Mid-State Health Network

Board of Directors Meeting ~ July 2, 2024 ~ 5:00 p.m.

Board Meeting Agenda

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

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

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

   Motion to Approve the Agenda of the July 2, 2024 Meeting of the MSHN Board of Directors
4. Public Comment (3 minutes per speaker)
5. **Action Item:** 2024 MSHN Revised Corporate Compliance Plan *(Page 6)*

   Motion to approve and acknowledge receipt of the Revised 2024 Corporate Compliance Plan.
6. Harm Reduction Presentation *(Page 34)*
7. Chief Executive Officer's Report *(Page 41)*
8. Deputy Director's Report *(Page 60)*
9. Chief Financial Officer's Report

   Financial Statements Review for Period Ended May 31, 2024 *(Page 80)*

   ACTION ITEM: Receive and File the Preliminary Statement of Net Position and Statement of Activities for the Period ended May 31, 2024, as presented
10. **ACTION ITEM:** Contracts for Consideration/Approval *(Page 89)*

    The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2024 Contracts, as Presented on the FY 2024 Contract Listing
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 05/07/2024 *(Page 91)*
    13.2 Receive Policy Committee Minutes 06/04/2024 *(Page 96)*
    13.3 Receive Operations Council Key Decisions 05/22/2024 *(Page 98)* and 06/17/2024 *(Page 100)*

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.

****

Board of Directors Meeting Materials:
Click **HERE**
or visit MSHN's website at:
https://midstatehealthnetwork.org/stakeholders-resources/board-councils/board-of-directors/fy2024-meetings

****

Upcoming FY24 Board Meetings

Board Meetings convene at 5:00pm unless otherwise noted

September 10, 2024
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

Pending Approval:
November 5, 2024
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

****

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

13.4 Approve the following policies:

13.4.1 Advance Directives *(Page 102)*

13.4.2 Customer Handbook *(Page 105)*

13.4.3 Customer Service *(Page 108)*

13.4.4 Enrollee Rights *(Page 112)*

13.4.5 Information Accessibility/Limited English Proficiency (LEP) *(Page 115)*

13.4.6 Medicaid Beneficiary Appeals/Grievances *(Page 120)*

13.4.7 Regional Consumer Advisory Council *(Page 125)*

13.4.8 SUD Recipient Rights *(Page 130)*

13.4.9 Compliance Reporting and Investigations *(Page 133)*

13.4.10 Disclosure of Ownership Policy *(Page 136)*

14. Other Business

15. Public Comment (3 minutes per speaker)

16. Adjourn

Please thank the Mid-State Health Network Directors and Staff for floral lantern for Gretchen.

During a time
like this
we realize how much
our friends and relatives
really mean
to us....
Your expression
of sympathy will always
be remembered.

Bill & Sue

MSHN
Mid-State Health Network

FY24 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		517.230.5911		CEI	2025
Brodeur	Greg	brodeurgreg@gmail.com		989.413.0621		Shia Health & Wellness	2027
DeLaat	Ken	kend@nearnorthnow.com		231.414.4173		Newaygo County MH	2026
Gibb	Bruce	brucegibb@gmail.com		989.975.0156		HBH	2026
Griesing	David	davidgriesing@yahoo.com		989.823.2687		TBHS	2027
Grimshaw	Dan	midstatetitlesvcs@mstsinc.com		989.823.3391	989.823.2653	TBHS	2026
Hicks	Tina	tmhicksmshn64@gmail.com		989.576.4169		GIHN	2027
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2027
Ladd	Jeanne	stixladd@hotmail.com		989.634.5691		Shia Health & Wellness	2027
McFarland	Pat	pjmcfarland52@gmail.com		989.225.2961		BABHA	2026
McPeek-McFadden	Deb	deb2mcmail@yahoo.com		616.794.0752	616.343.9096	The Right Door	2027
Nyland	Gretchen	gretchen7080@gmail.com		616.761.3572		The Right Door	2025
O'Boyle	Irene	irene.oboyle@cmich.edu		989.763.2880		GIHN	2026
Palmer	Paul	ppalmer471@ymail.com		517.256.7944		CEI	2025
Pawlak	Bob	bopav@aol.com		989.233.7320		BABHA	2025
Peasley	Kurt	peasleyhardware@gmail.com		989.560.7402	989.268.5202	MCN	2027
Phillips	Joe	joe44phillips@hotmail.com		989.386.9866	989.329.1928	CMH for Central	2026
Raquepaw	Tracey	tl.raquepaw@icloud.com	raquepawt@michigan.gov	989.737.0971		Saginaw County CMH	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	2026
Twing	Susan	set352@hotmail.com		231.335.9590		Newaygo County MH	2025
Williams	Joanie	jkwms1@gmail.com		989.860.6230		Saginaw County CMH	2026
Woods	Ed	ejw1755@yahoo.com		517.392.8457		LifeWays	2027

MSHN
Mid-State Health Network

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

ACA: Affordable Care Act

ACT: Assertive Community Treatment

ARPA: American Rescue Plan Act (COVID-Related)

ASAM: American Society of Addiction Medicine

ASAM CONTINUUM: Standardized assessment for adults with SUD needs

ASD: Autism Spectrum Disorder

BBA: Balanced Budget Act

BH: Behavioral Health

BHH: Behavioral Health Home

BPHASA – Behavioral and Physical Health and Aging Services Administration

BH-TEDS: Behavioral Health–Treatment Episode Data Set

CC360: CareConnect 360

CCBHC: Certified Community Behavioral Health Center

CAC: Certified Addictions Counselor
Consumer Advisory Council

CEO: Chief Executive Officer

CFO: Chief Financial Officer

CIO: Chief Information Officer

CCO: Chief Clinical Officer

CFR: Code of Federal Regulations

CFAP: Conflict Free Access and Planning (Replacing CFCM)

CLS: Community Living Services

CMH or CMHSP: Community Mental Health Service Program

CMHA: Community Mental Health Authority

CMHAM: Community Mental Health Association of Michigan

CMS: Centers for Medicare and Medicaid Services (federal)

COC: Continuum of Care

COD: Co-occurring Disorder

CON: Certificate of Need (Commission) – State

CPA: Certified Public Accountant

CQS: – Comprehensive Quality Strategy

CRU: Crisis Residential Unit

CS: Customer Service

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

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

CW: Children's Waiver

DAB: Disabled and Blind

DEA: Drug Enforcement Agency

DECA: Devereux Early Childhood Assessment

DMC: Delegated Managed Care (site visits/reviews)

DRM: Disability Rights Michigan

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

D-SNP: Dual Eligible Special Needs Plan

EBP: Evidence-Based Practices

EEO: Equal Employment Opportunity

EMDR: Eye Movement & Desensitization Reprocessing therapy

EPSDT: Early and Periodic Screening, Diagnosis and Treatment

EQI: Encounter Quality Initiative

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

FC: Finance Council

FI: Fiscal Intermediary

FOIA: Freedom of Information Act

FSR: Financial Status Report

FTE: Full-time Equivalent

FQHC: Federally Qualified Health Centers

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

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

HHP: Health Home Provider

HIPAA: Health Insurance Portability and Accountability Act

HITECH: Health Information Technology for Economic and Clinical Health Act

HMP: Healthy Michigan Program

HMO: Health Maintenance Organization

HRA: Hospital Rate Adjuster

HSAG: Health Services Advisory Group (contracted by state to conduct External Quality Review)

HSW: Habilitation Supports Waiver

ICD-10: International Classification of Diseases – 10th Edition

ICO: Integrated Care Organization (a health plan contracted under the Medicaid/Medicare Dual eligible pilot project)

ICTS: Intensive Community Transitions Services

I/DD: Intellectual/Developmental Disabilities

IDDT: Integrated Dual Diagnosis Treatment

IOP: Intensive Outpatient Treatment

ISF: Internal Service Fund

IT/IS: Information Technology/Information Systems

KPI: Key Performance Indicator

LBSW: Licensed Baccalaureate Social Worker

LEP: Limited English Proficiency

LLMSW: Limited Licensed Masters Social Worker

LMSW: Licensed Masters Social Worker

LLPC: Limited Licensed Professional Counselor

LPC: Licensed Professional Counselor

LOCUS: Level of Care Utilization System

LTSS: Long Term Supports and Services

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

MAT: Medication Assisted Treatment (see MOUD)

MCBAP: Michigan Certification Board for Addiction Professionals

MSHN
Mid-State Health Network

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

MichiCANS: Michigan Child and Adolescent Needs and Strengths

MiHIA: Michigan Health Improvement Alliance

MiHIN: Michigan Health Information Network

MLR: Medical Loss Ratio

MMBPIS: Michigan Mission Based Performance Indicator System

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

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

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

MPHI: Michigan Public Health Institute

MRS: Michigan Rehabilitation Services

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

NAMI: National Association of Mental Illness

NASMHPD: National Association of State Mental Health Program Directors

NCQA: National Committee for Quality Assurance

NCMW: National Council for Mental Wellbeing

OC: Operations Council

OHCA: Organized Health Care Arrangement

OHH: Opioid Health Home

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

PRTF: Psychiatric Residential Treatment Facility

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

RHC: Rural Health Clinic

RR: Recipient Rights

RRA: Recipient Rights Advisor

RRO: Recipient Rights Office/Recipient Rights Officer

SAMHSA: Substance Abuse and Mental Health Services Administration (federal)

SAPT: Substance Abuse Prevention and Treatment (when it includes an "R", means "Recovery")

SARF: Screening, Assessment, Referral and Follow-up

SCA: Standard Cost Allocation

SDA: State Disability Assistance

SED: Serious Emotional Disturbance

SB: Senate Bill

SIM: State Innovation Model

SMI: Serious Mental Illness

SPMI: Severe & Persistent Mental Illness

SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income (Social Security)

SSN: Social Security Number

SUD: Substance Use Disorder

SUD OPB: Substance Use Disorder Regional Oversight Policy Board

SUGE: Bureau of Substance Use, Gambling and Epidemiology

TANF: Temporary Assistance to Needy Families

THC: Tribal Health Center

UR/UM: Utilization Review or Utilization Management

VA: Veterans Administration

VBP: Value Based Purchasing

WM: Withdrawal Management (formerly "detox")

WSA: Waiver Support Application

WSS: Women's Specialty Services

YTD: Year to Date

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

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 2024 Corporate Compliance Plan was revised by the MSHN Compliance Committee, Regional Compliance Committee and the Operations Council with recommendation for approval to the MSHN Board of Directors. The revisions were based on required action identified by the Office of Inspector General after review of the MSHN Corporate Compliance Plan. The attached change log for the 2024 Revised 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 and acknowledges receipt of the Revised 2024 Corporate Compliance Plan.

MSHN Compliance Related Updates

Change Log

Document	Change
2024 MSHN Compliance Plan	
VI. Structure of the Compliance Program, B. MSHN Compliance Officer	Added language about reporting compliance related matters to the CEO. Pg. 7
XII. Reporting and Investigations, A. Reporting of Suspected Medicaid Violations and/or Misconduct	Revised Language to include "waste" Pg. 17
	Added language about MSHN contacting OIG if questions about how to classify an investigation Pg. 17
	Added language about submitting OIG Fraud Referral forms using the secure file transfer process in place. Pg. 17 - 18
	Added language regarding MSHN and the provider network cooperating with any authorized government agency regarding investigations or prosecution and making available documentation, etc. Pg 18
	Added language about process for MSHN and provider network with overpayments. Pg 18
	Added language about violations over $5000 /referrals to OIG and restrictions to MSHN and provider network contact once submitted to OIG. Pg 18
	Added language about OIG sanctioning/terminating provider from Medicaid. Pg. 19
XII. Reporting and Investigations, B. Process for Investigation	Removed "not involving fraud or abuse" Pg. 19
XIV. Submission of Program Integrity Activities/Report	Added language referencing Schedule E (reporting requirements), and the Compliance Program Crosswalk report. Pg. 21
XIV. Submission of Program Integrity Activities/Report	Added language regarding the annual reports. Pg. 21
MSHN Compliance Process/Governance Flow Chart	Added language for MSHN Compliance Officer to report to the CEO for compliance related matter. Pg. 24

CORPORATE COMPLIANCE PLAN
2024

Mid-State Health Network, Corporate Compliance Committee: December 13, 2023; Revisions Approved 05/2024
Mid-State Health Network, Regional Compliance Committee: December 15, 2023; Revisions Approved 05/2024
Mid-State Health Network, Operations Council Approved: January 22, 2024; Revisions approved May 22, 2024
Mid-State Health Network PIHP Board Adopted: March 05, 2024

TABLE OF CONTENTS

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 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 also manages 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.

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 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, considered not caused by criminally negligent actions, but rather the misuse of resources

V. COMPLIANCE PROGRAM

A. 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 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.
- 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 of Conduct, Policies and Procedures* – the organization must have written policies, procedures, andstandards of conduct that articulate the organization's commitment to comply with all applicable statutory, regulatory and Medicaid requirements.
- *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.

B. Compliance Policies and Procedures

While the Compliance Plan provides the framework of the Compliance Program, the Compliance Policies and Procedures provide more specific guidance.

Written policies and procedures which direct the operation of the compliance program, include, at a minimum, the following elements:
- Duties and responsibilities of the compliance officer and Compliance Committees.
- How and when employees will be trained.
- How employee reports of noncompliance will be handled.
- Guidelines on how the compliance department will interact with the internal audit department.

- Guidelines on how the compliance department will interact with the legal department.
- Guidelines on how the compliance department will interact with the Human Resources department.
- Duties and responsibilities of management in promoting compliance among employees and responding to reports of non-compliance.
- Ensuring that prospective employees receive appropriate background screening and agree to abide by the Contractor's code of conduct.
- Conducting periodic reviews, at least annually, of the code of conduct and the compliance policies and procedures.
- Monitoring of compliance in Contractor and Subcontractor/Network Provider systems and processes.
- Monitoring of potential Fraud, Waste and Abuse in provider billings and beneficiary utilization.
- Performing an investigation of targets selected for audit, including triage and review processes.
- Confidentiality and non-retaliation.
- Appropriate disciplinary action for non-compliance with applicable statutory and Medicaid program requirements as well as failure to report actual or suspected non-compliance.
- Reasonable and prudent background background investigations for current employees and employees of subcontractors/network providers.

Refer to **Attachment A** for a list of the Policy and Procedure categories that are part of the Compliance Program.

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 MSHNCompliance 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 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 toprovide 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 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.

- 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 all 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.
- Authority and independence to make reports directly to the board of directors and/or senior management concerning actual or potential cases of non-compliance.
- Reports compliance related matters to the Chief Executive Officer.
- 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

Commented [KZ1]: 01. Policies and Procedures, Subsection 01.A. Compliance Plan – 3 (line 12 on crosswalk):

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 every other month 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. The standards of conduct will be distributed to all employees and all employees will be required to certify that they have read, understand, and agree to comply with the standards.

- 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 contractual providers of Medicaid services to assure appropriate documentation is available as needed to support claims payments and cost reimbursements.

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.
- 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, Standards of Conduct and applicable Medicaid statutory, regulatory, and contractual requirements. 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 and staff are required to sign certifications that they have completed the appropriate training. The Compliance Officer must receive training by an entity other than himself/herself.

Training will be provided upon hire for new employees within 90 days of the date of hire and during orientation for new BoardMembers. All current staff and Board Members will receive annual training that re-emphasizes Medicaid statutory, regulatory, and contractual requirements and the Contractor's code of conduct.In addition, annual training will be provided to promote information sharing between departments and to enhance referrals regarding fraud, waste and abuse.

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.

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

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 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 that allows for anonymous reporting
- 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 and contractual requirements. 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 Corporate Compliance Committee, MSHN Regional Compliance Committee and MSHN Board of Directors through the Annual Compliance Report.

The compliance program will be evaluated, no less than annually, for overall effectiveness.

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

<u>Financial and Billing Integrity</u>

- 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 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 and equipment are completed asrequired;
- 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
- Questionnaire for exiting employee regarding any observed violations of the compliance program, including the code of conduct, was well as violations of applicable statutes, regulations, and Medicaid program requirements.

Additional External Monitoring and Auditing Activities:

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

Data Mining Activities:

Utilize statistical models, complex algorithms, and pattern recognition programs to detect possible fraudulent or abusive practices.

XII. REPORTING AND INVESTIGATIONS

MSHN will have a distinct unit that has adequate staffing and resources to investigate incidents and develop and implement corrective action plans to assist in preventing and detecting potential fraud, waste and abuse activities.

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, waste, and abuse to the MSHN Compliance Officer. The report will be submitted in writing utilizing the Office of Inspector General (OIG) Fraud Referral Form.
- The MSHN Compliance Officer will complete a preliminary investigation, as needed, to determine if a suspicion of fraud exists. Questions regarding whether suspicions should be classified as fraud, waste or abuse will be directed to MDHHS-OIG prior to referral.
- If there is suspicion of fraud, and an overpayment of $5,000 or greater is identified, the MSHN Compliance Officer will report the suspected fraud ~~and abuse~~ to the MDHHS Office of Inspector General and the Attorney General – Health Care Fraud Division (AG-~~HCFU~~HCFD) using the OIG Fraud ReferralForm using the designated secure File

Commented [AD2]: OIG. 03.A.FW Auditing (Line 18)

Commented [AD3]: 03.B. Reporting FWA- 3 (Line 25)

Transfer Process (sFTP) for each entity.

- The MSHN Compliance Officer will inform the appropriate provider network member when a report is made to the MDHHS Office of Inspector General.
- MSHN Compliance Officer and provider network member staff will present the fraud referral case to the OIG and the AG-~~HCFU~~HCFD.
- MSHN Compliance Officer will defend potential credible allegation of fraud in any appeal should the referral result in suspension issued by the MDHHS OIG.
- MSHN will cease all efforts to take adverse action against or collect overpayments from the provider until authorized by the MDHHS OIG and follow the guidance/direction provided by the MDHHS Office of InspectorGeneral regarding investigation and/or other required follow up.
- MSHN and the provider network will cooperate fully with investigations or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation must include providing, upon request, information, access to records, and access to interview employees and consultants, including but not limited to those with expertise in administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation or prosecution. ~~involving theMDHHS Office of Inspector General and/or the Department of Attorney General and adhere to any subsequent legal action that may result from such investigation.~~
- Overpayments due to fraud, waste, or abuse must be reported to MDHHS-OIG.
    1. If MSHN identifies an overpayment involving potential fraud prior to identification by MDHHS-OIG, the findings will be referred to MDHHS-OIG and MSHN will wait for further instruction from MDHHS-OIG prior to recovering the overpayment.
    2. If MSHN identifies an overpayment involving~~due to fraud,~~ waste, or abuse prior to identification by MDHHS- OIG , MSHN will void or correct applicable encounters, recover the overpayment, and report the overpayment on the quarterly report to OIG.
- If MSHN's provider network identifies an overpayment, they will:
    1. Notify the contracted entity, in writing, of the reason for the overpayment and the date the overpayment was identified.
    2. Return the overpayment to the contracted entity within 60 days of the date the overpayment was identified.

OIG Guidance for Violations over $5,000.00

When overpayments of ~~violations are over~~ $5,000.00 or greater or identified involving a potential credible allegation of fraud, this must be promptly referred to ~~and reported to~~ MDHHS-OIG and the Attorney General's Health Care Fraud Division (AG-HCFD using the MDHHS-OIG Fraud Referral Form. ~~,~~MSHN and the provider network will not take any of the following actions unless otherwise instructed by MDHHS-OIG.

- Contact the subject of the referral about any matters related to the referral.
- Enter into or attempt to negotiate any settlement or agreement regarding the referral with the subject of the referral; or
- Accept any monetary or other thing of valuable consideration offered by the subject of the referral in connection with the findings/overpayment.

If the State makes a recovery from an investigation and/or corresponding legal action where Contractor has sustained a documented loss, the State shall not be obligated to repay any monies recovered to the Contractor.

Commented [AD4]: 03.B Reporting FWA (Line 23) 04.A. Referral Processes (Line 30)

Commented [AD5]: 03.A. FWA Preliminary Investigations-2 (Line 20)

Formatted

Formatted

Commented [AD6]: 3.B. Reporting FWA -4 (Line 26)

Formatted: Indent: Left: 1.61", No bullets or numbering

Formatted: Font: 11 pt, Bold, Underline

Formatted: Font: 11 pt

Formatted: Bulleted + Level: 1 + Aligned at: 1.61" + Indent at: 1.86"

Formatted: Indent: Left: 1.86"

Commented [AD7]: 03.B. Reporting FWA-1 (Line 23) 04.A Referral Processes (Line 30)

Formatted: Font: 11 pt

When MDHHS-OIG sanctions (suspends and/or terminates from the Medicaid Program) providers, including for credible allegations of fraud 42 CFR § 455.23, the Contractor must, at minimum, apply the same sanction to the provider upon receipt of written notification of the sanction from MDHHS-OIG. The Contractor may pursue additional measures/remedies independent of the State. If MDHHS OIG lifts a sanction, the Contractor may elect to do the same.

Commented [AD8]: 04.B Payment Suspension (Line 31).

Formatted: Indent: Left: 1.36"

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:
    1. Provider Information, if applicable (Name, Address, Phone Number, NPI Number, Email)
    2. Complainant Information (Name, Address, Phone Number, NPI number [if applicable], Medicaid ID # [if applicable], Email)
    3. Consumer Information, if applicable (Name, Address, Phone Number, Email)
    4. Summary of the violation and/or misconduct
    5. Date(s) of the violation and/or misconduct
    6. Supporting documentation, if any (i.e. claims data, audit findings, etc.)
    7. 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 be reported on the OIG Quarterly Program Integrity Report.

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/Prevention/Disciplinary Guidelines

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

In all cases, disciplinary action must be applied on a case-by-case basis and in a consistent manner.

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

XIV. Submission of Program Integrity Activities/Report

The PIHP, and the provider network will log and track all program integrity activities performed. The provider network will utilize the MDHHS OIG Quarterly Program Integrity Report 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~~according to Schedule E requirements, using the provided template.

Commented [AD9]: 03.B Reporting FWA-6 (Line 28)

The PIHP will submit to MDHHS-OIG an annual Program Integrity Report containing details of the improper payments identified, overpayments recovered, and costs avoided for the program integrity activities conducted by the Contractor for the preceding year. The report will also address the plan of activities for the current and upcoming fiscal year and all provider and service-specific program integrity activities.

The PIHP will submit to MDHHS-OIG an annual Compliance Program Crosswalk which includes completion of the MDHHS-OIG report template in addition to policies, procedures, and other documentation related to the standards on the report template.

XV. Communication of Requirements

The PIHP will issue a contract, Provider Manual, Bulletins, and/or other means of communication to the provider network regarding services covered under contract. This communication will serve as a source of information for providers regarding Medicaid covered services, policies and procedures, statutes, regulations, and special requirements.

The communication will provide all Providers with, at a minimum, the following information:

- Description of the Michigan Medicaid managed care program and covered populations;
- Scope of Benefits;
- Covered Services;
- Emergency services responsibilities;
- Grievance/appeal procedures for both Enrollee and Provider;
- Medical necessity standards and clinical practice guidelines;
- Policies and procedures including, at a minimum, the following information:
    - Policies regarding provider enrollment and participation;
    - Policies detailing coverage and limits for all covered services;
    - Policies and instructions for billing and reimbursement for all covered services;
    - Policies regarding record retention;
    - Policies regarding Fraud, Waste and Abuse;
    - Policies and instructions regarding how to verify beneficiary eligibility;
- Primary Care Physician responsibilities;
- Requirements regarding background checks;
- Other Subcontractors'/Network Providers' responsibilities;
- Prior authorization and referral procedures;
- Claims submission protocols and standards, including instructions and all information necessary for a clean claim;
- Medical records standards;
- Payment policies;
- Enrollee rights and responsibilities.
- Self-reporting mechanisms and polices.

The Provider Manual, Bulletins and all Provider policies and procedures will be reviewed at least annually to ensure that current practices and contract requirements are reflected in the written policies and procedures.

XVI. 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 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
   https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

3. False Claims Act
   https://oig.hhs.gov/fraud
   http://www.legislature.mi.gov
   https://www.justice.gov/civil/false-claims-act

4. 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005)
   https://www.cms.gov/regulations-and-guidance/legislation/deficitreductionact/downloads/guide.pdf

5. Michigan Mental Health Code
   http://www.legislature.mi.gov/(S(alilhmd3eeauncuk5s0ey4hu))/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

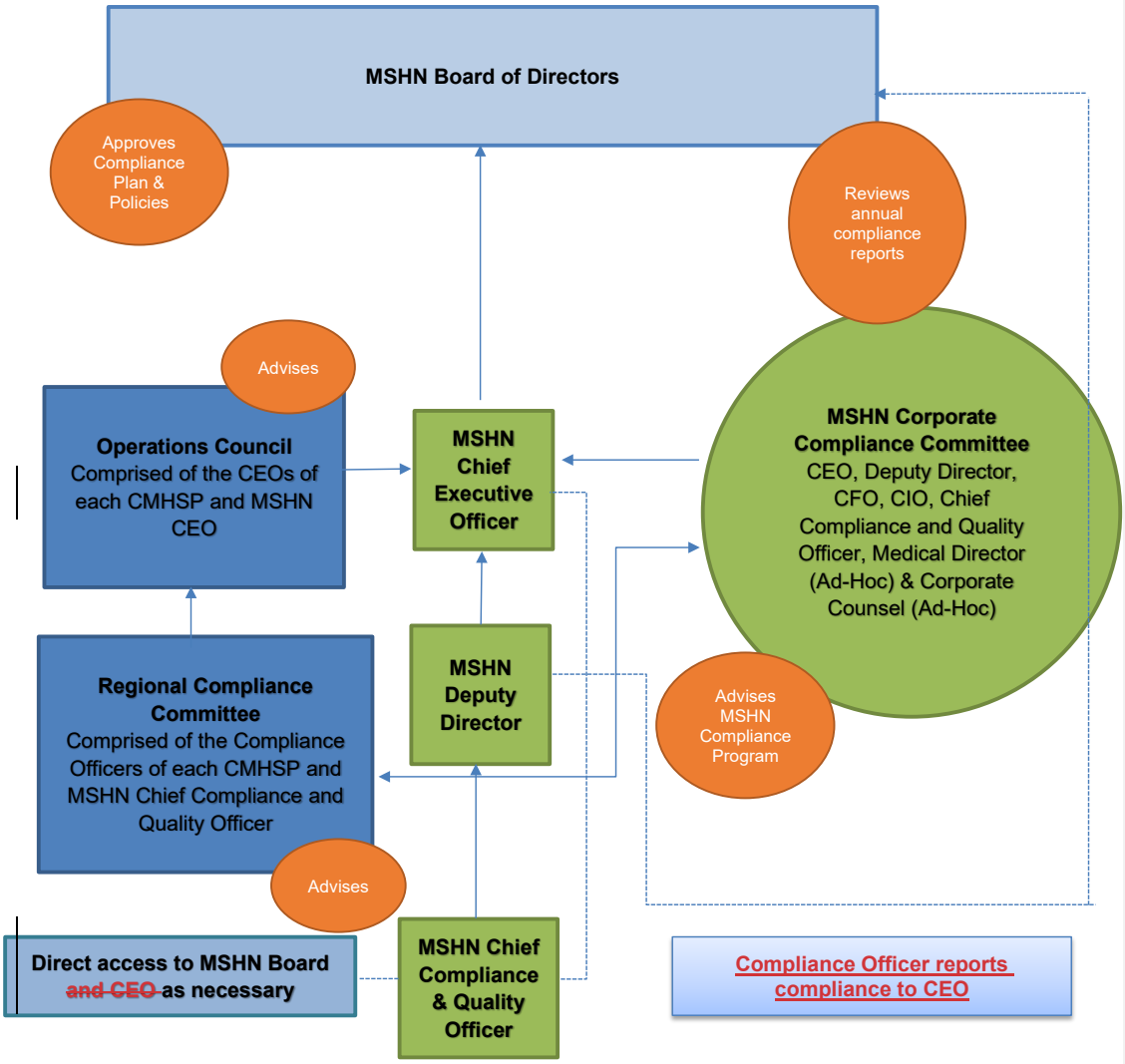
Quality

Service Delivery System

Utilization Management

Attachment B

Mid-State Health Network Compliance Process/Governance



ATTACHMENT C

MSHN Compliance Officer in coordination with the MSHN CorporateCompliance 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	Implement processes and monitoring to ensure compliance with statecontract 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
HCBS Planning and implementation of changes	Review capacity, changes in waiver 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,	Karen Amon, 989-895-2214, kamon@babha.org
CMH for Central Michigan,	Kara Laferty, 989.772.5938, 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,	AmyLou Douglas, 989-797-3506 amylou.douglas@sccmha.org
Shiawassee County CMH,	Vickey Hoffman, 989-723-0757, vhoffman@shiabewell.org
Tuscola Behavioral Health Systems	Julie Majeske, 989-673-6191, jmajeske@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)

Harm Reduction:

Reducing Stigma & Saving Lives

July 2, 2024

Sarah Andreotti, BS, CPC
SUD Prevention Administrator

Dani Meier, PhD, MSW, MA
Chief Clinical Officer

1

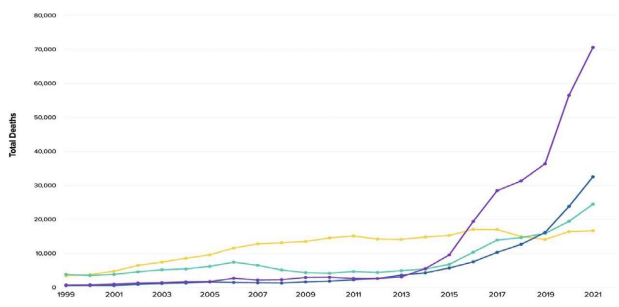
MSHN
Mid-State Health Network

1

Fentanyl is Driving Overdose Deaths

Trends in U.S. Drug Overdose Deaths (1999 - 2021)

The overdose crisis has evolved over time and is now largely characterized by deaths involving illicitly manufactured synthetic opioids, including fentanyl, and, increasingly, stimulants.



