Public Hearing meeting of the Mid-State Health Network Board of Directors to order at 5:02 pm. Mr. Ed Woods introduced new board members, Richard Swartzendruber and Beverly Wiltse from Huron Behavioral Health and gave them a warm welcome.

2. **Roll Call**

   Secretary Kurt Peasley provided the roll call for Board Members in attendance.

Board Member(s) Present: Brad Bohner (LifeWays), Bruce Cadwallender (Shiawassee), Ken DeLaat (Newaygo), David Griesing (Tuscola)-arrived at 5:04 p.m., Dan Grimshaw (Tuscola), John Johansen (Montcalm), Jeanne Ladd (Shiawassee)-arrived at 5:04 p.m., Pat McFarland (Bay-Arenac), Ken Mitchell (CEI), Gretchen Nyland (Ionia), Irene O'Boyle (Gratiot), Kurt Peasley (Montcalm), Tracey Raquepaw (Saginaw), Tom Ryder (Bay-Arenac), Kerin Scanlon (CMH for Central Michigan)-arrived at 5:11 p.m., Richard Swartzendruber (Huron), Susan Twing (Newaygo), Beverly Wiltse (Huron), and Ed Woods (LifeWays)

Board Member(s) Remote: Tina Hicks (Gratiot)

Board Member(s) Absent: Joe Brehler (CEI), Mike Cierzniewski (Saginaw), Deb McPeek-McFadden (Ionia), and Joe Phillips (CMH for Central Michigan)

Staff Member(s) Present: Joseph Sedlock (Chief Executive Officer), Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Sherry Kletke (Executive Assistant), and Dalontrius McDaniel (HCBS Waiver Coordinator)

Staff Member(s) Remote: None

Members of Public Remote: Bryan Krogman (CEO-CMHCM)

3. Approval of Agenda for September 13, 2022

Board approval was requested for the Agenda of the September 13, 2022, Public Hearing.

MOTION BY KEN MITCHELL SUPPORTED BY JOHN JOHANSEN FOR APPROVAL OF THE AGENDA OF THE SEPTEMBER 13, 2022, PUBLIC HEARING, AS PRESENTED. MOTION CARRIED: 16-0.

4. Fiscal Year 2023 Budget Presentation

Ms. Leslie Thomas presented the FY2023 MSHN Regional Budget as distributed at the time of the meeting and answered questions posed by board members.

5. Public Comment

Mr. Ed Woods read a letter written by CEO, Christopher Pinter from Bay-Arenac Behavioral Health, in support of the MSHN Fy2023 budget proposal.

6. Board Comment

There was no board comment.

7. Adjournment

MOTION BY TRACEY RAQUEPAW, SUPPORTED BY KEN MITCHELL TO ADJOURN THE MSHN PUBLIC HEARING. MOTION CARRIED: 19-0.

The MSHN Public Hearing adjourned at 5:20 p.m.

Mid-State Health Network SUD Oversight Policy Advisory Board
Wednesday, August 17, 2022, 4:00 p.m.
CMH Association of Michigan (CMHAM)

Meeting Minutes

1. Call to Order

Chairperson John Hunter called the MSHN SUD Regional Oversight Policy Board (OPB) of Directors Organizational Meeting to order at 4:00 p.m.

Board Member(s) Present: Lisa Ashley (Gladwin) – arrived at 4:10 p.m., Sandra Bristol (Clare), Bruce Caswell (Hillsdale), John Hunter (Tuscola), Bryan Kolk (Newaygo), Jim Moreno (Isabella), Vicky Schultz (Shiawassee), Deb Thalison (Ionia), Kim Thalison (Eaton), Ed Woods (Jackson)

Board Member(s) Remote: Nichole Badour (Gratiot), Robert Luce (Arenac)

Board Member(s) Absent: Steve Glaser (Midland), Christina Harrington (Saginaw), Joe Murphy (Huron), Scott Painter (Montcalm), Jerrilynn Strong (Mecosta), Todd Tennis (Ingham), David Turner (Osceola)

Alternate Members Present: Linda Howard (Mecosta)

Staff Members Present: Amanda Ittner (Deputy Director), Sherry Kletke (Executive Assistant), Dr. Dani Meier (Chief Clinical Officer), Leslie Thomas (Chief Financial Officer)

Staff Members Remote: Joseph Sedlock (Chief Executive Officer), Sarah Andreotti (Lead Prevention Specialist), Sarah Surna (Prevention Specialist), Kari Gulvas (Prevention Specialist), Dr. Trisha Thrush (Director of SUD Services and Operations)

2. Roll Call

Secretary Bruce Caswell provided the Roll Call for Board Attendance and informed the Board Chair, John Hunter, that a quorum was not present for Board meeting business. With the arrival of an eleventh OPB member at 4:10 p.m. a quorum was established, and business could be conducted as follows.

3. Approval of Agenda for August 17, 2022

Board approval was requested for the Agenda of the August 17, 2022 Regular Business Meeting, as presented.

MOTION BY BRYAN KOLK, SUPPORTED BY JIM MORENO, FOR APPROVAL OF THE AUGUST 17, 2022 REGULAR BUSINESS MEETING AGENDA, AS PRESENTED. MOTION CARRIED: 11-0.

4. Approval of Minutes from the June 15, 2022 Regular Business Meetings

Board approval was requested for the draft meeting minutes of the June 15, 2022 Regular Business Meeting.

MOTION BY BRUCE CASWELL, SUPPORTED BY VICKY SCHULTZ, FOR APPROVAL OF THE MINUTES OF THE JUNE 15, 2022 MEETING, AS PRESENTED. MOTION CARRIED: 11-0.

5. Public Comment

There was no public comment.

6. Board Chair Report

Mr. John Hunter informed board members of the upcoming Annual Substance Use and Co-Occurring Disorders Conference scheduled for September 18th – 20th. Ms. Sherry Kletke will email the conference details to the members tomorrow, Thursday August 18, 2022. MSHN will sponsor members interested in attending. The reduced, early bird, rate expires on August 27, 2022, so if members are interested in the conference, please contact Sherry Kletke preferably prior to that date.

Board approval was requested for the FY2023 Board calendar, as presented. Mr. Hunter asked members to note the location change for the upcoming meetings to Community Mental Health Association of Michigan's new address at 507 S. Grand Ave in downtown Lansing.

MOTION BY BRUCE CASWELL, SUPPORTED BY BRYAN KOLK, FOR APPROVAL OF THE FY2023 BOARD CALENDAR, AS PRESENTED. MOTION CARRIED: 11-0.

7. Deputy Director Report

Ms. Amanda Ittner provided an overview of the written report included in the board meeting packet, and available on the MSHN website, highlighting:

- Open Meetings Act – There has been no further updates. MSHN continues to await finalization.
- COVID Update-The Federal Government has indicated they will give states 60 days' notice prior to formally ending the Public Health Emergency (PHE). Therefore, the current PHE notice to Michigan needed to occur by August 14, 2022, which didn't occur. MSHN assumes

that means the PHE will be extended another 90 days, pushing it into January 2023. MDHHS has authorized Direct Care Worker Premium Payments to continue through FY23.

- Opioid Health Home – MSHN will implement a pilot program to begin on October 1, 2022 working with Victory Clinical Services that participated in a separate pilot program through another region. An Opioid Health Home is a model of care that provides comprehensive care management and coordination services to Medicaid beneficiaries with an Opioid Use Disorder (OUD).

- Provider Network Adequacy Assessment (NAA) – MDHHS developed parameters for PIHPs to ensure compliance with CFR requirements that includes time and distance standards. After a review of the results, one recommendation MSHN developed is to conduct provider expansion feasibility analysis for SUD residential and withdrawal management services.

- Health Services Advisory Group (HSAG) External Quality Review – HSAG finalized the review of MSHN in July. The results of the review should be available by October 2022. The full report will be shared with the board once available.

- Recovery Housing Supplemental Payment – After analysis and tracking of FY22 expenses, MSHN projects to spend less than our Block Grant allocations and has announced recovery housing providers were eligible for provider stabilization. One payment was distributed in July and anticipate another payment in August.

Board Members expressed interest in understanding more about the services offered through the Opioid Health Homes (OHHs). Ms. Sherry Kletke will distribute more information about services provided through OHHs.

8. Chief Financial Officer Report

Ms. Leslie Thomas provided an overview of the financial reports included in board meeting packets:

- FY2022 PA2 Funding and Expenditures by County
- FY2022 PA2 Use of Funds by County and Provider
- FY2022 Substance Use Disorder (SUD) Financial Summary Report as of June 2022

Board Members raised the question regarding available funds from the taxation on recreational marijuana. MSHN will distribute information regarding the Michigan Regulation and Taxation of Marijuana Act distributed to Michigan municipalities and counties.

9. FY23 Substance Use Disorder PA2 Contract Listing

BOARD APPROVED OCTOBER 19, 2022

Ms. Leslie Thomas provided an overview and information on the FY23 Substance Use Disorder (SUD) PA2 Contract Listing as provided in the packet.

MOTION BY JIM MORENO, SUPPORTED BY BRYAN KOLK, FOR APPROVAL OF THE FY2023 SUBSTANCE USE DISORDER (SUD) PA2 CONTRACT LISTING, AS PRESENTED. MOTION CARRIED: 8-0; 3 abstained.

10. SUD Operating Update

Dr. Dani Meier provided an overview of the written SUD Operations Report as included in the board meeting packet, highlighting:

- Synar – formal checks to make sure youth are not accessing tobacco products. The FY21 sales rate was over 20%. This year, FY22 was only 8.11% which is a huge improvement.
- MSHN scored 100% compliance on the MDHHS SUD Site review performed on 7/29/22.
- After continuous evaluation of capacity, network adequacy and gaps in service, MSHNs SUD Treatment team has issued an RFI for Montcalm and other underserved counties.
- Mobile Care Unit (MCU) was deployed in 2019. Multiple models have been implemented on the unit, hoping to serve the rural, underserved areas. Utilization rates have remained low despite multiple efforts to increase services. Therefore, MSHN has requested of MDHHS and been approved to re-deploy the MCU to provide Harm Reduction Services beginning in FY23.
- MSHNs Veteran Navigator assisted a local veteran to behavioral health resources after expressing suicidal thoughts. Using Mental Health First Aid to assess the situation, the Veteran Navigator connected the person to care.

11. Other Business

Ms. Amanda Ittner reminded members that have not completed the annual disclosure of ownership, controlling interest and criminal convictions form to complete the form located in their member folder. If the form isn't found in a member folder, that means MSHN has received their completed form. For those members participating by phone and MSHN doesn't have the completed form or complete information, Ms. Sherry Kletke will be reaching out to those members.

12. Public Comment

There was no public comment.

13. Board Member Comment

Each Board member gave comments on items of importance to them and initiatives in their respective counties.

Appreciation was expressed to Ms. Sherry Kletke for all her work in supporting the Oversight Policy Board.

14. Adjournment

Chairperson John Hunter adjourned the MSHN SUD Oversight Policy Advisory Board Meeting at 5:19 p.m.

Meeting minutes submitted respectfully by:
MSHN Executive Assistant

BOARD APPROVED OCTOBER 19, 2022

MSHN
Mid-State Health Network

Mid-State Health Network Board of Directors
Executive Committee Meeting Agenda
Friday, October 21, 2022 - 9:00 a.m.

Members Present: Ed Woods, Chairperson; Irene O'Boyle, Vice Chairperson; Kurt Peasley, Secretary; Pat McFarland, Member at Large; David Griesing, Member at Large

Others Present: Ken DeLaat

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

1. **Call to order:** Chairperson Woods called this meeting of the MSHN Board Executive Committee to order at 9:00 a.m.

2. **Approval of Agenda**: Motion by K. Peasley supported by D. Griesing to approve the agenda for the October 21, 2022, meeting of the MSHN Executive Committee. Motion carried.

3. **Guest Board Member Comments**: K. DeLaat emailed J. Sedlock an article from New York Times and appreciated his response.

4. **Board Matters**
   - 4.1 November 2022 Draft Board Meeting Agenda: J. Sedlock summarized board meeting matters, including presentation of the MSHN External Compliance Examination and MSHN Compliance Plan Updates. The Executive Committee reviewed the draft agenda presented, noting the agenda may have further adjustments as the meting packet is prepared. Masking is required to enter the hospital.
   - 4.2 Update: Annual CEO performance review (if any): Ms. O'Boyle reported that Mr. Sedlock provided a list of candidates to be contacted for the "360" portion of his performance review, from which Ms. O'Boyle selected those to receive the survey. 360 survey distribution has begun, noting the process is on schedule. Board members will receive a link to complete the evaluation shortly after the board meeting. Ms. O'Boyle reported that Mr. Sedlock is not connected to this process in any way.
   - 4.3 Applicability of Board Approved Cost-of-Living increase to MSHN CEO: Mr. Sedlock presented a memorandum outlining Executive Committee and/or Board considerations on the general topic off whether board actions involving compensation adjustments to all-staff apply to his contractual position or whether they do not. Executive Committee requests that future motions prepared by MSHN administration are explicit as to whether proposed actions include or exclude the CEO. Executive Committee clarifies its intention that board approved cost of living increases apply to the CEO and future contractually specified compensation should adjust based on any interim board approved "all-staff" increases. The chairperson will ask for a motion to this effect at the November board meeting.
   - 4.4 Other (if any): None

5. **Administration Matters**
   - 5.1 MSHN Leadership Off-Site Planning Sessions – Follow-up: Mr. Sedlock reported that the MSHN Leadership Team had a very productive two-day planning session. Much of the focus was on improvements in the leadership team functioning based on staff and stakeholder feedback, agency functioning, culture, and dynamics, internal organizational structure to meet future demands and business requirements, focusing the agency's work on health disparities, diversity, equity and

inclusion. There will be monthly leadership development sessions to focus on addressing an/or resolving areas identified at this meeting and to build on the progress made.

5.2 MSHN All—Staff Meeting, Training, and Holiday Luncheon: J. Sedlock reported that the MSHN will hold its first in-person all-staff meeting since March 2020 on December 8. The event will include a MSHN-provided luncheon, a two-hour training, and a one-hour staff meeting.

5.3 MSHN Public Health Emergency Declaration and MSHN Post-Covid Operations Plans/Considerations: A. Ittner reported that the national public health emergency (PHE) was extended through January 2023 and that CMS will provide 60 days' advance notice to states that the public health emergency will end. MDHHS anticipates that the PHE will not be extended beyond January 2023. However, no notice has been received as of this meeting. MDHHS is circulating proposed post-public health emergency policies. Ms. Ittner reported that MSHN provided notice to MSHN personnel that its post-pandemic operations plan will go into effect on December 5, 2022, with in-office staff meetings beginning in January 2023. High-level details of the plan and phase-in were provided.

5.4 Other (if any): None

6. Other

6.1 Any other business to come before the Executive Committee: None; David Griesing will not be physically present at board meeting, but plans to call in.

6.2 Next scheduled Executive Committee Meeting: 12/16/2022 –The Committee can be called together if there is a need prior to the next Executive Committee meeting.

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

8. **Adjourn:** This meeting was adjourned at 9:29 a.m.

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, OCTOBER 4, 2022 (VIDEO CONFERENCE)

***Members Present**:* Irene O'Boyle, Kurt Peasley, John Johansen, Jeanne Ladd, David Griesing

Staff Present: Amanda Ittner (Deputy Director); Sherry Kletke (Executive Assistant)

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 Kurt Peasley, supported by Irene O'Boyle, to approve the October 4, 2022, Board Policy Committee Meeting Agenda, as presented. Motion Carried: 5-0.

3. **POLICIES UNDER DISCUSSION**

Ms. Irene O'Boyle expressed that the Autism Spectrum Disorder Benefit Policy appears more procedurally in nature, rather than policy, and requests that Administration review the policy to remove procedure language and present the revised policy at the next Policy Committee meeting.

MOTION by Irene O'Boyle, supported by David Griesing, to remove the Autism Spectrum Disorder Policy for further review to remove procedure language and to present at the next Policy Committee meeting. Motion carried: 5-0.

