Mid-State Health Network

Board of Directors Meeting ~ March 3, 2026 ~ 5:00 p.m.

Board Meeting Agenda

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

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

1. Call to Order

   Remind members of the Board Member Conduct Policy

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

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

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

2. Roll Call

3. **ACTION ITEM:** Approval of the Agenda

   Motion to Approve the Agenda of the March 3, 2026 Meeting of the MSHN Board of Directors

4. Public Comment (3 minutes per speaker)

5. **ACTION ITEM:** FY2026 Quality Assessment and Performance Improvement Program (QAPIP) and the FY2025 Annual Effectiveness and Evaluation Report (*Page 6*)

   Motion to approve the Quality Assessment and Performance Improvement Program (QAPIP) for October 1, 2025 through September 30, 2026 and the Annual Effectiveness and Evaluation Report for October 1, 2024 to September 30, 2025

6. **ACTION ITEM:** MSHN FY2025 Annual Compliance Summary Report (*Page 13*)

   Motion to acknowledge receipt of and approve the FY2025 Annual Compliance Summary Report

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Our Mission:

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

Our Vision:

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

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Board of Directors Meeting Materials:
Click **HERE**
or visit MSHN's website at:
https://midstatehealthnetwork.org/stakeholders-resources/board-councils/board-of-directors/fy2026-meetings

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Upcoming FY26 Board Meetings

Board Meetings convene at 5:00pm Unless otherwise notes

May 5, 2026
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

July 7, 2026
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

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

7. **ACTION ITEM:** FY2025 Board Self Assessment *(Page 55)*

   Motion to receive and file the FY2025 Board Self-Assessment report

8. Chief Executive Officer's Report *(Page 59)*

9. Deputy Director's Report *(Page 78)*

10. Chief Financial Officer's Report

    Financial Statements Review for Period Ended January 31, 2026 *(Page 83)*

    ACTION ITEM: Receive and File the Preliminary Statement of Net Position and Statement of Activities for the Period ended January 31, 2026, as presented

11. **ACTION ITEM:** Contracts for Consideration/Approval

    A. ACTION ITEM: FY25 Contract Listing for Consideration/Approval ***(Page 91)***

    The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2025 Contracts, as presented on the FY 2025 Contract Listing

    B. ACTION ITEM: FY26 Contract Listing for Consideration/Approval ***(Page 93)***

    The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2026 Contracts, as presented on the FY 2026 Contract Listing

12. Executive Committee Report

13. Chairperson's Report

14. **ACTION ITEM:** Consent Agenda

    Motion to Approve the documents on the Consent Agenda

    14.1 Approval Board Meeting Minutes 11/18/2025 *(Page 95)*
    14.2 Receive Board Meeting Notes 01/06/2026 *(Page 99)*
    14.3 Receive Board Executive Committee Minutes 12/19/2025 *(Page 103)*
    14.4 Receive Policy Committee Meeting Minutes 12/02/2025 *(Page 104)* and 02/03/2026 *(Page 106)*
    14.5 Receive SUD Oversight Policy Board Meeting Minutes 10/15/2025 *(Page 107)*
    14.6 Receive Operations Council Key Decisions 11/17/2025 *(Page 111)* and 12/15/2025 *(Page 112)* and 01/26/2026 *(Page 114)*
    14.7 Receive Preliminary Statement of Net Position and Statement of Activities for the period ended November 30, 2025 *(Page 116)*
    14.8 Approve the following policies:
    14.8.1 SUD Income Eligibility *(Page 123)*
    14.8.2 New CMHSP Participation in the MSHN Region *(Page 125)*

15. Other Business

16. Public Comment (3 minutes per speaker)

17. Adjourn

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FY26 MSHN Board Roster

Current as of 12/2025

Last Name	First Name	Email 1	Email 2	Phone 1	Phone 2	Appointing CMHSP	Term Expiration
Bock	Patty	pjb1873@gmail.com		989.975.1094		HBH	2026
Bohner	Brad	bbohner@tds.net		517.294.0009		LifeWays	2028
Brodeur	Greg	brodeurgreg@gmail.com		989.413.0621		Shia Health & Wellness	2027
Conley	Patrick	conleypat@gmail.com		585.734.6847		BABHA	2028
DeLaat	Ken	kend@nearnorthnow.com		231.414.4173		Newaygo County MH	2026
Garber	Cindy	cgarber@shiawassee.net		989.627.2035		Shia Health & Wellness	2027
Griesing	David	davidgriesing@yahoo.com		989.545.9556	989.823.2687	TBHS	2027
Grimshaw	Dan	midstatetitlesvcs@mstsinc.com		989.823.3391	989.823.2653	TBHS	2026
Hanna	Tim	thanna280@gmail.com		517.230.8773		CEI	2028
Hicks	Tina	tinamariemshn@outlook.com		989.576.4169		GIHN	2027
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2027
McFarland	Pat	pjmcfarland52@gmail.com		989.225.2961		BABHA	2026
McPeek-McFadden	Deb	deb2mcmail@yahoo.com		616.794.0752	616.343.9096	The Right Door	2027
O'Boyle	Irene	irene.oboyle@cmich.edu		989.763.2880		GIHN	2026
Vacant						CEI	2025
Peasley	Kurt	peasleyhardware@gmail.com		989.560.7402	989.268.5202	MCN	2027
Phillips	Joe	joe44phillips@hotmail.com		989.386.9866	989.329.1928	CMH for Central	2026
Purcey	Linda	dpurcey1995@charter.net		616.443.9650		The Right Door	2028
Raquepaw	Tracey	tl.raquepaw@icloud.com	raquepawt@michigan.gov	989.737.0971		Saginaw County CMH	2028
Scanlon	Kerin	kscanlon@tm.net		502.594.2325		CMH for Central	2028
Schultz	Lori	ljodas63@gmail.com		616.293.8435		Newaygo County MH	2028
Swartzendruber	Richard	rswartzn@gmail.com		989.269.2928	989.315.1739	HBH	2026
Williams	Joanie	joanie.williams1977@gmail.com		989.860.6230		Saginaw County CMH	2026
Woods	Ed	ejw1755@yahoo.com		517.392.8457		LifeWays	2027

Administration:

Sedlock	Joe	joseph.sedlock@midstatehealthnetwork.org	517.657.3036	989.529.9405	
Ittner	Amanda	amanda.ittner@midstatehealthnetwork.org	517.253.7551	989.670.8147	
Thomas	Leslie	leslie.thomas@midstatehealthnetwork.org	517.253.7546	989.293.8365	
Kletke	Sherry	sheryl.kletke@midstatehealthnetwork.org	517.253.8203	517.285.5320	

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

ACA: Affordable Care Act

ACT: Assertive Community Treatment

ARPA: American Rescue Plan Act (COVID-Related)

ASAM: American Society of Addiction Medicine

ASAM CONTINUUM: Standardized assessment for adults with SUD needs

ASD: Autism Spectrum Disorder

BBA: Balanced Budget Act

BH: Behavioral Health

BHH: Behavioral Health Home

BPHASA – Behavioral and Physical Health and Aging Services Administration

BH-TEDS: Behavioral Health–Treatment Episode Data Set

CC360: CareConnect 360

CCBHC: Certified Community Behavioral Health Center

CAC: Certified Addictions Counselor
Consumer Advisory Council

CEO: Chief Executive Officer

CFO: Chief Financial Officer

CIO: Chief Information Officer

CCO: Chief Clinical Officer

CFR: Code of Federal Regulations

CFAP: Conflict Free Access and Planning (Replacing CFCM)

CLS: Community Living Services

CMH or CMHSP: Community Mental Health Service Program

CMHA: Community Mental Health Authority

CMHAM: Community Mental Health Association of Michigan

CMS: Centers for Medicare and Medicaid Services (federal)

COC: Continuum of Care

COD: Co-occurring Disorder

CON: Certificate of Need (Commission) – State

CPA: Certified Public Accountant

CPS: Children's Protective Services

CQS: – Comprehensive Quality Strategy

CRU: Crisis Residential Unit

CS: Customer Service

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

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

CW: Children's Waiver

DAB: Disabled and Blind

DEA: Drug Enforcement Agency

DECA: Devereux Early Childhood Assessment

DMC: Delegated Managed Care (site visits/reviews)

DRM: Disability Rights Michigan

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

D-SNP: Dual Eligible Special Needs Plan

EBP: Evidence-Based Practices

EEO: Equal Employment Opportunity

EMDR: Eye Movement & Desensitization Reprocessing therapy

EPSDT: Early and Periodic Screening, Diagnosis and Treatment

EQI: Encounter Quality Initiative

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

FC: Finance Council

FI: Fiscal Intermediary

FOIA: Freedom of Information Act

FSR: Financial Status Report

FTE: Full-time Equivalent

FQHC: Federally Qualified Health Centers

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

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

HB: House Bill

HCBS: Home and Community Based Services

HHP: Health Home Provider

HIPAA: Health Insurance Portability and Accountability Act

HITECH: Health Information Technology for Economic and Clinical Health Act

HMP: Healthy Michigan Program

HMO: Health Maintenance Organization

HRA: Hospital Rate Adjuster

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

HSW: Habilitation Supports Waiver

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

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

ICTS: Intensive Community Transitions Services

I/DD: Intellectual/Developmental Disabilities

IDDT: Integrated Dual Diagnosis Treatment

IOP: Intensive Outpatient Treatment

ISF: Internal Service Fund

IT/IS: Information Technology/Information Systems

KPI: Key Performance Indicator

LBSW: Licensed Baccalaureate Social Worker

LEP: Limited English Proficiency

LLMSW: Limited Licensed Masters Social Worker

LMSW: Licensed Masters Social Worker

LLPC: Limited Licensed Professional Counselor

LPC: Licensed Professional Counselor

LOCUS: Level of Care Utilization System

LTSS: Long Term Supports and Services

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

MAT: Medication Assisted Treatment (see MOUD)

MCBAP: Michigan Certification Board for Addiction Professionals

MCO: Managed Care Organization

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

MDHHS: Michigan Department of Health and Human Services

MDOC: Michigan Department of Corrections

MEV: Medicaid Event Verification

MHP: Medicaid Health Plan

MI: Mental Illness

Motivational Interviewing

MICAS: Michigan Intensive Child and Adolescent Services

MichiCANS: Michigan Child and Adolescent Needs and Strengths

MiHIA: Michigan Health Improvement Alliance

MiHIN: Michigan Health Information Network

MLR: Medical Loss Ratio

MMBPIS: Michigan Mission Based Performance Indicator System

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

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

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

MPHI: Michigan Public Health Institute

MRS: Michigan Rehabilitation Services

NAA:: Network Adequacy Assessment

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

NAMI: National Association of Mental Illness

NASMHPD: National Association of State Mental Health Program Directors

NCQA: National Committee for Quality Assurance

NCMW: National Council for Mental Wellbeing

OC: Operations Council

OHCA: Organized Health Care Arrangement

OIG: Office of Inspector General

OMT: Opioid Maintenance Treatment - Methadone

OP: Outpatient

OTP: Opioid Treatment Provider (formerly methadone clinic)

OWQP: Only Willing and Qualified Provider

PA: Public Act

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

PAC: Political Action Committee

PCP: Person-Centered Planning

Primary Care Physician

PEO: Professional Employer Organization

PEPM: Per Eligible Per Month (Medicaid funding formula)

PFS: Partnership for Success

PI: Performance Indicator

PIP: Performance Improvement Project

PIHP: Prepaid Inpatient Health Plan

PMV: Performance Measure Validation

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

PRTF: Psychiatric Residential Treatment Facility

PTSD: Post-Traumatic Stress Disorder

QAPIP: Quality Assessment and Performance Improvement Program

QAPI: - Quality Assessment Performance Improvement

QHP: Qualified Health Plan

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

QRT: Quick Response Team

RCAC: Regional Consumer Advisory Council

REMI: MSHN's Regional Electronic Medical Information software

RES: Residential Treatment Services

RFI: Request for Information

RFP: Request for Proposal

RFQ: Request for Quote

RHC: Rural Health Clinic

RR: Recipient Rights

RRA: Recipient Rights Advisor

RRO: Recipient Rights Office/Recipient Rights Officer

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

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

SARF: Screening, Assessment, Referral and Follow-up

SCA: Standard Cost Allocation

SDA: State Disability Assistance

SED: Serious Emotional Disturbance

SB: Senate Bill

SIM: State Innovation Model

SMI: Serious Mental Illness

SPMI: Severe & Persistent Mental Illness

SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income (Social Security)

SSN: Social Security Number

SUD: Substance Use Disorder

SUDHH: Substance Use Disorder Health Home

SUD OPB: Substance Use Disorder Oversight Policy Board

SUGE: Bureau of Substance Use, Gambling and Epidemiology

TANF: Temporary Assistance to Needy Families

THC: Tribal Health Center

UR/UM: Utilization Review or Utilization Management

VA: Veterans Administration

VBP: Value Based Purchasing

WM: Withdrawal Management (formerly "detox")

WSA: Waiver Support Application

WSS: Women's Specialty Services

YTD: Year to Date

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

Background:

FY 2026 Quality Assessment and Performance Improvement Program (QAPIP) Plan and FY2025 Annual Effectiveness and Evaluation Report:

To comply with the Medicaid Managed Specialty Supports and Services Contract, specifically as it relates to the description of the QAPIP and Annual Effectiveness and Evaluation:

> "The PIHP must have a written description of its QAPIP which specifies 1.) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2.) the components and activities of the QAPIP including those as required below; 3.) the role for recipients of service in the QAPIP; and 4.) the mechanisms or procedures to be used for adopting and communicating process and outcome improvement."

And specifically, as it relates to the Governing Body Responsibilities:

> "The QAPIP must be accountable to a Governing Body that is a PIHP Regional Entity. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:
>
> A. Oversight of QAPIP - There is documentation that the Governing Body has approved the overall QAPIP and an annual QI plan.
>
> B. QAPIP progress reports - The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions.
>
> C. Annual QAPIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.
>
> D. The Governing Body submits the written annual report to MDHHS following its review. The report will include a list of the members of the Governing Body."

Please refer to the FY25 MSHN QAPIP Report Executive Summary for an overview and highlights from the full FY25 MSHN QAPIP Report and the FY26 MSHN QAPIP Plan Executive Summary for an overview and highlights from the full FY26 MSHN QAPIP Plan.

Recommended Motion:

The MSHN Board of Directors has reviewed and approves the Quality Assessment and Performance Improvement Program (QAPIP) Plan for the period of October 1, 2025– September 30, 2026, and the Annual Effectiveness and Evaluation Report for the period of October 1, 2024 - September 30, 2025.

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2026 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) PLAN EXECUTIVE SUMMARY

Executive Summary FY26 QAPIP Plan

Purpose

The Fiscal Year (FY) 2026 QAPIP Plan outlines Mid-State Health Network's (MSHNs) ongoing strategy to monitor, assess, and continuously improve the quality of behavioral health and substance use disorder services provided throughout Region 5. This year's plan reflects alignment with the Michigan Department of Health and Human Services (MDHHS) 2023–2026 Comprehensive Quality Strategy (CQS), federal managed care regulations (42 CFR §438.330), and the organization's Strategic Plan and Quintuple Aim priorities (Better Health, Better Care, Better Value, Better Provider Systems, and Better Equity).

Overview of FY26 Plan Revisions

Building upon the FY2025 QAPIP framework, the FY2026 QAPIP plan has been modernized, restructured, and expanded to enhance transparency, accountability, and data-driven performance management.

1. Structural and Organizational Updates

- Reorganized table of contents and formatting for clarity and consistency
- New separated sections for External Audits & Reviews, Financial Oversight, Long-Term Supports and Services (LTSS)/Home and Community Based Services (HCBS), Provider Qualifications, Cultural Competence, and Relevant Policies & Attachments were added
- Overall, strengthened alignment with the Michigan Department of Health and Human Services (MDHHS) QAPIP standards and Pre-Paid Inpatient Health Plan (PIHP) contractual obligations

2. Organizational Structure and Leadership

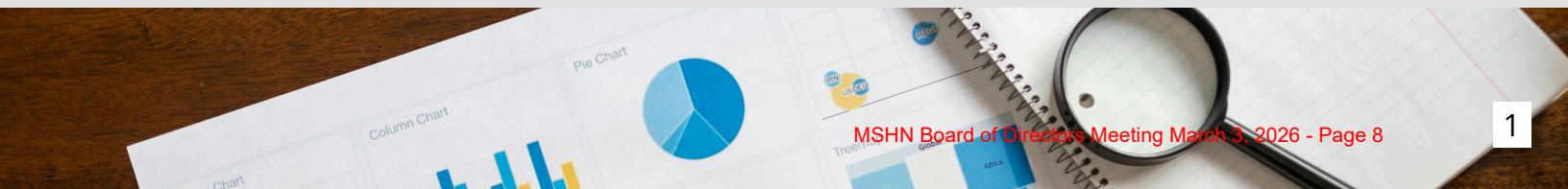
- Clarified Quality Improvement Council's (QICs) role as the coordinating body for all performance measurement and improvement activities
- Updated council/committee descriptions to emphasize collaboration, accountability, and stakeholder inclusion. FY26 introduces streamlined descriptions of councils, committees, and provider responsibilities, full descriptions of councils/committees were placed in an appendix to streamline the QAPIP plan itself
- Adds language clarifying provider accountability under 42 CFR 438.608 and reinforces use of formal charters aligned with the Strategic Plan

3. Performance Management and Measurement

- Expanded details on data governance and establishment of performance measures
- Integration of a Performance Management Process Map aligned with the Plan-Do-Study-Act (PDSA) model
- Wording alignment with Balanced Scorecard indicators and the MDHHS Behavioral Health Quality Program

4. QAPIP Priorities

- Overall, the QAPIP workplan has been brought in to each relevant QAPIP priority section to clearly delineate the goals and activities associated with each area rather than having two separate documents
- Language has been streamlined and updated in each QAPIP priority section to capture requirements while also outlining any significant changes for FY26



Executive Summary FY26 QAPIP Plan

Overview of FY26 Plan Revisions Continued

4. QAPIP Priorities

- Michigan Mission Based Performance Indicator System (MMBPIS): Changes primarily reflect MDHHS discontinuation of most MMBPIS indicators beginning FY2026 while retaining Indicator #2 (timeliness of biopsychosocial assessments) as mandated by MDHHS
- Performance Improvement Projects (PIPs): Continues existing PIPs on racial and ethnic disparity reduction, designated as Remeasurement Period 3 per MDHHS extension through FY2026
- Performance Based Incentive Payment Measures (PBIP): Expands PBIP details to specify Calendar Year (CY) 2026 metrics and validation requirements
- Stakeholder Experience of Care: Streamlined language to specify ongoing consumer satisfaction survey work within MSHN for FY26
- Adverse Events: Expanded definitions and restructured language was utilized for adverse event classification (Immediate Reportable, Sentinel, Critical, and Risk Events), consistent with MDHHS Critical Incident Reporting requirements
- Behavior Treatment: Added quarterly trend analysis language and expanded wording around oversight
- Utilization Management: Updated language and integrated the Utilization Management plan into the FY26 QAPIP plan for consistency in messaging within this area
- Integrated Care: Updated section on Integrated Care Initiatives, highlighting Behavioral Health Homes, SUD Health Homes, and population health into FY2026. Removed Certified Community Behavioral Health Clinic (CCBHC) areas due to changes effective FY26 with PIHP oversight
- Practice Guidelines: Enhanced focus on wording around evidence-based and trauma-informed practices with measurable fidelity tracking and delegated review expectations
- Long Term Supports and Services (LTSS)/Home and Community Based Services (HCBS): New dedicated section detailing integration of HCBS performance monitoring, quality indicators, and consumer experience results—supporting federal HCBS rule compliance
- Cultural Competence: Reinforced commitment to cultural competence with updated wording in this section linking the QAPIP to diversity initiatives
- Provider Network Oversight: Restructured sections allow for ease of end-reader through all of the provider network areas of oversight including provider qualifications/credentialing and provider monitoring and follow-up
- Financial Oversight: Updated wording in section describing fiscal accountability and QAPIP alignment with budgetary review processes

5. Definitions/Acronyms: Definitions not referenced within the FY26 QAPIP plan were removed and this section was streamlined to only definitions needed for this plan

6. Relevant Resources: All resources have been updated with most up-to-date documents and links

7. Relevant Policies & Procedures: Now cross-referenced directly within the QAPIP with direct links to MSHN website for transparency and ease of access

8. Attachments: Attachments were directly embedded within the QAPIP plan for ease of reader and reference

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2025 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) REPORT EXECUTIVE SUMMARY

Executive Summary FY25 QAPIP Report

Overview

The Fiscal Year (FY) 2025 Quality Assessment and Performance Improvement Program (QAPIP) Report reflects MSHN's annual evaluation of the effectiveness of its system-wide quality initiatives across Region 5. The review demonstrates sustained progress in the delivery of high-quality, person-centered, and equitable behavioral health and substance use disorder (SUD) services, with measurable improvement in access, outcomes, and stakeholder satisfaction.

The FY25 measurement period (October 1, 2024 to September 30, 2025) includes all twelve Community Mental Health Services Program (CMHSP) participants, SUD providers, and affiliated networks within MSHN's 21-county service region. The report summarizes performance results, external review outcomes, and recommendations that inform the FY26 QAPIP Plan.

QAPIP Report Highlights

MSHN maintains a robust, data-driven performance management system, integrating state and federal metrics, regional dashboards, and quality indicators across the domains of access, effectiveness, experience of care, and safety. Some key areas of highlight for the FY25 QAPIP Report include:

Michigan Mission-Based Performance Indicator System (MMBPIS)

- **Performance:** MSHN exceeded the state average on 9 of 18 indicators, maintaining strong outcomes in timeliness, follow-up, and engagement
- **Barriers Identified:** Ongoing workforce shortages, high rates of consumer no-shows, and inconsistent data interpretations between PIHPs
- **Next Steps (FY26):** Continue monitoring Indicators 1, 2, and 3, with Indicator #2 retained for Michigan Department of Health and Human Service (MDHHS) compliance, Indicator #1 for Network Adequacy, and Indicator #3 for the ongoing Performance Improvement Project (PIP)

Priority Populations

- **Performance:** Pregnant individuals experienced a marked improvement, from 35% compliance in FY23 to nearly 60% in FY25, with non-pregnant populations increasing from 80% to 87%
- **Effective Interventions:** Centralization of access for SUD withdrawal management and residential services led to improved timeliness of admission
- **Next Steps (FY26):** Continue targeted access initiatives to achieve full compliance with timeliness standards for all priority populations

Performance-Based Incentive Program (PBIP)

- **Performance/Status:** Partially met; MSHN continues to perform well in most metrics but noted variation in employment and follow-up measures
- **Next Steps (FY26):** Maintain ongoing improvement monitoring in FY26 to close gaps and reduce identified disparities consistent with MDHHS performance benchmarks

Performance Improvement Projects (PIPs)

- **Performance:** MSHN continued implementation of two long-term Performance Improvement Projects focused on reducing racial and ethnic disparities in access and penetration rates for behavioral health services:
  - **PIP #1: Access Disparity Reduction**
    - Statistically significant improvement- the disparity between Black/African American and White populations was statistically eliminated ($p > .05$) in FY25 Remeasurement 3 (CY2025 YTD)
    - Demonstrates sustained positive regional impact of interventions implemented across CMHSPs.
  - **PIP #2: Penetration Rate Disparity Reduction**
    - The disparity was reduced from 2.06% (CY21) to 1.51% (CY25 YTD), showing continuous narrowing of the gap, though not yet fully eliminated
- **Next Steps (FY26):** Continue current interventions through Remeasurement Period 3 (CY2025) and maintain focus on data-driven equity improvements in FY26

Executive Summary FY25 QAPIP Report

Overview of FY25 Report Continued

Stakeholder Experience and Satisfaction

- **Performance:** MSHN achieved consistently high satisfaction rates across all surveyed populations:
  - Adult Mental Health: 91%, Children/Family Services: 91%, SUD Services: 90%, Long-Term Supports & Services (LTSS): 91%
- **Next Steps (FY26):** Continue use of MHSIP and YSS surveys in FY26 and transition to the CAHPS Behavioral Health Survey in FY27 under MDHHS's new three-year Behavioral Health Quality Strategy

Adverse Events and Behavior Treatment

- **Performance:** MSHN met or partially met most objectives related to adverse event management
  - Improvement areas identified include timeliness of reporting and remediation documentation in the Critical Incident Reporting System (CIRS)
- **Next Steps (FY26):** Develop training tools on sentinel and critical incident classifications, continue quarterly data validation, reconciliation through CRM and regional dashboard enhancements in FY26

Clinical Practice, Behavior Treatment, and Long-Term Supports and Services (LTSS)

- **Performance:**
  - Adoption of 1915(i) State Plan Amendment (SPA) clinical guidelines and publication of all practice standards on the MSHN website for transparency
  - Enhanced Behavior Treatment Plan oversight and Assertive Community Treatment (ACT) fidelity monitoring
  - Ongoing improvement in oversight of vulnerable individuals through regular site reviews and utilization monitoring
- **Next Steps (FY26):** Maintain practice guideline dissemination, fidelity tracking, and regional utilization reviews for ACT and LTSS services. Continue integration of Home and Community Based Services (HCBS) and 1915(i) program oversight within the QAPIP framework

Utilization Management (UM)

- **Performance:**
  - Maintained >90% compliance with service authorization and ABD timeliness standards
  - Conducted regional analysis of service utilization and medical necessity; identified discrepancies between MichiCANS decision-support recommendations and service authorizations
- **Next Steps (FY26):** Continue regional UM improvement activities in FY26, focusing on cross-system consistency and integration with person-centered planning

Integrated Care and Health Homes

- **Performance:** Maintained active participation in Behavioral Health Homes (BHH), SUD Health Homes (SUDHH), and Certified Community Behavioral Health Clinics (CCBHCs) in FY25
  - Established regional dashboards for tracking performance metrics
  - Improvement noted in cross-sector coordination and health outcomes; however, CCBHC oversight transitions to MDHHS beginning FY26
- **Next Steps (FY26):** Maintain focus on BHH and SUDHH quality improvement programs and refine integrated care reporting structures

Provider Monitoring and Oversight

- **Performance:**
  - Participated in six external reviews (Health Services Advisory Group (HSAG) and MDHHS), achieving strong compliance ratings:
    - HSAG PMV: Validation confirmed data accuracy and quality improvement infrastructure
    - MDHHS 1915(c)/(i) Waiver Review: Compliant - No corrective actions required
- **Common Review Findings:** Credentialing documentation gaps, delayed grievance acknowledgment, and inconsistent tracking mechanisms
- **Next Steps (FY26):** Strengthen credentialing oversight under the new MDHHS Universal Credentialing System (implemented successfully in FY25). Continue corrective action plan monitoring and alignment with 42 CFR §438 requirements

Council and Committee Effectiveness

- **Performance:** All MSHN councils and committees demonstrated continued engagement and measurable progress in FY25

Background

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

> "Contractor must ensure that regular, periodic evaluations of its compliance program occur to determine the program's overall effectiveness. This periodic evaluation of program effectiveness may be performed internally, either by the compliance officer or other internal source - or by an external organization. These periodic evaluations must be performed at least annually, or more frequently, as appropriate. "

The 2025 Annual Compliance Summary Report was reviewed by the MSHN Compliance Committee, Regional Compliance Committee and the Operations Council with recommendation for approval to the MSHN Board of Directors. The attached Executive Summary for the Compliance Summary Report 2025 provides a brief overview of the full report.

Recommended Motion:

The MSHN Board approves and acknowledges receipt of the 2025 Annual Compliance Summary Report.

MSHN

Mid-State Health Network

ANNUAL COMPLIANCE REPORT
FY2025- EXECUTIVE SUMMARY

OVERVIEW

The Compliance Summary Report provides a review of the effectiveness of activities performed throughout Fiscal Year 2025 as part of the MSHN Compliance Program and identified within the MSHN Compliance Plan. Those activities include internal and external monitoring and oversight reviews; customer service complaints; compliance investigations and compliance related training and review.

The FY25 report (October 1, 2024, to September 30, 2025) includes all twelve Community Mental Health Services Program (CMHSP) participants, SUD providers, and affiliated networks within MSHN's 21-county service region. The report summarizes activity results, trends, and analysis of the data.

COMPLIANCE REPORT HIGHLIGHTS

MSHN has a comprehensive compliance program focused on the MSHN Compliance Plan tasks and activities and recommendations related to the MSHN strategic plan, supported by findings and outcomes from internal and external monitoring and oversight site reviews, as well as contractual requirements and issues identified through the Customer Service and Compliance System. Some key areas of highlight for the FY25 Compliance Report include:

Recommendations

FY26: (*The following are new, or continued, recommendations that have been identified as potential areas of risk for non-compliance with established standards)*

- The MSHN Quality Assurance and Performance Improvement Managers, in coordination with the SUD treatment and provider staff, will provide an opportunity for one-on-one follow-up and additional training to providers, specific to findings from the previous oversight review, within six months from MSHN approval of provider plans of correction.
- Develop training opportunities, and compliance newsletter, to promote compliance with state and federal requirements.
- Grievance and Appeal report templates will be updated to ensure all required fields are being reported.
- Implement tracking mechanisms to monitor adherence to required timeframes for completion of standards related to grievances, appeals, and adverse benefit determinations.
- Develop practices/processes to ensure compliance with recommendations made during FY2025 Health Services Advisory Group reviews.

FY25: (The following are the FY2025 recommendations that were completed.)

- Identify additional region-wide data mining activities to detect possible deficiencies and/or non-compliance with established standards.
- Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies region wide.
- CMHSP standards: MSHN Behavioral Health team, and the corresponding workgroups, will address and identify ways in which the region can improve compliance in areas that are continually below the established standards or expectations.
- SUD Standards: MSHN will incorporate training topics into the Lunch and Learn training series provided quarterly to the provider network and focus on areas that fall below 80% compliance. This will be coordinated with the MSHN SUD Treatment team as they facilitate the training.
- MSHN will perform additional spot checks prior to submitting data to HSAG to ensure that the cases meet eligibility requirements.
- A causal/barrier analysis will be completed annually to ensure the barriers identified are reduced or eliminated, and to identify if any new barriers exist that require the development of interventions for both subgroups.

Internal Monitoring and Auditing

Community Mental Health Service Participants (CMHSP):

- **Performance:** (The following represent the overall compliance for all standards on each tool.)
  - DMC Tool: 90%
  - Clinical Chart: 93%

- Program Specific: 84%
- Provider Network: 85%
- BH TEDS Business Process: 88%

- **Strengths:**
  - Utilization of an evidence-based trauma screening tool.
  - Home-Based and ACT services are consistently delivered within the consumer's home and/or community.
  - Documenting multiple outreach attempts following missed appointments.
- **Quality Improvement Opportunities:**
  - Services are not provided as indicated in the Individual Plan of Service, and when services change, plans are not consistently updated.
  - Annual contract monitoring/quality assessments of the provider network are not completed annually as required.
  - Services are not consistently offered at the amount/scope/duration noted in individual plans of service

Substance Use Disorder (SUD): **(The following represent the overall compliance for all standards on each tool.)**

- **Performance:**
  - DMC Tool: 87%
  - Clinical Chart: 87%
  - Program Specific: 77%
  - Staff Training & Credentialing: 72%
- **Strengths:**
  - Outpatient providers consistently offer the required weekly hours of care.
  - Treatment plans include documentation of the intended evidence-based intervention(s).
- **Quality Improvement Opportunities:**
  - Progress notes do not consistently include an individual's progress towards meeting an identified goal and/or objective.
  - ASAM Continuums lack clinical summaries and justification for the recommended services/level of care.

Medicaid Event Verification (MEV):

- **Performance: (average score on 7 attributes reviewed)**
  - CMHSP: 96%
  - SUD: 94%
- **Strengths Identified:**
  - CMHSP: Improvement in 4 attributes
  - SUD: Improvement in 2 attributes
- **Quality Improvement Opportunities:**
  - Continue to monitor recommendations from previous quarters until their status is complete or satisfactory.

External Monitoring and Auditing (Health Services Advisory Group and MDHHS)

MDHHS - Waiver Review:

- ***Performance:*** MSHN was found to be compliant with implementation of corrective action.

HSAG - Performance Based Improvement Projects (PIP):

- **Performance:** MSHN continued implementation of two long-term Performance Improvement Projects focused on reducing racial and ethnic disparities in access and penetration rates for behavioral health services:
  - **PIP #1: Access Disparity Reduction**
    - Statistically significant improvement- the disparity between Black/African American and White populations was statistically eliminated ($p > .05$) in FY25 Remeasurement 3 (CY2025 YTD)
    - Demonstrates sustained positive regional impact of interventions implemented across CMHSPs.
  - **PIP #2: Penetration Rate Disparity Reduction**
    - The disparity was reduced from 2.06% (CY21) to 1.51% (CY25 YTD), showing continuous narrowing of the gap, though not yet fully eliminated
- **Next Steps (FY26):** Continue current interventions through Remeasurement Period 3 (CY2025) and maintain focus on data-driven equity improvements in FY26.

HSAG - Performance Measurement Validation Review:

- **Performance:**
  - Data Integration and Control- Thirteen Standards: 100%
  - Denominator Validation - Seven Standards (2 NA): 100%
  - Numerator Validation – Five Standards: 100%
  - Performance Measures- Fourteen Measures (1 NA) Fully Validated: 100%
- **Recommendations:**
  - Perform increased spot checks on data before submitting data to HSAG.
  - Continue with its improvement efforts related to indicator #2.

HSAG - Network Adequacy Verification Review:

- **Performance:**
  - Met the time/distance standards for adult services reviewed
  - Did not meet the time/distance standards for one pediatric service reviewed
- **Next Steps (FY26):**
  - MDHHS will follow up with PIHPs to address network gaps and areas of improvement.

HSAG – Compliance Monitoring Review:

- **Performance:**
  - Overall compliance score of 90% on the eight standards reviewed.
- **Recommendations:**
  - Implement mechanisms to monitor adherence to grievance and appeals by reviewing periodic reports on acknowledgement turnaround times.
  - Enhance meeting minutes to capture Governing Board discussion and feedback on the QAPIP description, work plan activities, evaluation, and progress reports.

HSAG – Encounter Data Validation Review:

- **Performance:**
  - There were no notable issues identified with the record omission and surplus rates for MSHN's institutional and professional encounters.
- **Key Findings:**
  - Institutional Encounters: Nearly all key data elements had omission rates below 2.5 percent, indicating that, for all records with values present in MSHN's data files, the same values were also mostly present in MDHHS' submitted data files.
  - Institutional Encounters: All but one data element had surplus rates of 0.0 percent, indicating that, for all records with values present in MDHHS' data files, the same values were also present in MSHN's submitted data files.
  - Professional Encounters: The majority of key data elements had omission rates of 0.0 percent, indicating that for all records with values present in MSHN's data files, these key data element values were also present in MDHHS' submitted data files.

Customer Service

- **Performance:** The total number of Customer Services contacts received in FY2025 was 193, a 67.8% increase from FY2024. By comparison, there were 115 contacts in FY2024.
- **Activities Implemented:**
  - The MSHN Adverse Benefit Determination (ABD) Technical Guide was updated with expanded information to assist provider staff in meeting the ABD requirements.
  - The quarterly Appeal and Grievance Regional Analysis Report was utilized to evaluate the quarterly MDHHS Grievance and Appeal data for regional trends and quality improvement.
- **Recommendations:**
  - FY25 Customer Service data did not identify systemic issues but identified issues at the individual provider level. Quality improvement initiatives will occur during the Customer Service Committee, utilizing the quarterly Appeal and Grievance Regional Analysis Report to support provider compliance.

Compliance

- **Performance:** The total number of compliance investigations completed by the MSHN Compliance Officer in FY2025 was 33. By comparison, there were 32 completed in FY2024. This resulted in an increase of 3.13% in FY2025 from FY2024.
- **Office of Inspector General (OIG) Quarterly Report:**
  - 205 activities were reported during FY2025
  - 144 activities were closed during FY2025
  - Overpayments requiring adjustments totaled $638,990.33.
- **Data Mining Activities:**
  - Death Data Report: Compares the death list from Care Connect 360 to service data from MSHN's information management system. There should be no instance where a service is provided to a recipient after the date of death.
  - Results: FY25 included 71 unique individuals, accounting for 704 encounters. There were no instances where a date of service was reported after the date of death.
- **Trends:**
  - The number of referrals from the OIG for allegations of fraud, waste and abuse continue to increase each year, showing a potential for increasing oversight by the OIG for the behavioral health system.
- **Subpoenas:**
  - MSHN received 3 (three) subpoenas during FY2025 requesting records. MHSN did have records for 2 (two) of the cases and those records were provided as signed releases were provided.
- **Notification of Breach(s):**
  - There were 6 (six) instances reported involving a breach of protected health information. Out of the instances, 1 (one) was reported from a Substance Use Provider, 4 (four) were reported from CMHSPs and 1 (one) was reported by MSHN staff.
- **Activities Implemented:**
  - Tested compliance software and made recommendations for revisions/updates to forms and process
  - Trained CMHSP staff in the use of the compliance software
  - Operationalized updates/revisions to Office of Inspector General (OIG) quarterly report and fraud referral process
  - Development of process for reporting OIG monthly overpayment report
  - Revised Privacy Notice to include changes in federal requirements
- **Recommendations:**
  - Continue to explore and identify additional region wide data mining activities to detect possible deficiencies and/or non-compliance with established standards.
  - Expand communication to MSHN staff and provider network by utilizing Constant Contact, emails, webpage and other communication means for compliance related updates for providers including trends and quality improvement efforts.
  - Develop reports that can be used to extract data from the compliance software to identify trends and quality improvement efforts.
  - Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies.