Synthetic opioids excluding methadone overdose deaths increased **97-fold**

Psychostimulants with abuse potential (primarily methamphetamine) overdose deaths increased **59-fold**

Cocaine overdose increased **6.4-fold**

Rx opioid overdose deaths increased **4.9-fold**

This graph shows the total number of drug overdose deaths in the United States from 1999 to 2021 (the 2021 are provisional).The data shows that overdose deaths involving synthetic opioids excluding methadone have increased 97-fold. Overdose deaths involving psychostimulants (primarily methamphetamine) with abuse potential have increased 59-fold.,, Overdose deaths involving cocaine have increased 6.4-fold. And overdose deaths involving prescription opioids have increased 4.9 -fold. Source: National Vital Statistics System Mortality File

2

2

What's Harm Reduction?

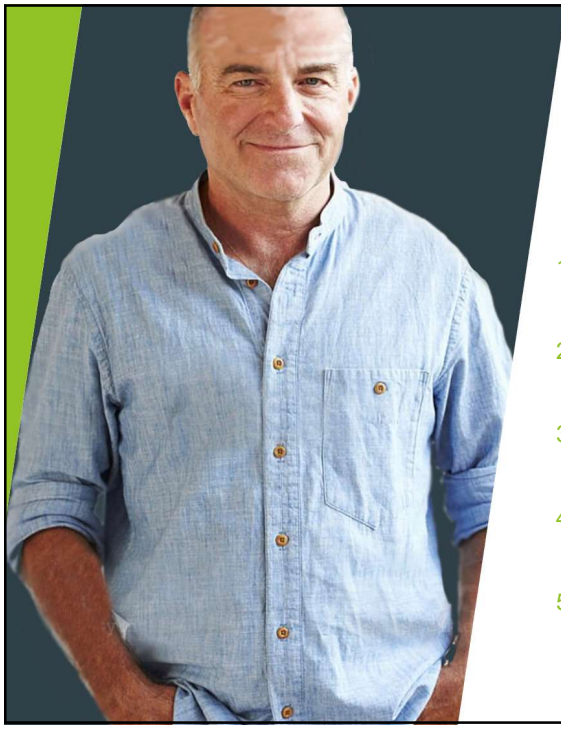
U.S. Department of Health & Human Services

SAMHSA
Substance Abuse and Mental Health Services Administration

"Harm reduction is an *evidence-based approach* to reduce the negative ... public health impacts of behavior associated with alcohol and other substance use *at both the individual and community levels*."

3

3



Principles of Harm Reduction

1. Focus is on reducing harm & saving lives.
2. Treat people who use drugs (PWUD) with dignity.
3. Accept that drug use may occur despite risk.
4. Avoid pre-defined outcomes (like abstinence).
5. Promote connection & hope.

4

MSHN
Mid-State Health Network

4

Tools of Harm Reduction

- Education on SUD, safe use & infectious disease risks
- Provide Narcan & fentanyl strips
- Referrals to SUD treatment
- Syringe service programs (SSPs)
- Overdose Prevention Centers (OPCs)

5

MSHN Mid-State Health Network

5

Tools of Harm Reduction

- 16 Narcan Vending Machines in Region 5 (currently or pending)
- Overdose Prevention Training-(Narcan)
- Needle Exchange Programs (18)
- HIV & Hepatitis C testing (ICHC's)
- First Aid Kits (for wound care)
- Safer sex education & supplies
- Fentanyl Test Strips
- Xylazine Test Strips
- Sharps Containers
- CPR Face Shields

6

Myth: *"People don't recover"*

Harvard Study (2017)

- 10% of American Adults have experienced a SUD
- 9.1% of them are in recovery

CDC Study (2018)

- 3 out of 4 who have a SUD recover

Fact: Most people recover.

7

MSHN Mid-State Health Network

7

Harm Reduction (SSPs & OPCs)

MYTHS:

1. MYTH: Harm Reduction "encourages" drug use.
2. MYTH: Harm reduction programs increase danger to nearby residents.
3. MYTH: SSPs/OPCs increase crime in neighborhoods where they are located.
4. MYTH: It costs taxpayers too much.

FACTS:

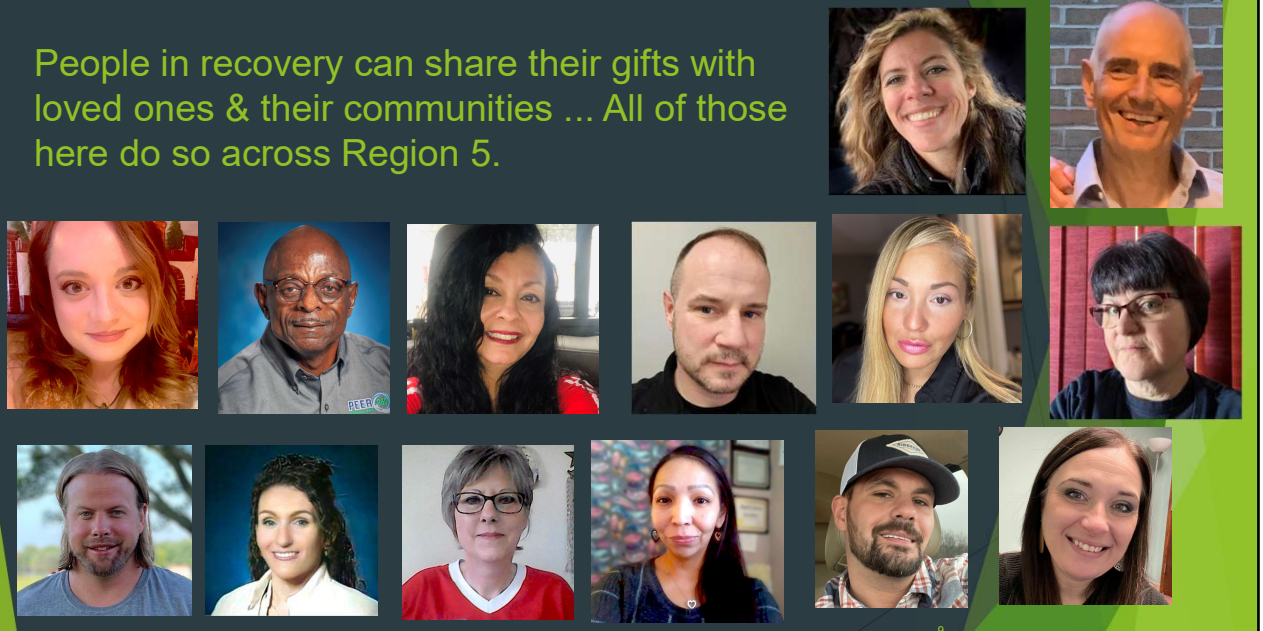
1. FACT: SSP users are 5X more likely to enter SUD treatment & 3X more likely to stop using drugs. OPC users are 30% more likely to enter treatment.
2. FACT: OPCs reduce public use & reduce used needles discarded in public areas.
3. FACT: There's no documented increase in crime. NIMBY objections evaporate.
4. FACT: Studies show that for every dollar spent on harm reduction, >$2 is saved in public health costs

8

MSHN Mid-State Health Network

8

People in recovery can share their gifts with loved ones & their communities ... All of those here do so across Region 5.



9

***Note**: These photos are shared thanks to the generosity, courage & permission of the people pictured here.*

9

Harm Reduction creates opportunity: A chance for change & recovery.

10

10

MSHN Region Harm Reduction Activity

- Harm Reduction Vending Machines around the region contain items such as Narcan kits, fentanyl and xylazine test strips, Deterra medication disposal pouches, wound care kits, CPR face shields and more. Each of the below counties have at least one vending machine, and some have more than one.
  - Arenac (coming soon- location pending)
  - Bay
  - Eaton
  - Gratiot
  - Hillsdale
  - Ingham (2 in place, 2 additional coming soon)
  - Ionia
  - Jackson
  - Saginaw (coming soon- location pending)
  - Tuscola (4)

11

MSHN Mid-State Health Network

11

MSHN Region Harm Reduction Activity

In FY23, providers around the MSHN region distributed

1,160
Fentanyl Test Strips

3,586
Naloxone Kits

To date in FY24, providers around the MSHN region distributed

295
Deterra Bags

45
First Aid Kits

MSHN Mid-State Health Network

12

References

- SAMHSA Harm Reduction (2022)
- National Institute of Health (NIH) Report with meta-analysis of 75 previous studies on Overdose Prevention Centers (2021)
- Canadian Medical Association study on impact of OPC on survival, HIV & Hep C rates, referrals to treatment & lowered costs
- The cost-effectiveness of Vancouver's supervised injection facility. CMAJ. 2008;179(11):1143-1151. doi:10.1503/cmaj.080808
- A Social Cost Perspective in the Wake of the Portuguese Strategy for the Fight against Drugs, International Journal of Drug Policy (2014).
- Prevalence and correlates of ever having a substance use problem and substance use recovery status among adults in the United States, 2018, Drug and Alcohol Dependence, Volume 214 (2020)

13

MSHN Mid-State Health Network

13

MSHN
Mid-State Health Network

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
May/June 2024

- Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) has been awarded the "Agency of the Year" award by the Michigan chapter of the National Association of Social Workers. This award is a high honor and a reflection of the dedication and commitment to excellence by CMHA-CEI. A short video is available at this link.
- Michigan Department of Health and Human Services (MDHHS) is conducting its review of MSHN and Community Mental Health Service Program (CMHSP) operations under performance standards for the Children's Waiver Program, Habilitation Supports Waiver, Waiver for Children with Serious Emotional Disturbance, and the 1915(j) SPA (State Plan Amendment). The review began May 28, 2024, and continues through July 31, 2024.

PIHP/REGIONAL MATTERS

1. Conflict Free Access and Planning (CFAP) Update:

In recent weeks, MDHHS announced its decision to require that CMHSPs cannot conduct or provide both service planning (case management/supports coordination) and Home and Community Based Services (HCBS) delivery for the same beneficiary. CMHSPs are permitted to provide both service planning and HCBS service delivery, but not to the same beneficiary. Background on this has been provided in previous board reports. The MSHN Board passed another resolution of opposition at its May 2024 board meeting, which was distributed to policy makers and others.

I reported at the May 2024 Board meeting that MDHHS had scheduled a Pre-Paid Inpatient Health Plan (PIHP)/MDHHS contract meeting intended to focus exclusively on CFAP requirements. That meeting was cancelled and has not been rescheduled as of the date of this report.

MDHHS used a portion of the regular MDHHS/PIHP Operations Meeting on June 6 to provide an update on Conflict Free Access and Planning. My *informal* notes follow. Of note, there were NO DOCUMENTS reviewed or provided. (As of the date this report was finalized, there have been no official documents of any kind received from MDHHS).

- MDHHS expectation is that PIHPs and CMHSPs will come into compliance with the CFAP requirements (separation of entity conducting service planning from entity responsible for service delivery)
- Webinar planned for beneficiaries and their circles of support planned for June 20 and June 24
    - PIHPs expressed concern about this. In particular, that the field has not been effectively engaged in dialog to inform and address questions/concerns/resistance/objection. In particular, that beneficiaries will come to the CMHSPs with their questions and to date are not equipped to answer beneficiary questions/concerns.

    - MDHHS acknowledged the position the field is in and stated they will take this back and consider.
- MDHHS stated it is developing written resources to "enable PIHPs to submit required implementation plans" including the bulleted items below. MDHHS notes that these materials are still being finalized and to expect them "in the next week or two."
    - FAQ document(s)
    - Working with Wayne State, Michigan Developmental Disabilities Institute (MI-DDI), to develop resource materials for beneficiaries and their supporters.
    - A code chart/table of Healthcare Common Procedure Coding System (HCPCS) codes that are within the CFAP rule in Michigan.
    - A PIHP Implementation Plan template required for use by PIHPs – indicated a "survey style" template that will have links for each CMHSP in a region to complete, submit to PIHP, and PIHP compiles and submits one implementation strategy for the region.
    - Exception/Designation process – criteria still in development for only willing/qualified provider designation (no longer using the term "exception/exemption"); application form being finalized.
- PIHPs stated implementation would not be considered based upon a PowerPoint. MDHHS stated that the Technical Requirement (TR) is in development and will be released as the basis for regional planning to proceed from and that it intends the TR "to be added to contracts" and it is working on revising other Medicaid/State policies applicable to CFAP.
    - MDHHS acknowledged that PowerPoint presentations have been distributed in the past. PIHPs noted that each constituent group was exposed to/provided with a different slide deck that had different covered populations and other differences between them. MDHHS acknowledged and stated that this has been "evolving" as they have engaged various stakeholders. PIHPs stated these different versions introduce even more confusion. MDHHS acknowledged and says written guidance (see above) should clarify.
- MDHHS acknowledged that the timeline has moved, and it will be publishing new implementation plan due dates but may not move the 10/01/24 implementation date.
- MDHHS stated that procedural safeguards are expected to continue, especially in areas where a single willing/qualified provider designation is made but is expected system wide.
- PIHPs asked if MDHHS was initiating dialog with Centers for Medicare and Medicaid (CMS) for a statewide exemption from the federal rule. The MDHHS answer was that MDHHS is engaged in regular conversation with CMS about that issue and related. Megan Groen emphatically pointed out that it is highly unlikely and that there is absolutely no indication that CMS would entertain or approve such a broad exemption.
- PIHPs expressed ongoing concerns about impacts on beneficiaries, making system more complex, etc. (similar to arguments our region has expressed on the record). MDHHS reiterated that it is committed to a full and complete implementation of the CFAP as required by federal rule.
- PIHPs asked if MDHHS has any intention of addressing opposition/resistance in the field or if they're just going to press ahead.
    - MDHHS stated that it will contact each region to establish regional meetings/dialogs intended to address issues raised by the field and/or by each PIHP (and it's regional partners). Expect these to be scheduled by MDHHS "soon."

- In my view, it is clear that the intention of MDHHS is to press ahead notwithstanding whatever comes out of regional dialogs.

2. **Healthy Transitions Crisis Residential Unit:**

Mid-State Health Network is pleased to announce that our in-region crisis residential unit, which has been in development for two years, will be opening for admissions June 17. Licensing and Regulatory Affairs (LARA) issued the appropriate license (6/11/24) and MDHHS has approved the required crisis residential services application (6/12/24). While many have been involved in developing this critical crisis services resource, I would like to acknowledge Dr. Todd Lewicki, MSHN Chief Behavioral Health Officer, for his patience, perseverance, attention to detail, and leadership in making this service a reality in the MSHN region.

3. **COVID Un-Wind Update (as of May 31):**

The Mid-State Health Network region has experienced a cumulative reduction of over 103,000 in the number of eligibles in the MSHN region for the period July 2023 through May 2024. (My last report was over 81,000). This has a direct impact on regional revenues. MSHN is following these developments very closely, and we note that all PIHPs are experiencing similar impacts. MDHHS reported on May 29 that there have been 1.6 million renewals while 778,000 persons statewide have been disenrolled. The pace of disenrollments should slow as the 13-month period for reestablishing eligibility ends soon.

4. **MSHN Cost Containment Plan – Partial Access Centralization:**

BACKGROUND:
MSHN's current delegated "no wrong door" access model for Substance Use Disorder (SUD) services has the important advantage of allowing individuals to directly access a service provider of their choice. That model also presents a number of ongoing challenges, some of which span years, which have led to inconsistent access and screening practices throughout the region resulting in system inefficiencies, in many cases a poor access experience for individuals seeking services, and often placement in an inappropriate level of care. Some of the primary challenges of the current delegated model are described below:

- Duplicate screening experience for individuals - Providers can't see existing screenings conducted in other settings, resulting in duplicate screening experiences for beneficiaries.
- Referrals to inappropriate levels of care - especially in relation to withdrawal management, residential treatment, and recovery residential services.
- Inaccurate/Incomplete knowledge of MSHN SUD provider system and available services - Individuals conducting access activities at CMHSPs and SUD providers have varying qualifications and levels of knowledge about SUD treatment and recovery resources, leading to incorrect or incomplete information being provided to individuals seeking services at times.
- Inconsistent data entry in MSHN's Regional Electronic Medical Information (REMI) system - resulting in MSHN's inability to accurately track and monitor screening activity, especially to ensure correct level of care and other medical necessity considerations.
- Ensuring consumer choice - The current delegated access model allows Substance Use Disorder Service Providers (SUDSPs) to perform screenings and generate referrals to their own agencies. In addition to the concerns about potential conflict of interest, this also suggests that providers may experience a self-confirming bias in determining that an individual needs the specific ASAM level of care offered by the provider.

- Inability to track Block Grant treatment episodes - As part of the Substance Abuse Prevention and Treatment (SAPT) Block Grant management plan, MSHN implemented limits of one episode of care every 12 months on high-cost services (withdrawal management, residential, and recovery housing). Currently providers are unable to see the treatment history in REMI to know if a person has already utilized the service during the last 12 months.
- Existing referral processes for corrections-involved individuals for residential-based services are circumvented by parole agents (84% of the time).

CHANGES TO BE IMPLEMENTED:

After careful study of these and other issues and available options to remedy them, our leadership team has approved a plan, effective on and after 10/01/2024, whereby MSHN will *partially centralize* access to SUD services. Details include:

- Access to and authorization of high cost/high intensity services, including withdrawal management, residential treatment, and recovery housing, will be centralized at MSHN's utilization management (UM) and Access department. This will mean our provider system and CMHSPs will no longer process those referrals, instead linking directly with MSHN UM/Access.
- Access to all other levels of care and types of services would continue to be delegated to the CMHSP and SUD provider system.
- An internal implementation team will be formed which will be responsible for developing a detailed plan for all related steps needed to carry out these changes, including communications with providers and other stakeholders, any IT-system related improvements, and other system engineering elements.

ADDITIONAL CONSIDERATIONS:

It is not possible for existing UM personnel to absorb a change of this magnitude. Thus, our leadership team will expand the UM/Access operations by three new positions and the existing UM Specialists will continue to support UM operations. These positions have been posted so that onboarding can occur before the target date of 10/01/2024 for full implementation. This planned expansion is possible through the redesignation of approved but unfilled positions in the FY 24 MSHN budget.

There are many benefits to making these changes, including addressing the issues briefly stated in the "background" section above. *In addition, MSHN projects that implementing the plan outlined briefly here, even after hiring the three positions noted, will SAVE up to about $2M annually.* As you are aware, the fiscal position of the region – especially this year – benefits from the generation of savings. It is also our responsibility as good stewards of public funds.

5. **Open Meetings Act "Restoration" Update:**

House Bill 5725 was introduced May 14, 2024, by Representative Alexander – District 98 (co-sponsored by St Germaine - 62, Martin – 68, Kunse – 100, and Bierlein – 97). HB 5725 would basically amend the Open Meetings Act to allow PIHPs and CMHSPs to have Board members attend virtually so long as the Board had passed a resolution to permit it and there is a quorum in the room.

All of the sponsors are Republicans and the likelihood of it moving this spring/summer is therefore relatively low unless there is a push for Democrats to make it happen as a bipartisan effort.

6. **MSHN By-Laws:**

As most readers are aware, the MSHN Board Bylaws have been out of sync with the Open Meetings Act, which has changed several times during the pandemic. In addition, a few other minor edits are desired by some members of the MSHN Operations Council. About 4 months ago, a subcommittee of the Operations Council met to ask the MSHN attorney for advice on several proposed changes. Following is a brief summary of proposed changes:

- Remove sentence indicating if there is any conflict between Operating Agreement and Bylaws, Operating agreement prevails.
- Remove outdated "coordinating agency" language and replace with "Department-designated community mental health entity" (which is the term used in the public health code).
- Remove "without limitation" within the phrase "The power to enter into contracts with a CMHSP…"
- Adjust very specific quorum and voting language with a more generic statement that requires MSHN Board to abide by the open meetings act as it may exist from time to time.
- Add anti-discrimination language applicable to the Board.

MSHNs Board of Directors does NOT have a vote on the bylaws. Two-thirds of the region's CMHSP Participants must approve any changes to the bylaws for them to be effective and applicable to MSHN. My office will provide a customizable resolution and a tracked changes version of the bylaws for member CMHSP board action. I have asked the region's CMHSP Participants to complete these resolutions by December 31, 2024.

7. **Regional Autism Funding Mechanism Change:**

For the past five-six months, the Operations Council has been considering changing the method for distributing revenues for Autism Services.

When autism services were first rolled out (2016-2017) by MDHHS, the payments came to PIHPs as case rates. Even though this region's revenue distribution method as detailed in the Operating Agreement is sub-capitation, we adopted a case rate distribution methodology because that is how the revenue was coming to MSHN. The regional operating agreement was amended to reflect and document this (Under article 4.12: "Beginning October 1, 2017, autism program funding will be disbursed to CMHSP Participants based on the ratio of Autism consumers served as compared to the regional total served in the program, or as recommended by the Finance Council and approved by the Operations Council.") MSHN is not free to alter or deviate from the operating agreement. The last phrase gives MSHN some flexibility to alter arrangements for this specific revenue stream if the Finance and Operations Councils approve (an important detail - see below).

A few years after that rollout, MDHHS changed the revenue distribution method from a case rate to a capitation (Per Eligible Per Month or "PEPM"). The regional Finance Council and Operations Councils reaffirmed the desire to keep the in-region distribution method based on consumer counts (as quoted above).

Earlier this fiscal year, some Operations Council members began to question why MSHN was maintaining a case rate distribution method when the "standard" regional funding mechanism is sub-capitation. The genesis of the origins of the discussion centered around some CMHSPs views that their revenue picture would improve if we reformed the payment system to be consistent with all other MSHN funding - sub

capitation, and that philosophically returning to the sub-capitation arrangement is consistent with the original structure of the powers/duties of the PIHP to fund the region on a sub-cap basis. There was little objection to the philosophical argument, but more objection to changing the formula for revenue distribution because it is also true that some CMHSPs would show less Autism revenue (and some CMHSPs would show more) if the system for financing was changed.

MSHN agreed to develop a plan to phase out case rate funding and phase in sub-capitation funding. MSHN proposed, and the regional Finance Council supported, a three-year plan (FY25 - 50% PEPM, 50% case rate; FY 26, 75% PEPM, 25% case rate; FY 27 - 100% PEPM). The CMHSP CEOs did not support that proposal and MSHN agreed to propose an alternative, which we did at the June 17, 2024 Operations Council meeting. The new proposal is a five-year smoothing/implementation plan (FY 25 - 80 Case Rate/20% Capitation; FY 26 - 60%/40%; FY 27 - 40%/60%; FY 28 - 20%/80%; FY29 - All PEPM/Capitation). (Give the flexibility in the operating agreement language noted above, the Operations Council and MSHN agreed to add an explanatory note of the change just detailed, which I will do in the near future). MSHN and the Operations Council have agreed to this five-year smoothing plan

At the CMHSP level, there is likely to be increases or decreases in the identified "Autism" revenue as this is implemented.

It is critical to note two things:
1) the revenue coming into MSHN is unchanged by these above described elements. The only thing that changes is how that revenue is distributed from MSHN within the region.
2) No matter how the revenue is distributed, MSHN is responsible for all medically necessary service costs. 100%. So if a change in the funding mechanism means one, several or all show revenue under expenditure due to the smoothing plan implementation, MSHN must still cover the shortfall.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

8. WHODAS Selected as I/DD Assessment and Screening Tool:

After terminating the Supports Intensity Scale assessment tool for beneficiaries living with Intellectual/Developmental Disabilities in March 2023 (just over one year ago), MDHHS has announced that it has selected the World Health Organization Disability Assessment Schedule v 2.0. Following are pertinent excerpts from the MDHHS announcement memorandum (dated June 5, 2024):

In the fall of 2023, the MDHHS developed an assessment panel workgroup that included clinical and administrative professionals from PIHPs and CMHSPs, Medicaid beneficiaries, advocates, and family members of Medicaid beneficiaries from across the State of Michigan to support the selection of a replacement for the Supports Intensity Scale (SIS-A). Panel Members reviewed four candidate assessments and provided a recommendation to MDHHS. The four candidate assessments reviewed were Functional Assessment Standardized Items (FAS*), Adult Needs and Strengths Assessment (ANSA), Adaptive Behavioral Assessment System (ABAS3) and WHODAS 2.0.

General Tentative Timeline for WHODAS 2.0 Implementation:

- MDHHS defining implementation details (current)
- Begin gathering steering committee members (Fall 2024)
- Steering Committee launched (Winter 2025)
- Training (Spring 2025)
- Implementation (Fall 2026)

9. **Veteran Problem-Solving Courts:**

(Excerpted from Gongwer News Service, 05/17/24) Michigan's treatment and problem solving courts saw continued success over the past year, with some producing graduates that were four-times less likely to be convicted of a new offense within three years of admission to a program.

That data came from the Problem-Solving Courts Annual Report released Friday, tracking the progress of 207 Michigan alternative court systems between October 1, 2022, and September 30, 2023.

The report was released ahead of Armed Forces Day. Of particular note, the report highlighted that unemployment among veterans treatment court graduates dropped by 82 percent between 2022 and 2023.

Other key findings show that graduates of adult drug court programs were, on average, four-times less likely to be convicted of a new offense within three years of admission to a program. In that same vein, graduates of sobriety court programs were, on average, more than three-times less likely to be convicted of a new offense within three years of admission to a program.

Those who used ignition interlock devices were five-times less likely to reoffend within three years of admission, as well.

Unemployment dropped by 88 percent for sobriety court graduates and hybrid drug-sobriety court graduates.

Adult circuit mental health court graduates were on average nearly two-times less likely to commit another crime within three years of admission to a program. Unemployment among those graduates dropped by 88 percent and had an average 99 percent improvement in mental health and quality of life following completion of a program.

The report also states that Michigan remains a national leader with 28 veteran treatment courts.

In a press conference Friday, Supreme Court Justice Kyra Harris Bolden, the high court liaison for the state's problem solving and treatment courts, thanked Governor Gretchen Whitmer and the Legislature for their continued support of the programs by offering operational funds to support the programs each year.

"As a former state legislator who previously voted in favor of these funding bills, this is where I have a unique vantage point," Bolden said. "Thanks to state and federal funding, (the State Court Administrative Office) was able to grant more than $14 million to Michigan problem solving courts in fiscal year 2023. In addition, SCAO measures the performance of these programs every year so that we can better support them. This helps them to achieve more positive outcomes for participants, which is evidenced by the compelling data contained in this report."

Bolden was joined by 62-A District Judge Pablo Cortes from the Kent County Veterans Treatment Court, 80th District Judge Joshua Farrell with the Clare/Gladwin County Veterans Treatment Court, Kevin Scott, a volunteer veteran peer mentor with the 36th District Veterans Treatment Court in Detroit and the 19th District Veterans Treatment Court in Dearborn, and Matthew Fisher, a veteran graduate and volunteer peer mentor with Redford Township's 17th District Veterans Treatment Court.

Each extolled the value of the treatment court systems, their personal experiences with it and why it works.

Gongwer News Service asked what Bolden and others on the call would say to naysayers who might still believe that problem solving and treatment courts were not worth the money and resources being spent on them.

Scott said the resources spent on the program were indeed necessary to continue providing the type of support, guidance, intimacy and compassion seen specifically in veterans treatment courts under the tutelage of the judges and administrators who run them.