4. POLICIES UNDER BIENNIAL REVIEW

Mr. John Johansen invited members if there were any comments to the revisions made to the Service Delivery Chapter policies being presented under biennial review listed below. Ms. Irene O'Boyle requested the addition of two acronym definitions be added to the Home and Community Based Services Compliance Monitoring Policy under the definition section. Ms. Jeanne Ladd suggested an edit to the Autism Spectrum Disorder Benefit policy which has already been moved and supported to be removed for further review.

CHAPTER: SERVICE DELIVERY

1. AUTISM SPECTRUM DISORDER BENEFIT
2. BEHAVIORAL HEALTH RECOVERY ORIENTED SYSTEM OF CARE
3. CHILDREN'S HOME AND COMMUNITY BASED SERVICES WAIVER
4. COMMUNITY DEPENDENT LIVING PLACEMENT
5. CULTURAL COMPETENCY
6. EMERGENCY SERVICES POSTSTABILIZATION
7. EVIDENCE-BASED PRACTICES
8. HABILITATION SUPPORTS WAIVER
9. HOME AND COMMUNITY BASED SERVICES COMPLIANCE MONITORING

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

10. INDIAN HEALTH SERVICES/TRIBALLY-OPERATED FACILITY/URBAN INDIAN CLINIC SERVICES (I/T/U)
11. INPATIENT PSYCHIATRIC HOSPITALIZATION STANDARDS
12. OUT-OF-STATE PLACEMENTS
13. PERSON/FAMILY CENTERED PLAN OF SERVICE
14. SERIOUS EMOTIONAL DISTURBANCE WAIVER
15. SERVICE PHILOSOPHY & TREATMENT
16. STANDARDIZED ASSESSMENT
17. SUD SERVICES MEDICATION ASSISTANCE TREATMENT
18. SUD SERVICES OUT OF REGION COVERAGE
19. SUD SERVICES-WOMEN'S SPECIALTY SERVICES
20. SUPPORT INTENSITY SCALE
21. SUPPORTS INTENSITY SCALE QUALITY LEAD
22. TELEMEDICINE
23. TRAUMA INFORMED SYSTEMS OF CARE

MOTION by Irene O'Boyle, supported by Kurt Peasley, to approve and recommend the policies under biennial review as presented with the removal of the Autism Spectrum Disorder Benefit to be revised and presented at the next Policy Committee Meeting. Motion carried: 5-0.

5. NEW BUSINESS

There was no new business. Mr. John Johansen expressed appreciation to the new members and included a reminder to each member to respond with feedback by the requested due dates when the policies are distributed for review. Ms. Amanda Ittner stated that administration is always available to members if any questions arise about the policies presented.

6. ADJOURN

Mr. John Johansen adjourned the Board Policy Committee Meeting at 10:20 a.m.

Meeting Minutes respectfully submitted by:
MSHN Executive Support Specialist

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MSHN
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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 09/19/2022

Members Present: Lindsey Hull; Maribeth Leonard; Carol Mills; Sharon Beals; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; Bryan Krogman; Sandy Lindsey; Sara Lurie
Members Absent: Chris Pinter
MSHN Staff Present: Joseph Sedlock; Amanda Ittner; For applicable topics: Leslie Thomas and Kim Zimmerman

Agenda Item	Action Required				
CONSENT AGENDA	Item B: pg. 10 – item e-concerned about additional reporting for Autism on authorizations and encounters pg. 11 – Did the letters go out regarding non-response of providers on the HCBS survey. Pg 12 – Does MSHN know of any CSUs in development in our region? Joe is not aware of any development yet. Item K: 3rd QRT FUH Report - Sandy and Skye are the MSHN Contact Item L: In regards to the data charts in the IT Department report, what is the incoming and outgoing mean? MSHN will confirm and have Steve add descriptors, but we believe it is the incoming encounters to MSHN and the outgoing encounters to the State.				
	Consent items approved with the above discussion MSHN will add descriptors to the charts.	By Who	Amanda	By When	10.1.22
FY22 SAVINGS ESTIMATES THROUGH JULY, 2022	L. Thomas reviewed the FY22 Saving Estimates through July, 2022				
	Informational Only	By Who	N/A	By When	N/A
FY23 COMPLIANCE PLAN	K. Zimmerman reviewed the summary of recommended changes.				
	Operations Council reviewed and recommended to proceed with MSHN Board approval	By Who	K. Zimmerman	By When	November Board Meeting
BEHAVIORALHEALTH HOME BACKGROUND AND OVERVIEW	A. Ittner reviewed the BHH background and overview. The following CMHs indicated interest in participating. • Saginaw • Central • Newaygo				
	CMHSP participants interested in participating as a HH partner should respond via email to Amanda along with their point person.	By Who	CMHSPs	By When	10.1.22
REGIONAL COVID RELATED UPDATES/PLANNING (IF ANY)	CEI is seeing an increase in the COVID in the homes TBHS has the highest COVID positivity rate at this point since at any time during the pandemic.				

Agenda Item	Action Required				
	Discussion only	By Who	N/A	By When	N/A
SYSTEM REDESIGN-ONGOING DIALOG/DISCUSSION/REGIONAL STRATEGIES (IF ANY)	Nothing new at this point. Not anticipating any new legislation proposed until after the election.				
	Discussion only	By Who	N/A	By When	N/A
MSHN/CMHSP CONTRACT ATTACHMENT H	Discussed contract H being a template for reporting the 24/7 Access to MSHN related to the SUD allocation to CMHs for covering functions. MSHN has been utilizing this form for reporting related activities for the last couple of years.				
	Discussion only	By Who	N/A	By When	N/A
REGIONAL PROVIDER STABILIZATION ISSUES	Provider stabilization funds continue through September 2023. Guidance already includes extension through FY23.				
	Informational Only	By Who	N/A	By When	N/A
MSHN BOARD APPROVED STRATEGIES	MSHN Board approved the extension of the provider crisis staffing stabilization program through March 2023 in the amount of $5m and will re-evaluate in March. Discussion regarding operating the program in the same structure.				
	MSHN will publish revised guidance on the website for the crisis staffing stabilization program.	By Who	J. Sedlock	By When	10.1.22
STATE HOSPITALS ADMISSION/DISCHARGE LETTER FOLLOW UP	MDHHS has asked to meet regarding the regional letter MSHN sent in with our concerns. C. Mills has offered to participate in the meeting to give specific examples. Sandy also offered and has concerns with judicial admissions.				
	MSHN to meet with MDHHS and will coordinate with those CMHs wishing to participate	By Who	J. Sedlock	By When	10.1.22

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 10.17.2022

Members Present: Lindsey Hull; Sharon Beals; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; Sandy Lindsey
Members Absent: Maribeth Leonard; Carol Mills; Bryan Krogman; Chris Pinter; Sara Lurie
MSHN Staff Present: Joseph Sedlock; Amanda Ittner; For applicable items: Todd Lewicki

Agenda Item	Action Required				
CONSENT AGENDA	Item G. Joe Sedlock provided background on the DD Council request.				
	Sandy will email out information that she sent in response to questions received from the DD council on this topic.	By Who	S. Lindsey/J. Sedlock	By When	10.20.22
Operations Council Annual Report	J. Sedlock reviewed the Ops Council Annual Report and asked for feedback. Upcoming goals should be FY23.				
	Annual report will be included in the PIHP QAPIP	By Who	J. Sedlock	By When	10.31.22
1915(i) Workgroup Charter	T. Lewicki reviewed the intent of the 1915(i)-workgroup charter. MSHN has been receiving questions and recommending workgroup to clarify process, develop policy and prepare for October 2023 compliance. PIHP role will be similar to HSW, except there is no expected upload of documents. The workgroup is expected to convene at least a year until operational process running.				
	Operations Council supports the recommended workgroup. Todd has the list of 1915(i) attendees.	By Who	T. Lewicki	By When	
HSW Regional Slot Allocation	T. Lewicki reviewed the status of the current HSW slot allocation and that MSHN is under 95% utilization. The region is at risk of losing slots. MSHN has been working with CMHs to submit and review HSW applications. State is considering reviewing the allocation across the state, possibly next FY.				
	Informational Only	By Who	N/A	By When	N/A
Reschedule June 19, 2023 Operations Council Meeting (recommend June 12 – virtual meeting)	J. Sedlock asked for any objection to move this meeting. It is already scheduled as virtual and won't change. No objection.				
	MSHN will make the calendar adjustment	By Who	J. Sedlock	By When	12.1.22
Regional COVID related updates/planning (if any)	FPHE was extended another 90 days into January. The state indicated they don't expect another extension and therefor, the system should prepare for the PHE end.				
	Amanda will send out notice once the 60-day notice is received.	By Who	A. Ittner	By When	12.1.22

Agenda Item	Action Required				
System Redesign-ongoing dialog/discussion/regional strategies (if any)	Action alert came out from the association today regarding some discussion happening during lame duck session.				
	Discussion only	By Who	N/A	By When	N/A
WSA Import Proposal	Discussed the request from PCE regarding CCBHC data exchange from the WSA into PCE. A couple concerns noted: 1) MDHHS going directly to a vendor, 2) if other vendors were involved and 3) exchange from PCE to WSA would be valuable to the system. Amanda clarified with the state that Streamline is also involved and has this topic for discussion in the CCBHC meeting on Tuesday.				
	J. Sedlock will discuss 1) with PIHP Directors/MDHHS meeting.	By Who	J. Sedlock	By When	11.10.22
COLA	T. Warner discussed the increased cost of living and social security indicating 8.3%. Some boards have included a 4% COLA. Discussed if any CMHs use incentives being used as performance based. Timeliness, productivity, etc.				
		By Who		By When	

MSHN
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POLICIES AND PROCEDURES MANUAL

Chapter:	**Service Delivery System**		
Title:	**Behavioral Health Recovery Oriented System of Care**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** ~~Annually~~Biennial **Author:** SUD Workgroup and HITP Director	**Adopted Date: 1.06.2015** **Review Date:** 01.12.2021 ~~**Revision Eff. Date:**~~	**Related Policies:** Service Philosophy & Treatment

Purpose

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

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

Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Change Log:

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

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Children's Home and Community-Based Services Waiver (CWP) Policy**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** ~~Annually~~ Biennial **Author:** Waiver Coordinator	**Adopted Date:** **Review Date:** 11.10.2020	**Related Policies:**

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Purpose

This policy sets forth the guidelines and expectations for Mid-State Health Network's (MSHN) administration of the Children's Home and Community-Based Waiver Program (CWP).

Policy

A. MSHN shall administer the CWP program in accordance with the Prepaid Inpatient Health Plan (PIHP) contract and the Medicaid Provider Manual.

B. This program is designed to provide in-home services and support to Medicaid-eligible children with developmental disabilities, who would otherwise be at risk of out-of-home placement into an Immediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

C. CWP beneficiaries must be enrolled through the Michigan Department of Health and Human Services (MDHHS) enrollment process by the Prepaid Inpatient Health Plan (PIHP) designee. The enrollment process must include verification that the beneficiary meets all of the follow eligibility criteria:

   a. The child must have a developmental disability (as defined in Michigan state law), be less than 18 years of age, and in need of habilitation services.

   b. The child must reside with his birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.

   c. The child is at risk of being placed into an ICF/IID facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/IID facility but, with appropriate community support, could return home.

   d. The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).

   a. The child's intellectual or functional limitations indicate that he/she would be eligible for health, habilitative, and active treatment services provided at the ICF/IID level of care. Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-

determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

~~b. The child must meet the disability criteria for Social Security.~~

D. CWP beneficiaries must receive at least one of the following children's waiver services per month in order to retain eligibility. ~~Children's waiver services include the following:~~

a. Community Living Supports (CLS)
b. Enhanced Transportation
~~c. Environmental Accessibility Adaptations (EAAs)~~
~~d.~~c. Family Training
~~e.~~d. Non-Family Training
~~f. Fencing~~
~~g.~~e. Financial Management Services/Fiscal Intermediary Services
~~h.~~f. Respite Care
~~i. Specialized Medical Equipment and Supplies~~
~~j.~~g. Specialty Services (including Music, Art, Recreation, and Massage Therapies)
h. Overnight Health and Safety Support

E. Other CWP supports/services include:

a. Environmental Accessibility Adaptations (EAAs)
b. Fencing
~~k.~~c. Specialized Medical Equipment and Supplies

~~E.~~F. The beneficiary's services and supports must be specified in the individual's plan of services developed through the person-centered planning process that must be specific to:

a. Medical necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.
b. Amount: The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.
c. Scope: The parameters within which the service will be provided, including Who (e.g., professional, paraprofessional, aide supervised by a professional); How (e.g., face-to- face, telephone, group or individual); and Where (e.g., community setting, office, beneficiary's home).
d. Duration: The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.

~~F.~~G. MSHN shall establish adequate procedures to assure effective administration of the program across the region including:

~~a. Prescreen, Initial Application, and Eligibility~~
~~b. Annual Recertification~~
~~c. Disenrollment and Transfer~~
~~d.~~a. Prior Review and Approval Request (PRAR)
~~e. Specialized Medical Equipment and Supplies~~
~~f. Clinical Review Team~~

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

CWP: Children's Home and Community-Based Services Waiver Program
EAA: Environmental Accessibility Adaptations
MDHHS: Michigan Department of Health and Human Services
PIHP: Prepaid Inpatient Health Plan
PRAR: Prior Review and Approval Request
ICF/IID: Intermediate Care Facility for Individuals with Intellectual Disabilities – 42 CFR 435.1009 – an institution (or distinct part of an institution) that (a) is primarily for the diagnosis, treatment, or rehabilitation of people with developmental disabilities or persons with related conditions; and (b) provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.
Developmental Disability: means either of the following:

1. If applied to an individual older than 5 years, a severe, chronic condition that meets all of the following requirements:
    a. Is attributable to a mental or physical impairment or a combination of mental and physical impairments
    b. Is manifested before the individual is 22 years old
    c. Is likely to continue indefinitely
    d. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
        i. Self-care
        ii. Receptive and expressive language
        iii. Learning
        iv. Mobility
        v. Self-direction
        vi. Capacity for independent living
        vii. Economic self-sufficiency
    e. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
2. If applied to a minor, birth to age 5, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (1) if services are not provided.

Other Related Materials

N/A

References/Legal Authority

MDHHS – PIHP Contract;
MDHHS Medicaid Provider Manual: Section 14 – Children's Home and Community-Based

Services Waiver (CWP)

Change Log:

Date of Change	Description of Change	Responsible Party
07.2020	NEW Policy	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery		
Title:	~~Out-of-State Placements Procedure~~Community-Based Dependent Living Placement Policy		
Policy: ☐ ☒ Procedure: ~~☒~~ ☐ Page: 1 of 3	Review Cycle: ~~Annually~~Biennial Author: MSHN Chief Behavioral Health Officer~~Provider Network Management Committee~~	Adopted Date: 01.12.2021 Review Date: ~~09.2019~~07.2022	Related Policies: Service Delivery System ~~Out-Of-State Placement~~

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Purpose

This ~~procedure~~policy exists to provide process clarification ~~to~~and assure ongoing regional compliance with the ~~out- of state~~ community-based dependent living placement process stipulated by the Michigan Administrative Rules~~Mental Health Code~~ 330.1701-1704.~~.~~

~~Procedure~~Policy

MSHN and its Community Mental Health Service Program (CMHSP) Participants ~~The Placing Agency~~ shall comply with Michigan Administrative Rules for the placement of ~~A~~adults who have a Mental Illness or Intellectual Disability into community based dependent living settings.

1. The Placing Agency shall, in regard to an individual being considered for ~~out of state~~ dependent living placement, be responsible for~~determine~~ all of the following:
   i. Assess a recipient's need for placement into a dependent living setting.
   ii. Determine the type of dependent living setting required to meet the recipient's needs.
   ~~iii. Determine and document that the recipient's needs cannot be met by qualified Providers within the State of Michigan, or lack capacity to do so.~~
   ~~iv.~~iii. Develop the recipient's individual plan of service and supports ("treatment plan").
   ~~v.~~iv. Coordinate all necessary arrangements for the placement of the recipient into a dependent living setting.
   ~~vi.~~v. Monitor and evaluate the provision of services to the recipient.
   ~~vii.~~vi. Protect the rights of the recipient including informing recipient/guardian of how to file complaints against the licensee or placing agency.