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Mid-State Health Network

Annual Compliance Report FY2025

(October 01, 2024 – September 30, 2025)

Prepared by Chief Compliance and Quality Officer & Compliance Administrator: Nov/Dec 2025
Reviewed and Approved by MSHN Compliance Committee: January 7, 2026
Reviewed by Regional Compliance Committee: January 16, 2026
Reviewed by MSHN Leadership:
Reviewed by MSHN Operations Council:
Reviewed and Approved by MSHN Board:

Table of Contents

Purpose

The Compliance Summary Report provides an overview of the effectiveness of activities performed throughout Fiscal Year 2025 as part of the MSHN Compliance Program and identified within the MSHN Compliance Plan. Those activities include internal and external monitoring and oversight reviews; customer service complaints; compliance investigations and compliance related training and review.

Each section includes an overview of activity results, trends, and analysis of the data. Recommendations for areas of quality improvement for the upcoming year are identified.

Recommendations

Recommendation focus areas are identified from the MSHN Compliance Plan tasks and activities related to the MSHN strategic plan, supported by findings and outcomes from internal and external monitoring and oversight site reviews, as well as contractual requirements and issues identified through the Customer Service and Compliance System.

Fiscal Year 2026

The following are new, or continued, recommendations that have been identified as potential areas of risk for non-compliance with established standards.

Note: If an established process for monitoring and oversight already exists, and a deficiency is noted, recommendations are not made to avoid duplication of efforts.

Area of Risk: Substance Use Disorder (SUD) providers' implementation of plans of correction resulting from MSHN oversight monitoring, related to staffing turnover and staffing shortages within the provider agencies.

> *Recommendation: The MSHN Quality Assurance and Performance Improvement Managers, in coordination with the SUD treatment and provider staff, will provide an opportunity for one-on-one follow-up and additional training to providers, specific to findings from the previous oversight review, within six months from MSHN approval of provider plans of correction.*
>
> *Lead Staff:* Amy Dillon, Compliance Administrator

Area of Risk: Compliance with established Compliance and Program Integrity related standards for MSHN staff and the provider network.

> *Recommendation*: Develop training opportunities, and compliance newsletter, to promote compliance with state and federal requirements.
>
> *Lead Staff:* Kim Zimmerman, Chief Compliance and Quality Officer

Area of Risk: Compliance with Customer Service Standards

Recommendation: Grievance and Appeal report templates will be updated to ensure all required fields are being reported. This includes tracking of oral and written notice of extensions.

Recommendation: MSHN will implement tracking mechanisms to monitor adherence to required timeframes for completion of standards related to grievances, appeals, and adverse benefit determinations.

Lead Staff: Dan Dedloff, Customer Service and Rights Manager

Area of Risk: Compliance with external site review recommendations.

Recommendation: Develop practices/processes to ensure compliance with recommendations made during FY2025 Health Services Advisory Group reviews.

Lead Staff: Amy Dillon, Compliance Administrator

FISCAL YEAR 2025

The following is a status update on the FY2025 areas of risk and progress made toward implementing the recommendations. Any recommendations that did not have a status of "complete" have been moved to the FY2026 Recommendations section for continuation.

Area of Risk: Compliance with established Compliance and Program Integrity related standards.

Recommendation: Identify additional region-wide data mining activities to detect possible deficiencies and/or non-compliance with established standards.

Status: Complete
Data mining activities have been explored with the Chief Information Officer and the MSHN Compliance Committee. One potential option identified was reviewing the H2016 code for any duplication of services. Prior to MSHN implementing this data mining activity, the Office of Inspector General (OIG) completed a data mining activity in August 2025 involving the H2016 code and shared the results with MSHN. The OIG identified 24 records that had potential for double billing of this code. MSHN investigated each of these records and determined that there were no cases where double billing occurred, but rather the issues were related to voids being rejected or not properly submitted. All issues were corrected. The Chief Compliance and Quality Officer has continued to have a dialog with other PIHPs as to what data mining activities they are completing. At this time, MSHN will continue to explore options for any areas determined to be at risk for new data mining for FY2026 but will not continue this as a formal recommendation.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Recommendation: Develop training opportunities to promote compliance with state and federal requirements.

Status: Not Complete
Training opportunities have continued to be explored with the Regional Compliance Committee and the PIHP Compliance Officers workgroup. The RELIAS training was not updated last year but will be reviewed by both the PIHP Compliance Officer Workgroup as well as the Regional Compliance Committee for any needed revisions. MSHN will also be utilizing a new compliance

software for FY2026 that will provide training and education options for compliance activities and a request has been made to the OIG to provide more regular training opportunities in areas such as completing and investigation. This will continue to be explored during FY2026.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Area of Risk: Compliance with established Program Integrity related standards.

Recommendation: Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies region wide.

Status: Complete
This has been an ongoing discussion during the Regional Compliance Committee meetings. Each CMHSP has methods for looking at risk locally. MSHN completed a risk assessment utilizing the Department of Justice Evaluation of Compliance Program tool during FY2023/2024. While there were areas noted for improvement, there were not areas noted as out of compliance. MSHN will review this again during FY2026 to determine if another risk assessment should be completed. MSHN is also utilizing a new compliance software for FY2026 that will provide data region wide on compliance activities and provide an opportunity to trend and analysis data for quality improvement.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Area of Risk: Delegated Managed Care Reviews

Recommendation: CMHSP standards: MSHN Behavioral Health team, and the corresponding workgroups, will address and identify ways in which the region can improve compliance in areas that are continually below the established standards or expectations.

Status: Complete
While efforts are anticipated to continue, MSHN and CMH staff have made significant strides toward identifying areas for improvement and strengthening compliance. In addition to discussions with Waiver Workgroups, the Behavioral Health team provided newly required HCBS training and opportunities to discuss changing policies and procedures related to waivers, qualifications, and the Autism program. The MSHN QAPI team also provided training and technical assistance with CMH staff during FY25 Delegated Managed Care Reviews.

Recommendation: SUD Standards: MSHN will incorporate training topics into the Lunch and Learn training series provided quarterly to the provider network and focus on areas that fall below 80% compliance. This will be coordinated with the MSHN SUD Treatment team as they facilitate the training.

Status: Complete
The MSHN SUD Treatment team has continued to conduct monthly Lunch and Learn trainings on a variety of topics, including those suggested by the QAPI team based on compliance review results. The QAPI team has also implemented individual, optional provider training during reviews and 6 months after each review.

Lead Staff: Amy Dillon, Compliance Administrator

Area of Risk: Compliance with external quality review requirements (Health Services Advisory Group (HSAG – Performance Measure Validation Review and Performance Improvement Project)

Recommendation: MSHN will perform additional spot checks prior to submitting data to HSAG to ensure that the cases meet eligibility requirements.

Status: *Complete but ongoing.*
MSHN has implemented ongoing quarterly sampling and validation of member-level detail files to ensure accurate reporting of indicator compliance, population designation, and Medicaid eligibility across all performance indicators. Programming updates were completed in 2025 in MSHN's electronic medical record to flag non-Medicaid individuals being submitted by a provider so they can be removed prior to submission to MDHHS. Reminders were provided to the Quality Improvement Council (QIC) on appropriate documentation and coding of performance indicators and discussions are ongoing relating to interventions being implemented for indicators 2, 3, and 4a. MSHN continues to monitor these interventions and sampling validation through quarterly reviews and oversight at the QIC to ensure consistency and sustainability.

Recommendation: A causal/barrier analysis will be completed annually to ensure the barriers identified are reduced or eliminated, and to identify if any new barriers exist that require the development of interventions for both subgroups. The effectiveness of each intervention will be evaluated to determine if the interventions will continue, be revised, or discontinued based on the data reviewed.

Status: *Complete*
MSHN undertook a comprehensive review of its Performance Improvement Projects to ensure alignment with state-defined goals and to better understand the root causes behind the lack of statistically significant improvements. As part of this effort, MSHN revisited the causal/barrier analysis with input from the Quality Improvement Council to revise/update this in 2025. In addition to this, MSHN engaged a contractor to conduct a comprehensive analysis of interventions being implemented. This analysis assessed the effectiveness of current strategies, identified gaps, and provided recommendations for adjustments. Based on these findings, MSHN refined its causal/barrier analysis and updated the intervention work plan to better address performance challenges, with ongoing monitoring incorporated into the overall project structure.

Lead Staff: Kara Laferty, Quality Manager

Internal Monitoring and Auditing

MSHN conducts annual provider network monitoring. Any findings identified require the provider to submit a plan of correction. MSHN then conducts follow-up reviews to ensure that the plans of correction were implemented and that our provider network is compliant with federal and state guidelines, rules, requirements, and laws. The following is a snapshot of the site review results for both the Community Mental Health Service Providers (CMHSP) and the Substance Use Disorder (SUD) Providers.

CMHSP Provider Delegated Managed Care Reviews

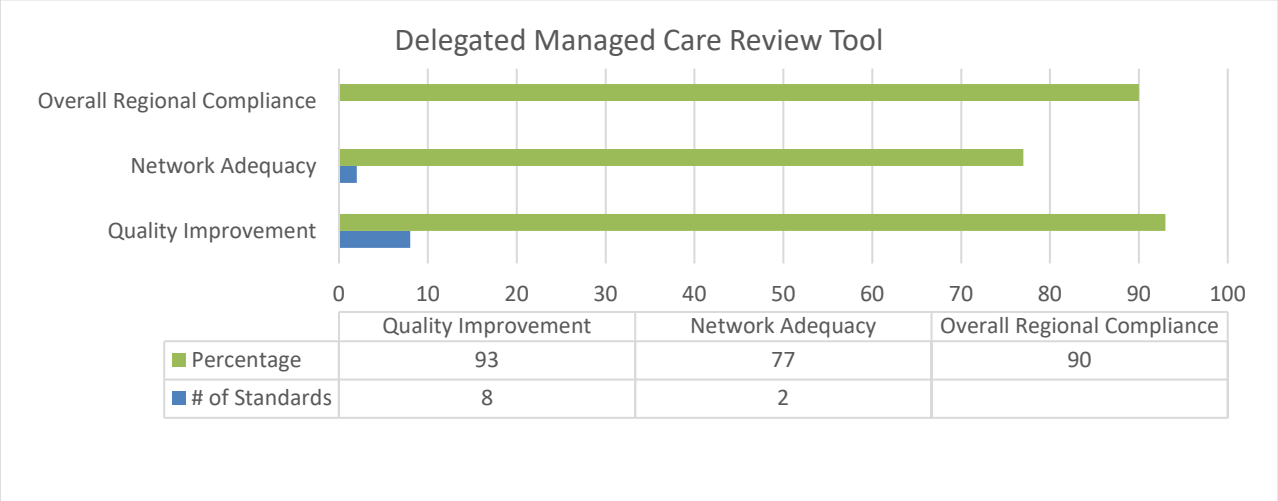
With the support and approval of the CMH Quality Improvement Council and Operations Council, MSHN modified the Delegated Managed Care Review process, effective in FY24. The new process covers all required review sections, but rather than reviewing them all in one year, the reviews are conducted on a three-year cycle. MSHN has aligned Delegated Managed Care reviews with external reviews (i.e., MDHHS, HSAG) when possible, which typically require CMHs to provide duplicate documentation for each review. These changes were implemented to enhance efficiency, minimize duplication, and streamline the review process for MSHN and CMHs. MSHN also changed the review cycle from calendar year to fiscal year.

FY25 was Year 2 of the MSHN 3-year review cycle. MSHN reviewed areas of Quality Improvement, Provider Network, BH-TEDS, and program and chart reviews for Autism, Assertive Community Treatment (ACT), Home-

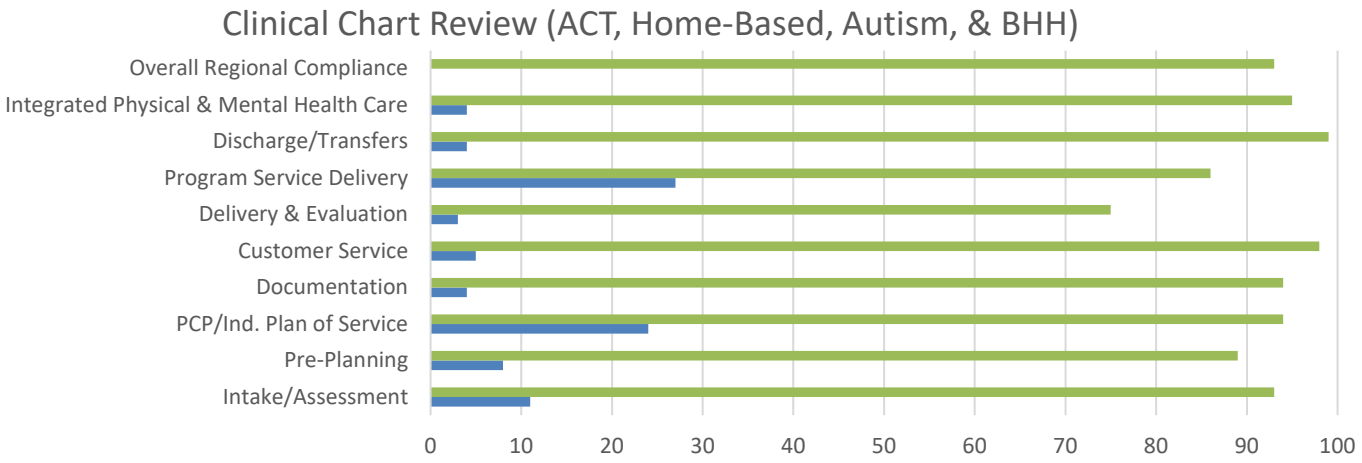
Based Services, and Behavioral Health Homes (BHH). Reviews were conducted for nine (9) of the twelve (12) CMHs in the MSHN region: Montcalm Care Network, Tuscola Behavioral Health System, The Right Door for Hope Recovery and Wellness, Gratiot Integrated Health Network, LifeWays, Shiawassee Health and Wellness, Newaygo CMH, CMH for Central Michigan, and Community Mental Health for Clinton, Eaton, and Ingham Counties.

Results

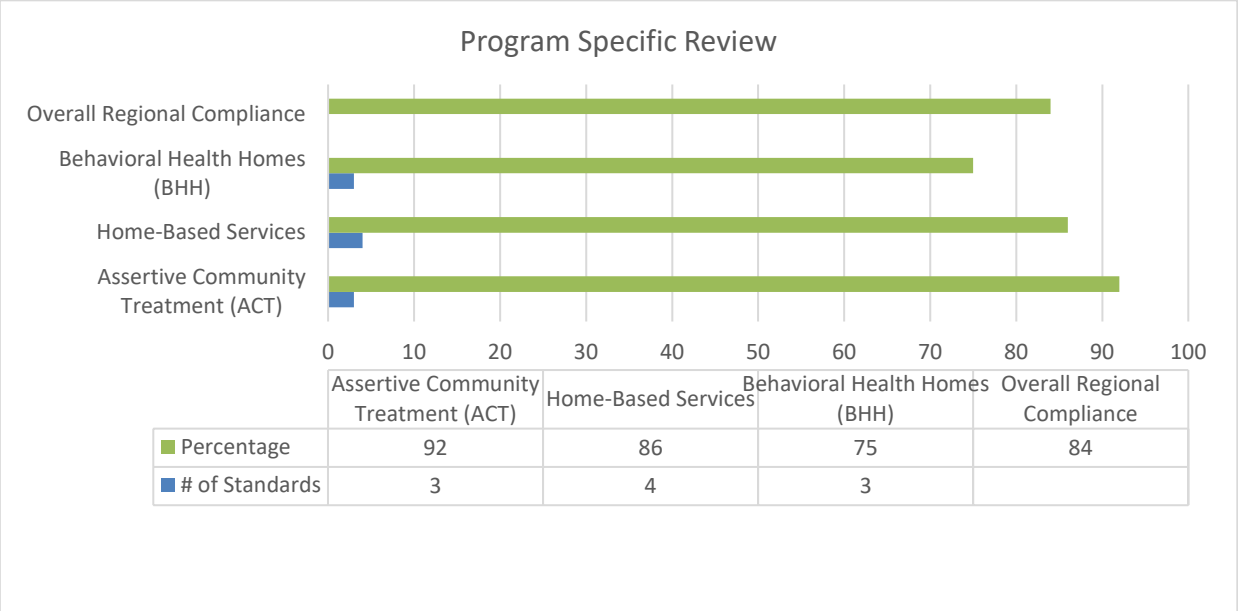
Six (6) different review tools were used to conduct the reviews. Below is a summary of scores by each review tool. The tables below show the cumulative results of each review tool.



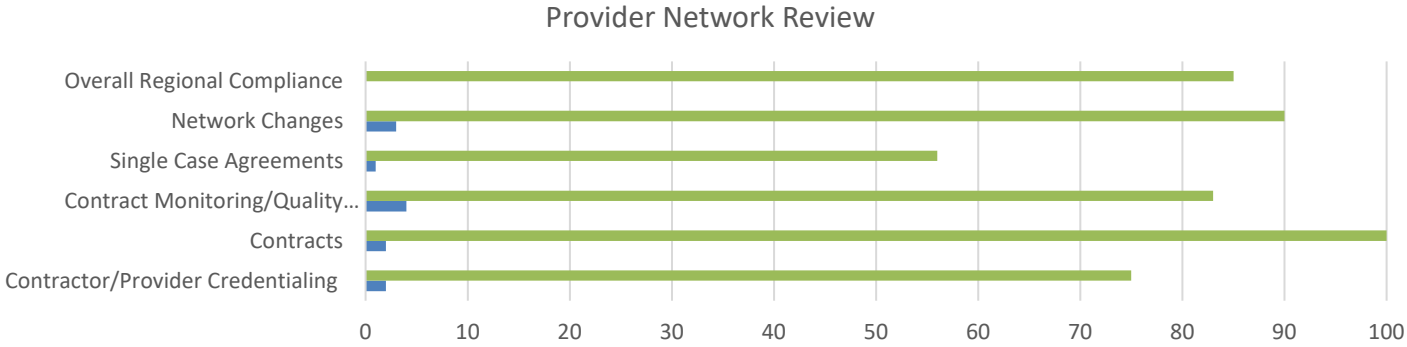
	Quality Improvement	Network Adequacy	Overall Regional Compliance
Percentage	93	77	90
# of Standards	8	2	



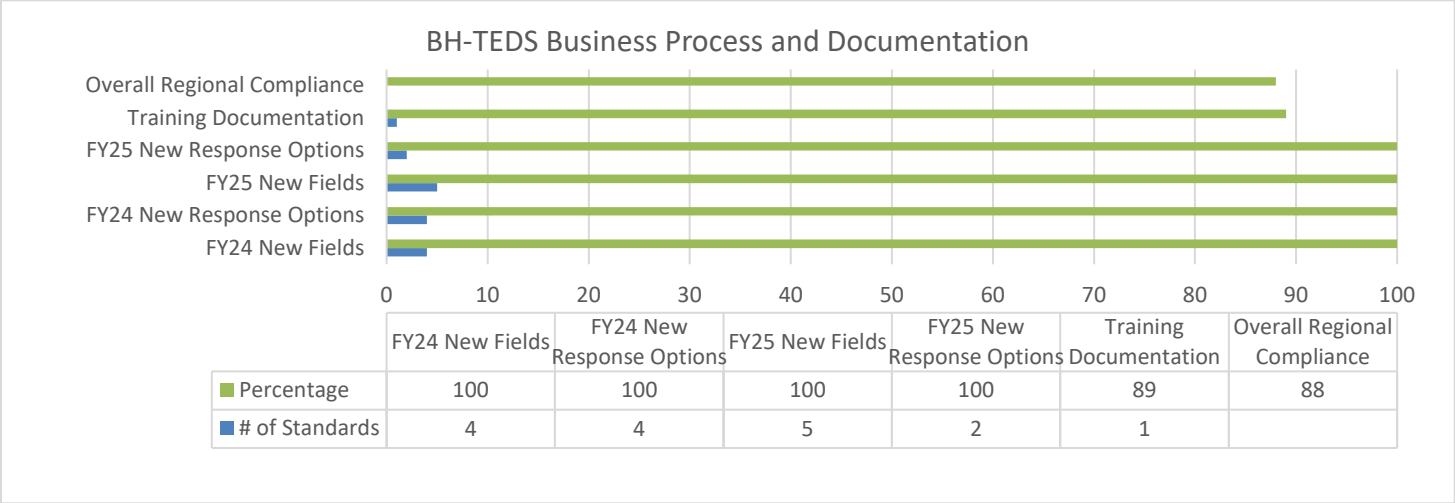
	Intake/Assessment	Pre-Planning	PCP/Ind. Plan of Service	Documentation	Customer Service	Delivery & Evaluation	Program Service Delivery	Discharge/ Transfers	Integrated Physical & Mental Health Care	Overall Regional Compliance
Percentage	93	89	94	94	98	75	86	99	95	93
# of Standards	11	8	24	4	5	3	27	4	4	



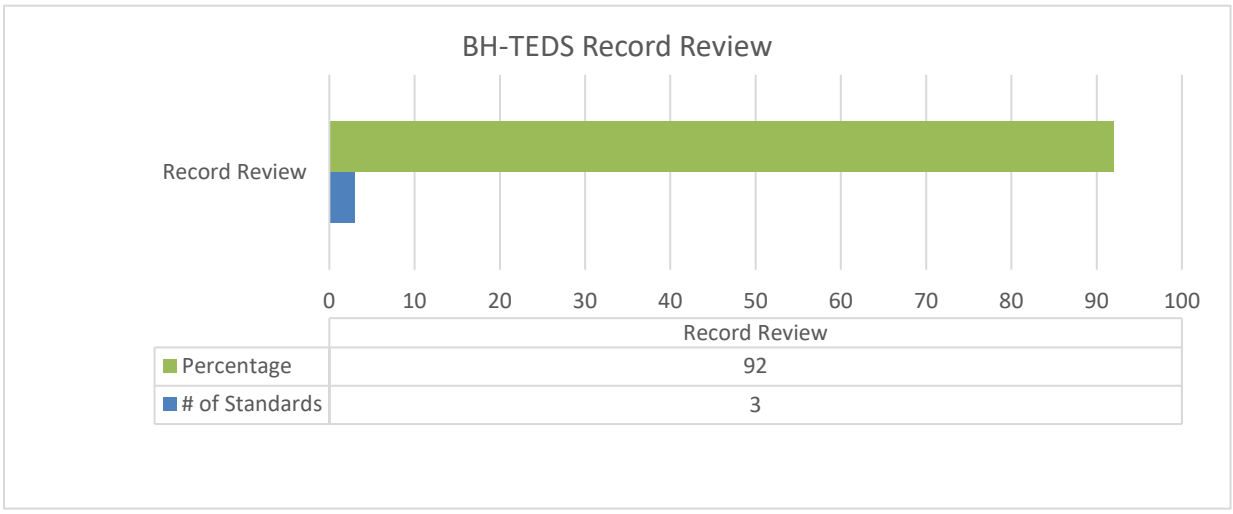
	Assertive Community Treatment (ACT)	Home-Based Services	Behavioral Health Homes (BHH)	Overall Regional Compliance
Percentage	92	86	75	84
# of Standards	3	4	3	



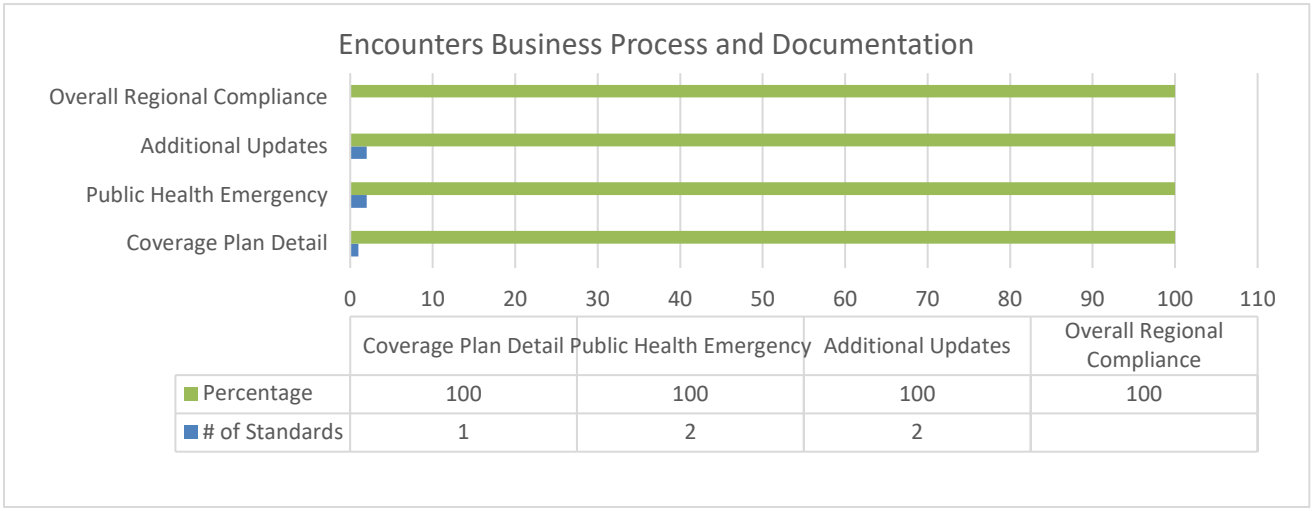
	Contractor/Provider Credentialing	Contracts	Contract Monitoring/Quality Assessments	Single Case Agreements	Network Changes	Overall Regional Compliance
Percentage	75	100	83	56	90	85
# of Standards	2	2	4	1	3	



	FY24 New Fields	FY24 New Response Options	FY25 New Fields	FY25 New Response Options	Training Documentation	Overall Regional Compliance
Percentage	100	100	100	100	89	88
# of Standards	4	4	5	2	1	



	Record Review
Percentage	92
# of Standards	3



	Coverage Plan Detail	Public Health Emergency	Additional Updates	Overall Regional Compliance
Percentage	100	100	100	100
# of Standards	1	2	2	

Strengths

- CMHSPs utilize an evidence-based trauma screening tool.
- CMHSP Home-based and ACT services are consistently delivered within the consumer's home and/or community.
- CMHSPs are documenting multiple outreach attempts following missed appointments.

Improvement/Recommendations

- Services are not provided as indicated in the Individual Plan of Service, and when services change, plans are not consistently updated
- Consumers in home-based services do not consistently receive 4 hours of service each month.
- Annual contract monitoring/quality assessments of the provider network are not completed annually as required.
- Single Case Agreements do not include all required elements.
- Services are not consistently offered at the amount/scope/duration noted in individual plans of service.

Substance Use Disorder Service Provider Delegated Function Reviews

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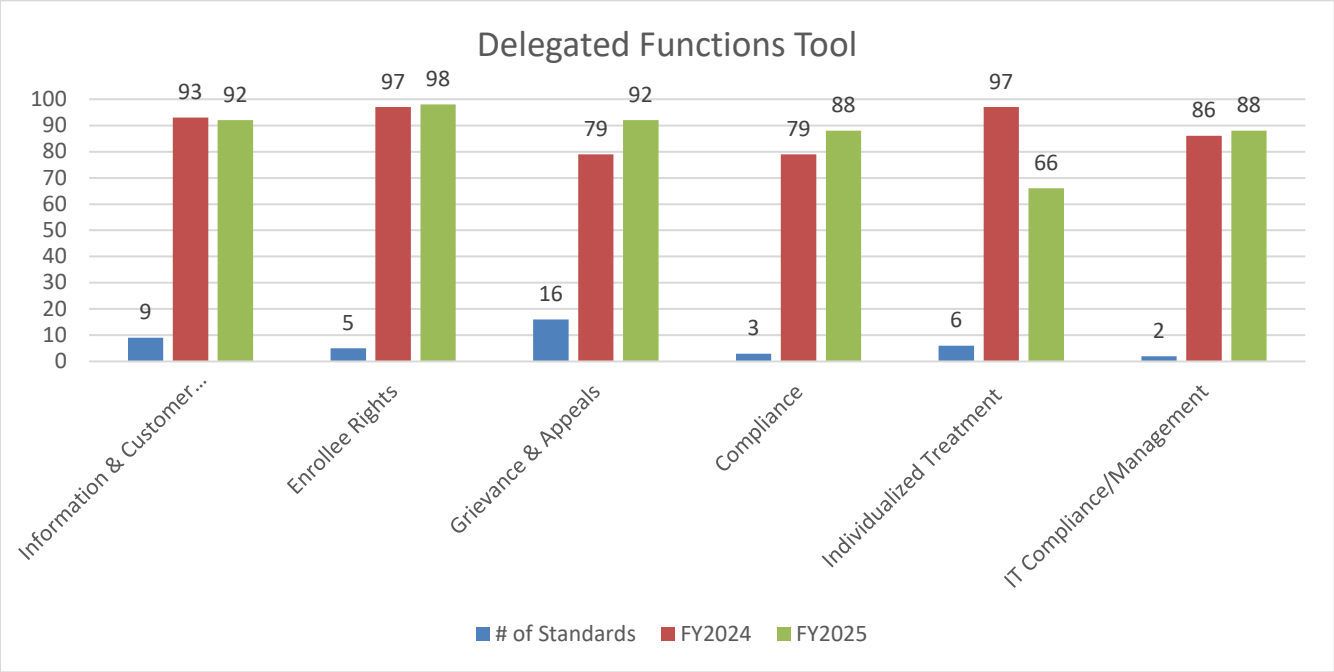
During FY2025, both full and interim reviews were completed. The interim reviews are conducted to ensure compliance and implementation of approved corrective action plans for findings identified in the previous review. Interim reviews do not receive a score; rather, they are determined to be compliant or non-compliant. Full reviews encompass chart reviews, validation of process requirements, review of staff files, and verification of policies and procedures. For providers outside the MSHN region, MSHN honors the monitoring and auditing conducted by the PIHP for the area where the providers are located. To ensure statewide reciprocity and efficiency, MSHN reviews include standards established by a statewide workgroup.

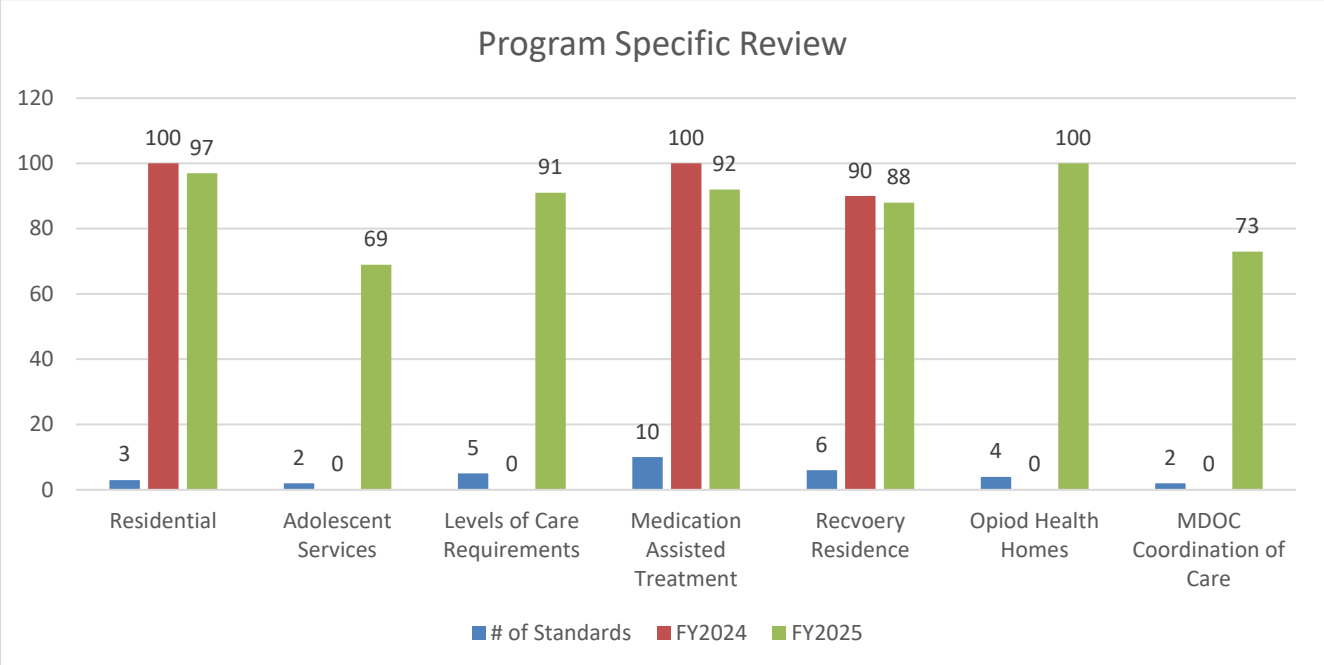
MSHN conducted thirteen (13) full reviews and 7 (seven) interim reviews throughout FY25.

Results

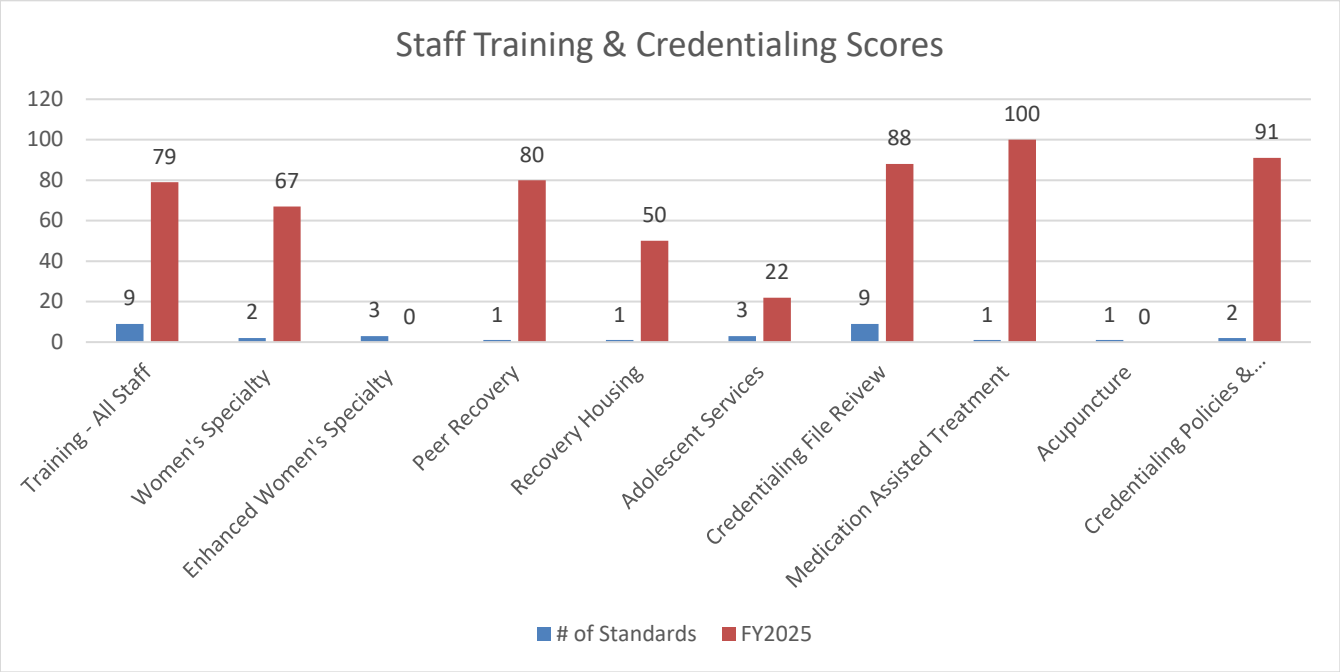
Four (4) different review tools were used to conduct the reviews. Below is a summary of scores by each review tool. The tables below show the cumulative results of each review tool.



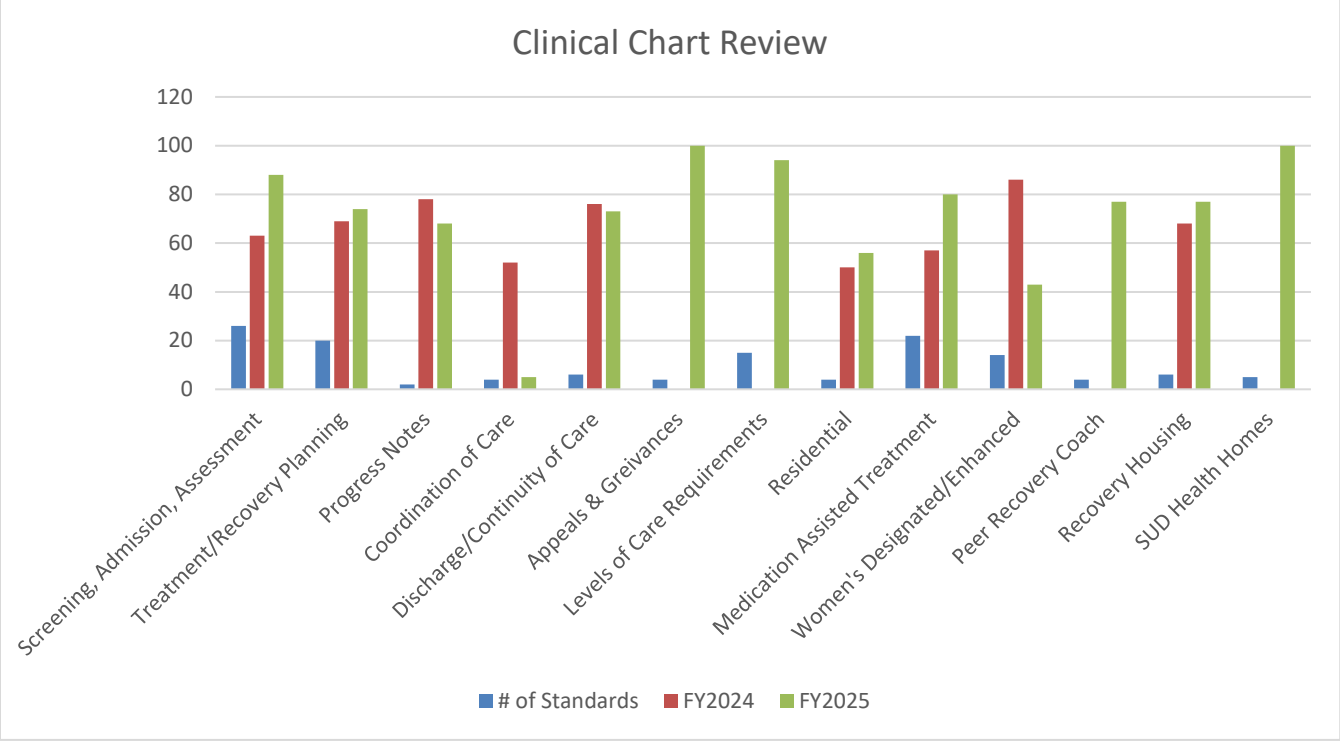
**The number of standards varies from year to year based on requirements.*



**All sections reviewed do not apply to all providers. The number of standards varies from year to year, depending on the requirements. "0" means the section was not reviewed. This does not mean that the standards in the section were not reviewed in previous years; rather, they were reviewed in other sections of the review tools and were not individually scored as their own section.*



**All sections reviewed do not apply to all providers. The number of standards varies from year to year, depending on the requirements. These sections were not reviewed during FY24 so there is no comparison in standards.*



**All sections reviewed do not apply to all providers. The number of standards varies from year to year, depending on the requirements. "0" means the section was not reviewed. This does not mean that the standards in the section were not reviewed in previous years; rather, they were reviewed in other sections of the review tools and were not individually scored as their own section in FY24.*

Strengths

- SUD providers are consistently utilizing an evidence based trauma screening tool.
- Treatment plans include documentation of the intended evidence based intervention(s) such as Cognitive Behavioral Therapy.
- Outpatient providers consistently offer the required weekly hours of care.