"I tell them all the time, that this has the ability to change lives, and it does, and I am a product of the process. That's the phrase that I use: a product of the process," Scott said. "I went from an individual who was non-law-abiding when I was introduced to Veterans Treatment Court, to by God's grace and mercy, by surrounding me with individuals who believed in me, in a court that was supportive, to right now."

Scott said he is currently in the dissertation completion phase of his doctorate in community care and counseling with the concentration in traumatology.

"No one can tell me that this court doesn't work. No one can tell me that this court doesn't help veterans because I am, as I said, a product of the process," Scott added.

Farrell said he was a numbers guy, and he knows the veterans that come into his program have a high success rate. He heard negative comments about the program when it started in his jurisdiction. The statistics, however, paint a different picture.

"One of the statistics they shared with us early on is that about 85 percent of all crimes in this country are committed with people that suffer from substance abuse. And the other 85 percent rule is that about 85 percent of individuals who reoffend within three months (do so) of being released from jail," Farrell said. "The statistics support that incarceration is on average, three to five times more expensive than treatment. So, I rely very heavily on those factors."

Farrell said that kind of mentality was the simple definition of insanity.

"If you want to keep doing the same thing and expect different results, it's not going to happen. These type of veterans and specialty treatment courts have provided us an opportunity to give our service members some additional assistance that not only do they deserve, but we should be providing," he said. "I try to reason with individuals that had negative thoughts and I tried to invite them to attend our sessions to be a positive force for these individuals. And we know that it's successful."

10. **Veteran Mental Health Bills:**

(Excerpted from Gongwer Capital News Service, 05/14/2024) A year after beginning work on the legislation, the House Military, Veterans and Homeland Security Committee heard testimony on bills targeting veteran mental health through a centralized office in state government.

HB 5276, HB 5277, HB 5279 and HB 5280 would codify mental health resources and the availability of these resources to veterans through the Michigan Veterans Affairs Agency, centralizing the resources to one office.

HB 5276, sponsored by Rep. Jennifer Conlin (D-Ann Arbor), chair of the committee, would establish the Office of Mental Health and Suicide Prevention within the agency.

While MVAA would have the ability to implement the office and appoint the head officers, the new office would be required under law to collect and disseminate data on substance abuse disorders, PTSD and veteran suicide.

The office could also issue grants to support efforts and resources to improve veteran mental health while also creating a mental health resource guide, shared at no cost to veterans and service members to better understand mental health issues.

"This mental health package was to create a comprehensive set of tools that MVAA can use to tackle service members' and veterans' mental health, be it something newly established or through the codification of existing efforts on their part, while providing support for their families," Conlin said.

HB 5277, sponsored by Rep. Christine Morse (D-Texas Township), would require the Department of Military and Veteran Affairs to enter into an interagency agreement with the Department of Health and Human Services to conduct a statewide outreach program on veteran mental health and substance abuse.

The agreement would ultimately create and operate a program to utilize these resources to reach those dealing with life transitions after active-duty service.

Morse said in 2020, approximately 5.2 million veterans nationwide experienced a behavioral health condition, and more than half of those individuals did not receive treatment within the first year. On top of that, more than 90 percent of veterans that experienced a substance abuse disorder did not receive treatment in the first year.

Morse said her bill aims to increase access to care by formalizing this partnership between the two agencies to maximize efficiency in reaching veterans better.

"It can be difficult to find those resources that do exist for veterans, but also there is a continued stigma around seeking help for behavioral health issues and substance use disorder," Morse said.

There is not another model for this cooperation across the United States, but Morse said the agencies already had an informal partnership that the legislation is looking to codify to stay consistent in how the offices are operating.

HB 5279, sponsored by Rep. Felicia Brabec (D-Pittsfield Township), would require the DMVA to "resurrect" and operate the buddy-to-buddy program that offers one-to-one mentoring and support to current serving members and veterans of the military, connecting individuals to those who understand their mental health issues.

"To me, this program is a win-win-win," Brabec said. "It's a win for our servicemembers. It's a win for the veterans and mentors who are serving, and it's a win for our state because we're being able to address the mental health crisis in another way."

HB 5280, sponsored by Rep. William Bruck (R-Erie), would create mental health screenings through the MVAA to identify the warning signs of PTSD after getting back home.

Bruck told his own story of coming back to his home after serving a combat tour in Iraq for a year and a half, not knowing what do with himself and not understanding why he was having major reactions to things that normally would not upset him, unknowingly suffering from PTSD.

"Once life hits you, you realize 'I'm not necessarily the same as I was when I left,'" Bruck said. "'I'm having issues.' This screening will identify, as it says in the lingo, the warning signs of post-traumatic stress disorder. Those are sometimes easy to spot, and sometimes hard to spot."

Outside of this package, HB 5720, sponsored by Rep. Bob Bezotte Jr. (R-Howell), is "companion legislation" that would also provide more screenings and mental health resources to the National Guard in addition to serving military members and veterans.

Joshua Parish, founder of VETLIFE, a nonprofit that provides resources to veterans, said that the MVAA has its own agency issues that would need to be dealt with before giving the office more codified responsibility on mental health.

Parish cited issues such as only having one accredited veteran's service officer for every 1,712 veterans in Michigan and a consistent change of directors in the agency for the past decade.

General Martin Steele with the Veteran Health Leadership Coalition said the state should invest more funding for new wave therapy and rehabilitation efforts for veterans such as MDMA treatments and psilocybin therapy, or the use of psychedelics.

When it comes to the cost of these mental health proposals, Conlin said since many of these programs are already in process, yet not codified into law, there would not need to be a specific amount of money appropriated to making these improvements happen.

Other points of conversation included why the programs were not prevalent before the bills if these programs existed. Conlin said many of the programs had fallen by the wayside because they were not centralized, depicting the main reason the package was created.

Conlin said with this package, there would be a centralized organization to make sure veterans are able to access these resources and have one person to spearhead every aspect of these resources like transition programs and mentoring.

"It's about kind of codifying into statute the programs that existed and future programs that will exist in a more centralized way," Conlin said.

FEDERAL/NATIONAL UPDATES AND ACTIVITIES

11. **Economic Impact of Health Inequalities in the U.S.:**

The Deloitte Center for Health Solutions released the new report entitled *The Projected Costs and Economic Impact of Mental Health Inequities the United States*. "The report emphasizes the necessity for ongoing and focused research and dialogue to tackle these critical issues and the dire need to understand the connection between body and mind when addressing health inequities. The findings underscore the significant impact and intersectionality of mental health conditions on the trajectory of other major chronic diseases in America, including cardiovascular disease, diabetes, and Human Immunodeficiency Virus (HIV)."

12. **Federal Action Plan to Implement National Suicide Strategy:**

Building on the Administration's release in April 2024 of a suicide National Strategy, HHS "has released a first-ever *Federal Action Plan* to guide our efforts over the next decade. This strategy calls on all of us to:

- ***Care*** about suicide prevention through a thoughtful strategy that blends prevention, intervention, treatment, and postvention support.
- ***Connect*** our prevention efforts to community and culture as key protective factors for health and wellbeing.
- ***Collaborate*** with public and private sector partners, people with suicide-centered lived experience, and those disproportionately affected by suicide to achieve meaningful, equitable, and measurable advancement in suicide prevention.

Realizing the full vision of the National Strategy, particularly for populations most affected by suicide, will require a coordinated, comprehensive, and sustained effort by many partners. Guiding federal agencies' efforts is a Federal Action Plan with over 200 priority actions to be implemented, monitored, and evaluated."

13. **Health Policy 101:**

The Kaiser Family Foundation has released a new resource—*Health Policy 101*—which explains the basics on a range of topics about health programs and policy, such as Medicare and Medicaid, the Affordable Care Act (ACA), health care costs and affordability, women's health issues, and the politics of health care. Health Policy 101 chapters are available online and can be downloaded in PDF format.

14. **Federal Updates to Quality Measures:**

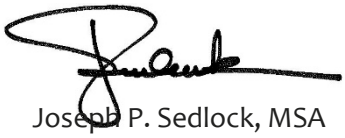
CMS has "released a State Health Official (SHO) Letter that describes the 2025 updates to the core set of children's health care quality measures for Medicaid and Children's Health Insurance Program (CHIP) (Child Core Set) and the core set of health care quality measures for adults enrolled in Medicaid (Adult Core Set). CMS encourages states to use Core Set data to identify disparities in care and develop initiatives and policies to advance health equity and improve outcomes. As part of these efforts, for 2025 Core Set reporting, states will be required to report stratified data for some, but not all, mandatory measures. The letter provides additional guidance to states specific to 2025 mandatory reporting of the Child Core Set and the behavioral health measures on the Adult Core Set, and includes reporting requirements for stratified data. States are encouraged to use Core Set data to identify disparities in care and develop initiatives and policies to advance health equity and improve outcomes."

15. **Social Determinants of Health – What Works Fact Sheets:**
Centers for Disease Control (CDC) relates that "the Community Guide has easy-to-read summaries of Community Preventive Services Task Force (CPSTF) recommendations and findings for evaluated intervention approaches." These brief summaries feature tables that may be viewed online or printed as handouts, making them useful for communications with decision makers and partners. You can use the findings listed in the tables to identify intervention strategies you could use for your community. The What Works fact sheets have been updated to include this latest CPSTF recommendation, including Social Determinants of Health.

16. **Waiver of Copayment for Veterans:**
The Veteran's Administration (VA) has published a *Notice of Intent To Exempt Copayments for the First Three Mental Health Care Outpatient Visits Annually*. "VA intends to implement a new law that prohibits the

collection of copayments for the first three mental health care outpatient visits of a Veteran in a calendar year for which the Veteran would otherwise be required to pay a copayment. VA's current regulations regarding copayments do not include an exemption for this purpose, but VA will revise them soon to align with the law. In April 2024, VA was able to modify its systems and processes to comply with the law for qualifying appointments that occurred on or after June 27, 2023. By law, the exemption will expire on December 29, 2027. Implementation will be applicable upon publication in the Federal Register."

Submitted by:



Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 06/20/2024

Attachments:

- MSHN Michigan Legislative Tracking Summary

MSHN
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 June 17, 2024:

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 4131 (PA 52)	Health Insurers (Liberati) Modifies coverage for health care services provided through telemedicine.	Signed by the Governor (6/6/2024; Signed: June 6, 2024, Effective: September 3, 2024)
HB 4169	Occupational Therapists (Rogers) Enacts occupational therapy licensure compact.	Passed in House (4/30/2024; 103-6; immediate effect)
HB 4170	Occupational Therapists (Wozniak) Modifies licensure process for occupational therapists to incorporate occupational therapy licensure compact.	Passed in House (4/30/2024; 103-6; immediate effect)
HB 4201	Liquor Licenses (Grant) Eliminates sunset of carryout sales and delivery of alcoholic liquor by an on-premises licensee.	Received in Senate (5/3/2023; To Regulatory Affairs Committee)
HB 4213 (PA 54)	Telemedicine (Morse) Provides definition of distant site for a telemedicine visit.	Signed by the Governor (6/6/2024; Signed: June 6, 2024, Effective: September 3, 2024)
HB 4498	Disabilities Discrimination (Bierlein) Requires pre-suit notice of civil actions under the persons with disabilities civil rights act and provides an opportunity to comply.	Introduced (5/2/2023; To Judiciary Committee)
HB 4523 (PA 44)	Mental Health Court (Hope) Modifies violent offender eligibility for mental health court.	Signed by the Governor (5/22/2024; Signed: May 22, 2024, Effective: August 19, 2024)
HB 4525 (PA 45)	Drug Treatment Court (Filler) Modifies violent offender eligibility for drug treatment court.	Signed by the Governor (5/22/2024; Signed: May 22, 2024, Effective: August 19, 2024)
HB 4576	Behavioral Health Services (VanderWall) Provides specialty integrated plan for in behavioral health services.	Introduced (5/16/2023; To Health Policy Committee)
HB 4577	Mental Health (VanderWall) Provides updates regarding the transition from specialty prepaid inpatient health plans to specialty integration plans.	Introduced (5/16/2023; To Health Policy Committee)
HB 4579 (PA 51)	Telehealth Visits (Price) Requires reimbursement rate for telehealth visits to be the same as reimbursements for office visits.	Signed by the Governor (6/6/2024; Signed: June 6, 2024, Effective: September 3, 2024)
HB 4580 (PA 53)	Telehealth Visits (Brabec) Requires reimbursement rate for telehealth visits to be the same as reimbursements for office visits.	Signed by the Governor (6/6/2024; Signed: June 6, 2024, Effective: September 3, 2024)

MSHN
Mid-State Health Network

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 4690	Substance Abuse (Coffia) Modifies notice of a defendant's right to secular substance abuse disorder treatment.	Committee Hearing in House Judiciary Committee (6/21/2023)
HB 4693	Open Meetings (Fitzgerald) Allows nonelected and noncompensated public bodies to meet remotely.	Introduced (5/30/2023; To Local Government and Municipal Finance Committee)
HB 4707	Health Insurers (Brabec) Modifies coverage for intermediate and outpatient care for substance use disorder.	Advanced to Third Reading in House (10/24/2023)
HB 4745	Mental Health (BeGole) Expands petition for access to assisted outpatient treatment to additional health providers.	Introduced (6/14/2023; To Health Policy Committee)
HB 4746	Mental Health (Steele) Provides outpatient treatment for misdemeanor offenders with mental health issues.	Introduced (6/14/2023; To Health Policy Committee)
HB 4747	Mental Health (Kuhn) Expands hospital evaluations for assisted outpatient treatment.	Introduced (6/14/2023; To Health Policy Committee)
HB 4748	Mental Health (Tisdel) Allows use of mediation as a first step in dispute resolution.	Introduced (6/14/2023; To Health Policy Committee)
HB 4749	Community Mental Health (Harris) Provides community mental health oversight of competency exams for defendants charged with misdemeanors.	Introduced (6/14/2023; To Health Policy Committee)
HB 4769	Gender Neutral References (Coffia) Makes certain references in the mental health code gender neutral.	Introduced (6/15/2023; To Government Operations Committee)
HB 4817	Open Meetings (Carter, B.) Modifies procedures for electronic meetings of public bodies.	Introduced (6/15/2023; To Local Government and Municipal Finance Committee)
HB 4833	Substance Use Treatment (Puri) Modifies licensure for substance use disorder service programs.	Committee Hearing in House Health Policy Committee (6/13/2024)
HB 4841	Adult Foster Care (Young) Provides for enhanced standards on adult foster care facilities.	Committee Hearing in House Families, Children and Seniors Committee (9/19/2023)
HB 4960	Employment Discrimination (Snyder) Prohibits employers and labor organizations from requesting or maintaining a record of certain criminal history information about a job applicant or employee.	Reported in Senate (4/18/2024; By Civil Rights, Judiciary and Public Safety Committee)
HB 5077	Naloxone (VanderWall) Provides distribution of naloxone under the	Received in Senate (4/30/2024; To Health Policy Committee)

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
	administration of opioid antagonist act to any individual.	
HB 5078	Controlled Substances (Rheingans) Provides distribution of opioid antagonists by employees and agents of agencies under the administration of opioid antagonists act.	Received in Senate (4/30/2024; To Health Policy Committee)
HB 5114	Mental Health Professionals (Rheingans) Expands definition of mental health professional to include physician assistants, certified nurse practitioners, and clinical nurse specialists-certified, and allows them to perform certain examinations.	Reported in House (5/22/2024; Substitute H-3 adopted; By Health Policy Committee)
HB 5124	Controlled Substances (Bollin) Modifies crime of manufacturing, delivering, or possession of with intent to deliver heroin or fentanyl to reflect changes in sentencing guidelines.	Committee Hearing in House Criminal Justice Committee (3/12/2024)
HB 5125	Controlled Substances (Lightner) Allows probation for certain major controlled substances offenses.	Committee Hearing in House Criminal Justice Committee (3/12/2024)
HB 5126	Controlled Substances (Witwer) Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver heroin or fentanyl.	Committee Hearing in House Criminal Justice Committee (3/12/2024)
HB 5127	Disabled Veterans (McFall) Extends eligibility for disabled veteran registration plate to partially disabled veterans.	Received in Senate (5/30/2024; To Veterans and Emergency Services Committee)
HB 5128	Controlled Substances (Skaggs) Modifies crime of manufacturing, delivering, or possession of with intent to deliver heroin or fentanyl to reflect changes in sentencing guidelines.	Introduced (10/12/2023; To Criminal Justice Committee)
HB 5129	Controlled Substances (Wilson) Allows probation for certain major controlled substances offenses.	Introduced (10/12/2023; To Criminal Justice Committee)
HB 5130	Controlled Substances (Filler) Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver heroin or fentanyl.	Introduced (10/12/2023; To Criminal Justice Committee)
HB 5178	Syringe Service Programs (Rheingans) Provides for syringe service programs.	Committee Hearing in House Health Policy Behavioral Health Subcommittee (6/13/2024)
HB 5179	Drug Paraphernalia (Rheingans) Modifies definition of drug paraphernalia.	Passed in House (6/13/2024; 77-32; Given Immediate Effect)

MSHN
Mid-State Health Network

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 5184	Social Workers (Brabec) Modifies social work licensure requirements and includes licensure for licensed clinical social workers.	Committee Hearing in House Health Policy Behavioral Health Subcommittee (6/13/2024)
HB 5185	Social Workers (Edwards) Modifies social work licensure requirements and includes licensure for licensed clinical social workers.	Committee Hearing in House Health Policy Behavioral Health Subcommittee (6/13/2024)
HB 5276	Mental Health (Conlin) Establishes office of mental health within the Michigan department of military and veterans affairs.	Advanced to Third Reading in House (6/13/2024; With committee substitute H-1 adopted.)
HB 5277	Mental Health (Morse) Establishes office of mental health within the Michigan veterans affairs agency.	Advanced to Third Reading in House (6/13/2024; With committee substitute H-2 adopted.)
HB 5278	Mental Health (Bezotte) Establishes veteran service officer mental health training program.	Introduced (10/26/2023; To Military, Veterans and Homeland Security Committee)
HB 5279	Mental Health (Brabec) Establishes office of mental health peer mentorship program within the Michigan department of military and veterans affairs.	Reported in House (6/11/2024; Substitute H-1 adopted; By Military, Veterans and Homeland Security Committee)
HB 5280	Mental Health (Bruck) Establishes Michigan azimuth bridge program for transitioning military service members' mental health.	Advanced to Third Reading in House (6/13/2024; With committee substitute H-1 adopted.)
HB 5343	Mental Health Professionals (Arbit) Requires insurance providers to panel a mental health provider within a certain time period of application process.	Committee Hearing in House Health Policy Committee (2/6/2024)
HB 5344	Health Benefits (Brabec) Requires nonprofit health care corporation to panel a mental health provider within a certain time period of the application process.	Committee Hearing in House Health Policy Committee (2/6/2024)
HB 5345	Mental Health Parity (Arbit) Provides mental health parity and addiction equity compliance.	Committee Hearing in House Health Policy Committee (2/6/2024)
HB 5346	Mental Health Parity (Coffia) Requires certain annual reports of health insurers relating to mental health parity.	Committee Hearing in House Health Policy Committee (2/6/2024)
HB 5347	Health Insurers (Mentzer) Requires certain annual reports of nonprofit health care corporations.	Committee Hearing in House Health Policy Committee (2/6/2024)

MSHN
Mid-State Health Network

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 5371	Behavioral Health Clinics (Brabec) Provides certification and funding for certified community behavioral health clinics.	Committee Hearing in House Health Policy Behavioral Health Subcommittee (6/13/2024)
HB 5372	Behavioral Health Clinics (Green) Provides certification for certified community behavioral health clinics.	Committee Hearing in House Health Policy Behavioral Health Subcommittee (6/13/2024)
HB 5698	Mental Health (Young) Provides for screening and treatment for post traumatic prison disorder and requires certain other mental health screening, planning, and treatment of incarcerated individuals.	Introduced (5/1/2024; To Criminal Justice Committee)
HB 5720	National Guard (Bezotte) Provides for access to resources by National Guard members.	Advanced to Third Reading in House (6/13/2024)
HB 5725	Open Meetings (Alexander) Authorizes remote meeting participation for members of a public body meeting as a board of a prepaid inpatient health plan in certain circumstances.	Introduced (5/14/2024; To Local Government and Municipal Finance Committee)
HB 5736	Veterans' Services And Benefits (Mentzer) Requires employers to post notice of veterans' services and benefits.	Committee Hearing in House Labor Committee (6/13/2024)
HB 5819	Veterans (Coffia) Modifies veterans trust fund act and removes period of war service requirement.	Introduced (6/13/2024; To Military, Veterans and Homeland Security Committee)
SB 27 (PA 41)	Health Insurance (Anthony) Provides equitable coverage for behavioral health and substance use disorder treatment.	Signed by the Governor (5/21/2024; Signed: May 21, 2024, Effective: August 18, 2024)
SB 28	Mental Health (Anthony) Expands definition of restraint.	Introduced (1/18/2023; To Health Policy Committee)
SB 227 (PA 50)	Child Protection (Lauwers) Modifies conditions for emergency safety intervention in a children's therapeutic group home.	Signed by the Governor (6/6/2024; Signed: June 6, 2024, Effective: June 6, 2024)
SB 399	Mental Health (Bellino) Modifies competitive grant program.	Introduced (6/21/2023; To Appropriations Committee)
SB 499	Controlled Substances (Irwin) Exempts conduct associated with entheogenic plants and fungi from criminal penalties in certain circumstances.	Introduced (9/14/2023; To Regulatory Affairs Committee)
SB 540	Veterans (Hertel, K.) Creates Michigan veterans coalition grant program.	Introduced (10/3/2023; To Veterans and Emergency Services Committee)
SB 541	Veterans (Hauck) Creates Michigan veterans coalition fund.	Introduced (10/3/2023; To Veterans and Emergency Services Committee)

MSHN
Mid-State Health Network

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
SB 542	Controlled Substances (Hertel, K.) Allows choice of formulation, dosage, and route of administration for opioid antagonists by certain persons and governmental entities if department of health and human services distributes opioid antagonists free of charge.	Introduced (10/3/2023; To Health Policy Committee)
SB 546	Liquor Licenses (Hauck) Modifies license to sell alcoholic liquor for consumption on the premises of a certain conference centers.	Received in House (3/19/2024; To Regulatory Reform Committee) Passed in Senate (3/19/2024; 37-0; Earlier advanced to Third Reading.)
SB 574	Veteran Benefits (Singh) Creates Tricare premium reimbursement program.	Introduced (10/10/2023; To Appropriations Committee)
SB 641	Open Meetings (McBroom) Revises provisions of open meetings act relating to virtual attendance and participation of members of public bodies at public meetings.	Introduced (11/7/2023; To Oversight Committee)
SB 647	Tobacco Products (Shink) Eliminates preemption of local ordinances pertaining to the sale of tobacco products or the licensure of distributors.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 648	Tobacco Products (Chang) Creates excise tax on e-cigarettes and certain other tobacco products.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 649	Tobacco Products (Cherry) Prohibits advertising for sale, displaying for sale, marketing, or selling a nicotine or tobacco product that has characterizing flavor.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 650	Tobacco (Cherry) Revises reference to 1915 PA 31 in the age of majority act of 1971.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 651	Tobacco Products (Singh) Requires license to sell a nicotine or tobacco product at retail.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 652	Tobacco (Singh) Revises reference to 1915 PA 31 in the age of majority act of 1971.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 653	Tobacco (Cavanagh) Revises reference to 1915 PA 31 in the age of majority act of 1971.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 654	Youth Tobacco Act (Wojno) Sunsets criminal penalties and civil sanctions for minors that purchase, possess, or use	Introduced (11/9/2023; To Regulatory Affairs Committee)

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
	tobacco products, vapor products, or alternative nicotine products.	
SB 695	Adult Foster Care (Singh) Modifies definitions and licensing provisions under adult foster care facility licensing act.	Committee Hearing in House Families, Children and Seniors Committee (6/18/2024)
SB 802	Mental Health (Wojno) Provides inclusion of mental health and substance use disorder services with the Michigan crisis and access line.	Introduced (3/19/2024; To Health Policy Committee)
SB 806	Mental Health (Hauck) Requires psychological evaluation on a minor in a hospital emergency room longer than a certain period of time due to a mental health episode.	Introduced (4/9/2024; To Health Policy Committee)
SB 870	Remote Meetings (McCann) Provides for remote meeting participation of certain public body members with disabilities.	Introduced (5/9/2024; To Civil Rights, Judiciary and Public Safety Committee)
SB 915	Mental Health (Hertel, K.) Revises person requiring treatment and modifies certain procedures for treatment.	Introduced (6/12/2024; To Health Policy Committee)
SB 916	Mental Health (Santana) Provides outpatient treatment for misdemeanor offenders with mental health issues.	Introduced (6/12/2024; To Health Policy Committee)
SB 917	Mental Health (Irwin) Expands hospital evaluations for assisted outpatient treatment.	Introduced (6/12/2024; To Health Policy Committee)
SB 918	Mental Health (Wojno) Expands petition for access to assisted outpatient treatment to additional health providers.	Introduced (6/12/2024; To Health Policy Committee)
HCR 5	Psychological Trauma (Conlin) A concurrent resolution to urge the United States Congress, Department of Defense, and Department of Veterans Affairs to prioritize research and investment in non-technology treatment options for servicemembers and veterans who have psychological trauma as a result of military service.	Passed in Senate (9/7/2023; Voice Vote)

REPORT OF THE MSHN DEPUTY DIRECTOR
to the Board of Directors
May/June

Balanced Scorecard Measures for FY24

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

Universal Credentialing Update and Semi-Annual Report – FY24

Public Act 282 of 2020 required Michigan Department of Health and Human Services (MDHHS) to create a Universal Credentialing program to establish, maintain, and revise, as necessary, a uniform Community Mental Health (CMH) services credentialing program. This program is intended to create uniformity in the state to streamline providing community mental health services and to enhance workforce development, training education, and service delivery. The Universal Credentialing program must adhere to national standards from accrediting bodies that have been approved by the department and comply with the national certification standards for community mental health counselors and professionals.

MDHHS created a work group to develop and test the universal credentialing system. The workgroup membership includes 11 agencies, of which MSHN and Bay-Arenac Behavioral Health participate from our region. The development of the system in the Customer Relation Management (CRM) under MDHHS was deployed in February 2023 for testing. The workgroup members have received training and continue to test the functions. MSHN staff are working with Ten16, as an SUD provider, to test the application, submission, verification and approval process. Due to feedback in testing, the individual credentialing system is on hold currently and only the organizational credentialing is required. However, MDHHS has indicated implementation for FY25 to roll the system out to all providers along with providing additional training opportunities prior to the required implementation date. Also anticipated for FY25 is a move to three-year recredentialing reviews as opposed to the two-year requirement currently.

MSHN continues to monitor the organizational and individual credentialing requirements delegated to the CMHSPs through a semi-annual reporting process. The below chart depicts the results of the FY24Q1-Q2 results. Corrective action plans are required for CMHSPs who fall under 90% compliance with the standards.

The MDHHS Universal Credentialing system will require that Pre-paid Inpatient Health Plans (PIHPs) and CMHSPs use the program for credentialing of licensed individuals (direct staff or direct contract) and all organizational provider network credentialing. The system includes an online application process, primary source verification documentation uploads, and tracking of expiration dates including those of primary source verification and credentialing/re-

credentialing, and automatically sends decision letters to the providers within the system. The tracking built into this system will improve credentialing performance across our region and across the state.

	BABHA	CMH-CEI	CMH-CM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMHA	SHW	TBHS	TRD
Report Summary												
# Of Individuals	17	90	10	7	39	0	18	9	18	14	13	30
# Of Organizations	0	19	94	0	13	4	2	0	16	2	5	26
Total Reported	**17**	**109**	**104**	**7**	**52**	**4**	**20**	**9**	**34**	**16**	**18**	**56**
# Initial Credentialing	10	49	8	7	28	3	11	1	10	8	14	13
# Recredentialing	7	60	96	0	24	1	9	8	24	8	4	43
% Compliant Initial LIP Credentaling Decision within 90 days												
Non-Compliant over 90 days	0%	0%	0%	0%	7%	0%	0%	0%	10%	0%	7%	0%
Compliant - within 90 days	100%	100%	100%	100%	93%	100%	100%	100%	90%	100%	93%	100%
% Compliant with Recredentialing 2-year Timeframe- Org and LIP												
Over 2 years (non-compliant)	0%	3%	11%	#DIV/0!	0%	100%	0%	25%	4%	0%	0%	0%
Within 2 years (compliant)	100%	97%	89%	#DIV/0!	100%	0%	100%	75%	96%	100%	100%	100%

For the full report on Compliance activities, see the link below: ***Compliance, Customer Service and Quality Department Report FY24Q2*.**

Compliance and Quality Department Report FY24Q2

Included in the Compliance and Quality Department report is the Customer Service section that details the activities related to customer inquiries. Dan Dedloff, MSHN's Customer Service and Rights Manager, provides an avenue for consumers, providers, stakeholders, and staff to request general information, technical assistance, file complaints, grievances and appeals. All requests are captured and included in a data repository for review and analysis by the regional customer services committee. The following data tables include information collected for FY24.