2. ~~In addition, the~~ The Placing Agency shall not place a recipient in a ~~determine that the Out of State~~ dependent living setting unless all of the following criteria are met before placement: ~~meets the Provider requirements of both the MSHN and the State of Michigan by requiring the following:~~
   i. An individual plan of service has been developed for the recipient.
   ii. If a specialized program is called for in the recipient's individual plan of service, the dependent living setting is certified to provide the program.
   iii. The placing agency has made an onsite inspection, or obtained an inspection completed in the previous 12 months from another CMHSP. The placing agency has determined that the dependent living setting has sufficient resources to provide all the services that the dependent living setting is required to provide in the recipient's individual plan of service. In addition, an annual review should be completed onsite to ensure continued care and compliance with the treatment plan.
   iv. The consent of the recipient, or the recipient's guardian, has been obtained for the placement.
   v. The dependent living setting has written operating policies and procedures which are in place and enforced by the dependent living setting and which are in compliance with the laws of the State of Michigan. The dependent living setting agrees to make the operating policies and procedures available to the recipient, provide the information in alternative formats and provide assistance to the recipient with understanding the language used in the procedures, if needed.
   vi. The dependent living setting agrees to maintain and limit access to records that document the delivery of the services in the recipient's individual plan of service in accordance with all

applicable statutes, rules, and confidentiality provisions. The dependent living setting agrees to make recipient's record available to the recipient or their representative, provide the record in alternative format and assist the recipient with understanding the language used, if needed.

3. The Placing Agency is responsible for the development of the recipient's individual plan of service. An initial individual plan of service shall be provided upon placement and a comprehensive plan developed within 30 days. The individual plan of service shall consist of a treatment plan, a support plan, or both. The individual plan of service shall focus on the needs and preferences of the client and be developed by a planning team comprised of the following entities: ~~and be provided in accordance with the Michigan Medicaid Provider Manual.~~

   i. The recipient
   ii. Individuals of the recipient's choosing (friends, family, relatives, natural supports)
   iii. Professionals as needed or desired

If the client is not satisfied with his or her individual plan of service or modifications made to the plan, the client may object and request a review of the objection by the client services manager in charge of implementing the plan. The review shall be initiated within 5 working days of receipt of the objection. Resolution shall occur in a timely manner. If the client is not satisfied with the resolution, the client may notify his or her client services manager of the client's wish to appeal the resolution to the placing agency. The placing agency shall initiate a review of the appeal within 5 working days and reach a resolution in a timely manner.

4. The placing agency shall promptly review, revise, or modify a recipient's plan of service because of any of the following:

   i. The recipient has achieved an objective set forth in the recipient's individual plan of service.
   ii. The recipient has regressed or lost previously attained skills or otherwise experienced a change in condition.
   ~~3.~~iii. The recipient has failed to progress toward identified objectives despite consistent effort to implement the individual plan of service.

~~4. The individualized written plan of services is the fundamental document in the recipient's record. A provider shall retain all periodic reviews, modifications, and revisions of the plan in the recipient's record. In addition, the provider shall ensure that all staff providing services to an individual shall be adequately trained to implement the treatment plan.~~
~~The plan shall identify, at a minimum, all of the following:~~

~~(a) All individuals, including family members, friends, and professionals that theindividual desires or requires to be part of the planning process.~~
~~(b) The services, supports, and treatment that the recipient requested of the provider.~~
~~(c) The services, supports, and treatment committed by the responsible mental health agency to honor the recipient's request~~
~~(d) The person or persons who will assume responsibility for assuring that the committed services and supports are delivered.~~
~~(e) When the recipient can reasonably expect each of the committed services and supports to commence, and, in the case of recurring services or supports, how frequently, for what duration, and over what period of time.~~
~~(f) How the committed mental health services and supports will be coordinated with the recipient's natural support systems and the services and supports provided by other public and private organizations.~~
~~(g) Limitations of the recipient's rights. Limitations of the recipient's rights, any intrusive behavior treatment techniques, or any use of psycho-active drugs for behavior control purposes shall be reviewed and approved by a behavior treatment committee meeting the requirements of the Michigan Medicaid Provider Manual.~~
~~(h) Any limitation shall be justified, time-limited, and clearly documented in the plan of service. Documentation shall be included that describes attempts that have been made to~~

~~avoid limitations, as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the limitations in the future.~~

~~(i) Strategies for assuring that a recipient has access to needed and available supports identified through a review of his or her needs. Areas of possible need may include any of the following:~~

~~(i) Food.~~
~~(ii) Shelter.~~
~~(iii) Clothing.~~
~~(iv) Physical health care.~~
~~(v) Employment.~~
~~(vi) Education.~~
~~(vii) Legal services.~~
~~(viii) Transportation.~~
~~(ix) Recreation.~~

~~(j) A specific date or dates when the overall plan, and any of its subcomponents will be formally reviewed for possible modification or revision.~~

~~5. The plan shall not contain privileged information or communications.~~

~~6. The individual plan of service shall be formally agreed to in whole or in part by the responsible mental health agency and the recipient and his or her guardian, if any. If the appropriate signatures are unobtainable, then the responsible mental health agency shall document witnessing verbal agreement to the plan. Copies of the plan shall be provided to the recipient and his or her guardian, if any.~~

Applies to

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

Definitions

CMHSPs: Community Mental Health Service Programs
MDCH: Michigan Department of Community Health
MSHN: Mid-State Health Network
Placing Agency: The CMHSP requesting Out-of-State Placement
PNMC: Provider Network Management Committee

Other Related Materials

References/Legal Authority

Michigan ~~Mental Health Code~~ Administrative Rules 330.1701-1704.

Change Log:

Date of Change	Description of Change	Responsible Party
01.2015	New Policy	C. Mills, PNMC
01.2017	Review	Waiver Coordinator
03.2019	Annual Review	Director of Provider Network Management Systems
09.2020	Annual Review	Director of Provider Network Management Systems
08.2022	Biennial Review	Chief Behavioral Health Officer; Clinical Leadership Committee

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	**Cultural Competency Policy**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Deputy Director	**Adopted Date:** 01.05.2016 **Review Date:** 11.10.2020	**Related Policies:**

Purpose

This policy is intended to define the expectations for Mid-State Health Network (MSHN) and its Provider Network to provide culturally competent supports and services.

Policy

It is the policy of MSHN and its Provider Network to effectively provide services to recipients of all cultures, ages, races, gender, sexual orientation, socioeconomic status, languages, ethnic backgrounds, spiritual beliefs and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each person. In addition, MSHN and its Provider Network value workforce diversity and actively engage in culturally competent employment practices.

In furtherance of this policy MSHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area.

Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

To effectively demonstrate such commitment, MSHN's Provider Network shall have five components in place:

(1) A method of community assessment;
(2) Sufficient policy and procedure to reflect the PIHP's value and practice expectations;
(3) A method of service assessment and monitoring;
(4) Ongoing training to assure that staff are aware of, and able to effectively implement, policy; and
(5) The provision of supports and services within the cultural context of the recipient.

Competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment and economic factors, etc.

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
Cultural Competency: is an acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of

cultural knowledge, and resources and flexibility within service models to work toward better meeting the needs of minority populations.
MSHN: Mid-State Health Network
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:
MSHN Utilization Management Plan

References/Legal Authority:
Medicaid Managed Specialty Supports and Services Contract: Concurrent 1915(B)/(c) Waiver Programs, the Health Michigan Program and Substance Use Disorder Community Grant Programs

Change Log:

Date of Change	Description of Change	Responsible Party
03.18.2015	New Policy	Deputy Director
02.28.2018	Annual Review	Deputy Director
02.28.2019	Annual Review	Deputy Director
08.31.2020	Biennial Review	Deputy Director
09.09.2022	Biennial Review	Deputy Director

MID-STATE HEALTH NETWORK
POLICIES MANUAL

Chapter:	**Service Delivery System**		
Title:	**Emergency & Post-Stabilization Services**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 4	**Review Cycle:** Biennial **Author:** Clinical Leadership and Utilization Management Committee	**Adopted Date: 03.01.2022** **Review Date:**	**Related Policies:** Inpatient Psychiatric Hospitalization Standards

Purpose

Federal and State legal authorities require Medicaid managed care entities, including Prepaid Inpatient Health Plans (PIHP), to provide coverage and payment for emergency services and post-stabilization care services. The definition and descriptions of emergency medical conditions, emergency services, and care services focus heavily on physical health and serious bodily impairment. However, the same coverage provisions and requirements for emergency services and post-stabilization care services are still applicable to the PIHP for the scope of services which it is responsible to provide to Medicaid and Healthy Michigan Plan beneficiaries. The purpose of this policy is to provide clarity and definition to the scope of behavioral health and substance use disorder (SUD) emergency services and post-stabilization care services covered by Mid-State Health Network (MSHN) and furnished through its Community Mental Health Service Program (CMHSP) Participants.

Policy

Emergency Medical Condition/Emergency Situation

The definition of emergency medical condition found in 42 CFR 438.114(a) is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

For the purpose of this policy in the context of behavioral health emergencies, MSHN and its CMHSP Participants use the definition of emergency situation found in Section 300.1100(a)(25) of the Michigan Mental Health Code to be synonymous with the Federal definition of emergency medical condition. An emergency situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a minor is experiencing a serious emotional disturbance, and 1 of the following applies:

a. The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally.
b. The individual is unable to provide himself or herself food, clothing, or shelter or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
c. The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

MSHN does not limit what constitutes an emergency situation on the basis of specific diagnoses or symptoms. To assure understanding of the problem from the point of view of the person who is seeking help, methods for determining emergent situations must incorporate consumer or family-defined crisis situations.

Emergency Services

Emergency services are covered inpatient and outpatient services that are as follows:

a. Furnished by a provider that is qualified to furnish these services
b. Needed to evaluate or stabilize an emergency medical condition/emergency situation

MSHN, via delegation to its CMHSP Participants, provides the following types of emergency services described in the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter:

- Crisis Intervention - Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy. Crisis intervention may occur in a variety of settings, including but not limited to the CMHSP offices, hospital emergency department, beneficiary home, schools, jails, and other community settings.
- Inpatient Psychiatric Hospital Pre-Admission Screening - Pre-admission screening to determine if an individual requires psychiatric inpatient hospitalization or whether alternative services are appropriate and available to treat the individual's needs. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Inpatient pre-screening services must be available 24-hours-a-day/7-days-a-week. Pre-admission screenings most often occur in hospital emergency departments although they can take place in other settings such as CMHSP offices, jails, or other community settings.
- Intensive Crisis Stabilization Services - Intensive crisis stabilization services (ICSS) are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated. ICSS may be provided where necessary to alleviate the crisis situation, and to permit the beneficiary to remain in, or return more quickly to, his usual community environment. ICSS can also be used for post-stabilization care once the immediate crisis situation has been addressed. Most ICSS are delivered by a mobile crisis team and typically occur at the beneficiary's home or other community settings where the beneficiary is located.
- Outpatient Partial Hospitalization – Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the individual does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the individual's present treatment needs. The Severity of Illness/Intensity of Service criteria for admission assume that the individual is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Coverage and Payment: Emergency Services

The Michigan Mental Health Code 330.1206 (1) (a) requires that all Community Mental Health Service Programs must provide 24/7 crisis emergency service and stabilization for persons experiencing acute emotional, social, or behavioral dysfunctions. These services are funded through the per eligible per month (PEPM) subcapitation payment the CMHSP receives from the PIHP. There is never a cost to the beneficiary for emergency services provided by the PIHP and its CMHSP Participants. No prior authorization is needed.

When necessary, a beneficiary may seek services through the hospital emergency room. Disposition of the psychiatric emergency will be the responsibility of the PIHP (via delegation to its CMHSP Participants).

The PIHP is involved in resolving the psychiatric aspect of the emergency situation. Any medical treatment including medical clearance screening, stabilization and emergency physician services needed by the beneficiary while in the emergency room is beyond the contractual requirements of the PIHP (Michigan Medicaid Provider Manual Hospital Chapter, Section 3.14.D Psychiatric Screening and Stabilization Services).

MSHN and its CMHSP Partners adhere to the MDHHS County of Financial Responsibility (COFR) Technical Requirements when a beneficiary requires emergency services from a different PIHP or CMHSP provider outside of the MSHN PIHP region.

Post-stabilization Care Services

Post-stabilization care services means covered services, related to an emergency medical condition/emergency situation that are provided after an individual is stabilized to maintain the stabilized condition or to improve or resolve the individual's condition. MSHN, via delegation to its CMHSP Participants, provides the following types of post-stabilization care services as described in the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter:

- Inpatient Psychiatric Hospital Admission- Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness/Intensity of Service criteria for admission are based upon the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.
- Crisis Residential – Services are designed for individuals who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/Family Driven, Youth-Guided, and recovery/resiliency-oriented approach. Services must be designed to resolve the immediate crisis and improve the functioning level of the individual to allow them to return to less intensive community living as soon as possible.
- Outpatient Partial Hospitalization – Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the individual does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the individual's present treatment needs. The Severity of Illness/Intensity of Service criteria for admission assume that the individual is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Coverage and Payment: Post-stabilization Care Services

The Michigan Medicaid Provider Manual requires prior authorization for post-stabilization psychiatric services from the PIHP or CMHSP for all Medicaid beneficiaries who reside within the service area covered by the PIHP. The following sections of the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter contain specific prior authorization requirements and provider qualifications for each type of post-stabilization care service:

Section 6.3 - Crisis Residential
Sections 8.1 and 8.2 - Inpatient Psychiatric Hospital Admissions
Section 9.1.A - Intensive Crisis Stabilization Services
Section 10 - Outpatient Partial Hospitalization Services

The MSHN Finance Claims Procedure includes provision for reimbursement of claims for emergency and post-stabilization services provided to beneficiaries of the MSHN region if the provider is not contracted with the PIHP/CMHSP and/or if prior authorization was not obtained but it can be determined that, but for the urgency of the need, the service would have been pre-authorized by MSHN or the CMHSP.

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/Acronyms:

CMHSP: Community Mental Health Service Programs
COFR: County of Financial Responsibility
Consumers/Beneficiaries: Refers to those individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan

References/Legal Authority

1. Medicaid Managed Specialty Supports and Services MDHHS/PIHP Contract
2. 42 CFR 438.114(a-f)
3. Michigan Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter

Change Log:

Date of Change	Description of Change	Responsible Party
01-2022	New policy	Director of Integrated Care and Utilization Management
09.2022	Biennial Review	Chief Behavioral Health Officer

MSHN
Mid-State Health Network

POLICY & PROCEDURE MANUAL

Chapter:	Service Delivery		
Title:	Clinical Practice Guidelines and Evidence-Based Practices		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Compliance Officer	Adopted Date: 11.04.2014 Review Date: 01.12.2021	Related Policies: Quality Management

Purpose

To establish service provision parameters and expectations of the Community Mental Health Services Program(CMHSP) Participants and the Substance Use Disorder Prevention and Treatment Provider System of the Mid-State Health Network (MSHN) region regarding the network-wide use of nationally accepted or mutually agreed upon clinical practice guidelines and evidence-based practices (EBP).

Policy

MSHN supports and requires the use of nationally accepted and mutually agreed upon clinical practice guidelines including EBPs to ensure the use of research-validated methods for the best possible outcomes for service recipients as well as best value in the purchase of services and supports. Practice guidelines include clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served.

While MSHN does support the use of promising and emerging practices, interventions that are considered experimental or indicate risk of harm to human subjects are not supported within the Pre-paid Inpatient Health Plan (PIHP) region unless approved in accordance with MSHN's Research Policy and by the Michigan Department of Health and Human Services (MDHHS).