Improvement/Recommendations

- Progress notes do not consistently include an individual's progress towards meeting an identified goal and/or objective.
- ASAM Continuums lack clinical summaries and justification for the recommended services/level of care.
- Charts lack evidence that the consumer was informed of, or included, any chosen natural/community/professional supports in the treatment/recovery process.
- Adolescent service providers are not completing the required training.

Medicaid Event Verification Site Reviews

To ensure compliance with federal and state regulations, MSHN conducts oversight of the Medicaid, Healthy Michigan Plan, and Block Grant claims/encounters submitted within the Provider Network. This is accomplished by completing Medicaid Event Verification (MEV) reviews of claims/encounters submitted for services provided for all twelve (12) Community Mental Health Service Providers (CMHSPs) and substance use disorder (SUD) treatment providers who serve within the MSHN region.

The Medicaid Event Verification review involves a claims test that tests 7 (seven) attributes. The attributes tested are as follows:

A.) Code is an allowable service code under the contract
B.) Beneficiary is eligible on the date of service
C.) Service is included in the beneficiary's individual plan of service/treatment plan
D.) Documentation of the service agrees to the claim date and time of service
E.) Documentation of the service provided falls within the scope of the service code billed
F.) Amount billed/paid does not exceed contractually agreed upon amount
G.) Modifiers are used in accordance with the HCPCS/MDHHS guidelines

The following is a summary of MEV reviews conducted in Fiscal Year 2025. During Q4 of FY2025, twelve (12) Medicaid Event Verification (MEV) reviews were completed. Of those, six (6) were for CMHSPs and six (6) were for SUD treatment providers.

CMHSP Results

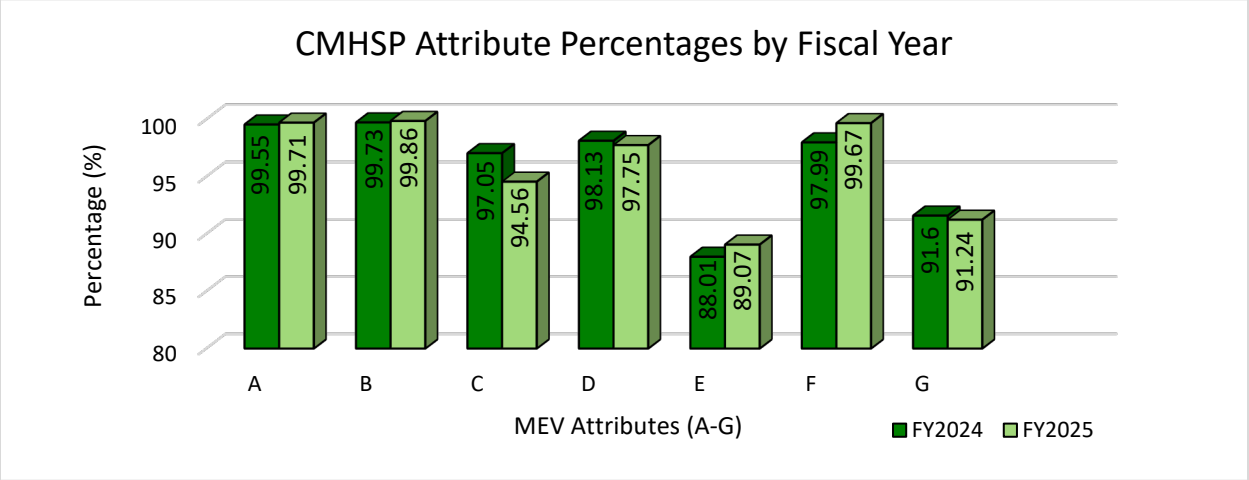
CMHSP MEV reviews are conducted bi-annually (twice a year). The table below includes the score per CMHSP for all attributes reviewed. Data presented in the table below is relative to all twelve (12) CMHSPs who had reviews completed in FY25 (Q1-Q4) and includes data for both reviews for the full fiscal year, October 1, 2024 – September 30, 2025.

The CMHSP MEV reviews completed in Q4 were for Bay-Arenac Behavioral Health Authority, Gratiot Integrated Health Network, Huron Behavioral Health, LifeWays, Saginaw County Community Mental Health Authority, and Shiawassee Health and Wellness.

CMHSP	A	B	C	D	E	F	G
BABHA	100%	100%	100%	98.36%	86.31%	100%	96.14%
CEI	100%	100%	87.25%	96.34%	94.30%	100%	94.66%
CMHCM	100%	100%	97.91%	97.18%	86.30%	96.99%	75.84%
Gratiot	100%	100%	100%	96.3%	92.54%	100%	93.59%
Huron*	97.74%	99.59%	94.43%	99.34%	85.55%	100%	93.09%
Lifeways	99.82%	98.90%	94.99%	99.16%	92.11%	99.82%	87.77%
Montcalm	100%	100%	96.72%	96.72%	87.30%	100%	87.31%
Newaygo	100%	100%	97.84%	99.41%	86.53%	100%	96.13%
Saginaw	100%	100%	88.37%	96.07%	89.69%	99.85%	90.05%
Shiawassee	100%	100%	93.90%	99.34%	89.69%	99.18%	88.04%
The Right Door	100%	100%	99.18%	98.78%	92.49%	100%	92.67%
Tuscola	100%	100%	96.46%	95.17%	87.75%	100%	98.63%
MSHN Average*	**99.71%**	**99.86%**	**94.56%**	**97.75%**	**89.07%**	**99.67%**	**91.24%**

**Note: Each CMHSP is typically reviewed twice during the fiscal year. The percentages in this table represent the average of those reviews for each CMHSP. An exception is Huron, which includes three reviews this time, as its FY2024 Q4 review was conducted in FY2025 Q1. Because this table displays equal-weighted averages per CMHSP (i.e., each CMHSP counts once regardless of how many reviews were completed), the "MSHN Average" row does not represent an average of the table rows above. Instead, the MSHN Average is calculated using all individual reviews conducted (25 total reviews across 12 CMHSPs) to provide a weighted average that reflects the full scope of FY2025 audit activity.*

The following chart provides a comparison from FY2024 through FY2025 for the attributes tested:



SUD Results

SUD MEV reviews are conducted annually. The data presented in the table below is relative to the SUD providers who had reviews completed in FY25 (Q1-Q4) and includes review data for all twenty-three (23) SUD providers for the full fiscal year, October 1, 2024 – September 30, 2025.

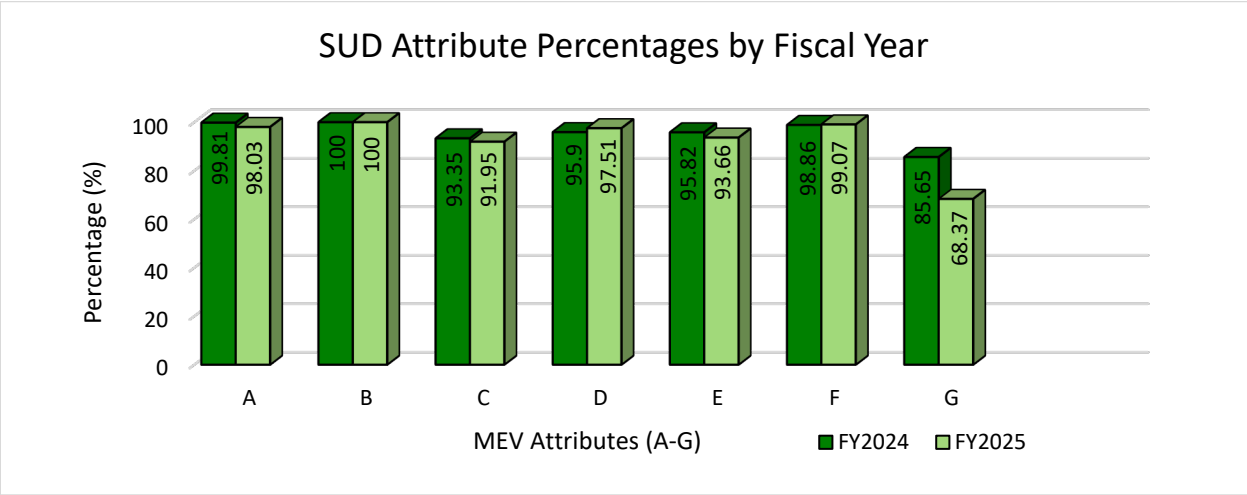
The SUD MEV reviews completed in Q4 were for Arbor Circle Counseling, Cristo Rey Community Center, Dot Caring Centers, Family Services & Children's Aid, List Psychological Services, and Saginaw Odyssey House.

SUD	A	B	C	D	E	F	G
SUD Providers*	98.02%	100%	92.29%	98.99%	88.80%	98.61%	66.80%
MSHN Average*	98.03%	100%	91.95%	97.51%	93.66%	99.07%	68.37%

**Note: SUD provider reviews are conducted annually, with a different set of providers reviewed each quarter. The percentages on the top line reflect scores from the current quarter, while the second line shows the year-to-date (YTD) average of all SUD reviews completed during FY2025.*

**Note: Saginaw Odyssey House appears twice in this dataset - once for a review originally scheduled for FY2024 Q4 (but completed in FY2025 Q1), and once for its regularly scheduled FY2025 Q4 review. As a result, it is included once in the current quarter's data (top row) and twice in the cumulative data (bottom row). The MSHN Average is calculated using all individual reviews conducted (24 reviews across 23 providers) and reflects a weighted average that captures the full scope of FY2025 audit activity.*

The following chart provides a comparison from FY2024 through FY2025 for the attributes tested:



Trends

Overall, CMHSPs achieved an average valid claims score of 74.08% for reviews conducted in FY2025 Q4, while SUD providers averaged 56.23%. For the full fiscal year, the average scores were 77.75% for CMHSPs and 68.37% for SUD providers. Since the valid claims score is not an average of the tests (but the percentage of valid claims reviewed), it tends to trend low (even though individual attribute scores may be high). This score is calculated by taking the total number of valid claims divided by the total number of claims. (A claim is deemed "valid" if all attributes tested receive a "Y"/Yes rating.) For example, a review having 400 valid claims of 502 claims reviewed would score 79.68% for the Percentage of Valid Claims.

In FY2024, we began tracking an additional score in addition to the valid claim's percentage – the average of attributes tested. CMHSPs had an average attribute score of 95.22% in FY2025 Q4, while SUD providers averaged 91.93% during the same period. For the full fiscal year, the average attribute scores were 95.98% for CMHSPs and 94.28% for SUD providers. We will continue to trend this data in addition to the usual valid claims score.

Regionally the CMHSPs have shown slight improvements from FY2024 to FY2025 for the following attributes:

1. A. The code is allowable service code under the contract
2. B. Beneficiary is eligible on the date of service
3. E. Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
4. F. Amount billed/paid does not exceed contractually agreed upon amount

These improvements may be attributed to an increased focus on improving the quality of documentation, improved staff training, ongoing monitoring and oversight, and increased education and technical assistance provided by the Medicaid Event Internal Auditor during the review process. Furthermore, MSHN has safeguards in place to guard against duplicate and incomplete claims being submitted.

Alternatively, the SUD providers have shown considerable improvements from FY2024 to FY2025.

1. D. Documentation of the service agrees to the claim date and time of service
2. F. Amount billed/paid does not exceed contractually agreed upon amount

This may be attributed to continued training and technical assistance provided by MSHN to the providers as part of the MEV site reviews. The SUD provider network is also improving their

understanding of the required supporting documentation to show compliance with the attributes.

External Monitoring and Auditing

The Michigan Department of Health and Human Services (MDHHS) requires periodic reviews to ensure compliance with state and federal regulations. The MDHHS Federal Compliance Department conducts the 1915(i) and 1915(c) waiver reviews. The MDHHS contracts with the Health Services Advisory Group, Inc. (HSAG) to serve as the External Quality Review Organization (EQRO) for Medicaid behavioral health programming.

MDHHS Waiver Review

MDHHS conducted an interim review of 1915(c) waivers, which include the Habilitation Supports Waiver (HSW), the Waiver for Children with Serious Emotional Disturbance (SEDW), and the Children's Waiver Program (CWP). The review also included the 1915i SPA (iSPA) waiver. The review focused on ensuring the implementation of approved plans of correction from the comprehensive evaluation conducted the previous year. The review was not scored; instead, it was determined to be compliant or non-compliant. MSHN was found to be compliant, and no further action was needed.

MDHHS – Health Services Advisory Group (HSAG): Performance Measurement Validation Review

Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA). State Medicaid agencies must ensure that performance measures reported by their managed care organizations (MCOs) are validated. The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements. HSAG completed MSHN's review remotely on July 2, 2025.

HSAG validated a set of performance indicators that were developed and selected by the Michigan Department of Health and Human Services (MDHHS). The review consisted of interviews, system demonstrations, review of data output files, verification of primary sources, observation of data processing, and review of data reports.
Compliance was assessed through a review of the following:

- Information Systems Capabilities Assessment Tool (ISCAT)
- Source Code (programming language) for performance indicators
- Performance Indicator reports
- Supporting documentation
- Evaluation of system compliance

The following is a summary of the PMV site review report. The full report is available on the MSHN website.

Results/Trends

MSHN received a status of "Reportable" indicating the performance indicators were compliant with the State's specifications and the rate can be reported.

- Data Integration and Control- Thirteen Standards: 100%
- Denominator Validation - Seven Standards (2 NA): 100%
- Numerator Validation – Five Standards: 100%
- Performance Measures- Fourteen Measures (1 NA) Fully Validated: 100%

Recommendations

Among the recommendations from this review were the following:

- HSAG recommends that MSHN perform increased spot checks on data before submitting data to HSAG.
- HSAG recommends that MSHN and CEI proceed with the outlined remediation plan. Additionally, HSAG recommends that CEI increase its sample size for cases reviewed each quarter for these performance indicators to improve the accuracy of the reported data and to ensure alignment with the reporting requirements. MSHN should also complete testing once the warning error is programmed in REMI to ensure that it is appropriately applied and captures non-Medicaid individuals as expected.
- Although MSHN confirmed that this was an isolated issue, HSAG recommends that MSHN perform increased spot checks on Bay-Arenac's indicator #1 reported data before submitting to HSAG. This should include performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements and that the appropriate times are captured. Additionally, HSAG recommends that MSHN continue to collaborate with the CMHSP to enhance existing processes or implement additional ones, as necessary, to improve the accuracy of indicator #1 data. Continued training or retraining with staff should be provided if necessary.
- HSAG recommends that MSHN and CEI proceed with the outlined remediation plan (T1020 procedure code issue). Additionally, HSAG recommends that CEI increase its sample size for cases reviewed each quarter for this performance indicator to enhance the accuracy of the reported data and ensure alignment with reporting requirements.
- HSAG recommends that MSHN continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 75th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

MDHHS – Health Services Advisory Group (HSAG): Network Adequacy Verification Review

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HSAG began conducting Network Adequacy Verification (NAV) reviews in fiscal year 2024. The review is an annual review. The focus of the review was to validate PIHP data as it applies to network adequacy indicators set by MDHHS for fiscal year 2025.

Results/Next Steps

MDHHS completed the time and distance and provider-to-enrollee ratio calculations for each region based on the submitted data provided by each PIHP. Below is a summary of the compiled results.

Adult Services

Service	Time/Distance Percentage Rate		Provider to Enrollee Ratio Met or Unmet
Assertive Community Treatment (1:30,000)			Met (1:19,006)
Crisis Residential Programs (16 Beds Per 500,000 Total Population)	96.1%	87.9%	Met (127:1,643,130)
Opioid Treatment Programs (1:35,000)	100%	99.5%	Met (1:12,008)
Psychosocial Rehabilitation Programs (1:45,000)	99.3%	93.8%	Met (1:38,011)
Inpatient Psychiatric Services	99.6%	94.9%	

*Time/Distance percentage rates above are based on the PIHP's overall percentages.

Pediatric Services

Service	Time/Distance Percentage Rate		Provider to Enrollee Ratio Met or Unmet	Baseline Data Results
Inpatient Psychiatric Services	86.1%	66%		
Crisis Residential Programs (8-12 Beds Per 500,000 Total Population)	50%	33%	Met (30:1,643,130)	
Home-Based Services (1:2,000)			Met (1:1,214)	
Wraparound (1:5,000)			Met (1:4,673)	
Intensive Crisis Stabilization				1:7,711
Respite Services				DCW Ratio 1:707 Beds 1:12,852
Parent Support Partner Services				1:10,281
Youth Peer Support Services				1:25,703

**MDHHS did not perform time/distance calculations on Home-Based, Wraparound, Parent Support Partner, and Youth Peer Support services due to variations in provider deployment procedures and service locations.

Timeliness

Service	Aggregate Average Percentage of enrollees starting services within 14 calendar days of assessment.	CMHSPs under 90%
Assertive Community Treatment	81.75%	BABH (57%) GIHN (not providing services) LifeWays (57%) MCN (not providing services) NCCMH (not providing services) SCCMH (50%) TRD (not providing services)
Home-Based Services	75%	BABH (61%) CMHCM (81%) CMHCEI (61%) GIHN (82%) HBH (70%) LifeWays (54%) MCN (78%) NCCMH (85%) SCCMH (80%) SHW (75%) TRD (80%)
Wraparound	77.5%	BABH (75%) CMHCM (77%) CMHCEI (64%) GIHN (67%) LifeWays (21%) NCCMH (75%) SCCMH (87%) TRD (64%

*Average percentages in red did not meet the 90% benchmark 42 CFR 438.68(e)(2)

Other

Aggregated Total percentage of reported providers accepting new enrollees	Aggregated Total percentage of providers with reported physical accessibility	Aggregated Total percentage of reported providers with cultural and linguistic capabilities
99.5%	99.5%	100%

American Society Addiction Medicine (ASAM) Level of Care (LOC)

Outpatient ASAM LOC	Residential ASAM LOC	Withdrawal Management ASAM LOC
2.5 (Only available outside of catchment area)	3.3 (Only available outside of catchment area) 3.7 (Only available outside of catchment area)	1.0 WM 2.0 WM

MDHHS will follow up with PIHPs to address network gaps and areas of improvement needed.

MDHHS – Health Services Advisory Group (HSAG): Compliance Monitoring Review

HSAG conducts the Compliance review over a period of three (3) years and includes a review of thirteen (13) different standards. FY2025 was year one of the review cycle and included a review of eight (8) of the thirteen (13) standards. The review took place on June 6, 2025.

Results/Trends

The following is a summary of the Compliance Monitoring site review report. MSHN has submitted a plan of correction for findings identified. The full report is available on the MSHN website.

MSHN achieved an overall compliance score of 90%.

Standard II – Emergency and Post Stabilization Services: 100%
Standard VII – Provider Selection: 88%
Standard VIII- Confidentiality: 95%
Standard IX- Grievance and Appeal Systems: 79%
Standard X – Subcontractual Relationships and Delegation: 100%
Standard XI – Practice Guidelines: 100%
Standard XII – Health Information Systems: 78%
Standard XIII – Quality Assessment and Performance Improvement Program: 100%

HSAG made several recommendations throughout the report. Below is an abbreviated summary of some of the recommendations. In addition to implementing plans of correction, MSHN will consider recommendations when updating processes.

Standard II – Emergency and Post Stabilization Services

- Recommendation to update policy to include a list of services covered under the PIHP's scope of work (e.g., preadmission screening, crisis intervention) as the PIHP confirmed that these services do not require prior authorization and should be removed from the list of emergency services.
- Recommend policy update to add all federal provisions in elements 4-13, (recommending including verbatim to the federal rule) with an explanation of how the PIHP meets the intent of each requirement.
- HSAG recommends that the PIHP consult with MDHHS for further guidance related to the MMBPIS three-hour prescreen decision indicator in relation to the one-hour requirement for authorization of post-stabilization care services.

Standard VII – Provider Selection

- HSAG recommends that the PIHP have its credentialing committee members sign off on a nondiscrimination attestation to ensure an understanding of nondiscriminatory practices.
- HSAG strongly recommends that the PIHP consult with MDHHS on the appropriate mechanism to use to verify the provider has no malpractice lawsuits that resulted in conviction of criminal neglect or misconduct, settlements, and/or judgments within the last five years. HSAG further recommends that the PIHP develop and implement a clear policy and procedure to reflect the guidance provided by MDHHS.

Standard VII- Confidentiality

- Although the PIHP explained that most Health Insurance Portability and Accountability Act of 1996 (HIPAA)-related incidents and member rights requests under the HIPAA Privacy Rule are handled through delegated entities since these are the entities primarily serving members, HSAG continues to strongly recommend that the PIHP have detailed and comprehensive HIPAA-related policies, procedures, and training materials in place to support awareness of all confidentiality-related requirements under the HIPAA Privacy Rule and Michigan Mental Health Code, and ensure that the policies, procedures, and training materials outline the responsibilities of both the PIHP and its entities delegated to manage privacy and security incidents and member rights requests. Additionally, HSAG recommends that the PIHP enhance its *Delegated Functions Tool* to incorporate the PIHP's mechanisms, ensuring that all staff and delegated entities adhere to the member's privacy rights under the HIPAA Privacy Rule. Lastly, although the PIHP discussed expectations and monitoring processes for staff training, both upon hire and annually, HSAG strongly recommends that the PIHP document and track staff training as completed (e.g., by obtaining signed attestations and storing certifications).
- Although the PIHP required the use of the MDHHS-5515 Consent to Share Behavioral Health Information form, which included a section for members to confirm whether they received or declined a copy of the form, should the PIHP (or its delegates) obtain consent for disclosing PHI for reasons outlined in 45 CFR §164.508, HSAG strongly recommends that the PIHP (or its delegates) ensure it has an appropriate HIPAA authorization form available as well as a process outlined in a policy or procedure to further demonstrate that members are provided a copy of the signed authorization form as required under 45 CFR §164.508(c)(4). Additionally, HSAG continues to strongly recommend that the PIHP ensure its oversight process of its delegates includes a component to evaluate the procedures for providing each member with a copy of any signed authorization or consent form to ensure compliance with the requirements under this element (e.g., enhance its *Delegated Functions Tool*).

Standard IX – Grievance and Appeal Systems

- HSAG recommends that the PIHP implement mechanisms to monitor adherence to this requirement by reviewing periodic reports on acknowledgement turnaround times.
- The PIHP's system did not have a dedicated reportable field to track extensions and could only document an extension in the notes section of the module. While the PIHP had no grievance resolution time frame extensions, as it is a contractual requirement (for the PIHP to apply an extension and for members to request an extension), HSAG recommends that the PIHP enhance its system to track and report on the extension provisions.
- The PIHP's system did not have a dedicated reportable field to track oral and written notice of extensions and could only document extension notices in the notes section of the module. While the PIHP had no grievance resolution time frame extensions, as it is a contractual requirement (for the PIHP to apply an extension and for members to request an extension), HSAG recommends that the PIHP enhance its system to track and report on the extension provisions.
- While the *CS_Medicaid_Enrollee_Appeals_Grievances_Procedure* confirmed that an expedited appeal resolution would be granted when supported by the provider, a specific statement assuring that punitive action would not be taken against a provider who requests or supports a member's appeal was not located. HSAG recommends that the PIHP include this statement in its procedures and provider-facing materials, such as the provider manual.
- HSAG recommends that the PIHP enhances its mechanisms to ensure that the responsible decision-maker and the credentials of the decision-maker are clearly identified with each appeal record. Of note, the PIHP also received this recommendation during the SFY 2022 compliance review.

Standard X – Subcontractual Relationships and Delegation

- The PIHP confirmed that it had not revoked delegation for poor performance during the time period under review, but indicated that the PIHP would keep MDHHS involved in any discussions related to delegate non-compliance resulting in revocation of delegated responsibilities and would provide advanced notification to MDHHS as required. Therefore, the PIHP received a *Met* score for this element. However, as the reporting requirement was not documented within a policy or procedural document, HSAG strongly recommends that the PIHP include the 10-day advance notice to MDHHS reporting requirement in a policy and/or procedural document to ensure staff members are aware that MDHHS must be notified 10 business days in advance of issuing a notice of revocation to its delegate(s).

Standard XII – Health Information Systems

- Across all PIHPs, HSAG received conflicting information regarding whether disenrollment reasons/codes are provided to the PIHPs from MDHHS. HSAG recommends that all PIHPs consult with MDHHS regarding the disenrollment data being shared. If MDHHS provides disenrollment reasons to the PIHPs, HSAG strongly recommends that the PIHP ensure its information system has the capability to store these disenrollment reasons/codes.
- HSAG strongly recommends that the PIHP develop its own policies and procedures for its Patient Access API. Within these policies and procedures, the PIHP should include:
  - All Patient Access API federal provisions under 42 CFR §431.60 and any applicable cross-references.
  - A description of how the PIHP's API meets the intent of each federal provision.
  - A table that includes all USCDI data elements and a cross-reference to which data elements the PIHP has available within its system and the specific data fields that these data elements are being extracted from (and therefore accessible via the API).
  - A description of how the PIHP oversees PCE to ensure the Patient Access API meets all federal provisions, including timeliness requirements.
  - A description of how the PIHP incorporates a mechanism to conduct routine testing of the API.
  - All new requirements outlined under the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).

Standard XIII – Quality Assessment and Performance Improvement Program

- HSAG continues to recommend the PIHP enhance its meeting minutes to capture Governing Board discussion and feedback on the QAPIP description, work plan activities, evaluation, and progress reports. HSAG made this recommendation during the 2022 compliance review, which the PIHP did not fully address.
- HSAG continues to recommend that the PIHP develop a root cause analysis (RCA) template for all CMHSPs and SUD providers to use so the PIHP can ensure that all required components are included. HSAG made this recommendation during the 2022 compliance review, which the PIHP did not fully address.

MDHHS – Health Services Advisory Group (HSAG) – Encounter Data Validation Review

The FY25 EDV review was the third year of HSAG's three-year review cycle. The purpose of the review is to evaluate the extent to which encounters submitted by the PIHPs to MDHHS are complete and accurate by comparing data extracted from the PIHPs' and MDHHS's data systems. MDHHS and each PIHP extracted data from their systems in accordance with the exact specifications. For the PIHPs, the EDV study included institutional and professional encounter data. The following information was provided as part of a data discrepancy report for MSHN.

Record Completeness and Accuracy

There are two aspects of record completeness—record omission and record surplus:

- **Record omission**: A record is present in the PIHP's submitted data files for the study but is absent from MDHHS' data files.
- **Record surplus**: A record is present in MDHHS' data files but is absent from the PIHP's submitted data files.

The MDHHS encounter data is considered relatively complete when both record omission and record surplus rates are low. The following table displays the percentage of record omission and record surplus for the MSHN and MDHHS submissions, with **lower rates indicating better performance** across the institutional and professional encounter types.

Record Omission and Surplus

Encounter Type	Record Omission	Record Surplus
Institutional	0.0%	1.4%
Professional	0.0%	3.3%

There were no notable issues identified with the record omission and surplus rates for MSHN's institutional and professional encounters.

Institutional Encounters – Key Findings:

- Nearly all key data elements had omission rates below 2.5 percent, indicating that, for all records with values present in MSHN's data files, the same values were also mostly present in MDHHS' submitted data files. One exception was noted for the *Secondary Diagnosis Code(s)* data element, which had an omission rate of 10.1 percent.
- All but one data element had surplus rates of 0.0 percent, indicating that, for all records with values present in MDHHS' data files, the same values were also present in MSHN's submitted data files. The only exception was the *Discharge Date* data element, which had a surplus rate of 100 percent.
- The data element missing rates for the majority of evaluated key data elements were below 1.0 percent. Notable exceptions were observed for the *Secondary Diagnosis Code(s)* (31.6 percent) and *Procedure Code* (98.0 percent) data elements.
- For records that matched between the two data sources and had data element values populated in both sources, ten of the evaluated data elements showed high accuracy rates of 100 percent. However, four data elements showed lower accuracy: *Detail Service From Date* (84.4 percent), *Detail Service To Date* (84.4 percent), *Admission Date* (86.9 percent), *Secondary Diagnosis Code(s)* (69.0 percent)

Professional Encounters – Key Findings

- The majority of key data elements had omission rates of 0.0 percent, indicating that for all records with values present in MSHN's data files, these key data element values were also present in MDHHS' submitted data files. Exceptions were noted for: *Billing Provider NPI* (6.1 percent), *Rendering Provider NPI* (6.1 percent), *Service Provider Address* (7.2 percent), and *Secondary Diagnosis Code(s)* (32.9 percent).
- All data elements had surplus rates of 0.0 percent, indicating that for all records with values present in MDHHS' data files, the same values were also present in MSHN's submitted data files.
- The data element missing rates for majority of evaluated key data elements were 0.5 percent or less. Notable exceptions observed across both data sources included the *Service Provider Address* (82.0 percent), *Secondary Diagnosis Code(s)* (46.2 percent), and *Procedure Code Modifier(s)* (33.8 percent) data elements.
- For records that matched between the two data sources and had data element values populated in both sources, eleven of the evaluated data elements showed high accuracy rates exceeding 95.0 percent. However, three data elements showed lower accuracy: *Rendering Provider NPI* (46.8 percent), *Secondary Diagnosis Code(s)* (84.3 percent), and *Header Paid Amount* (94.0 percent).

Follow Up

An aggregated report for Michigan is expected to be sent directly to MDHHS. The report is typically posted to the

MDHHS website in March or April of the following year.

MDHHS – Health Services Advisory Group (HSAG) -Performance Improvement Project

MDHHS requires that the PIHP conduct and submit a Performance Improvement Project (PIP) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid consumers in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves. By assessing PIPs, HSAG assesses each PIHP's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients," according to the Code of Federal Regulations (CFR) at 42 CFR 438.364(a)(2).

MSHN's Performance Improvement Project for 2022 through 2025 is: *Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population without a decline in performance for the white population.* Please note that due to procurement efforts at MDHHS, they have extended the Performance Improvement Projects for another year, CY2025 will now be the third remeasurement period.

Data for the baseline and comparison remeasurement periods can be found in the table below:

Indicator 3: The percentage of new persons who are Black/African American or White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment								
Time Period	Indicator Measurement	White Numerator	White Denominator	Percentage	Black Numerator	Black Denominator	Percentage	p-Value (Goal p value <0.500)
01/01/2021 - 12/31/2021	Baseline	6050	8737	69.25%	837	1294	64.68%	.00108
01/01/2023 - 12/31/2023	Remeasurement 1	5649	8968	62.99%	822	1371	59.96%	.03297
01/01/2024 – 12/31/2024	Remeasurement 2	4874	7450	65.42%	777	1273	61.04%	.00274
01/01/2025 – 06/30/2025	Remeasurement 3	2234	3432	65.09%	390	600	65%	1

Results/Trends

Validation Rating: Design and Implementation

- Percentage of Evaluation Elements Met: 100%
- Percentage of Critical Elements Met: 100%
- MSHN Validation resulted in a *High Confidence* rating.

MSHN met 100% of the requirements for data analysis and the implementation of improvement strategies. MSHN used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers. Timely interventions were implemented and were reasonably linked to the corresponding barriers.

Validation Rating: Outcomes

- Percentage of Evaluation Elements Met: 33%
- Percentage of Critical Elements Met: 100%
- MSHN Validation resulted in a *No Confidence* rating.

MSHN did not demonstrate statistically significant improvement over the baseline performance for the disparate subgroup (Black/African American population). The PIHP did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups without a decline in performance for the comparison subgroup (White population) with the second remeasurement period.

Based on recommendations from HSAG, MSHN will address the following:

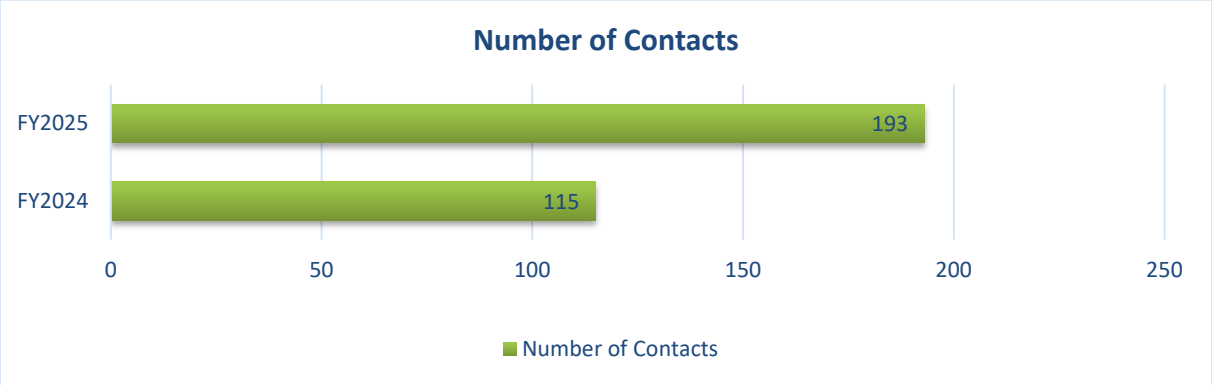
- The performance indicators have not yet achieved the goals for the PIP. MSHN included intervention efforts occurring at the community mental health services program (CMHSP) level, but the PIHP will also include efforts that have occurred at the plan level in the final report for CY2025 (remeasurement 3).
- MSHN will revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to identify if any new barriers exist that required development of interventions for both subgroups.
- MSHN will continue to evaluate the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.

Customer Service/Compliance Reporting

Customer Service involves processing agency customer inquiries, facilitating communication, and taking action in response to inquiries, complaints, grievances and appeals.

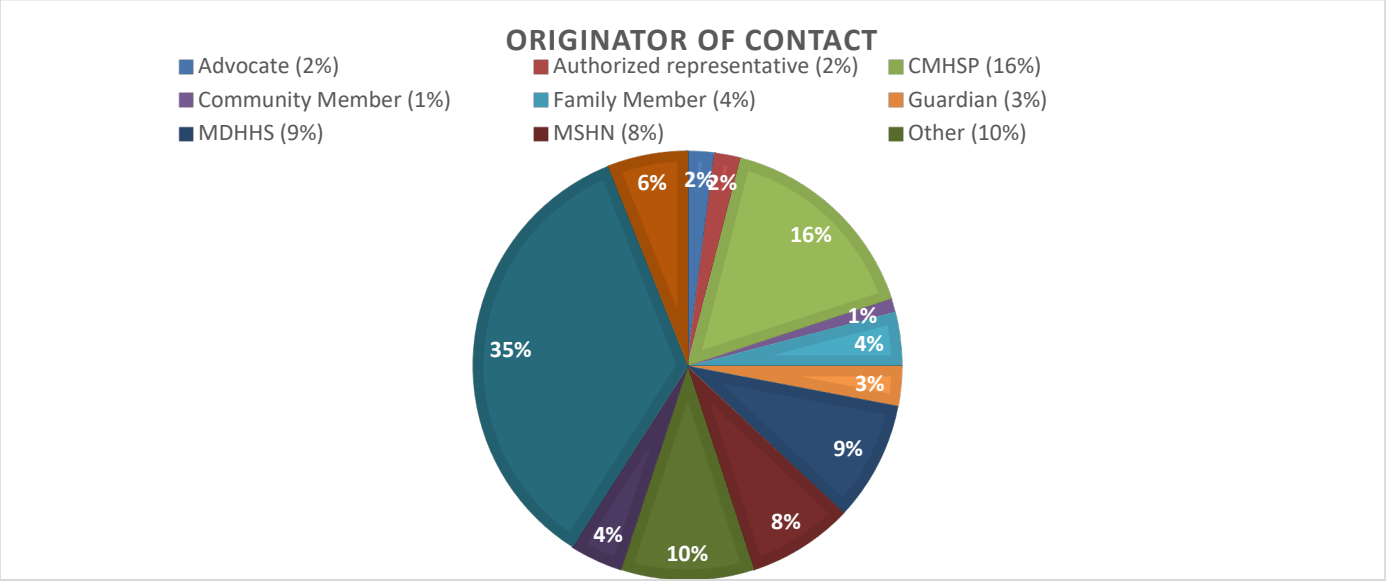
Customer Service Contacts

The total number of Customer Services contacts received in FY2025 was 193, a 67.8% increase from FY2024. By comparison, there were 115 contacts in FY2024.