CUSTOMER SERVICE CONTACTS PER PROVIDER

	Contact Type			Type of Resolution			
Provider (CMHSP & SUD)	Consumer Based Customer Service	Non-Consumer Based Customer Service	Grand Total	Immediate Resolution	Resolution In-Process	Resolution through Follow-up	Grand Total
Bear River Health	1	-	1	-	-	1	1
Community Mental Health for Central Michigan	-	4	4	2	1	1	4
Gratiot Integrated Health Network	-	2	2	2	-	-	2
Harbor Hall	1	-	1	1	-	-	1
LifeWays	-	2	2	2	-	-	2
McCullough Vargas & Associates	1	1	2	-	1	1	2
Mid-Michigan Recovery Services	1	-	1	-	1	-	1
MTC	4	-	4	1	2	1	4
None	-	2	2	1	-	1	2
Saginaw County Community Mental Health Authority	1	1	2	1	-	1	2
Samaritas	-	1	1	1	-	-	1
Sunrise Centre	1	-	1	-	-	1	1
Ten16	1	-	1	-	1	-	1
The Right Door for Hope, Recovery and Wellness	1	-	1	-	-	1	1
Victory Clinical Services	1	-	1	-	-	1	1
WAI-IAM	1	-	1	-	-	1	1
Grand Total	14	13	27	11	9	10	27

FY24 MDHHS Member Appeals Reporting Results (Q1)								
Grievance Category	Number of Cases Closed	Number of Cases Per 100 Members	Number of Decisions Made Timely-Standard	Number of Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited	Percent Timely-All Cases	Percent Untimely-All Cases *
MEDICAL NECESSITY CRITERIA NOT MET	15	0.04	14	1	0	0	93%	7%
NOT A PIHP-COVERED BENEFIT	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
CLINICAL DOCUMENTATION NOT RECEIVED	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
TREATMENT/ SERVICE PLAN GOALS MET	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
MEMBER NOT ELIGIBLE FOR SERVICES	2	0.01	2	0	0	0	100%	0%
MEMBER NON-COMPLIANT WITH TREATMENT/ SERVICE PLAN	5	0.01	5	0	0	0	100%	0%
FAILURE OF THE PIHP/CMHSP/SUD PROVIDER TO RENDER A DECISION TIMELY	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
OTHER	3	0.01	3	0	0	0	100%	0%
NOT APPLICABLE	73	0.20	73	0	0	0	100%	0%
Total	98	0.26	97	1	0	0	99%	1%

*Field will display "#DIV/0!" if there are no reported cases per category.

	Count	Percentage
Appeals	98	
Appeals Upheld	21	21%
Appeals Overturned	73	74%
Appeals Partially Upheld/Overturned	4	4%

For the full report, including follow-up actions related to information above, ***see the link below: Compliance, Customer Service and Quality Department Report FY24Q2.***

Medicaid and Healthy Michigan Disenrollments

On August 10, 2023, MSHN received notice that MDHHS would begin sending a monthly file to the PIHPs that includes the Medicaid and Health Michigan Disenrollments. MDHHS extended the time frame by 30 days to allow individuals time to submit required renewal documentation. Operations Council has continued to monitor the rate of disenrollments throughout the year. As a region, the monthly average rate is 2.4% of total enrollees are being disenrolled with the total % of disenrollment since June at 20.5% (equating to 103,441 individuals loosing Medicaid/Healthy Michigan). As of the end of May, MSHN's Medicaid and Healthy Michigan enrollees is approximately 401,500. MSHN continues to work closely with the CMHSPs to monitor the rate of disenrollments and follow up accordingly where appropriate.

Submitted by:

Amanda L. Ittner
Finalized: 6.20.24

Attached: *Balanced Scorecard FY2024;* ***Links to Reports****:* Compliance, Customers Service and Quality Department Report FY24Q2

MSHN FY24- Board of Directors and Operations Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN Ages 19-64	MDHHS PIHP Contract: Performance Bonus Measure	72%	72%			Baseline year to set benchmark and target		TBD	TBD	TBD
	Percent of individuals who receive follow up care within 30 days after an emergency department visit for alcohol or drug use. (FUA)	MSHN Strategic Plan FY19-20; MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	Not Available	Not Available			100%		>=28%	24%-27%	<=23%
	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year. (Rolling 12 months)	Aligns with strategic plan goal improve population health and integrated care activities.	Report being built by MSHN IT	56%			Michigan 2023: 70.31%		TBD	TBD	TBD
	The percentage of discharges for children who were hospitalized for treatment of selected mental illness or intentional self harm diagnosis and who had a follow up visit with a mental health provider within 30 days of discharge.(FUH)	HEDIS-NCQA	76%	Not Available			70%		>=70%	0	<70%
BETTER CARE	The percentage of Intensive Crisis Stabilization Service calls deployed in a timely manner.	Aligns with annual MDHHS reporting process and improving children/adolescent timely access to care.	91%	89%			>=95%		95-100%	90-94%	<90%
	Initiation of AOD Treatment. Percentage who initiated treatment within 14 days of the diagnosis. (Inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, medication treatment).	Aligns with best practices for assisting individuals to initiate services and engage in continuation of care.	Initiation: 47.74% (1-1-2023 thru 12-31-2023)	Initiation: 47.54% (3-1-2023 thru 2-29-2024)			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: 29.75% (1-1-2023 thru 12-31-2023)				Above Michigan 2020 levels; E: 12.5% (2016)		Increase over National levels	No change from National levels	Drop below National levels
	Engagement of MAT Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of OUD within 30 days of the initiation visit.	Aligns with best practices for assisting individuals to initiate services and engage in continuation of care.	Initiation: 86.80% Engagement: 47.49% (1-1-2023 thru 12-31-2023)	Initiation: 86.11% Engagement: 47.61% (3-1-2023 thru 2-29-2024)			Increase over MSHN 2020 levels (I: 88.69%; E: 54.67%)		Increase over 2020 levels	No change from 2020 levels	Drop below 2020 levels
	Continuum of Care - Consumers moving from inpatient psychiatric hospitalization will show in next LOC within 7 days, and 2 additional appts within 30 days of first step-down visit. (Quarterly)	MSHN and its CMHSP participants will explore clinical process standardization, especially in the areas of access, emergency services, pre-admission screening, crisis response and inpatient stay management and discharge planning.	I: 38.12%; E: 20.46%	I: 38.67%; E: 20.52%			Increase over FY 2019 (I: 38.85%; E: 19.21%)		increase over 2019	No change from 2019 levels	Below 2019 levels
	The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (Plan All Cause Readmissions)	MSHN Strategic Plan, MSHN UM Plan; Measurement Portfolio NQF 1768	12.8%	13.0%			<=15%		<=15%	16-25%	>25%
BETTER VALUE	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	88%	88%			≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
	MSHN reserves (ISF)	RESERVE'S TARGET SUFFICIENT TO MEET FISCAL RISK RELATED TO DELIVERY OF MEDICALLY NECESSARY SERVICES AND TO COVER ITS MDHHS CONTRACTUAL LIABILITY.	Data not available	Data not available			7.5%		> 6%	≥ 5% and 6%	< 5%
	Develop and implement Provider Incentives (VBP, ER FU, Integration)	MSHN will develop methodologies, within established rules, to incentivize providers to cooperate with the PIHP to improve health or other mutually agreeable outcomes.	2	2			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.	94%	96%			95% or greater		95-100%	90-94%	<90%

MSHN FY24- Board of Directors and Operations Council - Balanced Scorecard

									Target Ranges		
Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level			
	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages	MSHN Strategic Plan FY21-22, Federal Parity Requirements	1%	0.08%			<= 5%		<=5%	6%-10%	>=11%
	Medical Loss Ratio is within CMS Guidelines	MSHN WILL MAINTAIN A FISCAL DASHBOARD TO REPORT FINANCE COUNCIL'S AGREED UPON METRICS.	Data not available	Data not available			85%		≥ 90%	> 85% and < 90%	≤ 85%
	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP	MDHHS PIHP Contract: Performance Bonus Incentive Program	77%	83%			100%		>=75%	50%-74%	<50%
BETTER PROVIDER SYSTEMS	Percentage of consumers indicating satisfaction with LTSS (Annual Comprehensive Total)	NCI-Satisfaction Section	Not Applicable	Not Applicable			TBD		80%	75%-80%	75%
	Managed Care Information Systems (REMI) Enhancements	Patient Portal, BTPR, Critical incidents, EVV, etc.	2	3			4		3	2	1
	Determine feasibility of CLS/Specialized Residential servcies regional contract template and monitoring	Strategic Plan - Better Provider Systems	Data not available for Dec and Mar	Data not available for Dec and Mar			Not Started				
	Improve data availability (Foster Care/child Welfare, SDoH, Employment & Housing, Autism Reporting, etc.)	MSHN FY24-25 Strategic Plan - MSHN will increase regional use of information technology data systems to support population health management.	33%	75%			100%		75%	50%	25%
BETTER EQUITY	The disparity between the white population and at least one minority who initiated treatment (AOD) within 14 calendar days will be reduced. (IET-Initiation disparity)	MDHHS PIHP Contract: Performance Bonus Incentive Program	Not Available	Not Available			TBD		TBD	TBD	TBD
	The disparity between the white population and at least one minority group who engaged in treatment (AOD or MAT) within 34 calendar days will be reduced. (IET-Engagement disparity)	MDHHS PIHP Contract: Performance Bonus Incentive Program	Not Available	Not Available			TBD		TBD	TBD	TBD
	Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities between the white and minority adults and children who receive follow-up care within 30 days following a psychiatric hospitalization (FUH)	MDHHS PIHP Contract: Performance Bonus Incentive Program	2	Not Available			0		0	1	2
	PIP 1 - The racial disparities between the black/African American population and the white population will be reduced or eliminated without a decline in performance for the white population. (Yes=The disparity is not statistcially lower than the White population and the index rate did not decrease)	EQR-PIP#1 Strategic Plan	No	Not Available			Yes		Yes	No change	No

MSHN FY24 - Opioid Health Home - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2023	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Performance Level	Target Ranges		
	*Please Note: * Indicates Pay for Performance Measure*										
BETTER CARE	**Initiation of Alcohol and Other Drug Dependence Treatment within 14 days (IET 14)***	CMS Health Home Core Set (2023)	86.21%	Not Available	Not Available				<previous reporting period	no change	>previous reporting period
BETTER CARE	**Engagement of Alcohol and Other Drug Dependence Treatment within 34 days (IET 34)***	CMS Health Home Core Set (2023)	82.76%	Not Available	Not Available				<previous reporting period	no change	>previous reporting period
BETTER CARE	**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 7 days (FUA 7)***	CMS Health Home Core Set (2023)	100%	Not Available	Not Available				>58%		<58%
BETTER CARE	**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 30 days (FUA 30)***	CMS Health Home Core Set (2023)	100%	Not Available	Not Available				>58%		<58%
BETTER CARE	**Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries***	CMS	Not Available	Not Available	Not Available						
BETTER HEALTH	Controlling High Blood Pressure (CBP)	CMS Health Home Core Set (2023)	33.3%	Not Available	Not Available				<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Screening for Depression and Follow-Up Plan (CDF)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available						
BETTER HEALTH	Colorectal Cancer Screening (COL)	CMS Health Home Core Set (2023)	Not Applicable	Not Available	Not Available						
BETTER CARE	Follow-Up After Hospitalization for Mental Illness within 7 days (FUH 7)	CMS Health Home Core Set (2023)	100.0%	Not Available	Not Available				<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Hospitalization for Mental Illness within 30 days (FUH 30)	CMS Health Home Core Set (2023)	100%	Not Available	Not Available				<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness within 7 days (FUM 7)	CMS Health Home Core Set (2023)	20%	Not Available	Not Available				<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness within 30 days (FUM 30)	CMS Health Home Core Set (2023)	40%	Not Available	Not Available				<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available						
BETTER CARE	Plan All-Cause Readmission Rate (PCR)	CMS Health Home Core Set (2023)	33%	Not Available	Not Available				<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Prevention Quality Indicator: Chronic Conditions Composite (PQI 92)	CMS Health Home Core Set (2023)	102 per 1,000 beneficiaries	Not Available	Not Available				<previous reporting period	no change	>previous reporting period
BETTER EQUITY	Admission to a Facility from the Community (AIF)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available						
BETTER CARE	Inpatient Utilization (IU)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available						

MSHN FY24 - Community Certified Behavioral Health Clinic - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	CCBHC Program	Actual Value (%) DY2022	Actual Value (%) DY2023	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Target Value	Performance Level	Target Ranges		
BETTER CARE	Follow-Up After Hospitalization for Mental Illness-7 Days (FUH - Adults) MSHN Ages 18-64.	CMS Adult Core Set (2023)	Michigan CCBHC Program	46.0%	45.8%	Not Available - requested to be added in ICDP	Not Available - requested to be added in ICDP	58.0%		>58%		<58%
			CEI	44.79	43.13%			58.0%		>58%		<58%
			Lifeways					58.0%		>58%		<58%
			The Right Door	71.7%	49.45%			58.0%		>58%		<58%
			SCCMHA	48.0%	50%			58.0%		>58%		<58%
BETTER CARE	Follow-Up After Hospitalization for Mental Illness-30 days (FUH - Adults) MSHN Ages 18-64.	CMS Adult Core Set (2023)	Michigan CCBHC Program	70.1%	69.9%	Not Available	Not Available	58.0%		>58%		<58%
			CEI	67.6%	67.6%	71.2%	68%	58.0%		>58%		<58%
			Lifeways			Not Available	Not Available	58.0%		>58%		<58%
			The Right Door	91.5%	78.1%	69.8%	77%	58.0%		>58%		<58%
			SCCMHA	78.1%	75.3%	64.4%	56%	58.0%		>58%		<58%
BETTER CARE	Follow-Up After Hospitalization for Mental Illness-7 days (FUH-Child/Adolescents) MSHN. Ages 6-17.	CMS Child Core Set (2023)	Michigan CCBHC Program	59.6%	59.4%	Not Available - requested to be added in ICDP	Not Available - requested to be added in ICDP	70.0%		>70%		<70%
			CEI	67.4%	75.2%			70.0%		>70%		<70%
			Lifeways					70.0%		>70%		<70%
			The Right Door	63.2%	52.9%			70.0%		>70%		<70%
			SCCMHA	53.3%	56.3%			70.0%		>70%		<70%
BETTER CARE	Follow-Up After Hospitalization for Mental Illness 30 days (FUH-Child/Adolescents) MSHN. Ages 6-17.	CMS Child Core Set (2023)	Michigan CCBHC Program	83.5%	81.5%	Not Available	Not Available	70.0%		>70%		<70%
			CEI	92.2%	91.0%	83.5%	86%	70.0%		>70%		<70%
			Lifeways			Not Available	Not Available	70.0%		>70%		<70%
			The Right Door	89.5%	*100%	66.7%	63%	70.0%		>70%		<70%
			SCCMHA	100.0%	81.3%	75.0%	58%	70.0%		>70%		<70%
Better Health	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN Ages 19-64	CMS Adult Core Set (2023)	Michigan CCBHC Program	56.7%	54.9%	Not Available	Not Available	58.5%		>58.5%		<58.5%
			CEI		58.45%	79.8%	73%	58.5%		>58.5%		<58.5%
			Lifeways			Not Available	Not Available	58.5%		>58.5%		<58.5%
			The Right Door		74.68%	98.8%	84%	58.5%		>58.5%		<58.5%
			SCCMHA		59.20%	64.7%	66%	58.5%		>58.5%		<58.5%
Better Care	Initiation of Alcohol and Other Drug Dependence Treatment MSHN. Ages 13+	CMS Adult Core Set (2023)	Michigan CCBHC Program	43.5%	41.2%	Not Available	Not Available	I -25%		>25%		<25%
			CEI		42.07%	52.9%	56%	I -25%		>25%		<25%
			Lifeways			Not Available	Not Available	I -25%		>25%		<25%
			The Right Door		42.31%	38.9%	50%	I -25%		>25%		<25%
			SCCMHA		35.78%	50.0%	35%	I -25%		>25%		<25%
Better Care	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Child) MSHN Ages 6-17.	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	47.9%	Not Available	Not Available	Not Available			>23.9%		<23.95%
			CEI		88.29%	83.14%	84.10%	23.9%		>23.9%		<23.95%
			Lifeways			26.72%	16.67%	23.9%		>23.9%		<23.95%
			The Right Door		82.26%	82.80%	86.61%	23.9%		>23.9%		<23.95%
			SCCMHA		13.28%	39.53%	31.61%	23.9%		>23.9%		<23.95%
Better Care	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Adults) MSHN Ages 18+	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	67.60%	Not Available	Not Available	Not Available	12.5%		>12.5%		<12.5%
			CEI	37.0%	74.55%	75.68%	75.73%	12.5%		>12.5%		<12.5%
			Lifeways			43.20%	37.50%	12.5%		>12.5%		<12.5%
			The Right Door	15.0%	76.11%	69.62%	68.57%	12.5%		>12.5%		<12.5%
			SCCMHA	31.0%	55.42%	72.58%	73.85%	12.5%		>12.5%		<12.5%
	Please note: the QBP is only pertinent to Medicaid CCBHC costs and beneficiaries											
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness (FUM-7) Initiation. Ages 6+	CMS Adult Core Set (2023)	Michigan CCBHC Program		59.9%	Not Available	Not Available					
			CEI		47%	57.6%	41%			>previous	no change	<previous
			Lifeways			Not Available	Not Available			>previous	no change	<previous
			The Right Door		56%	53.6%	59%			>previous	no change	<previous
			SCCMHA		57%	45.8%	47%			>previous	no change	<previous
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness (FUM-30) Engagement. Ages 6+	CMS Adult Core Set (2023)	Michigan CCBHC Program		75.4%	Not Available	Not Available					
			CEI		69%	65.4%	62%			>previous	no change	<previous
			Lifeways			Not Available	Not Available			>previous	no change	<previous
			The Right Door		74%	69.6%	74%			>previous	no change	<previous
			SCCMHA		76%	77.8%	66%			>previous	no change	<previous
			Michigan CCBHC Program	22%	39.7%							

MSHN FY24 - Community Certified Behavioral Health Clinic - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	CCBHC Program	Actual Value (%) DY2022	Actual Value (%) DY2023	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Target Value	Performance Level	Target Ranges		
BETTER CARE	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-7) Ages 13+	CMS Adult Core Set (2023)	CEI	22%	40%	Not Available	Not Available			>previous	no change	<previous
			Lifeways							>previous	no change	<previous
			The Right Door	23%	47.2%					>previous	no change	<previous
			SCCMHA	0%	55.8%					>previous	no change	<previous
BETTER CARE	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-30) Ages 13+	CMS Adult Core Set (2023)	Michigan CCBHC Program		60.5%							
			CEI		61.7%					>previous	no change	<previous
			Lifeways							>previous	no change	<previous
			The Right Door		69.2%					>previous	no change	<previous
			SCCMHA		70.5%					>previous	no change	<previous
BETTER HEALTH	Plan All-Cause Readmission Rate (PCR-AD)^ Ages 18+	CMS Adult Core Set (2023)	Michigan CCBHC Program	12%	10.0%	Not Available	Not Available					
			CEI	11%	9%	12.0%	11%			<previous	no change	>previous
			Lifeways			Not Available	Not Available			<previous	no change	>previous
			The Right Door	7.14%	12%	8.2%	11%			<previous	no change	>previous
			SCCMHA	8.60%	8%	16.2%	16%			<previous	no change	>previous
BETTER CARE	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD-AD)^ Ages 18-64.	CMS Adult Core Set (2023)	Michigan CCBHC Program	80.92%	81.7%	Not Available	Not Available					
			CEI	86.3%	85%	82.0%	86%			>previous	no change	<previous
			Lifeways			Not Available	Not Available			>previous	no change	<previous
			The Right Door	82.6%	86%	96.9%	93%			>previous	no change	<previous
			SCCMHA	82%	83%	84.0%	83%			>previous	no change	<previous
BETTER CARE	Follow-up care for children prescribed ADHD medication. Initiation Phase (ADD-CH)^ Ages 6-12.	CMS Child Core Set (2021)	Michigan CCBHC Program	63.4%	61.7%	Not Available	Not Available					
			CEI	61.05	55%	77.8%	77%			>previous	no change	<previous
			Lifeways			Not Available	Not Available			>previous	no change	<previous
			The Right Door	63.64%	78%	100.0%	93%			>previous	no change	<previous
			SCCMHA	60.71%	56%	88.8%	87%			>previous	no change	<previous
BETTER CARE	Follow-up care for children prescribed ADHD medication. C & M Phase (ADD-CH)^ Ages 6-12.	CMS Child Core Set (2021)	Michigan CCBHC Program	69.74%	68.6%	Not Available	Not Available					
			CEI	59.38%	59%	95.2%	93%			>previous	no change	<previous
			Lifeways			Not Available	Not Available			>previous	no change	<previous
			The Right Door	61.54%	88%	100%*	100%			>previous	no change	<previous
			SCCMHA	55.56%	80%	100.0%	96%			>previous	no change	<previous
BETTER HEALTH	Antidepressant Medication Management Acute Phase (AMM-AD) ^ Ages 18+.	CMS Adult Core Set (2023)	Michigan CCBHC Program	49.06%	51.7%	Not Available	Not Available					
			CEI	52.0%	51%	77.5%	Not Available			>previous	no change	<previous
			Lifeways			Not Available	Not Available			>previous	no change	<previous
			The Right Door	54%	64%	32.1%	44%			>previous	no change	<previous
			SCCMHA	45%	48%	75.0%	Not Available			>previous	no change	<previous
BETTER HEALTH	Antidepressant Medication Management Cont. Phase (AMM-AD) ^ Ages 18+.	CMS Adult Core Set (2023)	Michigan CCBHC Program	30%	30.9%	Not Available	Not Available					
			CEI	32%	34%	22.5%	Not Available			>previous	no change	<previous
			Lifeways			Not Available	Not Available			>previous	no change	<previous
			The Right Door	31.2%	42%	70.6%	Not Available			>previous	no change	<previous
			SCCMHA	31.8%	25%	14.8%	Not Available			>previous	no change	<previous
BETTER CARE	Engagement of Alcohol and Other Drug Dependence Treatment MSHN. Ages 13+.	CMS Adult Core Set (2023)	Michigan CCBHC Program	12.3%	13.2%	Not Available	Not Available					
			CEI	11.5%	15%	44.6%	35%			>previous	no change	<previous
			Lifeways			Not Available	Not Available			>previous	no change	<previous
			The Right Door	9%	15%	30.6%	37%			>previous	no change	<previous
			SCCMHA	15%	16%	43.1%	35%			>previous	no change	<previous
BETTER CARE	Time to Initial Evaluation (I-EVAL): Percent of consumers with an initial evaluation within 10 Business Days. Total (all ages)	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	58%	Not Available	Not Available	Not Available					
			CEI	64.1%	70.2%	61%	56%	Increase		>previous	no change	<previous
			Lifeways			80%	82%	Increase		>previous	no change	<previous
			The Right Door	77.5%	59.3%	79%	79%	Increase		>previous	no change	<previous
			SCCMHA	57%	28%	67%	67%	Increase		>previous	no change	<previous
BETTER CARE	Time to Initial Evaluation (I-EVAL): Mean Number of Days until Initial Evaluaton	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	20.78	Not Available	Not Available	Not Available					
			CEI	12.80	10.28	6	10	>=10 days		>=10 days		<10 days
			Lifeways			8	9	>=10 days		>=10 days		<10 days
			The Right Door	14.77	21.15	8	8	>=10 days		>=10 days		<10 days
			SCCMHA	18.57	28.86	13	13	>=10 days		>=10 days		<10 days

MSHN FY24 - Community Certified Behavioral Health Clinic - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	CCBHC Program	Actual Value (%) DY2022	Actual Value (%) DY2023	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Target Value	Performance Level	Target Ranges		
BETTER CARE	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	32.5%	Not Available	Not Available	Not Available					
			CEI	7.9%	8.8%	4%	4%	Increase		>previous	no change	<previous
			Lifeways			14.81%	7%	Increase		>previous	no change	<previous
			The Right Door	38.1%	47%	30%	29%	Increase		>previous	no change	<previous
			SCCMHA	24.4%	47%	33%	33%	Increase		>previous	no change	<previous
BETTER CARE	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)^ All ages	CMS Child Core Set (2023)	Michigan CCBHC Program	44.3%	Not Available	Not Available	Not Available					
			CEI	3.7%	6.2%	1%	1%	Increase		>previous	no change	<previous
			Lifeways			0%	0%	Increase		>previous	no change	<previous
			The Right Door	84.9%	68.9%	51%	52%	Increase		>previous	no change	<previous
			SCCMHA	75.3%	62%	57%	61%	Increase		>previous	no change	<previous
BETTER HEALTH	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC) Ages 18 +	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	48.7%	Not Available	Not Available	Not Available					
			CEI	3.3%	21.0%	9%	13%	Increase		>previous	no change	<previous
			Lifeways			72%	82%	Increase		>previous	no change	<previous
			The Right Door	47.5%	64.1%	36%	39%	Increase		>previous	no change	<previous
			SCCMHA	61.0%	62%	41%	44%	Increase		>previous	no change	<previous
BETTER HEALTH	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC) Ages 18 +	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	48.5%	Not Available	Not Available	Not Available					
			CEI	0.0%	18.1%	9%	12%	Increase		>previous	no change	<previous
			Lifeways			3%	4%	Increase		>previous	no change	<previous
			The Right Door	36.8%	61.8%	68%	69%	Increase		>previous	no change	<previous
			SCCMHA	58.0%	76%	68%	70%	Increase		>previous	no change	<previous
BETTER CARE	Screening for Depression and Follow-Up Plan: Age 12+ (CDF-AD)	CMS Adult Core Set (2023)	Michigan CCBHC Program	37.2%	Not Available	Not Available	Not Available					
			CEI	1.2%	4.6%	2%	3%	Increase		>previous	no change	<previous
			Lifeways			48%	34%	Increase		>previous	no change	<previous
			The Right Door	40.9%	41.1%	38%	38%	Increase		>previous	no change	<previous
			SCCMHA	75.7%	50%	37%	36%	Increase		>previous	no change	<previous
BETTER CARE	Depression Remission at Twelve Months (DEP-REM-12) Ages 12+	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program	13.0%	Not Available	Not Available	Not Available					
			CEI	0.0%	0.0%	1%	1%	Increase		>previous	no change	<previous
			Lifeways			0%	*	Increase		>previous	no change	<previous
			The Right Door	2.5%	4%	3%	3%	Increase		>previous	no change	<previous
			SCCMHA	0.0%	0%	37%	0%	Increase		>previous	no change	<previous
BETTER PROVIDER SYSTEM	Patient Experience fo Care Survey (PEC) Ages 18+ (annual comprehensive score)	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program		Not Available	Not Available						
			CEI		80%	80%		TBD				
			Lifeways		NA	NA		TBD				
			The Right Door		81%	81%		TBD				
			SCCMHA		75%	75%		TBD				
BETTER PROVIDER SYSTEM	Youth/Family Experience fo Care Survey (Y/FEC) Ages <18 (annual comprehensive score)	SAMHSA Metrics and Quality Measures (2016)	Michigan CCBHC Program		Not Available	Not Available						
			CEI		82%	82%		TBD				
			Lifeways		NA	NA		TBD				
			The Right Door		78%	78%		TBD				
			SCCMHA		84%	84%		TBD				