Standards:

A. CMHSP Participants and the Substance Use Disorder Prevention and Treatment Provider System under contract to provide prevention and/or treatment services for mental health and/or substance use disorders will deliver services in a manner which reflects the values and expectations contained in nationally accepted or mutually agreed upon practice guidelines.
   a. The guidelines should include but are not limited to the following practice guidelines:
      i. Inclusion Practice Guideline
      ii. Housing Practice Guideline
      iii. Consumerism Practice Guideline
      iv. Personal Care in Non-specialized Residential Settings
      v. Family Driven and Youth Guided Policy and Practice Guideline
      vi. Employment Works! Policy
      vii. School to Community Transition
   b. Adoption, development, and implementation of practice guidelines
      i. Key concepts of recovery and resilience, wellness, person-centered planning/individual treatment planning and choice, self-determination, and cultural competency are critical to the success of implementation of practice guidelines or treatment.
      ii. Practices will appropriately match the presenting clinical and/or community needs as well as demographic and diagnostic characteristics of the individuals to be served.
      iii. Programs will ensure the presence of foundational practice skills including motivational interviewing, trauma informed care, and positive behavioral supports.
      iv. Practices which are not evidence-based should be replaced with practices that are, where feasible.
      v. Promising or emerging EBPs may be conditionally explored or supported where appropriate to meet the needs of person served.
      vi. CMHSP Participants and Substance Use Disorder Service Providers (SUDSP) will review

service and clinical practices for EBP endorsement, offering an array of EBPs which best meet the needs of the persons served.

vii. Evidence for EBP prevention programs must come from one of these sources: a) Federal Registries; b) Peer Reviewed Journals; c) Community Based Process Best-Practices; or d) Other sources of documented effectiveness.

c. Monitoring and Evaluation
   i. Oversight of practice guidelines and EBPs will be provided by the responsible contractor and will be reviewed as part of the MSHN site review and monitoring process.
   ii. Contractors must report to MSHN any practices being used to support and/or provide clinical interventions for/with individuals.
   iii. Evidence-based practices will be monitored, tracked, and reported, including summary information provided to MSHN through the annual assessment of Network Adequacy.
   iv. Requisite staff training, supervision/coaching, certifications and/or credentials for specific clinical practices as needed will be required, verified, and sustained as part of the credentialing, privileging and/or contracting processes.
   v. Fidelity reviews shall be conducted and reviewed as part of local quality improvement programs or as required by MDHHS

d. Communication
   i. Persons served as well as other key stakeholders will be routinely provided with practice guidelines relevant for their services and supports.
   ii. Practice Guideline expectations will be included in contracts.

Applies to:

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

Definitions:

Clinical Practice Guidelines: The Institute of Medicine (IOM) defines clinical practice guidelines as "statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."
CMHSP: Community Mental Health Services Program; A program operated under Chapter 2 of the Michigan Mental Health Code-Act 258 of 1974 as amended.
Evidence Based Practices (EBP): treatments that have been researched academically or scientifically, been proven effective, and replicated by more than one investigation or study
MSHN: Mid-State Health Network; A regional entity formed for the purpose of carrying out the provisions of Section 1204b of the Mental Health Code relative to serving as the prepaid inpatient health plan to manage Medicaid specialty supports and services.
PIHP: An organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR part 401, as amended, regarding Medicaid managed care.

References/Legal Authority:

Medicaid Managed Specialty Supports and Services Contract
MDHHS Quality Assessment and Performance Improvement Program for Specialty Prepaid Inpatient Health Plans Technical Requirement

Change Log:

Date of Change	Description of Change	Responsible Party
11.2014	New Policy	Chief Compliance Officer
11.2015	Policy Review	Chief Clinical Officer
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
09.2022	Biennial Review	Chief Behavioral Health Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Habilitation Supports Waiver Policy		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** HCBS Manager	**Adopted Date:** 7.1.2014 **Review Date:** 11.10.2020	**Related Policies:** ~~HSW~~ Service Philosophy & Treatment

Purpose: This policy sets forth the guidelines and expectations for Mid-State Health Network's (MSHN) administration of the Habilitation Supports Waiver (HSW) program.

Policy:
MSHN shall administer the HSW program in accordance with the Prepaid Inpatient Health Plan (PIHP) contract and the Medicaid Provider Manual.

HSW beneficiaries must be enrolled through the Michigan Department of Health and Human Services (MDHHS) enrollment process by the Prepaid Inpatient Health Plan (PIHP) designee. The enrollment process must include verification that the beneficiary (all must apply):

- Has a developmental disability (as defined in Michigan Mental Health Code MCL 330.1100 (20))
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require Intermediate Care Facility/~~Intellectual Developmental~~for Individual with Intellectual Disabilit~~ies~~ies (ICF/I~~D~~ID) level of care services;
- Chooses to participate in the HSW in lieu of ICF/I~~D~~ID services;
- Habilitation services under the HSW are not otherwise available to the individual through a local educational agency.
- HSW beneficiaries must receive at least one HSW habilitative service per month in order to maintain eligibility. Habilitative services include Community Living Supports, Out-of-Home Non-Vocational Habilitation, Prevocational Services, and Supported Employment.

The beneficiary's services and supports must be specified in the individual's plan of services developed through the person-centered planning process that must be specific to:

- Medical necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.
- Amount: The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.
- Scope: The parameters within which the service will be provided, including Who (e.g., professional, paraprofessional, aide supervised by a professional); How (e.g., face-to-face, telephone, taxi or bus, group or individual); and Where (e.g., community setting, office, beneficiary's home).
- Duration: The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.

MSHN shall establish adequate procedures to assure effective administration of the program across the region including:

- Initial Application and Eligibility,
- Annual Recertification,
- Disenrollment and Transfer Procedure
-

Applies to

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

Definitions
CMHSP: Community Mental Health Service Provider
HSW: Habitation Support Waiver
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
ICF/II~~D~~D: (Intermediate Care Facility~~/Intellectual Developmental Disability~~ for Individuals with Intellectual Disabilities 42 CFR 435.1009) Institution for individuals with developmental disabilities or persons with related conditions means an institution (or distinct part of an institution) that (a) Is primarily for the diagnosis, treatment, or rehabilitation of people with developmental disabilities or persons with related conditions; and (b) Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.
Developmental Disability: means either of the following:

1. If applied to an individual older than 5 years, a severe, chronic condition that meets all of the following requirements:
    a. Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
    b. Is manifested before the individual is 22 years old.
    c. Is likely to continue indefinitely.
    d. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
        i. Self-care.
        ii. Receptive and expressive language.
        iii. Learning.
        ~~iii.~~iv. iv. Mobility.
        v. Self-direction.
        vi. Capacity for independent living.
        ~~vii.~~ Economic self-sufficiency.
        vii.
    e. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
2. If applied to a minor from birth to age 5, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (a) if services are not provided.

Other Related Materials:
N/A

References/Legal Authority
The MDHHS – PIHP Contract
MDHHS, Medicaid Provider Manual; Section 15 – Habilitation Supports Waiver Program for Persons with Developmental Disabilities~~, January 2020~~
Intermediate Care Facility/~~Intellectual Developmental Disability~~for Individuals with Intellectual Disabilities
42 CFR 435.1009; and Michigan Mental Health Code MCL 330.1100 (20).

Change Log:

Date of Change	Description of Change	Responsible Party
April, 2014	New policy	M. Neering N. Miller
January, 2017	Reviewed policy no recommended changes	Waiver Coordinator
October, 2017	Reviewed policy no recommended changes	Waiver Coordinator
July, 2020	Biennial Review	Waiver Coordinator
09.2022	Biennial Review	Chief Behavioral Health Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Home and Community Based Services (HCBS) Compliance Monitoring		
Policy: ☒ Procedure: ☐ Page: 1 of 1	Review Cycle: Biennial Author: HCBS Waiver Manager	Adopted Date: 07.10.2018 Review Date: ~~11~~07.~~10~~28.~~2020~~2022	Related Policies:

Purpose:
To ensure that the Mid-State Health Network (MSHN) conducts monitoring and coordination of oversight of the Provider Network with the Community Mental Health Services Program (CMHSP), specifically Home and Community Based Services (HCBS) Program Rule compliance with federal and state regulations through a collaborative, standardized procedure for conducting reviews.

Policy:
MSHN will ensure that its member CMHSPs and their contractual providers of residential and nonresidential home and community-based services are compliant with the Federal HCBS Final Rule.

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

~~**Monitoring and Review:**~~
~~This policy will be reviewed annually~~ biennially ~~by MSHN's HCBS Manager in collaboration with the MSHN HCBS/HSW Workgroup.~~

Definitions:
CMHSP: Community Mental Health Services Program
HCBS: Home and Community Based Services
MSHN: Mid-State Health Network
Out of Compliance: the status of a provider who has answered the HCBS survey in such a way as to require a corrective action plan to the identified area.
Provider: A provider, internal or external to the MSHN region, who has a current contractual agreement to provide Medicaid services to individuals the CMHSP supports.

Other Related Materials:
N/A

References/Legal Authority:
- The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s)
- MSA Bulletin 17-31 Compliance with Federal Home and Community Based Services (HCBS) Final Rule by New Providers
- MSHN Procedure–MSHN HCBS Monitoring Procedure

Change Log:

Date of Change	Description of Change	Responsible Party
03.2018	New Policy	Waiver Coordinator
02.2019	Annual Review	Waiver Coordinator
08.2020	Annual Review	HCBS Manager

07.2022	Biennial Review	HCBS Manager

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Indian Health Services/Tribally-Operated Facility/Urban Indian Clinic Services (I/T/U)		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Behavioral Health Officer	Adopted Date: 03.06.2018 Review Date: 11.10.2020	Related Policies:

Purpose

To ensure that the Mid-State Health Network (MSHN) has a policy that standardizes the regional service coverage approach to be consistent with the requirements of the Michigan Department of Health and Human Services (MDHHS) and Pre-Paid Inpatient Health Plan (PIHP) contract.

Policy

It is the policy of MSHN to pay any Indian Health Service, Tribal Operated Facility Organization/Program/Urban Indian Clinic (I/T/U), or I/T/U contractor, whether participating in the PIHP provider network or not, for PIHP authorized medically necessary covered Medicaid managed care services provided to Medicaid beneficiary/Indian enrollees who are eligible to receive services from the I/T/U provider either at a rate negotiated between the PIHP and the I/T/U provider, or if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

General

Under the Indian Self-Determination and Education Assistance Act (Public Law 93-638), tribal facilities, including Tribal Health Centers (THCs), are those owned and operated by American Indian/Alaska Native tribes and tribal organizations under contract or compact with Indian Health Service (IHS). Mental health and substance use disorder services provided at the THC to American Indian and Alaska Native beneficiaries do not require the authorization of MSHN.

American Indians and Alaska Natives who are Medicaid beneficiaries can obtain mental health or substance abuse treatment services directly from the THC or may choose to obtain services from a PIHP program. There is a process available for Tribal Health Providers to be reimbursed using Medicaid funds for providing behavioral health services, when the Tribal Health Provider has chosen not to be part of a Medicaid Health Plan's (MHP) or PIHP's provider network. Tribal Health Providers can also be paid by the PIHPs when they provide a covered medically necessary Medicaid service to a Medicaid eligible tribal member who has a serious mental illness or a substance use disorder. THC services are not included in the MDHHS §1915(b) Managed Specialty Services and Supports Waiver for PIHPs and substance use disorder services. THCs may refer tribal members to the PIHP/Community Mental Health Service Program (CMHSP) for mental health or substance abuse treatment services not provided at the THC.

Under the Michigan Medicaid State Plan, THCs have the option of choosing from one of three reimbursement mechanisms. The THC may elect to be reimbursed under only one of the options listed below, and the selected option applies to all beneficiaries receiving services at the THC.

The options are:

- A THC may choose to be certified as an IHS facility, sign the THC Memorandum of Agreement (MOA) and receive the IHS encounter rate in accordance with the terms of the MOA.
- Upon federal approval by the Health Resources and Services Administration, THCs may be reimbursed as a Federally Qualified Health Center (FQHC) by signing the FQHC Memorandum of Agreement. THCs choosing this option will receive the FQHC encounter rate set by the State in accordance with the Michigan Medicaid State Plan and federal regulations. The FQHC encounter rate applies to encounters for both native and non-native beneficiaries. A THC electing to be reimbursed as an FQHC is not required to have a contract with the managed care entity. If a THC

chooses to be reimbursed as a FQHC, the entity would be required to adhere to the same requirements specified in the FQHC Chapter of the Michigan Medicaid Manual.

- A THC may be reimbursed as a fee-for-service provider. THCs choosing this option receive payment for covered services. No additional reimbursement or settlement is made.

The PIHP will have a designated tribal liaison who will ensure that any tribal members seeking services through the PIHP/CMHSP are able to access services efficiently and without barriers by serving as a primary point of contact in the MSHN region and by providing guidance to CMHSP and SUD service providers who perform access responsibilities on behalf of the PIHP.

Applies to

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

Definitions

CMHSP: Community Mental Health Services Program
FQHC: Federally Qualified Health Center
IHS: Indian Health Service
I/T/U: Indian Health Service, Tribal Operated Facility Organization/Program/Urban Indian Clinic
MDHHS: Michigan Department of Health and Human Services MHP:
Medicaid Health Plan
MOA: Memorandum of Agreement
MSHN: Mid-State Health Network
PIHP: Pre-Paid Inpatient Health Plan
THC: Tribal Health Center

Other Related Materials References/Legal Authority

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program/MDHHS-PIHP Contract
Michigan Medicaid Provider Manual/Behavioral Health and Intellectual Disabilities Supports and Services

Change Log:

Date of Change	Description of Change	Responsible Party
10.29.2017	New policy	Utilization Management & Waiver Director
02.2019	Annual review	Chief Behavioral Health Officer
08.27.2020	Annual review	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Inpatient Psychiatric Hospitalization Standards**		
Policy: ☒ **Procedure:** ☒ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Director of Provider Network Mgmt Systems	**Adopted Date:** 11.07.2017 **Review Date:** 11.10.2020	**Related Policies:** MSHN Retrospective Sampling for Acute Services Policy

Purpose

To establish a single set of psychiatric inpatient provider performance standards, including pre-admission, admission, continuing care, and discharge.

Policy

MSHN, CMHSPs and providers shall adhere to *Section 8 – Inpatient Psychiatric Hospital Admissions* within the Behavioral Health and Intellectual and Developmental Disabilities Supports and Services chapter of the Medicaid Provider Manual, the Michigan Mental Health Code, Chapter 330, Act 258 of 1974, and the Michigan Department of Health and Human Services *Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes.*

A. Pre-Admission:

1. Emergency Services staff who are screening children shall complete 24 hours of child-specific training annually.
2. Provider shall maintain proper documentation of clinical presentation and disposition.
3. When known to the screening unit, screening unit personnel shall coordinate care with primary care physicians, substance use disorder treatment providers, alternative service providers and other individuals or organizations having an identified role in services and supports delivery to the consumer being served.
4. The screening unit shall furnish the Inpatient Psychiatric Hospital/Unit (IPHU) with necessary clinical, social, and demographic documentation to foster the admitting and discharge process.
5. The screening unit shall provide an admissions packet to the IPHU that has agreed to provide inpatient care to the consumer being served.
6. Established pre-admission screening tools will be used by pre-admission/crisis intervention staff. MSHN and its CMHSP participants use nationally-recognized written criteria based on sound clinical evidence (MCG Behavioral Health Medical Necessity Guidelines) to verify that admission decisions for acute care services are based on medical necessity.
7. In cases when the consumer is diverted from inpatient level of care to an alternative service, a crisis/safety plan shall be established. Whenever possible, a warm handoff occurs and CMHSPs conducts wellness checks, follow-up calls, face-to-face appointments, or any other appropriate safety monitoring activities warranted.
8. CMHSPs in the MSHN region shall provide emergency services, including pre-admission screening and related follow-up activities, including identification of and placement in appropriate psychiatric inpatient or alternative service settings regardless of where the consumer resides. MSHN shall pursue payment from other PIHPs for services. In all cases, communication(s) should occur with the CMHSP or PIHP in the catchment area of the residence of the consumer served. In no case should pre-admission screening activities be delayed while waiting for a response from the CMHSP/PIHP in the catchment area where the consumer resides. Established medical necessity and service utilization criteria are the only criteria to be used in making psychiatric admission determinations. Place of residence, willingness of another CMHSP or PIHP to authorize services, or other non-clinical factors are not pertinent to the determination of inpatient psychiatric or alternative service levels of care and related placement decisions. Arrangement for continuing stay reviews and other follow-up care should be worked out with the provider system that will be responsible for post-inpatient follow-up care.