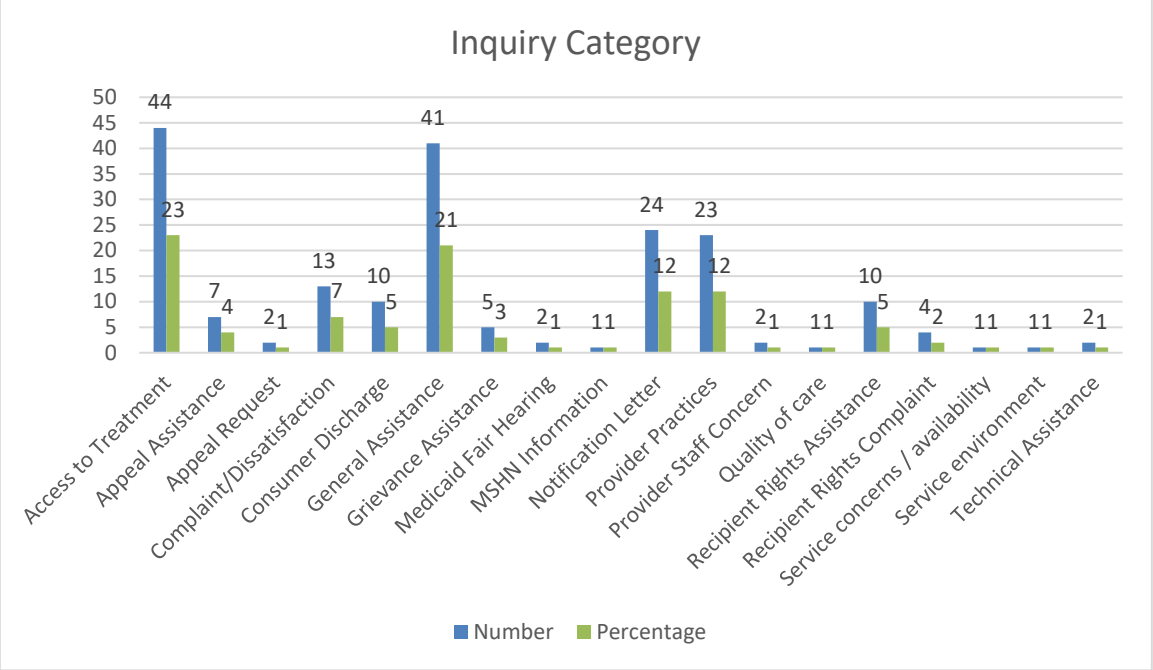


Originator of Contacts

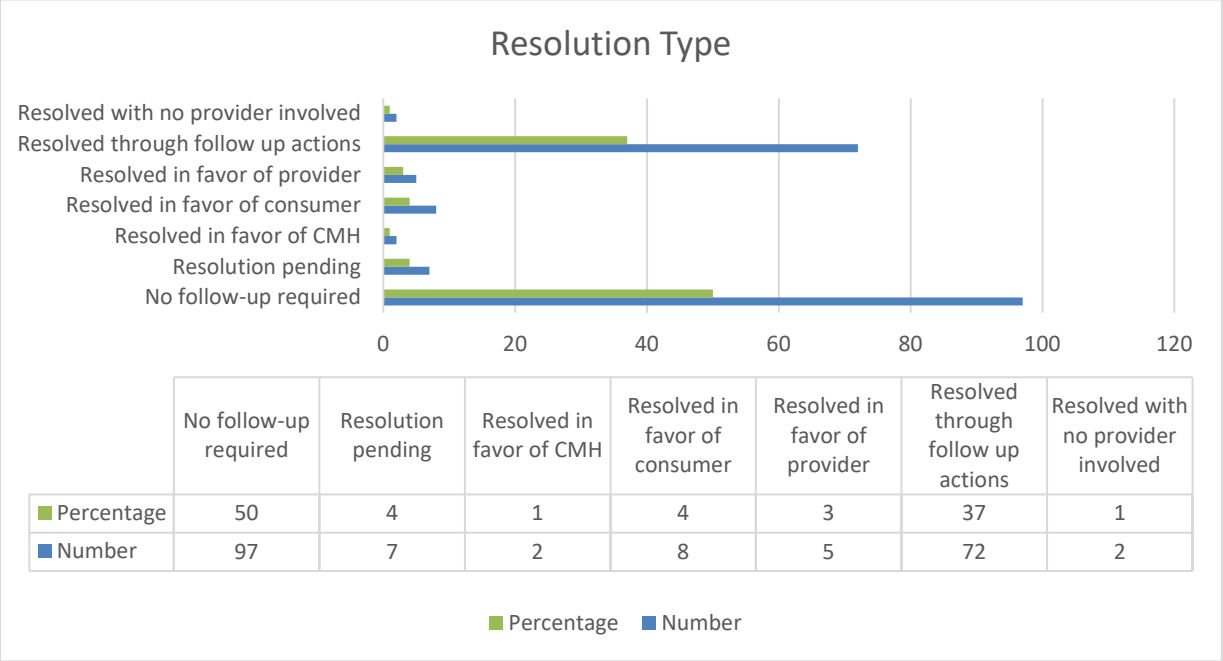
The following graph shows the percentages for each type of originator contact.



Customer Service Inquiry Category



Conclusion/Resolution Type



	No follow-up required	Resolution pending	Resolved in favor of CMH	Resolved in favor of consumer	Resolved in favor of provider	Resolved through follow up actions	Resolved with no provider involved
Percentage	50	4	1	4	3	37	1
Number	97	7	2	8	5	72	2

Percentage Number

Results/Trends

The following trends/changes were noted during FY2025:

- Overall Customer Service contacts increased by 67.8% in FY2025 (193) from FY2024 (115).
- Consumer contacts requiring follow-up action increased by 50% from 46 in FY2024 to 69 in FY2025.
- The highest number of consumer-based customer service complaints originated from Consumers themselves (52% / n=54) and MSHN (12% / n=12).
- The highest number of non-consumer customer service contacts originated from CMHSP staff (30% / n=27)
- The highest consumer complaint categories addressed Access to Treatment (15% / n=29), Provider Practices (9% / n=18), and Complaint/Dissatisfaction (6% / n=11). The highest non-consumer contact category involved requests for General Assistance (18% / n=34)

As part of MDHHS's state monitoring activities, PIHPs are required to submit Grievance reporting information using the state-developed reporting template. Report data submissions are on a quarterly basis, and the final report covers FY25 Q1-Q4.

FY25 MDHHS Grievance Reporting Results (Q1-Q4)						
Grievance Category	Number of Cases Closed	Number of Cases Substantiated	Percent Substantiated	Number of Cases Resolved within 90 Calendar Days	Average Number of Days for Resolution*	Percent Resolved within 90 Days
QUALITY OF CARE	30	22	73%	30	39	100%
ACCESS AND AVAILABILITY	29	21	72%	29	42	100%
INTERACTION WITH PROVIDER OR PLAN	11	7	64%	11	63	100%
MEMBER RIGHTS	3	1	33%	2	67	67%
TRANSPORTATION	0	0	#DIV/0!	0	#DIV/0!	#DIV/0!
ABUSE, NEGLECT, OR EXPLOITATION	0	0	#DIV/0!	0	#DIV/0!	#DIV/0!
FINANCIAL OR BILLING MATTERS	2	2	100%	2	#DIV/0!	100%
SAFETY/RISK MANAGEMENT	2	2	100%	2	#DIV/0!	100%
SERVICE ENVIRONMENT	4	4	100%	4	10	100%
OTHER	14	6	43%	12	95	86%
Total	**95**	**65**	**68%**	**92**	**25**	**97%**

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

As part of MDHHS' state monitoring activities, PIHPs are required to submit Appeals reporting information using the state-developed reporting template. Report data submissions are on a quarterly basis, and the report covers FY25 Q1-Q4.

FY25 MDHHS Appeals Reporting Results (Q1-Q4)								
Reason for Adverse Decision on Appeal	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	70	0.19	64	2	4	0	97%	3%
NOT A PIHP-COVERED BENEFIT	5	0.01	5	0	0	0	100%	0%
CLINICAL DOCUMENTATION NOT RECEIVED	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
TREATMENT/SERVICE PLAN GOALS MET	3	0.01	3	0	0	0	100%	0%
MEMBER NOT ELIGIBLE FOR SERVICES	5	0.01	5	0	0	0	100%	0%

MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN	18	0.05	18	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	35	0.09	31	3	1	0	91%	9%
NOT APPLICABLE	194	0.52	180	4	10	0	98%	2%
Total	330	0.88	306	9	15	0	97%	3%

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

	Count	Percentage
Appeals	330	
Appeals Upheld	121	37%
Appeals Overturned	202	61%
Appeals Partially Upheld/Overturned	9	3%

For FY2025, the grievance and appeal data were reviewed through the Regional Customer Service Committee (CSC) to identify trends and potential quality improvement efforts. The quarterly MDHHS grievance and appeal data will continue to be reviewed through the CSC.

Activities Implemented in FY2025

The following activities were implemented during FY2025.

- The quarterly Appeal and Grievance Regional Analysis Report was utilized to evaluate the quarterly MDHHS Grievance and Appeal data for regional trends and quality improvement.
- MSHN Customer Services continued to collaborate with MSHN staff to provide technical assistance to improve the quality of services through providers within MSHN's SUDSP network.
- MSHN provided ongoing technical support and training to the provider network in customer service, grievance and appeals, and recipient rights.
- The MSHN Adverse Benefit Determination (ABD) Technical Guide was updated with expanded information to assist provider staff in meeting the ABD requirements.

Recommendations for FY2026

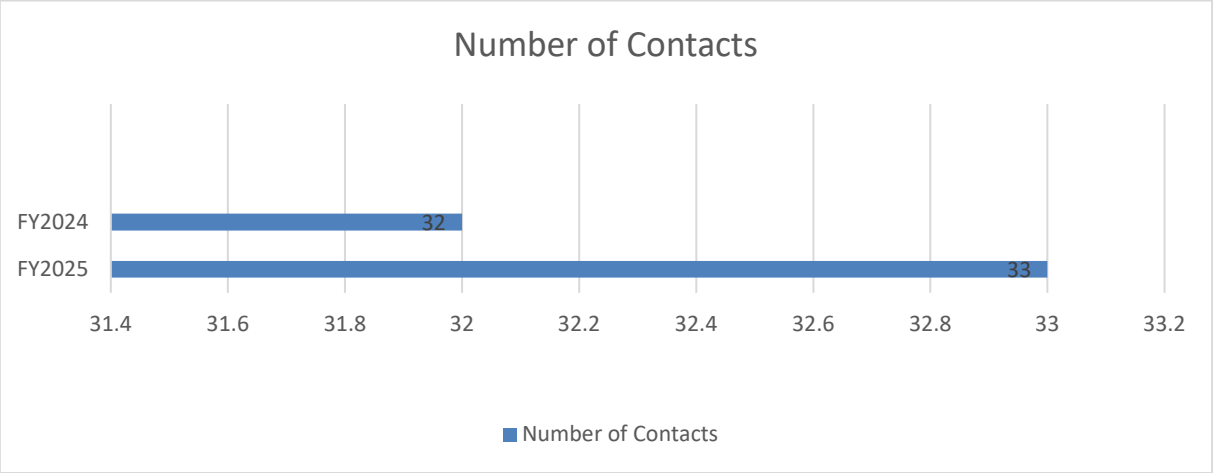
Based on FY25 Customer Service data, the following are recommended:

- The review of FY25 Customer Service data did not identify systemic issues but identified issues at the individual provider level requiring technical assistance. Quality improvement initiatives will occur during the Customer Service Committee, utilizing the quarterly Appeal and Grievance Regional Analysis Report to support provider compliance.

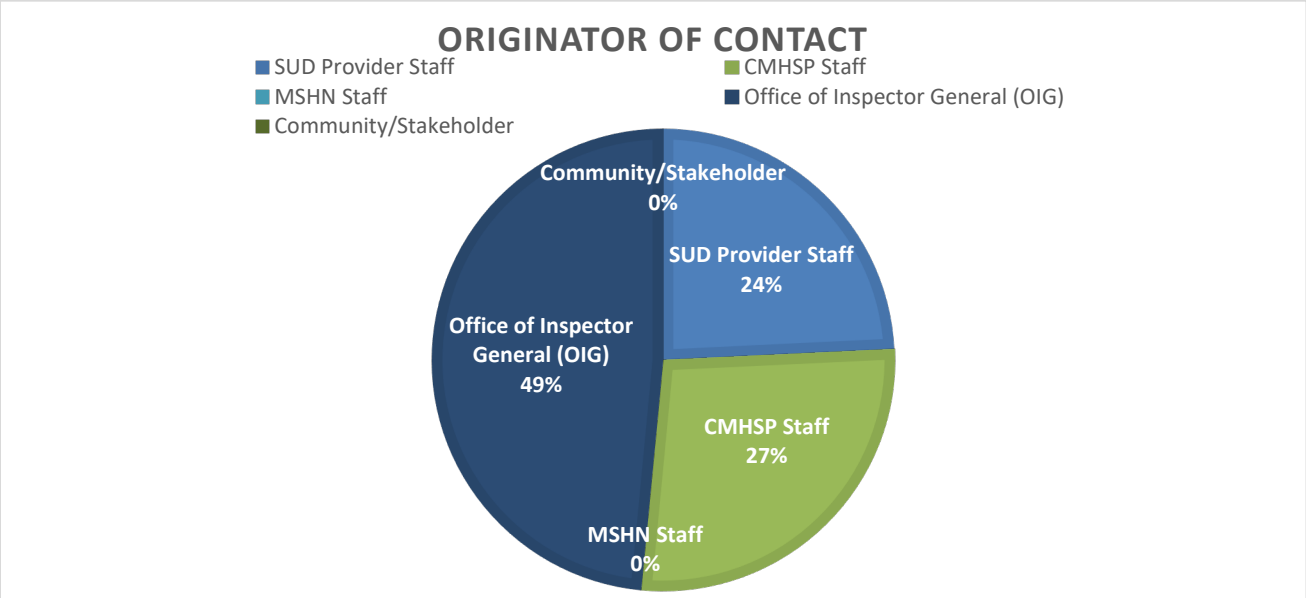
Compliance Reporting

Compliance Investigations

The total number of compliance investigations completed by the MSHN Compliance Officer in FY2025 was 33. By comparison, there were 32 completed in FY2024. This resulted in an increase of 3.13% in FY2025 from FY2024.

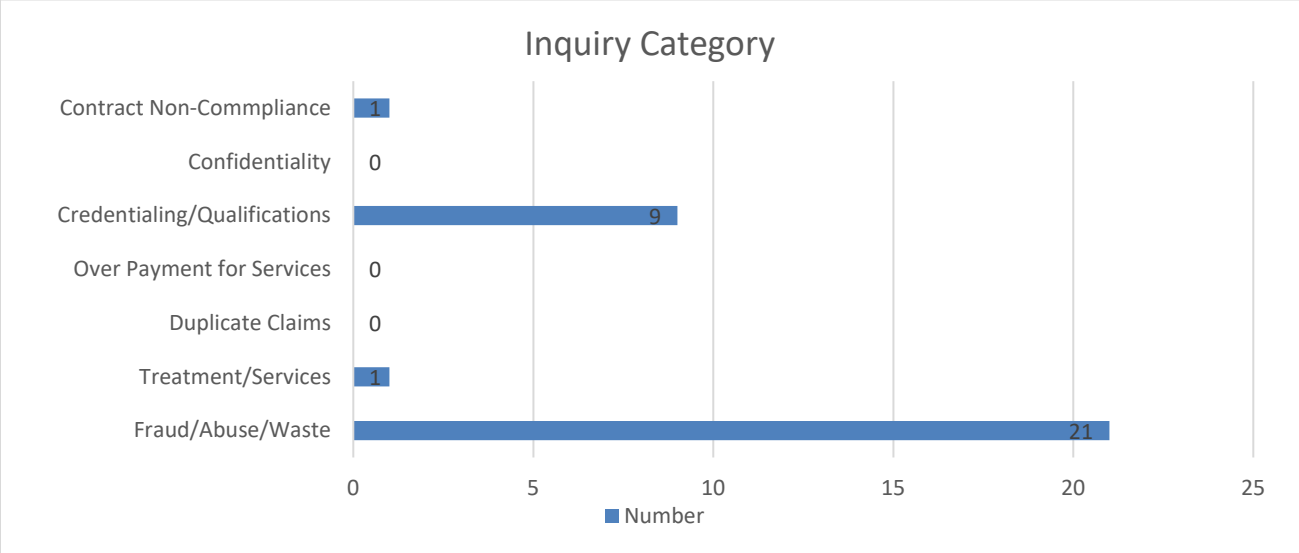


Originator of Contact



The percentage indicates the percent the originator represents of the total complaints.

Type of Compliance Investigation

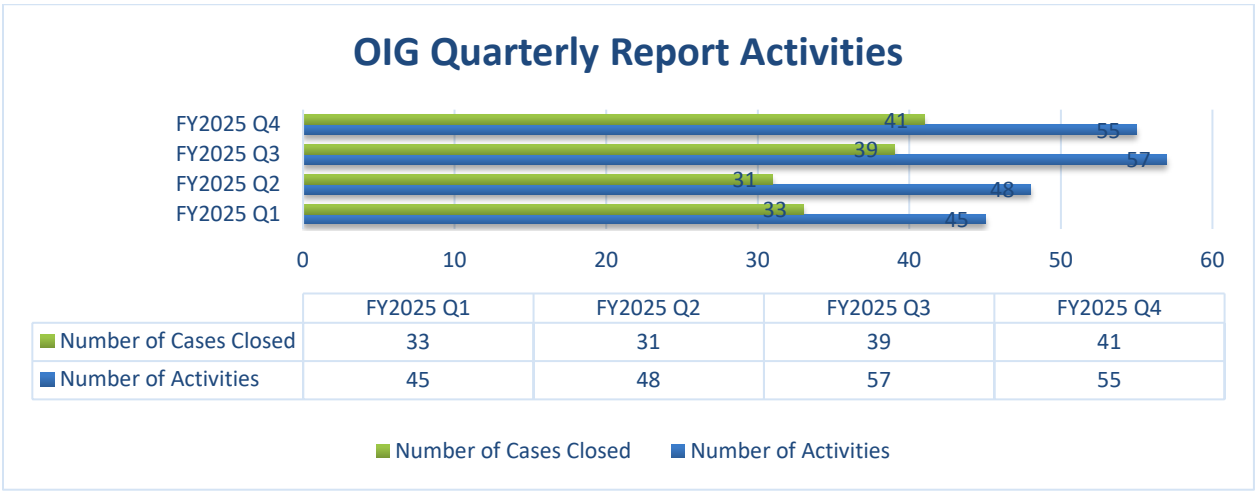


The percentage indicates the percentage the type represents of the total complaints.

Office of Inspector General Quarterly Report for FY2025

PIHPS are required to track and report program integrity activities performed within the region. The program activities must include, but are not limited to, the following activities: data mining, analysis of paid claims, audits performed, overpayments collected, identification of fraud, waste and abuse, provider dis-enrollments and contract terminations.

Below is a breakdown of activities reported for each quarter in FY25. Activities that are not closed out or finalized in the quarter reported carry over to the following quarterly report until resolved. Additionally, Medicaid Event Verification reviews are reported the quarter that they are considered completed/closed/finalized.



	FY2025 Q1	FY2025 Q2	FY2025 Q3	FY2025 Q4
Number of Cases Closed	33	31	39	41
Number of Activities	45	48	57	55

Most of the activities reported were a result of local and region wide Medicaid Event Verification activities, clinical record reviews and internal audits. The activities reported included inappropriate credentials/training, lack of supporting documentation, wrong use of modifiers, billing for incorrect dates and times, incorrect service codes and overpayment.

The total amount of overpayments that were adjusted as a result of the QIG quarter report activities was $638,990.33. While this was identified as an overpayment, many of the encounters could be corrected and resubmitted after the claims were voided which may have resulted in a lower recoupment/cost settled amount for FY2025.

DATA MINING ACTIVITIES

Data mining is a process for finding anomalies, patterns and correlations within data sets.
During FY2025, MSHN completed the following data mining activities.

1) Death Data Report (Q1, Q2, Q3, and Q4)
   a. This report compares the death list from Care Connect 360 to service data from MSHN's information management system. There should be no instance where a service is provided to a recipient after the date of death.
2) 90853 code: Group Psychotherapy
   a. This was a joint effort between the OIG and MSHN. The OIG pulled a report including this coder to see if there were any duplicate claims within the region.
3) H2016 code:
   a. This was a joint effort between the OIG and MSHN. The OIG pulled a report including this coder to see if there were any duplicate claims within the region.

Results/Trends

- The following are the data mining activities and results for FY2025 Q1 through Q4.
  - Death Data Report
    Results: FY25 results included 71 unique individuals, accounting for 704 encounters. There were no instances where a date of service was reported after the date of death.
  - 90853 code
    Results: There were 2 instances identified by the OIG as potential duplicate billing. Upon investigation by MSHN, it was determined that the services occurred on the same day, but at different times. Therefore, there was no duplicate billing.
  - H2016 code
    Results: The OIG identified 24 records where there was a potential for double billing of this code. MSHN investigated each of these records and determined that there were no cases where double billing occurred, but rather the issues were related to voids being rejected or not properly submitted. All issues were corrected.
- The number of referrals from the OIG for allegations of fraud, waste and abuse continue to increase each year, showing a potential for increasing oversight by the OIG for the behavioral health system.

SUBPOENA(S)

MSHN received 3 (three) subpoenas during FY2025 requesting records. MHSN did have records for 2 (two) of the cases and those records were provided as signed releases were provided. MSHN was not named as a defendant in any of the subpoenas.

NOTIFICATION OF BREACH(S)

During FY2025 within the MSHN region, there were 6 (six) instances reported involving a breach of protected health information. Out of the instances, 1 (one) was reported from a Substance Use Provider, 4 (four) were reported from CMHSPs and 1 (one) was reported by MSHN staff. In all situations, MSHNs breach policy and procedure was followed to remediate the situation and lessen the probability for future recurrence.

ACTIVITIES IMPLEMENTED IN FY2025

The following activities were implemented during FY2025.

- Data Mining Activities included:
  - Death Audit Compared to Encounters (Q1, Q2, Q3, and Q4)
  - Joint activity with the OIG:
    - H2016 code for duplication of billing
    - 90853 code for duplication of billing
- Research and selection of a vendor for Compliance Software to be used region wide
- Tested compliance software and made recommendations for revisions/updates to forms and process
- Trained CMHSP staff in the use of the compliance software
- Revised and approved the 2025 MSHN Compliance Plan
- Reviewed and approved the FY2024 Annual Compliance Summary Report inclusive of recommendations
- Operationalized updates/revisions to Office of Inspector General (OIG) quarterly report and fraud referral process
- Development of process for reporting OIG monthly overpayment report
- Revised Privacy Notice to include changes in federal requirements

RECOMMENDATIONS FOR FY2026

The following are recommendations for improvements in FY2026.

- Continue to explore, and identify additional region wide data mining activities to detect possible deficiencies and/or non-compliance with established standards
- Expand communication to MSHN staff and provider network by utilizing Constant Contact, emails, webpage and other communication means for compliance related updates for providers including trends and quality improvement efforts
- Develop reports that can be used to extract data from the compliance software to identify

trends and quality improvement efforts
- Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies
- Identify compliance related educational opportunities including those aimed at training compliance officers

COMPLIANCE TRAINING/REVIEW

Internal

MSHN Compliance Committee
Review Compliance Plan
Review of Compliance Policies and Procedures
Review Annual Compliance Summary Report

MSHN Regional Compliance Committee
Review Compliance Plan
Review Compliance Policies and Procedures
Review Annual Compliance Summary Report

MSHN Operations Council
Review Compliance Plan
Review Compliance Policies and Procedures
Review Annual Compliance Summary Report

MSHN Staff and Leadership
Receive Compliance Training as part of new hire orientation
Compliance Training for ongoing staff training through Relias
Review Compliance Plan
Review Compliance Policies and Procedures

Board of Directors
Review and approve Compliance Plan
Review and approve Compliance Policies
Review and approve Annual Compliance Summary Report

External

MSHN Compliance Plan and Compliance Line Available on Website- Compliance calls are received through the Compliance Line, the main line of MSHN or through the direct line to the Chief Compliance and Quality Officer.

MSHN Customer Service Line Available on Website - Customer Service calls are received through the Customer Services Line, the main line of MSHN or through the direct line to the Customer Services and Rights Specialist.

MSHN Contact information and reporting process located in Consumer Member Handbook "Guide to Services."

References

The following documents were used in the completion of the Compliance Summary Report and can be found in their entirety on Mid-State Health Networks website at:
https://midstatehealthnetwork.org/stakeholders-resources/quality-compliance/external-site-reviews

1. Health Services Advisory Group State Fiscal Year 2025 Validation of Performance Measures Report
2. Health Services Advisory Group State Fiscal Year 2025 Compliance Report
3. Health Services Advisory Group State Fiscal Yeat 2025 PIP Validation Report

MSHN
Mid-State Health Network

FY2025 Board of Directors Self-Assessment Report

Background

As part of the annual process, the MSHN Board of Directors complete a Self-Assessment Performance Evaluation. An annual Board evaluation gives everyone a chance to exercise responsibility for self-review and to re- affirm the public trust and ownership in Mid-State Health Network (MSHN). Such evaluations prohibit shortcomings that might otherwise go undetected. By completing such an assessment, the Board is accepting responsibility for accountability, self-regulation and advancement of Mid-State Health Network's mission. Evaluating performance produces opportunities for improvement and often re-energizes the Board through the knowledge that it is performing well.

Recommended Motion:

Motion to receive and file the FY2025 MSHN Board of Directors Self-Assessment report.

March 3, 2026

FY25 Response Rate 61% (14 out of 23 standing members) Note: Comments were extracted and provided verbatim

COLORS KEY: HIGHER LOWER

	MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY21-FY25)	Yes					No					Needs Improvement					Unsure				
		20/21	21/22	22/23	23/24	24/25	20/21	21/22	22/23	23/24	24/25	20/21	21/22	22/23	23/24	24/25	20/21	21/22	22/23	23/24	24/25
Mission, Vision and Strategic Direction	1. The Board participates in strategic planning	86%	95%	81%	92%	71%	0%	0%	0%	0%	0%	5%	0%	19%	0%	29%	9%	5%	0%	8%	0%
	2. The Board has a clear sense of needs and priorities for the region	71%	89%	67%	84%	77%	5%	0%	0%	0%	8%	14%	11%	24%	8%	15%	10%	0%	9%	8%	0%
	3. MSHN has a clear sense of direction	86%	100%	76%	75%	93%	0%	0%	0%	0%	0%	5%	0%	10%	17%	0%	9%	0%	14%	8%	7%
	4. The Board is advised on national, state and local trends for their effect on behavioral health services	90%	84%	86%	75%	86%	0%	0%	0%	0%	0%	10%	5%	14%	8%	14%	0%	11%	0%	17%	0%
	5. The Board is presented with information about the strengths and weaknesses of MSHN	85%	74%	66%	67%	86%	0%	0%	10%	0%	7%	5%	5%	10%	16%	0%	10%	21%	14%	17%	7%
	6. The Board receives adequate information, analysis, plans, proposals and background materials that enable decision making	95%	89%	71%	50%	71%	0%	0%	5%	0%	0%	5%	0%	10%	33%	29%	0%	11%	14%	17%	0%
	7. MSHN's strategic priorities are clear, specific and measurable	86%	74%	86%	83%	77%	5%	0%	4%	0%	7%	5%	10%	5%	0%	8%	4%	16%	5%	17%	8%
	8. The Board evaluates progress of opportunities for improvement that are identified	67%	74%	62%	58%	85%	5%	5%	9%	0%	7%	19%	16%	5%	25%	8%	9%	5%	24%	17%	0%
	Comments: 1)Challenging times but it is bringing faced with integrity. 2)Unclear at this time. Waiting for decision from the lawsuit that is pending. 3)There are inequities regarding fair CMH funding. Particularly regarding penetration rate. 4)None at this time. 5)As a new board member I am unclear with some of this. 6)Difficult to do in these uncertain times. 7)Our staff has been very helpful over the years in assisting the board with the development of a clear understandable direction in our Mission, Vision and Strategic plans, which has help to make MSHN a success.																				
CEO/Board Roles & Responsibilities	10. The Board asks "What" and "Why" and Expects the CEO to provide the "How"	90%	100%	81%	75%	79%	5%	0%	0%	0%	7%	5%	0%	14%	0%	7%	0%	0%	5%	25%	7%
	11. There is a mutual respect and open discussion between the Board and the CEO	100%	100%	100%	92%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	8%	0%
	12. Board communication to staff and providers is channeled through the CEO	86%	90%	100%	92%	86%	0%	0%	0%	0%	0%	0%	5%	0%	0%	0%	14%	5%	0%	8%	14%
	13. Revisions to all policies are reviewed and approved by the Board	95%	95%	90%	91%	86%	0%	5%	0%	0%	7%	0%	0%	10%	0%	0%	5%	0%	0%	9%	7%
	14. The Board receives timely and accurate communication	95%	100%	95%	75%	100%	0%	0%	0%	0%	0%	5%	0%	0%	17%	0%	0%	0%	5%	8%	0%
	Comments: 1)At times I am amazed at the ability by us to forge on. 2)It seems to be working correctly. 3)None at this time. 4)This is what contributes to the success of MSHN.																				
Resource Utilization & Risk Management	16. Board members are advised of key laws, rules and regulations and the implications for MSHN	100%	100%	81%	84%	100%	0%	0%	0%	0%	0%	0%	0%	5%	8%	0%	0%	0%	14%	8%	0%
	17. The Board has established policies, by-laws and operating agreements to reduce the risk of liability for the Board and MSHN	90%	89%	86%	92%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	10%	11%	14%	8%	0%
	18. Annually, or more often, the Board establishes priorities for the use of resources	95%	79%	71%	67%	83%	5%	0%	5%	0%	0%	0%	10%	10%	25%	0%	0%	11%	14%	8%	17%
	19. The Board receives routine financial reports including investment and risk management strategies	100%	95%	90%	75%	100%	0%	0%	0%	0%	0%	0%	5%	5%	17%	0%	0%	0%	5%	8%	0%
	20. The Board has an approved compliance plan and receives routine updates of compliance monitoring activities	95%	94%	95%	92%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	5%	6%	5%	8%	0%
	21. The Board receives regular reports of external quality review, audits and other monitoring activities inclusive of planned corrective action	95%	94%	86%	92%	100%	0%	6%	5%	0%	0%	0%	0%	0%	0%	0%	5%	0%	9%	8%	0%
	Comments: 1)Excellent data analysis and presentations. 2)Ok 3)None at this time. 4)Another strength of MSHN.																				

	MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY21-FY25)	Yes					No					Needs Improvement					Unsure				
		20/21	21/22	22/23	23/24	24/25	20/21	21/22	22/23	23/24	24/25	20/21	21/22	22/23	23/24	24/25	20/21	21/22	22/23	23/24	24/25
Public Trust	23. The public has opportunities to address concerns to the Board	100%	95%	90%	100%	100%	0%	0%	0%	0%	0%	0%	0%	10%	0%	0%	0%	5%	0%	0%	0%
	24. Public requests for action/change are addressed as appropriate	81%	89%	76%	67%	82%	5%	0%	0%	0%	0%	0%	0%	5%	0%	0%	14%	11%	19%	33%	18%
	25. Board members provide information and support Board positions with the media, key local/ state decision makers and legislators	71%	68%	65%	50%	55%	0%	5%	0%	8%	0%	10%	0%	5%	8%	18%	19%	27%	30%	34%	27%
	26. The Board reviews customer satisfaction feedback and evaluates concerns	57%	79%	71%	84%	82%	5%	5%	0%	0%	0%	19%	5%	5%	8%	9%	19%	11%	24%	8%	9%
	Comments: 1)Good efforts are made. 2)Communication is satisfactory. 3)None at this time. 4)We must remember when speaking to state officials or the public about MSHN, that we state the position of the board and not our own opinion.																				
Boardmanship	28. Members refrain from intruding on administrative issues that are the responsibility of the Mid- State Health Network CEO/staff except to monitor results and prohibit methods that conflict with policy	90%	100%	81%	50%	92%	5%	0%	0%	8%	0%	5%	0%	9%	17%	8%	0%	0%	10%	25%	0%
	29. Members do not exercise authority apart from the authorization of the full Board	95%	95%	90%	75%	85%	5%	5%	0%	0%	0%	0%	0%	0%	8%	0%	0%	0%	10%	17%	15%
	30. Members serve the best interest of Mid-State Health Network rather than personal or other professional interests	90%	95%	86%	84%	100%	0%	0%	0%	0%	0%	5%	0%	9%	8%	0%	5%	5%	5%	8%	0%
	31. Members are respectful of one another	95%	100%	90%	84%	92%	0%	0%	0%	0%	0%	5%	0%	10%	8%	8%	0%	0%	0%	8%	0%
	32. I am satisfied with the personal contribution I make to the Board	67%	79%	67%	75%	69%	0%	0%	5%	0%	0%	33%	21%	29%	8%	31%	0%	0%	0%	17%	0%
	Comments: 1)Great respect from all and to all. 2)Being a new member I do need improvement. 3)Not at this time. 4)As a new Board member I am still learning and feel I could contribute more. 5)In my option, we have improved in this during 2025, since the chair makes a statement at the beginning of each meeting.																				
Board Evaluation of Support Staff	34. I am satisfied that meetings are set up efficiently and in a timely manner	100%	100%	86%	92%	100%	0%	0%	0%	0%	0%	0%	0%	9%	0%	0%	0%	0%	5%	8%	0%
	35. I am satisfied that Board Packets are sent in a timely and complete manner and copies are made accessible	95%	100%	95%	92%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	5%	0%	5%	8%	0%
	36. Responsiveness to information requested is adequate, of good quality and timely	100%	100%	86%	92%	100%	0%	0%	0%	0%	0%	0%	0%	5%	0%	0%	0%	0%	9%	8%	0%
	37. Board member requests are handled in a polite, friendly and professional manner	95%	100%	95%	92%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	5%	0%	5%	8%	0%
	38. Board meeting minutes are accurate and presented in a timely manner	95%	100%	95%	92%	100%	0%	0%	0%	0%	0%	5%	0%	0%	0%	0%	0%	0%	5%	8%	0%
	Comments: 1)Can't get much better. 2)Everything is going smoothly. 3)Not at this time. 4)Exemplary support services. 5)Always are professionally completed. 6)Thanks to the staff for their great support in this area!																				

MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY21-FY25)		Yes					No					Needs Improvement					Unsure				
		20/21	21/22	22/23	23/24	24/25	20/21	21/22	22/23	23/24	24/25	20/21	21/22	22/23	23/24	24/25	20/21	21/22	22/23	23/24	24/25
Diversity, Equity and Inclusion	40. As a board member, I have a deep understanding of the health equity work of the agency	N/A	N/A	N/A	42%	31%	N/A	N/A	N/A	8%	8%	N/A	N/A	N/A	33%	46%	N/A	N/A	N/A	17%	15%
	41. As a board member, I deliberately establish consistent communication channels and bring the perspectives, feedback, needs and priorities of diverse communities, especially those affected by health disparities, into board decisions	N/A	N/A	N/A	42%	62%	N/A	N/A	N/A	0%	0%	N/A	N/A	N/A	33%	31%	N/A	N/A	N/A	25%	7%
	42. As a board member, I have a deep level of understanding of the diversity, equity and inclusion work of the agency	N/A	N/A	N/A	50%	67%	N/A	N/A	N/A	17%	8%	N/A	N/A	N/A	25%	17%	N/A	N/A	N/A	8%	8%
	43. The board ensures principles of diversity, equity and inclusion are incorporated into all MSHN policies	N/A	N/A	N/A	67%	77%	N/A	N/A	N/A	0%	0%	N/A	N/A	N/A	0%	8%	N/A	N/A	N/A	33%	15%
	44. The board ensures the agency actively engages people affected by health disparities in developing, planning and implementing health equity activities	N/A	N/A	N/A	67%	77%	N/A	N/A	N/A	0%	0%	N/A	N/A	N/A	0%	8%	N/A	N/A	N/A	33%	15%
	Comments: 1)I give it my best effort. Not sure what implications come when determining “deep” understanding. So I will just continue with never being complacent. 2)I’m not sure why this has a full section of questions. There should be no discrimination based on anything. 3)Ok 4)None at this time.																				
Visioning	46. My dream for Mid-State Health Network is: 1)To be able to keep on rolling regardless of what they throw in our path. 2)The best outcome for our consumers is always my first priority. 3)To keep the focus that we have and stay involved with the consumers in mind. 4)Stability in offering mental health care to citizens. 5)Continuation of current vision and strategies. 6)To continue to thrive in an ever-changing political climate. 7)To continue it's existence. 8)Good partnership and working relationships. We serve the people who need us. 9)Doing a better job of providing meaningful services to people unhappy with the "Mental Health" system as it's setup today. 10)Continue to serve our consumers in an efficient manner. 11)That we are still here next year.																				
	47. My greatest concern for Mid-State Health Network is: 1)No great concern. We have the integrity to handle whatever gets thrown at us. 2)What is the state government is doing? 3)Funding 4)My greatest concern is that the State of Michigan will be successful in privatizing behavior health. 5)Country government instability. 6)External forces seeking privatization. 7)It's possible demise. 8)Uncertainty of future. 9)Lawsuits and changes coming from the state. 10)Need to work better/communication and collaboration with the State . I'm not saying that it's our fault, but needs to improve. 11)For profit interference and litigation. 12)That we will not be here next year.																				
	48. With respect to Mid-State Health Network, I am proudest of: 1)The overall quality of the our management staff. 2)Keeping up to date with the latest information. 3)I am most proud of the engagement and communication we have with the region. 4)Willingness to challenge bad public policy. 5)The contributions to ensuring health equity. 6)The entire agency. 7)Their knowledge and serve. 8)Helping people we serve. 9)Our region and how we serve our consumers efficiently and effectively while serving as role models for other regions. 10)Our staff and all that they contribute to our success.																				
	49. I feel that Mid-State Health Network's greatest opportunity for improvement is: 1)Just in a general sense to become more of innovative force that cannot be overlooked. 2)Our vision to help in any and all opportunities in the best interest of the consumer. 3)To keep a high level of communication with all of its constituents. 4)Sustainable support for SUD services. 5)Making the community services better. 6)Continue to work within our region to serve our consumers. 7)Keep always looking for ways to improve.																				
	50. Other recommendations/feedback: 1)None 2)None at this time 3)It is a pleasure to be a part of this great organization as a board member.																				