MSHN FY24 - Behavioral Health Home - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2023	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Performance Level	Target Ranges		
	*Please Note: * Indicates Pay for Performance Measure*		*N=<30						
BETTER HEALTH	**Controlling High Blood Pressure (CBP)***	CMS Health Home Core Set (2023)	100%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER VALUE	**Reduction in Ambulatory Care: Emergency Department (ED) Visits (AMB)***	CMS Health Home Core Set (2023)	Not Available - Discontinued by MDHHS						
BETTER CARE	**Access to Preventive/Ambulatory Health Services (AAP)***	HEDIS NCQA	97.08%	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Screening for Depression and Follow-Up Plan (CDF)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available				
BETTER HEALTH	Colorectal Cancer Screening (COL)	CMS Health Home Core Set (2023)	n=0*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 7 days (FUA 7)	CMS Health Home Core Set (2023)	100%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 30 days (FUA 30)	CMS Health Home Core Set (2023)	100%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Hospitalization for Mental Illness within 7 days (FUH 7)	CMS Health Home Core Set (2023)	71.43%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Hospitalization for Mental Illness within 30 days (FUH 30)	CMS Health Home Core Set (2023)	100%*	Not Available	Not Available		>58%		<58%
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness within 7 days (FUM 7)	CMS Health Home Core Set (2023)	100%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Follow-Up After Emergency Department Visit for Mental Illness within 30 days (FUM 30)	CMS Health Home Core Set (2023)	100%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Initiation of Alcohol and Other Drug Dependence Treatment within 14 days (IET 14)	CMS Health Home Core Set (2023)	25%*	Not Available	Not Available		>25%		<25%
BETTER CARE	Engagement of Alcohol and Other Drug Dependence Treatment within 34 days (IET 34)	CMS Health Home Core Set (2023)	0%*	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER CARE	Plan All-Cause Readmission Rate (PCR)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Prevention Quality Indicator: Chronic Conditions Composite (PQI 92)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER EQUITY	Admission to a Facility from the Community (AIF)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available		<previous reporting period	no change	>previous reporting period
BETTER HEALTH	Inpatient Utilization (IU)	CMS Health Home Core Set (2023)	Not Available	Not Available	Not Available		<previous reporting period	no change	>previous reporting period

MSHN FY24 - Quality Improvement Council - Scorecard

Key Performance Areas	Key Performance Indicators	Regulatory Requirement Source	Aligns with	Actual Value (%) as of September 2023	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER CARE	Percent of all Medicaid Children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	MDHHS PIHP Contract: QAPIP	MMBPIS FY24 Codebook Indicator 1	98.49%	98.58%	Not Available			>=95%		>=95%	94%	<94%
BETTER CARE	Percent of all Medicaid Adult beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	MDHHS PIHP Contract: QAPIP	MMBPIS FY24 Codebook Indicator 1	99.55%	99.67%	Not Available			>=95%		>=95%	94%	<94%
BETTER CARE	The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non emergency request for service. Cumulative	MDHHS PIHP Contract: Michigan Mission Based Performance Indicator System	MMBPIS FY24 Codebook Indicator 2	60.70%	61.79%	Not Available			>=62.%		>=62.3%		<62.3%
BETTER CARE	The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. Cumulative	MDHHS PIHP Contract: Michigan Mission Based Performance Indicator System	MMBPIS FY24 Codebook Indicator 3	62.54%	59.72%	Not Available			>=72.9%		>=72.9%		<72.90%
BETTER CARE	Percent of child discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days	MDHHS PIHP Contract: QAPIP	MMBPIS FY24 Codebook Indicator 4a	97.83%	94.67%	Not Available			>=95%		>=95%	94%	<94%
BETTER CARE	Percent of adult discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days	MDHHS PIHP Contract: QAPIP	MMBPIS FY24 Codebook Indicator 4a	95.76%	95.20%	Not Available			>=95%		>=95%	94%	<94%
BETTER HEALTH	Percent of MI and DD children readmitted to an inpatient psychiatric unit within 30 days of discharge	MDHHS PIHP Contract: QAPIP	MMBPIS FY24 Codebook Indicator 10	8.81%	9.36%	Not Available			<=15%		<=15%	>=15.1%	>=16%
BETTER HEALTH	Percent of MI and DD adults readmitted to an inpatient psychiatric unit within 30 days of discharge	MDHHS PIHP Contract: QAPIP	MMBPIS FY24 Codebook Indicator 10	12.31%	10.73%	Not Available			<=15%		<=15%	>=15.1%	>=16%
BETTER PROVIDER SYSTEM	Percentage of adults indicating satisfaction with SUD services. (Annual Comprehenisve Total)	MDHHS PIHP Contract: QAPIP	SAMSHA 2005 MHSIP	95%	Not Applicable	Not Applicable			>=80%		80%	75%-80%	75%
BETTER PROVIDER SYSTEM	Percentage of children/families indicating satisfaction with mental health services (Annual Comprehensive Total)	MDHHS PIHP Contract: QAPIP	SAMSHA 2005 YSS	87%	Not Applicable	Not Applicable			>=80%		80%	75%-80%	75%
BETTER PROVIDER SYSTEM	Percentage of adults indicating satisfaction with mental health services (Annual Comprehensive Total)	MDHHS PIHP Contract: QAPIP	SAMSHA 2005 MHSIP	82%	Not Applicable	Not Applicable			>=80%		80%	75%-80%	75%
BETTER PROVIDER SYSTEM	Percentage of consumers indicating satisfaction with LTSS (Annual Comprehensive Total)	MDHHS PIHP Contract: QAPIP	NCI-Satisfaction Section	82%	Not Applicable	Not Applicable			TBD		80%	75%-80%	75%
BETTER EQUITY	PIP 1 - The racial disparities between the black/African American population and the white population will be reduced or eliminated without a decline in performance for the white population. (Yes=The disparity is not statistcially lower than the White population and the index rate did not decrease)	MDHHS PIHP Contract: QAPIP	EQR-PIP#1 Strategic Plan	No	No	Not Available			Yes		Yes	No change	No
BETTER EQUITY	PIP 2 - The racial or ethnic disparity between the black/African American minority penetration rate and the index (white) penetration rate will be reduced or eliminated. (Yes=The disparity is not statistically lower than the white population group, and the index rate did not decrease)	MDHHS PIHP Contract: QAPIP	Strategic Plan	No	No	Not Available			Yes		Yes	No change	No
BETTER HEALTH	The rate of critical incidents, per 1000 persons served, will demonstrate a decrease from previous measurement period. (CMHSP) (excluding deaths) Cumulative YTD	MDHHS PIHP Contract: QAPIP	MSHN QAPIP	8.560	3.393	Not Available			FY23 8.56		Decrease	No change	Increase
BETTER HEALTH	The rate, per 1000 persons served, of Unexpected Deaths will demonstrate a decrease from previous measurment period. (CMHSP) Cumulataive YTD	MDHHS PIHP Contract: QAPIP	MSHN QAPIP	1.047	0.463	Not Available			FY23 1.047		Decrease	No change	Increase
BETTER HEALTH	The percent of emergency intervention per person served will demonstrate a decrease from previous measurement period.	MDHHS PIHP Contract: QAPIP	MSHN QAPIP	0.009	0.008	Not Available			Decrease previous quarter .94%		Decrease	No change	Increase

MSHN FY24 - Customer Service Committee - Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER CARE	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal.	MDHHS PIHP Contract: Appeal and Grievance Resolution Processes Technical Requirement	98.97%	100.00%			95%		95%	91%-94%	90%
BETTER CARE	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance.	MDHHS PIHP Contract: Appeal and Grievance Resolution Processes Technical Requirement	100%	100%			95%		95%	91%-94%	90%

MSHN FY24 - Regional Compliance Committee - Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER CARE	Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines. CMHSP	MSHN QAPIP	N/A	N/A			Increase over 2023		Increase	No change	Decrease
BETTER CARE	Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines. SUD	MSHN QAPIP	N/A	N/A			Increase over 2023		Increase	No change	Decrease

MSHN FY24 - Provider Network Management Committee - Balanced Scorecard

									Target Ranges		
Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level			
BETTER PROVIDER SYSTEM	Develop an action plan to address repeat findings related to provider credentialing and recredentialing process requirements through training/technical assistance and monitoring; monitoring and oversight of CMHSPs demonstrate improvement in credentialing and credentialing systems;	HSAG and MDHHS Reviews	25%	50%			90%		>95%	80-94%	<79%
BETTER PROVIDER SYSTEM	Providers demonstrate increased compliance with the MDHHS/MSHN Credentialing and Staff Qualification requirements. (SUD Network and CMHSP Network)	QAPIP Goal; HSAG and MDHHS reviews	25%	50%			90%		>90%	70-89%	<70%
BETTER PROVIDER SYSTEM	Address recommendations from the 2023 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs.	MDHHS Network Adequacy Requirements	25%	50%			100%		>95%	80-94%	<79%
BETTER PROVIDER SYSTEM	Monitor and implement Electronic Visit Verification as required by MDHHS	MDHHS Reviews	Data not available for Dec and Mar	Data not available for Dec and Mar			Once Implemented		Complete	In Process	Not Started
BETTER PROVIDER SYSTEM	Advocate for direct support professionals to support provider retention (e.g. wage increase; recognition)	Strategic Plan - Better Provider Systems	25%	50%			100%		Complete	In Process	Not Started
BETTER PROVIDER SYSTEM	Determine feasibility of CLS/Specialized Residential servcies regional contract template and monitoring	Strategic Plan - Better Provider Systems	Data not available for Dec and Mar	Data not available for Dec and Mar			Not Started				
BETTER PROVIDER SYSTEM	Develop and implement regionally approved process for credentialing/re-credentialing reciprocity	QAPIP Goal; HSAG and MDHHS reviews	Data not available for Dec and Mar	Data not available for Dec and Mar			In Process		>80%	70-79%	<70%

MSHN FY24- Clinical Leadership Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year. (Rolling 12 months)	Aligns with strategic plan goal improve population health and integrated care activities.	Report being built by MSHN IT	55.56%			Michigan 2023: 70.31%	TBD			
BETTER HEALTH	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN Ages 19-64	MDHHS PIHP Contract: Performance Bonus Measure	72.20%	71.8%			Baseline year to set benchmark and target		75-100%	66-74%	<65%
BETTER CARE	The percentage of Intensive Crisis Stabilization Service calls deployed in a timely manner.	Aligns with annual MDHHS reporting process and improving children/adolescent timely access to care.	90.90%	89.40%			>=95%		95-100%	90-94%	<90%
BETTER VALUE	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization. (FYTD)	The MDHHS requirement of 95% slot utilization or greater.	93.60%	95.5%			95% or greater		95-100%	90-94%	<90%
BETTER CARE	Behavior Treatment Plan standards met vs. standards assessed from the delegated managed care reviews. (Quarterly)	MDHHS Technical Requirement for Behavior Treatment Plans.	94.00%	Not avail this quarter			95% or greater		95-100%	90-94%	<90%
BETTER CARE	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Quarterly)	Monthly autism benefit reporting on timeliness.	87.00%	87.0%			95%		95-100%	90-94%	<90%
BETTER CARE	Percent of individuals enrolled in the 1915(i) State Plan Amendment. (Quarterly)	MDHHS enrollment of persons eligible for the 1915(i) SPA benefit and HCBS Rule.	100.00%	100.0%			>=95%		95-100%	90-94%	<90%
BETTER CARE	Continuum of Care - Consumers moving from inpatient psychiatric hospitalization will show in next LOC within 7 days, and 2 additional appts within 30 days of first step-down visit. (Quarterly)	MSHN and its CMHSP participants will explore clinical process standardization, especially in the areas of access, emergency services, pre-admission screening, crisis response and inpatient stay management and discharge planning.	I: 38.12%; E: 20.46%	I: 38.67%; E: 20.52%			Increase over FY 2019 (I: 38.85%; E: 19.21%)		increase over 2019	No change from 2019 levels	Below 2019 levels
BETTER PROVIDER SYSTEM	MSHN Crisis Residential will be ready for full operation by 4/30/2024. (Cumulative Quarterly).	Aligns with strategic plan to increase access to acute care. Also aligns with MDHHS requirements for network adequacy.	59.00%	86.0%			25% growth per quarter		25% or greater growth	15%-24% growth	<15% growth

MSHN FY24 - Clinical SUD - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	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	51 activities FY24-Q1	92 activities FY24-Q2			144		>=144	<144 and >72	<=72
BETTER HEALTH	Increase network capacity for Medication Assisted Treatment	CONTINUE TO ADDRESS NETWORK CAPACITY FOR MEDICATION ASSISTED TREATMENT, INCLUDING AVAILABILITY OF METHADONE, VIVOTROL, AND SUBOXONE AT ALL MAT LOCATIONS. -	27 MAT sites	27 MAT sites			Increase MAT locations by 5% over FY20 (22)		>5%	No change	<5%
BETTER CARE	Increase percentage of individuals moving from residential level(s) of care who transition to a lower level of care within timeline of initiation (14 days) and engagement (2 or more services within 30 days subsequent to initiation).	Aligns with best practices for assisting individuals to initiate services and engage in continuation of care.	Initiation: 71.77% Engagement: 44.06% (1-1-2023 thru 12-31-2023)	Initiation: 70.46% Engagement: 43.95% (2-1-2023 thru 1-31-2024)			Increase over MSHN 2020 levels Initiation: 36.81% ; Engagement: 22.30%		Increase over 2020 levels	No change from 2020 levels	Drop below 2020 levels
BETTER CARE	Engagement of MAT Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of OUD within 30 days of the initiation visit.	Aligns with best practices for assisting individuals to initiate services and engage in continuation of care.	Initiation: 86.80% Engagement: 47.49% (1-1-2023 thru 12-31-2023)	Initiation: 86.11% Engagement: 47.61% (3-1-2023 thru 2-29-2024)			Increase over MSHN 2020 levels (I: 88.69%; E: 54.67%)		Increase over 2020 levels	No change from 2020 levels	Drop below 2020 levels
BETTER CARE	Initiation of AOD Treatment. Percentage who initiated treatment within 14 days of the diagnosis. (Inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, medication treatment).	Aligns with best practices for assisting individuals to initiate services and engage in continuation of care.	Initiation: 47.74% (1-1-2023 thru 12-31-2023)	Initiation: 47.54% (3-1-2023 thru 2-29-2024)			Above Michigan 2020 levels; I: 40.8%		Increase over National levels	No change from National levels	Drop below National levels
BETTER CARE	Engagement of AOD Treatment-Percentage who initiated treatment and who had 2 or more additional AOD services or medication treatment within 34 days of the initiation visit.	Aligns with best practices for assisting individuals to initiate services and engage in continuation of care.	Engagement: 29.75% (1-1-2023 thru 12-31-2023)	Engagement: 29.66% (3-1-2023 thru 2-29-2024)			Above Michigan 2020 levels; E: 12.5% (2016)		Increase over National levels	No change from National levels	Drop below National levels
BETTER EQUITY	The disparity between the white population and at least one minority who initiated treatment (AOD) within 14 calendar days will be reduced. (IET-Initiation disparity)	MDHHS PIHP Contract: Performance Bonus Incentive Program	Not Available	Not Available			TBD		TBD	TBD	TBD
BETTER EQUITY	The disparity between the white population and at least one minority group who engaged in treatment (AOD or MAT) within 34 calendar days will be reduced. (IET-Engagement disparity)	MDHHS PIHP Contract: Performance Bonus Incentive Program	Not Available	Not Available			TBD		TBD	TBD	TBD
BETTER CARE	Percent of discharges from a substance abuse withdrawal management unit who are seen for follow up care within seven days.	MDHHS PIHP Contract: Michigan Mission Based Performance Indicator System Indicator 4b	95%	Not Available			95%		95%	94%	<94%
BETTER CARE	The percentage of individuals identified as a priority popuation who have been screened and referred for services within the required timeframe.	MDHHS PIHP Contract: Access Standards.	34%	61%			>42%		>42%	41-35%	<35%
BETTER CARE	The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders (SUD). (Cumulative)	MDHHS PIHP Contract: Michigan Mission Based Performance Indicator System Indicator 2e	Not Available	Not Available			>75.3%		>75.5%		<75.5%

MSHN FY24 Information Technology Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of Decemeber 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September	Target Value	Performance Level	Target Ranges		
BETTER VALUE	Unique consumers submitted monthly	Contractual Reporting Oversight	90.7%	92.6%			85%		86.0%	85.0%	84.0%
BETTER VALUE	Encounters submitted monthly	Contractual Reporting Oversight	91.3%	96.9%			85%		86.0%	85.0%	84.0%
BETTER VALUE	BH-TEDS submitted monthly	Contractual Reporting Oversight	91.2%	89.1%			85%		86.0%	85.0%	84.0%
BETTER VALUE	Percentage of encounters with BH-TEDS	Contractual Reporting Oversight	98.5%	99.1%			95%		95.0%	94.0%	90.0%
BETTER CARE	Integrate MiCANS Assessment Tool into REMI (MDHHS soft start 10/1/2024)	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	0.00%	0.00%			100%		75%	50%	25%
BETTER HEALTH	Increase use cases with MiHIN (e-consents)	MSHN FY24-25 Strategic Plan - MSHN will pursue e-consent management opportunities to improve care coordination between behavioral health, physical health, and SUD systems of care.	1	1			2		2	1	0
BETTER HEALTH	Increase health information exchange/record sets OHH and BHH atribution files to ZTS, etc.)	MSHN will improve and standardize processes for exchange of data between MSHN and MHPs; CMHSPs and MSHN. Using REMI, ICDP and CC360 as well as PCP, Hospitals, MHPs.	1	2			2		2	1	0
BETTER PROVIDER SYSTEM	Managed Care Information Systems (REMI) Enhancements	Patient Portal, BTPR, Critical incidents, EVV, etc.	2	3			4		3	2	1
BETTER PROVIDER SYSTEM	Improve data use and quality (Race/Ethnicity Startification, Measure Repository, Predictive Modeling, etc.)	MSHN FY24-25 Strategic Plan - Increase overall efficiencies and effectiveness by streamlining and standardizing business tasks and processess as appropriate.	20%	45%			100%		75%	50%	25%
BETTER PROVIDER SYSTEM	Improve data availability (Foster Care/child Welfare, SDoH, Employment & Housing, Autism Reporting, etc.)	MSHN FY24-25 Strategic Plan - MSHN will increase regional use of information technology data systems to support	33%	75%			100%		75%	50%	25%
BETTER PROVIDER SYSTEM	Research change management system applications for use in areas such as contracts, policies, MDHHS guidance, etc.	MSHN FY24-25 Strategic Plan - Provider systems are fragile and stressed due to the magnitude and frequency of change.	0%	0%			100%		75%	50%	25%

MSHN FY24 - Integrated Care - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	Percent of individuals who receive follow up care within 30 days after an emergency department visit for alcohol or drug use. (FUA)	MSHN Strategic Plan FY19-20; MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	Not Available	Not Available			100%		>=28%	24%-27%	<=23%
BETTER HEALTH	Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use. (FUA	MDHHS/PIHP Contracted, Integrated Health Performance Bonus Requirements	Not Available	Not Available			0		0	1	2
BETTER CARE	The percentage of discharges for children who were hospitalized for treatment of selected mental illness or intentional self harm diagnosis and who had a follow up visit with a mental health provider within 30 days of discharge.(FUH)	HEDIS-NCQA	76.37%	Not Available			70%		>=70%		<70%
BETTER CARE	The percentage of discharges for adults who were hospitalized for treatment of selected mental illness or intentional self harm diagnosis and who had a follow up visit with a mental health provider within 30 days of discharge.(FUH)	HEDIS-NCQA	68.32%	Not Available			58%		>=58%		<58%
BETTER EQUITY	Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities between the white and minority adults and children who receive follow-up care within 30 days following a psychiatric hospitalization (FUH)	MDHHS PIHP Contract: Performance Bonus Incentive Program	2	Not Available			0		0	1	2
BETTER EQUITY	Review and research BH-TEDS Housing Data - develop outcomes related to Housing	MDHHS PIHP Contract: Performance Bonus Incentive Program	In Progress	In Progress			TBD		TBD	TBD	TBD
BETTER EQUITY	Review and research BH-TEDS Employment Data - develop outcomes related to Employment	MDHHS PIHP Contract: Performance Bonus Incentive Program	In Progress	In Progress			TBD		TBD	TBD	TBD
BETTER CARE	Percent of care coordination cases that were closed due to successful coordination.	MDHHS PIHP Contract: Performance Bonus Incentive Program	100%	40%			100%		>=50%	25%-49%	<25%
BETTER VALUE	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP	MDHHS PIHP Contract: Performance Bonus Incentive Program	76.70%	83.33%			100.0%		>=75%	50%-74%	<50%

MSHN FY24 - Finance Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Actual Value (%) as of June 2024	Actual Value (%) as of September 2024	Target Value	Performance Level	Target Ranges		
BETTER VALUE	MSHN reserves (ISF)	RESERVE'S TARGET SUFFICIENT TO MEET FISCAL RISK RELATED TO DELIVERY OF MEDICALLY NECESSARY SERVICES AND TO COVER ITS MDHHS CONTRACTUAL LIABILITY.	**Data not available**	**Data not available**			7.5%		> 6%	≥ 5% and 6%	< 5%
BETTER VALUE	Regional Financial Audits indicate unqualified opinion	MSHN WILL REVIEW CMHSP FINANCIAL AUDITS AND COMPLIANCE EXAMINATIONS TO IDENTIFY SIGNIFICANT DEFICIENCIES THAT IMPACT THE REGION.	100%	100%			100%		> 92%	< 92% and > 85%	≤ 85%
BETTER VALUE	No noted significant findings related to regional Compliance Examinations	MSHN WILL REVIEW CMHSP FINANCIAL AUDITS AND COMPLIANCE EXAMINATIONS TO IDENTIFY SIGNIFICANT DEFICIENCIES THAT IMPACT THE REGION.	Data not available	Data not available			100%		> 92%	< 92% and > 85%	≤ 85%
BETTER VALUE	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	88.00%	88%			≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
BETTER VALUE	Medical Loss Ratio is within CMS Guidelines	MSHN WILL MAINTAIN A FISCAL DASHBOARD TO REPORT FINANCE COUNCIL'S AGREED UPON METRICS.	Data not available	Data not available			85%		≥ 90%	> 85% and < 90%	≤ 85%
BETTER VALUE	Regional revenue is sufficient to meet expenditures (Savings estimate report)	MSHN WILL MONITOR TRENDS IN RATE SETTING TO ENSURE ANTICIPATED REVENUE ARE SUFFICIENT TO MEET BUDGETED EXPENDITURES.	Data not available	Data not available			100%		<100%	> 100% and <105%	>105%
BETTER VALUE	Develop and implement Provider Incentives (VBP, ER FU, Integration)	MSHN will develop methodologies, within established rules, to incentivize providers to cooperate with the PIHP to improve health or other mutually agreeable outcomes.	2	2			2		2	1	0

MSHN FY24 - Utilization Management Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of December 2023	Actual Value (%) as of March 2024	Target Value	Performance Level	Target Ranges		
BETTER CARE	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines.	MSHN UM Plan	Not Available	97.0%	100%		96-100%	94-95%	<93%
BETTER CARE	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person centered plan	MSHN Strategic Plan , MDHHS State Transition Plan; MDHHS Site Review Findings	72.73%	N/A	100%		100%	90%-99%	<90%
BETTER CARE	The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (Plan All Cause Readmissions)	MSHN Strategic Plan, MSHN UM Plan; Measurement Portfolio NQF 1768	12.82%	13.01%	<=15%		<=15%	16-25%	>25%
BETTER VALUE	Service Authorizations Denials Report demonstrates 90% or greater compliance with timeframe requirements for service authorization decisions and ABD notices	MSHN QAPIP Plan	97.77%	96.60%	> 90%		>90%	89-80%	<80%
BETTER VALUE	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages	MSHN Strategic Plan FY21-22, Federal Parity Requirements	1.00%	0.08%	<= 5%		<=5%	6%-10%	>=11%

MSHN
Mid-State Health Network

Background:

In accordance with the MSHN Board of Directors to review financials, at a minimum quarterly, the Preliminary Statement of Net Position and Statement of Activities for the Period Ending May 31, 2024, have been provided and presented for review and discussion.

Recommended Motion:

The MSHN Board of Directors receives and files the Preliminary Statement of Net Position and Statement of Activities for the Period Ending May 31, 2024, as presented.

Mid-State Health Network
Statement of Activities
As of May 31, 2024

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	
			FY24 Original Bdgt		FY24 Original Bdgt			
			66.67%					
1		Revenue:						
2		Grant and Other Funding	$ 371,985	134,024	247,990	(113,966)	36.03 %	1a
3		Medicaid Use of Carry Forward	$ 6,930,100	7,601,858	4,620,066	2,981,792	109.69%	1b
4		Medicaid Capitation	836,629,761	547,347,518	557,753,174	(10,405,656)	65.42%	1c
5		Local Contribution	1,550,876	1,163,157	1,033,918	129,240	75.00%	1d
6		Interest Income	1,300,000	2,285,147	866,666	1,418,480	175.78%	1e
7		Non Capitated Revenue	21,631,638	10,825,960	14,421,092	(3,595,132)	50.05%	1f
8		Total Revenue	868,414,360	569,357,664	578,942,906	(9,585,242)	65.56 %	
9		Expenses:						
10		PIHP Administration Expense:						
11		Compensation and Benefits	8,053,276	4,675,311	5,368,851	(693,541)	58.05 %	
12		Consulting Services	212,800	144,010	141,867	2,144	67.67 %	
13		Contracted Services	131,550	85,841	87,700	(1,859)	65.25 %	
14		Other Contractual Agreements	427,000	218,777	284,666	(65,890)	51.24 %	
15		Board Member Per Diems	18,900	8,750	12,600	(3,850)	46.30 %	
16		Meeting and Conference Expense	229,275	83,131	152,850	(69,718)	36.26 %	
17		Liability Insurance	32,500	33,259	21,667	11,592	102.34 %	
18		Facility Costs	158,254	120,890	105,503	15,387	76.39 %	
19		Supplies	353,575	182,137	235,716	(53,579)	51.51 %	
20		Other Expenses	992,000	735,352	661,334	74,018	74.13 %	
21		Subtotal PIHP Administration Expenses	10,609,130	6,287,458	7,072,754	(785,296)	59.26 %	2a
22		CMHSP and Tax Expense:						
23		CMHSP Participant Agreements	774,358,597	490,549,318	516,239,064	(25,689,746)	63.35 %	1b,1c,2b
24		SUD Provider Agreements	72,537,438	41,962,184	48,358,293	(6,396,109)	57.85 %	1c,1f,2c
25		Benefits Stabilization	1,401,000	2,214,440	934,000	1,280,440	158.06 %	1b
26		Tax - Local Section 928	1,550,876	1,163,157	1,033,917	129,240	75.00 %	1d
27		Taxes- IPA/HRA	24,055,503	26,789,698	16,037,002	10,752,696	111.37 %	2d
28		Subtotal CMHSP and Tax Expenses	873,903,414	562,678,797	582,602,276	(19,923,479)	64.39 %	
29		Total Expenses	884,512,544	568,966,255	589,675,030	(20,708,775)	64.33 %	
30		Excess of Revenues over Expenditures	$ (16,098,184)	$ 391,409	$ (10,732,124)			

Mid-State Health Network
Preliminary Statement of Net Position by Fund
As of May 31, 2024

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		5,513,633	0	5,513,633	1a
4	Chase MM Savings		13,860,912	0	13,860,912	
5	Savings ISF Account		0	25,559,559	25,559,559	1b
6	Savings PA2 Account		3,356,214	0	3,356,214	1c
7	Investment PA2 Account		3,499,228	0	3,499,228	1c
8	Investment ISF Account		0	31,997,737	31,997,737	1b
9	Total Cash and Short-term Investments		$ 26,229,987	$ 57,557,296	$ 83,787,283	
10	**Accounts Receivable**					
11	Due from MDHHS		34,371,413	0	34,371,413	2a
12	Due from Other Governments		53,508	0	53,508	2b
13	Due from Miscellaneous		376,350	0	376,350	2c
14	Total Accounts Receivable		34,801,271	0	34,801,271	
15	**Prepaid Expenses**					
16	Prepaid Expense Rent		4,529	0	4,529	2d
17	Prepaid Expense Other		20,352	0	20,352	2e
18	Total Prepaid Expenses		24,881	0	24,881	
19	**Fixed Assets**					
20	Fixed Assets - Computers		189,180	0	189,180	2f
21	Accumulated Depreciation - Computers		(189,180)	0	(189,180)	
22	Lease Assets		203,310	0	203,310	2g
23	Accumulated Amortization - Lease Asset		(152,920)	0	(152,920)	
24	Total Fixed Assets, Net		50,390	0	50,390	
25	**Total Assets**		**$ 61,106,529**	**$ 57,557,296**	**$ 118,663,825**	
26						
27	**Liabilities and Net Position**					
28	Liabilities					
29	Accounts Payable		$ 2,367,487	$ 0	$ 2,367,487	1a
30	Current Obligations (Due To Partners)					
31	Due to State		33,831,196	0	33,831,196	3a
32	Other Payable		4,746,235	0	4,746,235	3b
33	Due to Hospitals (HRA)		5,599,369	0	5,599,369	1a, 3c
34	Due to State-IPA Tax		981,572	0	981,572	3d
35	Due to CMHSP Participants		(748,134)	0	(748,134)	3e
36	Accrued PR Expense Wages		175,265	0	175,265	3f
37	Accrued Benefits PTO Payable		453,466	0	453,466	3g
38	Accrued Benefits Other		54,476	0	54,476	3h
39	Total Current Obligations (Due To Partners)		45,093,445	0	45,093,445	
40	Lease Liability		52,589	0	52,589	2g
41	Deferred Revenue		6,184,904	0	6,184,904	1b 1c
42	Total Liabilities		53,698,425	0	53,698,425	
43	Net Position					
44	Unrestricted		7,408,104	0	7,408,104	3i
45	Restricted for Risk Management		0	57,557,296	57,557,296	1b
46	Total Net Position		7,408,104	57,557,296	64,965,400	
47	**Total Liabilities and Net Position**		**$ 61,106,529**	**$ 57,557,296**	**$ 118,663,825**	

Mid-State Health Network
Notes to Financial Statements
For the Eight-Month Period Ended,
May 31, 2024

Please note: The Preliminary Statement of Net Position contains Fiscal Year (FY) 2023 cost settlement figures between the PIHP and Michigan Department of Health Human Services (MDHHS) as well as each Community Mental Health Service Program (CMHSP) Participants. CMHSP cost settlement figures were extracted from the final MDHHS Financial Status (FSR) Report.

Preliminary 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.
    b) The Savings Internal Service Fund (ISF) and Investment ISF reflect designated accounts to hold the Medicaid ISF funds separate from all other funding per the MDHHS contract. MSHN holds nearly $32 M in the investment account which is about 67% of the available ISF balance. The investment percentage is less than historical amounts should the Region need to access funds for service delivery and other operational expenses. The remaining portion is held in a savings account and available for immediate use if needed. Internal Service Funds are used to cover the Region's risk exposure. In the event current Fiscal Year revenue is spent and all prior year savings are exhausted, PIHPs can transfer ISF dollars and use for remaining costs. MSHN has had a fully funded ISF which is 7.5% of Medicaid Revenue for the last several Fiscal Years.
    c) The Savings PA2 account holds PA2 funds and is also offset by the Deferred Revenue liability account and investments exceeding $3.5 M.
2. Accounts Receivable
    a) More than 67% of the balance results from Certified Community Behavioral Health Centers' (CCBHC) supplemental funding which covers all mild to moderate recipients. Supplemental funding also covers a portion of the Prospective Payment System (PPS-1) for individuals with Severe Mental Impairments (SMI)/Severe Emotional Disturbance (SED)/Substance Use Disorder (SUD). In addition, revenue withholds contribute to 8% of the balance along with 16% of April and May's Hospital Rate Adjuster (HRA) payments. Lastly, the remaining balance stems from miscellaneous items.
    b) Due from Other Governments account is designated for Public Act (PA) 2 (liquor tax) payments. Two of MSHN's 21 counties have an outstanding balance for FY 24 quarter 2 collections.
    c) Approximately 67% of the balance in Due from Miscellaneous represents amounts owed from providers for Medicaid Event Verification (MEV) findings. The remaining amount represents advances made to SUD providers to cover operations.
    d) Prepaid Expense Rent balance consists of security deposits for MSHN office suites.
    e) Prepaid Expense Other represents payments for a BOX upgrade, MSHN's file storage platform and its Zoom platform.
    f) Total Fixed Assets - Computers represent the value of MSHN's capital asset net of accumulated depreciation. This item was not included in November's Financials but has been added back since the asset is still in use.
    g) The Lease Assets category is now displayed as an asset and liability based on a new Governmental Accounting Standards Board (GASB) requirement. The lease assets figure represents FY 2022 – 2025 contract amounts for MSHN's office space.
3. Liabilities

a) MSHN estimates FY 2022 and FY 2021 lapses totaling $13.5 M and $19.1 M to MDHHS, respectively. The lapse amounts indicate the ISF was fully funded for both fiscal years, and that savings fell within the second tier (above 5%). Per contractual guidelines MDHHS receives half of every dollar generated beyond this threshold until the PIHP's total savings reach the 7.5% maximum. 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) HRA 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 eligibles.
e) Due to CMHSP represents FY 23 projected cost settlement figures. During November each fiscal year, MSHN performs a preliminary settlement with its CMHSPs for 85% of the balance due by either party. The negative balance indicates MSHN's preliminary payments were higher than the projected final amounts owed to the CMHSPs listed below. These amounts will be collected during the region's final cost settlements, which generally occur in May or after Compliance Examinations are complete.

CMHSP	Cost Settlement	Payments/Offsets	Total
Montcalm	557,227.93	1,034,911.00	(477,683.07)
Tuscola	31,598.55	302,049.00	(270,450.45)
		GL Balance	(748,133.52)

f) Accrued payroll expense wages represent expenses incurred in May and paid in June.
g) Accrued Benefits PTO (Paid Time Off) payable is the required liability account set up to reflect paid time off balances for employees.
h) Accrued Benefits Other represents retirement benefit expenses incurred in May and paid in June.
i) The Unrestricted Net Position represents the difference between total assets, total liabilities, and the restricted for risk management figure.

Preliminary Statement of Activities – Column F now calculates the actual revenue and expenses compared to the full year's original budget. Revenue accounts whose Column F percent is less than 66.67% translate to MSHN receiving less revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 66.67% shows MSHN's spending is trending higher than expected.

1. Revenue
    a) This account tracks Veterans Navigator (VN) activity and other small grants. The variance is expected to lessen over time as CMHSP Clubhouse Grant payments are received.
    b) The region is estimating a $7.6 M savings carry forward. This number increased from March's Statement as a larger portion of CCBHC payments were charged to supplemental which reduced the amount paid by capitation. As a reminder, Medicaid Savings are generated when the prior year revenue exceeds expenses for the same period. In addition, 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 2023 Medicaid Carry Forward must be used as the first revenue source for FY 2024.
    c) Medicaid Capitation –The **majority** of this variance is due from MDHHS for Certified Community Behavioral Health Clinic (CCBHC) supplemental payments. Supplemental payments fully cover Prospective Payment System (PPS) rates (daily visits) for individuals classified as having mild to moderate Behavioral Health and/or SUD diagnoses. In addition, although Medicaid disenrollments exceeded numbers used in MDHHS rate setting projections, MSHN's budgeted figures for Medicaid Capitation revenue are less than a 1% variance of the actual funds received. Further, MSHN's April and May revenue is trending slightly upward which was anticipated based on the recalculations performed by MDHHS for the last six months of FY 24. MSHN will continue monitoring funding trends related to disenrollments and take necessary action to ensure the region's financial stability including a potential budget amendment later this fiscal year if indicated. Medicaid Capitation payment files are calculated and disbursed to CMHSPs based on a per eligible per month (PEPM) methodology and paid to SUD providers based on service delivery.
    d) Local Contribution is flow-through dollars from CMHSPs to MDHHS. Typically, revenue equals the expense side of this activity under Tax Local Section 928. Local Contributions were scheduled to reduce over the next few fiscal years until completely phased out. FY 2024 amounts owed will be the same as FY 2023.
    e) Interest income is earned from investments and changes in principle for investments purchased at discounts or premiums. Interest income is currently trending higher than budget amounts and will likely grow throughout the year. Please Note: The "change in market value" account activity has been removed for the FY 24 statements as MSHN's US treasury investments may be recorded at costs since they are held to maturity and the maturity date occurs within one year of purchase.
    f) This account tracks non-capitated revenue for SUD services which include Community Grant and PA2 funds. There is a large variance in this account because the budget amount represents the full MDHHS allocation amount regardless of planned spending. COVID dollars are the most unspent of Block Grants because of strict parameters regarding use of these funds.
2. Expense
    a) Total PIHP Administration Expense is slightly under budget. The line items with the largest dollar variances are Compensation and Benefits and Other Expenses. Other Expense balance is higher than budgeted because MiHIN's (technology provider – data exchange) entire FY 24 invoice was paid in October.

b) CMHSP participant Agreement expenses are under budget and correlates directly to Medicaid Capitation. MSHN funds CMHSPs based on per eligible per month (PEPM) payment file. The file contains CMHSP county codes which designate where the payments should be sent. MSHN sends the full payment less taxes and affiliation fees which support PIHP operations.
c) SUD provider payments are less than anticipated and paid based on need. (Please see Statement of Activities 1c and 1f.)
d) IPA/HRA actual tax expenses are higher 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).

MID-STATE HEALTH NETWORK
SCHEDULE OF INTERNAL SERVICE FUND INVESTMENTS
As of May 30, 2024

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	91282CDR9	1.19.22	1.20.22	12.1.23		1,992,391.23	2,000,000.00			
UNITED STATES TREASURY BILL	91282CDR9						(2,000,000.00)			
UNITED STATES TREASURY BILL	912797FU6	6.14.23	6.15.23	12.14.23		9,746,615.56	10,000,000.00			
UNITED STATES TREASURY BILL	912797FU6						(10,000,000.00)			
UNITED STATES TREASURY BILL	912797GC5	7.12.23	7.13.23	1.11.24		19,476,648.89	20,000,000.00			
							(20,000,000.00)			
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24		13,999,344.96	14,366,000.00			
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24			(14,366,000.00)			
UNITED STATES TREASURY BILL	912797JM0	12.12.23	12.14.23	4.9.24		9,833,206.75	10,000,000.00			
UNITED STATES TREASURY BILL	912797JM0	12.12.23	12.14.23	4.9.24			(10,000,000.00)			
UNITED STATES TREASURY BILL	912797JQ1	12.29.23	1.2.24	4.30.24		1,966,250.28	2,000,000.00			
UNITED STATES TREASURY BILL	912797JQ1	12.29.23	1.2.24	4.30.24			(2,000,000.00)			
UNITED STATES TREASURY BILL	912797HF7	1.9.24	1.11.24	4.11.24		19,998,137.44	20,261,000.00			
UNITED STATES TREASURY BILL	912797HF7	1.9.24	1.11.24	4.11.24			(20,261,000.00)			
UNITED STATES TREASURY BILL	912797GB7	4.10.24	4.10.24	7.11.24		9,999,897.42	9,999,897.42			
UNITED STATES TREASURY BILL	912797GB7	4.10.24	4.11.24	7.11.24		19,998,381.81	19,998,381.81			
UNITED STATES TREASURY BILL	912797KZ9	4.29.24	4.30.24	8.27.24		1,999,458.02	1,999,458.02			
UNITED STATES TREASURY BILL	912797KZ9	4.29.24	4.30.24	8.27.24		1,999,458.02	1,999,458.02			
JP MORGAN INVESTMENTS							31,997,737.25			31,997,737.25
JP MORGAN CHASE SAVINGS							25,314,380.45	0.010%	245,178.47	25,559,558.92
							$ 57,312,117.70		$ 245,178.47	$ 57,557,296.17

U.S. Treasury Bills – Treasury Bills, or T-Bills, are sold in terms ranging from a few days to 52 weeks. T-Bills are short-term debt issued and backed by the full faith and credit of the United States government. T-Bills are typically sold at a discount from the par amount (par amount is also called face value). You can hold a T-Bill until it matures or sell it prior to maturity. When a T-Bill matures, you are paid the par amount. Assuming the T-Bill is held to maturity, the difference between the par amount at maturity and the original cost is the amount of interest earned. **Source: U.S Treasury Direct**

U.S. Agencies – An agency security is a low-risk debt obligation that is issued by a U.S. government-sponsored enterprise (GSE). A Government-Sponsored Enterprise (GSE) bond is an agency bond issued by such agencies as Federal National Mortgage Association (Fannie Mae), Federal Home Loan Mortgage (Freddie Mac), Federal Farm Credit Banks Funding Corporation, and the Federal Home Loan Bank. Unlike Treasury securities, government agency bonds are not expressly backed by the full faith and credit of the U.S. government, but they do carry an implied backing due to the continuing ties between the agencies and the U.S. government. Most agency securities pay a semi-annual fixed coupon. **Source: Investopedia**

Chase does not generate statements in months when no investment activity occurs. In these instances, a position report provided by Chase is used to determine the investment principal. In addition, the change in market value is derived from the difference in market value and cost.

MID-STATE HEALTH NETWORK
SCHEDULE OF PA2 SAVINGS INVESTMENTS
As of May 31, 2024

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24		3,499,349.00	3,591,000.00	912797GM3		
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24			(3,591,000.00)			
UNITED STATES TREASURY BILL	912797JZ1	2.7.24	2.8.24	6.4.24		3,499,228.51	3,499,228.51			
JP MORGAN INVESTMENTS							3,499,228.51			3,499,228.51
JP MORGAN CHASE SAVINGS							3,353,444.17	0.010%	2,769.60	3,356,213.77
							$ 6,852,672.68		$ 2,769.60	$ 6,855,442.28

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 FY24 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 FY24 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2024 NEW AND RENEWING CONTRACTS
July 2024

CONTRACTING ENTITY	PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY24 COST REIMBURSEMENT CONTRACT AMOUNT	FY24 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY24 INCREASE/ (DECREASE)
PIHP ADMINISTRATIVE FUNCTION CONTRACTS					
Hazelton Publishing	Evidence-Based Practice Materials for SUD provider network	7.1.24 - 9.29.24	85,000	**214,138**	**129,138**
Healthy Transitions, LLC (fka FHPCC)	Crisis Residential Unit ($750 per day service rate)	6.1.24 - 9.30.24	260,000	**360,000**	**100,000**
			$ 345,000	**$ 574,138**	**$ 229,138**

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION (Revenue Contract)	CONTRACT TERM	FY24 CURRENT CONTRACT AMOUNT	FY24 TOTAL CONTRACT AMOUNT	FY24 INCREASE/ (DECREASE)
Michigan Department of Health & Human Services (EGrAMS)	Medicaid Managed Specialty Supports and Services Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs (FY25)	10.1.24 - 9.30.25	-	-	-
			$ -	$ -	$ -

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, May 7, 2024
MyMichigan Medical Center
Meeting Minutes

1. Call to Order

Chairperson Ed Woods called this meeting of the Mid-State Health Network Board of Directors to order at 5:00 p.m. Mr. Woods reminded members that those participating by phone may not vote on matters before the board and the Board Member Conduct Policy. Mr. Woods welcomed Mr. Bryan Krogman, Chief Executive Officer for Community Mental Health of Central Michigan. Mr. Woods asked for a moment of silence for board members that are currently experiencing medical issues. Mr. Joe Sedlock called on Dr. Todd Lewicki to introduce MSHN's newest staff member, Leah Hietala, Waiver Assistant.

2. Board Member Ten Year Service Recognitions

Mr. Joe Sedlock expressed gratitude to board members that have served on the board for ten consecutive years, and each was presented a plaque in acknowledgement of appreciation from MSHN. Board members recognized were Brad Bohner, Joe Brehler, Dan Grimshaw, John Johansen, Gretchen Nyland, Irene O'Boyle, Kurt Peasley, and Ed Woods.

3. Roll Call

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

Board Member(s) Present: Brad Bohner (LifeWays)-joined at 5:20 p.m., Joe Brehler (CEI), Greg Brodeur (Shiawassee), Ken DeLaat (Newaygo), Bruce Gibb (Huron), David Griesing (Tuscola), Dan Grimshaw (Tuscola)-arrived at 5:03 p.m., John Johansen (Montcalm), Pat McFarland (Bay-Arenac), Deb McPeek-McFadden (Ionia), Irene O'Boyle (Gratiot), Paul Palmer (CEI)-joined at 5:11 p.m., Bob Pawlak (Bay-Arenac), Kurt Peasley (Montcalm), Joe Phillips (CMH for Central Michigan), Tracey Raquepaw (Saginaw), Kerin Scanlon (CMH for Central Michigan)-joined at 5:09 p.m., Richard Swartzendruber (Huron), Susan Twing (Newaygo), and Ed Woods (LifeWays)

Board Member(s) Remote: Jeanne Ladd (Shiawassee)

Board Member(s) Absent: Tina Hicks (Gratiot), Gretchen Nyland (Ionia), and Joanie Williams (Saginaw)

Staff Member(s) Present: Joseph Sedlock (Chief Executive Officer), Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Sherry Kletke, (Executive Support Specialist), Dr. Todd

Lewicki (Chief Behavioral Health Officer), and Leah Hietala (Waiver Assistant)

4. Approval of Agenda for May 7, 2024

Board approval was requested for the Agenda of the May 7, 2024, Regular Business Meeting.

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY KURT PEASLEY, FOR APPROVAL OF THE AGENDA OF MAY 7, 2024, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 18-0.

5. Public Comment

There was no public comment.

6. FY2023 Audit Presentation

Mr. Derek Miller, from Roslund, Prestage and Company presented the financial audit of MSHN for fiscal year 2023 conducted by his firm. The opinion rendered by Roslund, Prestage and Company is that MSHNs financial statements present fairly, in all material respects, the respective financial position of the business-type activities, each major fund, and the aggregate remaining fund information of the Entity, as of September 30, 2023, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America. This opinion is the highest level available. Mr. Ed Woods thanked Mr. Miller and his team at Roslund, Prestage and Company for their ongoing assistance with MSHN financial audits. Mr. Woods also wished to thank Ms. Leslie Thomas for her work in ongoing integrity in leading the financial management of MSHN. Mr. Miller expressed appreciation on behalf of Roslund, Prestage and Company to Ms. Leslie Thomas and Ms. Amy Keinath for being well prepared for the audit every year.

MOTION BY TRACEY RAQUEPAW, SUPPORTED BY JOHN JOHANSEN, TO RECEIVE AND FILE THE FY2023 AUDIT REPORT OF MSHN COMPLETED BY ROSLUND, PRESTAGE AND COMPANY. MOTION CARRIED: 19-0.

7. FY2023 Board Self-Assessment

Ms. Irene O'Boyle summarized the FY2023 Board Self-Assessment results. The Board Self-Assessment trending report from FY2019 – FY2023 was included in board meeting packets. Twenty-one (21) of the current twenty-four (24) Board members completed the survey, which equates to an 87.5% participation rate. The Executive Committee will examine the low scored questions to review how they can assist board members in those categories. Mr. Ed Woods expressed his appreciation to Ms. O'Boyle for taking the lead on the Board Self-Assessment project.

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY DAVID GRIESING, TO RECEIVE AND FILE THE FY2023 BOARD SELF-ASSESSMENT REPORT. MOTION CARRIED: 20-0.

8. Network Adequacy Assessment Presentation

Ms. Amanda Ittner provided board members with a presentation of the Provider Network Adequacy Assessment. Members expressed interest in reviewing the timeliness to service data specific for each Community Mental Health Service Program (CMHSP). **Timeliness to Service Indicators** are available on the MSHN website.

9. Conflict Free Access and Planning

Mr. Joe Sedlock presented a recommendation that the MSHN Board of Directors and the MSHN region continue advocacy efforts directed toward MDHHS reconsideration of its decisions and to pass a resolution restating opposition to the design decision and requesting MDHHS reconsideration.

Board members proposed minor changes to the resolution as currently presented.

MOTION BY KURT PEASLEY, SUPPORTED BY IRENE O'BOYLE TO APPROVE AND COMMUNICATE TO POLICY MAKERS THE RESOLUTION OF THE MSHN BOARD OF DIRECTORS TO OPPOSE THE CONFLICT FREE ACESS AND PLANNING IMPLEMENTATION DECISIONS OF MDHHS AND TO REQUEST THAT MDHHS RECONSIDER ITS DECISION(S) FOLLOWING REVIEW AND APPROVAL BY THE EXECUTIVE COMMITTEE OF THE REVISED RESOLUTION. ROLL CALL VOTING IN FAVOR: BRAD BOHNER, JOE BREHLER, GREG BRODEUR, KEN DeLAAT, BRUCE GIBB, DAVID GRIESING, DAN GRIMSHAW, JOHN JOHANSEN, PAT McFARLAND, DEB McPEEK-McFADDEN, IRENE O'BOYLE, PAUL PALMER, BOB PAWLAK, KURT PEASLEY, JOE PHILLIPS, TRACEY RAQUEPAW, KERIN SCANLON, RICH SWARTZENDRUBER, SUSAN TWING, AND ED WOODS. VOTING IN OPPOSITION: NONE. MOTION CARRIED: 20-0.

10. Chief Executive Officer's Report

Mr. Joe Sedlock expressed his appreciation to Ms. Amanda Ittner for her coverage at the previous board meeting and to Ms. Leslie Thomas for her work on preparing the financials for the yearly audits discussed earlier. Mr. Sedlock also discussed several items from within his written report to the Board highlighting the following:

- PIHP/Regional Matters
    - Michigan Consortium for Healthcare Excellence (MCHE) Alternate Appointment Resolution
    - Conflict Free Access and Planning (CFAP) Update – The board was asked and agreed to convene a special board meeting to consider compliance when guidance is presented from MDHHS. Mr. Sedlock noted that the Operations Council will be consulted in advance of convening a special board meeting.
    - SOR Site Review
    - COVID Un-Wind Update; Regional Revenue Impact
    - Regional Cost Containment Strategies

- State of Michigan/Statewide Activities
    - Medicaid Health Plan Re-Bid – MI Healthy Life Award Announcement
- Federal/National Activities
    - Summary of Changes to 42 CFR Part 2, Confidentiality of SUD Records

11. Deputy Director's Report

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

- Annual Disclosure of Ownership, Controlling Interest, and Criminal Convictions
- Provider Network Adequacy Assessment – FY23
- Population Health and Integrated Care Plan 2024-2025

12. Chief Financial Officer's Report

Ms. Leslie Thomas provided an overview of the financial statements included within board meeting packets for the period ended March 31, 2024.

MOTION BY PAT McFARLAND, SUPPORTED BY PAUL PALMER, TO RECEIVE AND FILE THE PRELIMINARY STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDED MARCH 31, 2024, AS PRESENTED. MOTION CARRIED: 20-0.

13. Contracts for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2024 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 FY2024 contract listing.

MOTION BY DAVID GRIESING, SUPPORTED BY RICHARD SWARTZENDRUBER, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY24 CONTRACT LISTING. MOTION CARRIED: 20-0.

14. Executive Committee Report

Mr. Ed Woods informed board members the Executive Committee met on April 19, 2024, and reviewed the following:

- Board Self-Evaluation
- Conflict Free Access and Planning Draft Briefing Paper

15. Chairperson's Report

Mr. Ed Woods asked for volunteers to act as voting delegates for the Community Mental Health Association of Michigan (CMHAM) Member Assembly Meeting on Monday, June 10, 2024 at their Summer Conference in Traverse City. Voting delegates will be Mr. Ken DeLaat and Mr. Joe Sedlock. MSHN Administration will provide the delegate names to CMHAM.

16. 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 DAN GRIMSHAW, SUPPORTED BY KURT PEASLEY, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA WITH THE REMOVAL OF THE RESOLUTION TO APPOINT AN ALTERNATE MEMBER REPRESENTATIVE TO THE MICHIGAN CONSORTIUM FOR HEALTHCARE EXCELLENCE. APPROVE MINUTES OF THE MARCH 5, 2024 BOARD OF DIRECTORS MEETING; RECEIVE SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD MINUTES OF FEBRUARY 21, 2024; RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF APRIL 19, 2024; RECEIVE POLICY COMMITTEE MEETING MINUTES OF APRIL 2, 2024; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF FEBRUARY 26, 2024 AND MARCH 18, 2024 AND APRIL 15, 2024; AND TO APPROVE ALL THE FOLLOWING POLICIES: ACCESS SYSTEM, LEVEL OF CARE SYSTEM, RETROSPECTIVE SAMPLE REVIEW-ACUTE CARE SERVICES, AND UTILIZATION MANAGEMENT. MOTION CARRIED: 20-0

17. Other Business

Board approval was requested for the Resolution to Appoint an Alternate Member Representative to the Michigan Consortium for Healthcare Excellence listed as Item #16.6 removed from the Consent Agenda above.

MOTION TO APPROVE THE RESOLUTION TO APPOINT AN ALTERNATE MEMBER REPRESENTATIVE TO THE MICHIGAN CONSORTIUM FOR HEALTHCARE EXCELLENCE. ROLL CALL VOTING IN FAVOR: BRAD BOHNER, JOE BREHLER, GREG BRODEUR, KEN DeLAAT, BRUCE GIBB, DAVID GRIESING, DAN GRIMSHAW, JOHN JOHANSEN, PAT McFARLAND, DEB McPEEK-McFADDEN, IRENE O'BOYLE, PAUL PALMER, BOB PAWLAK, KURT PEASLEY, JOE PHILLIPS, TRACEY RAQUEPAW, KERIN SCANLON, RICH SWARTZENDRUBER, SUSAN TWING, AND ED WOODS. VOTING IN OPPOSITION: NONE. MOTION CARRIED: 20-0.

Mr. Woods welcomed Ms. Sara Lurie, Chief Executive Officer of Community Mental Health Authority for Clinton, Eaton, and Ingham Counties who arrived after the meeting had convened.

18. Public Comment

There was no public comment.

19. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 7:03 p.m.

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, JUNE 4, 2024 (VIDEO CONFERENCE)

***Members Present**:* John Johansen, Irene O'Boyle, Kurt Peasley, David Griesing, Jeanne Ladd-joined at 10:02 a.m.

Members Absent: None

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

1. CALL TO ORDER

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

2. APPROVAL OF THE AGENDA

MOTION by Irene O'Boyle, supported by David Griesing, to approve the June 4, 2024, Board Policy Committee Meeting Agenda as presented. Motion Carried: 4-0.

3. POLICIES UNDER DISCUSSION

There were no policies under discussion.

4. POLICIES UNDER BIENNIAL REVIEW

Mr. John Johansen invited Ms. Amanda Ittner to inform members of the revisions made to the policies listed below. Ms. Ittner provided an overview of the substantive changes within the policies. The Customer Service policies were reviewed by the Chief Compliance and Quality Officer and the Customer Service Committee. The Compliance Reporting and Investigations policy and the Disclosure of Ownership policy were revised to include recent mandates from the Office of Inspector General (OIG). The Travel policy was also updated to address requests to drive rather than fly to out-of-state conferences and to remove the daily amount established by the Internal Revenue Service (IRS) when meal receipts are provided. If no receipt is available, meal reimbursement will be made up to the daily amount established by the IRS.

CHAPTER: CUSTOMER SERVICE

1. ADVANCE DIRECTIVES
2. CUSTOMER HANDBOOK
3. CUSTOMER SERVICE
4. ENROLLEE RIGHTS
5. INFORMATION ACCESSIBILITY/LIMITED ENGLISH PROFICIENCY (LEP)
6. MEDICAID BENEFICIARY APPEALS/GRIEVANCES
7. REGIONAL CONSUMER ADVISORY COUNCIL
8. SUD RECIPIENT RIGHTS

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

CHAPTER: COMPLIANCE

1. COMPLIANCE REPORTING AND INVESTIGATIONS

CHAPTER: FINANCE

1. TRAVEL

CHAPTER: PROVIDER NETWORK

1. DISCLOSURE OF OWNERSHIP POLICY

A question was raised as to whether caregivers accompanying a staff or board member are eligible for reimbursement.

MOTION by David Griesing, supported by Jeanne Ladd, to approve and recommend the policies under biennial review as presented. Motion carried: 5-0.

5. NEW BUSINESS

MSHN Administration staff will follow up in regard to caregiver reimbursement and bring information back at a future policy committee meeting.

6. ADJOURN

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

Meeting Minutes respectfully submitted by:
MSHN Executive Support Specialist

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

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 05/22/2024

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

Members Absent:

MSHN Staff Present: Joseph Sedlock; Amanda Ittner; For applicable areas; Leslie Thomas, Skye Pletcher

Agenda Item	Action Required				
CONSENT AGENDA	No further discussion				
	Consent agenda acknowledged and received	By Who	N/A	By When	N/A
FY24 Regional Savings Estimates (through March 2024)	L. Thomas reviewed the FY24 Regional Savings Estimates No HM savings; Medicaid Savings of 4.9m. Use of ISF of approx. $500k to cover HM expenditures. Question regarding CCBHC savings estimated for T1040s look low for LifeWays. Leslie confirmed: The CCBHC numbers reported today on page 79 are full fiscal year estimates and accurate. The significant change in the amount being charged to capitation is related to the increase in the PPS-1's supplemental revenue rate. As a reminder, the supplemental rate covers all Mild/Moderate T1040's and a portion of SUD/SPMI ones. CMHSP concerns about the level of additional funding MSHN received vs other PIHPs at only 3.5m.				
	Leslie will follow up on CCBHC savings estimate and clarify annual FY24 projected savings vs. through March.	By Who	L. Thomas	By When	5.31.24
Regional Autism Financing Follow-Up	L. Thomas reviewed the regional Autism Financing as requested by Operations Council and proposes a three-year smoothing plan to change the funding to 100% PEPM. Recommendation to change from 3-year to a 5-year smoothing. Any future increase in rate setting could help facilitate this change. The distribution of Autism funding is validated in the Operating Agreement. Any recommended change would need to be amended in the Operating Agreement. Discussion regarding ABA services and contracted agencies who complete the assessment and services.				
	CMHSPs to review. MSHN will add this to the June agenda for discussion and decision.	By Who	CMHSPs	By When	6.15.24
2024 Compliance Plan	K. Zimmerman reviewed the proposed changes in the Compliance Plan due to changes in MDHHS contract requirements as identified by OIG.				
	Operations Council Approved the Compliance Plan proposed changes	By Who	CMHSPs	By When	5.22.24
2024—2025 Data Analytics Proposal	A.Ittner reviewed the proposal for Data Analytics Review and RFP along with the resource allocation from CMHSPs to participate and the issues faced currently with the data analytics provider. Discussion with Operations Council to discuss their support and resource capacity locally.				

Agenda Item	Action Required				
	Item will be added to the June meeting for further decision.	By Who	A.Ittner	By When	6.15.24
Conflict Free Access and Planning – Updates/Discussion	J. Sedlock reiterated that the meeting was cancelled for contract review for CFAP requirements. Waiver applications have been pended now from MDHHS due to service planning vs. service delivery needing to separate out even though the implementation date isn't until October 1, 2024. A meeting occurred today with MDHHS and providers regarding CFAP, which was stated that UM for HCBS services will be transition to the PIHP.				
	Discussion Only	By Who	N/A	By When	N/A
Network Adequacy Assessment	A.Ittner reviewed in summary the NAA results and the FY24 Recommendations. Feedback received regarding new initiatives to address the gaps. A.Ittner will be submitting the report to MDHHS which is due 5.31.24				
	Ops Council approved the report	By Who	A.Ittner	By When	5.31.24
CCBHC: Regional Care Coordination Agreement & FAQ	S. Pletcher reviewed the Regional Care Coordination Agreement and related FAQ that is required per CCBHC as part of the federal requirement. The CCBHC group has reviewed and provided feedback.				
	Operations council approved for regional use	By Who	S. Pletcher	By When	5.31.24
SUD Access	S. Pletcher reviewed and discussed the plans for MSHN to bring Screening and Access in house for SUD specific to Residential, Withdrawal Management and Recovery Housing.				
	Informational Only. CMHSPs that have feedback on this process should submit information directly to Skye Pletcher.	By Who	CMHSPs	By When	6.15.24
HCBS Use of Restrictions Memo	Discussion regarding concerns of HCBS regarding BTP. T. Lewicki has reviewed and is very concerned. MSHN through Todd has tried to influence and change this process. Concerns should be sent directly to Todd for inclusion in submission to MDHHS.				
	Todd will send out to Ops Council, the communication that MSHN recommended to MDHHS.	By Who	T. Lewicki	By When	5.25.24

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 06/17/2024

Members Present: Chris Pinter; Maribeth Leonard; Carol Mills; Julie Majeske; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; Bryan Krogman; Sandy Lindsey
Members Absent: Sara Lurie; Shiawassee CMH
MSHN Staff Present: Joseph Sedlock; Amanda Ittner

Agenda Item	Action Required				
CONSENT AGENDA	No discussion				
	Items reviewed and accepted	By Who	N/A	By When	N/A
Autism Financing Discussion	L. Thomas reviewed the proposal to move Autism funding to a 5-year smoothing plan. The Operating Agreement doesn't need to be amended for any change in Autism funding as long as Finance Council and Operations Council approve. Consensus to agree on principle and appreciate the smoothing plan. J. Sedlock will include a note in the Operating Agreement to document the decision to move Autism funding to the smoothing plan.				
	Operations Council approve to use the new smoothing plan, effective FY25	By Who	L. Thomas J. Sedlock	By When	7.1.24
PBIP/BHH/OHH Distribution Procedure	Group discussed the procedure revisions related to BHH and OHH risk and PIHP Admin risk. L. Thomas will incorporate feedback received and bring back to Finance Council and Operations Council to also include consideration of non-CMHSP BHH.				
	L. Thomas will bring forth revisions to the procedure	By Who	L. Thomas	By When	7.15.24
Psychiatric Inpatient Tiered Rate Workgroup Report	J. Sedlock reviewed the workgroup discussion and snapshot. CMHSP specific contracts hold the issues/concerns and compliance with tiered rates. Group will be meeting over the next couple of months to discuss implementation and compliance. MSHN will be drafting a letter for inclusion in the communication for contract negotiation to reinforce the regional strategy to assign regional rates. Information is due tomorrow from CMH workgroup members.				
	Discussion and update on workgroup	By Who	N/A	By When	N/A
MSHN Bylaws	Workgroup reviewed the Bylaws and only minor revisions would be included if we amended the bylaws. The group had different views on whether we should go through the process and update the bylaws. Support to move forward with edits and include general language with the OMA.				

Agenda Item	Action Required				
	MSHN will prepare a resolution and a draft tracked changes version of the document for CMHs to have Board approval by December 31, 2024.	By Who	CMHSPs	By When	12.31.24
Conflict Free Access and Planning-Updates/Discussion	J. Sedlock reviewed the edits to the Waiver renewal & 1915i that related to CFAP and the PIHP role in UM. Some CMHs have sent in a resolution opposing, a couple CMHs preparing them this month. Nothing new has come out from MDHHS				
	Discussion Only	By Who	N/A	By When	N/A
Data Analytics Discussion	Discussion regarding timing and feedback from CMHSPs.				
	Support to communicate with QIC, Finance and IT to request 2 appointments from each group to participate	By Who	A.Ittner	By When	N/A

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Customer Service**		
Title:	**Advance Directives**		
Policy: ☑ **Procedure:** ☐ ~~**Version:** 2.0~~ **Page:** 1 of 3	**Review Cycle:** ~~Annually~~Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 09.02.14 **Review Date:** ~~**Revision Eff. Date:**~~	**Related Policies:** Customer Service Policy

Purpose

To ensure that adult beneficiaries of Mid-State Health Network (MSHN), receive information on advance directives in accordance with 42 Code of Federal Regulations (CFR) 422.128 and 42 CFR 438.3.

Policy

MSHN delegates the responsibility for providing adult beneficiaries with information related to advance directives to its Community Mental Health Service Program (CMHSP) Participants/Substance Use Disorder (SUD) Provider Network.

1. CMHSP Participants/SUD Provider Network must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving care by or through the organization;

2. CMHSP Participants/SUD Provider Network:
   A. Are not required to provide care that conflicts with an advance directive; and
   B. Are not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive.
   C. Are prohibited from conditioning the provision of care based on whether or not the individual has executed an advance directive.

3. MSHN Standards for Advance Directives shall ensure that the CMHSP Participants/SUD Provider Network:

   A. Provides adult beneficiaries with written information on advance directives at the time of initial enrollment;
   B. Supplies information that includes a description of applicable state law and rights under applicable laws;
   C. Document in a prominent part of the individual's current medical record whether or not the individual has executed an advanced directive;
   D. Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
   E. Continuously updates written information to reflect any changes in state law as soon as possible but no later than 90 days after it becomes effective; and

F. Informs individuals that grievances concerning noncompliance with the advance directive requirements may be filed with Customer Services.

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:

Advance Directive: Document(s) or documentation allowing a person to give directions about future medical care and/or psychiatric care or to designate another person(s) to make medical decisions if the individual loses decision making capacity. Advance directives may include living wills, durable powers of attorney for health care, do-not-resuscitate (DNRs) orders, and right to die or similar documents listed in the Patient Self-Determination Act that express the individual's preferences
CFR: Code of Federal Regulations
CMHSP: Community Mental Health Service Program
CMHSP Participants/SUD Provider Network: refers to a CMHSP Participant and all Substance Use Disorder Prevention and Treatment Providers that are directly under contract with PIHP MSHN to provide services and/or supports through direct operations or through the CMHSP's subcontractors.
DNR: Do Not Resuscitate
MSHN: Mid-State Health Network
PIHP: Pre-paid Inpatient Health Plan
SUD: Substance Use Disorder

Other Related Materials:

N/A

References/Legal Authority:

1. State of Michigan/PIHP Contract: Schedule A: Statement of Work Contract Activities: Q. Observance of State and Federal Laws: 4. Advance Directives Compliance
2. Balanced Budget Act 438.3(j)
3. Center for Medicare and Medicaid Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Heath Plans- A Protocol for Determining Compliance with 42 CFR.
4. Michigan Mental Health Code 330.1433 & 330.1469a
5. Federal Patient Self-Determination Act Part 489
6. 42 CFR 422.128 and 42 CFR 438.3(j)

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer

11.2015	Annual Review	Director of Compliance, Customer Service and QI
11.21.2016	Annual Review	Customer Service Committee
12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review, addition of requirements	Customer Service Committee
03.16.2020	Annual Review, Reference/Legal Authority reference correction	Customer Service Committee
11.15.2021	Bi-annual Review, language added to meet contract requirements	Customer Service Committee
01.22.2024	Bi-ennial~~annual~~ Review, no changes	Customer Service Committee

Chapter:	Customer Service		
Title:	**Customer Handbook**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 12.03.2013 **Review Date: 07.05.2022** ~~**Revision Eff. Date:**~~	**Related Policies:** Customer Service

Purpose

To ensure that all customers that are served by the Community Mental Health Service Program (CMHSP) Participants and the Substance Use Disorder (SUD) Provider Network for Mid-State Health Network (MSHN) are provided a Regional Customer Handbook/Guide to Services that includes federal, and state of Michigan information required for mental health and substance use disorder services.

Policy

MSHN shall create, publish, and maintain a Customer Handbook/Guide to Services (referred to in the policy as the "Customer Handbook"), the core of which is uniform throughout the region.

- All customers and/or their legally responsible parties who request services shall be provided a Customer Handbook within a reasonable time from when they first come into service, annually, and when there are significant changes in the handbook content. Confirmation of receipt and/or offer of the Customer Handbook shall be in the customer's record. The Customer Services Handbook will be provided to the beneficiary by one of the following:
  - giving a copy to the beneficiary in person
  - mailing a printed copy to the beneficiary's mailing address,
  - emailing an electronic version after obtaining the beneficiary's written approval,
  - notifying the beneficiary by providing a written statement that identifies where the handbook can be found on the website,
  - other alternate distribution based on the request of the beneficiary.

- If/when Michigan Department of Health and Human Services (MDHHS) contractual requirement updates are made to the Customer Handbook, the CMHSP Participants and the SUD Provider Network shall provide supplemental materials (inserts, stickers) to customers receiving services to reflect the changes. To the extent possible, customers will be provided at least 30 days' notice before the intended effective date of any change that the State defines as significant in the information specified in 42 Code of Federal Regulations (CFR) 438.10(g)(2).

- Any customer, natural support, community member, or agency, including any external credentialing or payer agencies, may request and receive a copy of the Customer Handbook at any time.

- The Customer Handbook and the Prepaid Inpatient Health Plan (PIHP) Provider Directory shall be posted and/or linked on the MSHN website. Additionally, the respective Customer

Handbook and the Local Provider Directory shall be posted on each CMHSP Participant website.

- The Customer Handbook shall be published and updated by MSHN to ensure compliance with specific Michigan Department of Health and Human Services (MDHHS) technical requirements regarding content, and with specific federal requirements found in 42 CFR 438.10. Customer Handbooks shall include the date of publication and revision by MSHN.

- Although the Customer Handbook is standardized to include the MDHHS and MSHN required content, CMHSP Participants may tailor approved portions of the Customer Handbook to include local content.

- Customer Handbooks will be reviewed with consumer advisory councils and CMHSP Participants and the SUD Provider Network for feedback. MSHN shall maintain approval authority for changes to the Customer Handbook.

- Using MDHHS prescribed templates, the Customer Handbook shall include federal, and state required topics. MSHN will ~~as~~ensure approval is obtained from MDHHS and/or Centers for Medicaid and Medicare (CMS) for publication revisions prior to publishing the revised customer handbook.

- CMHSP Participants and the SUD Provider Network shall provide accommodations to the Customer Handbooks and the Provider Directory where required for customers where English is not their primary spoken language, or for impairments to visual, auditory, and/or literacy capabilities in accordance with federal and state laws, rules and guidelines. Efforts will be made to ensure all information in the Customer Handbook is easily understood.

- MSHN shall provide monitoring and oversight to ensure that CMHSP Participants and the SUD Provider Network provide the Customer Handbook to individuals ~~that~~ who are served according to the established standards.

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:

CFR: Code of Federal Regulations
CMHSP: Community Mental Health Service Program
CMS: Centers for Medicaid and Medicare
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

Customer Handbook: The handbook is a required set of information that must be provided to Medicaid beneficiaries at the start of treatment and at least annually.
Local Provider Directory: The Customer Handbook includes local CMHSP information including the provider directory for that CMHSP county/counties of service
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
SUD: Substance Use Disorder
SUD Provider Network: Refers to a SUD Provider that is directly under contract with the MSHN PIHP to provide services and/or supports.

References/Legal Authority:

1. 42 CFR 438.10 Information requirements
   State of Michigan/PIHP Contract: Schedule A: Statement of Work, Section 1. General Requirements, B. Customer Services Standards, 4. Customer Services Handbook Requirements

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New policy	Customer Services Committee
12.08.14	Annual review, format consistency	Customer Services Committee and Chief Compliance Officer
11.2015	Annual Review	Director of Compliance, Customer Services & Quality Improvement
11.21.2016	Annual Review	Customer Service Committee
12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review, language revised to match Attachment P6.3.1 language	Customer Service Committee
11.15.2021	Bi-annual Review, language updates to match contract requirements	Customer Service Committee
01.22.2024	Biennial ~~annual~~ Review, language updates to match contract requirements	Customer Service Committee

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	**Customer/Consumer Service**		
Policy: ☒ **Procedure:** ☐ ~~**Version:** 2.0~~ **Page:** 1 of 3	**Review Cycle:** ~~Annually~~ Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 12.03.2013 **Review Date:** ~~**Revision Eff. Date:**~~	**Related Policies:** Customer Service

Purpose

To ensure that primary and secondary consumers, as customers of Mid-State Health Network (MSHN), receive timely, accurate, understandable, and culturally ~~competent~~ appropriate services.

Policy

MSHN delegates the responsibility for Customer/Consumer Services to its Community Mental Health Services Program (CMHSP) Participants and Substance Use Disorder (SUD) Provider Network. The CMHSP Participants/SUD Provider Network shall convey an atmosphere that is welcoming, helpful, and informative for its customers.

MSHN Standards of Customer/Consumer Service ensure that CMHSP Participants/SUD Provider Network shall:

A. Establish a Customer Services Unit ~~which~~ that meets the needs of the Consumer/Customer served. The Customer Services Unit will provide Customer Services as defined by the Michigan Department of Health and Human Services (MDHHS) Pre-Paid Inpatient Health Plan (PIHP) Customer Services Standards. Customer Services must convey an atmosphere that is welcoming, helpful, and informative ~~and will orient~~ where individuals are oriented to the services and benefits that are available, including providing the Provider Directory Listing in accordance with the MSHN Provider Network Directory – Information Requirements policy. These standards apply to the CMHSP Participants/SUD Providers and to any entity to which they have delegated their customer service function;

B. When providing information electronically, it must be in a form that is readily accessible; it must be on the website in a location that is prominent and readily accessible; it must be in an electronic form ~~which~~ that can be electronically retained and printed; Customer/Consumer must be informed that the information is available in paper form without charge and provided within ~~5~~ five (5) business days upon request;

C. Ensure materials are written at the 6.9 grade reading level when possible (i.e., in some situations, it is necessary to include required terminology, medications, diagnosis, and conditions that do not meet the grade level criteria);

D. Provide information about how to access benefits, including authorization requirements, for mental health, primary healthcare, substance use disorder treatment and prevention, and other community-based services;

E. Provide information on available treatment options and alternatives. Provide information on the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure beneficiaries understand the benefits to which they are entitled and the extent to which, and how, after-hours crisis services are provided;

F. Provide information on cost-sharing, as appropriate;

G. Provide information on how to access the various recipient rights processes;

~~H.~~ Upon request, a~~A~~ssist customers with problems and inquiries regarding benefits;

~~I.~~

~~J. Assist customers~~ with ~~the~~ local complaint and grievance processes; and

~~K.~~

~~L.~~H. ~~Provide information on~~ local appeal and fair hearings processes, including expected timelines;

~~M.~~I. Provide the rules for emergency and post-stabilization services;

~~N.~~J. Provide information on quality and performance indicators and enrollee satisfaction;

~~O.~~K. Track and report patterns of potential problem areas for the organization;

~~P.~~L. Material must not contain false, confusing, and/or misleading information;

~~Q. Ensure all materials will be available in the languages appropriate to the people served within the PIHP's area for specific Non-English Language that is spoken as the primary language by more than 5% of the population in the PIHPs region. Such materials will be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002, Federal Register Vol. 65);~~

~~R. Ensure that beneficiaries are notified that oral interpretation is available for any language and written information is available in prevalent languages and auxiliary aids, such as Teletypewriter/Text Telephone (TTY/TDY) and American Sign Language (ASL), services are available upon request at no cost, and how to access those services. All written materials for potential enrollees must include taglines explaining the availability of written translations or oral interpretation along with the toll-free telephone number of the entity providing services as required by 42 CFR 438.71(a);~~

~~S. Ensure materials are available in alternative formats in accordance with the Americans Disability Act (ADA) and provide information on how to access information in the appropriate language format. Beneficiaries may access materials in a font size with a minimum font of 12pt and in large print in a font size no smaller than 18 point;~~

~~T. Provide required information at the time of admission and at least annually thereafter. The PIHP must give each individual written notice of any significant change in the information specified in 42 CFR 438.10(f)(6) at least 30 days before the intended effective date of the change;~~

~~U.~~M. Make a good faith effort to give written notice of termination of a contracted provider, by the later of 30 calendar days prior to the effective date of the termination, or within 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider;

~~V.~~N. Annually (e.g., at the time of person-centered planning) provide to the beneficiary the estimated annual cost of each covered support and service he/she is receiving; and

~~W.~~O. Provide an Explanation of Benefits (EOBs) to 5% of the consumers receiving services. The EOB distribution must comply with the State and Federal regulations regarding release of information as directed by MDHHS.

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/Acronyms:

CFR: Code of Federal Regulations
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
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
Primary Consumer: An individual who receives or has received services from MDHHS or CMHSP Participant(s): This includes those who receive or have received the equivalent mental health services from the private sector
Secondary Consumer: A family member, guardian, or advocate of an individual who receives or has received services from MDHHS or a CMHSP. This includes family members, guardians, or advocates of a person who has received the equivalent mental health services from the private sector
SUD: Substance Use Disorder
SUD Provider Network: Refers to a Substance Use Disorder Provider that is directly under contract with the MSHN PIHP to provide services and/or supports

References/Legal Authority:

1. 42 CFR 438.10: Information Requirements
2. 42 CFR 438.400 Appeals and Grievances
3. State of Michigan/PIHP Contract: Schedule 1. General Requirements, M. Beneficiary Services, 2. Written Materials, b. Additional Information Requirements
4. State of Michigan/PIHP Contract: Schedule 1. General Requirements, B. Customer Services Standards

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New policy	Customer Services Committee
11.2015	Annual review, format consistency	Director of Compliance, Customer Services & Quality Improvement
11.21.2016	Annual Review	Customer Service Committee
12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review, language added to meet reference requirements	Customer Service Committee
11.15.2021	Bi-annual Review, language added to meet contract requirements	Customer Service Committee
01.22.2024	Biennial ~~annual~~ Review, language added to meet contract requirements, removed content is present in the MSHN LEP Policy	Customer Service Committee

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	**Enrollee Rights**		
Policy: ☑ **Procedure:** ☐ ~~**Version:** 1.0~~ **Page:** 1 of 3	**Review Cycle:** ~~Annually~~ Biennial **Author:** Chief Compliance and Quality Officer; Customer Service Committee	**Adopted Date:** **Review Date:** ~~**Revision Eff. Date:**~~	**Related Policies:** Consumer Service Policy

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To ensure the legal authority and requirements for the rights and the protections for all recipients receiving community mental health and substance use disorder services authorized and/or delivered by the Mid-State Health Network (MSHN) Provider Network.

Policy

1. General rule:
    a. Each Community Mental Health Service Program (CMHSP) and Substance Use Disorder (~~CMHSP/~~SUD) Provider Network participant shall comply with any applicable Federal and State laws that pertain to enrollee rights and ~~ensures~~ ensure that its employees and contracted providers observe and protect those rights.

2. Guaranteed enrollee rights -
    a. Receive information in accordance with 42 Code of Federal Regulations (CFR) 438.10 - Information requirements.
    b. Be treated with respect and with due consideration for his or her dignity and privacy.
    c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
        i. The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 CFR 438.10(g)(2)(ii)(A) and (B).
    d. Participate in decisions regarding his or her health care, including the right to refuse treatment.
    e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

f. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.

g. An enrollee of a CMHSP/SUD Provider Network Participant has the right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210.

3. Free exercise of rights.

a. The CMHSP /SUD Provider Network Participant ensures that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the CMHSP/SUD Provider Network Participant treats the enrollee.

4. Compliance with other Federal and State laws.

a. Each CMHSP /SUD Provider Network Participant shall comply with any other applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

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:

CFR: Code of Federal Regulations
CMHSP: Community Mental Health Service Program
Enrollee: A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. 42 CFR 438.2.
MSHN: Mid-State Health Network
PIHP: Pre-paid Inpatient Health Plan
Provider Network: Refers to a CMHSP Participant and all Substance Use Disorder Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP/SUD Provider subcontractors.
SUD: Substance Use Disorder

Other Related Materials:

None

MSHN
Mid-State Health Network

References/Legal Authority:

1. 42 CFR 438.10 Information requirements
2. 42 CFR 438.100 Enrollee Rights
3. 42 CFR 438.206 Availability of services.
4. 42 CFR 438.207 Assurances of adequate capacity and services.
5. 42 CFR 438.208 Coordination and continuity of care.
6. 42 CFR 438.210 Coverage and authorization of services.
7. 45 CFR PART 160 – General Administrative Requirements
8. 45 CFR PART 164 – Security and Privacy

Change Log:

Date of Change	Description of Change	Responsible Party
03/16/2020	New policy	Director of Quality, Compliance, and Customer Service; Customer Service Committee
11.15.2021	Bi-annual Review, no recommended changes	Customer Service Committee
01.22.2024	Biennial ~~annual~~ Review, no significant changes	Customer Service Committee

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Customer Service**		
Title:	**Information Accessibility/Limited English Proficiency (LEP)**		
Policy: ☒ **Procedure:** ☐ ~~**Version:** 2.0~~ **Page:** 1 of 4	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 07.01.2014 **Review Date: 09.12.2023** ~~**Revision Eff. Date:**~~	**Related Policies:** Customer Service Policy

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

Mid-State Health Network (MSHN) and its provider network will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) due to literary or impairment reasons have meaningful access and equal opportunity to participate in the services, activities, programs, and other benefits.

Policy

A. MSHN delegates the responsibility for ensuring meaningful communication with LEP consumers/customers and their authorized representatives involving their medical conditions, benefits, and supports/services to the Community Mental Health Services Program (CMHSP) Participants and Substance Use Disorder (SUD) providers, with oversight and monitoring by MSHN. This includes client-specific and/or general information about:
   1. Managed care;
   2. Excluded populations;
   3. Covered benefits;
   4. Cost sharing (if any);
   5. Service area;
   6. Availability of interpreters

B. CMHSP Participants/SUD Provider Network, to ensure sufficient resources for persons with LEP, shall:
   1. Establish a methodology for identifying the prevalent non-English languages spoken by beneficiaries likely to be served in their service area;
   2. Determine the frequency that LEP persons may come in contact with their programs;
   3. Estimate the available resources required to meet the identified needs;
   4. Develop procedures for timely and effective communication between staff and persons with LEP.

C. CMHSP Participants/SUD Provider Network will ensure:
    1. All materials are available in language(s) appropriate to the people served within the PIHP's area for specific non-English language that is spoken as the primary language by more than 5% of the population in the PIHP's region. Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002, Federal Register Vol. 65, August 16, 2002).
    2. All materials are available in alternative formats in accordance with the Americans with Disabilities Act (ADA).
    3. Written materials critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, are available in the prevalent non-English language(s) within the service area and must include taglines explaining the availability of written translations or oral interpretation along with the toll-free telephone number of the entity providing services as required by 42 Code of Federal Regulations (CFR) 438.71(a) and 42 CFR 438.10(d)(2). Taglines must be printed in a conspicuously-visible font size.
    4. Beneficiaries may access materials in a font size with a minimum font of 12 point and in large print in a font size no smaller than 18 point.

D. The CMHSP Participants/SUD Provider Network shall ensure that beneficiaries are notified of how to access alternative formats, that oral interpretation is available for any language, and written information is available in prevalent languages. This includes interpretation services for the deaf, hard of hearing, and deaf/blind populations.

E. The CMHSP Participants/SUD Provider Network shall ensure that beneficiaries have timely access to support and services in their preferred language based on their language skills and in accordance with the Access Standards.

F. The CMHSP Participants/SUD Provider Network shall assure that designated employees and members of its provider network can obtain appropriate interpretation, translation, and/or communication services or technical equipment to meet the needs of beneficiaries in their service areas. This includes written materials and face-to-face or phone communications.

G. All interpreters, translators, and other aids needed to comply with this policy shall be provided without cost to the person being served.

H. The CMHSP Participants/SUD Provider Network shall have a local procedure in place that complies with the Michigan Department of Health and Human Services (MDHHS) Information Accessibility for Beneficiaries with LEP requirements, as well as the ADA.

I. The CMHSP Participants/SUD Provider Network must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds and those who are Deaf, Hard of Hearing, and Deaf and Blind. Treatment will be modified to effectively serve individuals

who are deaf, hard of hearing, and deaf and blind as determined by their language skills and preferences.

J. The CMHSP Participants/SUD Provider Network may only use Video Remote Interpreting (VRI) in emergencies, extenuating circumstances, or during a state or national emergency as a temporary solution until the provider can secure a qualified interpreter and in accordance with the R 393.5055 VRI standards, usage, limitations, educational, legal, medical, mental health standards.

K. The CMHSP Participants/SUD Provider Network shall comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it affects persons with LEP, 45 CFR 92.201, and Section 1557 of the Patient Protection and Affordable Care Act. It is expected that reasonable steps will be taken to provide meaningful access to each individual beneficiary with LEP, such as language assistance services, including but not limited to oral interpretation and written translation.

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:

ADA: Americans with Disabilities Act.
CFR: Code of Federal Regulations
CMHSP: Community Mental Health Service Program
Communication: The effective transmission of messages using spoken language, Braille, American Sign Language, or available technology as necessary.
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.
Interpretation: The oral transmittal of a message from one language to another, considering dialect, culture, and nuance.
Limited English Proficiency (LEP): Means being limited in the ability or unable to speak, read, and/or write the English language well enough to understand and be understood without the aid of an interpreter.
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
Population/Service Area: Includes any Medicaid beneficiary who may potentially receive services from MSHN and its provider network.
Prevalent: means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

Readily Accessible: means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.
SUD: Substance Use Disorder
SUD Provider Network: Refers to a SUD Provider directly under contract with PIHP MSHN to provide services and/or supports.
Translation: The written interpretation of a message from one language to another, conveying the original meaning of the text with linguistic precision.
VRI: Video Remote Interpreting

Other Related Procedures:
N/A

References/Legal Authority:
1. 42 CFR 438.10 Information Requirements
2. 42 CFR 438.400 Appeals and Grievances
3. State of Michigan/PIHP Contract: Schedule 1. General Requirements, M. Beneficiary Services, 2. Written Materials, b. Additional Information Requirements
4. State of Michigan/PIHP Contract: 1. General Requirements, Q. Observance of State and Federal Laws and Regulations, 8. Limited English Proficiency
5. Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002, Federal Register Vol. 65, August 16, 2002).
6. Office of Civil Rights Policy Guidance on Title VI "Language, Assistance to Persons with Limited English Proficiency"
7. The MICHIGAN DEPARTMENT OF CIVIL RIGHTS DIVISION ON DEAF AND HARD OF HEARING QUALIFIED INTERPRETER – GENERAL RULES (By authority conferred on the division on deaf and hard of hearing by section 8a of the deaf persons' interpreters act, 1982 PA 204, MCL 393.508a, section 9 of the division on deafness act, 1937 PA 72, MCL 408.209, and ERO 1996-2, MCL 445.2001, ERO 2003-1, MCL 445.2011, and ERO 2008-4, MCL 445.2025.)