9. Screening unit will work with MDHHS to secure consents for children/adolescents in foster care and may proceed with a verbal consent; preadmission disposition cannot be finalized until parent or guardian is present or in the case of State Wards, MDHHS has provided written authorization for psychiatric inpatient admission.
10. ACT consumers seeking psychiatric admission should be screened by an ACT team member as that team member would be in the best position to not only approve an admission but also divert it.

B. In-Region Pre-Admissions Between MSHN CMHSP Participants

In instances when a MSHN CMHSP participant (screening CMHSP) is conducting "courtesy" pre-admission screening activities for an individual that resides in the catchment of another MSHN CMHSP participant (authorizing CMHSP):

1. The screening CMHSP will initiate communication to the authorizing CMHSP as soon as possible. In no case should pre-admission screening activities be delayed while waiting for a response or authorization from the authorizing CMHSP.
2. Once a disposition recommendation has been reached the screening CMHSP is responsible for communicating the disposition recommendation and sharing all pre-admission screening documentation, lab work, additional hospital clinical records, etc. to the authorizing CMHSP.
3. The authorizing CMHSP has primary responsibility in facilitating all related follow-up activities including but not limited to: identification and placement in appropriate psychiatric inpatient unit, identification and placement in alternative service settings, development of crisis/safety plans, and discharge/transfer planning with the hospital emergency department. Exceptions may occur if the authorizing CMHSP is not responding in a timely manner or the authorizing CMHSP requests assistance from the screening CMHSP to facilitate placement. If the authorizing CMHSP requests assistance the screening CMHSP will provide support and coordination.
4. If there is disagreement regarding the disposition recommendation, consultation should be sought between the crisis services supervisors for the screening CMHSP and the authorizing CMHSP. If this is not possible or agreement is not reached, the screening CMHSP will act in the best interest of the consumer based on the clinical assessment and established medical necessity criteria. In no case should medically necessary services be delayed due to willingness of another CMHSP to authorize services.

C. Admission

1. The contractually required inpatient admission, severity of illness, and service selection criteria for both adults and children shall be the only criteria for admission to psychiatric inpatient admission and inpatient alternative service.
2. The screening unit making the determination that a consumer served meets psychiatric admission criteria shall provide an initial authorization to the psychiatric inpatient unit consistent with severity of illness, presenting problems and other clinical factors associated with the preadmission screening determination. Initial authorizations may vary between one (1) and three (3) days. Many of these elements are procedural and in the case of involuntary admissions, vary from court jurisdiction to court jurisdiction.
3. Screening unit shall ensure that emergency transportation of a consumer from the location of screening to the receiving psychiatric inpatient unit is coordinated. Safety of the consumer served, and the safety of those providing supports to the consumer, are the primary considerations in making transportation arrangement.
4. The screening unit is responsible for ensuring that families, guardians, service providers and others involved in the care, custody and service delivery of the consumer served are updated regularly on screening status, disposition, and placement efforts. Family members and others in the consumer's circle of support should receive communication as often as possible, and supportive assistance provided as needed.
5. Clinical determinations and formulations, eligibility determinations, service disposition and related information is documented per established CMHSP policies.

D. Continuing Stay

1. The Continuing Stay Criteria for Adults, Adolescents and Children shall be the only criteria used in determining authorization for continued stay in inpatient psychiatric hospitals/units. The number of

days authorized for continued stay is dependent on a number of variables, including medication effectiveness, clinical progress, co-morbidities and many other factors. Continued stay authorizations range from one (1) to three (3) days. The rationale considered in making a continued stay authorization shall be documented in the clinical record of the consumer served.

2. Assessment, discharge procedures, and aftercare planning shall be conducted by the Provider's staff and the Payor's staff functioning as a multi-disciplinary treatment team. The Payor is responsible for monitoring patient progress. To the extent possible, provider will coordinate care with other entities and individuals involved with the care of the consumer that is being served.

E. Discharge

1. All discharge planning will begin immediately at admission and continue as part of the ongoing treatment planning and review process. Discharge planning will involve the consumer, the consumer's family or significant others, as desired by the consumer, and the provider's staff and the payor's staff.
2. Provider shall submit a notification of discharge at least 48 hours preceding the discharge, if possible. Special consideration shall be given to weekend discharge with regard to additional supports needed to ensure safe transition of care to include transportation from hospital to next point of care or the consumer's home. Discharge summary shall be submitted to payor within 48 hours of discharge.
3. At the time of discharge, the provider may provide a supply of medications sufficient to carry through from date of discharge to the next business day, but not less than a two (2) day supply but shall issue a prescription for not less than fourteen (14) days.
4. Provider shall notify the Payor of persons discharged to community settings who are subject to judicial orders requiring community-based treatment.

Applies to:

☐All Mid-State Health Network Staff

☐ ☐Selected MSHN Staff, as follows:

☒MSHN CMHSP Participants~~'s Affiliates~~: ☒Policy Only Policy and Procedure

☒Other: Sub-contract Providers

Definitions

ACT: Assertive Community Treatment
CMHSP: Community Mental Health Services Program Participant
HCPCS/CPT: Healthcare Common Procedure Coding System/Current Procedural Terminology
IPHU: Inpatient Psychiatric Hospital/Unit
MSHN: Mid-State Health Network
Payor: A person, organization, or entity that pays for the services administered by a healthcare provider
PIHP: Pre-paid Inpatient Health Plan
Provider: Licensed Inpatient Hospital/Unit
Screening Unit: CMHSP Emergency Services or other CMHSP-Operated Pre-Admission Screening Unit

References/Legal Authority

- Medicaid Provider Manual, Section 8 – Inpatient Psychiatric Hospital Admissions within the Behavioral Health and Intellectual and Developmental Disabilities Supports and Services Chapter
- Michigan Mental Health Code, Chapter 330, Act 258 of 1974
- Michigan Department of Health and Human Services Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes.
- Michigan Department of Health and Human Services Memorandum: Assertive Community Treatment (ACT) Service Clarifications

Change Log

Date of Change	Description of Change	Responsible Party
07.2017	New Policy	Director of Provider Network Management Systems

02. 2019	Annual Review	Director of Provider Network Management Systems
06.2020	Added Clarifying Language regarding pre-admission screenings	Director of Utilization and Care Management
09.2022	Biennial Review	Chief Behavioral Health Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Out of State Placements		
Policy: ☒ Procedure: ☐ Page: 1 of 3	Review Cycle: Biennial Author: ~~Provider Network Management Committee~~ Clinical Leadership Committee	Adopted Date: 05.05.2015 Review Date: ~~11~~07.~~10~~28.2020~~2~~	Related Policies: ~~Service Delivery System~~

Purpose

This policy is established to provide guidelines for the placement of Mid-State Health Network (MSHN) ~~Adult~~ service recipients outside of the State of Michigan ~~into a community based residential dependent living setting,~~ in accordance with the Michigan Mental Health Code and the Michigan Medicaid Provider Manual.~~State of Michigan Administrative Rules. Persons under the age of 18 shall not be placed out of the State of Michigan for residential care.~~

Policy

~~It is the intent of~~ Mid-~~-~~State Health Network and its Community Mental Health Service Program (CMHSP) Participants will ~~to~~ comply with *Section 330.919 of the Michigan Mental Health Code Section 330.1919 - Contracts for services of agencies located in bordering ~~states as well Section 330 Michigan Administrative Rules Section 330.1701 – 330.1703~~ ~~and~~states* and the Michigan Medicaid Provider Manual regarding the placement of individuals ~~(adults)~~ outside of the state of Michigan.

~~Community Mental Health Service Programs (~~CMHSPs~~)~~ shall notify MSHN of their intent to place a Medicaid or Healthy Michigan Plan eligible beneficiary~~adult~~ out of state. ~~and keep them apprised of the status of the~~ MSHN, in collaboration with the CMHSP, will submit a request for placement approval to the appropriate division at ~~placement approval from~~ the Michigan Department of Health and Human Services (MDHHS). Placement shall not occur until MDHHS approves the out of state placement in writing. This policy is applicable to all out of state placements including but not limited to, inpatient psychiatric hospitalization, specialized residential treatment, and adult foster care settings.

Determination of Need

~~Only voluntary placements shall be considered for out of state residential services. The Provider will be the CMHSP, and act in accordance with State requirements for such placements.~~

The CMHSP must make a determination ~~in the placement of an individual outside of the State of Michigan~~ that the placement is clinically appropriate. All efforts should first be made to serve the needs of individuals within the State of Michigan.

If an out of state placement is being considered, the CMHSP shall notify ~~Mid-State Health Network (~~MSHN~~)~~ of its intentions and detail the history of the individual and services that have been provided, and clinical determination that needed services are not available within the State for that individual. MSHN shall submit to the State of Michigan a treatment summary, current assessment and PCP summary, discharge plan and monitoring of placement plan.

~~Placement shall not occur until the Michigan Department of Health and Human Services approves the out of state placement in writing.~~

The CMHSP shall meet the requirements of the Mental Health Code and the Michigan Medicaid Provider Manual ~~Administrative Rules~~ in seeking provision of out of state services.

These requirements include, but may not be limited to:

1) The CMHSP may contract as provided under ~~this~~ section 330.1919 of the Michigan Mental Health Code with a public or private agency located in a state bordering Michigan to secure services ~~under this act~~ for an individual who receives services through the county program.

2) The CMHSP may contract as provided under this section with a public or private agency located in a state bordering Michigan to provide services ~~under this act~~ in an approved treatment facility in this state for an individual who is a resident of the bordering state, except that such services may not be provided for an individual who is involved in criminal proceedings.

3) An individual does not establish legal residence in the state where the receiving agency is located while the individual is receiving services ~~pursuant to a contract executed under this section.~~

4) An individual who is detained, committed, or placed on an involuntary basis may be admitted and treated in another state. Court orders valid under the law of Michigan are granted recognition and reciprocity in the receiving state to the extent that the court orders relate to admission for the treatment or care of a mental disability. The court orders are not subject to legal challenge in the courts of the receiving state. An individual who is detained, committed, or placed under the law of Michigan and who is transferred to a receiving state continues to be in the legal custody of the authority responsible for the individual under the law of Michigan. Except in an emergency, such an individual may not be transferred, removed, or furloughed from a facility of the receiving agency without the specific approval of the authority responsible for the individual under the law of Michigan.

5) While in the receiving state, an individual is subject to all of the laws and regulations applicable to an individual detained, committed, or placed pursuant to the corresponding laws of the receiving state, except those laws and regulations of the receiving state pertaining to length of involuntary inpatient treatment, reexaminations, and extensions of involuntary inpatient treatment and except as otherwise provided by Michigan law. The laws and regulations of Michigan relating to length of involuntary inpatient treatment, reexaminations, and extensions of involuntary inpatient treatment apply.

~~3)~~

6) If an individual receiving treatment on a voluntary basis ~~pursuant to a contract executed under this section~~ requests discharge, the receiving agency shall immediately notify the CMHSP and shall return the individual to Michigan~~the sending state~~ as directed by the CMHSP within 48 hours after the request, excluding Saturdays, Sundays, and legal holidays, unless other arrangements are made with the CMHSP.

~~4)~~

7) If an individual leaves the receiving agency without authorization and the individual at the time of the unauthorized leave is subject to involuntary inpatient treatment under the laws of Michigan, the receiving agency shall use all reasonable means to locate and return the individual. The receiving agency shall immediately report the unauthorized leave of absence to the sending CMHSP. The receiving state has the primary responsibility for, and the authority to direct, the return of individuals within its borders and is liable for the cost of such action to the extent that it would be liable for costs if an individual who is a resident of the receiving state left without authorization.

8) An individual may be transferred between facilities of the receiving state if transfers are permitted by the contract ~~executed under this section~~ providing for the individual's care.

~~5)~~

~~6)~~9) Each contract executed for out of state ~~residential~~ services shall contain all of the following:

a) Establish the responsibility for payment for each service to be provided under the contract. Charges shall not be more or less than the actual cost of providing the service.

b) Establish the responsibility for the transportation of individuals to and from the receiving agency.~~residential facility.~~

c) Provide for reports by the receiving agency to the CMHSP on the condition of each individual covered by the contract.
d) Provide for arbitration of disputes arising out of the contract that cannot be settled through discussion between the contracting parties and specify how the arbitrators will be chosen.
e) Include provisions ensuring the nondiscriminatory treatment, as required by law, of employees, individuals receiving services, and applicants for employment and services.
f) Establish the responsibility for providing legal representation for an individual receiving services in a legal proceeding involving the legality of admission and the conditions of involuntary inpatient treatment.
~~f)~~g) Establish the responsibility for providing legal representation for an employee of a contracting party in legal proceedings initiated by an individual receiving treatment pursuant to the contract.
~~g)~~h) Include provisions concerning the length of the contract and the means by which the contract can be terminated.
~~h)~~i) Establish the right of the CMHSP and the State of Michigan to inspect, at all reasonable times, the records of the Provider and its treatment facilities to determine if appropriate standards of care are met for individuals receiving services under the contract.
j) Require the sending CMHSP to provide the receiving agency with copies of all relevant legal documents authorizing involuntary inpatient treatment of an individual who is admitted pursuant to the laws of Michigan.
~~i)~~k) Require each individual who seeks treatment on a voluntary basis to agree in writing to be returned to the State of Michigan upon making a request for discharge and require an agent or employee of the sending CMHSP to certify that the individual understands that agreement.
l) Establish the responsibility for securing a reexamination for an individual and for extending an individual's period of involuntary inpatient treatment.
m) Include provisions specifying when a receiving facility can refuse to admit or retain an individual.
~~j)~~n) Specify the circumstances under which an individual will be permitted a home visit or granted a pass to leave the facility, or both.

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

Definitions:
CMHSP: Community Mental Health Service Program responsible for requesting and managing the Out-of-State placement
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
~~PNMC: Provider Network Management Committee~~
Receiving Agency: Organization accepting the out of state placement
Responsible Mental Health Agency: Agency responsible for payment

Other Related Materials:
~~Out-Of-State Placement Procedure~~

References/Legal Authority:
Michigan Mental Health Code

Michigan Medicaid Provider Manual

Change Log:

Date of Change	Description of Change	Responsible Party
01.2015	New Policy	C. Mills, PNMC
05.2016	Annual Review	Director of Provider Network Management Systems, Provider Network Management Committee
02.2018	Annual Review	Director of Provider Network Management Systems, Provider Network Management Committee
03.2019	Annual Review	Director of Provider Network Management Systems, Provider Network Management Committee
07.2022	Biennial Review	Chief Behavioral Health Officer Clinical Leadership~~Provider Network Management~~ Committee

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POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	**Person/Family Centered Plan of Service**		
Policy: ☒ **Procedure:** ☐ ~~**Version:** 2.0~~ **Page:** 1 of 3	**Review Cycle:** ~~Annually~~Biennial **Author:** Clinical Leadership Committee/Chief Clinical Officer	**Adopted Date: 01.05.2016** **Review Date:** 01.12.2021 ~~**Revision Eff. Date:**~~	**Related Policies:** Service Philosophy

Purpose

To ensure that Mid-State Health Network (MSHN) and its CMHSP Participants have a consistent service philosophy across its network of care related to Person/Family Centered Planning. MSHN promotes a Person/Family Centered approach to the development of the individual plan of service and the delivery of supports and services in accordance with established state and federal regulations (reference Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program attachment P4.4.1.1).

Policy

The policy is intended to outline the required elements of Person/Family Centered Planning as required by MSHN and informed by the Medicaid Provider Manual, Section 2:

A. A preliminary plan of service is developed within seven (7) days of the commencement of services that will include a treatment plan, a support plan, or both.
B. Consumers are given information as needed on the array of mental health services, community resources and available providers.
C. Ensure that for each Person/Family Centered Plan, a pre-planning meeting is completed that includes addressing the information below. Documentation should reflect that the process took place in a timely manner (Items below are not required for those who receive short term outpatient therapy only, medication only, or those who are incarcerated)

    1. Who to invite;
    2. Where and when to have the meeting;
    3. What will be discussed, and not discussed, at the meeting;
    4. Any accommodations the consumer may need to meaningfully participate;
    5. Who will facilitate the meeting;
    6. Who will record what is discussed at the meeting; and
    7. The pre-planning meeting is to be completed with sufficient time to take all necessary/ preferred actions.