MSHN
Mid-State Health Network

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
January/February 2026

PIHP/REGIONAL MATTERS

1. Competitive Procurement of Prepaid Inpatient Health Plans (PIHPs):

On January 8, 2026, Judge Christopher Yates (Michigan Court of Claims) issued an opinion and order stating that the "Court hereby issues a declaratory pronouncement that the RFP (request for proposals), as drafted, impermissibly conflict with Michigan law in numerous respects, especially insofar as the RFP restricts CMHSPs (Community Mental Health Services Programs) from entering into financial contracts for the purpose of funding CMHSPs' managed care functions." Click this link to read the 19-page order. Importantly, this order stated that this is not a final order and does not resolve the case.

As previously reported, on 10/14/25 Judge Yates issued an opinion and order confirming that the State has the legal authority to utilize a competitive procurement system (in place of the existing sole source model) and confirming the legal authority of the State to reduce the number of PIHP regions (in effect, to define its regions). That order is linked here. Later in October 2025, Plaintiffs (Region 10 PIHP, St. Clair Community Mental Health, Southwest Michigan Behavioral Health (SWMBH), Integrated Services of Kalamazoo, Mid-State Health Network, and Saginaw County Community Mental Health) filed a motion for reconsideration. The motion for reconsideration is focused on a narrow element flowing from the 10/14/25 order and specifically asks Judge Yates to rule on whether MDHHS has the legal authority to define the geographic boundaries of regional entities. The court has not yet ruled on that motion. Of note, Mid-State Health Network (MSHN) is a regional entity created by the twelve CMHSPs listed at the left of this page for the purpose of operating under contract with the State as a PIHP.

Unlike the press releases used to communicate its intent to procure PIHP contracts and announce the procurement details, the State issued a recission of the RFP through a memo posted only to the State procurement website on January 29, 2026. The very short memo also indicated that no awards would be given by the State from the responses it had received to the original RFP.

The next day (01/30/26), the State filed a motion to dismiss this lawsuit on the basis that since the State cancelled the RFP, the PIHP/CMHSP lawsuit is moot. Plaintiff attorneys filed a brief opposing the State's motion on February 13, 2026. The State response to Plaintiff's response was filed on 02/17/26. Unless the court orders oral arguments, the Court will decide the motion on the basis of the briefs. Timing for either scenario is unknown and could occur quickly or weeks or even months from now.

On February 2, MSHN and SWMBH sent an email to Kristen Morningstar, MDHHS Director of the Specialty Behavioral Health Services Bureau, inviting MDHHS to re-engage with our PIHPs on the argument that since the procurement process concluded a communications blackout was no longer needed. We listed several significant operational matters and policy

implementation issues that require MDHHS guidance and engagement. As of February 19, there has been no response.

Meanwhile, because there has literally been no communication on these matters, we do not know whether or not the State is planning to release a new RFP, if so what new (if any) requirements will be within it, what timing and target dates are contemplated – in short, we have no information on which to plan; no information on which to base future decisions; no information that changes our "limbo" status. In our professional judgment, the State cannot possibly make its self-imposed deadline for transition of PIHP contracts to successors by 10/01/2026.

Last summer, MSHN Leadership conducted a review of operations and initiatives and made temporary decisions to expand, continue/sustain, suspend, or terminate some components of those operations. These decisions included suspending investment decisions (things like software, longer-term infrastructure) and, importantly, closing the MSHN substance use disorder provider network from onboarding new providers and/or approving longer term program-level investments.

Executive Leadership has recently reviewed those prior decisions in the context of the situation at hand (described above). With a few exceptions, we intend to continue those actions for the foreseeable future.

The lack of clear future direction as the context of our current operations is a heavy burden for our staff and their families, our providers, and other stakeholders. Our personnel have stayed with us throughout this series of events, very much to their credit and the credit of our leadership team.

Clearly, we don't know what's next. We will continue to engage with our regional partners and others to keep our system public and toward engineering and implementing meaningful improvements, many of which have been demanded by stakeholders for years. Meanwhile, MSHN is committed to continued excellence in our performance and will continue to carry out our contractual functions for as long as we have a contract with the State to do so, which we expect will be extended well beyond the original, now rescinded, target RFP implementation/transition date of 10/01/2026. Meanwhile, too, are the looming cuts to Medicaid due to the enactment of HR 1 in July 2025.

2. Freedom of Information Act Filing:

The Plaintiffs (listed on page 1 and including MSHN) have filed a freedom of information (FOIA) request for all bids submitted to the State in response to the original RFP. If we have an update, we will provide that information to the board at the March 3, 2026 meeting.

3. PIHP Lawsuit – FY 25 Contract:

Five PIHPs, Lakeshore Regional Entity, NorthCare, Northern Michigan Regional Entity, CMH Partnership of Southeast Michigan, and Region 10 PIHP, signed a "red-lined" version of the FY 25 PIHP contract offered by MDHHS. Those five PIHPs "red-lined" or crossed out several objectionable provisions, signed the contract, and returned it to the State. The State refused to sign those five contracts and instead invoked the two-year "transition to termination" clause in the last fully executed contract (FY 24). If there is no action by MDHHS to extend it, the two-year transition period ends 09/30/2026.

Lakeshore Regional Entity did not file, but the remaining four PIHPs listed above filed suit in the Court of Claims against the state on December 10, 2024. MSHN does not have benefit of the filings as a non-party to the litigation. There has been no action on this lawsuit from May 2025 until February 6, 2026. On that date a

hearing of oral arguments on these matters was ordered to be held on March 24, 2026 at 11:00 a.m. Those interested should be able to watch the proceedings by accessing the livestream at this link.

4. **Oakland PIHP Crisis Services:**

Oakland Community Health Network (OCHN) is a CMHSP and a PIHP. OCHN has been working at transitioning adult crisis services from contracted providers to its directly operated program responsibility. OCHN recently announced that the transition from Common Ground (the contracted provider) to OCHN was completed at the end of January.

OCHN stated in a press release that "Transition meetings between the organizations were initially productive and focused on program continuity and collaboration. However, discussions ultimately stalled as Common Ground shifted its focus toward financial demands rather than operational coordination for the people served. Throughout the transition, OCHN continued to operate in good faith, even after identifying an overpayment exceeding $1 million owed back to OCHN and the public system. As a public steward of taxpayer dollars, OCHN has a responsibility to Oakland County residents to ensure these funds are accounted for and appropriately redirected to direct services. Approximately 94% of OCHN funding is reinvested directly into the community to support individuals receiving behavioral health services."

"To date, OCHN has transitioned more than 55 employees from Common Ground to support the continuation of crisis services; this number is expected to grow as employees continue transitioning from Common Ground. These are familiar professionals many community members have worked with before, helping to ensure comfort, trust, and continuity during the transition. Staff who joined OCHN have shared their excitement about continuing to serve under OCHN's mission and the opportunity to help expand and improve crisis services for Oakland County residents."

"OCHN's focus remains, as it always has been, on ensuring continuity of care and protecting access to critical behavioral health services and prioritizing the needs of the people we serve. OCHN continues to partner with community agencies, law enforcement, healthcare systems, and local organizations to ensure coordinated, responsive crisis care. "

5. **Protect MI Care Coalition – Advocacy Update and Action Items:**

The MI Care Coalition is a broad based, grass roots, movement to oppose the significant reductions to Medicaid and cost increases of plans on the Affordable Care Act (ACA) Marketplace. Following are a couple of items that the Coalition is seeking your participation to amplify:

Health Insurance Affordability Survey:
Please also share our health insurance affordability survey with your networks. This survey will help us collect both personal stories and data to strengthen our advocacy for extending the enhanced premium tax credits. Take the survey at this link.

Advocacy Toolkit:
To make sharing easy, please make use of our advocacy toolkit, which includes sample posts, graphics, and messaging items that can help you get the word out to your networks which is available at this link.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

6. MDHHS Key Leadership Changes:

MDHHS announced the following key personnel staffing changes on 02/04/26:

- Jackie Sproat accepted the role of Senior Behavioral Health Information Technology Advisor. In this position, Jackie will continue reporting to Kristen Morningstar while focusing on IT systems work and strengthening cross-departmental coordination. She will also assume oversight of the CRM (Customer Relationship Manager – the State system for document/data management). Jackie had been the director of the Division of Contracts & Quality Management. MDHHS reports that this position is currently being updated and will be posted in late February.

- Belinda Hawks announced her retirement effective January 5, 2026. Belinda devoted 40 years to Specialty Behavioral Health Services, including 11 years with MDHHS. Belinda's most recent role was serving as the Federal Compliance Division Director The Division Director position is also being updated and will be posted in late February.

7. Mental Health Reform Legislation:

(Excerpted from a press release by the office of Rep. Donni Steele): The House Committee on Health Policy approved a bipartisan, three-bill package to modernize Michigan's Mental Health Code, strengthen crisis response, and improve coordination between courts, care providers, and families.

The package is anchored by House Bill 4412, which updates outdated mental health statutes to better reflect modern clinical practices, workforce realities, and public safety needs. According to the press release, this bill provides the structural improvements needed to make the system more responsive, while the companion bills (HB 4413 and 4414) build on that foundation to ensure disputes are resolved and treatment can continue when mental illness intersects with the justice system.

House Bill 4413 expands mediation options for individuals and families navigating disputes within the mental health system and improves transparency in how those disputes are handled. House Bill 4414 creates a structured diversion pathway that allows certain misdemeanor defendants to receive court-ordered assisted outpatient treatment when untreated mental illness is the underlying issue.

MSHN is tracking these and many other bills and will update the board as needed. For links and additional bill tracking information, please see the "Michigan Legislation Tracker" which is maintained by Sherry Kletke (MSHN Executive Support Specialist) attached to this board report.

8. 1915(c) Habilitation Supports Waiver Amendment Submission Announced:

On 02/12/26 MDHHS announced the opening of a public comment period on its draft 1915(c) Habilitation Supports Waiver amendment submission to the Centers for Medicare and Medicaid Services (CMS). Comments can be submitted by email to MDHHS-BHFederalCompliance@michigan.gov by March 16, 2026.

The amendment itself can be viewed at this link and is 276 pages in length. The waiver amendment is intended to be effective July 1, 2026.

While there is much in this amendment, I want to highlight a few observations that bear on our operating context and uncertainty (see page 1 of this report).

- Reference to PIHPs, CMHSPs and acknowledgement of the contracted networks of CMHSPs is evident throughout. This is a point in the now rescinded RFP that MDHHS sought to eliminate by eliminating delegation of provider network (in fact, all managed care) functions to CMHSPs. It was a key finding of the Court that doing so is contrary to Michigan law. Sections of the waiver amendment application also state that "The PIHPs delegate the responsibilities of plan development and monitoring to CMHSP, or contracted provider chosen by the individual or family."
- The waiver amendment clearly specifies "MDHHS contracts with *regional non-state public managed care entities* known as" PIHPs and that these PIHPs "are comprised of one or more CMHSPS." In my view, if approved by CMS, the federal agency would be approving this contracting arrangement – specifically with public regional entities. It also contains extensive description of MDHHS oversight of the PIHPs including any "affiliate CMHSPs within a PIHP region."
- With direct implications for conflict free access and planning, the waiver amendment specifies free choice of provider. In accordance with 42 Code of Federal Regulations (CFR) 431.151, which states in part that "a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.".

This is all very bewildering in that in our lawsuit against the State-issued RFP, the State was arguing against many of these very provisions. I'm not sure what to make of that other than, perhaps, the right hand doesn't know what the left hand was arguing, especially since we know this application has been in development for months – well before the court ruling.

What is not mentioned at all in the waiver application is any conflict of interest at the governance level of PIHPs – even while there is a fairly robust description of the "Conflict Free Access and Planning" (which is at the beneficiary level). More on Conflict Free Access and Planning in the next section of this report.

9. Conflict Free Access and Planning:

The State has been silent on Conflict Free Access and Planning (CFAP) for over a year. However, as just noted, there is robust description of the State's requirements to implement conflict free access and planning. The following is extracted directly from the State Waiver Amendment Application. (Capitalized material is new to this waiver amendment and is in caps in the original. Apologies to readers as all caps is difficult to read).

It is abundantly clear to me that the State fully intends to implement the conflict free access and planning designs it released publicly a couple of years ago and our region should prepare accordingly.

> The PIHPs delegate the responsibilities of plan development and monitoring to CMHSP, or contracted provider chosen by the individual or family. Michigan's providers, including CMHSPs in their role as provider, may not offer both service planning and direct services to the same beneficiary without an only willing and qualified provider designation.
>
> **Service Plan Development Safeguards.** Providers of Home and Community Based Services (HCBS) for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the

only willing and qualified entity in a geographic area, and the state devises conflict of interest protections.

THE STATE HAS CHOSEN TO LEVERAGE THE OPTION OF ALLOWING FOR ONLY WILLING AND QUALIFIED ENTITIES TO PROVIDE DIRECT SERVICES AND PERFORM ASSESSMENT AND PLANS OF CARE IN A GEOGRAPHICAL AREA.
WHEN PROVIDERS OF DIRECT SERVICE ARE GIVEN RESPONSIBILITY TO PERFORM ASSESSMENTS AND PLANS OF CARE, THEY MUST BE THE ONLY WILLING AND QUALIFIED ENTITY IN A GEOGRAPHICAL AREA.
THE ONLY WILLING AND QUALIFIED PROVIDER DESIGNATIONS (OWQP) ARE EVALUATED FOR THE SPECIFIC GEOGRAPHICAL AREA OF EACH COUNTY. WITHIN THAT COUNTY, EACH PROVIDER IS EVALUATED ACCORDING TO THE FOLLOWING CRITERIA:

1. A: PROVIDER IS LOCATED IN A RURAL COUNTY OF THE STATE, AS DEFINED BY MDHHS USING CENSUS BUREAU DATA
   B: PROVIDER IS A TRIBAL PROVIDER WITH EXPERIENCE AND KNOWLEDGE TO PROVIDE SERVICES TO INDIVIDUALS WHO SHARE A COMMON CULTURAL BACKGROUND, (MDHHS DEFINES TRIBAL PROVIDERS)
2. PROVIDER IS THE ONLY ENTITY OFFERING SERVICE PLANNING IN THE COUNTY, AS IDENTIFIED IN SPECIFICATIONS DEFINED BY MDHHS
3. PROVIDER DELIVERS HCBS SERVICE(S) DUE TO LACK OF OTHER DIRECT SERVICE PROVIDERS IN THE COUNTY (MDHHS DEFINES "LACK OF OTHER DIRECT SERVICE PROVIDERS")

THE STATE WILL ENSURE THAT CONFLICT OF INTEREST PROTECTIONS WILL BE IMPLEMENTED.
CONFLICT OF INTEREST PROTECTIONS: MDHHS IS RESPONSIBLE FOR IDENTIFYING QUALIFIED PROVIDERS TO RECEIVE AN OWQP DESIGNATION USING CLEAR AND PUBLISHED SET OF CRITERIA.
MDHHS FACILITATES THE OWQP DESIGNATION PROCESS EVERY THREE YEARS.

A. MDHHS DEFINES THE CRITERIA FOR OWQP DESIGNEES, COMPLIANCE EXPECTATIONS AND REQUIREMENTS, INCLUDING ACCEPTABLE SAFEGUARDS TO LIMIT CONFLICTS OF INTEREST.
B. MDHHS WILL DIRECTLY OVERSEE AND MONITOR OWQP DESIGNATIONS THROUGH STATE POLICY, MEDICAID PROVIDER MANUAL LANGUAGE, CONTRACT LANGUAGE, SITE REVIEWS, AUDITS, AND DATA ANALYSIS.
C. MDHHS MONITORING WILL INCLUDE ONGOING EFFORTS TO EXPAND THE PROVIDER NETWORK TO MAXIMIZE CHOICE FOR BENEFICIARIES.
D. MDHHS CONDUCTS RETROSPECTIVE REVIEWS OF OWQP DESIGNATION APPLICATIONS FOR COMPLIANCE.

1. ONLY-WILLING-AND-QUALIFIED PROVIDER (OWQP): PROVIDERS WITH MDHHS-APPROVED OWQP DESIGNATION MUST ESTABLISH AND ATTEST TO SAFEGUARDS TO PROTECT AGAINST CONFLICTS OF INTERESTS. SAFEGUARDS REQUIRED FOR MDHHS-APPROVED OWQP DESIGNEES MUST INCLUDE, AT MINIMUM:
   A. AN OPPORTUNITY FOR THE PARTICIPANT TO DISPUTE THE STATE'S ASSERTION THAT THE CASE MANAGEMENT ENTITY IS THE ONLY WILLING AND QUALIFIED PROVIDER THROUGH AN ALTERNATIVE DISPUTE RESOLUTION PROCESS;
   B. ANNUAL EVALUATION BY A STATE AGENCY (MDHHS);
   C. ADMINISTRATIVELY SEPARATE THE PLAN DEVELOPMENT FUNCTION FROM THE DIRECT SERVICE PROVIDER FUNCTIONS (INCLUDING OVERSIGHT BY SEPARATE SUPERVISORS);
   D. REQUIRE THE INDIVIDUAL CONDUCTING SERVICE PLANNING OR ELIGIBILITY/NEEDS ASSESSMENT IS NOT THE SAME INDIVIDUAL PROVIDING DIRECT SERVICE.
2. OVERALL STRUCTURE: MICHIGAN'S PROVIDERS, INCLUDING CMHSPS IN THEIR ROLE AS PROVIDER, MAY NOT OFFER BOTH SERVICE PLANNING AND DIRECT SERVICES TO THE SAME

BENEFICIARY WITHOUT AN OWQP DESIGNATION. TO BE COMPLIANT WITH CFA&P REQUIREMENTS, CMHSPS MUST ARRANGE THEMSELVES IN ONE OF TWO SCENARIOS OR RECEIVE AN OWQP DESIGNATION AS THE THIRD SCENARIO.

A. SCENARIO 1: THE CMHSP CONTRACTS OUT BOTH SERVICE PLANNING AND DIRECT SERVICE FUNCTIONS TO PROVIDERS. THE CMHSP MUST ENSURE THAT A MEMBER IS REFERRED TO PROVIDER A FOR SERVICE PLANNING AND A SEPARATE PROVIDER B FOR DIRECT SERVICES.
B. SCENARIO 2: THE CMHSP DIRECTLY OFFERS BOTH SERVICE PLANNING AND DIRECT SERVICES AND CONTRACTS WITH PROVIDERS FOR THESE FUNCTIONS. THE CMHSP MAY CONTINUE TO PROVIDE SERVICE PLANNING OR DIRECT SERVICES TO A SINGLE MEMBER BUT MUST ENSURE A MEMBER IS REFERRED TO A SEPARATE PROVIDER A TO CONDUCT THE REMAINING FUNCTION.
C. SCENARIO 3: SEE INFORMATION ABOVE ON OWQP DESIGNATION.

3. THE PIHPS DELEGATE THE RESPONSIBILITIES OF PLAN DEVELOPMENT AND MONITORING TO CMHSP, OR CONTRACTED PROVIDER CHOSEN BY THE INDIVIDUAL OR FAMILY.
4. OVERALL SAFEGUARDS: MDHHS REQUIRES SAFEGUARDS AT SEVERAL LAYERS TO PROTECT AGAINST CONFLICTS OF INTEREST. SAFEGUARDS ARE IMPLEMENTED TO DEFINE, IDENTIFY, MITIGATE, AND MONITOR POTENTIAL OR ACTUAL CONFLICTS OF INTEREST.
    A. MDHHS OVERSEES THE DEVELOPMENT OF IMPLEMENTATION PLANS TO ACCOMPLISH THE MDHHS ESTABLISHED SAFEGUARDS.
    B. THE FOLLOWING SAFEGUARDS ARE IDENTIFIED IN CONTRACTS.
        i. MDHHS CONTRACTS WITH PIHPS RESTRICTS THE ENTITY (I.E., CMHSP OR CONTRACTED PROVIDER) THAT DEVELOPS THE PERSON-CENTERED SERVICE PLAN FROM PROVIDING SERVICES WITHOUT THE DIRECT APPROVAL OF THE STATE.
        ii. MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO MAINTAIN AND PUBLISH A COMPLETE PROVIDER DIRECTORY, INCLUDING INDEPENDENT FACILITATORS, IN HARD COPY AND WEB-BASED FORMATS. INFORMATION MUST BE UPDATED ON AN ONGOING BASIS TO MAINTAIN ACCURACY.
        iii. MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO BE RESPONSIBLE FOR UTILIZATION MANAGEMENT OF SERVICES COVERED UNDER THE SCOPE OF CFA&P IMPLEMENTATION. THE PIHP CANNOT DELEGATE THEIR AUTHORIZATION AND UTILIZATION MANAGEMENT RESPONSIBILITIES TO OTHER ENTITIES.
        iv. MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO PROVIDE FULL DISCLOSURE TO BENEFICIARIES AND ASSURANCE THAT BENEFICIARIES ARE SUPPORTED IN EXERCISING THEIR RIGHT TO FREE CHOICE OF PROVIDERS AND ARE PROVIDED INFORMATION ABOUT THE FULL RANGE OF WAIVER SERVICES, NOT JUST THE SERVICES FURNISHED BY THE ENTITY THAT IS RESPONSIBLE FOR THE SERVICE PLAN DEVELOPMENT.

MDHHS as the state Medicaid agency will deliver Habilitation Supports Waiver (HSW) services through contracted arrangements with its managed care PIHP regions. The PIHPs have responsibility for development and monitoring person-centered service plans and the network's implementation of the HSW services, which require additional conflict of interest protections including separation of service planning and service delivery TO ALIGN WITH THE MDHHS-APPROVED CFA&P SCENARIOS, AS OUTLINED IN MDHHS' CFA&P REQUIREMENTS AND PIHP CONTRACTS. IN RURAL AND/OR TRIBAL COMMUNITIES AND as outlined in MDHHS' Conflict- Free Access and Planning "Only Willing and Qualified Provider Designation" Process and approved by CMS, the State may approve an entity to provide both service planning and direct waiver services to the same beneficiary. In those limited circumstances and as defined in MDHHS' "ONLY WILLING AND QUALIFIED PROVIDER DESIGNATION"

PROCESS, the entity must implement protections to mitigate conflict of interest. Utilization management will be maintained by the PIHP.

THE ONLY WILLING AND QUALIFIED PROVIDER DESIGNATIONS ARE EVALUATED FOR THE SPECIFIC GEOGRAPHICAL AREA OF EACH COUNTY. WITHIN THAT COUNTY, EACH PROVIDER IS EVALUATED ACCORDING TO THE FOLLOWING CRITERIA:

1. A: PROVIDER IS LOCATED IN A RURAL COUNTY OF THE STATE, AS DEFINED BY MDHHS USING CENSUS BUREAU DATA; OR
   B: PROVIDER IS A TRIBAL PROVIDER WITH EXPERIENCE AND KNOWLEDGE TO PROVIDE SERVICES TO INDIVIDUALS WHO SHARE A COMMON CULTURAL BACKGROUND, (MDHHS DEFINES TRIBAL PROVIDERS); AND
2. PROVIDER IS THE ONLY ENTITY OFFERING SERVICE PLANNING IN THE COUNTY, AS IDENTIFIED IN SPECIFICATIONS DEFINED BY MDHHS
3. PROVIDER DELIVERS HCBS SERVICE(S) DUE TO LACK OF OTHER DIRECT SERVICE PROVIDERS IN THE COUNTY (MDHHS DEFINES "LACK OF OTHER DIRECT SERVICE PROVIDERS")

THE STATE WILL ENSURE THAT CONFLICT OF INTEREST PROTECTIONS WILL BE IMPLEMENTED.

IN ADDITION TO REGULAR MDHHS AUDITING PROCESSES, PIHPS WILL BE CONTRACTUALLY REQUIRED TO MONITOR Only Willing and Qualified Provider (OWQP) DESIGNEES TO ENSURE THEY ARE IMPLEMENTING POLICIES AND PROCEDURES AS INTENDED. PIHPS MAY USE AUTHORIZATION DATA, SERVICE PLAN AUDITS, AND GRIEVANCE AND APPEALS DATA TO INFORM COMPLIANCE WITH OWQP DESIGNATIONS.

ONLY CMHSPS/PROVIDERS WITH OWQP DESIGNATIONS MAY BE RESPONSIBLE FOR SERVICE PLAN MONITORING AND DIRECT SERVICES TO THE SAME BENEFICIARY. PROVIDERS/CMHSPS WITH OWQP DESIGNATIONS MUST ATTEST IN THEIR OWQP DESIGNATION APPLICATION THERE IS SEPARATION BETWEEN STAFF OFFERING SERVICE PLAN MONITORING AND STAFF OFFERING DIRECT SERVICES. ADDITIONALLY, THE PIHPS, ARE RESPONSIBLE FOR UTILIZATION MANAGEMENT FUNCTIONS, INCLUDING AUTHORIZATION OF THE SERVICE PLAN.

PROVIDERS/CMHSPS WITH OWQP DESIGNATIONS MUST ATTEST IN THEIR OWQP DESIGNATION APPLICATION THERE IS SEPARATION BETWEEN STAFF OFFERING SERVICE PLAN MONITORING AND STAFF OFFERING DIRECT SERVICES. METHODS TO ADMINISTRATIVELY SEPARATE SERVICE MONITORING FROM DIRECT SERVICE MUST BE APPROVED BY MDHHS THROUGH THE OWQP DESIGNATION APPLICATION PROCESS. PIHPS MUST VERIFY AND MONITOR THE ADEQUACY OF THE ADMINISTRATIVE SEPARATIONS OUTLINED BY THE CMHSP/PROVIDERS IN THEIR OWQP DESIGNATION APPLICATION.

10. Governor Whitmer's FY 27 Budget Recommendations:

(Excerpted from an email from CMH Association of Michigan Incoming CEO Alan Bolter): Governor Gretchen Whitmer's eighth and final executive budget recommendation was presented by State Budget Director Jen Flood. The budget doubles down on the administration's long-term priorities. Amid national economic uncertainty caused by tariffs and deep federal cuts to Medicaid and Supplemental Nutrition Assistance

Program (SNAP), the budget lowers costs, protects access to health care, and makes other key investments to help more families live, work, and play in Michigan.

The proposed FY27 spending plan is $88.1 billion, including a general fund total of $13.6 billion and a school aid budget totaling $21.4 billion. The budget is based on roughly $800 million in tax increases, $630 million in cuts and $400 million from the rainy day fund.

According to the Budget Director, the plan puts a premium on preventing cuts to Medicaid, the health program that roughly 1 in 4 Michiganders count on to cover their care. The One Big Beautiful Bill Act (OBBBA) pushed new eligibility requirements and costs for Medicaid and Supplemental Nutrition Assistance Program (SNAP) recipients onto the states.

According to the Budget Office, Kentucky is proposing a $1 billion rainy-day fund withdrawal to cover the shortfall. Washington is proposing to end corporate tax exemptions and use $1 billion in reserves. Alaska is proposing a new sales tax. Delaware is proposing tax increases. Idaho is looking at a 2% cut to K-12.

Whitmer's plan suggests $804.4 million in tax increases to gaming, tobacco, vaping and digital advertising as a way to make up for the declining federal dollars and new eligibility requirements for Medicaid and food assistance, among other health initiatives.

Despite steep health care increases, Whitmer is also hoping to raise enough money to get a new psychiatric hospital up and running to care for more people, a raise for health care workers and expanded community violence intervention services.

The Department of Health and Human Services (DHHS) estimates it will cost $97 million to implement the OBBBA. The state is being asked to cover 75% of SNAP benefits as opposed to 50% starting in FY 2027. That's another $97 million. To oversee Medicaid compliance means another 589 assistance payment workers, inspectors, analysts, supervisors and administrative assistants, costing $80.3 million more.

FEDERAL/NATIONAL UPDATES AND ACTIVITIES

11. List of All Presidential Executive Orders to Date

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

12. HR 1 ("One Big, Beautiful, Bill") Resources:

The National Council has released an *HR 1 Implementation Journey Map* "with clear, actionable information and guidance on the policy changes ahead, the roles of key stakeholders and the opportunities for engagement that matter most. As states move to implement the Medicaid provisions of H.R. 1, behavioral health providers will face both operational challenges and critical opportunities to shape the path forward."

Congressional Research Service
On June 13, 2025, the Congressional Research Service published a report entitled *Health Coverage Provisions in the One Big Beautiful Bill Act* (HR 1). The Service is the official "non-partisan" research arm supporting both houses of Congress. From the report:
This report includes three tables that provide an overview of the health coverage provisions in the OBBBA, along with the applicable current law for each provision and relevant Congressional Research Service contacts and resources. Table 1 includes provisions that apply to the Medicaid program. Table 2 includes provisions that affect the private health insurance market, but excludes provisions amending the Internal Revenue Code (IRC). Table 3 includes provisions related to Medicare. The report is available at https://www.congress.gov/crs-product/R48569.

Kaiser Family Foundation
(We have found KFF to be a non-partisan, timely, and accurate information source)

Tracking Implementation of the 2025 Reconciliation Law: Medicaid Work Requirements.
To implement Medicaid work requirements, states will need to make important policy and operational decisions, implement needed system upgrades or changes, develop new outreach and education strategies, and hire and train staff, all within a relatively short timeframe. The information tracked here can serve as a resource to understand Medicaid work requirements and state options, gauge readiness, and track implementation of the requirements, including: state/national data & policies, guidance & implementation questions, implementation/waiver status, and other resources. Available at https://www.kff.org/medicaid/medicaid-work-requirements-tracker-overview/

KFF maintains a resource entitled *Health Provisions in the 2025 Federal Budget Reconciliation Bill* updated July 8. The document provides a summary of Medicaid provisions in both the House and Senate versions of the reconciliation bill, plus that enacted into law by presidential signature on July 4. The resource also includes a separate implementation timeline highlighting key dates in the law. The comparison is divided into four categories: Medicaid, the Affordable Care Act, Medicare and Health Savings Accounts (HSAs). Available at https://www.kff.org/medicaid/tracking-the-medicaid-provisions-in-the-2025-budget-bill/.

CMS
CMS often refers to the OBBB as the "Working Families Tax Cut" (WFTC) legislation. The WFTC legislation included changes to the Medicaid program to be implemented in the coming years, including the introduction of community engagement requirements for certain adults enrolled in Medicaid. Community engagement has potential to empower Medicaid beneficiaries through employment, education, or volunteer service so they can escape isolation and dependency, build confidence, and achieve self-sufficiency. A December 8, 2025 Center for Medicaid and CHIP Services (CMCS) Information Bulletin provides extensive information on "community engagement." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf.

13. HR 1 ("One Big, Beautiful, Bill") Medicaid Specifics:

Congressional Research Service
This link leads to a section-by-section summary of the bill prepared by the Congressional Research Service. The Medicaid section follows.

"Subtitle B--Health
Chapter 1--Medicaid
Subchapter A--Reducing Fraud and Improving Enrollment Processes

- (Sec. 71101) This section delays until FY2035 implementation of certain provisions of the rule titled *Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment*, which was issued by the Centers for Medicare & Medicaid Services (CMS) on September 21, 2023.
- Specifically, the section delays provisions of the rule that (1) specify that individuals who must pay a premium to enroll in Medicare hospital services, reside in a group payer state, and enroll during a general enrollment period may qualify for Medicare Savings Programs (MSPs) as early as the month of their entitlement to Medicare hospital services; (2) require states to use certain data from the Social Security Administration (SSA) to facilitate the enrollment of qualifying individuals in both MSPs and the Low-Income Subsidy (LIS) program under the Medicare prescription drug benefit; and (3) align the definition of family size under MSPs with the definition under the LIS program. (MSPs allow individuals to receive Medicare cost-sharing and premium assistance from state Medicaid programs if they meet certain income and resource criteria. The LIS program, also known as the Extra Help program, provides similar assistance with respect to cost-sharing for covered drugs under the Medicare prescription drug benefit.)
- The section provides $1 million for FY2026 for the CMS to implement this section and Sec. 71102 of this act.

(Sec. 71102) This section delays until FY2035 implementation of certain provisions of the rule titled *Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes*, which was issued by the CMS on April 2, 2024.

- Specifically, the section delays provisions of the rule that, among other changes, (1) allow state Medicaid programs to verify an individual's U.S. citizenship and identity through certain systems without additional proof of identity; (2) align certain Medicaid enrollment processes for those whose eligibility is not based on income with those that are based on income; and (3) establish additional timelines for Medicaid eligibility terminations, including when there is a change in an individual's circumstances.

(Sec. 71103) This section requires the CMS to establish a centralized system for states to check whether enrollees are simultaneously enrolled in Medicaid or the Children's Health Insurance Program (CHIP) in multiple states.

- Beginning no later than 2027, states must regularly obtain the addresses of Medicaid and CHIP enrollees from specified authorized sources. Beginning no later than FY2030, states must report on at least a monthly basis the Social Security numbers of enrollees to the CMS' newly established system. The CMS must notify states on at least a monthly basis of individuals who are enrolled in multiple states so that states may take appropriate action.
- The section provides $10 million for FY2026 and $20 million for FY2029 for the CMS to establish and maintain the new system, respectively.

(Sec. 71104) This section requires state Medicaid programs to check, beginning in 2028, the SSA's Death Master File on at least a quarterly basis to determine whether Medicaid enrollees are deceased.

(Sec. 71105) This section provides statutory authority for the requirement that state Medicaid programs check, as part of the provider enrollment and reenrollment process, whether providers are deceased through the SSA's Death Master File. Beginning in 2028, the section requires states to continue to check this database on at least a quarterly basis after providers are enrolled.

(Sec. 71106) This section includes Medicaid payments to individuals for whom there is insufficient information as to their eligibility as erroneous excess payments that may ultimately reduce a state's federal matching funds. These changes apply beginning in FY2030.

(Sec. 71107) This section requires state Medicaid programs to redetermine every six months, beginning with the first quarter after December 31, 2026, the eligibility of individuals who are enrolled in Medicaid as part of the Medicaid expansion population under the Patient Protection and Affordable Care Act. (That act allows states to extend Medicaid coverage to all adults under the age of 65 with incomes of up to 138% of the federal poverty level, including able-bodied adults without dependent children.)

- The section provides $75 million for FY2026 for the CMS to implement these provisions.

(Sec. 71108) This section caps home equity limits for Medicaid nursing facility or other long-term care services beginning in 2028.

- Currently, in order to qualify for such services, an individual's home equity may not exceed certain limits, as set by states in accordance with federal standards and adjusted annually for inflation. For 2025, home equity limits set by states must be between $730,000 and $1,097,000.
- The section caps the maximum home equity limit to $1 million, regardless of inflation. This limit does not apply to homes located on agricultural lots.

(Sec. 71109) This section generally restricts, beginning in FY2027, federal payment for Medicaid and CHIP to services for individuals who are U.S. residents and are either U.S. citizens, lawful permanent residents, Cuban-Haitian entrants, or Compact of Free Association migrants lawfully residing in the United States. The restrictions do not apply to certain mandatory emergency services provided to individuals who are not lawfully residing in the United States or to optional services provided to certain lawfully residing children and pregnant women.

- Current law authorizes federal payment with respect to additional categories of individuals, including refugees; noncitizens granted parole for at least one year, asylum, or related relief; and Violence Against Women Act (VAWA) self-petitioners. The section excludes these individuals from eligibility.
- The section provides $15 million for FY2026 for the CMS to implement these provisions.

(Sec. 71110) This section reduces the Medicaid federal matching rate for emergency services provided to individuals who are not lawfully residing in the United States but who would otherwise qualify for Medicaid as part of the Medicaid expansion population in states that have expanded Medicaid. Specifically, the section limits, beginning in FY2027, the Medicaid federal matching rate for emergency services provided to individuals who are not lawfully residing in the United States to the same matching rate as would otherwise apply for such services (rather than the enhanced federal matching rate for states that have expanded Medicaid).

- The section provides $1 million for FY2026 for the CMS to implement these provisions.

Subchapter B--Preventing Wasteful Spending

(Sec. 71111) This section delays until FY2035 implementation of certain provisions of the rule titled *Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting*, which was issued by the CMS on May 10, 2024.

- Specifically, the section delays provisions of the rule that, among other changes, (1) establish minimum staffing standards for nurses in Medicare and Medicaid long-term care facilities, including requiring a nurse to be onsite 24/7 and requiring a minimum of 3.48 total nurse staffing hours per resident per day; and (2) require state Medicaid programs to report on payments to direct care workers and support staff of nursing facilities and intermediate care facilities for individuals with intellectual disabilities.

(Sec. 71112) This section shortens the window for retroactive Medicaid coverage. Specifically, the section specifies that, beginning with the first quarter after December 31, 2026, Medicaid coverage may begin retroactively (1) for individuals in the Medicaid expansion population, one month prior to the application filing date; and (2) for all other individuals, two months prior to the application filing date. Additionally, CHIP coverage may retroactively begin two months prior to the application filing date. (Currently, coverage may begin three months prior to the application filing date.)

- The section provides $10 million for FY2026 for the CMS to implement these provisions.

(Sec. 71113) This section prohibits federal Medicaid payment for one year to nonprofit health care providers that serve predominantly low-income, medically underserved individuals (i.e., essential community providers) if the provider (1) primarily furnishes family planning services, reproductive health, and related care; (2) offers abortions in cases other than that of rape, incest, or life-threatening conditions for the woman; and (3) in FY2023, received federal and state Medicaid payments totaling more than $800,000.

- The section provides $1 million for FY2026 for the CMS to implement these provisions.

Subchapter C--Stopping Abusive Financing Practices

(Sec. 71114) This section requires states that had not chosen to expand Medicaid pursuant to the Patient Protection and Affordable Care Act prior to March 11, 2021, to do so by January 1, 2026, in order to receive the corresponding enhanced federal matching rate.

(Sec. 71115) This section generally limits Medicaid provider taxes beginning in FY2027.

- Under current law, states may impose a provider tax of up to 6% of net patient service revenues to potentially receive additional federal matching funds. The section precludes states that have not expanded Medicaid from increasing the rate of a provider tax beyond that currently in effect in order to qualify for federal matching funds. For states that have expanded Medicaid, a provider tax may not exceed the current rate or a specified rate, whichever is lower; the maximum rate gradually decreases from FY2028-FY2032, with a maximum rate of 3.5% beginning in FY2032 (these limits do not apply to nursing and intermediate care facilities, which are instead limited to current rates). The section additionally precludes states from imposing a new provider tax if there is not already one in effect.
- The section provides $20 million for FY2026 for the CMS to implement these provisions.

(Sec. 71116) This section provides $7 million per fiscal year for FY2026-FY2033 for the CMS to revise regulations so as to limit state-directed payments for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center under Medicaid managed care contracts to the payment rate for services under Medicare, rather than the average commercial rate. For states that cover the Medicaid expansion population, payment is limited to 100% of the Medicare rate; for other states, payment is limited to 110% of the Medicare rate.

Subchapter D--Increasing Personal Accountability

(Sec. 71119) This section requires, beginning not later than the first quarter after December 31, 2026 (or earlier, at the option of the state), individuals who are eligible for Medicaid as part of the Medicaid expansion population to engage in community service, work, or other activities in order to qualify for Medicaid.

- Specifically, the section requires these individuals to, on a monthly basis, (1) work at least 80 hours, (2) complete at least 80 hours of community service, (3) participate in a work program for at least 80 hours, (4) be enrolled at least half-time in an educational program, or (5) engage in any combination thereof for a total of at least 80 hours. Individuals may also qualify if they have a monthly income (or, for seasonal workers, an average monthly income over six months) that is at least as much as the equivalent of minimum wage multiplied by 80 hours.

- Individuals who are applying for Medicaid must demonstrate compliance with these requirements for one to three months (as determined by the state) consecutively and immediately prior to filing an application; individuals who are already enrolled in Medicaid must demonstrate compliance for one month or more (as determined by the state), whether or not consecutive, during the period between the individual's last eligibility determination and the next scheduled eligibility determination.
- States must verify an individual's compliance upon a determination or redetermination of eligibility but may also choose to verify compliance more frequently. States may not waive the new requirements. However, states may choose to provide an exception for individuals experiencing short-term hardships (e.g., hospitalization).
- The section excludes certain individuals from these requirements, including those with serious medical conditions or with dependent children aged 13 or younger.
- Upon request, the CMS may exempt a state from fully implementing these requirements until December 31, 2028. States requesting an exemption must demonstrate good faith efforts to comply with the requirements and provide a detailed timeline for implementation.
- The section provides $200 million to states and $200 million to the CMS for FY2026 to implement these requirements.

(Sec. 71120) This section requires, beginning in FY2029, states to institute cost-sharing requirements for individuals who are eligible for Medicaid as part of the Medicaid expansion population and whose family income exceeds the federal poverty line. Cost sharing may not exceed $35 for an item or service; total cost sharing for all individuals in a family may not exceed 5% of the family's income.

- The requirements do not apply to (1) services for which cost sharing is already prohibited (e.g., emergency services); (2) primary care, mental health, or substance use disorder services; or (3) services provided by federally qualified health centers, certified community behavioral health clinics, or rural health clinics. States may allow providers to condition the provision of services upon the payment of any required cost sharing.
- The section provides $15 million for FY2026 for the CMS to implement these provisions.

Subchapter E--Expanding Access to Care

(Sec. 71121) This section authorizes additional home and community-based services (HCBS) waivers (also known as Section 1915(c) waivers) for state Medicaid programs beginning on July 1, 2028. States may seek waivers to provide HCBS to individuals without the need for certain determinations as to whether an individual requires hospital or institutional care (as is required for current waivers). States must establish other needs-based criteria for such services.

- The section provides $50 million for FY2026 for the CMS to implement these provisions. It also provides $100 million for FY2027 to support state HCBS programs.

14. Great American Recovery Initiative:

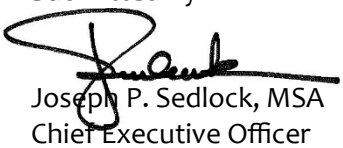
On Jan. 29, the Trump-Vance administration released an executive order to coordinate the federal government response to the substance use and addiction crisis.

The National Council is gathering details from the order and a White House fact sheet. In short, the "Great American Recovery Initiative" will be chaired by Department of Health and Human Services Secretary Robert F. Kennedy Jr., and Senior Advisor for Addiction and Recovery Kathryn Burgum, a substance use and recovery advocate and former first lady of North Dakota.

The Initiative will advise federal agencies on how to integrate programs on drug prevention, early intervention, treatment, recovery support and reentry. The Initiative is also tasked with consulting states,

Tribal nations, local governments, community and faith-based organizations, the private sector and philanthropic partners to identify effective recovery strategies to ensure more Americans receive life-saving care and support.

Submitted By:



Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 02/19/2026

Attachments:

- Michigan Legislation Tracker

Michigan Legislative Bill Tracking Update for Board of Directors

MSHN Mid-State Health Network

All bills in this compilation can be searched on the Michigan Legislature website by clicking here

Compiled by Sherry Kletke, Executive Support Specialist as of February 9, 2026

Bill Number	Title	Sponsors	Latest Action	Last Action Date
House Bills				
HB 4037	Records: health; health information exchange; establish certain requirements to operate a health data utility. Amends secs. 2501 & 2505 of 1978 PA 368 (MCL 333.2501 & 333.2505) & adds sec. 2508.	Julie Rogers (D)	Reported With Recommendation With Substitute (h-2)	May. 20, 2025
HB 4255	Crimes: controlled substances; crime of manufacturing, delivering, or possession of with intent to deliver certain controlled substances; modify penalties. Amends secs. 7401, 7410 & 7417 of 1978 PA 368 (MCL 333.7401 et seq.) & adds secs. 7410b & 7417a.	Sarah Lightner (R)	Referred To Committee On Civil Rights, Judiciary, And Public Safety	Apr. 28, 2025
HB 4256	Criminal procedure: sentencing guidelines; sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver certain controlled substances; amend. Amends sec. 13m, ch. XVII of 1927 PA 175 (MCL 777.13m). TIE BAR WITH: HB 4255'25	Ann Bollin (R)	Referred To Committee On Civil Rights, Judiciary, And Public Safety	Apr. 28, 2025
HB 4279	Military affairs: other; Michigan National Guard apprenticeship program; create. Creates new act.	Jaime Greene (R)	Reported With Recommendation With Substitute (h-3)	Sep. 03, 2025
HB 4280	Health occupations: social workers; limited licenses for bachelor's social worker and master's social worker; extend period for renewal. Amends sec. 18509 of 1978 PA 368 (MCL 333.18509).	Kimberly Edwards (D)	Referred To Committee On Health Policy	Mar. 19, 2025
HB 4412	Hospitalization	Donni Steele (R)	Reported by the Health Policy Committee with substitute H-1 adopted	Jan. 20, 2026
HB 4413	Outpatient Treatment	Mark Tisdel (R)	Reported by the House Health Policy Committee	Jan. 20, 2026
HB 4414	Outpatient Treatment	Thomas Kuhn (R)	Reported by the Health Policy Committee	Jan. 20, 2026
HB 4417	Health occupations: emergency medical services personnel; access to opioid antagonists; provide to life support agencies under certain circumstances. Amends 1978 PA 368 (MCL 333.1101 - 333.25211) by adding sec. 20911.	Mike Mueller (R)	Referred To Committee On Health Policy	Jun. 30, 2025
HB 4423	Appropriations: supplemental; funding for the county veteran service fund emergency relief program; provide for. Creates appropriation act.	Julie Rogers (D)	Referred To Committee On Appropriations	Apr. 30, 2025
HB 4428	Health: pharmaceuticals; 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; allow.	Alicia St. Germaine (R)	Referred To Committee On Regulatory Reform	May. 05, 2025
HB 4497	Controlled substances: drug paraphernalia; definition of drug paraphernalia; modify. Amends sec. 7451 of 1978 PA 368 (MCL 333.7451).	Carrie Rheingans (D)	Referred To Committee On Judiciary	May. 14, 2025
HB 4498	Health: other; syringe service programs; provide for. Amends secs. 7401, 7403, 7453 & 7457 of 1978 PA 368 (MCL 333.7401 et seq.) & adds sec. 5137.	Carrie Rheingans (D)	Referred To Committee On Health Policy	May. 14, 2025
HB 4548	Civil rights: general discrimination; discrimination because of ethnicity, including discrimination because of Jewish heritage; prohibit under the Elliot-Larsen civil rights act. Amends title & secs. 102, 103, 202, 203, 204, 205, 206, 207, 209, 210, 301, 302, 302a, 402, 502, 504, 505, 506 & 507 of 1976 PA 453 (MCL 37.2102 et seq.).	Noah Arbit (D)	Referred To Committee On Government Operations	Jun. 03, 2025
HB 4683	Insurance: health insurers; prior authorization requirements for mental health and substance use disorder; modify. Amends sec. 3425 of 1956 PA 218 (MCL 500.3425).	Mike McFall (D)	Referred To Committee On Insurance	Jun. 24, 2025
HB 4685	Insurance: health insurers; collaborative care model for mental health care; provide for. Amends 1956 PA 218 (MCL 500.100 - 500.8302) by adding sec. 3406uu.	Mike McFall (D)	Referred To Committee On Insurance	Jun. 24, 2025

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HB 4686	Crimes: controlled substances; creating, manufacturing, possessing, or using psilocybin or psilocin; allow under certain circumstances. Amends 1978 PA 368 (MCL 333.1101 - 333.25211) by adding sec. 7404a.	Mike McFall (D)	Referred To Committee On Families And Veterans	Jun. 24, 2025
HB 4739	Human services: medical services; coverage for diagnosis of autism spectrum disorders and treatment of autism spectrum disorders; require. Amends 1939 PA 280 (MCL 400.1 - 400.119b) by adding sec. 109u.	Will Snyder (D)	Referred To Committee On Insurance	Jul. 14, 2025
HB 4740	Insurance: health insurers; required coverage for autism spectrum disorders; modify. Amends sec. 3406s of 1956 PA 218 (MCL 500.3406s).	Will Snyder (D)	Referred To Committee On Insurance	Jul. 14, 2025
HB 4751	Civil rights: general discrimination; sexual orientation and gender identity or expression; remove as categories protected under the Elliott-Larsen civil rights act. Amends title & secs. 102, 103, 202, 203, 204, 205, 206, 207, 209, 302, 302a, 402, 502, 504, 505 & 506 of 1976 PA 453 (MCL 37.2102 et seq.).	Josh Schriver (R)	Referred To Committee On Government Operations	Jul. 28, 2025
HB 4777	Civil rights: general discrimination; gender identity or expression; remove from categories protected under Elliott-Larsen civil rights act. Amends title & secs. 102, 103, 202, 203, 204, 205, 206, 207, 209, 302, 302a, 402, 502, 504, 505 & 506 of 1976 PA 453 (MCL 37.2102 et seq.).	Brad Paquette (R)	Referred To Committee On Government Operations	Aug. 19, 2025
HB 4915	Health occupations: health professionals; implicit bias training; prohibit. Amends 1978 PA 368 (MCL 333.1101 - 333.25211) by adding sec. 16149.	Matt Maddock (R)	Referred To Committee On Regulatory Affairs	Dec. 15, 2025
HB 4953	Military affairs: other; child care reimbursement for National Guard members; provide for. Creates new act. TIE BAR WITH: HB 4958'25, HB 4962'25	Jason Woolford (R)	Referred To Committee On Appropriations	Sep. 15, 2025
HB 4958	Military affairs: other; tuition assistance for national guard members; modify. Amends secs. 3 & 4 of 2014 PA 259 (MCL 32.433 & 32.434). TIE BAR WITH: HB 4953'25	Kathy Schmaltz (R)	Referred To Committee On Appropriations	Sep. 15, 2025
HB 4962	Military affairs: other; Michigan National Guard member benefit fund; create. Creates new act. TIE BAR WITH: HB 4958'25, HB 4953'25	Ron Robinson (R)	Assigned Pa 31'25 With Immediate Effect	Nov. 03, 2025
HB 5105	Crimes: penalties; penalties regarding certain crimes involving marihuana; modify. Amends sec. 7401 of 1978 PA 368 (MCL 333.7401). TIE BAR WITH: HB 5107'25	Pauline Wendzel (R)	Referred To Committee On Regulatory Reform	Oct. 21, 2025
HB 5107	Marihuana: penalties and remedies; marihuana for personal use and possession; modify allowable amounts of. Amends secs. 5 & 15 of 2018 IL 1 (MCL 333.27955 & 333.27965). TIE BAR WITH: HB 5105'25	Mike Hoadley (R)	Referred To Committee On Regulatory Reform	Oct. 21, 2025
HB 5196	Corrections: other; screening and treatment for post traumatic prison disorder; provide for and require certain other mental health screening, planning, and treatment of incarcerated individuals. Amends sec. 67 of 1953 PA 232 (MCL 791.267) & adds secs. 34e, 67c & 67d.	Stephanie Young (D)	Referred To Committee On Judiciary	Oct. 29, 2025
HB 5302	Health: substance use disorder prevention; competitive grant program to provide grants for recovery community organizations; modify. Amends sec. 273b of 1974 PA 258 (MCL 330.1273b).	Jay DeBoyer (R)	Referred To Committee On Health Policy	Dec. 01, 2025
HB 5334	Health facilities: hospitals; assessment by preadmission screening unit of individual being considered for hospitalization within certain period after notification; require. Amends secs. 409 & 972 of 1974 PA 258 (MCL 330.1409 & 330.1972).	Matthew Bierlein (R)	Referred To Committee On Health Policy	Dec. 01, 2025
HB 5407	Property tax: exemptions; exemption for the surviving spouse of a disabled veteran; modify. Amends sec. 7b of 1893 PA 206 (MCL 211.7b).	William Bruck (R)	Referred To Committee On Government Operations	Dec. 17, 2025
HB 5453	Criminal procedure: other; prison diversion program for individuals in the possession of controlled substances; create. Amends 1927 PA 175 (MCL 760.1 - 777.69) by adding sec. 21c to ch. XVI.	Sarah Lightner (R)	Referred To Committee On Judiciary	Jan. 14, 2026
HB 5456	Military affairs: other; hyperbaric oxygen treatment pilot program; establish. Creates new act. TIE BAR WITH: HB 5457'26	Kathy Schmaltz (R)	Referred To Committee On Families And Veterans	Jan. 14, 2026

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Bill Number	Title	Sponsors	Latest Action	Last Action Date
HB 5457	Military affairs: other; hyperbaric oxygen therapy pilot program; establish. Creates new act. TIE BAR WITH: HB 5456'26	Kathy Schmaltz (R)	Referred To Committee On Families And Veterans	Jan. 14, 2026
HR 115	A resolution to urge the President of the United States and the United States Congress to fully fund Medicaid and to reject any proposal that would strip access to those in need and shift costs onto states, health care providers, and vulnerable individuals.	Denise Mentzer (D)	Referred To Committee On Government Operations	May. 21, 2025
HCR 1	A concurrent resolution to urge the Governor of Michigan to issue an executive directive that would require administrating agencies to assess if the implementation of their programs reduce Adverse Childhood Experiences (ACEs) and provide an annual report and data to the Legislature and general public about progress in reducing ACEs in Michigan.	Douglas Wozniak (R)	Reported With Recommendation Without Amendment	Oct. 27, 2025
Senate Bills				
SB 207	Veterans: other; Michigan veterans coalition fund; create. Creates new act. TIE BAR WITH: SB 208'25	Kevin Hertel (D)	Referred To Committee On Appropriations	Jun. 02, 2025
SB 208	Veterans: other; Michigan veterans coalition grant program; create. Creates new act. TIE BAR WITH: SB 207'25	Roger Hauck (R)	Referred To Committee On Appropriations	Jun. 02, 2025
SB 215	Veterans: benefits; Michigan consumer protection act; amend to enhance protections for individuals applying for veterans benefits. Amends sec. 3k of 1976 PA 331 (MCL 445.903k).	Sylvia Santana (D)	Referred To Committee On Appropriations	Jun. 02, 2025
SB 219	Mental health: hospitalization; person requiring treatment; revise, and modify certain procedures for treatment. Amends secs. 401, 427, 430, 461, 468, 472a & 475 of 1974 PA 258 (MCL 330.1401 et seq.).	Kevin Hertel (D)	Referred To Committee On Health Policy	May. 20, 2025
SB 220	Mental health: other; hospital evaluations for assisted outpatient treatment; expand. Amends secs. 206a & 429 of 1974 PA 258 (MCL 330.1206a & 330.1429).	Jeff Irwin (D)	Referred To Committee On Health Policy	May. 20, 2025
SB 221	Criminal procedure: mental capacity; outpatient treatment for misdemeanor offenders with mental health issues; provide for. Amends 1974 PA 258 (MCL 330.1001 - 330.2106) by adding sec. 1021 & ch. 10A. TIE BAR WITH: SB 219'25	Sylvia Santana (D)	Referred To Committee On Health Policy	May. 20, 2025
SB 222	Mental health: other; petition for access to assisted outpatient treatment; expand to additional health providers. Amends sec. 473 of 1974 PA 258 (MCL 330.1473).	Paul Wojno (D)	Referred To Committee On Health Policy	May. 20, 2025
SB 237	Military affairs: other; Michigan National Guard apprenticeship program; create. Creates new act.	Thomas Albert (R)	Referred To Committee On Regulatory Affairs	Apr. 21, 2025
SB 239	Veterans: other; Vietnam veteran era bonus extension act; create. Creates new act.	Kevin Daley (R)	Referred To Committee On Appropriations	Apr. 21, 2025
SB 398	Health: substance use disorder treatment; substance use disorder services programs requirements; modify, and prohibit the promulgation of certain rules. Amends secs. 6230 & 6234 of 1978 PA 368 (MCL 333.6230 & 333.6234).	Joseph Bellino (R)	Referred To Committee On Health Policy	Sep. 03, 2025
SB 399	Controlled substances: drug paraphernalia; definition of drug paraphernalia; modify. Amends sec. 7451 of 1978 PA 368 (MCL 333.7451).	Jeff Irwin (D)	Referred To Committee On Insurance	Jun. 30, 2025
SB 400	Insurance: health insurers; prior authorization for certain opioid use disorder and alcohol use disorder medications; prohibit. Amends 1956 PA 218 (MCL 500.100 - 500.8302) by adding sec. 3406ww.	Kevin Hertel (D)	Referred To Committee On Insurance	Jun. 30, 2025
SB 401	Health: pharmaceuticals; co-prescribing of naloxone with opioid drugs; require. Amends sec. 17744b of 1978 PA 368 (MCL 333.17744b).	Sylvia Santana (D)	Referred To Committee On Insurance	Jun. 30, 2025
SB 430	Crimes: controlled substances; crime of manufacturing, delivering, or possession of with intent to deliver heroin or fentanyl; modify to reflect changes in sentencing guidelines. Amends sec. 7401 of 1978 PA 368 (MCL 333.7401).	Stephanie Chang (D)	Placed On Order Of Third Reading	Oct. 28, 2025

Michigan Legislative Bill Tracking Update for Board of Directors

MSHN
Mid-State Health Network

All bills in this compilation can be searched on the Michigan Legislature website by clicking here

Compiled by Sherry Kletke, Executive Support Specialist as of February 9, 2026

Bill Number	Title	Sponsors	Latest Action	Last Action Date
SB 431	Criminal procedure: sentencing guidelines; sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver heroin or fentanyl; amend. Amends sec. 13m, ch. XVII of 1927 PA 175 (MCL 777.13m). TIE BAR WITH: SB 0430'25	Sarah Anthony (D)	Placed On Order Of Third Reading	Oct. 28, 2025
SB 432	Criminal procedure: probation; probation for certain major controlled substances offenses; allow. Amends sec. 1, ch. XI of 1927 PA 175 (MCL 771.1). TIE BAR WITH: SB 0430'25	Roger Victory (R)	Placed On Order Of Third Reading	Nov. 04, 2025
SB 462	Tobacco: licenses; nicotine or tobacco products; require license to sell at retail. Amends title & secs. 1, 4 & 5 of 1915 PA 31 (MCL 722.641 et seq.) & adds secs. 1a, 1c, 1e, 1g, 1i, 1k & 1o. TIE BAR WITH: SB 0465'25	Sam Singh (D)	Referred To Committee On Regulatory Reform	Dec. 17, 2025
SB 465	Tobacco: licenses; requirement that a person hold a license to sell a nicotine or tobacco product at retail; create certain temporary exemptions to. Amends 1915 PA 31 (MCL 722.641 - 722.645) by adding sec. 1m. TIE BAR WITH: SB 0462'25	Joseph Bellino (R)	Referred To Committee On Regulatory Reform	Dec. 17, 2025
SB 555	Individual income tax: revenue distributions; earmark for MiAble fund; provide for. Amends sec. 51 of 1967 PA 281 (MCL 206.51). TIE BAR WITH: SB 556'25	Michael Webber (R)	Referred To Committee On Housing And Human Services	Sep. 17, 2025
SB 556	Individual income tax: other; MiAble fund; create. Amends 2015 PA 160 (MCL 206.981 - 206.997) by adding sec. 3a. TIE BAR WITH: SB 555'25	Michael Webber (R)	Referred To Committee On Housing And Human Services	Sep. 17, 2025
SB 628	Human services: medical services; coverage for syringe service programs; provide for. Amends 1939 PA 280 (MCL 400.1 - 400.119b) by adding sec. 109t.	Rosemary Bayer (D)	Referred To Committee On Housing And Human Services	Oct. 29, 2025
SB 629	Health: other; syringe service programs; provide for. Amends secs. 7401, 7403, 7453 & 7457 of 1978 PA 368 (MCL 333.7401 et seq.) & adds sec. 5137.	Rosemary Bayer (D)	Referred To Committee On Housing And Human Services	Oct. 29, 2025
SR 3	A resolution to authorize the Senate Majority Leader to commence legal action, on behalf of the Senate, to compel the House of Representatives to fulfill its constitutional duty to present to the Governor the nine remaining bills passed by both houses during the One Hundred Second Legislature.	Winnie Brinks (D)	Adopted	Jan. 21, 2025
SR 50	A resolution to urge the President of the United States and the United States Congress to fully fund Medicaid and to reject any proposal that would strip access to those in need and shift costs onto states, health care providers, and vulnerable individuals.	Kevin Hertel (D)	Adopted	May. 19, 2025

MSHN
Mid-State Health Network

Community Mental Health Member Authorities

Bay Arenac Behavioral Health

CMH of Clinton.Eaton.Ingham Counties

CMH for Central Michigan

Gratiot Integrated Health Network

Huron Behavioral Health

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

LifeWays CMH

Montcalm Care Center

Newaygo County Mental Health Center

Saginaw County CMH

Shiawassee Health and Wellness

Tuscola Behavioral Health Systems

REPORT OF THE MSHN DEPUTY DIRECTOR
to the Board of Directors
January/February

Provider Network Adequacy Assessment – FY25

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

1) Maximum time and distance
2) Medicaid to Enrollee Ratios
3) Timely appointments
4) Language, Cultural competence, and Physical accessibility

MSHN delegates Network Management to the Community Mental Health Service Programs (CMHSPs), including assurance of sufficient capacity to meet the community needs. In FY24, the MSHN region met all requirements for Time/Distance and Provider Enrollee Ratios except for Pediatric Crisis Residential. However, timely appointments for Assertive Community Treatment, Home-Based and Wraparound services were not met by the majority of the CMHSPs.

For FY25, MDHHS included additional data collection elements as Informational Only for; Community Living Supports, Skill Building, Targeted Case Management, Pre-Admission Screening, Outpatient, and Autism.

MSHN and the CMSHPs began assessing the adequacy of our regional Network in January 2026 that already included many of the new elements. The Board of Directors will receive a summary presentation on the results of the FY25 Network Adequacy Assessment in May 2026.

Michigan Health Endowment Fund

In 2025, MSHN was awarded a $300,000 grant from the Michigan Health Endowment Fund. MSHN submitted a proposal to improve access, quality of care and timeliness of that care by proactively identifying potential health risks using real-time data and predictive models.

MSHN proposed building and deploying predictive models for improved identification and risk stratification for most at-risk populations.

These models will include the following:

- Identify enrollees most likely at-risk for psychiatric inpatient.
- Identify most at-risk enrollees for substance use disorder.

- Identify enrollees not diagnosed but most at risk for anxiety/depression.

Short-term value impacts include the following:

- Identify enrollees for intervention who otherwise may have gone unidentified.
- Identify enrollees for intervention earlier than previously able.
- Higher levels of enrollee engagement, as evidenced by a variety of metrics, including touches, successful contact, new cases opened for care management, etc.

Over the long-term, the ultimate goal is to increase the quality of care while lowering costs.

MSHN anticipates regional expansion and improved outreach to approximately 1500 individuals in the first year of implementation. A priority population of children will be utilized in the risk stratification, along with other possible data points such as foster children, or additional Social Determinants of Health (SDOH) data (e.g., demographics, geography, etc.).

MSHN in collaboration with Vital Data Technologies, utilized data from standard claims, including pharmacy, demographics, eligibility, encounter, provider, and lab data to conduct predictive analytics. MSHN is currently working to integrate the model results into action alerts, developing workflows and care pathways, with an anticipated operational date of October 2026.

Utilization Management and Access Department Update

The MSHN Utilization Management and Access (UM) department provides oversight of access and referral for substance use disorder (SUD) treatment services and authorization of SUD treatment services. The UM department also provides support and technical assistance to the SUD provider network related to these content areas. The linked report below provides updates on:

1. Utilization reviews: prospective, concurrent, and retrospective,
2. External policies and regulations which impact utilization and authorizations, and
3. Plan for future initiatives and targeted improvement efforts.

One of the many content areas in the quarterly report includes an analysis of authorizations that are auto approved as well as those that require a Utilization Management Specialist to review. The table below indicates the total number of authorizations processed in MSHN's electronic management system each quarter during FY25.

FY 25	Auto Approved	Concurrent Review	Total	Average Rate of Concurrent Review	Average Number of Concurrent Reviews per Week
Q1	5881	1379	7081	19.5%	106
Q2	5764	1345	7109	23.3%	104
Q3	5223	1637	6860	23.8%	126
Q4	5134	1382	6516	21.2%	106

In FY25, MSHN implemented a centralized access and authorization process for SUD Residential and Withdrawal Management. From July 1 to September 30, 2025, the MSHN Access Center received 1,231 Substance Use Disorder (SUD) Requests for Service (RFS) and completed 1,065 level of care (LOC) determinations at the PIHP level, along with 740 administrative LOC reviews. While provider-conducted LOC determinations were recorded, the primary focus at MSHN remained on PIHP-level activity. Collectively, all sources accounted for 4,879 LOC determinations during the quarter, highlighting the network capacity to efficiently respond to community needs.

For more information on Utilization and Access Reviews, ***see the link below: FY25 Q4 Access-Utilization Management Department Report.***

FY25 Integrated Health Initiatives Updates

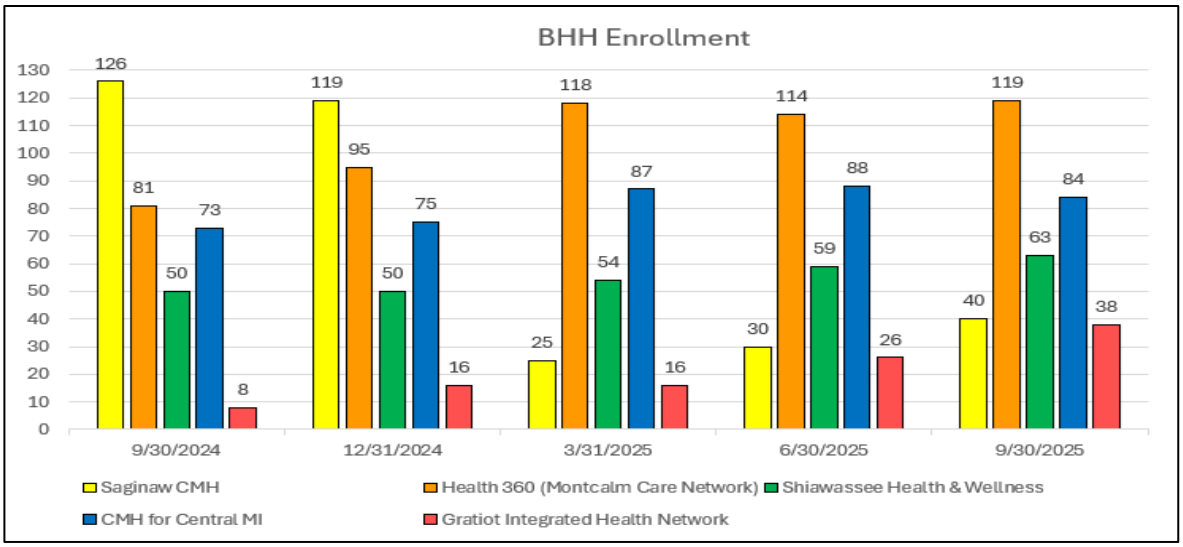
Behavioral Health Home

Behavioral Health Homes (BHH) provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. For enrolled beneficiaries, the BHH functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model also elevates the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness.

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

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Service

As of September 30, 2025, MSHN enrollment in BHH totaled 344 beneficiaries.



Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs provide a comprehensive range of mental health and substance use disorder services to eligible individuals including;

- All persons with a mental health and/or substance use disorder (SUD)
- Any person with a mental health or SUD International Classification of Diseases (ICD)-10 diagnosis code, severity of needs does not factor into eligibility (includes the Mild-to-Moderate)
- Individuals with an intellectual/developmental disability diagnosis
- Those without insurance or an ability to pay

As of September 30, 2025, MSHN enrollment in CCBHCs totaled 25,314 beneficiaries.

CCBHC Site	Medicaid Enrolled	% Medicaid (Total Enrollment)	Non-Medicaid Enrolled	% Non-Medicaid (Total Enrollment)	Total Enrolled
CEI CMH	11,125	78%	3,060	22%	14,185
LifeWays	1,406	93%	113	7%	1,519
Saginaw CMH	5,964	95%	298	5%	6,262
The Right Door	2,445	73%	903	27%	3,348
Total Region	**20,940**	**83%**	**4,374**	**17%**	**25,314**

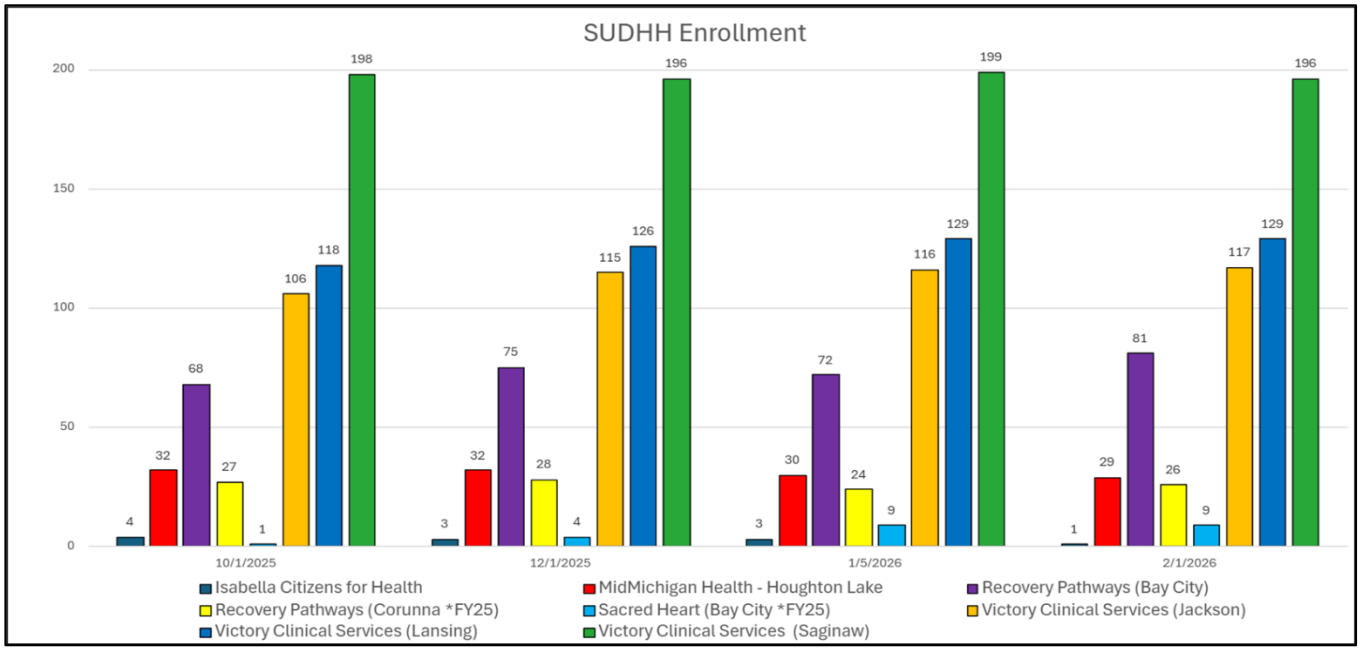
As of October 1, 2025, all oversight and monitoring responsibilities for CCBHCs were transferred to MDHHS with PIHPs no longer having any oversight and monitoring responsibilities.

Substance Use Disorder Health Home

Substance Use Disorder Health Home (SUD HH) is a model of care that provides comprehensive care management and coordination services to Medicaid beneficiaries with an Opioid Use Disorder, Alcohol Use Disorder, or Stimulant Use Disorder. The SUD HH functions as the central point of contact for directing patient-centered care across the broader health care system. SUD HH services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical

and behavioral health conditions. Beneficiaries work with an interdisciplinary team of providers that includes a Health Home Director, Behavioral Health Specialist, Peer Recovery Coach/Community Health Worker/Medical Assistant, Medical Consultant, and Psychiatric Consultant. The SUD HH model is designed to increase access to health care, reduce unnecessary emergency room visits and unnecessary hospital admissions, increase hospital post-discharge follow up, elevate the role of peer recovery coaches and community health workers in particular to foster empathy, and improve overall health and wellness.

As of September 2025, MSHN has a total of ***526 beneficiaries*** **enrolled** in 8 unique SUD Health Home locations.



For more information on population health activities, ***see the link below: FY25 Integrated Health Report.***

Submitted by:

Amanda L. Ittner
Finalized: 2.19.26

Link

FY25 Integrated Health Report
FY25 Q4 Access and Utilization Management Report

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 January 31, 2026, 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 January 31, 2026, as presented.

Mid-State Health Network
Statement of Activities
As of January 31, 2026

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	
			FY26 Original Budget		FY26 Original Budget			
			33.33%					
1	Revenue:							
2	Grant and Other Funding		$ 374,568	89,516	124,856	(35,340)	23.90 %	1a
3	Prior FY Medicaid Carryforward		$ 9,887,364	12,223,430	3,295,788	8,927,642		1b
4	Medicaid Capitation		814,257,869	280,375,089	271,419,290	8,955,799	34.43%	1c
5	Local Contribution		1,550,876	457,950	516,959	(59,009)	29.53%	1d
6	Interest Income		1,100,000	333,697	366,666	(32,970)	30.34%	1e
7	Non Capitated Revenue		18,218,063	5,350,028	6,072,688	(722,659)	29.37%	1f
8	Total Revenue		845,388,740	298,829,710	281,796,247	17,033,463	35.35 %	
9	Expenses:							
10	PIHP Administration Expense:							
11	Compensation and Benefits		9,072,517	2,856,124	3,024,173	(168,049)	31.48 %	
12	Consulting Services		130,000	5,178	43,333	(38,156)	3.98 %	
13	Contracted Services		114,400	25,061	38,133	(13,072)	21.91 %	
14	Other Contractual Agreements		570,900	188,040	190,300	(2,261)	32.94 %	
15	Board Member Per Diems		20,820	3,360	6,940	(3,580)	16.14 %	
16	Meeting and Conference Expense		99,280	20,729	33,094	(12,364)	20.88 %	
17	Liability Insurance		30,000	24,715	10,000	14,715	82.38 %	
18	Facility Costs		188,536	91,978	62,845	29,133	48.79 %	
19	Supplies		207,250	55,903	69,083	(13,180)	26.97 %	
20	Other Expenses		1,083,450	564,236	361,150	203,086	52.08 %	
21	Subtotal PIHP Administration Expenses		11,517,153	3,835,324	3,839,051	(3,728)	33.30 %	2a
22	CMHSP and Tax Expense:							
23	CMHSP Participant Agreements		715,270,064	246,549,406	238,423,355	8,126,051	34.47 %	1b,1c,2b
24	SUD Provider Agreements		65,677,623	21,108,421	21,892,541	(784,120)	32.14 %	1c,1f,2c
25	Benefits Stabilization		860,000	286,667	286,667	0	33.33 %	2d
26	Tax - Local Section 928		1,550,876	457,950	516,959	(59,009)	29.53 %	1d
27	Taxes- IPA/HRA		49,174,082	15,594,642	16,391,360	(796,718)	31.71 %	2e
28	Subtotal CMHSP and Tax Expenses		832,532,645	283,997,086	277,510,882	6,486,204	34.11 %	
29	Total Expenses		844,049,798	287,832,410	281,349,933	6,482,477	34.10 %	
30	Excess of Revenues over Expenditures		$ 1,338,942	$ 10,997,300	$ 446,314			

Mid-State Health Network
Preliminary Statement of Net Position by Fund
As of January 31, 2026

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		29,451,057	0	29,451,057	1a
4	Chase MM Savings		33,275,912	0	33,275,912	
5	Savings ISF Account		0	13,432,479	13,432,479	1b
6	Savings PA2 Account		3,012,866	0	3,012,866	1c
7	Investment PA2 Account		3,499,172	0	3,499,172	1c
8	Investment ISF Account		0	22,498,120	22,498,120	1b
9	Total Cash and Short-term Investments		$ 69,239,007	$ 35,930,599	$ 105,169,606	
10	**Accounts Receivable**					
11	Due from MDHHS		34,605,473	0	34,605,473	2a
12	Due from CMHSP Participants		5,354,202	0	5,354,202	2b
13	Due from Other Governments		59,699	0	59,699	2c
14	Due from Miscellaneous		361,346	0	361,346	2d
15	Total Accounts Receivable		40,380,720	0	40,380,720	
16	**Prepaid Expenses**					
17	Prepaid Expense Rent		4,529	0	4,529	2e
18	Prepaid Expense Other		909	0	909	2f
19	Total Prepaid Expenses		5,438	0	5,438	
20	**Fixed Assets**					
21	Fixed Assets - Computers		189,180	0	189,180	2g
22	Accumulated Depreciation - Computers		(189,180)	0	(189,180)	
23	Lease Assets		190,989	0	190,989	2h
24	Accumulated Amortization - Lease Asset		(164,442)	0	(164,442)	
25	Total Fixed Assets, Net		26,547	0	26,547	
26	**Total Assets**		**$ 109,651,712**	**$ 35,930,599**	**$ 145,582,311**	
27						
28	**Liabilities and Net Position**					
29	Liabilities					
30	Accounts Payable		$ 11,992,954	$ 0	$ 11,992,954	1a
31	Current Obligations (Due To Partners)					
32	Due to State		36,219,731	0	36,219,731	3a
33	Other Payable		4,769,374	0	4,769,374	3b
34	Due to Hospitals (HRA)		13,279,948	0	13,279,948	1a, 3c
35	Due to State-IPA Tax		578,674	0	578,674	3d
36	Due to State Local Obligation		70,231	0	70,231	3e
37	Due to CMHSP Participants		1,956,538	0	1,956,538	3f
38	Accrued PR Expense Wages		121,923	0	121,923	3g
39	Accrued Benefits PTO Payable		515,406	0	515,406	3h
40	Accrued Benefits Other		82,820	0	82,820	3i
41	Total Current Obligations (Due To Partners)		57,594,645	0	57,594,645	
42	Lease Liability		26,590	0	26,590	2h
43	Deferred Revenue		4,935,093	0	4,935,093	1b 1c
44	Total Liabilities		74,549,282	0	74,549,282	
45	Net Position					
46	Unrestricted		35,102,430	0	35,102,430	3j
47	Restricted for Risk Management		0	35,930,599	35,930,599	1b
48	Total Net Position		35,102,430	35,930,599	71,033,029	
49	**Total Liabilities and Net Position**		**$ 109,651,712**	**$ 35,930,599**	**$ 145,582,311**	

Mid-State Health Network
Financial Statement Notes
For the Four-Month Period Ended,
January 31, 2026

Please note: The Statement of Net Position contains preliminary Fiscal Year (FY) 2025 cost settlement figures between the Pre-Paid Inpatient Health Plan (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 Interim MDHHS Financial Status Report (FSR) submitted in November 2025.

Preliminary Statement of Net Position:

1. Cash and Short-Term Investments
    a) The Cash Chase Checking and Chase Money Market Savings accounts are the cash line items available for operations.
    b) The Savings Internal Service Fund (ISF) and Investment ISF reflect designated accounts to hold the Medicaid ISF funds separate from all other funding per the MDHHS contract. MSHN holds nearly $22.5 M in investments, which is about 63% of the total ISF net position balance (row 49 col C). The investment portfolio has been temporarily reduced and moved to ISF Savings should the Region need to access funds for service delivery and other operational expenses. Internal Service Funds are used to cover the Region's risk exposure. In the event current Fiscal Year revenue is spent, and all prior year savings are exhausted, PIHPs can transfer ISF dollars and use them for remaining costs.
    c) The PA2 Savings PA2 and Investment accounts hold funds used to primarily cover Prevention services in MSHN's 21-county Region and is offset by the Deferred Revenue liability account.
2. Accounts Receivable
    a) Fiscal Year 2026 October through January Hospital Rate Adjustor (HRA) amounts account for 38% of the balance. HRAs are State Directed Payments and contractually required by MDHHS. In addition, withholds are also 38% of the total with miscellaneous amounts accounting for the remaining balance.
    b) Due From CMHSP Participants reflect FY 2025 projected cost settlement activity. Final cost settlements generally occur in May after the fiscal year ends and once Compliance Examination are complete.

CMHSP	Cost Settlement	BHH Settlement	Payments/Offsets	Total
CEI	14,958,116.00	-	12,714,398.00	2,243,718.00
Central	946,545.00	5,615.64	804,564.00	147,596.64
The Right Door	3,489,905.00	-	2,966,420.00	523,485.00
Lifeways	1,174,467.00	-	998,297.00	176,170.00
Saginaw	13,478,281.00	15,287.02	11,456,539.00	2,037,029.02
Tuscola	1,508,028.00	-	1,281,824.00	226,204.00
Total	**35,555,342.00**		**30,222,042.00**	**5,354,202.66**

    c) Due from other governments account consists of Public Act 2 amounts owed from one county for FY 25 quarter four liquor tax collections. PA2 funds are used primarily for Prevention Activities in MSHN's 21-county Region.
    d) The balance in Due From Miscellaneous is split 37% and 63% (respectively) for Medicaid Event Verification (MEV) findings and cash advances needed to cover operations for few SUD providers.
    e) Prepaid Expense Rent balance consists of security deposits for MSHN office suites.
    f) Prepaid Expense Other has a small balance for FY 2026 Relias payments.

g) Total Fixed Assets - Computers represent the value of MSHN's capital asset net of accumulated depreciation.
h) The Lease Assets category is now displayed as an asset and liability based on a new Governmental Accounting Standards Board (GASB) Number 87 requirement. The lease assets figure represents FY 2022 – 2026 contract amounts for MSHN's office space.

3. Liabilities
a) MSHN estimates FY 2022 and FY 2021 lapses totaling $13.5 M and $17.6 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. MSHN also owes MDHHS nearly $4.8 M for CCBHC supplemental over payments which primarily cover services for mild to moderate persons.
b) This amount is related to SUD provider payment estimates and is needed to offset the timing of payments.
c) HRA is a pass-through account for dollars sent from MDHHS to cover supplemental payments made to psychiatric hospitals. HRA payments are intended to encourage hospitals to have psychiatric beds available as needed. Total HRA payments are calculated based on the number of inpatient hospital services reported.
d) Due To State – Insurance Plan Assessments Tax are now paid by MDHHS as gross adjustments and no longer based on monthly Per Eligible Per Month (PEPM) funds.
e) Due To State Local Obligation balance represents two CMHSP making an advance payment for FY 2026 quarter two.
f) Due To CMHSP represents FY 2025 projected cost settlement figures. Final amounts will be paid during the region's final cost settlements, which generally occur in May or after Compliance Examinations are complete.

CMHSP	Cost Settlement	BHH Settlement	Payments/Offsets	Total
Bay	5,413,517.00	-	4,662,967.00	750,550.00
Gratiot	2,204,991.00	-	1,874,242.00	330,749.00
Huron	1,521,614.00	-	1,293,372.00	228,242.00
Montcalm	779,963.00	(311.98)	662,968.00	116,683.02
Newaygo	444,829.00	-	378,105.00	66,724.00
Shiawassee	3,117,644.00	(4,055.74)	2,649,998.00	463,590.26
Total	**13,482,558.00**	**(4,367.72)**	**11,521,652.00**	**1,956,538.28**

g) Accrued Payroll Expense Wages represent expenses incurred in January and paid in February.
h) Accrued Benefits PTO (Paid Time Off) is the required liability account set up to reflect paid time off balances for employees.
i) Accrued Benefits Other represents retirement benefit expenses incurred in January and paid in February.
j) The Unrestricted Net Position represents the difference between total assets, total liabilities, and the restricted for risk management figure.

Statement of Activities – Column F calculates the actual revenue and expenses compared to the full year's original budget. Revenue accounts whose Column F percent is less than 33.33% translate to MSHN receiving less revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 33.33% show MSHN's spending is trending higher than expected.

1. Revenue
    a) This account tracks Veterans Navigator (VN) activity and CMHSP Clubhouse Grant payments used to assist those served with their Medicaid deductibles.
    b) Medicaid Savings are generated when the prior year revenue exceeds expenses for the same period. PIHPs may retain up to 7.5% of savings using a tiered formulary.
    c) Medicaid Capitation – There is a positive variance in this account which shows actual revenue is trending higher than budgeted. The original FY 2026 budget submitted to the board in September contained revenue estimates from MDHHS's draft rate certification data however the final document calculated revenue significantly higher than anticipated. Please note, Medicaid Capitation payment files are calculated and disbursed to CMHSPs based on a per eligible per month (PEPM) methodology and paid to SUD providers based on service delivery.
    d) Local Contribution is flow-through dollars from CMHSPs to MDHHS. Typically, revenue equals the expense side of this activity. Local Contributions were scheduled to reduce over the next few fiscal years until completely phased out. FY 2026 amounts are the same as FY 2025.
    e) Interest income is earned from investments and changes in principle for investments purchased at discounts or premiums. The amount earned is slightly lower than the budget, however this variance should lessen over the fiscal year as capitation revenue is trending sufficiently to cover ongoing operations. (Please see Statement of Net Position 1b.)
    f) This account tracks non-capitated revenue for SUD services which include Community Grant and PA2 funds. There is a large variance in this account because the budget amount represents the full MDHHS allocation amount regardless of planned spending.
2. Expense
    a) Total PIHP Administration Expense is slightly under budget. The other expenses line includes several vendor expenses. MiHIN (data exchange technology) is one such vendor and the FY 2026 invoice was paid in full which is the primary cause for being over budget.
    b) CMHSP participant Agreement shows a large variance when comparing actual to budget. The variance is related to the notes in item 1c above as more revenue is received, more is expensed to the CMHSPs. MSHN funds CMHSPs based on per eligible per month (PEPM) payment files. The files contain CMHSP county codes which designate where the payments should be sent. MSHN sends the full payment less affiliation fees which support PIHP operations.
    c) SUD provider payments are trending under budget and paid based on need. (Please see Statement of Activities 1c and 1f.)
    d) Benefit stabilization amounts are paid to CMHSPs for SUD access activities and assistance with cash flow if needed to cover operational expenditures in excess of their PEPMs.
    e) IPA/HRA actual tax expenses are lower than the budget. Beginning in FY 2026, Insurance Plan Assessment (IPA) dollars will be based on Michigan's Treasury assessment member months and paid by MDHHS in a quarterly lump sum. In prior fiscal years, the payment was included in capitation. 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 January 31, 2026

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	912797RE9	6.30.25	7.1.25	10.28.25		9,999,615.49	10,137,000.00			
UNITED STATES TREASURY BILL	912797RE9						(10,137,000.00)			
UNITED STATES TREASURY BILL	912797QY6	9.16.25	9.16.25	12.11.25		1,999,690.69	2,018,000.00			
UNITED STATES TREASURY BILL	912797QY6						(2,018,000.00)			
UNITED STATES TREASURY BILL	912797TG2	12.9.25	12.11.25	4.7.26		2,499,120.76	2,499,120.76			
UNITED STATES TREASURY BILL	912797PD3	10.27.25	10.28.25	1.22.26		19,999,350.29	20,175,000.00			
UNITED STATES TREASURY BILL	912797PD3						(20,175,000.00)			
UNITED STATES TREASURY BILL	912797SM0	1.21.26	1.22.26	4.23.26		19,998,999.63	19,998,999.63			
JP MORGAN INVESTMENTS							22,498,120.39			22,498,120.39
JP MORGAN CHASE SAVINGS							13,177,920.57	0.020%	254,558.48	13,432,479.05
							$ 35,676,040.96		$ 254,558.48	$ 35,930,599.44

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 January 31, 2025

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	912797QQ3	8.15.25	8.19.25	11.13.25		3,499,118.27	3,533,000.00			
UNITED STATES TREASURY BILL	912797QQ3						(3,533,000.00)			
UNITED STATES TREASURY BILL	912797RT6	11.12.25	11.13.25	2.12.26		3,499,171.34	3,499,171.34			
JP MORGAN INVESTMENTS							3,499,171.34			3,499,171.34
JP MORGAN CHASE SAVINGS							3,009,532.65	0.010%	3,333.23	3,012,865.88
							$ 6,508,703.99		$ 3,333.23	$ 6,512,037.22

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

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

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

MSHN
Mid-State Health Network

Background

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

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

Therefore, MSHN presents the attached FY25 Contract Listing for Board approval and authorization of the Chief Executive Officer to sign.

Recommended Motion:

The MSHN Board authorizes its Chief Executive Officer to sign and fully execute the contracts as presented and listed on the FY25 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2025
January 2026

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	FY 2025 CONTRACT AMOUNT	FY 2025 TOTAL CONTRACT AMOUNT	INCREASE/ (DECREASE)
	MDHHS CONTRACT				
Michigan Department of Health & Human Services	Medicaid Managed Specialty Supports and Services Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs (FY25) - Amendment 3 (Capitation), 4 (CCBHC), and 5 (ESTA and Minimum Wage)	10.1.24 - 9.30.25	$ -	-	-

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 FY26 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 FY26 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2026
January 2026

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	FY 2025 CONTRACT AMOUNT	FY 2026 TOTAL CONTRACT AMOUNT	INCREASE/ (DECREASE)
PIHP ADMINISTRATVE FUNCTION CONTRACTS					
RedHead Creative Consultancy	Media Campaign to Reduce SUD Stigma ($25,000 already executed)	1.1.26 - 9.30.26	$ 99,000	61,764	$ (37,236)
			$ 99,000	$ 61,764	$ (37,236)

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	FY 2026 ORIGINAL AMOUNT	FY 2026 TOTAL CONTRACT AMOUNT	INCREASE/ (DECREASE)
SUD SERVICE PROVIDER CONTRACTS (Cost Reimbursement/Fee for Service) NOTE: Fee for Service contracts show "-" amount					
Addiction Treatment Services	Treatment Contract	10.1.25 - 9.30.26	$ -	-	-
Cherry Health Services	Substance Use Disorder Health Home (SUD HH)	2.1.26 - 9.30.26	$ -	-	-
MidMichigan Community Services	Substance Use Disorder Health Home (SUD HH)	2.1.26 - 9.30.26	$ -	-	-
Mid-Michigan Recovery Services	Substance Use Disorder Health Home (SUD HH)	2.1.26 - 9.30.26	$ -	-	-
Montcalm Care Network	Substance Use Disorder Health Home (SUD HH)	2.1.26 - 9.30.26	$ -	-	-
Professional Psychological & Psychiatric Services	Substance Use Disorder Health Home (SUD HH)	2.1.26 - 9.30.26	$ -	-	-
Recovery Pathways	Substance Use Disorder Health Home (SUD HH)	2.1.26 - 9.30.26	$ -	-	-
Shiawassee Health and Wellness	Substance Use Disorder Health Home (SUD HH)	2.1.26 - 9.30.26	$ -	-	-
Face Addiction Now (FAN)	Overdose Prevetion - Street Outreach (OSF)	3.1.26 - 9.30.26	$ 180,348	277,378	97,030
Home of New Vision	Comm Recovery Initiative and Transportation	4.1.26 - 9.30.26	$ 460,875	527,434	66,559
Peer 360	Overdose Prevention Materials, Comm Recovery Office Space, and Transportation	3.1.26 - 9.30.26	$ 1,300,000	1,334,341	34,341
Randy's House	Community Recovery Initiative	4.1.26 - 9.30.26	$ 100,000	164,507	64,507
			$ 2,041,223	2,303,660	262,437
MDHHS CONTRACT					
CONTRACTING ENTITY	**CONTRACT SERVICE DESCRIPTION**	**CONTRACT TERM**	**FY 2026 ORIGINAL AMOUNT**	**FY 2026 AMENDED AMOUNT**	**INCREASE/ (DECREASE)**
Michigan Department of Health & Human Services (EGrAMS)	SUD - Administration	10.1.25 - 9.30.26	$ 720,182	582,086	(138,096)
	Healing and Recovery Comm Engagement	10.1.25 - 9.30.26	$ 150,000	472,823	322,823
			$ 870,182	$ 1,054,909	$ 184,727

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, November 18, 2025
MyMichigan Medical Center
Meeting Minutes

1. Call to Order

Chairperson Ed Woods called this meeting of the Mid-State Health Network Board of Directors to order at 5:00 p.m. Mr. Woods reminded members that those participating by phone may not vote on matters before the board unless absent due to military duty, disability, or health-related condition and will relax the Board Member Conduct Policy due to the current volatile environment with the PIHP Procurement matters. Mr. Woods informed the Board that Paul Palmer's service to the MSHN and CEI board has ended due to his moving away. Mr. Woods attended a CEI meeting to recognize Mr. Palmer's contributions to the MSHN regional board. Mr. Woods informed board members the November per diem and mileage payments for members will be processed in December. Mr. Woods called for a moment of silence to honor and remember two board members from the Community Mental Health Authority for Clinton, Eaton, and Ingham Counties who passed away in recent weeks.

2. Roll Call

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

Board Member(s) Present: Patty Bock (Huron), Patrick Conley (BABH), Ken DeLaat (Newaygo), David Griesing (Tuscola), Dan Grimshaw (Tuscola), Tim Hanna (CEI), Tina Hicks (Gratiot), John Johansen (Montcalm), Pat McFarland (BABH), Deb McPeek-McFadden (The Right Door), Irene O'Boyle (Gratiot), Joe Phillips (CMH for Central Michigan), Linda Purcey (The Right Door), Tracey Raquepaw (Saginaw), Kerin Scanlon (CMH for Central Michigan)-arrived at 5:09 p.m., Richard Swartzendruber (Huron), Joanie Williams (Saginaw), and Ed Woods (LifeWays)

Board Member(s) Remote: Kurt Peasley (Montcalm)-Covington, LA and Lori Schultz (Newaygo)-Newaygo, MI

Board Member(s) Absent: Brad Bohner (LifeWays), Greg Brodeur (Shiawassee), and Cindy Garber (Shiawassee)

Staff Member(s) Present: Joseph Sedlock (Chief Executive Officer), Amanda Ittner (Deputy Director), and Leslie Thomas (Chief Financial Officer)

3. Approval of Agenda for November 18, 2025

Board approval was requested for the Agenda of the November 18, 2025, Regular Business Meeting.

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY DAVID GRIESING, FOR APPROVAL OF THE AGENDA OF NOVEMBER 18, 2025 REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

4. Public Comment

There was no public comment.

5. MSHN External Compliance Examination Report Presentation

Ms. Christina Schaub, Auditor from Roslund, Prestage and Company, presented the report on compliance and highlighted key information included in the MSHN Fiscal Year 2024 Compliance Examination conducted by the firm and provided within board member packets. The audit found MSHN complied in all material respects with the specified requirements; that no control deficiencies were found; no material non-compliance with laws, regulations, or contracts were identified; and no fraud was found.

MOTION BY TINA HICKS, SUPPORTED BY KEN DeLATT, TO RECEIVE AND FILE THE REPORT ON COMPLIANCE OF MID-STATE HEALTH NETWORK FOR THE YEAR ENDED SEPTEMBER 30, 2024. MOTION CARRIED UNANIMOUSLY.

6. Chief Executive Officer's Report

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

- PIHP/Regional Matters
  - Competitive Procurement of Prepaid Inpatient Health Plans
  - Progress on Improving Penetration Rates in Substance Use Disorder Services for People of Color
  - Regional Anti-Stigma Campaigns
  - Regional Finances
- State of Michigan/Statewide Activities – See written report for details.
- Federal/National Updates and Activities
  - Supplemental Nutritional Assistance Program (SNAP)

7. Deputy Director's Report

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

- Michigan Mission Based Performance Indicator System (MMBPIS)
- Performance Improvement Projects (PIPs)
- 2025 Satisfaction Survey Results
- Innovation in Behavioral Health

8. Chief Financial Officer's Report

Ms. Leslie Thomas provided an overview of the financial statements included within board meeting packets for the period ended September 30, 2025.

MOTION BY TIM HANNA, SUPPORTED BY PATRICK CONLEY, TO RECEIVE AND FILE THE PRELIMINARY STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDED SEPTEMBER 30, 2025, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

9. Contracts for Consideration/Approval

A. FY25 Contract Listing for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2025 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 FY2025 contract listing.

MOTION BY JOHN JOHANSEN , SUPPORTED BY RICH SWARTZENDRUBER, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY2025 CONTRACT LISTING. MOTION CARRIED UNANIMOUSLY.

B. FY26 Contract Listing for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2026 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 FY2026 contract listing.

MOTION BY TRACEY RAQUEPAW, SUPPORTED BY IRENE O'BOYLE, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY2026 CONTRACT LISTING. MOTION CARRIED UNANIMOUSLY.

10. Executive Committee Report

Mr. Ed Woods informed board members the Executive Committee met on October 17, 2025, and reviewed the following:

- Contingency Planning

11. Chairperson's Report

- Mr. Woods reported that he is meeting weekly with the Deputy Director and Chief Executive Officer.

12. 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 DEB McPEEK-McFADDEN, SUPPORTED BY JOHN JOHANSEN, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE SEPTEMBER 9, 2025 BOARD OF DIRECTORS MEETING; APPROVE MINUTES OF THE SEPTEMBER 9, 2025 PUBLIC HEARING; RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF OCTOBER 17, 2025; RECEIVE SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD MEETING MINUTES OF AUGUST 20, 2025; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF SEPTEMBER 15, 2025 AND OCTOBER 20, 2025. MOTION CARRIED UNANIMOUSLY.

13. Other Business

There was no other business.

14. Public Comment

There was no public comment.

15. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 5:51 p.m.

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, January 6, 2026
MyMichigan Medical Center
Informational Meeting Notes

1. Call to Order

Chairperson Ed Woods and Vice Chairperson Irene O'Boyle were not present. Secretary Deb McPeek-McFadden called this meeting of the Mid-State Health Network Board of Directors to order at 5:01 p.m.

Ms. McPeek-McFadden reminded members that those participating by phone may not vote on matters before the board unless absent due to military duty, disability, or health-related condition. Ms. McPeek-McFadden asked for a moment of silence to honor the recent passing of board member Kurt Peasley's mother and to wish Chairperson Ed Woods' son well recovering from a recent stroke and for the passing of Malkia Newman, co-chair of the CMHA Persons Served Advisory Group and a well-known advocate across the state. Ms. McPeek-McFadden introduced and welcomed Tammy Warner, Executive Director at Montcalm Care Network.

2. Roll Call

Ms. Sherry Kletke provided the roll call for Board Members in attendance and informed the board chair there was not a quorum present to conduct business.

Board Member(s) Present: Patrick Conley (BABH), Dan Grimshaw (Tuscola), Tina Hicks (Gratiot), John Johansen (Montcalm), Pat McFarland (BABH), Deb McPeek-McFadden (The Right Door), Joe Phillips (CMH for Central Michigan), Linda Purcey (The Right Door), Kerin Scanlon (CMH for Central Michigan)-arrived at 5:13 p.m., and Richard Swartzendruber (Huron)

Board Member(s) Remote: Patty Bock (Huron)-Bad Axe, MI; Brad Bohner (LifeWays)-Osseo, MI; Ken DeLaat (Newaygo)-Newaygo, MI; David Griesing (Tuscola)-Sebring, FL; Tim Hanna (CEI)-DeWitt, MI: Irene O'Boyle (Gratiot)-Zapata, TX; Kurt Peasley (Montcalm)-Covington, LA; Tracey Raquepaw (Saginaw)-Birch Run, MI; and Lori Schultz (Newaygo)-Newaygo, MI

Board Member(s) Absent: Greg Brodeur (Shiawassee), Cindy Garber (Shiawassee), Joanie Williams (Saginaw), and Ed Woods (LifeWays)

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

3. Approval of Agenda for January 6, 2026

There was no quorum present to seek board approval for the Agenda of the January 6, 2026, Regular Business Meeting.

4. Public Comment

There was no public comment.

5. FY2026 Quality Assessment and Performance Improvement Program (QAPIP) and the FY2025 Annual Effectiveness and Evaluation Report

Ms. Amanda Ittner presented an overview of the FY2026 QAPIP and the FY2025 Annual Effectiveness and Evaluation report summarized within board meeting packets. Links to the full documents were included on the motion sheet and a copy of the full documents were available in the meeting room for board member review. Administration will seek board approval at the March meeting.

6. Chief Executive Officer's Report

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

- PIHP/Regional Matters
  - Competitive Procurement of Prepaid Inpatient Health Plans
- State of Michigan/Statewide Activities
  - Michigan Health Policy Forum (Fall, 2025)
- Federal/National Updates and Activities
  - HR 1 ("Big, Beautiful, Bill") Implementation Resource
  - Federal Health Policy Tracker

7. Deputy Director's Report

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

- Performance Bonus Incentive Pool Report
- Balanced Scorecard
- Health Insurance Update
- Crisis Residential Regional Contract Update

8. Chief Financial Officer's Report

Ms. Leslie Thomas provided an overview of the financial statements included within board meeting packets for the period ended November 30, 2025.

9. Contracts for Consideration/Approval

Due to the lack of quorum, the FY2026 contract listing provided in the meeting packet will be included for the Board of Directors meeting in March for approval.

10. Executive Committee Report

Ms. Deb McPeek-McFadden called on Ms. Irene O'Boyle to discuss the Board Self-Evaluation process. Ms. Irene O'Boyle announced the FY2025 Board Self-Evaluation will be emailed to members tomorrow, Wednesday January 7, 2026. The Board Self-Evaluation is conducted annually and consists of the same questions as asked every year. Ms. Sherry Kletke will send the survey to members by email through Survey Monkey. Members will be given two weeks to complete the survey and the survey will close at the end of the day on Friday, January 23, 2026. Results of the survey will be available at the February Executive Committee Meeting and presented to the full board at the March Board of Directors meeting. Ms. O'Boyle encouraged all Board members to participate by completing the board self-evaluation in the timeframe offered.

Ms. Amanda Ittner informed members the Executive Committee discussed meeting requirements under the Open Meetings Act specific to subcommittees of the board (Policy, Nominating and Executive) and related legal counsel review. MSHN Administration will be adding public comment as an agenda item to all committee meetings and will post committee meeting notices on our website. Discussion occurred regarding continuation of remote committee meetings versus in person. The board will take action (if needed) on this matter at the March board meeting.

11. Chairperson's Report

Mr. Joe Sedlock informed members NatCon 2026 is scheduled for April 27-29, 2026 in Denver, Colorado. MSHN will determine sponsorship to a board member(s) once more information is known about the PIHP Procurement Process.

12. Approval of Consent Agenda

Due to lack of quorum, items on the consent agenda will be included in the March Board of Directors meeting.

13. Other Business

There was no other business.

14. Public Comment

There was no public comment.

15. Adjournment

The MSHN Board of Directors Informational Meeting adjourned at 6:03 p.m.

Mid-State Health Network Board of Directors
Executive Committee Meeting Minutes
Friday, December 19, 2025 - 9:00 a.m.

Members Present:	Ed Woods, Chairperson; Irene O'Boyle, Vice Chairperson; Deb McPeek-McFadden, Secretary; Kurt Peasley, Member at Large; David Griesing, Member at Large
Others Present:	John Johansen
Staff Present:	Amanda Ittner, Deputy Director; Joseph Sedlock, Chief Executive Officer

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

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

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

4. **Board Matters:**
   - 4.1 Draft January 6, 2026 Regular Board Meeting Agenda: The draft board meeting agenda was reviewed noting that there will be a presentation of the FY 26 Quality Assessment and Performance Improvement Program Plan and the FY 25 effectiveness report. One table copy of each of these reports will be available (and noted on the annotated agenda for Chairperson Woods to announce). Also noted that there may be extended conversation on legal and/or procurement related matters. The board agenda is not final until approved by the board at the January 6, 2026 meeting.
   - 4.2 2025 Board Self-Assessment: J. Sedlock noted that the board self-assessment is normally completed in January for review by the Executive Committee in February and full board in March. This meeting packet contained the board self-assessment survey we have used for many years. Administration will distribute the survey by online means after I. O'Boyle prompts members to complete it at the January 2026 board meeting.
   - 4.3 Committee Meetings under Open Meetings Act: A. Ittner led a discussion of committee meeting requirements under the open meeting act. Executive Committee discussed options. Administration will propose several process changes that were discussed today.
   - 4.4 Other: None

5. **Administration Matters**
   - 5.1 MDHHS Competitive Procurement of PIHPs – Updates: MDHHS has not released any information publicly relating to the procurement of PIHP contracts.
   - 5.2 Lawsuit Update: Three days of evidentiary hearings concluded December 10, 2025. We are awaiting a ruling in the case and will provide detailed information and our best analysis of what it means for the system, MSHN, and our region as soon as we can after receipt of the ruling. The committee discussed details of several aspects of the lawsuit.
   - 5.3 Contingency Planning: J. Sedlock and A. Ittner discussed a chart they developed to help stakeholders understand several potential future contingencies that could be pursued depending on related decisions that are not within our control. A. Ittner noted that at our all-staff meeting held 12/11/25 there was appreciation for the transparency and planning of agency leadership.
   - 5.4 Other: None

6. **Other**
   - 6.1 Any other business to come before the Executive Committee: None
   - 6.2 Next scheduled Executive Committee Meeting: 02/20/2026, 9:00 a.m.

7. **Guest MSHN Board Member Comments**: J. Johansen commented on the committee meeting item above.

8. **Adjourn:** The meeting was adjourned at 9:36 a.m.

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, DECEMBER 2, 2025 (VIDEO CONFERENCE)

***Members Present**:* John Johansen, Kurt Peasley, and David Griesing

Members Absent: Tina Hicks and Irene O'Boyle

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

1. CALL TO ORDER

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

2. APPROVAL OF THE AGENDA

MOTION by David Griesing, supported by Kurt Peasley, to approve the December 2, 2025, Board Policy Committee Meeting Agenda as presented. Motion Carried: 3-0.

3. POLICIES UNDER DISCUSSION

There were no policies under discussion.

4. POLICIES UNER REVIEW

Mr. John Johansen invited Ms. Amanda Ittner to provide a review of the substantive changes within the SUD Income Eligibility policy under the Finance Chapter. Ms. Ittner informed policy committee members the addition of excluded purchases allowed using block grant funds are based upon changes in the contract language from Michigan Department of Health and Human Services.

MOTION by Kurt Peasley, supported by David Griesing, to approve and recommend the policies under review to the Board of Directors. Motion carried: 3-0.

5. NEW BUSINESS

Voting by Email Discussion: Ms. Amanda Ittner informed members the MSHN bylaws state committees shall meet as directed by the Entity Board and follow the same rules of order and documentation as the Board. MSHN Administration also reviewed the Open Meetings Act and the only reference to committees is under the definition of a public body. MSHN Administration notes that board committees are typically only voting to recommend action to the full Board and the committees don't constitute a quorum of board (i.e., less than 13 members) and have been operating under the guidelines that committees can carry out business in any venue the committee determines. MSHN Administration has contacted legal counsel to clarify the ability of committees to vote remotely and indicated the preference of continuing to meet remotely. Administration recommends we wait until legal clarification is received and then a recommendation will be presented to the board and policy committee as appropriate. Members supported the continuation of video committee meetings as they are open to the public and allow for discussion and only object to email voting which doesn't allow opportunities for discussion.

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

6. ADJOURN

Mr. John Johansen adjourned the Board Policy Committee Meeting at 10:14 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

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, FEBRUARY 3, 2026 (VIDEO CONFERENCE)

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

Members Absent: Tina Hicks

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

1. CALL TO ORDER

Mr. John Johansen called the Board Policy Committee meeting to order at 10:01 a.m.

2. APPROVAL OF THE AGENDA

MOTION by David Griesing, supported by Kurt Peasley, to approve the February 3, 2026, Board Policy Committee Meeting Agenda as presented. Motion carried unanimously.

3. POLICIES UNDER DISCUSSION

There were no policies under discussion.

4. POLICIES UNER REVIEW

Mr. John Johansen invited Ms. Amanda Ittner to provide a review of the substantive changes included within the New Community Mental Health Service Program Participation in the MSHN Region policy under the General Management Chapter due to the Michigan Department of Health and Human Services Request for Proposal.

MOTION by David Griesing, supported by Irene O'Boyle, to approve and recommend the policy under review to the Board of Directors. Motion carried unanimously.

5. NEW BUSINESS

Committee Meeting Discussion: Ms. Amanda Ittner informed members that Administration has discussed the current format of committee meetings and proposed changes with legal counsel. Administration will propose recommendations to the Executive Committee later this month and will present the recommendations to the full Board in March for action. Recommendations will include adding public comment to committee agendas, public notice of committee meetings, and moving to in-person or update only committee meetings.

6. ADJOURN

Mr. John Johansen adjourned the Board Policy Committee Meeting at 10:17 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

Mid-State Health Network SUD Oversight Policy Advisory Board
Wednesday, October 15, 2025, 4:00 p.m.
MyMichigan Medical Center
300 E. Warwick Dr.
Alma, MI 48801

Meeting Minutes

1. Call to Order

Chairperson Bryan Kolk called the MSHN SUD Regional Oversight Policy Board (OPB) of Directors Meeting to order at 4:04 p.m. Mr. Kolk reminded members participating virtually may not participate in or vote on matters before the board unless absent due to military duty, disability, or health-related condition. Mr. Kolk introduced and welcomed new members, Pamela Schumacher appointed from Bay County and Mike Visnaw appointed from Gladwin County and welcomed new alternate member, Melanie Thume, appointed from Gladwin County.

Board Member(s) Present:	Irene Cahill (Ingham), Jacob Gross (Clare), Charlean Hemminger (Ionia), Bryan Kolk (Newaygo), Karen Link (Huron), Charlie Mahar (Montcalm), Jim Moreno (Isabella), Emily Rayburn (Gratiot), Pamela Schumacher (Bay), Jerrilynn Strong (Mecosta), Kim Thalison (Eaton), Mike Visnaw (Gladwin), Dwight Washington (Clinton), and Ed Woods (Jackson)
Board Member(s) Remote:	None
Board Member(s) Absent:	Lori Burke (Shiawassee), Bruce Caswell (Hillsdale), Todd Gambrell (Midland), Christina Harrington (Saginaw), John Hunter (Tuscola), David Turner (Osceola), and Rachel Vallad (Arenac)
Alternate Member(s) Present:	None
Alternate Member(s) Remote:	Nicole Fickes (Clinton)-Laingsburg, MI
Staff Members Present:	Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Dr. Dani Meier (Chief Clinical Officer), Sarah Andreotti (Prevention Specialist), and Sherry Kletke (Executive Support Specialist)
Staff Members Remote:	Joe Sedlock (Chief Executive Officer), Cari Patrick (Prevention Specialist), Sarah Surna (Prevention Specialist), and Sherrie Donnelly (Treatment & Recovery Specialist)

2. Roll Call

   Ms. Sherry Kletke provided the Roll Call for Board Attendance and informed the Board Chair, Bryan Kolk, that a quorum was present for board meeting business.

3. Approval of Agenda for October 15, 2025

   Board approval was requested for the Agenda of the October 15, 2025 Regular Business Meeting, as presented.

   MOTION BY JIM MORENO, SUPPORTED BY CHARLIE MAHAR, FOR APPROVAL OF THE OCTOBER 15, 2025 REGULAR BUSINESS MEETING AGENDA, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

4. Approval of Minutes from the August 20, 2025 Regular Business Meeting

   Board approval was requested for the draft meeting minutes of the August 20, 2025 Regular Business Meeting.

   MOTION BY CHAR HEMMINGER, SUPPORTED BY JIM MORENO, FOR APPROVAL OF THE MINUTES OF THE AUGUST 20, 2025, MEETING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

5. Public Comment

   There was no public comment

6. Board Chair Report

   Mr. Bryan Kolk attended the Substance Use and Co-Occurring Disorder conference in September and appreciated the opportunity of the sponsorship from MSHN.

7. Deputy Director Report

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

   Regional Matters:

   - SUD Oversight Policy Board Annual Report
   - Michigan Department of Health and Human Services (MDHHS) Prepaid Inpatient Health Plan (PIHP) Procurement Update

   State of Michigan/Statewide Activities

   - Governor Whitmer Signs Continuation Budget to Continue Government Services for Michiganders as Legislature Finalizes Budget Bills
   - Legislature Finalizes the Budget Bills

8. Chief Financial Officer Report

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

- FY2025 PA2 Funding and Expenditures by County
- FY2025 PA2 Use of Funds by County and Provider
- FY2025 Substance Use Disorder (SUD) Financial Summary Report as of August 2025
- FY2026 Budget Overview

9. Substance Use Disorder PA2 Contract Listing

Ms. Leslie Thomas provided an overview and information on the FY26 Substance Use Disorder (SUD) PA2 Contract Listing as provided in the packet.

MOTION BY IRENE CAHILL, SUPPORTED BY JIM MORENO, FOR APPROVAL OF THE FY26 SUBSTANCE USE DISORDER (SUD) PA2 CONTRACT LISTING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

10. SUD Operating Update

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

- Data Collection Plans beginning in FY26 due to delays of the Michigan Prevention Data System
- FY25 MDHHS State Opioid Response Grant Site Review Full Compliance
- Monthly Lunch and Learn Series
- Equity Upstream Learning Collaborative Action Plan Implementation Reports
- Presentation to Midland Stakeholders Regarding Services and Supports available within the Michigan Public Behavioral Health System on October 28, 2025

11. Other Business

There was no other business.

12 Public Comment

There was no public comment.

13. Board Member Comment

A board member informed the other members of the Tribal Opioid Summit being held on November 5-6, 2025, at Soaring Eagle and will share the information.

14. Adjournment

Chairperson Bryan Kolk adjourned the MSHN SUD Oversight Policy Advisory Board Meeting at 4:48 p.m.

Meeting minutes submitted respectfully by:
MSHN Executive Support Specialist

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Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 11/17/2025

Members Present: Chris Pinter; Ryan Painter; Maribeth Leonard; Carol Mills; Julie Majeske; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; Bryan Krogman; Sandy Lindsey; Jeff Labun, Cassie Watson
Members Absent: Sara Lurie
MSHN Staff Present: Joseph Sedlock; Amanda Ittner; for applicable area Leslie Thomas

Agenda Item	Action Required				
CONSENT AGENDA	No items removed from the consent agenda for further discussion.				
	Informational Only	By Who	N/A	By When	N/A
2025-09 YEAR END SAVINGS ESTIMATES REVIEW	L. Thomas provided an overview of the FY25 Year-End Savings Estimate. Based on interim FY25 FSR submitted to MDHHS in November. Projections for FY25 include $12.2m for ISF contribution ($41.5m Medicaid, $11.5 funding for $24/7cash flow & $18m deficit HMP) BHH deficit in one CMH, overall surplus in BHH of 474k Estimating 4.5% ISF balance Earned Sick Time Act, Min Wage and Waskul questions still outstanding for FY26 implementation and reporting				
	Discussion and informational only	By Who	N/A	By When	N/A
PIHP PROCUREMENT DISCUSSION CONTINUATION/UPDATES (IF ANY) • **Lawsuit Updates** • **Contingency Planning – CMHSP Led Regional Entity Creation-Process Considerations** • **Other**	Verbal updates provided.				
	Internal Discussion Only	By Who	N/A	By When	N/A

MSHN
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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 12/15/2025

Members Present: Chris Pinter; Ryan Painter; Maribeth Leonard; Carol Mills; Tracey Dore; Tammy Warner; Sandy Lindsey; Sara Lurie, Jeff Labun, Cassie Watson; Julie Majeske; Bryan Krogman
Members Absent: Michelle Stillwagon; Kerry Possehn;
MSHN Staff Present: Joseph Sedlock; Amanda Ittner; and Kim Zimmerman (for applicable area)

Agenda Item	Action Required				
CONSENT AGENDA	No items removed for discussion				
	Acknowledged receipt	By Who	N/A	By When	N/A
FY25 QAPIP REPORT	Kim reported on FY25 QAPIP Executive Summary				
	Operations Council support to move forward with Board approval. Feedback due by Friday, 12/19.	By Who	K. Zimmerman	By When	12.20.25
FY26 QAPIP PLAN	Kim reported on the FY26 QAPIP Plan				
	Operations Council support to move forward with Board approval. Feedback due by Friday, 12/19.	By Who	K. Zimmerman	By When	12.20.25
PIHP PROCUREMENT DISCUSSION CONTINUATION/UPDATES (IF ANY) • **LAWSUIT UPDATES (VERBAL)** • **PROCUREMENT UPDATES (VERBAL)** • **CONTINGENCY PLANNING (ATTACHMENT)** • **POLICY DRAFT-CMHSP PARTICIPATION IN THE MSHN REGION**	Operations Council debriefed on the hearing from last week and awaiting the lawsuit results expected yet this week. Joe reviewed the Procurement Outcome Pathways diagram MSHN will utilize in planning for multiple outcomes. MSHN reviewed the CMHSP application to the MSHN region policy with the recommended edits related to more welcoming language.				
	MSHN requests review and feedback by January 9th to allow for second review at the January Operations Council meeting.	By Who	CMHSP	By When	1.9.26
LIMITED LICENSE UPDATE	MSHN provided a summary of the issue and related communications with MDHHS in the November operations packet. The concern was then brought to the association for advocacy with MDHHS and coordination across CMHSPs in the state to support and recommend changes.				

Agenda Item	Action Required				
	Still awaiting MDHHS response to the board association action. MEV process will continue but MSHN will accept a corrective action plan that indicates any systemic change will be on hold until a response is received.				
	Ops Council supported a hold on any systemic changes with billing for LL. MSHN will review our process and clarify with Ops Council any future MEV changes.	By Who	K. Zimmerman	By When	12.20.25
ICSS 24/7	Narrative application for 24/7 ICSS model as we don't have the ICSS handbook yet. Now required to have 24/7 mobile crisis. Some CMHs don't have this especially the rural counties. Discussion that Krista indicated zoom/video is acceptable.				
	CMHs will do their best to comply with the requirement.	By Who	CMHs	By When	12.20.25
MichiCANS 18-21	Sara indicated at the Children's issue workgroup, Phil indicated MichiCANS 18-21 comprehensive will be required as it's part of the state settlement. The workgroup said this issue should be brought to the PIHP CEO group with the multiple concerns and/or contract negotiations. The timeline for compliance is unknown, but MDHHS indicated they are currently not incompliance with the lawsuit.				
	Informational as this is coming forward from MDHHS.	By Who	N/A	By When	N/A

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 01/26/2026

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

Agenda Item	Action Required				
CONSENT AGENDA	No items removed from consent agenda for discussion.				
	Information and updates	By Who	N/A	By When	N/A
FY26 CONSUMER HANDBOOK • **CHANGE LOG**	K. Zimmerman reviewed the FY26 changes to the consumer handbook reviewed and presented by Customer Service Committee as identified in the change log. Still awaiting final version of tag lines template from MDHHS.				
	Approved with the inclusion of edits provided from CMHCM.	By Who	K. Zimmerman	By When	2.1.26
ESTA, MINIMUM WAGE, WASKUL	L. Thomas reviewed the background and summary provided in the packet that was also presented and reviewed by the Finance Council with no edits or revisions noted. No response yet from MDHHS on the Waskul implementation questions however Jackie Sprout indicated she has sent the questions on to the compliance department. ESTA/MIN Wage/DCW: New L letter that replaces the 24-29 with L 24-59. Concerns with ability to manage SD budgets and including total budgets (having a maximum) but not allowed to have a maximum budget. Leslie will submit another question to clarify this item as she supports all other services should be based on CMH negotiated rates. Recommend a regional response to providers: "Not able to implement Waskul until clarification/detail on how to implement is received from MDHHS". This was already supported by PNC in October. CFO's meeting with Keith tomorrow regarding rate setting clarification for FY26. Leslie with follow up with Joe after the meeting to review updates and discuss next steps. Will an estimate on financial impact be provided? Included in the additional notes in the attached.				
	Leslie will submit another question to MDHHS. Ops supported continued response to providers as recommended by PNC in October.	By Who	L. Thomas	By When	3.1.26

Agenda Item	Action Required				
MEDICAID/HMP ENROLLMENT DECLINES	Medicaid/HMP has been declining. PIHP CFO's collected information statewide and shared with MDHHS and PIHPs CEO. Discussion will occur tomorrow with Keith White to adjust the enrollment numbers included in the rates.				
	MSHN staff will keep region posted.	By Who	L. Thomas/A.Ittner	By When	3.1.26
PIHP PROCUREMENT DISCUSSION CONTINUATION/UPDATES (IF ANY) • **LAWSUIT/RULING UPDATES/DISCUSSION, IF ANY** • **PROCUREMENT UPDATES/DISCUSSION, IF ANY** • **FUTURE PLANNING DISCUSSION** ○ **From a Systems Improvement Perspective, What are the top three-five priorities of beneficiaries, communities, advocates, providers, CMHSPs, MDHHS, and other stakeholders?**	No updates as of today from MDHHS. Group discussed and brainstormed ideas for systems improvements as identified by beneficiaries, communities, advocates, providers, CMHSPs, MDHHS, and other stakeholders. Joe drafted document that includes a list of items, which will be discussed in the future for any action and distributed to the group. Joe will also add information from the advocates and association documents.				
	Ongoing agenda item for future discussions	By Who	J. Sedlock	By When	3.1.26

Mid-State Health Network
Statement of Activities
As of November 30, 2025

Rows Numbers		A	B	C	D	E	F	
						(C - D)	(C / B)	
			Budget Annual	Actual Year-to-Date	Budget Year-to-Date	Budget Difference	Actual % of Budget	
			FY26 Original Budget 16.67%		FY26 Original Budget			
1		Revenue:						
2		Grant and Other Funding	$ 374,568	22,153	62,428	(40,275)	5.91 %	1a
3		Prior FY Medicaid Carryforward	$ 9,887,364	12,223,430	1,647,894	10,575,536		1b
4		Medicaid Capitation	814,257,869	137,845,129	135,709,645	2,135,484	16.93%	1c
5		Local Contribution	1,550,876	371,086	258,479	112,607	23.93%	1d
6		Interest Income	1,100,000	138,442	183,334	(44,891)	12.59%	1e
7		Non Capitated Revenue	18,218,063	2,359,695	3,036,343	(676,650)	12.95%	1f
8		Total Revenue	845,388,740	152,959,935	140,898,123	12,061,811	18.09 %	
9		Expenses:						
10		PIHP Administration Expense:						
11		Compensation and Benefits	9,072,517	1,421,759	1,512,086	(90,327)	15.67 %	
12		Consulting Services	130,000	6,033	21,667	(15,634)	4.64 %	
13		Contracted Services	114,400	14,552	19,066	(4,515)	12.72 %	
14		Other Contractual Agreements	570,900	100,887	95,150	5,738	17.67 %	
15		Board Member Per Diems	20,820	2,030	3,470	(1,440)	9.75 %	
16		Meeting and Conference Expense	99,280	14,333	16,547	(2,214)	14.44 %	
17		Liability Insurance	30,000	24,715	5,000	19,715	82.38 %	
18		Facility Costs	188,536	67,817	31,423	36,394	35.97 %	
19		Supplies	207,250	32,946	34,541	(1,596)	15.90 %	
20		Other Expenses	1,083,450	369,195	180,575	188,620	34.08 %	
21		Subtotal PIHP Administration Expenses	11,517,153	2,054,267	1,919,525	134,741	17.84 %	2a
22		CMHSP and Tax Expense:						
23		CMHSP Participant Agreements	715,270,064	120,999,064	119,211,678	1,787,387	16.92 %	1b,1c,2b
24		SUD Provider Agreements	65,677,623	10,402,720	10,946,270	(543,551)	15.84 %	1c,1f,2c
25		Benefits Stabilization	860,000	143,333	143,334	0	16.67 %	2d
26		Tax - Local Section 928	1,550,876	371,086	258,479	112,607	23.93 %	1d
27		Taxes- IPA/HRA	49,174,082	7,797,321	8,195,680	(398,360)	15.86 %	2e
28		Subtotal CMHSP and Tax Expenses	832,532,645	139,713,524	138,755,441	958,083	16.78 %	
29		Total Expenses	844,049,798	141,767,791	140,674,966	1,092,825	16.80 %	
30		Excess of Revenues over Expenditures	$ 1,338,942	$ 11,192,144	$ 223,157			

Mid-State Health Network
Preliminary Statement of Net Position by Fund
As of November 30, 2025

Row Numbers		Column Identifiers A	B	C	D B + C	
1	**Assets**		**Behavioral Health Operating**	**Medicaid Risk Reserve**	**Total Proprietary Funds**	
2	**Cash and Short-term Investments**					
3	Chase Checking Account		15,960,706	0	15,960,706	1a
4	Chase MM Savings		13,275,073	0	13,275,073	
5	Savings ISF Account		0	13,737,144	13,737,144	1b
6	Savings PA2 Account		3,012,814	0	3,012,814	1c
7	Investment PA2 Account		3,499,172	0	3,499,172	1c
8	Investment ISF Account		0	21,999,041	21,999,041	1b
9	Total Cash and Short-term Investments		$ 35,747,765	$ 35,736,185	$ 71,483,950	
10	**Accounts Receivable**					
11	Due from MDHHS		23,291,555	0	23,291,555	2a
12	Due from CMHSP Participants		35,576,245	0	35,576,245	2b
13	Due from CMHSP - Non-Service Related		188,931	0	188,931	2c
14	Due from Other Governments		878,507	0	878,507	2d
15	Due from Miscellaneous		361,199	0	361,199	2e
16	Total Accounts Receivable		60,296,437	0	60,296,437	
17	**Prepaid Expenses**					
18	Prepaid Expense Rent		4,529	0	4,529	2f
19	Prepaid Expense Other		909	0	909	2g
20	Total Prepaid Expenses		5,438	0	5,438	
21	**Fixed Assets**					
22	Fixed Assets - Computers		189,180	0	189,180	2h
23	Accumulated Depreciation - Computers		(189,180)	0	(189,180)	
24	Lease Assets		190,989	0	190,989	2i
25	Accumulated Amortization - Lease Asset		(157,806)	0	(157,806)	
26	Total Fixed Assets, Net		33,183	0	33,183	
27	**Total Assets**		**$ 96,082,823**	**$ 35,736,185**	**$ 131,819,008**	
28						
29	**Liabilities and Net Position**					
30	Liabilities					
31	Accounts Payable		$ 10,316,216	$ 0	$ 10,316,216	1a
32	Current Obligations (Due To Partners)					
33	Due to State		36,219,732	0	36,219,732	3a
34	Other Payable		4,765,249	0	4,765,249	3b
35	Due to Hospitals (HRA)		6,639,974	0	6,639,974	1a, 3c
36	Due to State-IPA Tax		1,157,347	0	1,157,347	3d
37	Due to State Local Obligation		(16,633)	0	(16,633)	3e
38	Due to CMHSP Participants		1,956,538	0	1,956,538	3f
39	Accrued PR Expense Wages		213,206	0	213,206	3g
40	Accrued Benefits PTO Payable		515,406	0	515,406	3h
41	Accrued Benefits Other		61,455	0	61,455	3i
42	Total Current Obligations (Due To Partners)		51,512,274	0	51,512,274	
43	Lease Liability		33,182	0	33,182	2i
44	Deferred Revenue		5,572,004	0	5,572,004	1b 1c
45	Total Liabilities		67,433,676	0	67,433,676	
46	Net Position					
47	Unrestricted		28,649,147	0	28,649,147	3j
48	Restricted for Risk Management		0	35,736,185	35,736,185	1b
49	Total Net Position		28,649,147	35,736,185	64,385,332	
50	**Total Liabilities and Net Position**		**$ 96,082,823**	**$ 35,736,185**	**$ 131,819,008**	

Mid-State Health Network
Financial Statement Notes
For the Two-Month Period Ended,
November 30, 2025

Please note: The Statement of Net Position contains preliminary Fiscal Year (FY) 2025 cost settlement figures between the Pre-Paid Inpatient Health Plan (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 Interim MDHHS Financial Status Report (FSR) submitted in November 2025.

Preliminary Statement of Net Position:

1. Cash and Short-Term Investments
    a) The Cash Chase Checking and Chase Money Market Savings accounts are the cash line items available for operations.
    b) The Savings Internal Service Fund (ISF) and Investment ISF reflect designated accounts to hold the Medicaid ISF funds separate from all other funding per the MDHHS contract. MSHN holds nearly $21.9 M in investments, which is about 62% of the total ISF net position balance (row 50 col C). The investment portfolio has been temporarily reduced and moved to ISF Savings should the Region need to access funds for service delivery and other operational expenses. Internal Service Funds are used to cover the Region's risk exposure. In the event current Fiscal Year revenue is spent, and all prior year savings are exhausted, PIHPs can transfer ISF dollars and use them for remaining costs.
    c) The PA2 Savings PA2 and Investment accounts hold funds used to primarily cover Prevention services in MSHN's 21-county Region and is offset by the Deferred Revenue liability account.
2. Accounts Receivable
    a) Fiscal Year 2026 October and November Hospital Rate Adjustor (HRA) amounts account for 33% of the balance. HRAs are Stated Directed Payments and contractually required by MDHHS. In addition, withholds are 57% of the total with miscellaneous amounts accounting for the remaining balance.
    b) Due From CMHSP Participants reflect FY 2025 projected cost settlement activity. Final cost settlements generally occur in May after the fiscal year ends and once Compliance Examination are complete.

CMHSP	Cost Settlement	BHH Settlement	Payments/Offsets	Total
CEI	14,958,116.00	-	-	14,958,116.00
Central	946,545.00	5,615.64	-	952,160.64
The Right Door	3,489,905.00	-	-	3,489,905.00
Lifeways	1,174,467.00	-	-	1,174,467.00
Saginaw	13,478,281.00	15,287.02	-	13,493,568.02
Tuscola	1,508,028.00	-	-	1,508,028.00
Total	**35,555,342.00**		**-**	**35,576,244.66**

    c) Due from CMHSP Other consists of four CMHSPs owing for Relias services which is the regions training platform.
    d) Due from other governments account consists of Public Act 2 amounts owed from 11 counties for FY 25 quarter four liquor tax collections. PA2 funds are used primarily for Prevention Activities in MSHN's 21-county Region.
    e) The balance in Due From Miscellaneous is split 37% and 63% (respectively) for Medicaid Event Verification (MEV) findings and cash advances needed to cover operations for few SUD providers.
    f) Prepaid Expense Rent balance consists of security deposits for MSHN office suites.

g) Prepaid Expense Other has a small balance for FY 2026 Relias payments.
h) Total Fixed Assets - Computers represent the value of MSHN's capital asset net of accumulated depreciation.
i) The Lease Assets category is now displayed as an asset and liability based on a new Governmental Accounting Standards Board (GASB) Number 87 requirement. The lease assets figure represents FY 2022 – 2026 contract amounts for MSHN's office space.

3. Liabilities

a) MSHN estimates FY 2022 and FY 2021 lapses totaling $13.5 M and $17.6 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. MSHN also owes MDHHS $4.7 M for CCBHC supplemental over payments which primarily cover services for mild to moderate persons.
b) This amount is related to SUD provider payment estimates and is needed to offset the timing of payments.
c) HRA is a pass-through account for dollars sent from MDHHS to cover supplemental payments made to psychiatric hospitals. HRA payments are intended to encourage hospitals to have psychiatric beds available as needed. Total HRA payments are calculated based on the number of inpatient hospital services reported.
d) Due To State – Insurance Plan Assessments Tax contains funds held for payments associated with MDHHS Per Eligible Per Month (PEPM) funds. IPA taxes are applied to Medicaid and Healthy Michigan eligibles.
e) Due To State Local Obligation contains a negative balance as one CMHSP still owes for FY 2026 quarter one.
f) Due To CMHSP represents FY 2025 projected cost settlement figures. Final amounts will be paid during the region's final cost settlements, which generally occur in May or after Compliance Examinations are complete.

CMHSP	Cost Settlement	BHH Settlement	Payments/Offsets	Total
Bay	5,413,517.00	-	4,662,967.00	750,550.00
Gratiot	2,204,991.00	-	1,874,242.00	330,749.00
Huron	1,521,614.00	-	1,293,372.00	228,242.00
Montcalm	779,963.00	(311.98)	662,968.00	116,683.02
Newaygo	444,829.00	-	378,105.00	66,724.00
Shiawassee	3,117,644.00	(4,055.74)	2,649,998.00	463,590.26
Total	**13,482,558.00**	**(4,367.72)**	**11,521,652.00**	**1,956,538.28**

g) Accrued Payroll Expense Wages represent expenses incurred in November and paid in December.
h) Accrued Benefits PTO (Paid Time Off) is the required liability account set up to reflect paid time off balances for employees.
i) Accrued Benefits Other represents retirement benefit expenses incurred in November and paid in December.
j) The Unrestricted Net Position represents the difference between total assets, total liabilities, and the restricted for risk management figure.

Statement of Activities – Column F calculates the actual revenue and expenses compared to the full year's original budget. Revenue accounts whose Column F percent is less than 16.67% translate to MSHN receiving less revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 16.67% show MSHN's spending is trending higher than expected.

1. Revenue
    a) This account tracks Veterans Navigator (VN) activity and CMHSP Clubhouse Grant payments used to assist those served with their Medicaid deductibles.
    b) Medicaid Savings are generated when the prior year revenue exceeds expenses for the same period. PIHPs may retain up to 7.5% of savings using a tiered formulary.
    c) Medicaid Capitation – There is a positive variance in this account which shows actual revenue is trending higher than budgeted. The original FY 2026 budget submitted to the board in September contained revenue estimates from MDHHS's draft rate certification data however the final document calculated revenue significantly higher than anticipated. Please note, Medicaid Capitation payment files are calculated and disbursed to CMHSPs based on a per eligible per month (PEPM) methodology and paid to SUD providers based on service delivery.
    d) Local Contribution is flow-through dollars from CMHSPs to MDHHS. Typically, revenue equals the expense side of this activity. Local Contributions were scheduled to reduce over the next few fiscal years until completely phased out. FY 2026 amounts are the same as FY 2025.
    e) Interest income is earned from investments and changes in principle for investments purchased at discounts or premiums. The amount earned is lower than budget as the investment totals have been reduced to ensure sufficient cash on hand for ongoing operations. (Please see Statement of Net Position 1b.)
    f) This account tracks non-capitated revenue for SUD services which include Community Grant and PA2 funds. There is a large variance in this account because the budget amount represents the full MDHHS allocation amount regardless of planned spending.
2. Expense
    a) Total PIHP Administration Expense is slightly over budget. The other expenses line includes several vendor expenses. MiHIN (data exchange technology) is one such vendor and the FY 2026 invoice was paid in full which is the primary cause for being over budget.
    b) CMHSP participant Agreement shows a large variance when comparing actual to budget. The variance is related to the notes in item 1c above as more revenue is received, more is expensed to the CMHSPs. MSHN funds CMHSPs based on per eligible per month (PEPM) payment files. The files contain CMHSP county codes which designate where the payments should be sent. MSHN sends the full payment less taxes and affiliation fees which support PIHP operations.
    c) SUD provider payments are trending under budget and paid based on need. (Please see Statement of Activities 1c and 1f.)
    d) Benefit stabilization amounts are paid to CMHSPs for SUD access activities and assistance with cash flow if needed to cover operational expenditures in excess of their PEPMs.
    e) IPA/HRA actual tax expenses are lower than the budget. Beginning in FY 2026, Insurance Plan Assessment (IPA) dollars will be based on Michigan's Treasury assessment member months and paid in a quarterly lump sum. In prior fiscal years, the payment was included in capitation. 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 November 30, 2025

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	912797RE9	6.30.25	7.1.25	10.28.25		9,999,615.49	10,137,000.00			
UNITED STATES TREASURY BILL	912797RE9						(10,137,000.00)			
UNITED STATES TREASURY BILL	912797QY6	9.16.25	9.16.25	12.11.25		1,999,690.69	1,999,690.69			
UNITED STATES TREASURY BILL	912797PD3	10.27.25	10.28.25	1.22.26		19,999,350.29	19,999,350.29			
JP MORGAN INVESTMENTS							21,999,040.98			21,999,040.98
JP MORGAN CHASE SAVINGS							13,483,040.96	0.020%	254,103.53	13,737,144.49
							$ 35,482,081.94		$ 254,103.53	$ 35,736,185.47

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 November 30, 2025

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	912797QQ3	8.15.25	8.19.25	11.13.25		3,499,118.27	3,533,000.00			
UNITED STATES TREASURY BILL	912797QQ3						(3,533,000.00)			
UNITED STATES TREASURY BILL	912797RT6	11.12.25	11.13.25	2.12.26		3,499,171.34	3,499,171.34			
JP MORGAN INVESTMENTS							3,499,171.34			3,499,171.34
JP MORGAN CHASE SAVINGS							3,009,532.65	0.010%	3,281.99	3,012,814.64
							$ 6,508,703.99		$ 3,281.99	$ 6,511,985.98

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

POLICIES AND PROCEDURE MANUAL

Chapter:	**Finance**		
Title:	**Substance Use Disorder Treatment – Income Eligibility & Fees**		
Policy: X **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Financial Officer and Finance Manager	**Adopted Date: 11.2015** **Review Date:** 05.13.2025	**Related Policies:** Financial Management

Purpose:
Per contractual requirements with the Michigan Department of Health & Human Services (MDHHS) Mid-State Health Network (MSHN) is required to establish and maintain an income eligibility policy and procedure. The policy is intended to assure compliance with contractual obligations.

Policy:
MSHN requires use of a standardized income eligibility fee policy and procedure for all substance use disorder (SUD) treatment services. This policy is applicable to all treatment service modalities.

General Information:
Application of First and Third-Party Fees: The contract provisions with respect to the collection and reporting of first and third-party fees earned by a SUD Provider will be the first source of funding for the consumer. If benefits are exhausted or if the person needs a service not covered by that third party insurance, community block grant funds may be applied. It will be the SUD Provider's responsibility to develop and maintain policies and procedures regarding the collection and reporting of consumer fees and accounts receivable.

Consumer Eligibility: The income eligibility scale shall use a consumer's current annualized household income and the family size to determine the consumer's financial eligibility for a SUD treatment benefit from MSHN. Household income would include the income of the consumer's spouse, if living in the same home. It would also include the income of a significant other, if that consumer is cohabitating with the consumer and is engaged in the consumer's treatment process. Income would be excluded for estranged or separated spouses, for parents of any college-age consumer or adults living with parents if the parents only provide room and board. Income would also be excluded for adult children living at home if the parent is in treatment. Consumers whose family income falls at or below the guidelines identified in the attached "Income Eligibility for MSHN Benefits are eligible for a benefit subsidy as identified. Exceptions for income requirements may be made for consumer safety issues, continuity of care issues, and other items as reviewed and approved by MSHN staff. All exclusions should be documented in the consumer chart. The provider retains the authority to grant waivers to this policies and related procedures. If a waiver of income eligibility and fees is granted it shall be documented in the fee section of the consumer record.

- Income Verification: An Income Verification/Fee Agreement is to be completed at admission for each MSHN consumer that is funded through Community Block Grant dollars and signed by the consumer. In addition, proof of income must be documented in the consumer file (i.e., current pay stub, latest income tax return). Income should represent only legally obtained income. Annual gross income can be used, however, the most recent ninety (90) day period prior to admission should be reviewed to include any changes in employment.

Failure to secure and retain these items in the consumer's file will be grounds for non-reimbursement of services. If a consumer reports no income but is physically able to work, employment should be addressed as a treatment issue in the consumer's treatment plan.

An individual will not be denied service because of an inability to pay for services.

Non-allowable uses Block Grant:

- Inpatient hospital services except under conditions specified in federal law
- Cash payments to intended recipients of services
- Purchase, improve, or build (as applicable):
  - Land
  - Buildings and other facilities
  - Major medical equipment
- Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of funds
- Pay the salary of an individual in excess of Level I of the Federal Executive Schedule
- Funds shall not be used to purchase promotional items, including but not limited to clothing, commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags.

Applies to:

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

Definitions:

MDHHS: Michigan Department of Health & Human Services
MSHN: Mid-State Health Network
SUD: Substance Use Disorder

Other Related Materials:

- Financial Eligibility Worksheet
- MSHN Eligibility Procedure w. Attachment A (Income Verification Agreement)
- Financial Eligibility & Waiver Worksheet

References/Legal Authority:

- Michigan Mental Health Code
- Michigan Department of Health and Human Services Contract for Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program, and Substance Use Disorder Community Grant Programs

Change Log:

Date of Change	Description of Change	Responsible Party
08.2015	New Policy	Finance Manager
06.16.16	Policy Update	Chief Financial Officer
03.20.17	Policy Update	Chief Financial Officer
03.2018	Policy Update	Chief Financial Officer
03.2019	Policy Update	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
01.2023	Biennial Review	Chief Financial Officer
12.2024	Biennial Review	Chief Financial Officer
10.2025	Policy Update	Chief Financial Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter	General Management		
Title:	New CMHSP ~~Application or MDHHS Assignment to~~Participation in the MSHN Region		
Policy: ☒ Procedure: ☐ Page: 1 of 4	Review Cycle: Biennial Author: Chief Executive Officer	Adopted Date: 05.07.2019 Review Date: ~~09~~12.1~~50~~.20254	Related Policies:

Purpose

The purpose of this policy is to establish the general criteria and specific processes to be used in ~~evaluating~~ facilitating ~~potential~~ new Community Mental Health Services Program (CMHSP) participation in the ~~requests to become a part of th~~e Mid-State Health Network region. ~~or to evaluate Michigan Department of Health and Human Services (MDHHS) initiated assignment of a Community Mental Health Services Program to the Mid-State Health Network (MSHN) region.~~

Background

Section 2.4 of the Bylaws of Mid-State Health Network provides:

> "New CMHSP Participants may join the Entity upon written approval of two-thirds (2/3) of the governing bodies of the existing CMHSP Participants at the time of the admission request. The entity is prohibited from pursuing any actions to add CMHSP Participants or operate outside of the existing geographic area other than the process noted above. New CMHSP Participants added to the Entity will be entitled to any membership or governance rights in the same manner as the existing CMHSP Participants. Any new CMHSP Participants added under this section will forward any claims to existing Medicaid risk reserves to the Entity on a pro-rated basis upon date of admission as negotiated with Michigan Department of Health and Human Services (MDHHS)."~~"New CMHSP Participants to the Entity may be added pending written support from the State for purposes of preserving the community mental health system. If addition of these new CMHSP Participants to the Entity is not required by the State, it is seen as within the sole discretion of the existing CMHSP Participants. Thus when not required by the State, the addition of new CMHSP Participants to the Entity requires the approval of two-thirds (2/3) of the governing bodies of the existing CMHSP Participants, conveyed via a duly adopted written resolution of these governing bodies. New CMHSP Participants added to the Entity will be entitled to any membership or governance rights in the same manner as the existing CMHSP Participants. Any new CMHSP Participants added under this section will forward any claims to existing Medicaid risk reserves to the Entity on a pro-rated basis upon date of admission as negotiated with Michigan Department of Community Health (MDCH)." (MDCH no longer exists and has been succeeded by Michigan Department of Health and Human Services).~~

Policies

~~1)~~ ~~It is the policy of Mid-State Health Network to conduct due diligence activities as detailed in this policy and any related procedures in the event that :~~

1) It is the policy of Mid-State Health Network to conduct due diligence activities as detailed in this policy and any related procedures in the event that ~~A~~a new Community Mental Health Services Program (CMHSP) is being considered for~~requests~~ participation in the Mid-State Health Network Regional Entity.~~; and/or~~

~~2) The Michigan Department of Health and Human Services proposes to assign a CMHSP to the Mid-State Health Network Regional Entity.~~

2) It is the policy of Mid-State Health Network that the due diligence activities required under this policy are carried out by the MSHN Chief Executive Officer assisted by the MSHN Chief Financial Officer, MSHN Deputy Director and other MSHN executive management personnel pertinent to the subject matter being evaluated. The MSHN Operations Council shall appoint two representatives to consult, assist and advise in these due diligence activities. For the purposes of this policy only, this group hereinafter is called the Due Diligence Workgroup.

~~2)~~3) This Due Diligence Workgroup shall report monthly (and more often if needed) to the MSHN Operations Council and MSHN Executive Committee (or a special MSHN Board-Appointed committee, if so constituted), and to the MSHN Board at its regular meetings. Other sub-workgroups may be established by the Due Diligence Workgroup as needed to fulfill related due diligence activities. Requirements of the MSHN General Management, Appointed Councils, Committees, and Workgroups policy shall apply.

~~3)~~4) It is the policy of Mid-State Health Network for the Due Diligence Workgroup to request and evaluate any available information from the new CMHSP, ~~the~~ its current PIHP ~~associated with the CMHSP~~, and/or MDHHS in order to evaluate and analyze CMHSP historical, current and future financial, operational, programmatic performance and functional status, to assess the CMHSPs ability to perform to established standards in the MSHN region ,and to assess the impact of inclusion of the CMHSP on the existing CMHSP Participants, the MSHN Pre-Paid Inpatient Health Plan (PIHP) and the MSHN region. The Due Diligence Workgroup, at a minimum, shall request and evaluate the following:

a. A written, detailed rationale for the request to participate in ~~be a member of the~~ MSHN Regional Entity including identification of historical and current precipitating factors.
b. A detailed written disclosure of all matters where any aspect of the CMHSPs operations do not meet established standards or pose risk to the existing CMHSPs or MSHN. ~~This includes full disclosure of all matters involving finances, financial operations, short and long-term liabilities; full disclosure of pending and current legal matters, full disclosure of compliance matters, full disclosure of pending sanctions of any kind; and any other disclosure that may be requested by the Due Diligence Workgroup.~~
c. The most recent five years of audited financial statements and internal budget documents. ~~demonstrating the historical ability of the CMHSP to operate within its established revenue and within its established budget.~~
    1. It is desirable, but not a condition, that the CMHSP demonstrates at least 2 years of positive revenue and expense trends ~~that would be consistent with projected future geographic factors~~.
    2. There shall be no uncorrected material findings in the most recent two years of financial and compliance audits of the CMHSP.
    ~~1.~~
    2. ~~CMHSP is not under corrective action with the Michigan Department of Treasury~~

~~d.~~a. ~~There shall be no uncorrected material findings in the most recent two years of financial and compliance audits of the CMHSP.~~

~~e. The incoming CMHSP's Information Technology System must be validated by MSHN (or its designee) as fully operational/functional and interoperable with MSHN systems~~

~~f.~~d. Current status on all performance metrics, performance improvement projects and external entity reviews. It is desirable, but not a condition, that the CMHSP is not under corrective action with the MDHHS. If the corrective action plan places the MSHN region at risk, the CMHSP may be given an appropriate cure period or other reasonable consideration(s).

~~g.~~e. Current copy of the most recent CMHSP Community Needs Assessment and/or CMHSP provider network adequacy assessment and any status updates

~~h.~~f. Current status of all consumer affairs, including grievances and appeals, sentinel events, and all related quality information.

~~i. CMHSP demonstrates current service penetration and program unit costs that equal or exceed aggregate regional performance.~~

~~j. The historical geographic factor (and/or other factors used in rate setting) associated with the incoming CMHSP equals or exceeds the existing MSHN geographic factor.~~

~~k. Acceptable performance upon review of a pre-contract and/or pre-delegation site review(s) conducted by MSHN with participation from current MSHN CMHSP Participants. This may result in non-delegation of some or all managed care functions and may result in different delegations than the rest of the region in the sole discretion of the MSHN region.~~

~~4)~~5) It is the policy of Mid-State Health Network to establish certain stipulations that the incoming CMHSP and/or MDHHS must agree to. At a minimum, these stipulations are:

a. CMHSP commits to adoption of the existing MSHN Bylaws, Operating Agreement and established policies/procedures without qualification.
b. CMHSP has full certification from MDHHS. ~~including a fully compliant Recipient Rights Program~~
c. CMHSP holds current accreditation from a nationally-recognized entity compatible with the delivery of Medicaid specialty supports and services
d. Incoming CMHSP must have a balanced budget and at least one year of demonstrated ability to operate within provided revenue [Per Eligible Per Month (PEPM)]. Depending on historical and current operational circumstances, if this criterion cannot be met, the incoming CMHSP must provide an acceptable cost containment plan.
e. Incoming CMHSP must agree that MSHN will negotiate with MDHHS and/or the prior PIHP to ensure any related prior Internal Service Fund holdings associated with the incoming CMHSP is transferred to MSHN~~bring with it, from its current PIHP or MDHHS, if assigned, a fully funded Internal Service Fund (ISF) equal to the MDHHS-established maximum for PIHP ISFs (currently 7.5% of revenue)~~.
f. The incoming CMHSP must have retired (or have its own reserves sufficient to retire) any outstanding liabilities to the MDHHS and/or the prior PIHP, if any.
g. The incoming CMHSP must not be a party to current litigation ~~against the MDHHS.~~for which the MSHN region would become liable.
~~h.~~ The Incoming CMHSP must agree to adhere to the MSHN regional policies and procedures in place at the time of invitation/application ~~monitoring plan and sanctions for substandard fiscal, programmatic or other operational performance.~~

~~i. Negative financial impacts caused by rate misalignments of the incoming CMHSP, if any, must be supported by state funding to smooth this negative impact over an agreeable period of time.~~

~~j.~~h. ~~The incoming CMHSP must~~ including adoption of ~~adopt~~ the MSHN region's costing, cost allocation and cost reporting principles, policies and procedures.

~~k. If the Information Technology System of the incoming CMHSP is not validated as fully functional/operational and cross functional with existing MSHN systems, the incoming CMHSP, at its own expense, must correct that condition.~~

~~l. Incoming CMHSP (or MDHHS, if assigned) bears the costs of the MSHN region for confirming conditions and integrating it into the region (prior to application of regional administration fees)~~

~~m.~~i. MSHN reserves the right to ~~may~~ contractually obligate the incoming CMHSP to additional participant requirements during the transition process as a result of due diligence activities, which will be detailed in writing and adopted by the MSHN Board, which may continue until certain milestones to be detailed as a result of that process are met.

In the event that the CMHSP ~~and/or MDHHS~~ is ~~un~~willing ~~or un~~and able to accept MSHN stipulations after negotiations with the Due Diligence Workgroup, the appropriate party should provide a written proposal to include waiver of any due diligence stipulations of this policy or other recommendations which must be presented to the MSHN Operations Council for consideration, and from the Operations Council by the MSHN CEO to the MSHN Board of Directors.

~~1)~~ ~~Where the applicant is the CMHSP, t~~The MSHN Board ~~may~~ shall forward the proposal with a recommendation ~~from~~to ~~the~~ Boards of Directors to~~of~~ the current MSHN CMHSP Participants, which must act to accept or reject the applicant CMHSP by duly adopted resolution as stipulated in the MSHN Bylaws.

~~2) Where the State is the initiating party requiring the MSHN Regional Entity to accept the CMHSP, the MSHN Board shall make a decision that will mitigate the additional service, financial and legal risks to the region and the CMHSP Participants consistent with the established Bylaws and Operating Agreement.~~

~~5)~~6) It is the policy of Mid-State Health Network to reserve the right to identify additional considerations, stipulations or criteria depending upon the situation at the time of the ~~request~~ consideration of a CMHSPs ~~or MDHHS for~~ inclusion ~~of a CMHSP i~~in the MSHN region.

Applies to

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

Definitions

Terms used in this policy have the meaning defined in the MSHN Bylaws and/or the MSHN Operating Agreement.
CMHSP: Community Mental Health Service Program
ISF: Internal Service Fund
ENTITY: References to "the entity" are defined as Mid-State Health Network

~~MDCH: Michigan Department of Community Health~~
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PEPM: Per Eligible Per Month
PIHP: Pre-Paid Inpatient Health Plan

Other Related Materials

References/Legal Authority
Mid-State Health Network Bylaws, Section 2.4
MSHN Operating Agreement

Change Log:

Date of Change	Description of Change	Responsible Party
03.31.2019	New Policy	Chief Executive Officer
07.21.2020	Biennial Review	Chief Executive Officer
06.03.2022	Biennial Review	Chief Executive Officer
07.2024	Biennial Review	Chief Executive Officer
08.2025	Removal of appointed CMHSP by MDHHS	Chief Executive Officer
12.15.2025	Review due to MDHHS Request for Proposal	Chief Executive Officer