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New policy	Chief Compliance Officer
04.2016	Annual Review/Update	Customer Service & Recipient Rights Specialist
11.21.2016	Updated according to MDHHS/PIHP contract	Customer Service Committee
12.18.17	Annual Review	Customer Service Committee
12.03.18	Annual Review, additional language added	Customer Service Committee
03.16.2020	Annual Review, additional language added, edit to conform to definitions	Customer Service Committee
11.15.2021	Bi-annual Review, updated language from contract	Customer Service Committee

05.15.2023	Policy updates to include updated language from the PIHP contract	Customer Service Committee
01.22.2024	Biennial review, no changes	Customer Service Committee

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	**Medicaid Enrollee Appeals/Grievances**		
Policy: ☑ **Procedure:** ☐ **Page:** 1 of 5	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 07.01.2014 **Review Date:** 0~~7~~1.0~~5~~22.2024~~4~~ ~~**Revision Eff. Date:**~~	**Related Policies:** Consumer Services Policy

Purpose

To establish a process to resolve complaints and ensure recipient notification of a person's right to file appeals and grievances, including internal appeals, grievances, and administrative hearings related to dissatisfaction with services authorized and/or delivered by Mid-State Health Network's (MSHN) Provider Network.

Policy

MSHN delegates the responsibility for the appeals/grievance processes consistent with federal and state guidelines to the Community Mental Health Service Program (CMHSP) Participants and Substance Use Disorder (SUD) providers, with oversight and monitoring by MSHN, including:

1. Local Appeal process for recipients, guardians, or subcontracted providers to challenge an Adverse Benefit Determination by the CMHSP Participants/SUD Provider Network or its agents regarding a consumer's services;

2. The right to concurrently file a local Appeal of an Adverse Benefit Determination and a Grievance regarding other services complaints;

3. Access to the State Fair Hearing process after a local Appeal denial of an Adverse Benefit Determination is received;

4. The right to request and have Medicaid covered benefits continued during the local Appeal and/or the State Fair Hearing if the request for continuation of benefits is timely (on or before the latter of 10 calendar days from the date of the notice of Adverse Benefit Determination, or the intended effective date of the proposed Adverse Benefit Determination); customers may be asked to pay for a portion of the services received during the appeal and/or Fair Hearing process if the outcome upholds the decision being appealed;

5. A local grievance process for any recipient of the Pre-Paid Inpatient Health Plan (PIHP) to express dissatisfaction about any matter other than those that meet the definition of an "Adverse Benefit Determination" or those that meet the definition of a Recipient Rights issue;

6. Complaints should be resolved at the level closest to service delivery when possible, but information regarding access to all complaint resolution processes will be provided to the Medicaid Enrollee;

7. With the written consent from the Enrollee, the right to have a provider or other authorized representative acting on the Enrollee's behalf file an Appeal or Grievance or request a State Fair Hearing. The provider may file a Grievance or request a State Fair Hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so. Punitive action may not be taken against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so;

8. All processes will promote the resolution of concerns and improvement of the quality of care;

9. Each CMHSP Participant/ SUD Provider shall have a local procedure in place that is in compliance with the Michigan Department of Health and Human Services (MDHHS), Grievance and Appeal Technical Requirement and 42 Code of Federal Regulations (CFR) 438 Subpart F – Grievance and Appeal System.

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 Benefit Determination**:** A decision that adversely impacts a Medicaid Enrollee's claim for services due to: *(42 CFR 438.400)*

a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. *42 CFR 438.400 (b)(1).*
b. Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2).*
c. Denial, in whole or in part, of payment for a service. *42 CFR 438.400(b)(3).*
d. Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. *42 CFR 438.210(d)(1*).
e. Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. *42 CFR 438.210(d)(2).*
f. Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP. *42 CFR 438.400(b)(4).*
g. Failure of the PIHP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).*
h. Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).*

i. Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of the date of the request. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

j. For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under *§ 438.52(b)(2)(ii)*, to obtain services outside the network. *42 CFR 438.400(b)(6).*

k. Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. *42 CFR 438.400(b)(7).*

Adequate Notice of Adverse Benefit Determination**:** Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect. *42 CFR 438.404(c)(2).*

Advance Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination is to take effect. *42 CFR 438.404(c)(1); 42 CFR 431.211*.

Appeal: A review at the local level by a PIHP of an Adverse Benefit Determination, as defined above. *42 CFR 438.400*.

Authorization of Services: The processing of requests for initial and continuing service delivery. *42 CFR 438.210(b).*

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

CMHSP: Community Mental Health Service Program

Enrollee: A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program**.** *42 CFR 438.2*.

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the Enrollee requests the expedited review, the PIHP determines if the request is warranted. If the Enrollee's provider makes the request, or supports the Enrollee's request, the PIHP must grant the request. *42 CFR 438.410(a).*

Grievance: Enrollee's expression of dissatisfaction about PIHP/CMHSP service issues, other than an Adverse Benefit Determination**.** Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the Enrollee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, or an Enrollee's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision. *42 CFR 438.400*.

Grievance Process: Impartial local level review of an Enrollee's Grievance**.**

Grievance and Appeal System: The processes the PIHP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. *42 CFR 438.400*.

MDHHS: Michigan Department of Health and Human Services

Medicaid Services: Services provided to an Enrollee under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

MSHN: Mid-State Health Network

Notice of Resolution: Written statement of the PIHP of the resolution of a Grievance or Appeal, which must be provided to the Enrollee as described in *42 CFR 438.408*.
PIHP: Prepaid Inpatient Health Plan.
Recipient Rights Complaint: Written or verbal statement by a Enrollee, or anyone acting on behalf of the Enrollee, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.
Service Authorization: PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210.*
State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.
SUD: Substance Use Disorder
SUD Provider Network: Refers to a SUD Provider that is directly under contract with PIHP MSHN to provide services and/or supports

Other Related Procedures:

N/A

References/Legal Authority:

The following federal and state statutes establish the standards for MSHN's Appeals and Grievance procedures for Medicaid Recipients:
1. 42 CFR 438.10: Information Requirements
2. 42 CFR 431.200 Fair Hearings
3. 42 CFR 438.400 Appeals and Grievances
4. State of Michigan/PIHP Contract: Schedule 1. General Requirements, L. Grievance and Appeals Process
5.4. for Beneficiaries
6.5. State of Michigan/PIHP Contract attachment: Appeals and Grievances Technical Requirements (P.6.3.1.1)
7.6. Michigan Mental Health Code (MHC) MCL 330.1772 (Recipient Rights Complaints)
8.7. Michigan Mental Health Code (MHC) MCL 330.1705 (Medical Second Opinion)

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New policy	Chief Compliance Officer
04.2016	Annual Review/Formatting Update	Customer Service and Rights Specialist
11.21.2016	Annual Review, language edition	Customer Service Committee

10.16.2017	Annual Review, revised definitions	Customer Service Committee

12.3.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review	Customer Service Committee
11.15.2021	Bi-annual Review, updated language from contract	Customer Service Committee
01.22.2024	Biennial ~~annual~~ Review, no changes	Customer Service Committee

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	**Regional Consumer Advisory Council**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 5	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 12.03.2013 **Review Date: 07.05.2022** ~~**Revision Eff. Date:**~~	**Related Policies:** Customer Service Policy

Purpose

To ensure Mid-State Health Network (MSHN) integrates consumerism into policy development, service delivery provision, service delivery system evaluation, and quality assurance/performance improvement practices.

Policy

MSHN shall facilitate meaningful, region-wide consumer involvement in its policy development, service development, service delivery, service evaluation, and quality improvement activities by establishing a MSHN Regional Consumer Advisory Council (RCAC) for Prepaid Inpatient Health Plan (PIHP) operations that links to local Community Mental Health Service Program (CMHSP) Participant Consumer Advisory Councils to facilitate consumer participation.

A. Charter
   1. The MSHN RCAC is an advisory group of MSHN primary and secondary consumers. This group assists MSHN in identifying issues and areas of concern related to regional service delivery and managed care operations. It is a primary source of consumer input into the development of policies, procedures and operations where recipients of service may make recommendations for quality improvement.

   2. The MSHN RCAC will also focus on region-wide political and advocacy issues to ensure there is a public basis for management of the mental health and substance use disorder delivery system.

   3. The MSHN RCAC will also focus on region-wide opportunities for stigma reduction related to mental health and substance use disorder issues.

B. Membership
   1. The RCAC shall be comprised of 24-36 voting members made up of primary and secondary consumers. RCAC shall also include 12 non-voting CMHSP Participant staff liaisons and staff support from the MSHN Customer Service and Rights Manager. The RCAC shall report directly to the MSHN Board of Directors through the MSHN Deputy Director.

   2. RCAC Primary and Secondary Consumer Membership:
      i. Each CMHSP Participant shall be represented on the RCAC with 2-3 consumer representatives. Each CMHSP Participant shall independently choose the method to appoint its members to the RCAC.
      ii. The RCAC shall have a diverse and proportional membership representing the following populations: Adults with mental illness, adults with developmental

disabilities, children with mental illness, children with developmental disabilities, and individuals with substance use disorders. Further, at least half of RCAC membership shall be primary consumers. Thus, it shall be necessary for MSHN to coordinate CMHSP's appointees to the RCAC to ensure that it represents the populations served.

iii. For issues that require a vote, each voting member shall have one vote. The outcome of a vote is determined by the majority of those present.

3. RCAC Leadership:
   i. The RCAC shall elect officers, including a chairperson and vice-chairperson from within its voting membership. The MSHN Customer Service and Rights Manager will provide staff support to the RCAC; however, he/she shall not be a voting member. MSHN staff will assist in developing RCAC meeting agendas, facilitation of meetings, and any needed follow-up.

4. RCAC-CMHSP Participant Staff Liaisons:
   i. Each CMHSP Participant shall choose a staff liaison to maximize linkages to local CMHSP consumer advisory councils, performance improvement processes and administrative bodies, and other CMHSP staff for any necessary problem resolution.

C. Responsibilities
1. RCAC Member Responsibilities
   i. Regularly attend RCAC meetings to be held bi-monthly. The meetings may be held by a combination of in-person, teleconference, or other technology. MSHN staff and CMHSP Participant staff liaisons shall monitor attendance and will address the membership with any identified issues.
   ii. MSHN will reimburse RCAC members for pre-approved travel expenses for each meeting attended and a reasonable stipend for meeting attendance per protocols developed by MSHN.
   iii. Members will actively participate in RCAC discussions.
   iv. Members will provide input and make informed decisions as a representative of all the individuals served at their local CMHSP rather than act as a representative of themselves (i.e. avoid personal agendas).
   v. Review aggregate reports received from the Quality Assessment and Performance Improvement Program (QAPIP), provide recommendations, and give guidance and suggestions regarding consumer-related managed care processes.
   vi. Serve as the link between the RCAC and the local CMHSP Participant Consumer Advisory Council. Each member shall represent and vote in the best interests of the local consumers in a manner that embodies the local majority opinion.
   vii. Share ideas and activities that occur at the local CMHSP level and create an environment that fosters networking, idea sharing, peer support, best practices, and resource sharing.
   viii. Provide feedback for regional initiatives ~~designed~~ intended to encourage person-centered planning, self-determination, independent facilitation, anti-stigma initiatives, community integration, recovery and other consumer-directed goals.

2. MSHN Responsibilities
   i. Reimburse MSHN RCAC members for approved mileage and meeting attendance stipend as determined by a developed protocol.
   ii. Provide initial orientation and on-going education to MSHN RCAC members to foster informed decision making.
   iii. Facilitate the development of an open, non-judgmental environment in which RCAC members are comfortable ~~in~~ sharing opinions and ideas.
   iv. Provide pertinent reports and information to MSHN RCAC members.
   v. Share MSHN RCAC's minutes, recommendations/actions and suggestions with pertinent MSHN Councils and the MSHN Board of Directors. MSHN will develop a routine feedback loop to RCAC members on how feedback was used or the reasons that feedback was not used.
   vi. Ensure that the communication/links between the RCAC and the local CMHSP Consumer Advisory Council are effective and beneficial. MSHN will also ensure that immediate, CMHSP-specific needs or problems are brought to the attention of the local CMHSP Chief Executive Officers (CEOs) in a timely manner.
   vii. Promote the efforts and achievements of MSHN RCAC through special recognition and appreciation.

3. CMHSP Participant Staff Liaison to RCAC Responsibilities
   i. Assist RCAC CMHSP member representatives with the communication of pertinent regional information to local CMHSP Participant Consumer Advisory Councils, obtain feedback, and ~~as~~ensure attendance of its CMHSP representatives to MSHN RCAC.
   ii. Each CMHSP Participant staff liaison will assist its RCAC CMHSP member representatives in linking to local processes that ensure consumers' voices are heard, considered, and acted upon as appropriate.
   iii. CMHSP Participant staff liaisons will assist MSHN staff with problem-solving immediate local issues ~~that are~~ introduced by its representatives at the MSHN RCAC.

4. Council Process
   i. The RCAC shall receive and review reports from MSHN staff or their designee(s) on a regular basis.
   ii. The RCAC will report quarterly to the MSHN Board of Directors and identify RCAC recommendations for Board consideration.
   iii. The RCAC shall make recommendations to the MSHN Board of Directors based on a simple majority vote of RCAC members.
   iv. The MSHN staff representative and officers will communicate decisions and recommendations of the MSHN Board of Directors to RCAC members.

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:

CEO: Chief Executive Officer
CMHSP: Community Mental Health Service Program
CMHSP Consumer Advisory Council: The advisory council was established to serve in an advisory capacity to CMHSP Boards
Consumerism: Means active promotion of the interests, service needs, and rights of consumers receiving mental health and/or substance use disorder services
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
Informed Choice: Providing information to individuals to ensure understanding of their options that will inform their decision-making related to service provision
Local Consumer Advisory Council: Local CMHSP advisory group of primary and secondary consumers providing input into local CMHSP Participant service delivery, service evaluation, advocacy efforts, and performance improvement opportunities. The Local Consumer Advisory Councils are connected to the Regional Consumer Advisory Council to maximize local input into service delivery, service evaluation, advocacy efforts, and performance improvement opportunities within the region
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
Primary Consumer: An individual who receives or has received services from MDHHS or CMHSP Participant(s). This includes those who receive or have received the equivalent mental health services from the private sector
PIHP: Prepaid Inpatient Health Plan
QAPIP: Quality Assessment and Performance Improvement Plan
RCAC/Regional Consumer Advisory Council: Region-wide advisory group of primary and secondary consumers from all CMHSP Participants to provide input into MSHN PIHP service delivery, service evaluation, advocacy efforts, and performance improvement opportunities. The Regional Consumer Advisory Council (RCAC) is connected to the CMHSP Local Consumer Advisory Councils to maximize local input into PIHP service delivery, service evaluation, advocacy efforts, and performance improvement opportunities
Secondary Consumer: A family member, guardian, or advocate of an individual who receives or has received services from the MDHHS or a CMHSP. This includes family members, guardians, or advocates of a person who has received the equivalent mental health services from the private sector

References/Legal Authority:

1. Michigan Department of Health and Human Services Medicaid Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY19, including the "Consumerism Practice Guideline".
2. Act 258, Section 116(e), Public Acts of 1974 as amended, being MCL 330.1116, 1704, 1708.

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New Policy	Customer Service Committee
11.2015	Annual Review	Director of Compliance, Customer Services and QI
11.21.2016	Annual Review	Customer Service Committee
12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review	Customer Service Committee
11.15.2021	Bi-annual Review	Customer Service Committee
01.22.2024	Biennial ~~annual~~ Review, minor changes	Customer Service Committee

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	Recipient Rights for Substance Use Disorder Recipients		
Policy: ☑ Procedure: ☐ ~~Version: 2.0~~ Page: 1 of 3	Review Cycle: ~~Annually~~Biennial Author: Chief Compliance and Quality Officer; Customer Service Committee	Adopted Date: Review Date: 1/22/24 ~~Revision Eff. Date:~~	Related Policies: Consumer Service Policy

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To ensure the legal authority and requirements for the rights and the protections for all recipients receiving substance use disorder (SUD) services authorized and/or delivered by the Mid-State Health Network (MSHN) Provider Network.

Policy

~~1)~~ A program shall ~~adopt~~ have a ~~official written~~ policiesy and procedure~~s~~ to ~~as~~ensure compliance with recipient rights requirements ~~rules and procedures~~ as set for in R 325.1391 to R 325.1399 of the Administrative Rules for Substance Abuse Program in Michigan.

~~2)~~

~~3)~~ The recipient rights policies and procedures shall be reviewed at least annually to consider any revisions that might be necessary~~. Such review and approval shall become a part of the administrative record of the program.~~

~~4)~~1)

~~5)~~2) ~~The~~ A program's recipient rights policiesy and procedure~~s~~ shall ~~meet~~address all of the following requirements:

a) Require ~~the~~a program ~~director~~ to ~~designate~~identify a staff member to function as the program rights advisor who shall do all of the following:
   i) Attend training concerning recipient rights procedures.
   ii) Receive and investigate all recipient rights complaints.
   iii) Communicate directly with the Mid-State Health Network (MSHN) regional rights consultant when a complaint cannot be resolved at the program level.

   ~~* Where staffing permits, the program rights advisor shall not be a provider of counseling services.~~

b) Outline the method of filling recipient requests to review, copy, or receive a summary of recipient treatment or prevention service case records.

c) Provide simple mechanisms for notifying recipients of their rights, reporting apparent rights violations, determining whether in fact violations have occurred, and for ensuring that firm, consistent, and fair remedial action is taken in the event of a violation of these rules.

4) Copies of recipient rights policies and procedures shall be provided to ~~each member of the program~~ staff. Each staff member of the program shall review the policies and procedures and shall sign a form provided by the department which indicates that he or she understands, and shall abide by, the policies and procedures. ~~The form shall be explained to the staff by the program director.~~ A signed copy shall be maintained in the staff personnel file and a signed copy shall be retained by the staff member.

5) A treatment program may choose to restrict specific rights of a recipient based on the program policies and procedures. These restrictions are permissible only when there is a documented therapeutic purpose and timeframe in the recipient's record. A restriction shall not be for more than 30 days without being renewed in writing in the recipient record and shall be signed by a licensed health professional.

(6) As part of the admission procedure to a program, a recipient shall receive all of the following:
   a) If incapacitated, receive the procedures described in this subrule as soon as feasible, but not more than 72 hours after admission to an approved service program.
   b) A written description of the recipient rights.
   c) A written description of any restrictions of the rights based on program policy.
   d) An oral explanation of the rights in language which is understood by the recipient.
   e) A form that indicates that the recipient understands the rights and consents to specific restrictions of rights based on program policy. The recipient shall sign this form. A copy of the form shall be provided to the recipient and also become a part of the recipient's record.
   f) A recipient rights complaint violation form shall be provided to the recipient after completing the consent form.

7) Rights of recipients shall be displayed on a poster provided by the department in a public area of all licensed programs. The poster shall indicate the program rights advisor's name and phone number.

8) ~~The administrator of the department, with approval of~~ Mid-State Health Network (MSHN), the regional entity, shall designate a staff member of MSHN to act as the recipient rights consultant for the region. The designation shall be renewed annually. The MSHN recipient rights consultant shall conduct recipient rights activities according to procedures outlined by the department.

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:

Department: means the department of licensing and regulatory affairs (LARA).
MSHN: Mid-State Health Network
PIHP: Pre-paid Inpatient Health Plan
Provider Network: Refers to a CMHSP Participant and all Substance Use Disorder Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP/SUD Provider subcontractors.
Regional Entity: means an agency designated by the state to coordinate substance use disorder services in a specified region.
SUD: Substance Use Disorder

Other Related Materials:

Recipient Rights definitions found within Mich Admin Code. R 325.1301

References/Legal Authority:

1. Mich Admin Code, R 325.1391 to R 325.1399. Administrative Rules Substance Use Disorders Service Program
2. Michigan Public Health Code Act 368 of 1978, Article 6, Substance Abuse
3. Michigan Public Health Code Act 258 of 1974, Chapter 2A, Substance Use Disorder Services

Change Log:

Date of Change	Description of Change	Responsible Party
12/03/18	New policy	Director of Quality, Compliance, and Customer Service
03.16.2020	Annual Review; revisions to match Mich Admin Code revisions	Customer Service Committee
11.15.2021	Bi-annual Review, minor language updates	Customer Service Committee
01.22.2024	Biennial ~~annual~~ Review, language updates based upon changes in the Administrative Code	Customer Service Committee

Chapter:	Compliance		
Title:	Compliance Reporting and Investigations		
Policy: ☒ Procedure: ☐ Page: 1 of 3	Review Cycle: Biennial Author: Chief Compliance Officer and Quality Improvement Council	Adopted Date: 04.07.2015 Review Date: 11.07.2023	Related Policies: Compliance & Program Integrity

Purpose

To ensure Mid-State Health Network (MSHN) staff and its Provider Network report suspected violations, misconduct and Medicaid fraud, waste and abuse, complete investigations, and complete the required reporting in accordance with the MSHN Compliance Plan; Reporting and Investigations.

Policy

Suspected Medicaid Fraud, Waste, and/or Abuse:

MSHN staff and its Provider Network, shall report all suspected Medicaid fraud, waste, and abuse to the MSHN Compliance Officer in accordance with standards established in the MSHN Compliance Plan. Investigations shall be conducted in accordance with the MSHN Compliance Plan, Reporting and Investigations.

- Allegations involving suspected fraud will be reported to the MSHN Compliance Officer.
- Under the direction of MSHN's Compliance Officer, a preliminary investigation will be completed to determine if a suspicion of fraud exists.
- If suspicion of fraud exists, a report will be made in writing by the MSHN Compliance Officer utilizing the Office of Inspector General Fraud Referral Form.
- If there is suspicion of fraud, and involves an overpayment of $5,000 or more, MSHN's Compliance Officer will report the suspected fraud ~~and abuse~~ to the Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG).
- MSHN's 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 necessary follow up.
- All suspicion of fraud ~~and abuse~~ will be reported on the Quarterly OIG Program Integrity Report template.

Suspected Violations and/or Misconduct (not involving Medicaid Fraud~~, Waste, and/or Abuse~~):

MSHN staff and its Provider Network, shall report all suspected violations and/or misconduct to the MSHN Compliance Officer and/or the appropriate Community Mental Health Service Program (CMHSP) Participant/Substance Use Disorder (SUD) Provider designated Compliance Officer. Reporting and Investigations shall be conducted in accordance with the MSHN Compliance Plan, Reporting and Investigations.

- Where internal investigation substantiates a reported violation, corrective action plans will be initiated by MSHN staff or its Provider Network.
- Corrective action plans developed by the Provider Network shall be submitted to the MSHN Compliance Officer within thirty (30) days of the approved plan.
- The MSHN Compliance Officer shall review corrective action plans and ensure, as appropriate,

prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, coordinating with the CMHSP designee for follow-up monitoring and oversight, and implementing system changes to prevent a similar violation from recurring in the future.

Required Reporting:
MSHN's Provider Network shall submit compliance activity reports quarterly to the MSHN Compliance Officer utilizing the Office of Inspector General program integrity report template. Minimally the report will include the following:

- Tips/grievances received
- Data mining and analysis of paid claims, including audits performed based on the results
- Audits performed
- Overpayments collected
- Identification and investigation of fraud, waste and abuse (as these terms are defined in the "Definitions" section of this contract
- Corrective action plans implemented
- Provider dis-enrollments
- Contract terminations

Reporting Period/Due Dates to MSHN:

- January through March: May 1st
- April through June: August 1st
- July through September: November 1st
- October through December: February 1st

The MSHN Compliance Officer will prepare a quarterly summary report of the Provider Network and direct MSHN compliance activities and present to the MSHN Compliance Committee and the Regional Compliance Committee. ~~–~~An annual summary report of the regional compliance activities will be presented to the MSHN Board of Directors and the MSHN Operations Council.

To the extent consistent with applicable ~~law~~ federal and state law, including, but not limited to 42 Code of Federal Regulations (CFR) Part 2, HIPAA, and the Michigan Mental Health Code, the Pre-Paid Inpatient Health Plan (PIHP) must disclose protected health information to MDHHS-OIG or the Department of Attorney General upon their written request, without first obtaining authorization from the beneficiary to disclose such information.~~is required to comply with MDHHS-OIG's requests for documentation and information related to program integrity and compliance~~.

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:
Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care.
CMHSP: Community Mental Health Service Program
Fraud: The intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or another person.
MDHHS: Michigan Department of Health and Human Services

MSHN: Mid-State Health Network
OIG: Office of Inspector General
PIHP: Prepaid Inpatient Health Plan
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.
SUD: Substance Use Disorder
Waste: Overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions, but rather the misuse of resources.

Other Related Materials:
MSHN Compliance Plan
MSHN Compliance Investigation Reports Office of Inspector General Fraud Referral Form
MSHN Compliance Activity Report Template
MSHN Contract Compliance Procedure

References/Legal Authority:
1. 42 Code of Federal Regulations 455.17 – Reporting Requirements
2. 42 Code of Federal Regulations 438.608: Program Integrity Requirement
3. 42 Code of Federal Regulations, Part 2: Confidentiality of Substance Use Disorder Patient Records
4. State of Michigan/PIHP Contract: Schedule A: Statement of Work Contract Activities: R. Program Integrity
5. Michigan Mental Health Code
6. Code of Federal Regulations, Section 42: 438.608 – Program Integrity Requirements

Change Log:

Date of Change	Description of Change	Responsible Party
03.2015	New Policy	Chief Compliance Officer
03.2016	Annual Review	Director of Compliance, Customer Service & Quality
08.2016	Annual Review	Director of Compliance, Customer Service & Quality
08.2017	Annual Review	Director of Compliance, Customer Service & Quality
08.2018	Annual Review	Director of Compliance, Customer Service & Quality
09.2019	Annual Review	Director of Compliance, Customer Service, & Quality
08.2021	Bi-Annual Review; Updated references	Chief Compliance and Quality Officer
08.2023	Biennial Review; Updated reporting for suspected fraud.	Chief Compliance and Quality Officer
05.2024	Updated to include OIG feedback	Chief Compliance and Quality Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Provider Network Management		
Title:	Disclosure of Ownership, Control, and Criminal Convictions		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle: Biennial** **Author:** Chief Financial Officer	**Adopted Date: 01.05.2016** **Review Date: 03.05.2024**	**Related Policies:** Provider Network Management Provider Credentialing and Re-Credentialing Quality Monitoring and Oversight

Purpose

Federal regulations require Prepaid Inpatient Health Plans (PIHPs) to disclose information about individuals with ownership or control interests in the PIHP. These regulations also require the PIHP to identify and report any additional ownership or control interests for those individuals in other entities, as well as identify when any of the individuals with ownership or control interests have spousal, parent-child, or sibling relationships with each other.

Policy

Mid-State Health Network (MSHN) and Community Mental Health Service Providers (CMHSP) shall comply with the federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 Code of Federal Regulations (CFR) §455 Subpart B. In addition, MSHN shall ensure that any and all contracts, agreements, purchase orders, or leases to obtain spaces, supplies, equipment, or services provided under the Medicaid agreement require compliance with 42 CFR §455.104-106. Pursuant to 42 CFR §455.104: the State will review ownership and control disclosures submitted by the MSHN/CMHSP and any of MSHN/CMHSP Subcontractors and/or Network Providers.

MSHN shall develop procedures to address the following:

- disclosure statement requirements;
- when disclosures are obtained;
- monitoring provider networks;
- reporting with regard to criminal offense;
- delegation and oversight

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

CFR: Code of Federal Regulations
CMHSP: Community Mental Health Services Program
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan

References/Legal Authority

42CFR §455 Subpart B
42CFR §455.104-106
The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s)
Social Security Act, Sections 1128(a) and 1128(b)(1)(2), or (3)

Attachments

MSHN Ownership and Disclosure Form

Change Log

Date of Change	Description of Change	Responsible Party
07.2015	New policy	Director of Provider Network Management Svcs
11.2017	Annual Review, No Revisions	Director of Provider Network Management Svcs
10. 2018	Annual Review, No Revisions	Director of Provider Network Management Svcs
09.2019	Annual Review, No Revisions	Director of Provider Network Management
11.2021	Biennial Review – No Changes	Contract Specialist
12.2023	Biennial Review	Contract Specialist
04.20214	Added language pursuant to 42 CFR §455.104 -OIG annual review	Chief Compliance and Quality Officer