D. Provide information/education on what an Independent or External Facilitator is and how to request the use of one. Not required for consumers receiving short term outpatient therapy or medication only. Consumers must have a choice of at least two facilitators.

E. Each plan is individualized to meet the consumer's medically necessary identified needs and includes:

1. A description and documentation of the consumer's individually identified goals, preferences, strengths, abilities, and natural supports.
2. Outcomes identified by the consumer and the steps to achieve the outcomes.
3. Risk factors and measures in place to minimize them, including backup plans and strategies.
4. Services and supports needed to achieve the outcomes (including community resources and other publicly funded programs such as Home Help).
5. Amount, scope and duration of medically necessary services and supports authorized by and obtained through the CMHSP.
6. Estimated/prospective cost of services and supports authorized by the community mental health system.
7. Roles and responsibilities of the consumer, the CMHSP staff, allies, and providers in implementing the plan.
8. The plan should be written in plain language that is easily understood by the individual and others supporting him/her. The language in the service plan must also be understandable by individuals with disabilities and those with limited English proficiency, in accordance with federal law.
9. The plan should be finalized and include informed consent of the individual and his/her representative (if applicable).
10. Signatures on the plan should include the consumer, his/her representative (if applicable) and the providers responsible for the implementation of the plan (at a minimum, this includes the person or entity responsible for coordinating the individual's services and supports).
11. In accordance with 42 CFR 438.208(b)(2)(i), coordination of services between settings of care, which includes appropriate discharge planning for short and long-term hospitalizations.
~~10.~~12. Any effort to restrict the certain rights and freedoms listed in the HCBS Final Rule must be justified by a specific and individualized assessed health or safety need and must be addressed through the PCP process and documented in the IPOS.

F. The plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the consumer's needs, changes in the consumer's condition as determined through the PCP process or changes in the consumer's preferences for support). A review of the plan can be requested at any time by the consumer or his/her guardian. A formal review of the plan with the consumer and his/her guardian or authorized representative shall occur at least every 12 months or more frequently if the consumer requests it or there is a change in service needs. Reviews should work from the existing plan of service to amend or update it as circumstances, needs, preferences or goals change or to develop a completely new plan if so desired by the consumer.

G. The consumer is provided a copy of the plan within 15 business days of the conclusion of the PCP process.

H. There is a process to identify and train staff at all levels on the philosophy of PCP. Staff who are directly involved in the implementation of the PCP are provided with additional training, including direct care level staff being trained on consumer specific plans of service.

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/Acronyms:

CMHSP: Community Mental Health Service Program

Consumer/Customer: Refers to individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.
IPOS: Individual Plan of Service
Independent Facilitator: An individual chosen by the consumer to serve as the consumer's guide throughout the PCP process, assisting with pre-planning activities and co-leads any PCP meeting(s) with the consumer.
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PCP: Person-Centered Planning

References/Legal Authority:

- Michigan Department of Health and Human Services Medicaid Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY15, including the "Person Centered Planning Policy and Practice Guideline".
- Mental Health Code, Section 330.1700(g).
- 42 CFR 438.208(b)(2)(i) Coordination and Continuity of Care

Change Log:

Date of Change	Description of Change	Responsible Party
10.2015	New policy	Chief Clinical Officer
02.2017	Annual Review	Chief Clinical Officer
02.2018	Annual Review	Chief Clinical Officer
01.2019	Annual Review	Chief Behavioral Health Officer
07.2020	Annual Review	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Severe Emotional Disturbance Waiver (SEDW)		
Policy: ☒ Procedure: ☐ Page: 1 of 2	**Review Cycle:** Biennial **Author:** Chief Behavioral Health Officer	**Adopted Date:** 11.10.2020 **Review Date:** 11.10.2020	**Related Policies:**

DO NOT WRITE IN SHADED AREA ABOVE

Purpose
This policy sets forth the guidelines and expectations for Mid-State Health Network's (MSHN) administration of the Severe and Emotional Disturbance Waiver (SEDW) program.

Policy
MSHN shall administer the SEDW program in accordance with the Prepaid Inpatient Health Plan (PIHP) contract and the Medicaid Provider Manual.

I. Eligibility
SEDW beneficiaries must be enrolled through the Michigan Department of Health and Human Services (MDHHS) enrollment process by the Prepaid Inpatient Health Plan (PIHP) designee. The enrollment process must include verification that the beneficiary meets the following (all must apply):

A. Meet the current MDHHS contract criteria for the state psychiatric hospital for children (Hawthorn Center) and be at risk of hospitalization.
B. Demonstrate serious functional limitations that impair their ability to function in the community. The functional criteria will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS).
~~C. The Preschool and Early Childhood Functional Assessment Scale (PECFAS) will be required for any child 4-6 years old (Intake, quarterly and at exit from CMHSP). For children 3-4 years old in SED Waiver and Wraparound PECFAS is required.~~
~~D. CAFAS will be required for any child 7-17 years old (Intake, quarterly and at exit from CMHSP) For youth aged 18-21 that are involved in the SED Waiver and Wraparound the CAFAS is required~~
~~E.~~C. CAFAS®/~~PECFAS~~ score of 90 or greater for children age 7 to 12 ~~12 or younger~~; or
D. CAFAS® score of 120 or greater for children age 13 to 18;
~~F.~~E. For children ages 3 to 7, elevated PECFAS subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others
~~G.~~F. Be under the age of ~~21;~~ 18 when approved for the waiver. If a child on the SEDW turns 18, continues to meet all non-age-related eligibility criteria, and continues to need waiver services, the child can remain on the waiver up to their 21st birthday
~~H.~~G. Reside with his/her birth or adoptive parents(s), or
~~I.~~H. In the home of a relative who is the child's legal guardian, or
~~J.~~I. In foster care or therapeutic foster care, with a permanency plan to return home.
~~K.~~J. Be financially eligible for Medicaid when viewed as a family of one (i.e., when parental income and assets are waived);
~~L.~~K. Be in need of waiver services in order to remain in the community
~~M.~~L. SEDW beneficiaries must receive at least one SEDW service per month in order to maintain eligibility. The beneficiary's services and supports must be specified in the individual's plan of services developed through the person-centered planning process that must be specific to:

1. Medical necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.
2. Amount: The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.
3. Scope: The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.
4. Duration: The parameters within which the service will be provided, including Who (e.g., professional, paraprofessional, aide supervised by a professional); How (e.g., face-to-face, telephone, taxi or bus, group or individual); and Where (e.g., community setting, office, beneficiary's home).

II. Caregiver Roles and Expectations

If the child resides with his or her birth/adoptive family or is a temporary ward of the state, the birth/adoptive family must be willing and able to do the following:

A. Choose SEDW services as an alternative to hospitalization,
B. Participate in the development of the individual plan of service (IPOS),
C. Obtain and submit required documentation (e.g. Waiver Certification form, signed IPOS, etc.),
D. Allow services to be provided in the home setting,

~~**III. Administration of the SEDW**~~

~~MSHN shall establish adequate procedures to assure effective administration of the program across the region including:~~

~~A. Initial Screening, Application and Service Start,~~
~~B. Annual Recertification,~~
~~C. SEDW Slot Transfer, and~~
~~D. SEDW Financial Monitoring.~~

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

CAFAS: Child and Adolescent Functional Assessment Scale
IPOS: Individual Plan of Service
MDHHS: Michigan Department of Health and Human Services
PECFAS: Preschool and Early Childhood Functional Assessment Scale
PIHP: Pre-Paid Inpatient Health Plan
SEDW: Waiver for Children with Serious Emotional Disturbance

Other Related Materials

N/A

References/Legal Authority

Medicaid Managed Specialty Supports and Services FY20 MDHHS/PIHP Contract
Michigan Medicaid Provider Manual

Change Log:

Date of Change	Description of Change	Responsible Party

07.2020	NEW Policy	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer

MSHN
Mid-State Health Network

MID-STATE HEALTH NETWORK
POLICIES MANUAL

Chapter:	**Service Delivery System**		
Title:	**Service Philosophy & Treatment**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 6	**Review Cycle:** Biennial **Author:** Clinical Leadership and Utilization Management Committee	**Adopted Date:** 12.03.2013 **Review Date:** 11.10.2020	**Related Policies:** Utilization Management UM Access

Purpose

To ensure that Mid-State Health Network (MSHN) and its Community Mental Health Service Program (CMHSP) Participants have a consistent service philosophy across its network of care related to person-centered planning, integrated care, housing, employment, and self-determination. MSHN promotes a person-centered approach to all service planning and delivery of supports and services in the community, consistent with Michigan Department of Health and Human Services (MDHHS) policy direction.

Policy

A. Person-Centered/Family-Centered Planning
   1. MSHN shall be committed to ensuring that all individuals have the freedom and right to create an Individual Plan of Service that is developed through a person-centered planning process without regard to age, disability or residential setting, as required in the Michigan Mental Health Code and defined in the MDHHS Person Centered/Family-Centered Planning Policy and Practice Guideline.
   2. Standards
      i. CMHSPs Participants shall support person-centered/family-centered planning in the creation, development, and implementation of all consumer services.
      ii. MSHN shall ensure that CMHSP Participants provide comprehensive information to consumers about the risks and benefits of services including their freedom or right to participate in decision-making regarding their health, treatment options, and services that will be provided.
      iii. MSHN shall monitor the implementation of person-centered planning for adults and family-centered planning for minor children and families through an annual on-site audit of each CMHSP Participant and through consumer satisfaction surveys.

B. Integrated Care
   1. MSHN shall utilize a coordinated, person-centered/family-centered system of care that allows for comprehensive care from primary care, mental health and substance use disorder providers.
   2. MSHN shall make a coordinated approach to service delivery available to its consumers. This is an essential element of treatment and supports and produces the best outcomes for people with multiple and complex healthcare needs.
   3. Standards
      i. Coordination shall include health care providers who shall work collaboratively to improve functioning and promote recovery and resiliency.
         - The MSHN provider network will implement practices to encourage all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the consumer's Medicaid Health Plan.

         - The MSHN provider network will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to

the attention of the individual along with information about the need for intervention and how to obtain it.

ii. Consideration shall be given to system-wide, cost-effective interventions and supports that produce the highest level of outcomes.
iii. MSHN shall have written agreements with the Medicaid Health Plans in the service area.
iv. Interagency agreements shall meet the requirements in 42 CFR Part 2.
v. Outcomes that represent improvements in significant aspects of clinical services and supports will be shared among health care providers to assist in identifying over and underutilization and patterns of service delivery.
vi. Health information exchange shall be supported through the use of technology to assure timely and accurate access to pertinent clinical information consistent with related rules and regulations for protected health information and confidentiality.
    - As authorized by the consumer, MSHN provider network members will include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered plan.
    - Information sharing across the provider network will focus on essential aspects of the provision of health care and will assist with population health management as well as the coordination of individual care in accordance with requirements for confidentiality and protection of health information.

C. Collaboration with Community Agencies

MSHN through its CMHSP provider network must work closely with local public and private community-based organizations and providers to address prevalent human conditions and issues that relate to a shared customer base to provide a more holistic health care experience for the consumer. Such agencies and organizations may include local health departments, local Department of Health and Human Service, Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), community and migrant health centers, nursing homes, Area Agency and Commissions on Aging, Medicaid Waiver agents for the Home Community Based Waiver (HCBW) program, school systems, and Michigan Rehabilitation Services. Local coordination and collaboration with these entities will make a wider range of essential supports and services available to the PIHP beneficiaries. PIHPs through the region's CMHSPs will coordinate with these entities through participation in multi-purpose human services collaborative bodies, and other similar community groups.

The MSHN through its CMHSP provider network shall have written coordination agreements with each of the pertinent agencies noted above describing the coordination arrangements agreed to and how disputes between the agencies will be resolved. To ensure that the services provided by these agencies are available to all PIHP eligible consumers, an individual contractor shall not require an exclusive contract as a condition of participation with the PIHP.

Agreements shall assure that coordination regarding mutual recipients is occurring between the PIHP and/or its provider network, and primary care physicians. This policy shall minimally address all recipients of PIHP services for whom services or supports are expected to be provided for extended periods of time (e.g., people receiving case management or supports coordination) and/or those receiving psychotropic medications.

D. Housing

1. MSHN's provider network shall assist consumers/guardians with decisions about the most appropriate residential option for persons with disabilities.
2. CMHSP Participants within MSHN will maintain an established plan to work with community housing partners to promote desirable housing and residential options for persons with disabilities.
3. Standards:

i. An array of housing choices and related resources and supports shall be made available to persons served in their local communities and, whenever possible, shall allow for the individual to integrate into his/her home and community of choice.
ii. Each CMHSP Participant shall demonstrate leadership in suggesting, developing and refining local housing options to meet consumer needs and choices in their local communities.
iii. The residential option selected shall be based upon the needs and desires of the individual as part of the individual's person-centered plan.
iv. Housing options shall be based on the least restrictive setting that will best meet the needs of the individual.
v. CMHSP Participants will include cultural considerations when assisting consumers and guardians with residential options.
vi. Consumers and guardians shall be offered comparative information about housing providers whenever available.
vii. Housing options shall support consumers' plans and goals, and shall also promote overall wellness, health, safety, quality of life, meaningful community activities, and the highest possible level of independence, including within supervised settings.
viii. Respect for personal privacy for consumers shall be a priority in all housing settings.
ix. Housing settings shall be safe, habitable and affordable. Home settings of individuals served shall be monitored, by the contracting organization, on a regular basis for the purpose of consumer welfare, regardless of whether PIHP or CMHSP funds pay for the costs of the housing.
x. CMHSP Participants shall offer mandatory and elective training on a regular basis to support housing providers and staff.
xi. CMHSPs shall maintain collaborative agreements and communications with housing providers and resources in their communities, including participation in local planning groups or coalitions.
xii. Each CMHSP participant shall have and make available written policies and procedures regarding housing assistance, supports, and resources for consumer and guardian decision-making, including the on-going assessment needs in consumer housing.

E. Self Determination
1. MSHN shall ensure that all individuals served through Community Mental Health Programs are given the freedom to pursue Self Determination (SD) arrangements that provide the individual the ability to guide and direct the services and supports they receive.
2. Standards
i. A Person/Family-Centered Planning Process will be used to identify supports and services and provide information on how to participate in SD arrangements.
ii. Participation in SD arrangements shall be voluntary and shall be made available in accordance with established MDHHS best practice guidelines and state and federal regulations.

F. Employment
1. MSHN recognizes that employment is an essential element of the quality of life for most people. CMHSP Participants shall work together to achieve consistency across the region in providing competitive integrated employment services.
2. Standards
i. MSHN will assure that all recipients, including those who have advocates or guardians, have genuine opportunities for freedom of choice and self-representation.
ii. MSHN shall promote community inclusion and participation, independence and productivity throughout its provider network.

iii. Service providers within MSHN shall identify outcomes based on the individual's life goals, interests, strengths, abilities, desires, and preferences.
iv. Service providers within MSHN shall explore in the pre-planning meeting the person's options for work that include competitive employment, community group employment, self-employment, transitional employment, volunteering, education/training, and internships as a means to future competitive employment.
v. CMHSP Participants shall promote the use of best employment practices including the MDHHS adopted evidence-based practice Individual Placement and Support for employment goals for persons with mental illness.
vi. CMSHP Participants shall share and reinforce the MDHHS Employment Works! Policy across it service delivery network.
vii. Each CMHSP Participant shall designate a local staff member who will provide leadership in employment initiatives and services and shall designate at least one staff who has expertise in benefits planning or the capacity to access the information in a timely manner.
viii. CMHSP Participants shall share local best employment practices across MSHN.
ix. MSHN shall collect accurate employment outcome data and submit the data to MDHHS for review in a timely manner.
x. CMHSP Participants shall establish strategies and partnerships with Michigan Rehabilitation Services (MRS) and the Michigan Commission for the Blind (MCB) where indicated to improve consistency of MRS/MCB supports for consumers.

G. Transitions from Institutional Care (Behavioral Health Psychiatric Care)
1. MSHN shall promote and support a smooth and safe transition for each individual who is released from an institution into the community.
2. CMHSP Participants shall ensure that each individual will obtain placement appropriate to the individual's needs and will have a provider that is able to provide supports and services that enable the individual to live successfully in the community.
3. When a continuing stay review has determined that an individual no longer meets the medical necessity criteria for the institutional placement, CMHSP Participants shall seek other alternatives in the community that are available to meet the individual's treatment needs. In seeking other alternatives, the CMHSP Participant shall make every effort to ensure that the following standards have been considered.
4. Standards:
i. An individualized discharge/transition plan shall be completed utilizing the person-centered planning process, incorporating the individual's strengths, needs, abilities, and preferences.
ii. The discharge/transition plan shall have input and participation from the individual, family, authorized representatives, treatment team, and other community resources or supports as applicable.
iii. The discharge/transition plan should include needed support systems and types of services that will allow for successful transition and integration into the community.
iv. The individual and/or support people shall be educated on all options available for community support services and types of services needed for a successful transition into the community.
v. The discharge/transition plan should address any barriers that may interfere with a successful transition. The placement should allow for freedom of choice while ensuring that resources are in place to meet the individual's basic needs and ensure that the needs of the individual are met safely.
vi. Communication and coordination should occur for all services in the community prior to release. This includes but is not limited to coordination for continuity of medications and follow-up appointments for continuity of medical and behavioral health treatment.
vii. Referral information and appointments scheduled should be documented and given to the individual and/or authorized representative.

viii. Discharge/transition planning will follow the standards that are included in the Housing Practice Guidelines, Person Centered Planning Policy and Practice Guideline, Consumerism Practice Guidelines, and the Inclusion Practice Guideline.

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/Acronyms:

CMHSP: Community Mental Health Service Programs
Consumerism: Means active promotion of the interests, service needs, and rights of consumers receiving mental health and/or substance use disorder services.
Customers/Consumers: Refers to those individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.
FQHC: Federally Qualified Health Centers
HCBW: Home Community Based Waiver
MCB: Michigan Commission for the Blind
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
MRS: Michigan Rehabilitation Services
PIHP: Prepaid Inpatient Health Plan
RHC: Rural Health Centers
SD: Self Determination Arrangement

References/Legal Authority

1. Medicaid Provider Manual
2. Balanced Budget Act of 1997
3. MDHHS PIHP Contract – Person-Centered Planning; Cultural Competence;
4. Out of Network Responsibility; Consumerism Practice Guideline; and Inclusion Practice Guideline
5. MDHHS CMHSP Contract – Recovery Policy & Practice Advisory; Self Determination Practice & Fiscal Intermediary Guideline; QI Programs for CMHSPs; Housing Practice Guideline
6. MDHHS/PIHP Contract: Attachment 3.4.4 (The Self Determination Policy and Practice Guidelines, March 18, 2012)
7. Inclusion Practice Guideline C6.9.3.2
8. Employment Works! C6.9.8.1
9. MDHHS –PIHP Contract Collaboration with Community Agencies 7.2
10. MDHHS-PIHP Contract Integrated Physical and Behavioral health 7.4
11. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program
12. Housing Practice Guidelines (Attachment P 6.8.2.2)
13. Person Centered Planning Policy and Practice Guideline (Attachment P 3.4.1.1)
14. Consumerism Practice Guidelines (Attachment P 6.8.2.3)
15. Inclusion Practice Guideline (Attachment P 6.8.2.1)
16. 2017 Behavioral Health Standards Manual, Commission on Accreditation of the Rehabilitation Facilities (69-75), 2017.
17. Quality Improvement Data (Attachment P 6.5.1.1)
18. 42 CFR Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New policy	Customer Service Committee
04.2015	Annual review, format consistency	CEO, Utilization Management Committee and Clinical Leadership Committee
07.2015	Added Community Collaboration section to address MDHHS requirements; added integrated healthcare standards	Chief Executive Officer
03.2017	Annual Review	Chief Executive Officer
02.2018	Annual Review	Chief Clinical Officer
01.2019	Annual Review	Chief Behavioral Health Officer
08.2020	Annual	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Standardized Assessment**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Clinical Leadership Committee; Director of Utilization, and Utilization Management Committee	**Adopted Date:** 04.07.2015 **Review Date:** 11.10.2020	**Related Policies:** Service Philosophy

Purpose

In accordance with best practice standards and the Mid-State Health Network (MSHN) contract with the Michigan Department of Health and Human Services (MDHHS), MSHN's provider network inclusive of Community Mental Health Service Program (CMHSP) Participants and the Substance Use Disorder (SUD) Provider Network shall administer or require administration of standardized assessments, for specific populations served, as defined by the Medicaid Managed Specialty Supports and Services Contract with the Pre-Paid Inpatient Health Plan (PIHP) .

Policy

MSHN shall assure through contract, policy and procedure that regional provider network members are administering the noted standardized assessments as required. These assessments include, where clinically and contractually indicated, the American Society of Addiction Medicine (ASAM) Criteria, Global Appraisal of Individual Needs (GAIN), Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS), Level of Care Utilization System (LOCUS), the Supports Intensity Scale (SIS), and the Devereaux Early Childhood Assessment (DECA). When necessary, MSHN shall work with CMHSPs and the SUD Provider Network to establish regional procedures for the administration and monitoring of standard assessment compliance.

MSHN staff or provider network members shall participate in MDHHS selection, planning and monitoring of standardized assessment administration as required.

Applies to:

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

Definitions:

ASAM: American Society of Addiction Medicine
CAFAS: Child and Adolescent Functional Assessment Scale
CMHSP: Community Mental Health Services Programs
DECA: Devereaux Early Childhood Assessment
GAIN: Global Appraisal of Individual Needs
LOCUS: Level of Care Utilization System
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PECFAS: Preschool and Early Childhood Functional Assessment Scale
PIHP: Pre-paid Inpatient Health Plan
Provider Network: MSHN's provider network is inclusive of and limited to the CMHSPs and the SUD Provider Network; Contracted providers for the administration of services to persons with substance use disorder services.
SIS: Supports Intensity Scale

Other Related Materials:
N/A

References/Legal Authority: MDHHS – PIHP
Contract and related amendments.

Change Log:

Date of Change	Description of Change	Responsible Party
01.2015	New Policy	CEO
03.2016	Annual Review.	Director of Utilization Management and Waiver Services
02.2017	Added standardized assessments by name.	Director of Utilization Management and Waiver Services
01.2018	No changes	Director of Utilization Management and Waiver Services
02.2019	Annual Review	Chief Behavioral Health Officer; Director of Utilization Management
08.2020	Annual Review	Chief Behavioral Health Officer, Director of Utilization and Care Management
09.2022	Biennial Review	Chief Behavioral Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery		
Title:	**SUD Services - Medication Assisted Treatment Inclusion**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** ~~Annually~~Biennial **Author:** Chief Clinical Officer SUD Medical Director Medical Director	**Adopted Date: 03.06.2018** **Review Date: 01.12.2021** ~~**Revision Eff. Date:**~~	**Related Policies:** Service Philosophy & Treatment

Purpose

Medication-Assisted Treatment (MAT) is a standard of care that is broadly recognized as foundational to any comprehensive approach to the national opioid addiction and overdose pandemic. MSHN seeks to ensure therefore that no MSHN client is denied access to or pressured to reject the full array of evidence-based and potentially life-saving treatment options, including MAT, that are determined to be medically necessary for the individualized needs of that client.

Policy

Following the recommendations by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), the American Society for Addiction Medicine (ASAM), the National Institute for Drug Abuse (NIDA), the Michigan Department of Health and Human Services (MDDHS)'s Office of Recovery Oriented Systems of Care (OROSC) Treatment Policies #5 and #6, and other state and national directives, MSHN-contracted SUD treatment providers are expected to adopt a MAT-inclusive treatment philosophy in which 1) the provider demonstrates willingness to serve all eligible treatment-seeking individuals, including those who are using MAT as part of their individual recovery plan at any stage of treatment or level of care, and without precondition or pressure to adopt an accelerated tapering schedule and/or a mandated period of abstinence, 2) the provider develops policies that prohibit disparaging, delegitimizing, and/or stigmatizing of MAT either with individual clients or in the public domain.

Abstinence-Based (AB) Providers – In the interest of offering client choice, MSHN will contract with AB providers who offer written policies and procedures stating the following:

1. If a prospective client, at the point of access, expresses his/her preference for an abstinence-based treatment approach, the access worker will obtain a signed MSHN Informed Consent form that attests that the client was informed in an objective way about other treatment options and recovery pathways including MAT, and the client is choosing an abstinence-based provider from an informed perspective.
2. When a client already on MAT (or considering MAT) is seeking treatment services (counseling, case management, recovery supports, and/or transitional housing) at the point of access to an AB facility, access staff will a) be accepting towards MAT as a choice, b) will not pressure the client to make a different choice, c) will work with that client to do a "warm handoff" to another provider of the client's choice by scheduling an appointment with the chosen provider that can provide those ancillary services while the client pursues his or her chosen recovery pathway that includes MAT, and d) will follow up with the chosen provider to ensure client admission.
3. Providers' written policies will include language that prohibits delegitimizing, and/or stigmatizing of MAT (e.g. using either oral or written language that frames MAT as "substituting one addiction for another") either with individual clients, written materials for distribution to clients, or in the public domain.

Applies to:

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

Definitions

AB: Abstinence-Based
ASAM: American Society for Addiction Medicine
CDC: Centers for Disease Control and Prevention
MAT: Medication-Assisted Treatment
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health and Human Services
OROSC: Office of Recovery Oriented Systems of Care
SAMHSA: Substance Abuse and Mental Health Services Administration
SUD: Substance Use Disorder

Other Related Materials

1. SAMHSA Treatment Improvement Protocol #43 - MAT for Opioid Addiction in Opioid Treatment Programs
2. U.S. Surgeon General – Treatment Options
3. National Institute on Drug Abuse Effective Treatment for Opioid Addiction
4. The Center for Disease Control "Vital Signs" – Today's Heroin Epidemic
5. White House Commission on Combating Drug Addiction and the Opioid Crisis White House Commission on Combating Drug Addiction and the Opioid Crisis – Letter to the President
6. ASAM National Practice Guideline
7. MDHHS MAT Guidelines for Opioid Use Disorders
8. MSHN 20222~~18~~ SUD Provider Manual

References/Legal Authority:

1. Behavioral Health and Developmental Disabilities Administration Treatment Policy #5
2. Behavioral Health and Developmental Disabilities Administration Treatment Policy #6

Change Log:

Date of Change	Description of Change	Responsible Party
12.2017	New Policy	Chief Clinical Officer, SUD Medical Director & Medical Director
02.2019	Annual Review	Chief Clinical Officer
10.2020	Annual Review	Chief Clinical Officer
08.2022	~~Annual~~ Biennial Review	Chief Clinical Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	**SUD Services – Out of Region Coverage**		
Policy: ☑ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** ~~Annually~~Biennial **Author: Utilization Mgmt. and Waiver Director**	**Adopted Date: 09.06.2016** **Review Date:** 01.12.2021 **~~Revision Eff. Date:~~**	**Related Policies:**

Purpose

The purpose of this policy is to delineate the Mid-State Health Network (MSHN) stance on MSHN-Medicaid consumer coverage for beneficiaries who receive residential or detoxification services outside of the MSHN region.

Policy

It is the policy of MSHN that for individuals receiving covered residential or detoxification services in a licensed out of region provider, that providers take no action to change the Medicaid county of residence of the individual receiving services.

Additional Guidance:

MSHN has established contracts with certain out of region (i.e., ~~i.e.~~ outside of the MSHN 21-county area) substance use disorder (SUD) treatment providers for residential and/or detoxification services. In other cases, MSHN will engage in "single-consumer" letters of agreement with providers not previously empaneled in the MSHN provider network to facilitate needed care.

It has been the historical practice of some SUD residential and/or detoxification treatment providers to contact local MDHHS eligibility personnel to transfer the consumer's Medicaid county of residence coverage to the county in which the treatment facility exists. Per the Medicaid Services Administration (MSA), there is no type of eligibility requirement dictating such a change in address when the consumer enters any treatment program.

The unintended consequence of switching any consumer's Medicaid coverage temporarily to a non-MSHN county results in the consumer being assigned to a different Pre-Paid Inpatient Health Plan (PIHP) region. In addition, when the consumer leaves the SUD provider and returns home, he or she will not be able to get medical or other covered services in their home county until the Medicaid coverage is returned to the original PIHP (MSHN) assignment. This represents a barrier to treatment that should not exist for beneficiaries. The MSHN access management system should be service-driven and facilitate meeting the needs of the client without risking disengagement or constructing unnecessary barriers to benefit utilization.

MSHN has established rates for reimbursement to account for any benefits that the provider may use on behalf of the consumer, making a consumer address change initiated by the SUD provider unnecessary.

The MSHN region also contains Medicaid Health Plan (MHP) coverages (~~i.e.~~i.e., Medicaid Regional Prosperity Regions) that include all plans in the lower peninsula such that when the MSHN consumer participates in an out-of-region SUD program, adequate healthcare coverage continues to exist for that consumer.

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:
CMHSP: Community Mental Health Service Program
MDHHS: Michigan Department of Health and Human Services
MHP: Medicaid Health Plan
MSA: Medicaid Services Administration
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
SUD: Substance Use Disorder

Other Related Materials:

References/Legal Authority:
MDHHS Bureaus of Substance Abuse and Addiction Services Treatment Policy #7
MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program
MDHHS Michigan Medicaid Health Plans beginning January 1, 2016
MSHN Technical Requirement: CMHSP Responsibilities for 24/7/365 Access for Individuals with Primary Substance Use Disorders

Change Log:

Date of Change	Description of Change	Responsible Party
08.08.2016	New Policy	Utilization Mgmt. & Waiver Director
02.28.2018	Annual Review	UM Director & Director of Provider Network Management Systems
3.2019	Annual Review	Chief Clinical Officer
10.2020	Annual Review	Chief Clinical Officer
08.2022	~~Annual~~Biennial Review	Chief Clinical Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**SUD Services-Women's Specialty Services**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** ~~Annually~~~~Biennail~~Biennial **Author:** SUD Workgroup, Health Integration, Treatment & Prevention Director	**Adopted Date: 07.07.2015** **Review Date:** 01.12.2021 ~~**Revision Eff. Date:**~~	**Related Policies:** Service Philosophy & Treatment

Purpose

The purpose of this policy is to establish the philosophy, requirements and procedure for women's substance use disorder (SUD) treatment services (Designated women's programs and gender competent programs) within the Mid-State Health Network (MSHN) region.

Standards

A. Substance Abuse Prevention and Treatment (SAPT) Block Grant requirements; (42U.S.C.96.124 [e])
B. Michigan Public Act 368 of 1978, Part 62, Section 333.6232.
C. Federal Regulation 45 CFR Part 96.
D. Michigan Department of Health & Human Services (MDHHS), Substance Abuse Treatment Policy #12, Women's Treatment Services (October 1, 2010).
E. Michigan Department of Health & Human Services (MDHHS), Substance Abuse Treatment Technical Advisory #8, Enhanced Women's Services (January 31, 2012)

Policy

MSHN strives to provide exceptional, gender-specific SUD prevention, treatment and recovery services, using the best quality, consumer-friendly, cost-efficient means possible. Women Specialty Service providers shall adhere to the following core values in delivery of care and service:

A. Family-Centered (Family is defined by the consumer)
B. Family Involvement
C. Build on Natural and Community Supports
D. Strength-based
E. Unconditional Care
F. Collaboration Across Systems
G. Team Approach across Agencies
H. Ensuring Safety
I. Gender/Age/Culturally Responsive Treatment
J. Self-sufficiency
K. Education and Work Focus
L. Belief in Growth, Learning, and Recovery
M. Outcome Oriented Services

Consumer Eligibility Criteria

- Pregnant women
- Women with dependent children
- Women attempting to regain custody of their children and/or women whose children are at-risk of out-of-home placement due to substance abuse
- Men who are the primary caregivers of dependent children
- Men, established as primary caregiver, attempting to regain custody of their children and/or men, established as primary caregiver, whose children are at-risk of out-of-home placement due to substance abuse

MSHN requires all providers screen and/or assess for the above eligibility.

Federal Requirements

Federal requirements are contained in 45 CFR (Part 96) section 96.124, and may be summarized as:

- Providers receiving funding from the state-administered funds set aside for WSS consumers must provide or arrange for the 5 types of services, as listed below. Use of state administered funds to purchase primary medical care and primary pediatric care must be approved, in writing, in advance, by the Department contract manager.

For eligible clients, the following federal services must be made available:

1. Primary medical care for women receiving SUD treatment.
2. Primary pediatric care for their children, including immunizations.
3. Gender specific SUD treatment and therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting.
4. ~~Child care~~Childcare while women are receiving these services, therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect.
5. Sufficient case management and transportation services to ensure that women and children have access to the services provided in the first 4 requirements.

The above five types of services may be provided through the MDHHS/PIHP agreement only when no other source of support is available and when no other source is financially responsible.

Women's Specialty Services may only be provided by providers that are designated as gender-responsive by the Michigan Department of Health & Human Services or certified as gender-competent by MSHN and that meet standard panel eligibility requirements. MSHN will maintain an accessible list of choice providers offering gender-competent treatment and identify providers that provide the additional services specified in the federal requirements.

Additional WSS information and requirements:

Providers should reference MSHN's 20222~~19~~ SUD Provider Manual for additional WSS information, including:

- Encounter Reporting Requirements
- Admission Preference & Interim Services
- Access Timeliness Standards
- Admission Priority Requirements
- WSS Service Delivery Tiers
- WSS Program Structure
- WSS Treatment

Applies to:

☒All Mid-State Health Network Staff

☐Selected MHN Staff, as follows:

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

☒ Other: Sub-contract Providers

Definitions:

MSHN: Mid-State Health Network

PIHP: Prepaid Inpatient Health Plan

SAPT: Substance Abuse Prevention and Treatment

SUD: Substance Use Disorder

WSS: Women's Specialty Services

Other Related Materials:
MSHN 20222~~17~~ SUD Provider Manual

References/Legal Authority:
1. MDHHS/BHDDA Substance Abuse Treatment Policy #12, Women's Treatment Services.
2. MDHHS/BHDDA Treatment Technical Advisory #08, Enhanced Women's Services

Change Log:

Date of Change	Description of Change	Responsible Party
03.03.2015	New Policy	Deputy Director
07.13.2016	Revisions	Lead Treatment Specialist
03.2017	Annual Review	Deputy Director
02.2018	Annual Review	Chief Clinical Officer
03.2019	Annual Review	Chief Clinical Officer
10.2020	Annual Review	Chief Clinical Officer
08.2022	Biennial ~~Annual~~ Review	Chief Clinical Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Supports Intensity Scale**		
Policy: ☒ **Procedure:**☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Behavioral Health Officer	**Adopted Date:** 07.07.2015 **Review Date:** ~~11~~07.~~10~~28.~~2020~~2022	**Related Policies:** ~~Service Delivery~~

Purpose

Mid-State Health Network (MSHN) shall administer the Supports Intensity Scale (SIS) in accordance with the Pre-Paid Inpatient (PIHP) contract with the Michigan Department of Health and Human Services (MDHHS).

Policy

MSHN shall comply with section 7.7.3 Supports Intensity Scale of the PIHP Contract. In accordance with the contract MSHN shall:

1. Ensure that each individual age 16 and older with an Intellectual/Developmental Disability who has also received a case management, supports coordination, or respite only service, is assessed using the Supports Intensity Scale (SIS) at minimum of once every 3 years (or more or if the person experiences significant changes in their support needs). ~~The PIHP will need to ensure that a proportioned number of assessments are completed each year to assure that all are done in the three-year cycle. Each three-year cycle will begin consecutive to the end of the previous three-year cycle.~~ PIHPs or their designee shall continue to engage, at least annually, individuals who did not participate (or declined) in the SIS assessment, to increase their understanding of the benefits of the process and how results will be used. The SIS is an essential and valued part of service planning.

2. Ensure an adequate team of trained and American Association on Intellectual and Developmental Disabilities (AAIDD) recognized as qualified SIS assessors across its region to ensure that all individuals are assessed in the required timeframe…"

To achieve the requirement for SIS administration, each CMHSP shall designate a "clinical contact" to facilitate communication between the assigned SIS Assessor and their respective organization. Clinical contacts or their designees will be responsible for communicating with the SIS Assessor, knowing the requirements to complete a valid SIS, scheduling the assessment times, and getting the SIS report into their Electronic Medical Record (EMR). Clinical contacts should attempt to set the SIS Assessment appointment at least 90 days in advance of the individual's person-centered plan expiration date as best practice to ensure SIS results can be included in the plan.

Applies to:

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

Definitions:

AAIDD: American Association on Intellectual and Developmental Disabilities
CMHSP: Community Mental Health Service Program
EMR: Electronic Medical Record
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan

SIS: Supports Intensity Scale
UM: Utilization Management

Related Materials:
SIS Procedure
Attachment A: Reporting and billing of valid SIS Claims

References/Legal Authority:
PIHP-MDHHS Contract ~~FY20~~FY22
Supports Intensity Scale Implementation Manual, July 2020

Change Log:

Date of Change	Description of Change	Responsible Party
06.2015	New Policy	Waiver Director, Chief Compliance Officer
04.2016	Annual Review/Update	UM & Waiver Director
02.2017	Annual review	UM & Waiver Director
01.2018	Annual review	UM & Waiver Director
02.2019	Annual Review	Chief Behavioral Health Officer
08.2020	Annual Review	Chief Behavioral Health Officer
07.2022	Biennial Review	Chief Behavioral Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Supports Intensity Scale Quality Lead Policy**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Behavioral Health Officer	**Adopted Date:** 07.05.2016 **Review Date:** ~~11~~07.~~10~~28.202~~0~~2 **Revision Eff. Date:**	**Related Policies:** Support Intensity Scale Policy

Purpose

Mid-State Health Network (MSHN) shall ensure that all Supports Intensity Scale (SIS) assessors meet quality and reliability standards and allow the completion of assessments within each three-year timeframe through development of a SIS Quality Lead.

Policy

MSHN shall comply with the Michigan Department of Health and Human Services (MDHHS) section 7.7.3 Supports Intensity Scale of the PIHP Contract and the MDHHS SIS Implementation Manual by identifying, developing, and utilizing a SIS Quality Lead.

PIHP SIS Quality Lead is a SIS assessor and ensures that all SIS assessors in the MSHN region continue to meet AAIDD quality and reliability standards and allow the completion of assessments ~~within the three-year timeframe~~relative to the appropriate timeframes established by MDHHS. The PIHP SIS Quality Lead is intended to be a liaison to the SIS assessors within the MSHN region as the individual responsible for the development and maturation of the region's SIS assessor skillsets. The SIS Quality Lead shall develop and maintain the appropriate skillset and meet the following criteria:

1. Passed (at the Qualified: Excellent-Excellent or higher level) an Interviewer Reliability and Qualification Review (IRQR) conducted by an American Association on Intellectual and Developmental Disabilities (AAIDD) recognized trainer;
2. Have experience conducting assessments for a range of individuals with varying needs and circumstances;
3. Participated in regular Quality Assurance and Drift Reviews to develop his or her skills.
4. Possess the ability to transform from a skills focus while conducting assessments to a needs and supports orientation;
5. Effective communication skills;
6. Public speaking skills;
7. Ability to relate well to groups;
8. Ability to work well with people with various backgrounds;
9. Effective audience management skills;
10. Flexibility with work schedule, including commitment to completing work within designated timeframes;
11. Willingness and eagerness to participate as an internal lead;
12. Analytical skills to address difficult questions or problematic participants;
13. Ability to effectively use audio-visual equipment;
14. Effective time management skills;
15. Flexibility to modify presentation based on audience;
16. Strong organizational skills;
17. Practical knowledge of adult learning strategies;
18. Ability to deal with ambiguity (the rules will not always be clear or multiple changes may need to occur);
19. As ambassadors of the SIS implementation strategy, the person selected should present a positive view of the process and have a solid understanding of the SIS process and the tool;
20. Always seek to improve effectiveness and achieve greater efficiencies in the implementation strategy; and
21. Demonstrate a sense of humor as the ability to promote humor in a SIS training session is essential.

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

Definitions:
AAIDD: American Association on Intellectual and Developmental Disabilities
CMHSP: Community Mental Health Service Program
IRQR: Interviewer Reliability and Qualification Review
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health and Human Services
PDR: Periodic Drift Review
PIHP: Prepaid Inpatient Health Plan
QL: Quality Lead
SIS: Supports Intensity Scale
UM: Utilization Management

Other Related Materials:
N/A

References/Legal Authority:
PIHP-MDHHS Contract ~~FY15~~ FY22
MDHHS SIS Implementation Manual

Change Log:

Date of Change	Description of Change	Responsible Party
04.2016	New Policy	UM & Waiver Director
02.2017	Annual review	UM & Waiver Director
01.2018	Annual review/No changes	UM & Waiver Director
02.2019	Annual Review	Chief Behavioral Health Officer
08.2020	Annual Review	Chief Behavioral Health Officer
07.2022	Annual Review	Chief Behavioral Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter	**Service Delivery System**		
Title:	**Substance Use Disorder (SUD) Services: Telemedicine**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Behavioral Health Officer & Chief Clinical Officer	**Adopted Date:** 07.09.2019 **Review Date:** 11.10.2020	**Related Policies:**

Purpose

The purpose of this policy is to delineate the use of synchronous (i.e. real-time two-way interactivity) telemedicine services using telecommunication technology to connect a patient with a health care professional in a different location.

Policy

It is the policy of Mid-State Health Network (MSHN) to make telemedicine available through the provider system to connect the individual served with an appropriately established professional for treatment involving substance use disorder (SUD).

The following standards must be met:

A. The telecommunication technology shall be synchronous (i.e. "real-time") between the individual and the health care professional.
B. The telecommunication technology must meet requirements for audio and visual compliance in accordance with current regulations and standards for privacy and security of all information shared via telemedicine.
C. Telecommunication systems using asynchronous (i.e. "store and forward" methods like email) transmission of data are not considered to be a part of this policy.
D. The real-time interactive system shall include the originating site (location of the individual in treatment at the time the service is furnished) and the distant site (provider). Authorized originating sites include:
    1) County mental health clinic or publicly funded mental health facility
    2) Federally Qualified Health Center (FQHC)
    3) Hospital (inpatient, outpatient, or critical access hospital)
    4) Office of a physician or other practitioner (including medical clinics)
    5) Hospital-based or CAH-based renal Dialysis Centers (including satellites)
    6) Rural health clinic
    7) Skilled nursing facility
    8) Tribal Health Center (THC)
    9) Mobile Health Care Unit
E. In compliance with the Michigan Insurance Code of 1956 (Act 218 of 1956), telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the individual is located.
F. The physician or practitioner at the distant site who is licensed under state law to furnish a covered telemedicine service may bill and receive payment for the service when it is delivered via a telecommunications system.
G. The provider shall have a contract with or be authorized by MSHN to perform telemedicine services and shall also be enrolled in Michigan Medicaid.
H. Providers can only bill for services listed on the Current Allowable Telemedicine Services list as appropriate.
I. The individual shall be provided and complete informed consent in verbal and written form prior to the delivery of telemedicine services.

J. The treating professional shall follow all professional licensing and ethical standards delineated by the state of Michigan related to his or her area of practice (i.e. counseling, psychology, social work, etc.) in addition to his or her governing accrediting body (i.e. APA, CRCC, NBCC, NASW, etc.).

Applies to

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

Definitions

APA: American Psychological Association
Asynchronous communication: Also known as store and forward, any electronic communication that does not occur in real-time, such as email, texts, blogs, social media, listservs, and newsgroups.
CAH: Critical Access Hospital
CRCC: Commission on Rehabilitation Counselor Certification.
Distant Site: the location of the professional providing the telemedicine service at time of delivery.
FQHC: Federally Qualified Health Center
MSHN: Mid-State Health Network
NASW: National Association of Social Workers.
NBCC: National Board for Certified Counselors.
Originating Site: the location of the individual in treatment at the time the service is furnished.
SUD: Substance Use Disorder(s)
Synchronous Communication: any electronic communication that occurs in real-time, such as video conferencing, webcams, telemedicine.
THC: Tribal Health Center

Other Related Materials

N/A

References/Legal Authority

Michigan Department of Health and Human Services, Michigan Medicaid Provider Manual
Michigan Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing
PIHP Encounter Reporting HCPCs and Revenue Codes/Current Allowable Telemedicine Services

Change Log:

Date of Change	Description of Change	Responsible Party
02.06.2019	New policy	Chief Behavioral Health Officer & Chief Clinical Officer
08.27.2020	Biennial Review	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery**		
Title:	**Trauma-Informed Systems of Care**		
Policy: ☒ **Procedure:** ☐ **Page: 1 of 2**	Review Cycle: Biennial **Authors:** Chief Clinical Officer, Chief Behavioral Health Officer	**Adopted Date: 07.07.2020** **Review Date:** 11.10.2020	**Related Policies**:

Purpose:
This policy ensures that Mid-State Health Network (MSHN) and its provider network promotes an understanding of trauma and its impact, develops and implements trauma-informed systems of care, and ensures availability of trauma-specific services for all persons served.

Policy:
It is the policy that MSHN and its provider network develop a trauma-informed system of care that is inclusive of internal staff, consumers across the developmental spectrum and throughout the full array of services offered. The following elements should be included:

I. Adoption of trauma informed culture: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization.
II. An organizational self-assessment for trauma-informed care, to be updated every three years. It should a) evaluate the extent to which providers' policies and practices are trauma-informed, b) identify organizational strengths and barriers, and c) include an environmental scan to ensure that the internal culture, environment, and building(s) are safe and trauma-sensitive.
III. Inclusion of strategies to address secondary trauma for all staff, including, but not limited to opportunities for supervision, trauma-specific incident debriefing, training, self-care, and other organizational support.
IV. Universal screening for trauma exposure and related symptoms for each population. The screening instrument should be culturally competent, standardized, validated, and appropriate for each population.
V. Trauma-specific assessment for all populations served. The assessment tool should be culturally competent, standardized, validated, and appropriate for each population.
VI. Trauma-specific services for each population using evidence-based practices (EBPs) or promising practice(s) are provided in addition to EBPs when no EBP is appropriate.
VII. Collaboration between MSHN, its provider networks, and community partners to support development of a trauma informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders.

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:

Adverse Childhood Experiences (ACEs): Stressful or traumatic events that children might experience including abuse, neglect, witnessing domestic violence, incarceration of a parent, or a family member with serious mental illness and/or a substance use disorder. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance abuse.

Populations Served: Includes children with serious emotional disturbance, adults with serious mental illness, persons with intellectual/developmental disabilities, persons with substance use disorders including co-occurring disorders.

Re-traumatization: A situation, attitude, interaction, or environment that replicates the events or dynamics of the original trauma and triggers the overwhelming feelings and reactions associated with them.

Secondary Trauma: The emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder. Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure.

Trauma: The results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or threatening and that have lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. Forms of traumatizing events include violence and assault, discrimination, racism, oppression, and poverty. These chaotic life conditions are directly related to chronic fear and anxiety and can have serious long-term effects on health and other life outcomes.

Trauma-informed Services: Services designed specifically to avoid re-traumatizing those who seek assistance as well as staff working in service settings. These services seek "safety first" and commit themselves to "do no harm".

Trauma-specific Services: Services or interventions designed specifically to address the consequences of trauma in the individual and to facilitate healing.

Other Related Materials:
N/A

References/Legal Authority:
Medicaid Managed Trauma Specialty Supports and Services Program,
FY20, Contract Amendment #1, Attachment 7.10.6.1

Change Log:

Date of Change	Description of Change	Responsible Party
04.2020	New Policy	Chief Behavioral Health Officer/Chief Clinical Officer
08.2020	New Policy	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer