Mid-State Health Network

Board of Directors Meeting ~ July 7, 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 July 7, 2026 Meeting of the MSHN Board of Directors

4. Public Comment (3 minutes per speaker)

5. **ACTION ITEM:** MSHN FY2026 Corporate Compliance Plan *(Page 6)*

   Motion to acknowledge receipt of and approve the FY2026 MSHN Corporate Compliance Plan

6. **ACTION ITEM:** Fiscal Year 2027 Board Meeting Calendar *(Page 37)*

   Motion to Adopt the FY2027 Mid-State Health Network Board of Directors Meeting Calendar as presented

7. Chief Executive Officer's Report *(Page 38)*

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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

September 1, 2026
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

Upcoming FY27 Board Meetings

Pending Board Approval

November 10, 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

8. Deputy Director's Report *(Page 57)*

9. Chief Financial Officer's Report

   Financial Statements Review for Period Ended May 31, 2026 *(Page 76)*

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

10. **ACTION ITEM:** Contracts for Consideration/Approval *(Page 86)*

    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

11. Chairperson's Report

    A. Board Member Ten Year Service Recognition

12. **ACTION ITEM:** Consent Agenda

    Motion to Approve the documents on the Consent Agenda

    12.1 Approval Board Meeting Minutes 05/05/2026 *(Page 88)*
    12.2 Receive Board Officer Briefing Notes 06/12/2026 *(Page 92)*
    12.3 Receive Draft Policy Committee Meeting Minutes 05/05/2026 *(Page 94)*
    12.4 Receive SUD Oversight Policy Board Meeting Minutes 04/15/2026 *(Page 96)*
    12.5 Receive Operations Council Key Decisions 05/18/2026 *(Page 99)* and 06/15/2026 *(Page 102)*
    12.6 Approve the following policies:
        12.6.1 Application Programming Interface *(Page 105)*
        12.6.2 Disqualified Individuals Policy *(Page 107)*
        12.6.3 Advance Directives *(Page 121)*
        12.6.4 Customer Handbook *(Page 124)*
        12.6.5 Customer Service *(Page 128)*
        12.6.6 Enrollee Rights *(Page 131)*
        12.6.7 Information Accessibility/Limited English Proficiency (LEP) *(Page 134)*
        12.6.8 Medicaid Beneficiary Appeals/Grievances *(Page 140)*
        12.6.9 Regional Consumer Advisory Council *(Page 145)*
        12.6.10 SUD Recipient Rights *(Page 150)*

13. Other Business

14. Public Comment (3 minutes per speaker)

15. Adjourn

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FY26 MSHN Board Roster

Current as of 05/20/2026

Last Name	First Name	Email 1	Email 2	Phone 1	Phone 2	Appointing CMHSP	Term Expiration
Brodeur	Greg	brodeurgreg@gmail.com		989.413.0621		Shia Health & Wellness	2027
Collins	Kevin	kevin.collins@lifewaysmi.org		517.425.2446		LifeWays	2028
Conley	Patrick	conleypat@gmail.com		585.734.6847		BABHA	2028
DeLaat	Ken	kend@nearnorthnow.com		231.414.4173		Newaygo County MH	2029
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	2029
Hicks	Tina	tmhicks64@gmail.com		989.576.4169		GIHN	2027
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2027
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	2029
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	2029
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
Schumacher	Pam	pschumacher82@gmail.com		989.415.9497		BABHA	2029
Smith	Mike	tybacore@gmail.com		878.315.4115		HBH	2029
Stapleton	Jack			989.225.5566		HBH	2029
Washington	Dwight	washindwi@gmail.com		517.974.1658		CEI	2028
White	Jason	jasoncardellwhite@gmail.com		517.648.5638		CEI	2028
Williams	Joanie	joanie.williams1977@gmail.com		989.860.6230		Saginaw County CMH	2029
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

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

> The Contractor must have a program integrity compliance program as defined in 42 CFR 438.608. The program integrity compliance program must include the following:
>
> i. Written policies and procedures that describe how the Contractor will comply with federal and State fraud, waste and abuse standards, and well publicized disciplinary standards for failure to comply.
> ii. The designation of a compliance officer who reports directly to the Chief Executive Officer and the Board of Directors, and a compliance committee, accountable to the senior management or Board of Directors, with effective lines of communication to the Contractor's employees.
> iii. Effective training and education for the compliance officer, senior management, and the Contractor's employees regarding fraud, waste and abuse, and the federal and State standards and requirements under this Contract. While the compliance officer may provide training to Contractor employees, "effective" training for the compliance officer means it cannot be conducted by the compliance officer himself/herself.
> iv. Provisions for internal monitoring and auditing. Audits must include post payment reviews of paid claims to verify that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities, etc.). Acceptable audit methodology examples include:
> 1. Record review, including statistically valid random sampling and extrapolation to identify and recover overpayments made to providers
> 2. Beneficiary interviews to confirm services rendered
> 3. Provider self-audit protocols
> 4. The frequency and quantity of audits performed should be dependent on the number of fraud, waste and abuse complaints received as well as high risk activities identified through data mining and analysis of paid claims
> v. Provisions for the Contractor's prompt response to detected offenses and for the development of corrective action plans. "Prompt response" is defined as action taken within 15 business days of receipt by the Contractor of the information regarding a potential compliance problem.

The 2026 Corporate Compliance Plan was revised by the MSHN Compliance Committee, Regional Compliance Committee and the Operations Council with recommendation for approval to the MSHN Board of Directors. The revisions were based on required action identified by the Office of Inspector General after review of the MSHN Corporate Compliance Plan. The attached change log for the 2026 Revised Corporate Compliance Plan provides an overview of the recommended revisions to the plan. In addition, the Corporate Compliance Plan as proposed is in compliance with and supports the MSHN Policy: General Management - Compliance and Program Integrity.

Recommended Motion:
The MSHN Board approves and acknowledges receipt of the Revised 2026 Corporate Compliance Plan.

MSHN Compliance Related Updates

Change Log

The following is a brief summary of the changes to the MSHN 2026 Compliance Plan. Most revisions are based on findings made by the Office of Inspector General after review of our annual submission of Report 6.9. For complete information on the changes, please refer to the MSHN 2026 Compliance Plan.

Document	Information/Narrative Added
2026 MSHN Compliance Plan	
VII. Compliance Standards, D. Workplace Standards of Conduct	MSHN's executive/chief/director level staff and compliance officer are not allowed to be employed by a MSHN subcontractor in such a capacity.
IX. Training, A. MSHN Employees and Board Members	MSHN will also determine under what circumstances it may be appropriate to train nonemployee agents and subcontractors.
XII. Reporting and Investigations	This compliance unit functions in the capacity of the Special Investigations Unit (SIU) for MSHN and is separate from utilization review and quality of care functions.
XII. Reporting and Investigations, A. Reporting of Suspected Violations and/or Misconduct	In the event the $5,000 threshold is not met, but there is still a heightened concern of a potential credible allegation of fraud (e.g. beneficiary harm or extenuating circumstances), MSHN will reach out to discuss the possibility of a referral with their assigned analyst as there can be exceptions that warrant referral.
	MSHN and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid must retain and make all records (including, but not limited to, financial, medical and enrollee grievance and appeal records, base data in 42 CFR 438. 5(c), Medical Loss Ratio (MLR) reports in 42 CFR 438. 8(k), and the data, information, and documentation specified in 42 CFR 438. 604, 438. 606, 438. 608, and 438. 610) available at the MSHN's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal and state personnel, including representatives from the MDHHS-OIG, the Michigan Department of Attorney General, DHHS OIG and the DOJ, or any duly authorized State or federal agency for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

	Reporting of recoveries will occur via monthly, quarterly, and annual submissions to MDHHS-OIG using the corresponding templates provided
	In the event MCE receives a repayment stemming from an external investigation State or federal), MCE must contact MDHHS-OIG within 30 calendar days to initiate the return of any applicable funds. Any applicable documentation will be requested at such time.
XII. Reporting and Investigations, B. Process for Investigation	At a minimum, all allegations within MDHHS-OIG audit referral will be investigated to either substantiate or refute any and all items within the complaint. In addition, a detailed summary of findings must be produced and include all items outlined in the audit referral.
XIV. Submission of Program Integrity Activities/Report	Compliance investigations will be reported/documented utilizing the Healthicity compliance software. The templates within Healthicity will be completed in their entirety upon completion of each activity. MSHN will utilize this information for required reporting to MDHHS-OIG, inclusive of monthly and quarterly reports.

CORPORATE COMPLIANCE PLAN
2026/2027

Mid-State Health Network, Corporate Compliance Committee: ~~January 15, 2025, revised May 21, 2025~~ May 20, 2026
Mid-State Health Network, Regional Compliance Committee: ~~January 17, 2025, revised May 30, 2025~~ May 22, 2026
Mid-State Health Network, Operations Council Approved: ~~February 25, 2025, revised June 16, 2025~~ June 15, 2026
~~Mid-State Health Network PIHP Board Adopted: March 07, 2025, revised July 01,2025~~

TABLE OF CONTENTS

I. OVERVIEW/MISSION STATEMENT

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

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

II. VALUE STATEMENT

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

III. SCOPE OF PLAN

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

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

IV. DEFINITIONS

These terms have the following meaning throughout this Compliance Plan.

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

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

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

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

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

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

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

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

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

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

V. COMPLIANCE PROGRAM

A. Compliance Plan

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

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

- Minimize organizational risk and improve compliance with billing requirements of Medicaid,

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

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

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

B. Compliance Policies and Procedures

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

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

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

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

VI. STRUCTURE OF THE COMPLIANCE PROGRAM

A. General Structure

- *MSHN Board of Directors*: MSHN's Board of Directors is responsible for the review and approval of the Compliance Plan and Policies and review of the Annual Compliance Report. The MSHN Board of Directors also routinely receives and reviews reports related to the Compliance Program based on recommendations from the MSHN Corporate Compliance Committee. The MSHN Board of Directors has the highest level of responsibility for the oversight of the Compliance Program. The Executive Committee of the Board shall review reports annually from the MSHN Compliance Officer (CO).

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

- *Compliance Officer:* The MSHN Compliance Officer has primary responsibility for ensuring that MSHN maintains a successful Compliance Program. In particular, the Compliance Officer oversees the implementation and effectiveness of the Compliance Plan and Compliance Policies, serves as the Chair of the Regional Compliance Committee and MSHN Corporate Compliance Committee, provides consultative support to the provider network and has responsibility for the day-to-day operations of the compliance program. The CEO, chief financial officer (CFO), and chief operating officer (COO), or any other individuals operating

in these roles, may not operate in the capacity of the compliance officer.

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

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

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

B. MSHN Compliance Officer

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

- Oversight of internal (PIHP Audits) and external provider network audits (MDHHS Audit and EQR Audit) and monitoring activities outlined in the compliance plan.
- Directs and is accountable for the implementation and enforcement of the Compliance Plan.
- Serves as chair of the MSHN's Corporate Compliance Committee and Regional Compliance Committee
- Provides leadership to MSHN compliance activity and consultative support to CMHSP Participants/SUD Providers.
- Responsible for oversight of MSHN efforts to maintain compliance with federal and state regulations and contractual obligations.
- Serves as the Privacy Officer for MSHN.
- Ensures that effective systems are in place by which actual or suspected compliance violations are reported in a timely manner to appropriate governing bodies.
- Reviews all reports of actual or suspected compliance violations received by MSHN from any source and ensures that effective investigation and/or other action is taken.
- Completes investigations referred by, and under the direction of, the Office of Inspector General
- Monitors changes in federal and state health care laws and regulations applicable to MSHN operations and disseminate to the region.
- Works collaboratively with other MSHN employees and CMHSP Participants/SUD Providers to ensure that auditing and monitoring protocols are designed to detect and deter potential compliance violations.
- Coordinates compliance training and education efforts for all MSHN staff and Board Members
- Ensures that performance improvement plans are adequate to ensure compliance and assures effective implementation of corrective action occurs to reduce risk of future occurrences.
- Authority and independence to make reports directly to the board of directors and/or senior management concerning actual or potential cases of non-compliance.
- Reports compliance related matters to the Chief Executive Officer.

- Prepares and submits the quarterly Office of Inspector General program integrity report
- Prepares and delivers an annual compliance report to the MSHN Board covering the fiscal year, including:
  - A summary of trends in the frequency, nature and severity of substantiated compliance violations;
  - A review of any changes to the Compliance Plan or program; and
  - An objective assessment of the effectiveness of the Compliance Plan and Program.

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

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

C. Regional Compliance Committee

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

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

D. MSHN Corporate Compliance Committee

The MSHN Corporate Compliance Committee meets every other month and its responsibilities include:

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

VII. COMPLIANCE STANDARDS

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

A. Standards of Conduct and Ethical Guidelines

MSHN and its Provider Network are committed to conducting the delivery of services and business operations in an honest and lawful manner and consistent with its Vision, Mission, and Values. As such, MSHN minimally establishes the following Standards of Conduct to clearly delineate the philosophy and values concerning compliance with the laws, regulations, contractual obligations, government guidelines and ethical standards applicable to the delivery of behavioral health care. The standards of conduct will be distributed to all employees and all employees will be required to certify that they have read, understand, and agree to comply with the standards.

- Provide through its Provider Network, high quality services consistent with MSHN Vision, Mission, and Values;
- Dedicated to ensuring that equality in voice and governance exists, and that the benefit to the citizens meets Medicaid standards while being provided in ways that reflect the needs and resources of the communities in which each CMHSP Participants/SUD Providers operate;
- Shared operating structure, using a committee-based system that creates many venues, allowing voices from across the region to be heard;
- MSHN operations are for service to the CMHSP Participants/SUD Providers in achieving high levels of regulatory compliance, quality of service, and fiscal integrity;
- MSHN exists to serve in the best interest of and to the benefit of all CMHSP Participants/SUD Providers and their consumers;
- Foster each CMHSP Participants/SUD Providers integration activities and locally driven work.
- Conduct business in an honest, legal and competent manner to prevent fraud, abuse and waste;
- Perform all duties in good faith and refrain from knowingly participating in illegal activities;
- Report any actual or suspected violation of the Compliance Plan, Standards of Conduct, MSHN policies or procedures, contract requirements, state and federal regulations or other conduct that is known or suspected to be illegal;
- Provide accurate information to federal, state, and local authorities and regulatory agencies when applicable;
- Promote confidentiality and safeguard all confidential information according to policy;
- Practice ethical behavior regarding relationships with consumers, payers, and other health care providers;
- Protect through its Provider Network, the integrity of clinical decision-making, basing care on identified medical necessity;
- Seek to continually maintain and improve work-related knowledge, skills, and competence; and
- Actively support a safe work environment, free from harassment of any kind.

These Standards of Conduct provide guidance for MSHN Board members and employees, as well as the provider network in performing daily activities within appropriate ethical and legal standards and establish a workplace culture that promotes prevention, detection, and resolution

of instances of conduct that do not conform with applicable laws and regulations. While the above standards are expected to be a framework for compliance, the issues addressed are not exhaustive. Therefore, MSHN Board Members, employees and its provider network staff are responsible for conducting themselves ethically in all aspects of business avoiding even the appearance of impropriety and in accordance with established policies and procedures.

B. Legal and Regulatory Standards

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

State/Federal Laws and Rules

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

Federal Medicaid Law, Regulations and Related Items

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

Other Relevant Legislation

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

C. Environmental Standards

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

environment, and the community.

D. Workplace Standards of Conduct

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

1. Confidentiality: MSHN is committed to protect the privacy of its consumers. MSHN Board members, employees, and contractual providers are to comply with the Michigan Mental Health Code, Section, 330.1748, Code of Federal Regulations (CFR), Title 42 and all other privacy laws as specified under the Confidentiality section of this document.
2. Drug and Alcohol: MSHN is committed to maintain its property and to provide a drug-free work environment that is both safe for our employees and visitors, as well as conducive to efficient and productive work standards.
3. Harassment: MSHN is committed to maintaining a work environment free of harassment for Board members, employees, and contractual providers. MSHN will not tolerate harassment based on sex, race, color, religion, national origin, disability, citizenship, chronological age, sexual orientation, union activity, or any other condition, which adversely affects their work environment.
4. Conflict of Interest: MSHN Board members, employees, and contractual providers shall avoid any action that conflicts with the interest of the organization. All Board members, employees, and contractual providers must disclose any potential conflict of interest situations that may arise or exist in accordance with established policies and procedures. MSHN's executive/chief/director level staff and compliance officer are not allowed to be employed by a MSHN subcontractor in such a capacity.
5. Reporting Suspected Fraud: MSHN Board, employees, and contractual providers shall report any suspected or actual "fraud, abuse or waste" of any funds, including Medicaid funds, to the organization.
6. Solicitation and Acceptance of Gifts: MSHN Board members, employees and contractual providers shall not solicit gifts, gratuities or favors. MSHN Board members, employees and contractual providers will not accept gifts worth more than $25, gratuities or favors of any kind from any individual, consumer, or organization doing business or seeking to do business with MSHN.
7. Workplace Bullying: MSHN defines bullying as "repeated" inappropriate behavior, either direct or indirect, whether verbal, physical, or otherwise, conducted by one or more persons against another or others, at the place of work and/or during the course of employment. Such behavior violates MSHN Code of Ethics, which clearly states that all employees will be treated with dignity and respect.
8. Workplace Violence and Weapons: MSHN takes violence and threats of violence extremely seriously. Any act or threat of violence by or against any employee, customer, supplier, partner, or visitor is strictly prohibited.
9. Political Contributions: MSHN shall not use agency funds or resources to contribute to political campaigns or activities of any political party.

Commented [KZ1]: 01.C - Conflict of Interest

E. Contractual Relationships

MSHN shall ensure that all contractual arrangements with providers are structured in accordance with federal and state laws and regulations and are in the best interest of the organization and

the consumers served. In order to ethically and legally meet all standards, MSHN will strictly adhere to the following:

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

F. Purchasing and Supplies

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

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

G. Marketing

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

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

H. Financial Systems Reliability and Integrity

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

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

In accord with the 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005) MSHN's fiscal processes shall monitor contractual providers of Medicaid services to assure appropriate documentation is available as needed to support claims payments and cost reimbursements.

I. Information Systems Reliability and Integrity

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

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

J. Confidentiality and Privacy

The MSHN Chief Compliance and Quality Officer serves as the Privacy Officer. MSHN is committed to protecting the privacy of its consumers and shall strictly govern the disclosure of any information to anyone other than those authorized in compliance with applicable privacy laws, regulations and contractual requirements. To ensure that all consumer information remains confidential, employees and contractual providers are required to comply with all confidentiality policies and procedures in effect, specifically to include the HIPAA Privacy Regulations, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 C.F.R. Part 2, 45 C.F.R. Part 160 &164 as outlined below:

- MSHN will follow the HIPAA requirements, as well as all applicable federal and state requirements, for the use of protected health data and information.
- MSHN will immediately report to the MDHHS any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements.
- Any breach of protected health information shall result in notification of the affected individuals as well as the HHS Secretary and the media in cases where the breach affects more than 500 individuals.
- Privacy Notice - MSHN will have a notice of privacy practices.
- Authorization - If protected mental health information is shared to an entity outside of MSHN for any purpose other than coordination of care, treatment, or payment of services, a signed authorization will be obtained from the consumer prior to sharing information. If substance

use treatment information is being shared, for any purpose, to an entity outside of MSHN, a signed authorization, by the consumer, will be obtained. The Michigan Behavioral Health Consent Form will be utilized for obtaining authorizations.

- MSHN will perform any necessary internal risk analysis or assessments to ensure compliance.
- Physical and electronic safeguards shall be in place for MSHN employees and premises, including, but not limited to, door locks, unique logins and secure passwords, firewall and virus protection, disaster recovery mechanisms, and secure email.
- Business Associate Agreement – MSHN will obtain assurances with all Business Associates that protected health care information shared with them, will be protected and appropriately safeguarded consistent with all applicable State and Federal laws and requirements.
- Qualified Service Organization Agreement (QSOA) - Third-party service providers must become qualified to service Part 2 Programs. This is achieved through the entity entering into a written agreement with the Part 2 Program in which it acknowledges that it is bound by the Part 2 confidentiality regulations and agrees to resist in judicial proceedings any efforts to obtain unauthorized access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment that may come into its possession.

VIII. AREAS OF FOCUS

The MSHN Compliance Officer under the direction of the MSHN Board of Directors, MSHN Corporate Compliance Committee and the MSHN Regional Compliance Committee, will identify areas of focus developed from recommendations from the previous year compliance effectiveness review that will guide the direction of MSHN compliance activities (**Attachment C**).

IX. TRAINING

A. MSHN Employees and Board Members

All MSHN Employees and Board members shall receive a copy of the MSHN Compliance Plan and training on the MSHN Compliance Plan, Compliance Policies, Standards of Conduct and applicable Medicaid statutory, regulatory, and contractual requirements. Additional training may be required for employees involved in specific areas of risk or as new regulations are issued. Records shall be maintained on all formal training and educational activities. MSHN staff and Board members are required to sign certifications that they have completed the appropriate training. The Compliance Officer must receive training by an entity other than himself/herself.

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

The Compliance Officer will provide ongoing information and education on matters related to health care fraud and abuse as disseminated by the Office of Inspector General, Department of Health and Human Services or other regulatory bodies. MSHN will also determine under what circumstances it may be appropriate to train nonemployee agents and subcontractors.

Commented [KZ2]: 03.B. Formal/Annual Training - 2

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

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

B. MSHN Provider Network

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

X. COMMUNICATION

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

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

XI. MONITORING AND AUDITING

Monitoring and auditing MSHN's operations is key to ensuring compliance and adherence to policies and procedures, contractual and other MDHHS requirements in critical operational areas. The internal auditors must be independent from the department under audit, competent to identify potential issues within the critical review areas and must have access to existing audit resources, relevant personnel, and all relevant operational areas. Written reports will be communicated to the Compliance Officer, the Compliance Committee and appropriate senior management and will contain findings, recommendations, and proposed corrective action.

The compliance program will have periodic evaluations, no less than annually, to determine overall effectiveness. The evaluation may be performed internally, either by the Compliance Officer or other internal source, or by an external organization. The evaluation will be reported as part of the Annual Compliance Effectiveness Report to the MSHN Compliance Committee, Regional Compliance Committee, Operations Council and the Board of Directors.

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

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

Information Systems Reliability and Integrity
- MSHN Information System employees and Provider Network staff monitor the reliability and integrity of the information system and data;
- Assure appropriate security and system backup and recovery processes are in place to address loss of information and that provide sufficient disaster recovery plans; and
- MSHN employees and Provider Network staff are trained on use of information systems and provided access based on role and job function.
- Network Providers, as required, are enrolled in the Michigan Medicaid Program via the State's Medicaid Management Information System

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

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

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

Quality and Utilization Reviews
- Review of delegated managed care functions (as identified in the MSHN/CMHSP Medicaid Subcontract);
- Review of SUD Provider Network in accordance with contracted functions

- Review of adherence and compliance with Quality Assessment and Performance Improvement Program (QAPIP) Plan; and
- Review of adherence and compliance with the Utilization Management (UM) Plan.

Additional Internal Monitoring and Auditing Activities

- Assessment of initial capacity and competency to perform delegated PIHP functions;
- Consumer Satisfaction Surveys;
- Review of MSHN contracts for administrative services;
- Contract Expense Monitoring;
- Monitor capacity and demand for services in the PIHP region through the Assuring Network Adequacy Report
- Review of Policies and Procedures for any needed revisions or development of new ones
- Questionnaires to poll staff and the provider network regarding compliance matters including effectiveness of training/education and related policies and procedures
- Questionnaire for exiting employee regarding any observed violations of the compliance program, including the code of conduct, was well as violations of applicable statutes, regulations, and Medicaid program requirements.

Additional External Monitoring and Auditing Activities:

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

Data Mining Activities:

Methods may include, but not limited to, statistical models, complex algorithms, and pattern recognition programs to detect possible fraudulent or abusive practices. All data mining activities performed (including all program integrity cases opened as a result) within the previous quarter will be reported to MDHHS-OIG. Data mining will be performed at least annually.

XII. REPORTING AND INVESTIGATIONS

MSHN will have a distinct compliance unit that has adequate staffing and resources to investigate incidents and develop and implement corrective action plans to assist in preventing and detecting potential fraud, waste and abuse activities. This compliance unit functions in the capacity of the Special Investigations Unit (SIU) for MSHN and is separate from utilization review and quality of care functions.

Commented [KZ3]: Added to address OIG requirement 02.C. Special Investigative Unit - 1 for report 6.9

A. Reporting of Suspected Violations and/or Misconduct

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

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

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

Violations Involving Suspected Fraud, Waste or Abuse:

- MSHN board members, employees, contractual providers and the provider network will report all suspected fraud, waste, and abuse to the MSHN Compliance Officer. The report will be submitted in writing utilizing the Office of Inspector General (OIG) Fraud Referral Form.
- The MSHN Compliance Officer will promptly complete a preliminary investigation, as needed, to determine if a suspicion of fraud exists. Questions regarding whether suspicions should be classified as fraud, waste or abuse will be directed to MDHHS-OIG prior to referral.
- If there is suspicion of fraud, and an overpayment of $5,000 or greater is identified, the MSHN Compliance Officer will report the suspected fraud to the MDHHS Office of Inspector General and the Attorney General – Health Care Fraud Division (AG-HCFD) using the OIG Fraud Referral Form using the designated secure File Transfer Process (sFTP) for each entity.
- In the event the $5,000 threshold is not met, but there is still a heightened concern of a potential credible allegation of fraud (e.g. beneficiary harm or extenuating circumstances), MSHN will reach out to discuss the possibility of a referral with their assigned analyst as there can be exceptions that warrant referral.
- The MSHN Compliance Officer will inform the appropriate provider network member when a report is made to the MDHHS Office of Inspector General.
- MSHN Compliance Officer will refer all potential Enrollee Fraud, Waste or Abuse to MDHHS through https://www.Michigan.gov/fraud (File a Complaint - Medicaid Complaint Form) or via the local MDHHS office and report all fraud, waste and abuse referrals made to MDHHS on the quarterly submission.
- MSHN Compliance Officer and provider network member staff will present the fraud referral case to the OIG and the AG-HCFD.
- MSHN Compliance Officer will defend potential credible allegation of fraud in any appeal should the referral result in suspension issued by the MDHHS OIG.
- MSHN will cease all efforts to take adverse action against or collect overpayments from the provider until authorized by the MDHHS OIG and follow the guidance/direction provided by the MDHHS Office of Inspector General regarding investigation and/or other required follow up.
- To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, MSHN and the provider network will cooperate fully with investigations or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation must include providing, upon request, information, access to records, and access to interview employees and consultants, including but not limited to those with expertise in administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation or prosecution. MSHN will follow the procedures and examples contained within the processes and associated guidance provided by MDHHS-OIG.
- MSHN and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid must retain and make all records (including, but not limited to, financial, medical and enrollee grievance and appeal records, base data in 42 CFR 438. 5(c), Medical Loss Ratio (MLR) reports in 42 CFR 438. 8(k), and the data, information, and documentation specified in 42 CFR 438. 604, 438. 606, 438. 608, and 438. 610) available at the MSHN's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation,

Commented [KZ4]: 08.A. Referral Processes - 1

inspection, investigation and/or prosecution by authorized federal and state personnel, including representatives from the MDHHS-OIG, the Michigan Department of Attorney General, DHHS OIG and the DOJ, or any duly authorized State or federal agency for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Commented [KZ5]: 09.C. Access - Review

- Overpayments due to fraud, waste, or abuse must be reported to MDHHS-OIG.
    1. If MSHN identifies an overpayment involving a credible allegation of I fraud prior to identification by MDHHS-OIG, the findings will be referred to MDHHS-OIG and MSHN will stand down and wait for further instruction from MDHHS-OIG prior to recovering the overpayment.
    2. MSHN will adjust all associated encounter claims identified and authorized by the OIG for overpayment recoupment within the required timeframes.
- If MSHN's provider network identifies an overpayment, they will:
    1. Notify the contracted entity, in writing, of the reason for the overpayment and the date the overpayment was identified.
    2. Return the overpayment to the contracted entity within 60 days of the date the overpayment was identified.
    3. MSHN will include a provision in all contracts with subcontractors and/or network providers giving MSHN the right to recover overpayments directly from providers for the post payment evaluations initiated and performed. These overpayment provisions do not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.
        - MSHN must specify:
            - The retention policies for the treatment of recoveries of all overpayments from the Contractor and/or Subcontractors to provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.
            - The process, timeframes, and documentation required for reporting the recovery of all overpayments.
            - The process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the Contractor and/or Subcontractor is not permitted to retain some or all recoveries of overpayments.
- Once all applicable appeal periods have been exhausted, The PIHP must adjust all associated encounter claims identified as part of their Program Integrity activities within CHAMPS within 45 days. Failure to comply may result in a gross adjustment for the determined overpayment amount to be taken from the PIHP.
    1. Contractor must resolve outstanding encounter corrections in the timeframe designated in any authorization granted by MDHHS-OIG.
    2. All adjustments must be performed regardless of recovery from the Subcontractor and/or Network Provider.
    3. Reporting of recoveries will occur via monthly, quarterly, and annual submissions to MDHHS-OIG using the corresponding templates provided.
- In the event MCE receives a repayment stemming from an external investigation (State or federal), MCE must contact MDHHS-OIG within 30 calendar days to initiate the return of any applicable funds. Any applicable documentation will be requested at such time.

Commented [KZ6]: 01.D. - Overpayment Reporting - 1

OIG Guidance for Violations over $5,000.00

When overpayments of $5,000.00 or greater or identified involving a potential credible allegation of fraud, this must be promptly referred to MDHHS-OIG and the Attorney General's

Health Care Fraud Division (AG-HCFD using the MDHHS-OIG Fraud Referral Form. MSHN and the provider network will not take any of the following actions unless otherwise instructed by MDHHS-OIG.

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

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

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

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

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

the rights, safety, or care of a recipient of Medicaid services. The Provider Network CEO/ED shall inform, in writing, the MSHN CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.

- Reports of suspected violations or misconduct may be made on a confidential basis to the extent possible.

B. Process for Investigation

All reports involving suspected fraud, waste and abuse will follow the guidance/direction of the MDHHS Office of Inspector General for any required investigation. MSHN will respond to all MDHHS-OIG audit referrals with a preliminary/~~n~~ initial findings report within the timeframe designated in the MDHHS-OIG referral and prior to the provider receiving a final notice with appeal rights. At a minimum, all allegations within MDHHS-OIG audit referral will be investigated to either substantiate or refute any and all items within the complaint. In addition, a detailed summary of findings must be produced and include all items outlined in the audit referral.

Commented [KZ7]: 07.A. FWA Auditing - 4

All reports of suspected wrongdoing, including MDHHS-OIG audit referrals, shall be investigated promptly following the process outlined in the MSHN Compliance Investigation Procedure. "Prompt response" is defined as action taken within 15 business days of receipt by the PIHP, or date sent by MDHHS-OIG, of the information regarding a potential compliance problem.

Commented [KZ8]: 07.A.FWA Auditing- 5

The investigation process and outcome will be documented and will be reported on the OIG Quarterly Program Integrity Report.

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

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

XIII. Corrective Actions/Prevention/Disciplinary Guidelines

Where an internal investigation substantiates a reported violation, corrective action will be initiated as identified within MSHN policies and procedures and the MSHN subcontracts with the CMHSP Participant/SUD Providers including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, the provision of a corrective action plan (as necessary) including follow-up monitoring of adequate implementation, and implementing system changes to prevent a similar violation from recurring in the future. Disciplinary Action may be imposed for failure to report actual or suspected noncompliance as well as failure to detect noncompliance when routine observation or due diligence should have provided adequate clues or

put one on notice.

In all cases, disciplinary action must be applied on a case-by-case basis and in a consistent manner. Violations such as misconduct or retaliation against an employee who reports a violation will carry more stringent disciplinary action.

Disciplinary Action will take into account the following:

- Degree of intent
- Amount of financial harm
- Whether the incident is a single incident or lasted over a long period of time.

Depending on the seriousness of the offense, the resulting action for MSHN staff could include additional training, verbal warning, written reprimand, suspension or termination of employment. The resulting action for the provider network would also depend on the seriousness of the offense and could include additional training, letter of contract non-compliance and termination of contract. Failure by Board Members to adhere to the requirements in the Compliance Plan will be addressed in accordance with the MSHN By-Laws.

Corrective Action Plans should minimally include the following description:

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

XIV. Submission of Program Integrity Activities/Report

The PIHP, and the provider network will log and track all program integrity activities performed. Compliance investigations will be reported/documented utilizing the Healthicity compliance software. The templates within Healthicity will be completed in their entirety upon completion of each activity. MSHN will utilize this information for required reporting to MDHHS-OIG, inclusive of monthly and quarterly reports. ~~The provider network will utilize the MDHHS-OIG Quarterly Program Integrity Report template to report quarterly to the PIHP~~. The PIHP will report the program integrity activities to the MDHHS Office of Inspector General, according to Schedule E requirements, using the provided template. If a provider is subject to a prepayment review, or any review requiring the provider to submit documentation to support a claim prior to being considered for payment, as a result of suspected fraud, waste and/or abuse, the MDHHS-OIG must be notified on the quarterly report.

The PIHP will submit to MDHHS-OIG an annual Program Integrity Report containing details of the improper payments identified, overpayments recovered, and costs avoided for the program integrity activities conducted by the Contractor for the preceding year. The report will also address the plan of activities for the current and upcoming fiscal year and all provider and service-specific program integrity activities. The report will include an attestation confirming compliance with the requirements found in 42 CFR 438.608 and 42 CFR 438.610.

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

If MSHN is unable to provide requested information within a designated timeframe, a one-time

extension in writing (email) no less than two business days prior to the due date, must be submitted to the MDHHS-OIG along with a status update and estimated date of completion.

XV. Communication of Requirements

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

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

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

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

XVI. References, Legal Authority and Supporting Documents

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

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

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

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

5. Michigan Mental Health Code
   http://www.legislature.mi.gov/(S(alilhmd3eeauncuk5s0ey4hu))/mileg.aspx?page=GetObject&objectname=mcl-Act-258-of-1974

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

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

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

ATTACHMENT A

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

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

Policy and Procedure Categories Include:

Compliance

Customer Service

Finance

General Management

Human Resources

Information Technology

Provider Network

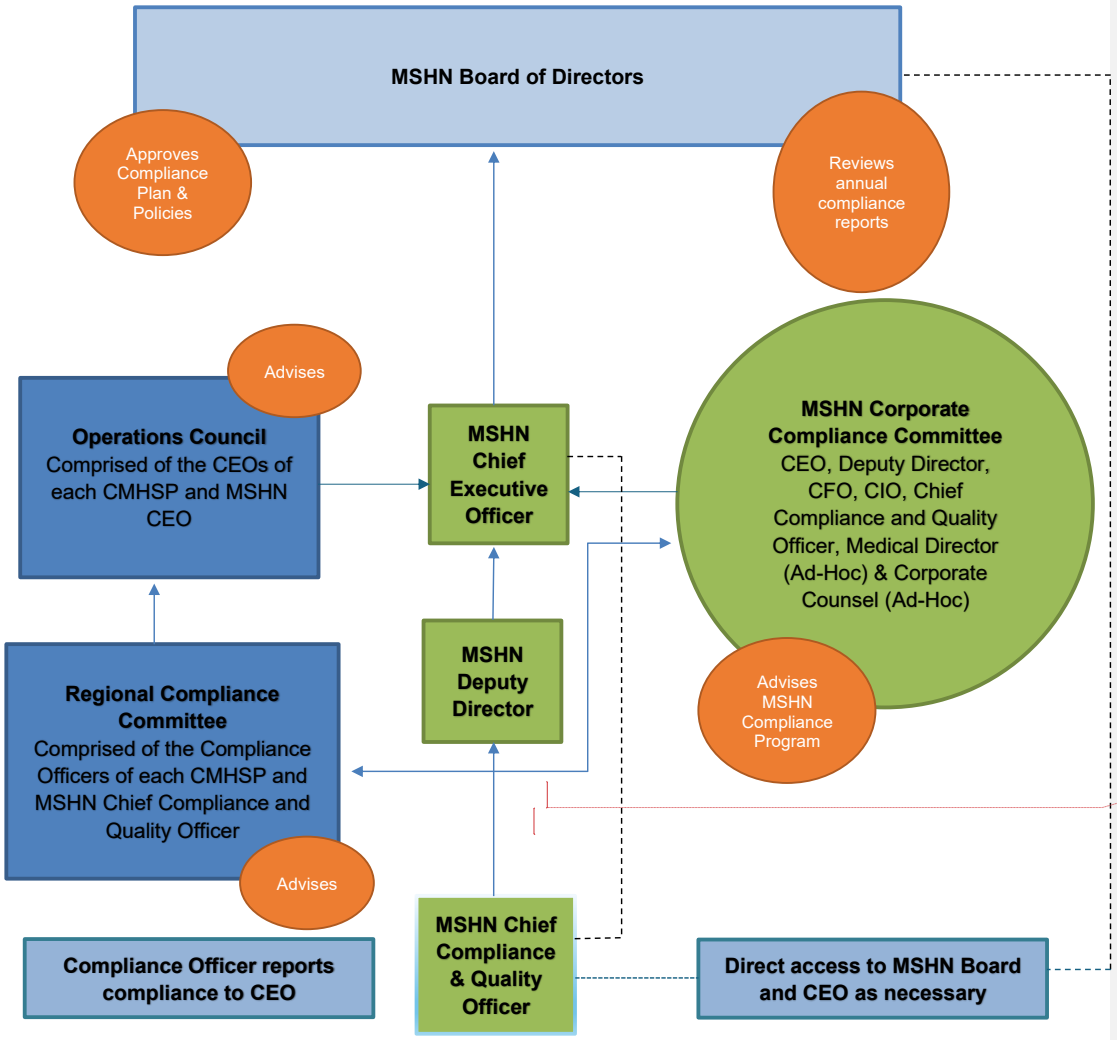
Quality

Service Delivery System

Utilization Management

Attachment B

Mid-State Health Network Compliance Process/Governance



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ATTACHMENT C

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

Area of Focus	Task
Compliance with established Compliance and Program Integrity related standards.	1) Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies region wide. 2) Identify additional region wide data mining activities to detect possible deficiencies and/or non-compliance with established standards. 3) Develop training opportunities to promote compliance with state and federal requirements.
Delegated Managed Care Reviews	1) 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 2) 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 trainings.
Compliance with external quality review requirements (Health Services Advisory Group (HSAG) – Performance Measure Validation Review)	1) MSHN will perform additional spot checks prior to submitting data to HSAG to ensure that the cases meet eligibility requirements. 2) 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.
Substance Use Disorder (SUD) Access Department Implementation	New initiative – Monitor to ensure effectiveness and compliance with identified standards.

ATTACHMENT D

MID-STATE HEALTH NETWORK

COMPLIANCE OFFICER CONTACT INFORMATION

Agency Name	Compliance Officer	Phone Number	Email	Agency Address
Mid-State Health Network	Kim Zimmerman	517-657-3018	Kim.zimmerman@midstatehealthnetwork.org	530 W. Ionia St., Lansing, MI 48933
Bay Arenac Behavioral Health	Melissa Prusi	989-497-1578	mprusi@babha.org	1010 N. Madison Ave, Bay City, MI 48708
Community Mental Health for Central Michigan	Renee Raushi	989-772-5938	rraushi@cmhcm.org	301 South Crapo St., Suite 100, Mt. Pleasant, MI 48858
Clinton-Eaton-Ingham Community Mental Health	Emily Ryan	517-346-8193	ryane@ceicmh.org	812 E. Jolly Rd., Lansing, MI 48910
Gratiot Integrated Health Network	Pam Fachting	989-466-4143	pfachting@gihn-mi.org	608 Wrigth Ave., Alma, MI 48801
Huron Behavioral Health	Levi Zagorski	989-269-9293	levi@huroncmh.org	1375 R. Dale Wertz Dr., Bad Axe, MI 48413
LifeWays Community Mental Health	Ken Berger	517-796-4526	Ken.berger@LifeWaysMI.org	1200 N. W. Ave. Jackson, MI 49202
Montcalm Care Network	Cece McIntyre	989-831-7520	Cece McIntyre <cmcintyre@montcalmcare.net>	611 N. State St., Stanton, MI 48888
Newaygo Community Mental Health	Andrea Fletcher	231-689-7542	afletcher@newaygocmh.org	1049 Newell St., White Cloud, MI 49349
The Right Door for Hope, Recovery and Wellness	Susan Richards	616-527-1790	srichards@rightdoor.org	375 Apple Tree Dr., Ionia, MI 48846
Saginaw Community Mental Health	AmyLou Douglas	989-797-3506	Amylou.douglas@sccmha.org	500 Hancock St., Saginaw, MI 48602
Shiawassee Health and Wellness	Vickey Hoffman	989-723-0757	vhoffman@shiabewell.org	1555 Industrial Dr., Owosso, MI 48867
Tuscola Behavioral Health Systems	Julie Majeske	989-673-6191	jmajeske@tbhs.net	323 North State Street, Caro, MI 48723

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

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

MSHN
Mid-State Health Network

TENTATIVE

FY2027 MID-STATE HEALTH NETWORK

REGIONAL BOARD OF DIRECTORS MEETING CALENDAR

(All meetings are scheduled to convene at 5:00 p.m. unless otherwise noted)

Meeting Date	Meeting Location
November 10, 2026 *(Adjusted due to Election Day)*	MyMichigan Medical Center 300 E. Warwick Dr. Alma, MI 48801
January 5, 2027	MyMichigan Medical Center 300 E. Warwick Dr. Alma, MI 48801
March 2, 2027	MyMichigan Medical Center 300 E. Warwick Dr. Alma, MI 48801
May 4, 2027	MyMichigan Medical Center 300 E. Warwick Dr. Alma, MI 48801
July 13, 2027 *(Adjusted due to Holiday)*	MyMichigan Medical Center 300 E. Warwick Dr. Alma, MI 48801
PUBLIC HEARING: September 7, 2027	MyMichigan Medical Center 300 E. Warwick Dr. Alma, MI 48801
BOARD MEETING: September 7, 2027	

Calendar is tentative until Board approved

MSHN
Mid-State Health Network

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
May/June 2026

Announcements:

Mid-State Health Network (MSHN) welcomes new board member Kevin Collins who was recently appointed to the regional board by LifeWays. Please join us in welcoming him!

MSHN is planning to reinstate our board newsletters beginning in October. MSHN leaders will contribute content for the information and education of our board members. Newsletters will be published in even numbered months when the governing board does not meet.

MSHN Strategic Plans were extended last year through October 2027 due to the competitive procurement activities and the instability and uncertainty it caused. We're no more certain of anything, but MSHN leadership will restart our strategic planning process this fall. This will likely involve a board strategic planning day on the date of the May 2027 board meeting.

PIHP/REGIONAL MATTERS

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

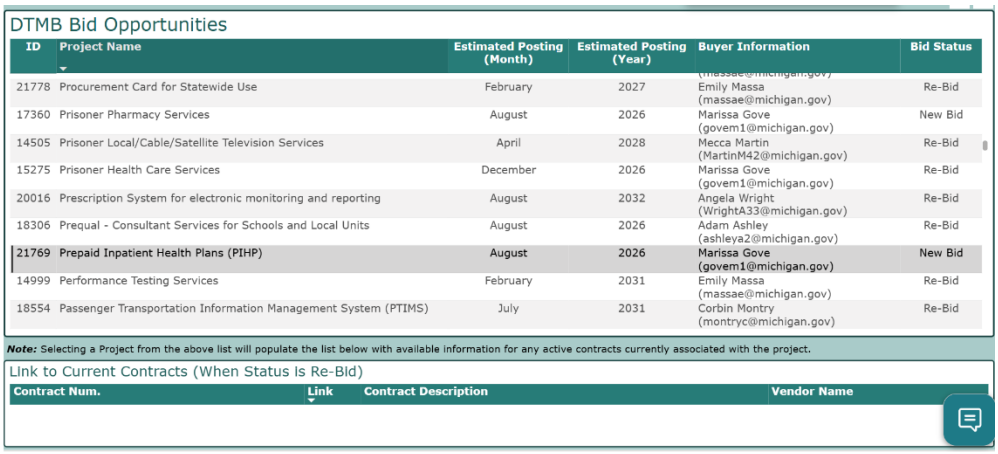
In a previous board report, I noted that MSHN had received confirmation that the Michigan Department of Health and Human Services (MDHHS) is developing a new Request For Proposal (RFP). To remind readers, this fact was revealed by an Assistant Attorney General in open court.

Over the recent Father's Day weekend, we learned that there is a posting of an intended procurement of Prepaid Inpatient Health Plans on the Department of Technology, Management and Budget Vendor Opportunity Dashboard with an estimated posting date of August 2026. This is listed as a new bid opportunity (interestingly not a rebid).

Of note, the Department of Technology, Management and Budget (DTMB) dashboard states, as it pertains to project dates, that:

> "Projects on the dashboard include the year and month when available. These dates are estimates only; the project may be posted in the month prior or the next consecutive month. Some planned projects will have no listed date. These projects are listed to provide the vendor community transparency into identified new bids and planned re-bids. Planned project dates populate when the State is actively developing a solicitation."

A screenshot of the DTMB posting follows. Nothing on the MDHHS website (where previous bidder qualifications, maps, etc., were posted) has changed. This is all the information we have at this time.



DTMB Bid Opportunities

ID	Project Name	Estimated Posting (Month)	Estimated Posting (Year)	Buyer Information	Bid Status
21778	Procurement Card for Statewide Use	February	2027	Emily Massa (massae@michigan.gov)	Re-Bid
17360	Prisoner Pharmacy Services	August	2026	Marissa Gove (govem1@michigan.gov)	New Bid
14505	Prisoner Local/Cable/Satellite Television Services	April	2028	Mecca Martin (MartinM42@michigan.gov)	Re-Bid
15275	Prisoner Health Care Services	December	2026	Marissa Gove (govem1@michigan.gov)	Re-Bid
20016	Prescription System for electronic monitoring and reporting	August	2032	Angela Wright (WrightA33@michigan.gov)	Re-Bid
18306	Prequal - Consultant Services for Schools and Local Units	August	2026	Adam Ashley (ashleya2@michigan.gov)	Re-Bid
21769	Prepaid Inpatient Health Plans (PIHP)	August	2026	Marissa Gove (govem1@michigan.gov)	New Bid
14999	Performance Testing Services	February	2031	Emily Massa (massae@michigan.gov)	Re-Bid
18554	Passenger Transportation Information Management System (PTIMS)	July	2031	Corbin Montry (montryc@michigan.gov)	Re-Bid

Note: Selecting a Project from the above list will populate the list below with available information for any active contracts currently associated with the project.

Link to Current Contracts (When Status is Re-Bid)

Contract Num.	Link	Contract Description	Vendor Name

Prior to this posting on the DTMB Vendor Opportunities website, there has been no denial, confirmation, or any other communication from the State about competitive procurement. I have been doing periodic outreach to Kristen Morningstar, the Director of Behavioral Health at MDHHS, primarily since the lawsuit outcomes in late January. There has been no response – not even an acknowledgement of receipt or a statement that she won't talk about it, including to my June 5, 2026 email stating in relevant part the following:

I am requesting a few pieces of information:

- *Confirmation that a new RFP is being developed (or is not being developed);*
- *Assuming that it is, the timeline that the State intends to follow for its release (and any other detail that can be released);*
- *Whether PIHPs will receive a contract (either new or extension) for FY 27 and when that will timeframe for this to occur;*
- *What the State intends to do in regions where the existing PIHP is in transition to termination.*

We really can't proceed effectively with planning, including making necessary commitments, until we receive clarity. Any response from you to these concerns is invited and appreciated.

Deputy Director Amanda Ittner and I also met with our outgoing and incoming MDHHS contract managers and asked the same four questions. The response we received was (paraphrasing) "we can't talk about anything you've asked about and nothing for FY 27." This was expected and these MDHHS employees are following the company line – which isn't the problem.

The problem, in my view, is that a governmental agency and its officials have such a company line in the first place over a fiscal year that begins in just under four months.

I am very concerned about the status of PIHP contracts for FY 27.

The field needs MDHHS to communicate its plans. Failing to do so magnifies operational paralysis, uncertainty, and instability – which are the very things they often assert as "the problem with the current system."

2. PIHP Competitive Procurement Lawsuit Updates

There are no new developments in the Competitive Procurement Lawsuit which MSHN and five other litigants have filed an appeal.

3. Behavioral Health Home Incentive

(Contributed by Elizabeth Philpott, Integrated Health Administrator): Launched in the MSHN region on May 1, 2023, the Behavioral Health Home (BHH) initiative advances Michigan's strategy to improve integrated care for Medicaid beneficiaries with qualifying serious mental illness/serious emotional disturbance (SMI/SED) diagnoses. The BHH serves as the central coordination model for enrolled beneficiaries, supporting comprehensive care management, stronger alignment between physical and behavioral health services, and improved transitions across primary, specialty, and inpatient care settings.

Five Community Mental Health Service Programs (CMHSPs) currently participate in the BHH initiative within the MSHN region: Saginaw County Community Mental Health Authority, Montcalm Care Network, Shiawassee Health & Wellness, Community Mental Health for Central Michigan, and Gratiot Integrated Health Network. MSHN continues to support regional expansion through its Health Home Standards Certification Process, which promotes consistent implementation and ensures new Health Home providers meet MDHHS Health Home Partner Standards. As of June 18, 2026, regional BHH enrollment totaled 380 beneficiaries.

In June 2026, MDHHS announced the FY25 BHH pay-for-performance (P4P) bonus awards, with all MSHN BHH Partners qualifying for a share of the $102,502.87 award. MSHN will allocate pay-for-performance funding based on FY25 case rates per paid enrollee. Although MDHHS permits PIHPs to retain up to 5% of these funds, MSHN has consistently directed 100% of P4P award dollars to participating Health Home Partners, reinforcing its commitment to reinvestment in regional Health Home implementation and partner performance.

Health Home Partner	Net Case Rate Payments	Pay for Performance	FY2025 BHH Surplus
Community Mental Health for Central Michigan	985	$26,866.00	$50,130.89
Gratiot Integrated Health Network	272	$7,421.21	$13,847.68
Montcalm Care Network	1,327	$36,193.76	$67,536.12
Saginaw County Community Mental Health Authority	518	$14,124.90	$26,356.49
Shiawassee Health and Wellness	656	$17,897.00	$33,395.09

4. Pharmacy Pilot

I reported in my last board update that MSHN has been asked by the MDHHS Substance Use, Gambling, and Epidemiology (SUGE) Section to consider a pilot project to support access to Medication Assisted Treatment/Medication for Opioid Use Disorders for individuals that contact the state warmline. Our team has developed a proposal to operate a small pilot in partnership with a commercial pharmacy and a provider in an urban center in our region and is awaiting a response from MDHHS/SUGE.

It's been three months. We were asked by the State to develop a proposal, which we did. And we haven't heard anything since.

5. Inter-Regional Dialogs

The MSHN region, represented by six of our CMHSP Chief Executive Officer's (CEO's), Amanda, and me, are meeting weekly with the CMHSP CEOs and Executive Leadership of another PIHP with a primary goal of working together to survive the anticipated request for proposals (RFP). These exploratory inter-regional conversations are focused on preserving the public behavioral health system, increased consistency in access and service array for beneficiaries, protecting the rights and statutory authorities of the CMHSP participants in both regions, identifying how we can jointly submit a future bid, potential future regional configurations, and operating in similar ways to benefit providers in common. Both regions are fiscally healthy and have operated similarly for years and this helps when we consider joint operations or standardization opportunities.

It is important to highlight that this is designed to be a CMHSP-led initiative. CMHSPs are the only entities that can create regional entities, including any future structural configurations.

The inter-regional discussions are taking place every week and have included key document exchanges and analysis of similarities and differences. Sandy Lindsey (Saginaw CEO) is co-chairing the meetings with another designee from the other region. Cassie Watson (LifeWays CEO) is providing logistical supports to the group.

6. Opioid Settlement Spending in the MSHN Region

This chart of communities in our region was prepared by Dr. Trisha Thrush, Director of SUD Services and Operations and shows spending and balances remaining in Opioid Settlement Funds as of May 1, 2026.

Community	Received	Expended	Balance	Spent Percent
Arenac County	$382,579.63	$25,000.00	$357,579.63	6.53%
Bay City	$141,804.85	$28,500.00	$113,304.85	20.10%
Bay County	$2,593,047.30	$882,449.56	$1,710,597.74	34.03%
Clare County	$578,872.75	$77,611.17	$501,261.58	13.41%
Clinton County	$1,144,805.12	$127,207.11	$1,017,598.01	11.11%
Eaton County	$3,683,769.11	$11,950.00	$3,671,819.11	0.32%
Gladwin County	$369,938.51	$88,508.54	$281,429.97	23.93%
Gratiot County	$746,970.68	$52,682.56	$694,288.12	7.05%
Hillsdale County	$888,439.80	$104,431.78	$784,008.02	11.75%
Huron Charter Township	$62,947.63	$66,994.63	($4,047.00)	106.43%
Huron County	$64,495.38	$91,480.00	($26,984.62)	141.84%
Ingham County	$5,069,648.16	$1,277,736.50	$3,791,911.66	25.20%
Ionia City	$55,505.68	$49,074.00	$6,431.68	88.41%

Community	Received	Expended	Balance	Spent Percent
Ionia County	$742,981.34	$297,719.00	$445,262.34	40.07%
Isabella County	$1,357,718.70	$0.00	$1,357,718.70	0.00%
Jackson City	$422,485.93	$639,000.00	($216,514.07)	151.25%
Jackson County	$1,293,641.65	$448,032.18	$845,609.47	34.63%
Mecosta County	$73,115.99	$159,958.70	($86,842.71)	218.77%
Midland City	$352,969.76	$0.00	$352,969.76	0.00%
Midland County	$665,251.11	$91,957.37	$573,293.74	13.82%
Montcalm County	$1,475,363.04	$700,163.00	$775,200.04	47.46%
Newaygo County	$1,111,786.08	$470,442.40	$641,343.68	42.31%
Osceola County	$456,679.38	$347,000.00	$109,679.38	75.98%
Saginaw Charter Township	$85,498.24	$0.00	$85,498.24	0.00%
Saginaw City	$444,350.35	$202,337.12	$242,013.23	45.54%
Saginaw County	$3,937,926.03	$100,959.24	$3,836,966.79	2.56%
Shiawassee County	$1,662,441.35	$677,407.41	$985,033.94	40.75%
Tuscola County	$186,190.30	$37,800.00	$148,390.30	20.30%

7. Overdose Surveillance Updates

The April overdose update for Michigan is available at this link. This report uses emergency department, emergency medical services, substance use disorder treatment, and postmortem toxicology testing data to provide insight into statewide trends, demographic patterns, geographic patterns, and drug-specific patterns. The report can be viewed as a PDF or as an interactive web version. (Click here to view the web version. Click here to view the PDF report). County-level overdose data is available through the following resources: MiTracking, or Michigan Substance Use Disorder Data Repository or Michigan Overdose Data to Action (MODA) Dashboard

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

8. Governor Whitmer Announces Departure of MDHHS Director Hertel; Acting Director Named:

On June 22, 2026, Governor Gretchen Whitmer announced Amy Epkey will serve as acting director of the Michigan Department of Health and Human Services (MDHHS). The governor also announced additional promotions and hires within the executive office.

"Today, I am proud to announce several talented public servants stepping into new roles to help our administration keep delivering for the people of Michigan," said Governor Whitmer. "Amy Epkey brings decades of experience in state government and a proven record of leadership, and I am confident she will continue the important work of the Department of Health and Human Services. I also want to thank Director Hertel for her dedicated service to our state. Under her leadership, MDHHS helped Michigan navigate unprecedented challenges, expanded access to health care, strengthened behavioral health services, and improved outcomes for families across our state. I am grateful for her partnership and wish her continued success in her next chapter."

Amy Epkey, Acting Director of MDHHS
Amy Epkey will serve as the acting director of MDHHS beginning July 1. Epkey previously held the Senior Deputy Director position for the Financial Operations Administration at MDHHS, where she oversaw the department's budget, contracts and grants, finance and accounting, audit functions and information technology financial support services. Responsible for overseeing the department's nearly $40 billion budget, Epkey has played a key role in negotiating with the Legislature on the passage of four bipartisan balanced budgets, developing and leading the implementation of strategic priorities, and ensuring alignment across all levels of the department.

Epkey has held numerous roles across departments in state government. She served as Senior Deputy Director for the Michigan Department of Environment, Great Lakes and Energy (EGLE), where she oversaw the department's annual budget, helped develop and implement EGLE's strategic plan, coordinated its training and outreach efforts and legal services and testified before the state Legislature on priority issues, among other duties. She also worked for the Michigan Department of Agriculture and Rural Development, where she eventually served simultaneously as policy advisor to the department director and the department's budget officer.

Epkey has a Bachelor of Business Administration from Grand Valley State University.

After leading the department since 2021, Director Hertel has announced her last day at MDHHS will be June 30. Under Director Hertel's leadership, the department has built out the community behavioral health continuum of care and designed two state-of-the-art state psychiatric hospitals, launched the Keep Kids Safe Action Agenda and redesigned the way children's services are delivered through the Children Services Administration (CSA) teaming model, implemented substance use disorder programming which lowered the overdose death rate by 47 percent since 2021, protected residents access to Medicaid and Supplemental Nutrition Assistance Program (SNAP), created scholarships and stipends to build the health care workforce, and recorded Michigan's lowest infant mortality rate in its history in 2025.

9. Mental Health Framework

Previous board reports have included detailed updates on this MDHHS initiative. On May 15, 2026 DHHS Behavioral Health Director Kristen Morningstar announced that "improving coordination, access, and quality

of care remains a top priority. In support of this goal and in response to your feedback, **MDHHS will temporarily delay the Mental Health Framework (MHF) Coverage Responsibility policy to allow time for system-wide preparation.** During this preparation period, MDHHS will continue advancing key Mental Health Framework activities, including:

- Increasing the number of beneficiaries with Level of Care Utilization System (LOCUS) and Michigan Child and Adolescent Needs and Strengths (MichiCANS) assessments on file and using these scores to assign the BH-COVER benefit plan.
- Reviewing utilization data to better understand service needs.
- Strengthening care coordination across Medicaid Health Plan (MHP) and PIHP systems, including joint care planning and expanded joint quality measures.
- Enhancing referral pathways to ensure beneficiaries are connected to and receive appropriate care and support when moving between systems.
- Continuing to clarify coverage responsibility for existing covered services to minimize provider confusion and abrasion.
- Deepening relationships between PIHPs/CMHs and MHPs to improve service delivery and overall health outcomes.

Meanwhile, Rep. VanderWall introduced HB 6022 which, if enacted, would essentially codify in law many of the elements of the Mental Health Framework. On June 4, the House Health Policy Committee heard testimony on the bill. Following is an excerpt from State Affairs (formerly Gongwer):

> ***Mental health agencies, health plans clash on bills changing preadmission screenings***
>
> *Members of the House Health Policy Committee heard testimony on a bill that would change who could evaluate patients and administer preadmission screenings for mental health patients during a meeting Wednesday.*
>
> *The legislation sparked debate among representatives, the Michigan Association of Health Plans and the Community Mental Health Association of Michigan.*
> *Under HB 6022, sponsored by Committee Chair Rep. Curt VanderWall, R-Ludington, authority would be expanded to contracted health plans and their delegates to provide evaluation and assessment of mental health patients. Contracted health plans would be managed care organizations that the Department of Health and Human Services would arrange for or contract with.*
>
> *Currently, community mental health service programs, or CMHSPs, are responsible for screening patients. The bill would also codify that community mental health service programs must provide a screening for a patient within three hours of being notified.*
>
> *"Many CMHs are good actors when it comes to this rule, but there are CMHs in southeast Michigan that will allow patients to sit an entire weekend in an emergency department because they argue the three hours begins when they check their voicemail on Monday mornings," VanderWall said.*
>
> *Under the legislation, if a community mental health agency could not conduct a screening within three hours, the hospital or contracted entity could conduct screening for the patient to be admitted, he said.*
>
> *Dominick Pallone, executive director for the Michigan Association of Health Plans, testified in support of the bill. He said the same entity that has financial responsibility should also hold operational control over ensuring that preadmission screening is happening timely and appropriately.*

"HB 6022 creates a clear and more accountable framework for conducting timely preadmission assessments and screening services," Pallone said.

Rep. Jamie Thompson, R-Brownstown Township, said she hears many stories about people in her district who have a difficult time receiving mental health treatment. She asked Pallone to illustrate a real-world example of a patient facing barriers to care and how the legislation would change this.

Pallone said an example he sees is someone ending up in the emergency room due to self-harming.

"In that scenario, they have both the physical ailment that landed them in the ER and the mental health ailment that landed them in the ER," he said.

Due to the "bifurcated" health system, once the physical, medical ailment is treated, the health plan's responsibility is over, and the hospital will begin to discuss discharging the patient.

"But the behavioral health need still exists," he said. "And so, you end up with an ER sometimes that's stuck in the middle of figuring out who's the responsible party, who do I go to for that preadmission screening."

Alan Bolter, CEO of the Community Mental Health Association of Michigan, testified in opposition to the bill. He said the legislation would not improve patient care and add more regulatory burdens for both patients and providers.

"Frankly, it's proposals like this that are the reasons why the system is complicated and difficult for people to navigate when we are adding additional hoops for people to jump through and providers having to provide those services," he said.

Committee members disagreed. Although Bolter said assessments for adults and children are completed within three hours 98% of the time, members asked how there could still be "first-responders" and constituents saying otherwise.

Thompson asked if the Community Mental Health Association of Michigan knew where those who weren't getting screened within three hours lived in the state, to which Bolter said no.

Rep. David Prestin, R-Cedar River, said CMHAM was exhibiting "protectionism" due to the present authority community mental health service programs have over preadmission screening.

Dr. Michael Brashears, CEO of Ottawa County CMH, recently wrote that "HB 6022 rewrites core functions of Michigan's mental health code by granting Medicaid contracted health plans parallel—and in many cases exclusive—authority over crisis screening, hospitalization decisions, and post-discharge coordination whenever they may be financially responsible for covered services. Practically, this replaces the community-accountable "front door" that CMHSPs have operated for decades with a payer-driven gateway controlled by private managed-care organizations. The bill alters definitions (e.g., "preadmission screening unit"), reallocates decision rights (e.g., Section 409 on sole responsibility), and inserts health plans into minors' processes (Sections 498e, 498f, 498h), court notification pathways (Section 464), and post-discharge coordination (new subsections in Section 409). The resulting framework fragments responsibility across entities whose incentives and policies vary by plan, undermining consistency, local oversight, and the person-centered continuity that has been central to Michigan's public mental health system."

10. MDHHS Psychiatric Hospitals Report 58% Reduction in Incidents and Injuries

(Excerpt from a 06/02/26 MDHHS Press Release): An innovative daily risk assessment and care planning process implemented at Michigan's four state psychiatric hospitals has cut the number of patient injuries by more than half and continues to improve care and reduce incidents of aggression and injuries to both patients and staff.

The Michigan Department of Health and Human Services (MDHHS) implemented the Dynamic Appraisal of Situational Aggression (DASA) in March 2024. Since then, there has been a 58% reduction in patient injuries and a 28% decrease in serious patient-related staff injuries. The state psychiatric hospitals were the first in the state to implement DASA.

"This is a great example of how our state hospitals continue to improve the way we provide top-quality care to our patients," said Elizabeth Hertel, MDHHS director. "This tool is helping keep patients and everyone around them safe while we treat them for some of the most serious behavioral health illnesses."

DASA is a daily risk assessment rating system used to evaluate the likelihood of aggression in behavioral health inpatients within the next 24 hours. Staff completing the DASA consider whether seven different kinds of behaviors are present that determine a rating of low, moderate or high risk of aggression.

Based on their DASA score, the Aggression Prevention Protocol is used to develop individualized intervention strategies that are implemented to prevent aggressive behavior before it begins. Strategies can include reassurance and distraction techniques, one-to-one nursing, medication or setting limits and establishing boundaries of acceptable behavior, as well as increased observation.

"This tool has continued to help our staff stop incidents of aggression before they start," said Dr. George Mellos, MDHHS State Hospital Administration senior deputy director. "Patient-to-staff aggression is the leading cause of workplace injury among our staff, and implementing this risk assessment tool has also helped improve working conditions by reducing incidents and injuries."

DASA and the Aggression Prevention Protocol was developed by the Centre for Forensic Behavioural Science at the Swinburne University of Technology in Melbourne, Australia. MDHHS' state psychiatric hospitals are the first psychiatric facilities in Michigan to implement the survey and protocol. State psychiatric hospitals in Virginia are using the tool as well as The Johns Hopkins Hospital in Baltimore and UCLA Medical Center, which implemented it in its emergency department.

MDHHS operates four inpatient psychiatric hospitals serving about 600 patients, Caro Psychiatric Hospital, Kalamazoo Psychiatric Hospital (KPH), Walter Reuther Psychiatric Hospital and the Center for Forensic Psychiatry (CFP). DASA was implemented at KPH in March 2024, Caro and Walter Reuther for adult patients in July 2024 and CFP and Walter Reuther for youth patients in September and August 2025, respectively.

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. Food and Drug Administration (FDA) Approves a New Naloxone Product

The FDA on June 16 "approved another over-the-counter intranasal naloxone product, Rextovy, a 4 milligram (mg) naloxone hydrochloride nasal spray for the emergency treatment of opioid overdose. Consumers may directly purchase this product without a prescription in places such as pharmacies, convenience stores, and online." The FDA announcement is available at this link.

13. Centers for Medicare and Medicaid Services Published "Behavioral Health Strategy

Centers for Medicare and Medicaid Services (CMS) has "published its *Behavioral Health Strategy* with the following strategic pillars:

- Focus on person-centered health promotion, early prevention and care opportunities, and integrative care across physical and behavioral health, particularly for children and adolescents
- Drive high value and evidence-based care with a focus on prevention and treatment through value-based payment models and quality measures
- Enhance access to effective technologies such as mobile and digital treatments and tools to enable high quality care and encourage healthy choices that can support wellness
- Engage and coordinate with states, people, providers, and communities for effective impact
- Coordinate with our federal partners to synergize and align federal programs in an evidence-informed and data-driven manner"

14. 988 Workforce/Staffing Report

A JAMA Network open investigation health policy article reports on *Workforce and Staffing at 988 Suicide & Crisis Lifeline Centers*. Its key points are:

- Question: What are the current staffing levels of 988 Lifeline centers, and what staffing challenges do these centers face?
- Findings: In this cross-sectional survey study using data from a national survey of 988 Lifeline centers, leaders from 77% of call centers across 47 US states and territories responded. A total of 71% of leaders reported that their center was understaffed; when asked about staffing-related difficulties, almost 90% of respondents reported difficulty with acquiring resources to hire.
- Meaning: This study suggests that 988 Lifeline center staffing shortages could be associated with operational demands, underscoring the importance of increased investments to bolster the 988 Lifeline workforce.

15. Suicide Deaths Article

A STAT article available at this link notes that "death by suicide is a male emergency. Although three times as many women as men report suicidal ideation and attempts, the vast majority of deaths by suicide in the U.S. — up to 80% — are among men. The reasons: higher impulsivity, lower reported fear of death, and, crucially, easy access to guns. The most recent report from Crisis Text Line — a nonprofit working with the 988 Suicide & Crisis Lifeline to provide free and confidential text-based mental health support — sheds light on another explanation: Men reach out for help a lot less than women."

16. CMS Releasing Rule on Medicaid Work Requirements enacted under HR 1

CMS has "released an Interim Final Rule (IFR) requiring that certain adult Medicaid applicants and enrollees must, as a condition of Medicaid eligibility, meet an 80 hours per month work requirement, through employment, education, work programs, or community service. The rule establishes a nationwide operational framework designed to promote economic stability, self-sufficiency, and independence. A fact sheet is available at this link.

- The rule establishes the standards states must use to implement the statutory work requirement, including clear expectations for eligibility determinations, exemptions, verification, and state reporting requirements. It reflects extensive coordination with states and builds on CMS' ongoing work to modernize eligibility systems and improve beneficiary interactions with states, while improving accountability.
    - A new study from the Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation finds the new requirements could reduce poverty by as much as 2.9 million people depending on a variety of conditions such as employment availability. (HHS information regarding the study is available at https://aspe.hhs.gov/reports/medicaid-work-requirements-should-incentivize-employment-reduce-poverty.)
- This rule defines which adults ages 19 through 64 will be required to demonstrate work requirement activities.
- The rule also defines which individuals are not subject to the requirement because of health-related needs and other qualifying circumstances. These exemptions include, but are not limited to, individuals who are pregnant, postpartum, disabled, medically frail, American Indian or Alaska Native, parents or caregivers of young children and people with disabilities, and those who are already complying with similar requirements through the Supplemental Nutrition Assistance Program (SNAP) or the Temporary Assistance for Needy Families (TANF) program.
- The rule also includes state data reporting requirements and establishes requirements for how states must assess and verify compliance and communicate the new requirement to Medicaid applicants and beneficiaries. These provisions are expected to promote transparency, reduce administrative burden, and ensure states provide clear, actionable guidance to new applicants and Medicaid beneficiaries on how to meet the new eligibility requirement.

CMS is supporting states as they implement the requirement through a combination of federal resources, technical assistance, and private-sector collaboration. This includes $200 million in Government Efficiency Grants authorized under the Working Families Tax Cut (WFTC) legislation to support state system modernization and administrative capacity, as well as more than $600 million in committed support from private-sector technology vendors to help states update eligibility and enrollment systems, and support for outreach to Medicaid beneficiaries. These investments build on CMS' broader modernization efforts, including

expanding the use of automation, data integration, and real-time verification to improve efficiency, strengthen oversight, and enhance the beneficiary experience.

The work requirement must be implemented no later than January 1, 2027, in applicable states, although some states—such as Nebraska —has already implemented, and other states are considering early implementation. This rule is being issued as an IFR with comment period to remain consistent with the legislative directive and implementation timeline established by the WFTC legislation. This approach helps to ensure timely implementation while allowing CMS to continue to collect and consider public feedback."

17. Certified Community Behavioral Health Clinic Publications Released

Substance Abuse and Mental Health Services Administration (SAMHSA) has "released two new publications related to Certified Community Behavioral Health Clinics (CCBHCs), for CCBHC clinic leadership and staff, state government officials and state mental health agencies to support improvement of the mental health systems within their states, especially through the use of CCBHC expansion funding.

- *Improving Housing Stability for People with Behavioral Health Needs Through the CCBHC Model* discusses how CCBHCs across the U.S. can work with specific groups to prioritize stable housing, and to explore collaborations with national, state and local partners to build a network of support for homeless individuals.
- *Impact and Opportunities for CCBHCs in Rural Communities* describes how CCBHCs are currently impacting access and quality of care in rural areas as well as the potential role of CCBHCs in rural areas.

18. Is The Federal Government Turning Against Medications for Treading Addiction?

A report published in Stat raises that question. "When Robert F. Kennedy Jr. took office in February 2025, he broke new ground as the first health secretary openly in recovery from addiction to drugs and alcohol. At a public appearance soon after, he delivered precisely the message that many substance use experts had hoped to hear: that evidence-based medications for treating opioid addiction, in particular, would remain essential components of the country's response to its drug overdose crisis. In the past year, however, the Trump administration has taken a decidedly more negative tack on medications for opioid use disorder, setting off alarm bells among public health experts, addiction physicians, and patient groups. In April, SAMHSA issued a "Dear Colleague" letter cautioning against the long-term use of methadone or buprenorphine, the drug commonly referred to as Suboxone.

"SAMHSA remains committed to expanding access to comprehensive, evidence-based treatment, including the use of medications … but we are equally committed to ensuring that medications are part of the pathway to long-term recovery and sobriety, self-sufficiency, and thriving, not as a default sentence to life-long medication use," the agency wrote. A year prior, the Trump administration appointed Michael Stuart, a former West Virginia state lawmaker best known in the drug policy community for introducing legislation to ban methadone treatment, as the top Health and Human Services lawyer. And in September, Rep. Houchin (R-Ind.) introduced legislation in Congress that would effectively roll back significant new flexibilities enacted by SAMHSA that aimed to make methadone treatment far more accessible. Taken together, the actions represent a resurgence of Republican hostility toward medication-assisted treatment, which in recent years had become a largely settled issue."

19. Grants Review by Federal Senior Officials

The US Office of Management and Budget (OMB) has "issued a proposed rule entitled *Regulation for Federal Financial Assistance* that would require senior political appointees review of discretionary awards and prioritize funding that would advance the administration's policy objectives and would allow federal grants to be cancelled at any time for any reason. If finalized, the rule would have broad implications for universities, research institutions, hospitals, nonprofits, state and local governments, and other organizations that receive federal funding. The deadline to comment on the proposed rule is July 13th."

Submitted By:

Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 06/23/2026

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 June 16, 2026

Bill Number	Title	Sponsors	Latest Action	Last Action Date
House Bills				
HB4037	Health Records Establishes certain requirements to operate a health data utility.	J. Rogers (D)	Reported With Recommendation With Substitute (h-2)	May 21, 2025
HB4255	Controlled Substances Modifies penalties for crime of manufacturing, delivering, or possession of with intent to deliver certain controlled substances.	S. Lightner (R)	Referred To Committee On Civil Rights, Judiciary, And Public Safety	Apr 29, 2025
HB4256	Controlled Substances Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver certain controlled substances.	A. Bollin (R)	Referred To Committee On Civil Rights, Judiciary, And Public Safety	Apr 29, 2025
HB4279	National Guard Creates Michigan National Guard apprenticeship program.	J. Greene (R)	Received in the Regulatory Affairs Committee	Feb 24, 2026
HB4280	Occupations - Social Workers Extends period for renewal for limited licenses for bachelor''s social worker and master''s social worker.	K. Edwards (D)	Referred To Committee On Health Policy	Mar 20, 2025
HB4412	Hospitalization Revises person requiring treatment and modifies certain procedures for treatment.	D. Steele (R)	Received: Health Policy Committee	Mar 24, 2026
HB4413	Outpatient Treatment Expands hospital evaluations for assisted outpatient treatment.	M. Tisdel (R)	Received: Health Policy Committee	Mar 24, 2026
HB4414	Outpatient Treatment Provides outpatient treatment for misdemeanor offenders with mental health issues.	T. Kuhn (R)	Received: Health Policy Committee	Mar 24, 2026
HB4417	Occupations - EMS Provides access to opioid antagonists to life support agencies under certain circumstances.	M. Mueller (R)	Referred To Committee On Health Policy	Jul 1, 2025
HB4423	Veteran Services Provides funding for the county veteran service fund emergency relief program.	J. Rogers (D)	Referred To Committee On Appropriations	May 1, 2025
HB4428	Opioid Antagonists Allows choice of formulation, dosage, and route of administration for opioid antagonists by certain persons and governmental entities if department of health and human services distributes opioid antagonists free of charge.	A. St. Germaine (R)	Referred To Committee On Regulatory Reform	May 6, 2025
HB4497	Drug Paraphernalia Modifies definition of drug paraphernalia.	C. Rheingans (D)	Referred To Committee On Judiciary	May 15, 2025
HB4498	Drug Paraphernalia Provides syringe service programs.	C. Rheingans (D)	Referred To Committee On Health Policy	May 15, 2025
HB4548	Discrimination Prohibits discrimination because of ethnicity, including discrimination because of Jewish heritage under the Elliott-Larsen civil rights act.	N. Arbit (D)	Referred To Committee On Government Operations	Jun 4, 2025
HB4683	Health Benefits Modifies prior authorization requirements for mental health and substance use disorder.	M. McFall (D)	Referred To Committee On Insurance	Jun 25, 2025
HB4685	Health Insurers Provides collaborative care model for mental health care.	M. McFall (D)	Referred To Committee On Insurance	Jun 25, 2025
HB4686	Controlled Substances Allows creating, manufacturing, possessing, or using psilocybin or psilocin under certain circumstances.	M. McFall (D)	Referred To Committee On Families And Veterans	Jun 25, 2025
HB4739	Insurance Coverage Requires coverage for diagnosis of autism spectrum disorders and treatment of autism spectrum disorders.	W. Snyder (D)	Referred To Committee On Insurance	Jul 15, 2025

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Mid-State Health Network

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Compiled by Sherry Kletke, Executive Support Specialist as of June 16, 2026

Bill Number	Title	Sponsors	Latest Action	Last Action Date
HB4740	Insurance Coverage Modifies the required coverage for autism spectrum disorders.	W. Snyder (D)	Referred To Committee On Insurance	Jul 15, 2025
HB4751	Discrimination Removes sexual orientation and gender identity or expression as categories protected under the Elliott-Larsen civil rights act.	J. Schriver (R)	Referred To Committee On Government Operations	Jul 29, 2025
HB4777	Discrimination Removes gender identity or expression from categories protected under Elliott-Larsen civil rights act.	B. Paquette (R)	Referred To Committee On Government Operations	Aug 20, 2025
HB4915	Implicit Bias Repeal Prohibits implicit bias training for health professionals.	M. Maddock (R)	Referred To Committee On Regulatory Affairs	Dec 16, 2025
HB5105	Marijuana Modifies penalties regarding certain crimes involving marihuana.	P. Wendzel (R)	Reported by the Regulatory Reform Committee with substitute H-1 adopted	May 21, 2026
HB5107	Marijuana Modifies allowable amounts of marihuana for personal use and possession.	M. Hoadley (R)	Reported by the Regulatory Reform Committee with substitute H-1 adopted	May 21, 2026
HB5196	Prisoner Mental Health Provides for screening and treatment for post traumatic prison disorder and requires certain other mental health screening, planning, and treatment of incarcerated individuals.	S. Young (D)	Referred To Committee On Judiciary	Oct 30, 2025
HB5302	Substance Use Modifies competitive grant program to provide grants for recovery community organizations.	J. DeBoyer (R)	Advanced to Third Reading with committee substitute H-1 adopted.	Apr 28, 2026
HB5334	Hospitals Requires assessment by preadmission screening unit of individual being considered for hospitalization within certain period after notification.	M. Bierlein (R)	Referred To Committee On Health Policy	Dec 2, 2025
HB5387	Veterans Includes missing veterans at risk in the missing senior or vulnerable adult alert.	C. Cavitt (R)	Reported by the Veterans and Emergency Services Committee	Jun 10, 2026
HB5407	Disabled Veterans Modifies exemption for the surviving spouse of a disabled veteran.	W. Bruck (R)	Reported by the Government Operations Committee	Apr 23, 2026
HB5453	Prison Diversion Programs Creates prison diversion program for individuals in the possession of controlled substances.	S. Lightner (R)	Reported by the Judiciary Committee	Jun 10, 2026
HB5456	Hyperbaric Oxygen Treatment Establishes hyperbaric oxygen treatment pilot program.	K. Schmaltz (R)	Reported by the Rules Committee with substitute H-3 adopted	May 14, 2026
HB5457	Hyperbaric Oxygen Therapy Establishes hyperbaric oxygen therapy pilot program.	K. Schmaltz (R)	Reported With Recommendation Without Amendment	Apr 21, 2026
HB5537	Kratom Prohibits production and sale of kratom.	C. Cavitt (R)	Received: Government Operations Committee	Mar 24, 2026

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Compiled by Sherry Kletke, Executive Support Specialist as of June 16, 2026

Bill Number	Title	Sponsors	Latest Action	Last Action Date
HB5715	National Guard Provides for direct deposit for compensation of Michigan national guard members	K. Schmaltz (R)	Received: Finance, Insurance and Consumer Protection Committee	Apr 28, 2026
HB5728	Substance Use Disorder Services Modifies references to licenses for certain substance use disorder services programs in the prudent purchaser act to include those exempt from licensure.	B. Schuette (R)	Referred To Committee On Health Policy	Mar 18, 2026
HB5729	Substance Use Disorder Services Modifies persons required to hold a substance use disorder services program license and requires uniform rules as is reasonable.	K. Schmaltz (R)	Referred To Committee On Health Policy	Mar 18, 2026
HB5730	Substance Use Disorder Services Modifies references to licenses for certain substance use disorder services programs in the municipal health facilities corporations act to include those exempt from licensure.	S. Frisbie (R)	Referred To Committee On Health Policy	Mar 18, 2026
HB5731	Substances Use Disorder Includes crisis stabilization units exemptions from the substance use disorder license requirement.	M. Tisdel (R)	Referred To Committee On Health Policy	Mar 18, 2026
HB5732	Substances Use Disorder Modifies references to licenses for certain substance use disorder services programs in the Michigan zoning enabling act to include those exempt from licensure.	L. Meerman (R)	Referred To Committee On Health Policy	Mar 18, 2026
HB5733	Substance Use Disorder Modifies references to licenses for certain substance use disorder services programs in the motor vehicle code to include those exempt from licensure.	C. VanderWall (R)	Referred To Committee On Health Policy	Mar 18, 2026
HB5734	Substance Use Disorder Modifies references to licenses for certain substance use disorder services programs in the nonprofit health care corporation reform act to include those exempt from licensure.	N. DeBoer (R)	Referred To Committee On Health Policy	Mar 18, 2026
HB5735	Substance Use Disorder Treatment Modifies references to licenses for certain substance use disorder services programs in the overdose fatality review act to include those exempt from licensure.	J. Thompson (R)	Referred To Committee On Health Policy	Mar 18, 2026
HB5736	Substance Use Disorder Services Modifies references to licenses for certain substance use disorder services programs in the patient's right to independent review act to include those exempt from licensure.	A. St. Germaine (R)	Referred To Committee On Health Policy	Mar 18, 2026
HB5737	Substance Use Disorder Services Modifies references to licenses for certain substance use disorder services programs in the social welfare act to include those exempt from licensure.	M. Harris (R)	Referred To Committee On Health Policy	Mar 18, 2026
HB5738	Substance Use Disorder Services Modifies references to licenses for certain substance use disorder services programs in the adult foster care facility licensing act to include those exempt from licensure.	K. Bohnak (R)	Referred To Committee On Health Policy	Mar 18, 2026
HB5885	Property Tax Clarifies when to deny a disabled veteran's exemption.	J. Woolford (R)	Referred To Committee On Government Operations	Apr 23, 2026
HB5903	Health Facilities Expands allowable use of hospital swing beds to include behavioral health patients.	M. Bierlein (R)	Referred To Committee On Health Policy	Apr 28, 2026
HB5943	Behavioral Health Ttransportation Provides behavioral health transportation licensing requirements.	S. Frisbie (R)	Referred To Committee On Health Policy	May 12, 2026
HB5944	Behavioral Health Transportation Provides coverage for behavioral health transportation.	A. O'Neal (D)	Referred To Committee On Health Policy	May 12, 2026
HB6020	Ibogaine Provides participation in ibogaine clinical trials.	J. Greene (R)	Referred to the Rules Committee by the Families and Veterans Committee	Jun 9, 2026

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HB6022	Mental Health Modifies authority for prescreening individuals for mental health services.	C. VanderWall (R)	Referred to the Rules Committee by the Health Policy Committee	Jun 10, 2026
HB6028	Veteran''s Court Modifies veterans treatment court.	M. McFall (D)	Referred To Committee On Judiciary	Jun 2, 2026
HB6029	Veterans Requires consideration of veteran status in sentencing.	W. Bruck (R)	Referred To Committee On Judiciary	Jun 2, 2026
HR115	Medicaid 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.	D. Mentzer (D)	Referred To Committee On Government Operations	May 22, 2025
HCR1	Adverse Childhood Experiences 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.	D. Wozniak (R)	Reported With Recommendation Without Amendment	Oct 28, 2025
Senate Bills				
SB207	Veterans Creates Michigan veterans coalition fund.	K. Hertel (D)	Referred To Committee On Appropriations	Jun 3, 2025
SB208	Veterans Creates Michigan veterans coalition grant program.	R. Hauck (R)	Referred To Committee On Appropriations	Jun 3, 2025
SB215	Consumer Protections Amends Michigan consumer protection act to enhance protections for individuals applying for veterans benefits.	S. Santana (D)	Referred To Committee On Appropriations	Jun 3, 2025
SB219	Hospitalization Revises person requiring treatment and modifies certain procedures for treatment.	K. Hertel (D)	Referred To Committee On Health Policy	May 21, 2025
SB220	Hospital Evaluations Expands hospital evaluations for assisted outpatient treatment.	J. Irwin (D)	Referred To Committee On Health Policy	May 21, 2025
SB221	Mental Capacity Provides outpatient treatment for misdemeanor offenders with mental health issues.	S. Santana (D)	Referred To Committee On Health Policy	May 21, 2025
SB222	Outpatient Treatment Expands petition for access to assisted outpatient treatment to additional health providers.	P. Wojno (D)	Referred To Committee On Health Policy	May 21, 2025
SB237	National Guard Creates Michigan National Guard apprenticeship program.	T. Albert (R)	Referred To Committee On Regulatory Affairs	Apr 22, 2025
SB239	Vietnam Veterans Creates Vietnam veteran era bonus extension act.	K. Daley (R)	Referred To Committee On Appropriations	Apr 22, 2025
SB398	Controlled Substances Modifies substance use disorder services programs requirements and prohibits the promulgation of certain rules.	J. Bellino (R)	Referred by the Health Policy Committee to the Rules Committee	Mar 11, 2026
SB399	Drug Paraphernalia Modifies definition of drug paraphernalia.	J. Irwin (D)	Referred To Committee On Insurance	Jul 1, 2025

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SB400	Health Insurers Prohibits prior authorization for certain opioid use disorder and alcohol use disorder medications.	K. Hertel (D)	Referred To Committee On Insurance	Jul 1, 2025
SB401	Pharmaceuticals Requires co-prescribing of naloxone with opioid drugs.	S. Santana (D)	Referred To Committee On Insurance	Jul 1, 2025
SB430	Controlled Substances Modifies crime of manufacturing, delivering, or possession of with intent to deliver heroin or fentanyl to reflect changes in sentencing guidelines.	S. Chang (D)	Placed On Order Of Third Reading	Oct 29, 2025
SB431	Opioid Drugs Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver heroin or fentanyl.	S. Anthony (D)	Placed On Order Of Third Reading	Oct 29, 2025
SB432	Controlled Substances Allows probation for certain major controlled substances offenses.	R. Victory (R)	Placed On Order Of Third Reading	Nov 5, 2025
SB462	Tobacco/Nicotine Licenses Requires license to sell nicotine or tobacco products at retail.	S. Singh (D)	Referred To Committee On Regulatory Reform	Dec 18, 2025
SB465	Tobacco/Nicotine Licenses Creates certain temporary exemptions to the requirement that a person hold a license to sell a nicotine or tobacco product at retail.	J. Bellino (R)	Referred To Committee On Regulatory Reform	Dec 18, 2025
SB555	MiABLE Fund Provides for earmark to MiABLE Fund from the income tax.	M. Webber (R)	Referred To Committee On Housing And Human Services	Sep 18, 2025
SB556	MiABLE Fund Creates MiABLE Fund.	M. Webber (R)	Referred To Committee On Housing And Human Services	Sep 18, 2025
SB628	Medical Services Provides for coverage for syringe service programs.	R. Bayer (D)	Referred To Committee On Housing And Human Services	Oct 30, 2025
SB629	Controlled Substances Provides for syringe service programs.	R. Bayer (D)	Referred To Committee On Housing And Human Services	Oct 30, 2025
SB799	Mental Health Facilities Provides licensure for adult residential psychiatric programs.	R. Bayer (D)	Referred To Committee On Housing And Human Services	Feb 26, 2026
SB800	Mental Health Facilities Enacts sentencing guideline for facility that receives or maintains an adult who requires residential psychiatric care when the facility''s license has been revoked or suspended or it has refused to renew its license.	S. Santana (D)	Referred To Committee On Housing And Human Services	Feb 26, 2026
SB845	Occupations - Social Workers Modifies social work licensure.	S. Chang (D)	Referred To Committee On Housing And Human Services	Mar 18, 2026
SB846	Occupations - Social Workers Creates social worker scholarship fund.	R. Bayer (D)	Referred To Committee On Housing And Human Services	Mar 18, 2026
SB917	Mental Health Provides 988 crisis lifeline system fund and telecommunications fee.	R. Bayer (D)	Referred To Committee On Housing And Human Services	Apr 22, 2026
SB927	Medical Services Provides coverage for behavioral health transportation.	M. Huizenga (R)	Referred To Committee On Health Policy	Apr 23, 2026

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SB928	Behavioral Health Transportation Provides behavioral health transportation licensing requirements.	M. Huizenga (R)	Referred To Committee On Health Policy	Apr 23, 2026
SB953	Data Collection Establishes standards for public bodies collecting and reporting data related to race and ethnicity.	D. Camilleri (D)	Referred To Committee On Oversight	May 13, 2026
SB954	Data Collection Repeals classifications used in state agency writings requesting racial or ethnic identification.	D. Camilleri (D)	Referred To Committee On Oversight	May 13, 2026
SB955	Data Collection Modifies certain writings requesting racial or ethnic identification.	D. Camilleri (D)	Referred To Committee On Oversight	May 13, 2026
SB1007	Guardians Requires appointing certain guardians after considering least restrictive means.	R. Bayer (D)	Referred To Committee On Housing And Human Services	May 21, 2026
SR3	102nd Legislature 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.	W. Brinks (D)	Adopted	Jan 22, 2025
SR50	Medicaid 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.	K. Hertel (D)	Adopted	May 20, 2025

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

Compliance Activities Summary

The MSHN Board of Directors Chairperson requested administration review at a high level of the regional risk for fraud. The summary below provides activities both internal and external that occur to identify, detect and reduce fraud.

While MSHN's Compliance Plan, Policies and Annual Compliance Report outline in detail the requirements and activities, the below is to highlight at a high level the Prepaid Inpatient Health Plan's (PIHP's) role in reducing and detecting potential Medicaid fraud.

- Annual assessment of high-risk areas (outlined in the compliance plan)
  - New or changes in Medicaid Policy
  - Environmental factors (state & federal)
  - Low performance areas identified through internal and external reviews
- Quarterly Review of Medicaid Billable services – Medicaid Event Verification
  - MSHN conducts reviews to ensure appropriate documentation of billed services (percent of claims each quarter for Community Mental Health Service Programs [CMHSPs] and Substance Use Disorder [SUD] providers)
- Quality Reviews of Programs Requirements (on-site or desk reviews via electronic chart review)
  - Every 3 years full review
  - Interim years corrective action review
- Data Mining Activities
  - Review data for identified areas of risk (duplicate billings, past date of death, etc.)
- Assess Provider Compliance prior to Contracting – precontract review and site visit
- Review Michigan Department of Health and Human Services (MDHHS) site visit results for Waiver Services, Certifications, SUD, Grants, etc.
- Review of HSAG Compliance Review findings
- Regional Compliance meetings:
  - PIHP/CMHSP compliance officers
  - PIHP compliance officers
  - Office of Inspector General (OIG)/PIHP compliance officers
  - MSHN compliance committee
- Conduct compliance investigations on all reported suspected fraud
- Completion of Compliance Risk Assessment (Department of Justice Tool)
- Office of Inspector General (OIG) monthly, quarterly and annual reports
  - Review for trends and potential risk areas

MSHN Regional Efforts to Address H.R. 1 Impacts

Our region is closely monitoring the impacts of H.R. 1, estimating a significant reduction in Healthy Michigan Plan enrollees in the spring of 2027 and the impact of reduced match drawdown dollars due to the change in federal allowable drawdown – reducing the federal portion of Medicaid.

MSHN is working closely with the Community Mental Health's (CMH's) to:

- Prepare/expand supports for beneficiaries in maintaining coverage.

- Many CMHs have a dedicated staff imbedded in or coordinated with MDHHS Medicaid benefit eligibility programs to ensure renewal information is provided to sustain Medicaid/HMP. This will expand to ensure coordination of work requirement paperwork, exemptions and 6-month renewal determinations.
- Implement administrative cost reduction strategies
    - Reviewing regional administrative operations for consolidation and/or reduction.
        - Information technology (Electronic Health Record [EHR], data analytics)
        - Human Resources (Professional Employment Organization (PEO)
        - Use of artificial intelligence (AI) for automation
        - Finance (contract software)
        - Compliance (regional and statewide use of compliance software)
        - Reduction in physical lease expense & related office support (PIHP)
        - Training platforms
- Develop alternative/lower cost services
    - Increase access to children's residential crisis – develop new provider in region (reduce inpatient cost)
    - Increase intensive outpatient utilization
    - Increase intensive care coordination and wraparound
- Assess increased demand for emergency services (due to loss of coverage) and impact on community and safety net.
    - Work with local community to address safety net
- Review Healthy Michigan Benefit Plan
    - Financial impact FY27 Q3&Q4

MSHN is also monitoring the State Budget Director workgroup objectives – May 2026 (as applicable to behavioral health):

- Require MDHHS and Medicaid managed care organizations to jointly streamline administrative requirements and achieve at least 1% savings
- Eliminate duplicative audits and redundant reporting requirements
- Tighten oversight of Applied Behavioral Analysis (ABA) services to ensure clinical appropriateness and adherence to existing contract standards
- Expanding Certified Community Behavioral Health Clinics
- Evaluating the structure of Michigan's behavioral health system

Home and Community-Based Services (HCBS) Rules Require Utilization Management Changes

Mid-State Health Network (MSHN) conducted a comprehensive review of its utilization management (UM) responsibilities, particularly those tied to Home and Community-Based Services (HCBS)—to assess compliance with federal Conflict-Free Access and Planning (CFAP) requirements and to clarify the division of responsibilities between the PIHP and Community Mental Health Service Programs (CMHSPs).

The analysis evaluates:

- How UM functions are currently performed across HCBS and non-HCBS services.
- Whether PIHP responsibilities are being appropriately executed (non-delegated).
- What structural changes are needed to ensure compliance, efficiency, and consistency across the region.

The Centers for Medicare and Medicaid Services (CMS) HCBS Final Rule and MDHHS guidance explicitly require PIHPs to retain all UM and authorization responsibilities for HCBS and CMHSPs are allowed to conduct assessments,

planning, and service recommendations, but cannot authorize HCBS services. This separation is intended to prevent conflicts of interest between service planning and service authorization.

Currently MSHN, through the Waiver Department, conducts eligibility oversight and monitoring of UM across four HCBS Waiver Benefits.

- Habilitation Supports Waiver (HSW) - 1,539
- Children's Waiver Program (CWP) - 62
- Serious Emotional Disturbance Waiver (SEDW) - 182
- 1915(i) State Plan Amendment (SPA) - 6,315

Only **HSW** currently meets the intent of non-delegated PIHP UM, while the remaining three benefits lack sufficient PIHP review of:

- Biopsychosocial assessments (BPS)
- Individual Plans of Service (IPOS)
- Assessment tool results
- Concurrent and retrospective utilization data

This gap affects **6,559 individuals** and represents the largest compliance risk.

For non-HCBS services, MSHN delegates most prospective and concurrent UM to CMHSPs, while retaining:

- Policy development
- Retrospective review
- Monitoring of medical necessity criteria

Major Challenges currently exist in implementing a non-delegated model for HCBS UM activities:

- The volume of HCBS and 1915(i) cases makes full PIHP review operationally unsustainable without additional staffing.
- MDHHS itself has acknowledged difficulty meeting UM requirements for 1915(i) due to statewide volume.
- Potential expansion of CFAP to other services (e.g., ABA/Autism) could further increase workload.

MSHN along with our CMHSP Chief Executive Officers (CEOs) created a workgroup to consider the recommendations below to ensure compliance with federal and state waiver requirements.

1. Strengthen PIHP UM for HCBS
    - Require PIHP review of BPS, IPOS, and assessment tools at initial and annual intervals.
    - Add concurrent and retrospective UM review processes.
2. Modernize Regional Benefit Plans
    - Update benefit plans using Level of Care Utilization System (LOCUS), Michigan Child and Adolescent Needs and Strengths (MichiCANS), World Health Organization Disability Assessment Schedule (WHODAS), American Society of Addiction Medicine (ASAM), and utilization data.
    - Standardize authorization ranges across the region.
3. Improve Data Infrastructure
    - Require CMHSPs to submit authorization data to PIHP.
    - Use Electronic Medical Record (EMR) access to reduce documentation burden.
    - Use of AI automation tools to reduce administrative burden
    - Implement statistically driven outlier detection and sampling.
4. Clarify UM Roles Across the System
    - Reaffirm PIHP as the authorizer and CMHSP as the operational assessor/planner.
    - Consider the Only Willing and Qualified Provider (OWQP) designation to mitigate conflicts of interest.
5. Plan for Potential Expansion of CFAP
    - Prepare for the possibility that MDHHS may apply CFAP UM requirements to additional services such as ABA.

MSHN's current UM structure is partially aligned with federal and state expectations. However, significant enhancements—particularly for CWP, SEDW, and 1915(i)—are required to achieve full compliance with non-delegated PIHP UM responsibilities. MSHN will continue to update the board as the workgroup finalizes the recommendations for improved compliance.

MDHHS Quality Strategy Update FY26

In October 2023, MDHHS Bureau of Specialty Behavioral Health Services began a comprehensive review of the existing quality assessment and performance improvement program toward the goal of developing and implementing a new program. The transformed program was designed to be more comprehensive, better defined, with a more rigorous methodology that aligns with other state and national requirements. To facilitate a more seamless and efficient rollout of the updated quality program, MDHHS and MPHI created a three-year rollout strategy. This strategy will phase in new measures over three years. In brief, the three-year rollout strategy is as follows:

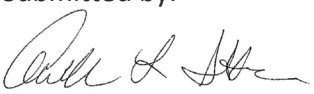
- Year One (YR1 - CY2025): The first year focus was on aligning reporting requirements for PIHPs with Centers for Medicare and Medicaid Services (CMS) Core Set & National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) reporting. By the end of YR1 measure roll-out, all required CMS Core Set measures will be disaggregated by PIHP and race/ethnicity. PIHPs were still responsible for reporting Michigan Mission Based Performance Indicator System (MMBPIS) measures. The MDHHS will be responsible for the YR1 measures listed here: ADD, FUY, APM, APP, FUA, FUM and IET.
- Year Two (YR2 -CY2026): The second year focus is on rolling out stratification of measures, along with adding several key measures. In alignment with 2025 CMS Core Set reporting requirements, the following measures will be rolled out stratified by race and ethnicity, gender and geography. In FY26, most MMBPIS measures are phased out; however, PIHPs are still required to submit measures 2a-d (Access-Timeliness/First Request). In addition to the YR1 measures listed above, MDHHS will also be responsible for the YR2 measures listed here: SSD, HPCMI, OUD and SAA.
- Year Three (YR3 - CY2027): The third year will focus on implementing patient experience and Home and Community Based Services (HCBS) measures. Both standard Consumer Assessment of Healthcare Providers and Systems (CAHPS) (included in the required CMS Quality Rating System) and HCBS CAHPS measures are included. All plans (Managed Care Organizations [MCOs], PIHPs and Prepaid Ambulatory Health Plans [PAHPs]) are required to have a Quality Rating System (QRS) publicly available by 2027. In addition to the YR1 and YR2 measures listed above, starting Jan. 1, 2027, MDHHS will also be responsible for the YR3 measures listed here: CAHPS, HCBS CAHPS, MLTSS-1, MLTSS-2, MSC and CDF.

The quality measures used in this assessment are the CMS Core Set Measures and the NCQA HEDIS measures. Both CMS and NCQA publish national performance benchmarks for their respective measures. Descriptions of all the acronyms MDHHS will be responsible for can be found at the Behavioral Health Quality Overhaul – 3YR Rollout Strategy link.

MSHN's quality department provides an excellent summary of these changes along with our regional performance and has been attached to this report for Board review. The table below summarizes MSHN's performance with additional areas noted for improvement initiatives related to each indicator in the details of the report.

YR1 Measures (FY2026, CY2025 data) - Benchmarks (Informational for FY26)					
Metric Code	**Measure**	**YR1 Benchmark**	**PBIP FY26**	**BH Quality Overhaul Year**	**Status (FY25)**
ADD-INT	ADHD Medication Follow-Up - Initiation Phase (ages 6–12)	52.60%	-	YR1	Above benchmark
ADD-CONT	ADHD Medication Follow-Up - Continuation Phase (ages 6–12)	61.20%	-	YR1	Above - watch
FUH-30CH	Follow-Up After Hospitalization for Mental Illness - ages 6–17	79.00%	Yes	YR1	Above benchmark
FUH-30AD	Follow-Up After Hospitalization for Mental Illness - ages 18–64	62.00%	Yes	YR1	Above - watch
FUH-30	Follow-Up After Hospitalization for Mental Illness - age 6+	-	-	YR1	-
APM-TOTGC	Metabolic Monitoring - Children/Adolescents on Antipsychotics	27.60%	-	YR1	Above - watch
APP-TOT	First-Line Psychosocial Care - Children/Adolescents on Antipsychotics	65.60%	-	YR1	Above benchmark
FUA-30CH	Follow-Up After ED Visit within 30 days - Substance Use, ages 13-17	35.60%	-	YR1	Above - watch
FUA-30AD	Follow-Up After ED Visit within 30 days - Substance Use, ages age 18+	36.30%	-	YR1	Above benchmark
FUA-30	Follow-Up After ED Visit within 30 days - Substance Use, age 13+	-	Yes	YR1	-
FUM	Follow-Up After ED Visit - Mental Illness, ages 6+	60.80%	-	YR1	-
IET14-TOT	SUD Treatment Initiation within 14 Days	40.00%	Yes	YR1	BELOW
IET34-TOT	SUD Treatment Engagement within 34 Days, age 13+	15.00%	Yes	YR1	BELOW
YR2 Measures - Begin tracking now (FY2027 benchmarks, CY2026 data)					
Code	**Measure**	**YR2 Benchmark**	**PBIP FY26**	**BH Quality Overhaul Year**	**Status**
SAA-AD	Adherence to Antipsychotic Medications — Schizophrenia (adults)	65.49%	Yes	YR2	Above - watch
SSD	Diabetes Screening — Schizophrenia/Schizoaffective Disorder	79.21%	-	YR2	Above - watch
OUD	Use of Pharmacotherapy for Opioid Use Disorder	70.41%	-	YR2	Above benchmark
YR3 Measures - Begin tracking January 1st, 2027 (FY2028 benchmarks, CY2027 data)					
Code	**Measure**	**YR3 Benchmark**	**PBIP FY26**	**BH Quality Overhaul Year**	**Status**
CDF	Screening for Depression and Follow-up Plan	-	-	YR3	-
SSD	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	-	-	YR3	-

Submitted by:



Amanda L. Ittner
Finalized: 6.24.26

Attached:
HEDIS Quality Measures Report

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HEDIS Metrics

HEDIS Quality Measure Requirements and Expectations

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Purpose:

As a subcontractor of Mid-State Health Network (MSHN), each Community Mental Health (CMH) provider is contractually obligated to monitor, review, and improve performance on the national HEDIS/CMS Core Set behavioral health quality measures. MSHN is responsible to MDHHS for regional aggregate performance against benchmarks established under the 3-Year BH Quality Rollout Strategy and is subject to financial consequences under the PBIP FY26. CMH performance directly determines MSHN's regional rates. Out-of-compliance cases at the individual case level must be identified, reviewed, and actioned locally through improvement processes and action.

***Please note that for HEDIS metrics, MSHN is responsible for all Medicaid eligible inviduals within the region, not just those being served by the PIHP/CMHSP system.**

CMH Provider Obligations:

Individual case review	Improvement plans
• Review out-of-compliance consumers for each HEDIS metric (that have touched the CMH system) and determine reasoning for the individual being out-of-compliance using MSHN-provided member-level detailed data • Review race/ethnicity detail data to identify any equity gaps that may exist within your organization • Utilize ICDP for ongoing and more up-to-date tracking of care alerts to identify those that need follow-up for each metric. Please note that Care Alerts are the best way of seeing these individuals	• Participate in MSHN monthly QIC meetings to discuss any regional improvement plans as well as CMHSP plans • If the CMHSP falls below established MDHHS benchmarks for the quarter, an improvement plan should be identified and discussed within the CMHSP (these plans should include root cause analysis, specific interventions with owners, and 90-day re-measurement/follow-up to determine if interventions are working)

FY Breakdown for Quality Rollout/MDHHS Quality Transformation:

FY2026	FY2027	FY2028+
• YR1 metrics active; benchmarks informational • Implement CAPs/improvement plans for measures below benchmarks now (also review for all metrics marked as “Above-watch” • Begin tracking YR2: SAA, SSD, OUD, HPCMI	• YR2 benchmarks active - formal scoring begins • All measures must stratified by race/ethnicity, gender, and geography	• YR3: CAHPS + HCBS measures added (not on metrics list as MDHHS will be responsible for these) • All benchmarks tied with financial consequences • Public QRS reporting required (MDHHS to publish reporting)

Reference Documents:

MDHHS BH Quality Overhaul 3-Year Rollout Strategy Q&A (2025)
MDHHS PBIP FY26 | MSHN CY2022–2024 YR1 Quality Report (Aug 2025)
CMS BH Core Set 2025–2026

HEDIS Quality Measures FY2025 Performance

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FUM	Follow-Up After ED Visit - Mental Illness, ages 6+	60.80%	-	YR1	-
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SAA-AD	Adherence to Antipsychotic Medications — Schizophrenia (adults)	65.49%	Yes	YR2	Above - watch
SSD	Diabetes Screening — Schizophrenia/Schizoaffective Disorder	79.21%	-	YR2	Above - watch
OUD	Use of Pharmacotherapy for Opioid Use Disorder	70.41%	-	YR2	Above benchmark
YR3 Measures - Begin tracking January 1st, 2027 (FY2028 benchmarks, CY2027 data)					
Code	**Measure**	**YR3 Benchmark**	**PBIP FY26**	**BH Quality Overhaul Year**	**Status**
CDF	Screening for Depression and Follow-up Plan	-	-	YR3	-
SSD	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	-	-	YR3	-

HEDIS Metric Specifications

ADD – Follow-Up Care for Children Prescribed ADHD Medication

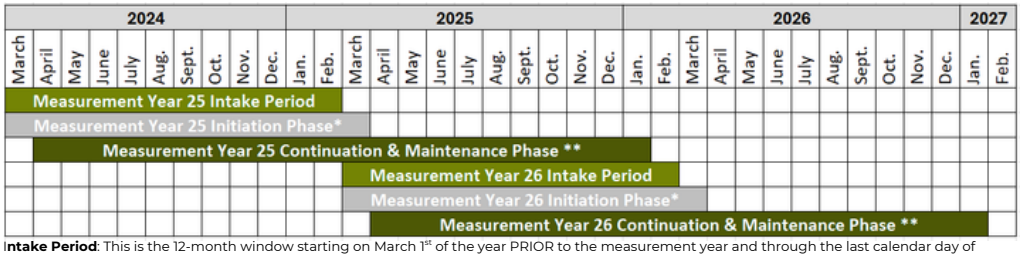
(Initiation Phase + Continuation & Maintenance Phase)

MSHN
Mid-State Health Network

Measure Description:

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

- Initiation Phase: The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.
- Continuation and Maintenance (C & M) Phase: The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.



Intake Period: This is the 12-month window starting on March 1st of the year PRIOR to the measurement year and through the last calendar day of February of the measurement year.

***Initiation Phase:** A follow-up visit must take place with a practitioner with prescribing authority within 30-days after the Initiation Phase following the Index Prescription Start Date.

****Continuation and Maintenance Phase:** At least 2 follow-up visits on different dates of service with any practitioner must take place from 31-300 (9 months) after the IPSD ended. Note: Only one of the two visits (during the 31-300 days after the IPSD) may be an electronic visit or virtual check-in.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement year.
- Members with a diagnosis of narcolepsy any time during their history through December 31 of the measurement year.
- Do not include laboratory claims (POS: 81).

Codes Included in the HEDIS Measure:

Description	Code
Outpatient POS (Initiation Phase and C & M Phase)	**CPT** Visit Setting Unspecified: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99252-99255 ***with*** Outpatient POS: 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72
	OR *Intensive Outpatient Encounter or Partial Hospitalization* **POS:** 52 ***OR*** *Community Mental Health Center* **POS:** 53 ***OR*** Telehealth **POS:** 02, 10
BH Outpatient Visit (Initiation Phase and C & M Phase)	**CPT:** 98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015 **UBREV:** 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983
Health and Behavior Assessment or Intervention (Initiation Phase and C & M Phase)	**CPT:** 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171
Partial Hospitalization or Intensive Outpatient (Initiation Phase and C & M Phase)	**HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 **UBREV:** 0905, 0907, 0912, 0913
Telephone Visits (Initiation Phase and C & M Phase)	**CPT:** 98966-98968, 99441-99443
Online Assessments (C & M Phase)	**CPT:** 98970-98972, 98980, 98981, 99421-99423, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250-G2252 *Note:* Only one of the two visits (during the 31–300 days after the IPSD) may be an e-visit or virtual check-in.

ADHD Medications:

Description	Prescription
CNS stimulants	Dexmethylphenidate, Dexmethylphenidate-serdexmethylphenidate, Dextroamphetamine, Lisdexamfetamine, Methylphenidate, Methamphetamine
Alpha-2 receptor agonists	Clonidine, Guanfacine
Miscellaneous ADHD medications	Atomoxetine, Viloxazine

NOTE: Dispensing events from different medication value sets are considered different drugs. Dispensing events from the same medication value sets are considered the same drug.

Ways Providers can Increase Performance

General Improvement Areas:

- Educate members, parents, and guardians on medication adherence and the importance of taking medications as prescribed.
- Send appointment reminders to the parents and/ or guardians of members to ensure they attend necessary appointments.
- Discuss concurrent treatment options that complement medication management such as psychotherapy, peer supports, and/ or parenting groups.
- Implement strategies to coordinate with other providers involved in the member's care.
- Communicate with primary care physicians and other providers involved with the member's treatment to ensure continuity and coordination of care to support a whole person approach.

Specific Clinical Care Improvement Areas:

- Creation of an ADHD Clinical Pathway
  - Standardize ADHD protocols directly in the Electronic Medical Record (EMR)- this would include auto-generation of 30 day, 60 day, and 90 day follow-up reminders
- Implement Pharmacological and Behavioral Dual Track Model
  - Require same-week or same-day scheduling with both prescriber and therapist
  - Flag cases that are not receiving psychotherapy services

APP – Use of Psychosocial Care for Children on Antipsychotics

(Psychosocial visit within 30 days of new antipsychotic prescription)

MSHN
Mid-State Health Network

Measure Description:

The percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Definitions:

- Intake Period: January 1 through December 1 of the measurement year
- IPSD: Index Prescription Start Date is the earliest prescription dispensing date for an antipsychotic medication where the date is in the intake period and there is a negative medication history
- Negative Medication History: A period of 120 days prior to the IPSD when the individual had no antipsychotic medications dispensed for either new or refill prescriptions

Exclusions:

- Members for whom first-line antipsychotic medications may be clinically appropriate: members with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder on at least two different dates of service during the measurement year
  - Do not include laboratory claims (POS: 81)
- Members who use hospice services or elect to use a hospice benefit any time during the measurement period
- Members who die any time during the measurement year

Codes Included in the HEDIS Measure:

Description	Code
Psychosocial Care	**CPT:** 90832-90834, 90836-90840, 90845-90847, 90849, 90853, 90875, 90876, 90880 **HCPCS:** G0176, G0177, G0409-0411, H0004, H0035-H0040, H2000, H2001, H2011-H2014, H2017-H2020, S0201, S9480, S9484, S9485
Residential Behavioral Health Treatment	**HCPCS:** H0017-H0019, T2048

Medications:

Description	Prescription
Miscellaneous Antipsychotic Agents	Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Risperidone, Ziprasidone
Phenothiazine Antipsychotics	Chlorpromazine, Fluphenazine, Perphenazine, Thioridazine, Trifluoperazine
Thioxanthenes	Thiothixene
Long-acting Injections	Aripiprazole, Aripiprazole lauroxil, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone
Psychotherapeutic Combinations*	Fluoxetine-olanzapine, Perphenazine-amitriptyline

Ways Providers can Increase Performance

General Improvement Areas:

- Each time a member between the ages of 1-17 is prescribed a new antipsychotic medication, ensure there is documentation of a psychosocial care visit within 30 days of the index prescription start date (IPSD).
- Additional monitoring of children and adolescents prescribed antipsychotics as they are more at risk for serious health concerns, including weight gain, extrapyramidal side effects, hyperprolactinemia and some metabolic side effects including glucose and cholesterol levels.
- Educate and inform parents/guardians of the increased side effect burden of multiple concurrent antipsychotics on children's health and the implications for future physical health concerns including obesity and diabetes.
- Schedule telehealth appointments for patients who had a new prescription for an antipsychotic medication.
- Educate staff about timeline requiring psychosocial care in appropriate timeframe related to medication dispensing (90 days prior through 30 days after)

APM – Metabolic Monitoring for Children on Antipsychotics

(Glucose + LDL annually for ages 1–17)

Mid-State Health Network

Measure Description:

The percentage of children or adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:

- The percentage of children and adolescents on antipsychotics who received blood glucose testing.
- The percentage of children and adolescents on antipsychotics who received cholesterol testing.
- The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Exclusions:

- Members who use hospice service or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement year.

Codes Included in the HEDIS Measure:

Codes to Identify Blood Glucose and Cholesterol Testing

Description	Code
Glucose Lab Test	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
HbA1c Lab Test	**CPT:** 83036, 83037
Cholesterol Lab Test	**CPT:** 82465, 83718, 83722, 84478
LDL C Tab Test	**CPT:** 80061, 83700, 83701, 83704, 83721

Medications:

Antipsychotic Medications

Description	Prescription
Miscellaneous Antipsychotic Agents	Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Risperidone, Ziprasidone
Phenothiazine Antipsychotics	Chlorpromazine, Fluphenazine, Perphenazine, Thioridazine, Trifluoperazine
Thioxanthenes	Thiothixene
Long-Acting Injections	Aripiprazole, Aripiprazole lauroxil, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone

Antipsychotic Combination Medications

Description	Prescription
Psychotherapeutic Combinations	Fluoxetine-olanzapine, Perphenazine-amitriptyline

Please submit a request for coverage when prescribing Psychotherapeutic Combination medications.

Prochlorperazine Medications

Description	Prescription
Phenothiazine Antipsychotics	Prochlorperazine

Ways Providers can Increase Performance

General Improvement Areas:

- Set process for psychiatric providers to order labs for consumers on antipsychotic medications to have their blood glucose or HbA1c, LDL-C or cholesterol drawn annually (at minimum).
- Schedule follow-up appointments and metabolic lab tests after the second anti-psychotic prescription.
- Monitor children on antipsychotic medications to avoid metabolic health complications such as weight gain and diabetes.
- Facilitate care coordination between the patient's primary care and behavioral health providers.
- Educate parents/guardians about the signs of metabolic disturbances, including long term consequences of pediatric and adolescence obesity and poor cardiometabolic outcomes in adulthood.
- Establish a baseline and continuously monitor metabolic indices to ensure appropriate management of side effects of antipsychotic medication therapy.

Specific Clinical Care Improvement Areas:

- Development of an Antipsychotic Prescribing Dashboard
  - Would track all individuals stratified by age (youth and adults)
  - Integrate lab orders and results directly into dashboard to show last metabolic labs and flag individuals who require lab orders and testing for psychiatric providers to have access to
  - Review weekly by nurses for coordination of care needs
- Partner with local labs to co-locate into clinics to bring same-day lab services into behavioral health clinics

FUA – Follow-Up After Emergency Department Visit for Substance Use

(7-day & 30-day follow-up)

Mid-State Health Network

Measure Description:

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.

Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement year.

Medications:

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	Disulfiram (oral)
Antagonist	Naltrexone (oral and injectable)
Other	Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications

Description	Prescription
Antagonist	Naltrexone (oral & injectable)
Partial agonist	Buprenorphine (sublingual tablet, injection, implant), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Ways Providers can Increase Performance

General Improvement Areas:

- Schedule follow-up visits for patients with a primary diagnosis of SUD, or any diagnosis of drug overdose, within 7 days of being seen in the ED (please note that telephone and/or telehealth appointments within the required timeframe meets compliance).
- Block same-day or next-day appointment slots for ED follow-ups.
- Partner with inpatient units to schedule outpatient appointments prior to discharge.
- Consumer engagement- schedule text reminders 72 and 24 hours prior to appointments
  - Implement follow-up calls for individuals who no show appointments (within 2 hours of missed appointments)
- Ensure that follow-up visits are coded appropriately. Educate providers on what codes qualify for follow-up visits.

Codes Included in the HEDIS Measure:

Description	Code
ED Visit	**CPT:** 99281-99285 **UBREV:** 0450-0452, 0456, 0459, 0981
AOD Abuse and Dependence	**ICD-10:** F10-16.xxx, F18.xxx, F19.xxx
Substance Induced Disorders	**ICD-10:** F10.90, F10.920-F10.99, F11.90, F11.920-F11.99, F12.90, F12.920-F12.99, F13.90, F13.920-F13.99, F14.90, F14.920-F14.99, F15.90, F15.920- F15.99, F16.90, F16.920-F16.99, F18.90, F18.920-F18.900, F19.90, F19.920-F19.99
Unintentional Drug Overdose	**ICD-10:** T40.xxxx-T43.xxxx, T51.xxxx
Outpatient Visit with ***any*** diagnosis of SUD, substance use, or drug overdose ***or*** *with* a mental health provider	**CPT** Visit Setting Unspecified: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** Outpatient **POS:** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72
BH Outpatient Visit with ***any*** diagnosis of SUD, substance use, or drug overdose ***or*** *with* a mental health provider	**CPT:** 98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015 **UBREV:** 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983
Partial Hospitalization or Intensive Outpatient with ***any*** diagnosis of SUD, substance use, or drug overdose ***or*** *with* a mental health provider	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-23, 99231-99233, 99238-99239, 99252-99255 ***with*** **POS:** 52 **HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 **UBREV:** 0905, 0907, 0912, 0913
Nonresidential Substance Abuse Treatment Facility Visit with ***any*** diagnosis of SUD, substance use, or drug overdose ***or*** *with* a mental health provider	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** Non-residential Substance Abuse Treatment Facility **POS:** 57, 58
Community Mental Health Center Visit with ***any*** diagnosis of SUD, substance use, or drug overdose ***or*** *with* a mental health provider	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** **POS:** 53
Peer Support Service with ***any*** diagnosis of SUD, substance use, or drug overdose	**HCPCS:** G0140, G0177, H0024, H0025, H0038-H0040, H0046, H2014, H2023, S9445, T1012, T1016
Opioid Treatment Services Billed Monthly or Weekly with ***any*** diagnosis of SUD, substance use, or drug overdose	**HCPCS** OUD Monthly Office Based Treatment: G2086, G2087 **HCPCS** OUD Weekly Non-Drug Service: G2071, G2074-G2077, G2080
Telehealth Visit with ***any*** diagnosis of SUD, substance use, or drug overdose ***or*** *with* a mental health provider	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** Telehealth **POS:** 02, 10
Telephone Visit with ***any*** diagnosis of SUD, substance use, or drug overdose ***or*** *with* a mental health provider	**CPT:** 98966-68, 99441-99443
Online Assessments (E-visit or Virtual Check-in) with ***any*** diagnosis of SUD, substance use, or drug overdose ***or*** *with* a mental health provider	**CPT:** 98970-98972, 98980-98981, 99421-99423, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250-G2252
Substance Use Disorder Services	**CPT:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012 **UBREV:** 0906, 0944, 0945 **ICD-10** Substance Abuse Counseling and Surveillance: Z71.41. Z71.51
Behavioral Health Assessment	**CPT:** 99408, 99409 **HCPCS:** G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049
Substance Use Services	**HCPCS:** H0006, H0028
Medication Treatment Event	**HCPCS** AOD Medication Treatment: G2069, G2070, G2072, G2073, H0020, H0033, J0570-J0575, J0577, J0578, J2315, Q9991, Q9992, S0109 **HCPCS** OUD Weekly Drug Treatment Service: G2069, G2070, G2072, G2073

FUH – Follow-Up After Hospitalization for Mental Illness

(7-day & 30-day follow-up)

Mid-State Health Network

Measure Description:

The percentage of discharges for members six years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and who had mental health follow-up service. Visits must occur after the date of discharge. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 30 days after discharge.
- The percentage of discharges for which the members received follow-up within 7 days after discharge.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement year.

Ways Providers can Increase Performance

General Improvement Areas:

- Discharge planning should begin upon admission to the hospital. Follow-up appointments must be scheduled prior to discharge. Please note that any follow-up visits completed on the same day a client is discharged do NOT close the care gap. A client must be seen within 7 days, but same day appointments as discharge do not count into this measure.
- Partner with inpatient units to schedule appointments prior to discharge.
- Consumer engagement- schedule text reminders 72 and 24 hours prior to appointments
- Implement follow-up calls for individuals who no show their follow-up appointments (within 2 hours of missed appointments)
- Ensure that follow-up visits are coded appropriately. Educate providers on what codes qualify for follow-up visits.
- Review medications with clients (and complete medication reconciliation) to ensure the client understands the purpose and appropriate frequency and method of administration of all medications prescribed. Provide psychoeducation regarding the importance of maintaining consistency and adherence to the medication regimen.
- Assist the client with resources, both local as well as benefit resources relating to transportation to lessen the impact of barriers in attending appointments.

Specific Clinical Care Improvement Areas:

- Build a Rapid-Response Discharge Team
  - Schedule appointments prior to discharge
  - Teams contact all patients within 24 hours of discharge for follow-up
  - If the consumer no-shows their follow-up appointment, a follow-up call and/or visit is conducted
- Reserve Crisis Follow-up Appointments Daily
  - Block appointment slots for hospital discharges and Emergency follow-ups

Codes Included in the HEDIS Measure:

Description	Code
Mental Health Diagnosis	**ICD-10:** F03.xxx, F20-25.xx, F28-34.xx, F39-45.xx, F48.xx, F50-53.xx, F59-60.xx, F63-66.xx, F68-69.xx, F80-82.xx, F84.x, F88-F95.xx, F98-99.xx
Mental Illness	**ICD-10:** F20-F25.xx, F28-F34.xx, F39-F44.xx, F53.xx, F60.xx, F63.xx, F68.xx, F84.xx, F90-F91.xx, F93-94.xx
Intentional Self-Harm	**ICD-10CM:** R45.851, T14.xxxx, T36-65.xxx, T71.xxxx, X71-83.xxx
Outpatient Visit *with* a mental health provider	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** Outpatient **POS:** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71-72
Outpatient Visit *with* any diagnosis of mental health disorder	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** Outpatient **POS:** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71-72
Behavioral Healthcare Outpatient Visit *with* a mental health provider	**CPT:** 98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510 **HCPCS:** G0155, G0176-G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036-H0037, H0039-H0040, H2000, H2010-H2011, H2013-H2020, T1015 **UBREV:** 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983
Behavioral Healthcare Outpatient Visit *with* any diagnosis of mental health disorder	**CPT:** 98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510 **HCPCS:** G0155, G0176-G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036-H0037, H0039-H0040, H2000, H2010-H2011, H2013-H2020, T1015 **UBREV:** 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983
Partial Hospitalization or Intensive Outpatient	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** **POS:** 52 **HCPCS** Partial Hospitalization: G0410-G0411, H0035, H2001, H2012, S0201, S9480, S9484-S9485 **UBREV:** 0905, 0907, 0912, 0913
Community Mental Health Center Visit	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-39, 99252-99255 ***with*** **POS:** 53 **CPT** BH Outpatient: 98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341-99342, 99344-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99483, 99492-99494, 99510 ***with*** **POS:** 53 **CPT** Transitional Care Management Services: 99495-99496 ***with*** **POS:** 53
Electroconvulsive Therapy	**CPT:** 90870 **ICD-10:** GZB0ZZZ-GZB4ZZZ ***with*** Outpatient **POS:** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72 **or POS:** 24, 52, 53
Telehealth Visit *with* a mental health provider	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** Telehealth **POS:** 02, 10
Telehealth Visit *with* any diagnosis of mental health disorder	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** Telehealth **POS:** 02, 10
Transitional Care Management Services *with* a mental health provider	**CPT:** 99495-99496
Behavioral Healthcare Setting	**UBREV:** 0513, 0900-0905, 0907, 0911-0917, 0919
Telephone Visit	**CPT:** 98966-98968, 99441-99443
Psychiatric Collaborative Care Management *with* a mental health provider	**CPT:** 99492-99494 **HCPCS:** G0512
Peer Support Services	**HCPCS:** G0140, G0177, H0024, H0025, H0038-H0040. H0046, H2014, H2023, S9445, T1012, T1016
Residential Behavioral Health Treatment	**HCPCS:** H0017-H0019, T2048 **CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-39, 99252-99255 ***with*** **POS:** 56

FUM – Follow-Up After Emergency Department Visit for Mental Illness

(7-day & 30-day follow-up)

MSHN
Mid-State Health Network

Measure Description:

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the members received follow-up within 7 days of the ED visit (8 total days).

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement year.

Ways Providers can Increase Performance

General Improvement Areas:

- Schedule follow-up appointments within 7 days of emergency department discharge with a healthcare practitioner before the client is discharged to reduce the likelihood of additional ED or hospital admissions. Please note that a telehealth, telephone, or in-person appointment within the required timeframe meets compliance for this metric.
- Utilize ADT data for early identification of discharges.
- Consumer engagement- schedule text reminders 72 and 24 hours prior to appointments.
- Implement follow-up calls for individuals who no show their follow-up appointment (within 2 hours of missed appointments).
- Ensure that follow-up visits are coded appropriately. Educate providers on what codes qualify for follow-up visits.
- Review medications with clients (and complete medication reconciliation) to ensure the client understands the purpose and appropriate frequency and method of administration of all medications prescribed. Provide psychoeducation regarding the importance of maintaining consistency and adherence to the medication regimen.
- Provide psychoeducation about the importance of the client's emotional well-being after ED visit and ensure that the individual has crisis resources.

Specific Clinical Care Improvement Areas:

- Build a Rapid-Response Discharge Team
  - Schedule appointments prior to discharge
  - Teams contact all patients within 24 hours of discharge for follow-up
  - If the consumer no-shows their follow-up appointment, a follow-up call and/or visit is conducted
- Reserve Crisis Follow-up Appointments Daily
  - Block appointment slots for hospital discharges and Emergency follow-ups

Codes Included in the HEDIS Measure:

Description	Code
Mental Health Diagnosis	**ICD-10:** F03.xxx, F20-25.xx, F28-34.xx, F39-45.xx, F48.xx, F50-53.xx, F59-60.xx, F63-66.xx, F68-69.xx, F80-82.xx, F84.x, F88-F95.xx, F98-99.xx
Mental Illness	**ICD-10:** F20-F25.xx, F28-F34.xx, F39-F44.xx, F53.xx, F60.xx, F63.xx, F68.xx, F84.xx, F90-F91.xx, F93-94.xx
Intentional Self Harm	**ICD-10:** R45.851, T14.xxxx, T36-65.xxxx, T71.xxxx
Outpatient Visit	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** **Outpatient POS:** 03, 05, 07, 09, 11-20, 22, 33, 49-50, 71-72
Behavioral Healthcare Outpatient Visit	**CPT:** 98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510 **HCPCS:** G0155, G0176-G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036-H0037, H0039-H0040, H2000, H2010-H2011, H2013-H2020, T1015 **UBREV:** 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983
Partial Hospitalization or Intensive Outpatient	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** **POS:** 52 **HCPCS** Partial Hospitalization: G0410-G0411, H0035, H2001, H2012, S0201, S9480, S9484-S9485 **UBREV:** 0905, 0907, 0912, 0913
Community Mental Health Center Visit	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-39, 99252-99255 ***with*** **POS:** 53
Electroconvulsive Therapy	**CPT:** 90870 **ICD-10:** GZB0ZZZ-GZB4ZZZ ***with*** **Outpatient POS:** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72 **or POS:** 24, 52, 53
Telehealth Visit	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** Telehealth **POS:** 02. 10
Telephone Visit	**CPT:** 98966-98968, 99441-99443
Online Assessment (E-visit or Virtual Check-in)	**CPT:** 98970-98972, 98980-98981, 99421-99423, 99457-99458 **HCPCS:** G0071, G2010, G2012, G2250-G2252
Peer Support	**HCPCS:** G0140, G0177, H0024, H0025, H0038-H0040, H0046, H2014, H2023, S9445, T1012, T1016
Psychiatric Collaborative Care Management	**CPT:** 99492-99494 **HCPCS:** G0512
Residential Behavioral Health Treatment	**HCPCS:** H0017-H0019, T2048 **CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 *with* **POS:** 52
Behavioral Healthcare Setting	**UBREV:** 0513, 0900-0905, 0907, 0911-0917, 0919, 1001

IET – Initiation & Engagement of Alcohol and Drug Treatment

(14-day initiation + 30-day engagement)

MSHN
Mid-State Health Network

Measure Description:

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- Initiation of SUD Treatment: The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visits or medication treatment within 14 days.
- Engagement of SUD Treatment: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement year.

Medications:

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	Disulfiram (oral)
Antagonist	Naltrexone (oral and injectable)
Other	Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications

Description	Prescription
Antagonist	Naltrexone (oral & injectable)
Partial agonist	Buprenorphine (sublingual tablet, injection, implant), Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Ways Providers can Increase Performance

General Improvement Areas:

- Avoid inappropriate use of diagnosis codes that are the result of alcohol or drug dependency (as these qualify clients for this measure).
- Schedule follow-up visits within 14 days, and at least two additional visits within 30 days when giving a diagnosis of alcohol or other drug dependence. Send appointment reminders 72 hours and 24 hours prior to the client's follow-up appointment. A telephone and/or telehealth appointment within the required timeframe meets compliance.
- Provide psychoeducation materials and resources that include information on the treatment process and options, including 12-step meetings and other community-based programs.
- Potential consideration for providers:
  - For patients using long-term medication for pain, use code Z79.891 (long-term current use of opiate analgesic), which does not denote an SUD diagnosis.
  - Use a "1" at the end of a substance use diagnosis code to document that the condition is in remission (e.g., F10.11, (Alcohol Use Disorder, Mild, In early or sustained remission)).
- Utilize peer supports to engage clients and encourage ongoing treatment.

Specific Clinical Care Improvement Areas:

- Immediate Engagement Protocol- after SUD diagnosis, assign:
  - Peer recovery specialist
  - First appointment within 7 days and engagement visit scheduled before the client leaves
- MAT-First Policy
  - Offer MAT the same day as diagnosis for OUD, alcohol use disorder, or stimulant cravings

Codes Included in the HEDIS Measure:

Description	Code
Alcohol Abuse and Dependence	**ICD-10:** F10.10, F10.120, F10.121, F10.129-F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180-F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229-F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280-F10.282, F10.288, F10.29
Opioid Abuse and Dependence	**ICD-10:** F11.10, F11.120-F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220-F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29
Other Drug Abuse and Dependence	**ICD-10:** F12.10, F12.120-F12.122, F12.129, F12.13, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220-F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F13.10, F13.120, F13.121, F13.129-F13.132, F13.139, F13.14, F13.150, F13.151, F13.159, F13.180-F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229-F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280-F13.282, F13.288, F13.29, F14.10, F14.120-F14.122, F14.129, F14.13, F14.14, F14.150, F14.151, F14.159, F14.180-F14.182, F14.188, F14.19, F14.20, F14.220-F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280-F14.282, F14.288, F14.29, F15.10, F15.120-F15.122, F15.129, F15.13, F15.14, F15.150, F15.151, F15.159, F15.180- F15.182, F15.188, F15.19, F15.20, F15.220-F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280-F15.282, F15.288, F15.29, F16.10, F16.120-F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, 16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F19.10, F19.120-F19.122, F19.129-F19.132, F19.139, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.220-F19.222, F19.229-F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280-F19.282, F19.288, F19.29
BH Outpatient Visit	**CPT:** 98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015 **UBREV:** 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983
Partial Hospitalization or Intensive Outpatient	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with* POS:** 52 **HCPCS** Partial Hospitalization: G0410-G0411, H0035, H2001, H2012, S0201, S9480, S9484-S9485 **UBREV:** 0905, 0907, 0912, 0913
Visit Setting Unspecified	**CPT:** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99252-99255 ***With* Outpatient POS**: 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72 ***or with* Partial Hospitalization POS**: 52 ***or with* Non-residential Substance Abuse Treatment Facility POS**: 57, 58 ***or with* Community Mental Health Center POS**: 53 ***or with* Telehealth POS**: 02, 10
Substance Use Disorder Service or Substance Abuse Counseling and Surveillance	**CPT:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012 **UBREV:** 0906, 0944, 0955 **ICD-10:** Z71.41, Z71.51
Opioid Treatment Services	OUD Weekly Non-Drug Service **HCPCS**: G2071, G2074, G2075, G2076, G2077, G2080 OUD Weekly Drug Treatment Service **HCPCS**: G2067, G2068, G2069, G2070, G2072, G2073 OUD Monthly Office Based Treatment **HCPCS**: G2086, G2087
Telephone Visits	**CPT:** 98966-98968, 99441-99443
Online Assessments (E-visits or Virtual Check-in)	**CPT**: 98970-98972, 98980, 98981, 99421-99423, 99457, 99458 **HCPCS**: G0071, G2010, G2012, G2250-G2252
Opioid Treatment	**HCPCS:** Weekly Treatment: G2067-2077 Monthly Treatment: G2086, G2087

SSD – Diabetes Screening for People on Antipsychotics

MSHN
Mid-State Health Network

Measure Description:

The percentage of members 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test (glucose test or HbA1c test) during the measurement year.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement year.
- Members with diabetes.
- Members who had no antipsychotic medications dispensed during the measurement year.

Ways Providers can Increase

General Improvement Areas:

- Provide psychoeducation to clients on the risk of diabetes, symptoms of onset, and the importance of screening for diabetes while taking antipsychotic medication.
- Schedule lab screening tests prior to next appointment.

Specific Clinical Care Improvement Areas:

- Build psychiatric provider alerts for missed labs into EMR- EMR to send flagged alerts every 60 days to nurses and/or psychiatric providers for patients overdue for labs.
- Build dashboard reporting to determine if clients prescribed antipsychotics have had labs completed for diabetes screening and provide reports to nurses/psychiatric providers to order labs.
- Build process to have nurses order appropriate diabetes screening labs as a standing order annually.
- Mobile lab days- coordinate with a mobile lab van or provider to visit clinic monthly to conduct routine screening labs.

Codes Included in the HEDIS Measure:

Description	Code
Diabetes - Exclusions	**ICD-10:** E10.xxxx, E11.xxxx, E13.xxxx, O24.xxxx
Schizophrenia	**ICD-10:** F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9
Bipolar Disorder	**ICD-10:** F30.10-F30.13, F30.2-F30.4, F30.8, F30.9, F31.0, F31.10-F31.13, F31.2, F31.30-F31.32, F31.4, F31.5, F31.60-F31.64, F31.70-F31.78
Other Bipolar Disorder	**ICD-10:** F31.81, F31.89, F31.9
Glucose Lab Test	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
HbA1c Lab Test	**CPT:** 83036, 83037 **CPT II:** 3044F (if HbA1c<7%), 3046F (if HbA1c>9%), 3051F (if HbA1c ≥ 7% and <8%), 3052F (if HbA1c ≥ 8% and <9%)
Telephone Visits	**CPT:** 98966-98968, 99441-99443
Telehealth POS	**POS:** 02, 10
Online Assessments	**CPT:** 98970-98972, 98980, 98981, 99421-99423, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250-G2252

Medications:

Diabetes Medications - Exclusions

Description	Prescription
Alpha-glucosidase Inhibitors	Acarbose, Miglitol
Amylin Analogs	Pramlintide
Antidiabetic Combinations	Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Dapagliflozin-saxagliptin, Empagliflozin-linagliptin, Empagliflozin-linagliptin-metformin, Empagliflozin-metformin, Ertugliflozin-metformin, Ertugliflozin-sitagliptin, Glimepiride-pioglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin
Insulin	Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin degludec-liraglutide, Insulin detemir, Insulin glargine, Insulin glargine-lixisenatide, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled
Meglitinides	Nateglinide, Repaglinide
Biguanides	Metformin
Glucagon-like Peptide-1 (GLP1)	Albiglutide, Dulaglutide, Exenatide, Liraglutide, Lixisenatide, Semaglutide
Sodium Glucose Cotransporter 2 (SGLT2) Inhibitor	Canagliflozin, Dapagliflozin, Ertugliflozin, Empagliflozin
Sulfonylureas	Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide
Thiazolidinediones	Pioglitazone, Rosiglitazone
Dipeptidyl Peptidase-4 (Ddp-4) Inhibitors	Alogliptin, Linagliptin, Saxagliptin, Sitaglipin

SSD Antipsychotic Medications

Description	Prescription
Miscellaneous Antipsychotic Agents	Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lumateperone, Lurasidone, Molindone, Olanzapine, Paliperidone, Quetiapine, Risperidone, Ziprasidone
Phenothiazine Antipsychotics	Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine
Psychotherapeutic Combinations	Amitriptyline-perphenazine
Thioxanthenes	Thiothixene
Long-acting Injections	Aripiprazole, Aripiprazole lauroxil, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone

OUD – Use of Opioids from Multiple Providers

Measure Description:

The percentage of members age 18 years and older, receiving prescription opioids for ≥15 days during the measurement year, who received opioids from multiple providers. Three rates are reported, identified below with the lower rate indicating better performance for all three rates:

- Multiple providers – the percentage of members receiving prescriptions for opioids from four or more different prescribers during the measurement year
- Multiple pharmacies – the percentage of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year
- Multiple prescribers and multiple pharmacies (four or more each) – the percentage of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement year.

Medications:

Description	Prescription
Opioid Medications	Benzhydrocodone, Buprenorphine (transdermal patch and buccal film), Butorphanol, Codeine, Dihydrocodeine, Fentanyl, Hydrocodone, Hydromorphone, Levorphanol, Meperidine, Methadone, Morphine, Opium, Oxycodone, Oxymorphone, Pentazocine, Tapentadol, Tramadol
Excluded Opioid Medications	Injectables, Opioid cough and cold products, Single-agent and combination buprenorphine products used as part of medication-assisted treatment of opioid use disorder (buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products), Ionsys® (fentanyl transdermal patch), Methadone for the treatment of opioid use disorder

Ways Providers can Increase Performance

General Improvement Areas:

- Review the Prescription Monitoring Program Registry for Michigan regularly.
- Educate patients on opioid safety, risks associated with the use of multiple opioids from different providers, and about use of Naloxone (Narcan).
- Set patient-prescriber expectations early on regarding controlled-substance prescriptions from other providers and the use of multiple pharmacies.
- Provide tools to the clients to help manage stressors and identify triggers for relapses.
- Only prescribe opioids when medically necessary, in the lowest effective dose, for the shortest duration necessary.
- Consider Medication Assisted Treatment (MAT) for opioid abuse or dependence.
- Note that members who see multiple providers and use multiple pharmacies are at a higher risk of overdose.
- Follow CDC, state and federal guidelines for prescribing opioids for chronic pain.
- Educate patients on the importance of utilizing singular pharmacy to fill prescriptions.

Specific Clinical Care Improvement Areas:

- Create Risk Flag Dashboard to flag individuals with:
  - Multiple prescribers
  - Early Refills
  - Multiple Pharmacies
  - History of Overdose
- Build non-Opioid Pain Pathways to include Physical Therapy, Behavioral health pain programs, acupuncture, CBT pain modules
- MAT Rapid Access Model- offer induction within 24 hours or same-day telehealth

SAA – Adherence to Antipsychotic Medications

MSHN Mid-State Health Network

Measure Description:

The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- A diagnosis of dementia. Do not include laboratory claims (POS: 81).
- ***DID NOT*** have at least two antipsychotic medication dispensing events. There are two ways to identify dispensing events:
  - Claim/encounter data: An antipsychotic medication (HCPCS J2794, J2798 and Long-acting Injections 28day Supply).
  - Pharmacy data: Dispensed an antipsychotic medication (Oral Antipsychotic Medications and Long-acting Injections)
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File.
- Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
  - **Frailty-** At least two indications of frailty with different dates of service during the measurement year. Do not include laboratory claims (POS: 81).
  - **Advanced Illness-** Either of the following during the measurement year or the year prior to the measurement year:
    - Advanced illness on at least two different dates of service. Do not include laboratory claims (POS: 81).
    - Dispensed dementia medication.
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with at least two indications of frailty, with different dates of service during the measurement year. Do not include laboratory claims (POS: 81).

Medications:

Dementia Medications (For Exclusion)

Description	Prescription
Cholinesterase Inhibitors	Donepezil, Galantamine, Rivastigmine
Miscellaneous Central Nervous System Agents	Memantine
Dementia Combinations	Donepezil-memantine

Oral Antipsychotic Medications

Description	Prescription
Miscellaneous Antipsychotic Agents (Oral)	Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lumateperone, Lurasidone, Molindone, Olanzapine, Paliperidone, Quetiapine, Risperidone, Ziprasidone
Phenothiazine Antipsychotics (Oral)	Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine
Psychotherapeutic Combinations (Oral)*	Amitriptyline-perphenazine
Thioxanthenes (Oral)	Thiothixene

**** Please submit a request for coverage when prescribing psychotherapeutic combination medications.***

Long-Acting Injections

Description	Prescription
Long-acting Injections 14-day Supply	Risperidone (excluding Perseris®)
Long-acting Injections 28-day Supply	Aripiprazole, Aripiprazole lauroxil, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate
Long-acting Injections 30-day Supply	Risperidone (Perseris®)

Codes Included in the HEDIS Measure:

Description	Code
Schizophrenia	**ICD-10:** F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9
BH Inpatient Stay with Schizophrenia diagnosis	**CPT:** 99304-99310, 99315, 99316 **HCPCS:** H0017-H0019, T2048 **UBREV:** 0100, 0101, 0110-0114, 0118-0124, 0128-0134, 0138-0144, 0148-0154, 0158-0160, 0164, 0167, 0169, 0190-0194, 0199, 0200-0204, 0206-0214, 0219, 0524, 0525, 0550-0552, 0559, 0660-0663, 06698, 0720-0724, 0729, 0987, 1000-1005
Acute Inpatient Stay with Schizophrenia diagnosis	**CPT:** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99252-99255 ***with*** **POS:** 21, 51
Outpatient Visit with Schizophrenia diagnosis	**CPT** Visit Setting Unspecified: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99252-99255 ***with*** **POS:** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72
BH Outpatient Visit with Schizophrenia diagnosis	**CPT:** 98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015 **UBREV:** 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983
Partial Hospitalization or Intensive Outpatient	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** **POS:** 52 **HCPCS** Partial Hospitalization: G0410-G0411, H0035, H2001, H2012, S0201, S9480, S9484-S9485 **UBREV:** 0905, 0907, 0912, 0913
Community Mental Health Center Visit	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-39, 99252-99255 ***with*** **POS:** 53
Electroconvulsive Therapy	**CPT:** 90870 **ICD-10:** GZB0ZZZ-GZB4ZZZ
ED Visit	**CPT:** 99281-99285 **UBREV:** 0450-0452. 0456. 0459. 0981
Telehealth Visit	**CPT** Visit Setting Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255 ***with*** Telehealth **POS:** 02, 10
Telephone Visits	**CPT:** 98966-98968, 99441-99443
Online Assessments	**CPT:** 98970-98972, 98980, 98981, 99421-99423, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250-G2252
Long-acting Injections 14-day Supply	**HCPCS:** J2794
Long-acting Injections 28-day Supply	**HCPCS:** J0401, J1631, J1943, J1944, J2358, J2426, J2680
Long-acting Injections 30-day Supply	**HCPCS:** J2798

Ways Providers can Increase Performance

General Improvement Areas:

- Engage in shared decision making with the patient to ensure they are at the center of care. Before prescribing an antipsychotic medication, assess the patient's treatment and medication history
- Telephone, telehealth and online appointments count towards patients being included in the measure. Note: Two appointments are needed on different dates of service for patients to be part of the measure.
- Routinely arrange the next appointment when the client is in the office. If the client misses a scheduled appointment, staff should contact them within two hours of missed appointment to follow-up and reschedule.

Specific Clinical Care Improvement Areas:

- Long-Acting Injectable (LAI) Program- create a system to identify and proactively convert nonadherent patients to LAI's
- Pharmacy Synchronization- align refill dates for all meds to one pickup date per month
- Home Medication Delivery- work with pharmacies to deliver medications for patients with transportation barriers

MSHN
Mid-State Health Network

Background:

In accordance with the MSHN Board of Directors to review financials, at a minimum quarterly, the Preliminary Statement of Net Position and Statement of Activities for the Period Ending May 31, 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 May 31, 2026, as presented.

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

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		FY26 Original Budget			
			66.67%					
1		Revenue:						
2		Grant and Other Funding	$ 374,568	172,588	249,712	(77,124)	46.08 %	1a
3		Prior FY Medicaid Carryforward	$ 9,887,364	13,555,997	6,591,576	6,964,421		1b
4		Medicaid Capitation	814,257,869	566,099,207	542,838,580	23,260,628	69.52%	1c
5		Local Contribution	1,550,876	1,146,524	1,033,917	112,606	73.93%	1d
6		Interest Income	1,100,000	542,458	733,333	(190,875)	49.31%	1e
7		Non Capitated Revenue	18,218,063	10,903,128	12,145,376	(1,242,247)	59.85%	1f
8		Total Revenue	845,388,740	592,419,902	563,592,494	28,827,409	70.08 %	
9		Expenses:						
10		PIHP Administration Expense:						
11		Compensation and Benefits	9,072,517	5,526,331	6,048,346	(522,015)	60.91 %	
12		Consulting Services	130,000	8,215	86,666	(78,451)	6.32 %	
13		Contracted Services	114,400	72,644	76,267	(3,623)	63.50 %	
14		Other Contractual Agreements	570,900	381,403	380,600	804	66.81 %	
15		Board Member Per Diems	20,820	6,300	13,880	(7,580)	30.26 %	
16		Meeting and Conference Expense	99,280	41,705	66,187	(24,482)	42.01 %	
17		Liability Insurance	30,000	32,953	20,000	12,953	109.84 %	
18		Facility Costs	188,536	140,995	125,690	15,304	74.78 %	
19		Supplies	207,250	108,345	138,167	(29,822)	52.28 %	
20		Other Expenses	1,083,450	892,487	722,300	170,187	82.37 %	
21		Subtotal PIHP Administration Expenses	11,517,153	7,211,378	7,678,103	(466,725)	62.61 %	2a
22		CMHSP and Tax Expense:						
23		CMHSP Participant Agreements	715,270,064	503,221,014	476,846,710	26,374,304	70.35 %	1b,1c,2b
24		SUD Provider Agreements	65,677,623	40,115,099	43,785,082	(3,669,982)	61.08 %	1c,1f,2c
25		Benefits Stabilization	860,000	8,073,333	573,333	7,500,000	938.76 %	2d
26		Tax - Local Section 928	1,550,876	1,146,524	1,033,918	112,606	73.93 %	1d
27		Taxes- IPA/HRA	49,174,082	32,266,710	32,782,721	(516,011)	65.62 %	2e
28		Subtotal CMHSP and Tax Expenses	832,532,645	584,822,680	555,021,764	29,800,917	70.25 %	
29		Total Expenses	844,049,798	592,034,058	562,699,867	29,334,191	70.14 %	
30		Excess of Revenues over Expenditures	$ 1,338,942	$ 385,844	$ 892,627			

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

Row Numbers		A	B	C	D B + C	
			Column Identifiers			
1	**Assets**		**Behavioral Health Operating**	**Medicaid Risk Reserve**	**Total Proprietary Funds**	
2	**Cash and Short-term Investments**					
3	Chase Checking Account		15,723,260	0	15,723,260	1a
4	Chase MM Savings		14,027,387	0	14,027,387	
5	Savings ISF Account		0	13,539,202	13,539,202	1b
6	Savings PA2 Account		2,295,020	0	2,295,020	1c
7	Investment General Savings Account		29,999,543	0	29,999,543	1a
8	Investment PA2 Account		3,499,937	0	3,499,937	1c
9	Investment ISF Account		0	22,599,142	22,599,142	1b
10	Total Cash and Short-term Investments		$ 65,545,147	$ 36,138,344	$ 101,683,491	
11	**Accounts Receivable**					
12	Due from MDHHS		16,410,415	0	16,410,415	2a
13	Due from CMHSP Participants		(1,869,583)	0	(1,869,583)	2b
14	Due from Other Governments		441,221	0	441,221	2c
15	Due from Miscellaneous		347,974	0	347,974	2d
16	Total Accounts Receivable		15,330,027	0	15,330,027	
17	**Prepaid Expenses**					
18	Prepaid Expense Rent		4,529	0	4,529	2e
19	Prepaid Expense Other		12,553	0	12,553	2f
20	Total Prepaid Expenses		17,082	0	17,082	
21	**Fixed Assets**					
22	Fixed Assets - Computers		189,180	0	189,180	2g
23	Accumulated Depreciation - Computers		(189,180)	0	(189,180)	
24	Lease Assets		190,989	0	190,989	2h
25	Accumulated Amortization - Lease Asset		(177,716)	0	(177,716)	
26	Total Fixed Assets, Net		13,273	0	13,273	
27	**Total Assets**		**$ 80,905,529**	**$ 36,138,344**	**$ 117,043,873**	
28						
29	**Liabilities and Net Position**					
30	Liabilities					
31	Accounts Payable		$ 9,212,785	$ 0	$ 9,212,785	1a
32	Current Obligations (Due To Partners)					
33	Due to State		32,634,494	0	32,634,494	3a
34	Other Payable		4,768,874	0	4,768,874	3b
35	Due to Hospitals (HRA)		6,505,659	0	6,505,659	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		5,052,565	0	5,052,565	3f
39	Accrued PR Expense Wages		215,993	0	215,993	3g
40	Accrued Benefits PTO Payable		515,407	0	515,407	3h
41	Accrued Benefits Other		76,814	0	76,814	3i
42	Total Current Obligations (Due To Partners)		50,910,520	0	50,910,520	
43	Lease Liability		13,340	0	13,340	2h
44	Deferred Revenue		4,433,425	0	4,433,425	1b 1c
45	Total Liabilities		64,570,070	0	64,570,070	
46	Net Position					
47	Unrestricted		16,335,459	0	16,335,459	3j
48	Restricted for Risk Management		0	36,138,344	36,138,344	1b
49	Total Net Position		16,335,459	36,138,344	52,473,803	
50	**Total Liabilities and Net Position**		**$ 80,905,529**	**$ 36,138,344**	**$ 117,043,873**	

Mid-State Health Network
Financial Statement Notes
For the Eight-Month Period Ended,
May 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 Final MDHHS Financial Status Report (FSR) submitted in February 2026.

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. MSHN recently acquired investments using more than $29 M from funds in the savings account.
   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 $22.6 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) April and May 2026 Hospital Rate Adjustor (HRA) amounts account for 40% of the Due from State balance. HRAs are State Directed Payments and contractually required by MDHHS. In addition, withholds are also 37% 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	8,987,334.62	-	12,714,398.00	(3,727,063.38)
Central	529,107.44	5,615.64	804,564.00	(269,840.92)
The Right Door	3,340,734.35	-	2,966,420.00	374,314.35
Saginaw	13,024,009.05	15,287.02	11,456,539.00	1,582,757.07
Tuscola	1,452,073.95	-	1,281,824.00	170,249.95
Total	**27,333,259.41**		**29,223,745.00**	**(1,869,582.93)**

   c) Due from other governments account consists of Public Act 2 amounts owed from one county for FY 25 quarter four and FY 26 quarter two outstanding 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 35% and 65% (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 2027 Relias payments with a larger portion related to Box (MSHN's filing system).

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 $1.2 M for FY 2025 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. The State owes MSHN approximately $1.2 M for disbursement to Michigan's Treasury Department.
e) Due to State – Local Obligation has a negative balance as MSHN issued the full quarter three payment to MDHHS and is awaiting collection from one CMHSP for their portion.
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	6,359,085.88	-	4,662,967.00	1,696,118.88
Gratiot	2,295,587.84	(623.96)	1,874,242.00	420,721.88
Huron	1,800,973.45	-	1,293,372.00	507,601.45
Lifeways	1,022,193.84	-	(998,297.00)	2,020,490.84
Montcalm	432,752.69	(311.98)	662,968.00	(230,527.29)
Newaygo	322,636.24	-	378,105.00	(55,468.76)
Shiawassee	3,347,681.39	(4,055.74)	2,649,998.00	693,627.65
Total	**15,580,911.33**	**(4,991.68)**	**10,523,355.00**	**5,052,564.65**

g) Accrued Payroll Expense Wages represent expenses incurred in May and paid in June.
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 May paid in June.
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 are less than 66.67% translate to MSHN receiving less revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 66.67% 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 slightly lower than the budget, however this variance should lessen over the fiscal year as capitation revenue is trending sufficiently to cover ongoing operations and allows for additional investments purchases with available funding. (Please see Statement of Net Position 1a and 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. There are two items containing significant variances:
        - Compensation and benefits line is significantly under budget. MSHN is currently evaluating staffing levels to ensure they are appropriate to conduct MDHHS contractual obligations.
        - 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. Currently two CMHSPs have received $7.5 M.
    e) IPA/HRA actual tax expenses are lower than the budget through May. 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 GENERAL SAVINGS INVESTMENTS
As of May 31, 2026

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Change in market value	Chase Savings Interest	Interest - Accrued	Prior period interest - (Info Only added to col H total)	Interest Earnings (Information Only)	Total Chase Balance
UNITED STATES TREASURY BILL	912797TZ0	2.10.26	2.11.26	6.9.26		29,999,542.58	29,999,542.58							
JP MORGAN INVESTMENTS							29,999,542.58		-		-			29,999,542.58
JP MORGAN CHASE SAVINGS							14,026,370.01	0.020%		1,016.93				14,027,386.94
							$ 44,025,912.59		$ -	$ 1,016.93	$ -	$ -	$ -	$ 44,026,929.52

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 INTERNAL SERVICE FUND INVESTMENTS
As of May 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	2,528,000.00			
UNITED STATES TREASURY BILL	912797TG2						(2,528,000.00)			
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	20,177,000.00			
UNITED STATES TREASURY BILL	912797SM0						(20,177,000.00)			
UNITED STATES TREASURY BILL	912797SA6	4.6.26	4.7.26	10.1.26			2,599,386.42			
UNITED STATES TREASURY BILL	912797UU9	4.21.26	4.23.26	8.18.26			19,999,755.54			
JP MORGAN INVESTMENTS							22,599,141.96			22,599,141.96
JP MORGAN CHASE SAVINGS							13,283,778.61	0.020%	255,423.17	13,539,201.78
							$ 35,882,920.57		$ 255,423.17	$ 36,138,343.74

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

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

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

MID-STATE HEALTH NETWORK
SCHEDULE OF PA2 SAVINGS INVESTMENTS
As of May 31, 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	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	3,532,000.00			
UNITED STATES TREASURY BILL	912797RT6						(3,532,000.00)			
UNITED STATES TREASURY BILL	912797TZ0	2.10.26	2.12.26	6.9.26		3,499,937.29	3,499,937.29			
JP MORGAN INVESTMENTS							3,499,937.29			3,499,937.29
JP MORGAN CHASE SAVINGS							2,291,595.36	0.010%	3,424.69	2,295,020.05
							$ 5,791,532.65		$ 3,424.69	$ 5,794,957.34

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 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
July 2026

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	FY 2026 ORIGINAL CONTRACT AMOUNT	FY 2026 TOTAL CONTRACT AMOUNT	INCREASE/ (DECREASE)
MDHHS CONTRACT					
Michigan Department of Health & Human Services (EGrAMS)	Prevention	10.1.25 - 9.30.26	**$ 2,190,162**	**2,220,647**	**30,485**
	SUD - Administration	10.1.25 - 9.30.26	**$ 582,086**	**551,601**	**(30,485)**
	Treatment and Access Management	10.1.25 - 9.30.26	**$ 6,416,823**	**6,866,823**	**450,000**
	SUD - Women's Specialty Services	10.1.25 - 9.30.26	**$ 929,872**	**479,872**	**(450,000)**
			$ 10,118,943	**$ 10,118,943**	**$ -**

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, May 5, 2026
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 the Board Member Conduct Policy noted on the agenda. Mr. Woods welcomed Mike Smith and Jack Stapleton to the board who have been appointed by Huron Behavioral Health and also welcomed Dwight Washington and Jason White appointed from Community Mental Health Authority of Clinton, Eaton, and Ingham Counties. Mr. Woods welcomed Sara Lurie, Chief Executive Officer of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties and Bryan Krogman, Executive Director of Community Mental Health for Central Michigan.

2. Roll Call

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

Board Member(s) Present: Greg Brodeur (Shiawassee), Patrick Conley (BABH), Ken DeLaat (Newaygo), David Griesing (Tuscola), Dan Grimshaw (Tuscola)-joined at 5:09 p.m., Tina Hicks (Gratiot), John Johansen (Montcalm), Deb McPeek-McFadden (The Right Door), Irene O'Boyle (Gratiot), Kurt Peasley (Montcalm), Joe Phillips (CMH for Central Michigan), Linda Purcey (The Right Door), Pam Schumacher (BABH), Mike Smith (Huron), Jack Stapleton (Huron), Dwight Washington (CEI), Jason White (CEI), Joanie Williams (Saginaw), and Ed Woods (LifeWays)

Board Member(s) Remote: None

Board Member(s) Absent: Cindy Garber (Shiawassee), Tracey Raquepaw (Saginaw), Kerin Scanlon (CMH for Central Michigan) and Lori Schultz (Newaygo)

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

Public Present: Sara Lurie, Chief Executive Officer of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties and

3. Approval of Agenda for May 5, 2026

Board approval was requested for the Agenda of the May 5, 2026, Regular Business Meeting.

MOTION BY KURT PEASLEY, SUPPORTED BY JACK STAPLETON, FOR APPROVAL OF THE AGENDA OF MAY 5, 2026 REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

4. Public Comment

There was no public comment.

5. FY2025 Audit Presentation

Ms. Christina Schaub, from Roslund, Prestage and Company presented the financial audit of MSHN for fiscal year 2025. The opinion rendered by Roslund, Prestage and Company is that MSHNs financial statements present fairly, in all material respects, the respective financial position of the business-type activities, each major fund, and the aggregate remaining fund information of the Pre-paid Inpatient Health Plan (PIHP), as of September 30, 2025, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America. This opinion is the highest level available. Mr. Ed Woods thanked Ms. Schaub and the team at Roslund, Prestage and Company for their ongoing assistance with MSHN financial audits. Mr. Woods also wished to thank Ms. Leslie Thomas for her work in ongoing integrity in leading the financial management of MSHN along with the CMHSPs. Ms. Schaub expressed appreciation on behalf of Roslund, Prestage and Company to Ms. Leslie Thomas and the Finance team for being well prepared for the audit every year. Mr. Joe Sedlock also acknowledged Leslie Thomas and the team for their daily work attending to the financial details and integrity of the organization.

MOTION BY KEN DeLAAT, SUPPORTED BY DEB McPEEK-McFADDEN, TO RECEIVE AND FILE THE FY2025 AUDIT REPORT OF MID-STATE HEALTH NETWORK COMPLETED BY ROSLUND, PRESTAGE AND COMPANY. 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
  - PIHP Competitive Procurement Lawsuit Updates

- Ruling on Motion to Reconsider
- Ruling on Defendant's (State of Michigan) Motion to Dismiss Due to Mootness

- PIHP Lawsuit – FY25 Contract
- Performance Bonus Incentive

- State of Michigan/Statewide Activities
  - House Panel Adopts Behavioral Health Report
  - Testimony of some providers before the House Oversight Committee on Child Welfare

7. Deputy Director's Report

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

- MSHN Board Committee Meetings Update
- Annual Disclosure of Ownership, Controlling Interest, and Criminal Convictions
- Innovations in Behavioral Health Update
- Quality Assessment and Performance Improvement Plan (QAPIP)

MOTION BY TINA HICKS, SUPPORTED BY PATRICK CONLEY, TO RECEIVE AND FILE THE FY2026 MSHN QAPIP WORKPLAN STATUS UPDATE FOR THE PERIOD ENDING APRIL 30, 2026, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

Ms. Ittner presented an overview of the FY2025 Network Adequacy Assessment to board members. Mr. Woods acknowledged Ms. Ittner and all others involved in compiling this very complex information. Ms. Amanda Ittner passed along appreciation to the Community Mental Health Service Programs for their support in providing data for the Network Adequacy Assessment.

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 March 31, 2026.

MOTION BY PATRICK CONLEY, SUPPORTED BY TINA HICKS, TO RECEIVE AND FILE THE PRELIMINARY STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDED MARCH 31, 2026, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

9. Contracts for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2026 contract listing provided in the board 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 DAVID GRIESING, SUPPORTED BY KURT PEASLEY, 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. Chairperson's Report

Chairperson Woods, Ms. Amanda Ittner, and Mr. Joe Sedlock expressed gratitude to board members that have served on the board for ten consecutive years, and each were presented with a plaque in acknowledgement of appreciation from MSHN. The board members recognized were Tina Hicks and Joe Phillips. Kerin Scanlon will be recognized at the July board meeting.

Mr. Woods addressed new board member comments from the Board Self-Assessment results presented at the March 2026 meeting.

Mr. Woods asked board members for their input on future board meeting locations, date, and time. Members agree to keep the current location and meeting schedule.

Mr. Woods asked for a volunteer to act as a voting delegate for the Community Mental Health Association (CMHA) Member Assembly Meeting coming up at the Summer Conference on June 8, 2026, in Traverse City. Mr. Patrick Conley will be the delegate for MSHN. MSHN Administration will provide Mr. Conley's name to CMHA.

11. 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 IRENE O'BOYLE SUPPORTED BY KURT PEASLEY, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE MARCH 3, 2026 BOARD OF DIRECTORS MEETING; RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF FEBRUARY 20, 2026; RECEIVE BOARD OFFICER BRIEFING NOTES OF APRIL 17, 2026, RECEIVE SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD MEETING MINUTES OF FEBRUARY 18, 2026; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF FEBRUARY 23, 2026 AND APRIL 20, 2026. MOTION CARRIED UNANIMOUSLY.

15. Other Business

There was no other business.

16. Public Comment

There was no public comment

17. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 6:28 p.m.

MSHN
Mid-State Health Network

Mid-State Health Network Board Officer Briefing
by Executive Leadership
Notes

Friday, June 12, 2026 - 9:00 a.m.

OFFICERS PRESENT: Ed Woods, Chairperson; Irene O'Boyle, Vice-Chairperson; Deb McPeek-McFadden, Secretary; Kurt Peasley, Member at Large; David Griesing, Member at Large
OFFICERS ABSENT:
OTHERS PRESENT: Kevin Collins; Ken DeLaat
STAFF PRESENT: Amanda Ittner, Deputy Director; Joseph Sedlock, Chief Executive Officer
STAFF ABSENT:

Purpose: *The purpose of this meeting is for MSHN Executive Leaders to brief the MSHN Board Officers on recent events, current operations, and future plans.*

1. **Welcome and Introductions:** Vice-Chairperson O'Boyle welcomed everyone to this Executive Leadership briefing, which began at 9:00 a.m.

2. **Public Comments:** None

3. **MSHN Executive Leadership Briefing Topics:**

   3.1. Planned Agenda for the July 7, 2026 Board Meeting: The draft board meeting agenda prepared by administration was presented.
   3.2. FY 27 Board Meeting Calendar: The draft FY 27 board meeting calendar prepared by administration was presented. There are two proposed adjustments to the normal first Tuesday meeting pattern: If the normal pattern is followed, the November 2026 board meeting falls on election day, which MSHN has historically tried to avoid, and the second is the July 2027 meeting due to proximity to the national holiday and high vacations during that week. MSHN Administration will be recommending at the board meeting that both these board meetings occur one week later as noted on the draft calendar.
   3.3. MDHHS Competitive Procurement of PIHPs – Updates: Officers were briefed by Deputy Director Amanda Ittner that the state has not released any information on a successor request for proposals to the one rescinded due to legal problems earlier this year. In our communications with the State, MSHN executive leadership either gets no response or even acknowledgement of our communications about it or told directly that '"we can't talk about it." This includes not being willing to inform us of their plan to contract with us for FY 27.
   3.4. Litigation Update(s): MSHN has joined the other five litigants to appeal unfavorable or unclear rulings in the procurement related lawsuit. In the lawsuit not involving MSHN regarding elements of FY 25 contracts that four PIHPs redlined and signed but MDHHS did not, oversimplified the court rule that those PIHPs were not entitled to a contract for that year if it was not mutually agreed to. However, the court is inviting discovery on the merits of the underlying legal issues in those proposed contracts. Discovery is in process and evidentiary hearings will not be scheduled until after discovery concludes.

3.5. Overview of Fraud, Waste, and Abuse Risk Management Activities: Summary of activities was included in the meeting packet. Focus is primarily on readiness for and prevention of risk under the increased federal focus on these areas, including areas where we interact with the Michigan Department of Health and Human Services Office of the Inspector General (OIG). This is informational, and will also be touched on when MSHN presents the compliance plan for approval at the July board meeting.

3.6. Inter-Regional Dialogs: A delegation of CMHSPs in the MSHN region are meeting with a delegation of CMHSPs from another region to explore options for collaboration, especially in joint operations under a future bid award scenario.

3.7. Strategic Planning: Strategic planning was suspended last year and the current plan extended due to the procurement-related activities, the passage or HR 1 and the impacts on Medicaid, and surrounding state and federal chaos. MSHN Administration intends to restart our regular strategic planning process in the fall, which will likely impact the May board meeting – which is usually a full day strategic planning session followed by a regular board meeting.

3.8. Other: MSHN held its all-staff summer meeting yesterday in Lansing.

4. **Public Comments:** None

5. **Concluding Comments:** Ms. O'Boyle reminded members that the next scheduled Board Officer Briefing Meeting will be 08/21/2026, 9:00 a.m. and thanked MSHN leadership and Board Officers for attending this briefing meeting, which ended at 9:28 a.m.

Mid-State Health Network (MSHN) Board Policy Committee Meeting
Tuesday, May 5, 2026
MyMichigan Medical Center
Meeting Minutes

Members Present: John Johansen, Tina Hicks, David Griesing, Kurt Peasley, Irene O'Boyle

Members Absent: None

1. **Call to Order**

   Mr. John Johansen called this meeting of the Mid-State Health Network Board Policy Committee to order at 4:00 p.m.

2. **Public Comment**

   There was no public comment.

3. **Approval of Agenda for May 5, 2026**

   Board approval was requested for the Agenda of the May 5, 2026, Board Policy Committee Meeting.

   MOTION BY KURT PEASLEY, SUPPORTED BY TINA HICKS, FOR APPROVAL OF THE AGENDA OF MAY 5, 2026 BOARD POLICY COMMITTEE MEETING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

4. **New Policy for Review**

   Mr. Johansen invited Ms. Amanda Ittner to provide background information for the creation of the new Application Programming Interface Policy under the Information Technology chapter included in the Policy Committee packet.

   Board members offered no feedback or edits to the new policy under review.

   MOTION BY IRENE O'BOYLE, SUPPORTED BY DAVID GRIESING, TO RECOMMEND THE NEW POLICY UNDER REVIEW TO THE BOARD OF DIRECTORS, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

5. **Policies Under Review**

   Mr. Johansen invited Ms. Ittner to provide a review of the substantive changes to the policies under review from the Compliance Chapter included in the Policy Committee packet.

   Board Members suggested the Disqualified Individuals Policy be revised to shorten the policy, moving the details into the procedure and recommends the revised policy be presented to the board at the July 2026 meeting.

MOTION BY IRENE O'BOYLE, SUPPORTED BY TINA HICKS, TO RECOMMEND THE COMPLIANCE POLICY UNDER REVIEW BE REVISED AND TO PRESENT THE REVISED POLICY TO THE BOARD OF DIRECTORS. MOTION CARRIED UNANIMOUSLY.

Mr. Johansen invited Ms. Ittner to provide a review of the substantive changes to the policies under review from the Customer Service Chapter included in the Policy Committee packet.

Members asked to have the sentence in Item #3D of the Advance Directives policy re-worded to provide clarity and to adjust the spacing in the definitions section of the same policy.

MOTION BY DAVID GRIESING, SUPPORTED BY TINA HICKS, TO RECOMMEND THE CUSTOMER SERVICE POLICIES UNDER REVIEW TO THE BOARD OF DIRECTORS, AS REVISED AND PRESENTED. MOTION CARRIED UNANIMOUSLY

6. **FY2026 Policy Committee Meeting Calendar**

Policy Committee members reviewed the FY2026 meeting calendar.

MOTION BY KURT PEASLEY, SUPPORTED BY IRENE O'BOYLE, TO APPROVE THE FY2026 POLICY COMMITTEE MEETING CALENDAR, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

7. **New Business**

Policy Committee Members favor receiving a hard copy of the meeting packet in advance of the scheduled meetings. Administration will mail the members a hard copy of the packet following distribution of the electronic packet for their review prior to the meeting.

Committee members raised the question of receiving a Per Diem payment for their time spent reviewing the policies in preparation for a meeting. Administration will process a per diem for each member on the date the packet is released to the members for their review.

Ms. Amanda Ittner reviewed the policy and procedure review schedule for calendar years 2026 and 2027.

8. **Public Comment**

There was no public comment.

9. **Adjournment**

The MSHN Board Policy Committee Meeting adjourned at 4:19 p.m.

Mid-State Health Network SUD Oversight Policy Advisory Board
Wednesday, April 15, 2026, 4:00 p.m.
CMH Association of Michigan (CMHAM)
507 S. Grand Ave.
Lansing, MI 48933

Meeting Minutes

1. Call to Order

Chairperson Bryan Kolk called the MSHN SUD Regional Oversight Policy Board (OPB) of Directors Meeting to order at 4:01 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 and also provided a reminder that only one vote is allowed per county for those counties that have the member and alternate present.

Board Member(s) Present:	Irene Cahill (Ingham), Jacob Gross (Clare), John Hunter (Tuscola), Bryan Kolk (Newaygo), Karen Link (Huron), Jim Moreno (Isabella), Pamela Schumacher (Bay), Kim Thalison (Eaton), Mike Visnaw (Gladwin), Dwight Washington (Clinton), and Ed Woods (Jackson)
Board Member(s) Remote:	Emily Rayburn (Gratiot)-Ithaca, MI and Rachel Vallad (Arenac)-Standish, MI
Board Member(s) Absent:	Bruce Caswell (Hillsdale), Christina Harrington (Saginaw), Charlean Hemminger (Ionia), Charlie Mahar (Montcalm), Alaynah Smith (Midland), Jerrilynn Strong (Mecosta), and David Turner (Osceola)
Alternate Member(s) Present:	Christa Merritt (Montcalm)
Alternate Member(s) Remote:	Nicole Fickes (Clinton)-Laingsburg, MI-arrived at 4:05 p.m.
Staff Members Present:	Amanda Ittner (Deputy Director), Dr. Trisha Thrush (Director of Substance Use Disorder Services and Operations), Sarah Andreotti (Prevention Administrator), and Sherry Kletke (Executive Support Specialist)
Staff Members Absent:	Leslie Thomas (Chief Financial Officer) and Dr. Dani Meier (Chief Clinical Officer)
Staff Members Remote:	Joe Sedlock (Chief Executive Officer), Sarah Surna (Prevention Specialist)

2. Roll Call

   Mr. Dwight Washington 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 April 15, 2026

   Board approval was requested for the Agenda of the April 15, 2026 Regular Business Meeting, as presented.

   MOTION BY JOHN HUNTER, SUPPORTED BY IRENE CAHILL, FOR APPROVAL OF THE APRIL 15, 2026 REGULAR BUSINESS MEETING AGENDA, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

4. Approval of Minutes from the February 18, 2026 Regular Business Meeting

   Board approval was requested for the draft meeting minutes of the February 18, 2026 Regular Business Meeting.

   MOTION BY PAM SCHUMACHER, SUPPORTED BY IRENE CAHILL, FOR APPROVAL OF THE MINUTES OF THE FEBRUARY 18, 2026, MEETING, AS PRESENTED. MOTION CARRIED UNANIMOUSLY.

5. Public Comment

   There was no public comment.

6. Board Chair Report

   Mr. Bryan Kolk announced new member Alaynah Smith and alternate member Jeanette Snyder both have been appointed from Midland County but unfortunately were not able to attend today's meeting. Mr. Kolk also offered well wishes to Jerri Strong who is recovering from surgery.

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:

   - Michigan Department of Health and Human Services (MDHHS) Prepaid Inpatient Health Plan (PIHP) Procurement Update
   - Provider Network Adequacy Assessment – FY25
   - Utilization Management and Access Department Update
   - FY25 Fiscal Review of Prevention and State Opioid Response Funds

8. Chief Financial Officer Report

   Ms. Amanda Ittner provided an overview of the financial reports included in board meeting packets:

   - FY2026 PA2 Funding and Expenditures by County

- FY2026 PA2 Use of Funds by County and Provider
- FY2026 Substance Use Disorder (SUD) Financial Summary Report of February 2026

9. SUD Operating Update

Dr. Trisha Thrush provided an overview of the written SUD Operations Report, highlighting the below and referenced the FY26 Q1 SUD County reports, both included in the board meeting packet:

- MPDS System has opened
- Updated Annual Planning Documents for FY27
- Prevention Conference May 6-7, 2026 in Frankenmuth
- Response to Proposed Changes to LARA SUD Administrative Rules
- Development of the FY27 Treatment Annual Plan
- Continued Implementation of the MDHHS Recovery Incentive Pilot
- Equity Upstream Status Report and Learning Collaborative Implementation Guide and Checklist

10. Other Business

There was no other business.

11 Public Comment

Board members provided information on community activities in their counties.

12. Board Member Comment

Board members provided a reminder of the Prevention Conference and if interested in attending to contact Sarah Andreotti, MSHN Prevention Administrator.

13. Adjournment

Chairperson Bryan Kolk adjourned the MSHN SUD Oversight Policy Advisory Board Meeting at 4:38 p.m.

Meeting minutes submitted respectfully by:
MSHN Executive Support Specialist

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 05/18/2026

Members Present: Chris Pinter; Ryan Painter; Carol Mills; Julie Majeske; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; Bryan Krogman; Sandy Lindsey; Sara Lurie, Jeff Labun, Cassie Watson

Members Absent:

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

Agenda Item	Action Required				
CONSENT AGENDA	Items received, no discussion				
	N/A	By Who	N/A	By When	N/A
SAVINGS ESTIMATES	L. Thomas reviewed the savings estimates through March 2026. • 61m surplus • 21m ISF contribution – ending ISF 57m 7.1% • 40m savings (5%) – no lapse to MDHHS Question on other PIHP's • One deficit, two with ISFs • Plan to discuss at next PIHP CFO meeting				
	Informational	By Who	N/A	By When	N/A
INTER-REGIONAL DIALOGS-	J. Sedlock reviewed the May 20 agenda for the "inter-regional dialog" with another PIHP, with goals to ensure consistency, transparency, standardization and opportunities for alignment. CMHSPs in both regions are interested in addressing provider and beneficiary concerns. T. Warner discussed her objective to align elements, such as standardized contracts, network application, and request MSHN staff lead that effort in applicable council/committee meetings. MSHN convene meetings with providers (jointly used by type) in the region to discuss their concerns and receive feedback that would improve standardization. MSHN should also review our current state of concerns and pain points. Messaging to providers should inform them of background, why and goals of the meeting/survey. This message can come from CMHs.				
	J. Sedlock will coordinate and lead this effort.	By Who	J. Sedlock	By When	7.1.26
BALANCED SCORECARD	A.Ittner reviewed the FY26 balanced scorecard inclusive of all council and committees as well as SUDHH and BHH for selected key performance metrics through March 2026. Some data is not available if utilized from cc360 – claims lag.				

Agenda Item	Action Required				
	Informational	By Who	N/A	By When	N/A
CONFLICT FREE ACCESS AND PLANNING • **NEED TO ESTABLISH A PROCESS FOR ENGINEERING UTILIZATION MANAGEMENT SYSTEMS**	J. Sedlock indicated he thinks we can convene a workgroup to develop a process to be in compliance with the non-delegation of UM in the Waivers/HCBS. To define Utilization Management at the managed care level vs service (CMH) role… building off the work already in process WSA, retrospective reviews, outliers, etc. First step to work on definition: Cassie, Chris, Kerry, Michelle, Julie. Sandy is concerned about the separation of service planning/delivery. CEI and BABH reviewing separation of CLS/Residential. Also concerned about CCBHC which requires both. Consideration for "Only wiling and qualified provider".				
	MSHN will schedule a first meeting in June.	By Who	J. Sedlock	By When	6.15.26
PIHP PROCUREMENT DISCUSSION CONTINUATION/UPDATES (IF ANY) • **MSHN OPERATIONS REVIEW/REINSTATEMENT** • **LAWSUIT/RULING UPDATES/DISCUSSION, IF ANY** • **PROCUREMENT UPDATES/DISCUSSION, IF ANY** • **FUTURE PLANNING DISCUSSION, IF ANY**	J. Sedlock provided updates. MSHN suspended/pause project review has been reviewed with most items now reinstated outside of hiring. Appeal file on May 13, 2026.				
	Informational	By Who	N/A	By When	N/A
MICHIGAN HOUSE OF REPRESENTATIVES OVERSIGHT SUBCOMMITTEE ON CHILD WELFARE SYSTEM	C. Watson requested this agenda item, with another hearing after this one. CMH CEO meeting two weeks ago, discussed that while the subcommittee didn't call out MSHN directly, they requested we document written response that identifies the issues and how they are addressed in our region and why. Alan Bolter was meeting with Chair Meerman, and then going to address, given the second subcommittee meeting.				
	Wait to see what Association distributes.	By Who	N/A	By When	N/A

Agenda Item	Action Required				
HUMANA/HIDE-SNP CONNECTION WITH CMHSP REQUESTED	FY27 HIDE-SNP expands to our region and Humana is interested in meeting with the Ops Council. Request background information on HIDE-SNP and implementation plan (role delineation) from Humana prior to any meeting. If materials provided, then schedule for June/July.				
	J. Sedlock will follow up with Humana	By Who	J. Sedlock	By When	6.1.26
FY27 BUDGET	L. Thomas reviewed the request from last month's Ops Council regarding H.R.1 impacts. Too early to obtain expense information from CMHSPs for expenditures. Expect FY27 rates from MDHHS after the fiscal year start. Estimate enrollees and the trends. Estimate HMP reductions. Alan distributed Governor's plan to address HR1 impacts.				
	Discussion only	By Who	N/A	By When	N/A
MENTAL HEALTH FRAMEWORK	Discussion last week about MHPs contacting CMHSPs and their providers to obtain contracts. On Friday, MDHHS issued an email indicating the MHF has been temporarily paused indicating items identified will be addressed in the respective MHP/PIHP meeting. The PIHP meeting is scheduled for June 4.				
	Table further action until after the PIHP meeting.	By Who	J. Sedlock	By When	7.1.26
FOIA	CEI received a FOIA for all employees' salary information. If others receive, request to respond standardized.				
	No other CMHs received yet.	By Who	N/A	By When	N/A
Regional Inpatient Workgroup	J. Sedlock reported that the CFO's and prior workgroup participants desire to reconvene this group. Joe will send out previous participants for CEO's to confirm appointment.				
	J. Sedlock will send out member list. CMHs to confirm if change needed.	By Who	J. Sedlock	By When	6.1.26

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 06/15/2026

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

Agenda Item	Action Required				
CONSENT AGENDA	Update and clarification related to HIDE/SNP in our Region – Outreach from Health Plans occurring with CMHs.				
	Acknowledge receipt of consent items	By Who	N/A	By When	N/A
2026 COMPLIANCE PLAN • **CHANGE LOG**	Kim Z. presented the changes to the 2026 Compliance Plan via the change log. The changes reflect the revisions required by the Office of Inspector General related to the audit conducted on MSHN's policies and procedures. There were no findings, but recommendations expected to be resolved or would be a finding in the next year. OIG requires very detailed information in the plan.				
	Support to move to the Board of Directors for approval	By Who	7.3.26	By When	K.Zimmerman
CONFLICT FREE – PIHP UTILIZATION MANAGEMENT	Todd and Skye presented the background and summary related to current activities conducted by MSHN and the CMHSPs related to Utilization Management as well as recommendations for changes to ensure compliance with the current Waiver approvals and HCBS regulations for review and consideration by the smaller workgroup of Operations Council. What additional work does this mean for CMH staff? There may be a change in rural designation if "census" is now used for "only willing and qualified provider" MDHHS has not issued clarification on UM yet. WHODASS: What is happening there? A: Pilot with SHW and LifeWays that kicked off last Friday, going into September. After Pilot, all CMHs will be trained. FY27 will be a rolling implementation. MichiCANS: Barb Groom (MSHN) is tracking all CMHs and workgroups, that the decision support models are getting better but not there yet. CCBHC: CFAP for CCBHC enrollees – Where does UM restrictions and service planning/service delivery apply? MHC concerns related to CMH local control.				
	Cassie, Chris, Kerry, Michelle and Julie are on the subgroup to review this document, create next steps and recommendations to come back to Operations Council.	By Who	J. Sedlock / A.Ittner	By When	8.1.26

Agenda Item	Action Required				
	J. Sedlock will schedule subgroup meeting to review.				
REGIONAL PCE ENHANCEMENTS TO ADDRESS MICHICANS & AUTHORIZATIONS	Skye reviewed the summary of PCE programming changes and recommendations coming from UMC/CLC. • Standardized Children's Biopsychosocial (BPS) with integrated MichiCANS interface • Authorization Tracking Dashboards & Enhanced Authorization Denial Functionality				
	Operations Council supported exploring implementation of the two items above.	By Who	S. Pletcher	By When	8.1.26
INTER-REGIONAL DIALOGS (S. LINDSEY, B. KROGMAN, C. MILLS, C. WATSON, C. PINTER, M. STILLWAGON, A. ITTNER, J. SEDLOCK)	Joe S. reviewed the progress of the discussions occurring within the inter-regional dialog. See notes from meetings to be distributed once final. Q: Encourage expansion from small group to whole CEO group as schedules allow. Current participants include Sandy, Bryan, Chris, Carol, Michelle.				
	CMHs to email Sandy, Cassie and copy Joe if you wish to attend and participate.	By Who	CMHs	By When	ASAP
PROVIDER NETWORK "PAIN POINTS"	Joe S. reviewed the summary provided by Joe and Tammy to categorize provider network pain-points. 1. Lack of Standardization Across CMHs and PIHPs 2. Contracting and Administrative Burden 3. Rate Adequacy and Transparency 4. Communication and Operational Considerations Joe developed a survey to prioritize the work. Tammy felt this was a little overwhelming. The CMHAM did its own survey on similar issues. Tammy recommends we find some easy wins with recommendations. She is willing to consolidate it and provide some recommendations to implement.				
	Tammy will provide summary recommendations to CMHs via weekly meeting and/or Operations Council	By Who	T. Warner	By When	8.1.26
PIHP PROCUREMENT DISCUSSION CONTINUATION/UPDATES (IF ANY)	No updates. Nothing in SIGMA, nothing on websites. Summary of the meeting with contract managers was sent out to CMHs. MDHHS indicated they could not comment. Joe sent a direct email to Kristen Morningstar of which she didn't acknowledge receipt or respond.				
	Informational only	By Who	N/A	By When	N/A
HUMANA/HIDE-SNP CONNECTION WITH CMHSP REQUESTED	Carol requested information on how CMHs respond to requests from MHPs. Humana is coming to the August meeting.				
	Discussion only	By Who	N/A	By When	N/A

Agenda Item	Action Required				
MSHN PREDICTIVE MODELING GRANT IMPLEMENTATION	Carol shared concerns with the workload related to the predictive model project. Amanda reviewed the grant received, objectives and the ask for June – September. Operations Council members shared the concerns about staff time and availability. MSHN reiterated that our staff can support this effort.				
	Amanda will share via email the request with Operations Council.	By Who	A.Ittner	By When	6.20.26

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Information Technology**		
Title:	**Application Programming Interface Policy**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Information Officer	**Adopted Date:** 12.01.2025 **Review Date:**	**Related Policies:**

Purpose

The purpose of this policy is to ensure Mid-State Health Network (MSHN) is in compliance with the rules published by the Centers for Medicare and Medicaid Services (CMS) related to availability and use of the application programming interface as required by Michigan Department of Health and Human Services (MDHHS).

Policy

MSHN is committed to following the rules for implementing the Provider Directory Application Programming Interface (API) as specified in 42 Code of Federal Regulations (CFR) §438.10 and the Client Data API as specified in 42 CFR §431.60 and 42 CFR §438.242 MSHN will ensure all stored data elements identified in 45 CFR §170.213 also known as the United States Core Data for Interoperability (USCDI) are accessible via the API and in compliance with the requirements as defined by 42 CFR §438.10 and §431.60, including;

- Having client data available within 24 hours of MSHN receiving the data.
- Having provider directory data available within 30 days of MSHN receiving the data.
- Having instructions for both members and API programmers easily available.
- Staying current on the data elements that are required for each area.

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

API: Application Programming Interface
CFR: Code of Federal Regulations
CMS: Centers for Medicare and Medicaid Services
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
USCDI: United State Core Data for Interoperability

Other Related Materials

N/A

References/Legal Authority

N/A

Change Log:

Date of Change	Description of Change	Responsible Party
12.01.2025	New Policy	Chief Information Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Compliance		
Title:	**Disqualified Providers**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 10	**Review Cycle: Biennial** **Author:** Chief Compliance & Quality Officer	**Adopted Date: 07.09.2019** **Review Date:** ~~11.07.2023~~	**Related Policies:** Provider Network Management Disclosure of Ownership, Control, and Criminal Convictions; Credentialing/Recredentialing

Purpose

To ensure individual providers are eligible to participate in federal and state health care programs (e.g.: Medicaid and Medicare) and are not excluded from participation based on federal and state regulations.

Policy

MSHN and its provider network shall not employ, contract with, authorize services for, reimburse services for, or seek reimbursement for services delivered, prescribed, or ordered by any individual if:

1. The individual has received a criminal history screening indicating a mandatory disqualifying conviction identified in 42 USC 1320a-7(a);
2. The individual has been the subject of a substantiated finding; or
3. The individual has direct access, or provides direct services, to program participants in a prescribed setting (inpatient hospital and specialized residential) and the individual has received a criminal history screening indicating a time-limited disqualifying conviction for which the time limitation has not yet been satisfied (MCL 20173a, MCL 330.1134a, MCL 400.734b).
4. The individual does not possess the appropriate/required degree, certification, training, etc. to perform their job functions.

~~**Reporting:**~~

~~1. All employees, directors, administrators, managers, and individuals with any other type of employment or consulting arrangement with MSHN are required to report the following to Human Resources within five (5) days of conviction or assessment imposition:~~

~~a. Any criminal conviction, felony or misdemeanor; and/or~~
~~b. The imposition of civil money penalties or assessments imposed under Subsection 1128A of the Social Security Act (Exclusion Regulations https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm).~~

~~2. Criminal conviction resulting in disqualifications are to be disclosed to MSHN's Compliance Officer by the CMHSP participants and MSHN direct contracted entities with regard to those offenses as detailed in Subsections 1128(a) and 1128(b)(1), (2), of (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under Subsection 1128A of the Act. The report to MSHN will be made within 15 business days of the discovery of the disqualification through electronic submission.~~

~~3. MSHN will notify, as required, the appropriate regulatory body that may include the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation and Contracts, Licensing and Regulatory Affairs (LARA) and the Office of Inspector General (OIG) when disclosures are made by providers regarding any offenses detailed in Subsections 1128(a) and 1128(b) (1), (2) or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under Subsection 1128A of the Act.~~

Mandatory and Time-Limited Disqualifications:

The tables below identify disqualifications for participation in a provider capacity in Medicare, Medicaid or any other Federal health care programs.

The following table applies to all personnel at MSHN and the Provider Network.

Disqualifications related to the Social Security Act, subsections 1128(a), 1128(b)(1), (2), and (3); 1128A; Title V, XX, XXI, XVII, and XIX; MCL 333.18263; 42 USC 1320a—7(a); Medicaid Provider Manual (General Information for Providers: Section 6—Denial of Enrollment, Termination and Suspension)
Mandatory Disqualifications Persons with the following convictions are Excluded from participating in Medicare and State health care programs
1. Any criminal convictions related to the delivery of an item or service under Medicare (Title XVIII), Medicaid (Title XIX) or other state health care programs (e.g., Children's Special Health Care Services, Healthy Kids), (Title V, Title XX, and Title XXI).
2. Any criminal convictions under federal or state law, relating to neglect or abuse of patients in connection with the delivery of a health care item or service.
3. Felony convictions occurring after August 21, 1996, relating to an offense, under federal or state law, in connection with the delivery of health care items or services or with respect to any act or omission in a health care program (other than those included in number 1 above) operated by or financed in whole or in part by any federal, state, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
4. Felony convictions occurring after August 21, 1996, under federal or state law, related to unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
5. The provider is convicted of violating the Medicaid False Claims Act, the Health Care False Claims Act, a substantially similar statute, or a similar statute by another state or the federal government.
6. The provider is excluded from participating in a provider capacity in Medicare, Medicaid or any other Federal health care programs.
7. Termination on or after January 1, 20112011, under Medicare or the Medicaid program, or the Children's Health Insurance Program (CHIP) of any other state.
Disqualifications related to the Medicaid Provider Manual (General Information for Providers: Section 6—Denial of Enrollment, Termination and Suspension)
Time-Limited Disqualifications Time Requirement*: 10 Years The provider has a federal or state felony conviction within the preceding 10 years of their provider enrollment application, including but not limited to, any criminal offense related to:
1. Murder, rape, abuse or neglect, assault, or other similar crimes against persons
2. Extortion, embezzlement, income tax evasion, insurance fraud, and other similar financial crimes
3. The use of firearms or dangerous weapons
A felony conviction of theft.
4. Any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
Disqualifications related to the Medicaid Provider Manual (General Information for Providers: Section 6—Denial of Enrollment, Termination and Suspension)
Time-Limited Disqualifications Time Requirement*: 5 Years The provider has a federal or state misdemeanor conviction within the preceding five years of their provider enrollment application, including but not limited to, any criminal offense related to:
1. Any misdemeanor crime listed as a permissive exclusion in 42 USC 1320a-7(b);
2. Rape, abuse or neglect, assault, or other similar crimes against persons;
3. Extortion, embezzlement, income tax evasion, insurance fraud, or other similar

financial crimes;
A misdemeanor conviction of theft.
4. Any misdemeanor that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

Applied Behavioral Analysis Technicians and Specialized Residential Settings

The following tables include additional disqualifications that apply to all staff working in a Specialized Residential Setting (adult foster care homes) and Applied Behavioral Analysis Technicians (ABA Techs). That includes an individual that has direct access, or provides direct services, to program participants in a prescribed setting and the individual has received a criminal history screening indicating a time-limited disqualifying conviction for which the time limitation has not yet been satisfied.

Disqualifications related to MCL 333.20173a, MCL 330.1134a and MCL 400.734b
Time-Limited Disqualifications **Time Requirement*: 15 years**
1. A felony that involves the intent to cause death or serious impairment of a body function, that results in death or serious impairment of a body function, that involves the use of force or violence, or that involves the threat of the use of force or violence
2. A felony involving cruelty or torture.
3. A felony under chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r (Vulnerable Adults chapter). https://www.legislature.mi.gov/(S(sigap145p0xoam2bb0t0lkxrp))/documents/mcl/pdf/mcl-328-1931-XXA.pdf
4. A felony involving criminal sexual conduct.
5. A felony involving abuse or neglect.
6. A felony involving the use of a firearm or dangerous weapon.
7. A felony involving the diversion or adulteration of a prescription drug or other medications.
Time-Limited Disqualifications **Time Requirement*: 10 years**
1. Convicted of a felony or attempt or conspiracy to commit felony, other than those described under the mandatory and the 15-year time limited disqualifications sections.
Time-Limited Disqualifications **Time Requirement*: 10 years**
1. A misdemeanor involving the use of a firearm or dangerous weapon with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence.
2. A misdemeanor under chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r (Vulnerable Adults chapter).
3. A misdemeanor involving criminal sexual conduct.
4. A misdemeanor involving cruelty or torture unless otherwise provided under the 5-year time limited disqualification section.
5. A misdemeanor involving abuse or neglect.
Time-Limited Disqualifications **Time Requirement*: 5 years**
1. A misdemeanor involving cruelty if committed by an individual who is less than 16 years of age.
2. A misdemeanor involving home invasion.
3. A misdemeanor involving embezzlement.

4. A misdemeanor involving negligent homicide or a violations of section 601d (10 of the Michigan vehicle code, 1949 PA 300, MCL 257.601d.
5. A misdemeanor involving larceny unless otherwise provided under the 1-year time limited disqualification section.
6. A misdemeanor of retail fraud in the second degree unless otherwise provided in the 1-year time limited disqualification section.
7. Any other misdemeanor involving assault, fraud, theft, or the possession or delivery of a controlled substance unless otherwise provided in the 1, 3, and 10-year time limited disqualifications sections.
Time-Limited Disqualifications **Time Requirement *: 3 years**
1. A misdemeanor for assault if there was no use of a firearm or dangerous weapon and no intent to commit murder or inflict great bodily injury.
2. A misdemeanor of retail fraud in the third degree unless otherwise provided under the 1-year time limited disqualification section.
3. A misdemeanor under part 74 (MCL 333.74 offenses related to controlled substances) unless otherwise provided under the 1-year time limited disqualification section.
Time-Limited Disqualifications **Time Requirement*: 1 year**
1. A misdemeanor under part 74 (MCL 333.74 offenses related to controlled substances) if the individual, at the time of conviction, is under the age of 18.
2. A misdemeanor for larceny of retail fraud in the second or third degree if the individual, at the time of the conviction, is under the age of 16.

*** Time requirement means the time required for completing all terms and conditions of sentencing, parole, and probation for the conviction prior to the date of application for employment or clinical privileges.**

Applies to

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

Definitions

A. **Behavioral Health**: refers to individuals with a Mental Health, Intellectual Developmental Disability and/or Substance Use Disorder or children with Serious Emotional Disturbances
B. **BHDDA:** Behavioral Health and Developmental Disabilities Administration
C. **CMHSP:** Community Mental Health Service Provider
D.A. **Conviction:** For purposes of the laws mentioned above, an individual or entity is considered to have been convicted of a criminal offense when:
1. A judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court, regardless of whether there is an appeal pending:
2. A finding of guilt against the individual or entity by a federal, state, tribal or local court,
3. A plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, tribal or local court.

E.B. **Direct Access:** Means access to an individual, an individual's property, or an individual's personal financial information (checking account information, credit cards, bank statements, etc.).
F. **LARA:** Licensing and Regulatory Affairs
G. **MDHHS:** Michigan Department of Health and Human Services
H.C. **MSHN:** Mid-State Health Network
I. **OIG:** Office of Inspector General

~~J. **Personnel:** For purposes of this policy, "personnel" means, employees, contractors, volunteers, interns, and any other staff.~~

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

~~L. **Subcontractors:** refers to an individual or organization that is directly under contract with a CMHSP to provide services and/or supports.~~

Other Related Materials

Medicaid Service Administration (MSA) Policy Bulletin 18-09: Home Help Agency Provider Standards

References/Legal Authority

42 U.S.C 1320a-7
Michigan Mental Health Code - MCL 330.1134a Public Health Code - MCL 400.734b
Michigan Public Health Code - MCL 333.20173a Public Health Code -MCL 333.18263
42 CFR 441.570
1128 A of the Social Security Act
1128 B of the Social Security Act
Medicaid Provider Manual: General Information for Providers: Section 6 – Denial of Enrollment, Termination and Suspension
Senate Bill No. 184 (revisions to ABA technician exclusions in the Michigan Public Health Code)
Attachment A: Excluded Convictions Worksheet

Change Log:

Date of Change	Description of Change	Responsible Party
04.25.2019	New Policy	Director of Compliance, Customer Service & Quality
09.2019	Updates based on Medicaid Provider Manual Revisions	Director of Compliance, Customer Service & Quality
10.2019	Added clarification for substantiated recipient rights complaints	Director of Compliance, Customer Service & Quality
12.2019	Added clarification for reporting disqualifications to MSHN and for substantiated recipient rights complaints	Director of Compliance, Customer Service & Quality
08.2021	Bi-Annual Review; Updated references; Added language consistent with Medicaid Provider Manual; added reference on staff qualifications	Chief Compliance and Quality Officer
08.2023	Biennial Review; Updates under "Reporting" section	Chief Compliance and Quality Officer
01/16/2026	Revised to include changes to the Medicaid Provider Manual	Chief Compliance and Quality Officer
06/2026	Removed procedural tasks to a new procedure	Chief Compliance and Quality Officer

Attachment A

Lookback Periods:

Reference the date of conviction in relation to the date of application or enrollment (i.e., within X years preceding the date of application/enrollment)

An exception is felonies for Specialized Residential Staff and ABA Techs, which are in reference to the date of completion of "all of the terms and conditions of his or her sentencing, parole and probation for that conviction".

An individual or entity is considered to have been convicted of a criminal offense when:

a judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending;

there has been a finding of guilt against the individual or entity by a federal, state, tribal or local court; or

a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, tribal, or local court.

(for behavioral technicians) a final conviction, the payment of a fine, a plea of guilty or nolo contendere if accepted by the court, or a finding of guilt for a criminal law violation or a juvenile adjudication or disposition by the juvenile division of probate court or family division of circuit court for a violation that if committed by an adult would be a crime.

The MSHN network providers are responsible for reviewing and verifying provider disqualifications within the sources provided. Sources below include additional details and descriptions of crimes that may fall into similar categories that may not be listed on the grid below.

Enrolled All Medicaid Prov.

CHECK	Automatic Disqualificatio ns	Law or Rule Reference
☐	Termination on or after Jan 1, 20112011, under Medicare, Medicaid or Children's Health Insurance Program (CHIP) of any other state	A
☐	Exclusion from participation in a provider capacity in Medicare, Medicaid or any other Federal health care programs	A
☐	Any conviction rRelated to the delivery of an item/service under Medicare or Medicaid or any state health care program.	A, C
☐	Any conviction related to patient abuse/neglect in connection with delivery of a health care item or service	A, C
☐	Any felony conviction relating to and offense in connection with the delivery of healthcare items or services or with respect to any act or omission in a health care program (other than those listed above) operated by or financed in whole or part by federal, state, local government agency consisting of fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.	A, C
☐	Felony conviction related to controlled substance – unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.	A
☐	Conviction for violating Violation of the Medicaid False Claims Act, the Health Care False Claims Act, a substantially similar statute, or a similar statute by another state or the federal gov't	A

☐	Failure to Comply w Enrollment & Screening Requirements: Failure to submit timely and accurate information; cooperate with MDHHS screening methods; submit sets of fingerprints as required within 30 days of a CMS or MDHHS request; permit access to provider locations for site visits; and/or comply with Medicaid policies regarding submission of claims and billing Medicaid beneficiaries. Falsification of information provided on the enrollment application or subsequent information requests. Inability to verify their identity	A, B

All Medicaid Prov.			Additional Req'ts for ABA Techs/Specialized Residential			
CHECK	Felony	Misdemeanor	Felony	Misdemeanor		Law or Rule Reference
☐	w/in 10 yrs	w/in 5 yrs			Any conviction that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.	A, D
				w/in 1 year	Subject to an order or disposition of not guilty by reason of insanity	D, H
Related to fraud, theft, embezzlement, breach of fiduciary responsibility, financial misconduct						
	After Aug. 21, 1996	After Aug. 21, 1996			Related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct [related to government programs]: in connection with the delivery of a health care item or service; OR	A, C
	After Aug. 21, 1996	After Aug. 21, 1996			with respect to any act or omission in a health care program (other than Medicaid & Medicare) operated by or financed in whole or in part by any Federal, State, or local government agency; OR	A, C
		After Aug. 21, 1996			with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency	A, C
☐	w/in 10 yrs	w/in 5 yrs	w/in 15 yrs after completion of parole/ probation		Extortion, theft, income tax evasion, insurance fraud, and other similar financial crimes	A, D
	w/in 10 yrs	w/in 5 yrs	w/in 15 yrs after completion of parole/ probation	w/in 5 yrs	Embezzlement	A, D
☐				w/in 5 yrs Larceny- if committed when <16 yrs, then w/in 1 yrw/in 5 yrs	Larceny, fraud or theft not otherwise addressed in this section.	D
☐				w/in 5 yrs. if committed when <16 yrs, then w/in 1 yr	Retail Fraud in the 2nd Degree	D
☐				w/in 3 yrs. if committed when <16 yrs old, then w/in 1 yr	Retail Fraud in the 3rd Degree	D

				w/in 5 yrs	Fraud or theft not otherwise addressed in this list	D
				w/in 5 yrs	Home invasion	D
					Subject to an order or disposition of not guilty by reason of insanity	D, H
	w/in 10 yrs		w/in 15 yrs after completion of parole/ probation		Murder	A, D
				w/in 5 yrs	Negligent homicide or a moving violation that is proximate cause of death of another person or serious impairment of body function	D, G

Enrolled All Medicaid Prov.			Additional Req'ts for ABA Techs/Specialized Residential			
CHECK	Felony	Misdemeanor	Felony	Misdemeanor		Law or Rule Reference
Abuse, Assault, Crimes related to harming others/Endangerment						
☐	w/in 10 yrs		w/in 15 yrs after completion of parole/ probation		Murder	A, D
☐				w/in 5 yrs	Negligent homicide or a moving violation that is proximate cause of death of another person or serious impairment of body function	D, G
☐	w/in 10 yrs		Includes attempts/ conspiracy to commit; w/in 15 yrs after parole/ probation	w/in 10 yrs*	Use of firearms or dangerous weapons *Additional info for misdemeanors for ABA Techs: …with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence	A, D
☐			Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation		Involving intent to cause death or serious impairment of a body function, that results in death or serious impairment of a body function, that involves the use of force or violence, or that involves the threat of the use of force or violence.	D
☐			Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation	w/in 10 yrs. if committed when <16 yrs old, then w/in 5 yrs	A felony involving crueltyCruelty or torture	D
☐	w/in 10 yrs	w/in 5 yrs	w/in 15 yrs after completion of parole/ probation	w/in 5 yrs. if no weapon and no intent to murder/ inflict great bodily injury, w/in 3 yrs	Assault or other similar crimes against persons	A, D
☐	w/in 10 yrs	w/in 5 yrs	Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probationw/in 15 yrs after completion of parole/ probation	w/in 10 yrs	Rape or other similar crimes against persons involving criminal sexual conduct	A, D

			Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation	w/in 10 yrs	Involving criminal sexual conduct	D
☒					Related to neglect or abuse of patients in connection with the delivery of a health care item or service.	A, C
☐	w/in 10 yrs	w/in 5 yrs	Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation	w/in 10 yrs	Abuse or neglect	A, D
☐			Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation	w/in 10 yrs	Substantiated finding of neglect, abuse, or misappropriation of property by a state or federal agency (regarding long term care facilities)related to chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r: Caregiver who intentionally causes serious physical harm or serious mental harm to a vulnerable adult Reckless act or reckless failure to act ofthe caregiver or other person with authority over the vulnerable adult causes serious physical harm or serious mental harm An operator/employee/individual acting on behalf of an unlicensed facility that is subject to licensure, who violates the adult foster care facility licensing act or public health code or rules and whose violation is a proximate cause of the death of a vulnerable adult Caregiver/person with authority over vulnerable adult or licensee convicted of felony due to repeated misdemeanor violations of the adult foster care licensing act regarding funds, retaliation against staff/ residents, obstruction, falsifying info, etc.	D, E

Enrolled All Medicaid Prov.			Additional Req'ts for ABA Techs/Specialized Residential			
CHECK	Felony	Misdemeanor	Felony	Misdemeanor		Law or Rule Reference
					Substantiated finding of neglect, abuse, or misappropriation of property by a state or federal agency (regarding long term care facilities)	D, I
			Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation	w/in 10 yrs	Related to chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r: • Caregiver who intentionally causes serious physical harm or serious mental harm to a vulnerable adult • Reckless act or reckless failure to act of the caregiver or other person with authority over the vulnerable adult causes serious physical harm or serious mental harm • An operator/employee/individual acting on behalf of an unlicensed facility that is subject to licensure, who violates the adult foster care facility licensing act or public health code or rules and whose violation is a proximate cause of the death of a vulnerable adult • Caregiver/person with authority over vulnerable adult or licensee convicted of felony due to repeated misdemeanor violations of the adult foster care licensing act regarding funds, retaliation against staff/ residents, obstruction, falsifying info, etc.	D, E
Medication, Prescriptions, Controlled Substances						
☐	After Aug. 21, 1996	w/in 5 yrs		in 5 yrs. if committed when <18 yrs old, then w/in 1 yr	Relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance (Per MSA provider enrollment on 02/14/20 excludes possession)	A, C
☐				w/in 3 yrs. if committed when <18 yrs old, then w/in 1 yr	• Manufacturing, creating, delivering, or possessing with intent to manufacture, create, or deliver a controlled substance, prescription form, or counterfeit prescription form • Dispensing, prescribing, or administering controlled substance outside the scope of practice of a practitioner, licensee, or applicant	D, F
☐			Includes attempts/ conspiracy to commit; w/in 15 yrs after parole/ probation		A felony involving the diversionDiversion or adulteration of a prescription drug or other medications	D
☐				w/in 5 yrs	Possession or delivery of a controlled substance	D

					~~Failure to Comply w Enrollment & Screening Requirements: Failure to submit timely and accurate information; cooperate with MDHHS screening methods; submit sets of fingerprints as required within 30 days of a CMS or MDHHS request; permit access to provider locations for site visits; and/or comply with Medicaid policies regarding submission of claims and billing Medicaid beneficiaries. Falsification of information provided on the enrollment application or subsequent information requests. Inability to verify their identity~~	~~A, B~~

~~A = Michigan Medicaid Manual; General Information for All Providers; Section 6 – Denial of Enrollment, Termination and Suspension; 6.1 Termination or Denial of Enrollment B = Social Welfare Act, Public Act 280 of 1939 (MCL 400.111b -111e) and 42 CFR 455.416~~
~~C = 42 USC 1320a-7 Exclusion of certain individuals and entities from participation in Medicare and state health care programs D = Public Act 19 of 2020 (Public Health Code revision) Section 18263 regarding behavioral technicians~~
~~E = Chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r regarding vulnerable adults~~
~~F = Public Health Code 333.7401 "Part 74" regarding controlled substances~~
~~G = Michigan vehicle code, 1949 PA 300, MCL 257.601d~~
~~H = Code of Criminal Procedure MCL 769.16b regarding not guilty by reason of insanity I = 42 USC 1395i-3a: Protecting residents of long-term care facilities~~

POLICIES AND PROCEDURE MANUAL

Chapter:	**Customer Service**		
Title:	**Advance Directives**		
Policy: ☑ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 09.02.14 **Review Date:** ~~07.02.2024~~	**Related Policies:** Customer Service Policy

Purpose

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

Policy

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

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

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

3. MSHN Standards for Advance Directives shall ensure that the CMHSP Participants/SUD Provider Network:
   A. Provides adult beneficiaries with written information on advance directives at the time of initial enrollment;
   B. Supplies information that includes a description of applicable state law and rights under applicable laws;
   C. Document in a prominent part of the individual's current medical record whether or not the individual has executed an advanced directive;
   D. Do n~~N~~ot condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
   E. Continuously updates written information to reflect any changes in state law as soon as possible but no later than 90 days after it becomes effective; and
   F. Informs individuals that grievances concerning noncompliance with the advance

directive requirements may be filed with Customer Services.

Applies to:

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

Definitions:

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

Other Related Materials:

N/A

References/Legal Authority:

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

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer
11.2015	Annual Review	Director of Compliance, Customer Service and QI
11.21.2016	Annual Review	Customer Service Committee

12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review, addition of requirements	Customer Service Committee
03.16.2020	Annual Review, Reference/Legal Authority reference correction	Customer Service Committee
11.15.2021	Bi-annual Review, language added to meet contract requirements	Customer Service Committee
01.22.2024	Biennial Review, no changes	Customer Service Committee
01.26.2026	Biennial Review, no changes	Customer Service Committee

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Customer Service**		
Title:	**Customer Handbook**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 12.03.2013 **Review Date:** ~~07.02.2024~~	**Related Policies:** Customer Service

Purpose

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

Policy

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

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

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

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

at any time.

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

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

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

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

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

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

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

Applies to:

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

Definitions/Acronyms:

CFR: Code of Federal Regulations
CMHSP: Community Mental Health Service Program
CMS: Centers for Medicaid and Medicare
Customer: Refers to individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.
Customer Handbook: The handbook is a required set of information that must be provided to Medicaid beneficiaries at the start of treatment and at least annually.
Local Provider Directory: The Customer Handbook includes local CMHSP information, including the provider directory for that CMHSP county/counties of service

MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
SUD: Substance Use Disorder
SUD Provider Network: Refers to a SUD Provider that is directly under contract with the MSHN PIHP to provide services and/or supports.

References/Legal Authority:

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

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New policy	Customer Services Committee
12.08.14	Annual review, format consistency	Customer Services Committee and Chief Compliance Officer
11.2015	Annual Review	Director of Compliance, Customer Services & Quality Improvement
11.21.2016	Annual Review	Customer Service Committee
12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review, language revised to match Attachment P6.3.1 language	Customer Service Committee
11.15.2021	Bi-annual Review, language updates to match contract requirements	Customer Service Committee
01.22.2024	Biennial Review, language updates to match contract requirements	Customer Service Committee
01.26.2026	Biennial Review, minor updates	Customer Service Committee

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	Customer/Consumer Service		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 12.03.2013 **Review Date:** ~~07~~.~~02.2024~~	**Related Policies:** Customer Service

Purpose

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

Policy

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

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

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

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

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

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

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

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

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

H. Upon request, assist customers with problems and inquiries regarding benefits; with local complaint and grievance processes; and local appeal and fair hearings processes, including expected timelines;

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

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

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

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

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

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

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

Applies to:

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

Definitions/Acronyms:

CFR: Code of Federal Regulations
CMHSP: Community Mental Health Service Program
Consumer/Customer: Refers to individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably
EOB: Explanation of Benefits
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan

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

References/Legal Authority:

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

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New policy	Customer Services Committee
11.2015	Annual review, format consistency	Director of Compliance, Customer Services & Quality Improvement
11.21.2016	Annual Review	Customer Service Committee
12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review, language added to meet reference requirements	Customer Service Committee
11.15.2021	Biennial Review, language added to meet contract requirements	Customer Service Committee
01.22.2024	Biennial Review, language added to meet contract requirements, removed content is present in the MSHN LEP Policy	Customer Service Committee
01.26.2026	Biennial Review, no changes	Customer Service Committee

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Customer Service**		
Title:	**Enrollee Rights**		
Policy: ☑ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer; Customer Service Committee	**Adopted Date:** **Review Date:** ~~07.02.2024~~	**Related Policies:** Consumer Service Policy

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

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

Policy

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

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

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

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

3. Free exercise of rights.

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

4. Compliance with other Federal and State laws.

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

Applies to:

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

Definitions:

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

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Other Related Materials:

None

References/Legal Authority:

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

Change Log:

Date of Change	Description of Change	Responsible Party
03/16/2020	New policy	Director of Quality, Compliance, and Customer Service; Customer Service Committee
11.15.2021	Bi-annual Review, no recommended changes	Customer Service Committee
01.22.2024	Biennial Review, no significant changes	Customer Service Committee
01.26.2026	Biennial Review, no changes	Customer Service Committee

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Customer Service**		
Title:	**Information Accessibility/Limited English Proficiency (LEP)**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 4	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 07.01.2014 **Review Date:** ~~07.02.2024~~	**Related Policies:** Customer Service Policy

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

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

Policy

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

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

C. CMHSP Participants/SUD Provider Network will ensure:

~~1.~~ 1. All materials are available in language(s) appropriate to the people served within the Pre-Paid Inpatient Health Plan's (PIHP's) area for specific non-English languages that ~~is~~ are spoken as the primary language by more than 5% of the population in the PIHP's region. Such materials shall be available in any language

alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002, Federal Register Vol. 65, August 16, 2002).

~~2.~~ 2. All materials are available in alternative formats in accordance with the Americans with Disabilities Act (ADA).

~~3.~~ 3. Vital ~~W~~written materials critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, are available in the prevalent non-English language(s) within the service area and must include taglines, printed in a conspicuously-visible font size, explaining the availability of written translations or oral interpretation along with the toll-free telephone number of the entity providing services as required by 42 Code of Federal Regulations (CFR) 438.71(a) and 42 CFR 438.10(d)(2). ~~Taglines must be printed in a conspicuously-visible font size~~ Conspicuously visible is defined as a font greater than the minimum font size of 12 point, is not a large font, and is more pronounced than the adjacent font.

~~4.~~ 4. ~~Beneficiaries may access~~Written materials ~~in~~will use easily understood language and format, use a font size ~~with a minimum font of~~no smaller than 12 point~~ and~~, 6.9 reading level, and be available in large print ~~in a font size no smaller than 18 point~~.

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

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

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

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

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

I. The CMHSP Participants/SUD Provider Network must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic

backgrounds and those who are Deaf, Hard of Hearing, and Deaf and Blind. Treatment will be modified to effectively serve individuals who are deaf, hard of hearing, and deaf and blind, ~~as determined by~~based on their language skills and preferences.

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

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

Applies to:

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

Definitions:

ADA: Americans with Disabilities Act.
CFR: Code of Federal Regulations
CMHSP: Community Mental Health Service Program
Communication: The effective transmission of messages using spoken language, Braille, American Sign Language, or available technology as necessary.
Consumer/Customer: Refers to individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.
Interpretation: The oral transmittal of a message from one language to another, considering dialect, culture, and nuance.
Limited English Proficiency (LEP): Means being limited in the ability or unable to speak, read, and/or write the English language well enough to understand and be understood without the aid of an interpreter.
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Pre-paid Inpatient Health Plan
Population/Service Area: Includes any Medicaid beneficiary who may potentially receive services from MSHN and its provider network.
Prevalent: means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

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

Other Related Procedures:

N/A

References/Legal Authority:

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

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New policy	Chief Compliance Officer
04.2016	Annual Review/Update	Customer Service & Recipient Rights Specialist
11.21.2016	Updated according to MDHHS/PIHP contract	Customer Service Committee
12.18.17	Annual Review	Customer Service Committee
12.03.18	Annual Review, additional language added	Customer Service Committee

03.16.2020	Annual Review, additional language added, edit to conform to definitions	Customer Service Committee
11.15.2021	Bi-annual Review, updated language from contract	Customer Service Committee
05.15.2023	Policy updates to include updated language from the PIHP contract	Customer Service Committee
01.22.2024	Biennial review, no changes	Customer Service Committee
01.26.2026	Biennial review, revisions due to language changes from the PIHP Customer Service Standards	Customer Service Committee

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POLICIES AND PROCEDURE MANUAL

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

Purpose

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

Policy

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

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

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

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

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

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

6. Complaints should be resolved at the level closest to service delivery when possible, but information regarding access to all complaint resolution processes will be provided to the Medicaid Enrollee;
7. With the written consent from the Enrollee, the right to have a provider or other authorized representative acting on the Enrollee's behalf file an Appeal or Grievance or request a State

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

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

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

Applies to:

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

Definitions:

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

a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. *42 CFR 438.400 (b)(1).*
b. Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2).*
c. Denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD. *42 CFR 438.400(b)(3).*
d. Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. *42 CFR 438.210(d)(1*).
e. Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. *42 CFR 438.210(d)(2).*
f. Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP. *42 CFR 438.400(b)(4).*
g. Failure of the PIHP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).*
h. Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).*
i. Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of

the date of the request. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

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

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

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

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

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

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

CFR: Code of Federal Regulations

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

CMHSP: Community Mental Health Service Program

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

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

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

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

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

MDHHS: Michigan Department of Health and Human Services

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

MSHN: Mid-State Health Network

Notice of Resolution: Written statement of the PIHP of the resolution of a Grievance or Appeal, which must be provided to the Enrollee as described in *42 CFR 438.408*.

PIHP: Prepaid Inpatient Health Plan.

Recipient Rights Complaint: Written or verbal statement by ~~a~~an Enrollee, or anyone acting on behalf of the Enrollee, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Service Authorization: PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210.*

State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

SUD: Substance Use Disorder

SUD Provider Network: Refers to a SUD Provider that is directly under contract with PIHP MSHN to provide services and/or supports

Other Related Procedures:

N/A

References/Legal Authority:

The following federal and state statutes establish the standards for MSHN's Appeals and Grievance procedures for Medicaid Recipients:

1. 42 CFR 438.10: Information Requirements
2. 42 CFR 431.200 Fair Hearings
3. 42 CFR 438.400 Appeals and Grievances
4. State of Michigan/PIHP Contract: Schedule 1. General Requirements, L. Grievance and Appeals Process for Beneficiaries
5. State of Michigan/PIHP Contract attachment: Appeals and Grievances Technical Requirements (P.6.3.1.1)
6. Michigan Mental Health Code (MHC) MCL 330.1772 (Recipient Rights Complaints)
7. Michigan Mental Health Code (MHC) MCL 330.1705 (Medical Second Opinion)

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New policy	Chief Compliance Officer
04.2016	Annual Review/Formatting Update	Customer Service and Rights Specialist
11.21.2016	Annual Review, language edition	Customer Service Committee
10.16.2017	Annual Review, revised definitions	Customer Service Committee

12.3.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review	Customer Service Committee
11.15.2021	Bi-annual Review, updated language from contract	Customer Service Committee
01.22.2024	Biennial Review, no changes	Customer Service Committee
01.26.2026	Biennial Review, minor changes	Customer Service Committee

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POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	**Regional Consumer Advisory Council**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 5	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer, Customer Service Committee	**Adopted Date:** 12.03.2013 **Review Date:** ~~07.02.2024~~	**Related Policies:** Customer Service Policy

Purpose

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

Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Applies to:

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

Definitions/Acronyms:

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

References/Legal Authority:

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

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Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New Policy	Customer Service Committee
11.2015	Annual Review	Director of Compliance, Customer Services and QI
11.21.2016	Annual Review	Customer Service Committee
12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review	Customer Service Committee
11.15.2021	Bi-annual Review	Customer Service Committee
01.22.2024	Biennial Review, minor changes	Customer Service Committee
01.26.2026	Biennial Review, no changes	Customer Service Committee

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Customer Service**		
Title:	**Recipient Rights for Substance Use Disorder Recipients**		
Policy: ☑ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Compliance and Quality Officer; Customer Service Committee	**Adopted Date:** **Review Date: 07.02.2024**	**Related Policies:** Consumer Service Policy

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

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

Policy

1) A program shall have a policy and procedure to ensure compliance with recipient rights requirements as set forth in R 325.1391 to R 325.1399 of the Administrative Rules for Substance Abuse Program in Michigan. The recipient rights policies and procedures shall be reviewed at least annually to consider any revisions that might be necessary

2) A program's recipient rights policy and procedure shall address all ~~of~~ the following requirements:
   a) Require a program to identify a staff member to function as the program rights advisor who shall do all of the following:
      i) Attend training concerning recipient rights procedures.
      ii) Receive and investigate all recipient rights complaints.
      iii) Communicate directly with the Mid-State Health Network (MSHN) regional rights consultant when a complaint cannot be resolved at the program level.
   b) Outline the method of filling recipient requests to review, copy, or receive a summary of recipient treatment or prevention service case records.
   c) Provide simple mechanisms for notifying recipients of their rights, reporting apparent rights violations, determining whether in fact violations have occurred, and for ensuring that firm, consistent, and fair remedial action is taken in the event of a violation of these rules.

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

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

(6) As part of the admission procedure to a program, a recipient shall receive all of the following:

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

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

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

Applies to:

☒ All Mid-State Health Network Staff

☐ Selected MSHN Staff, as follows:

☒ MSHN's Affiliates: ☒ Policy Only ☐ Policy and Procedure

☒ Other: Sub-contract Providers

Definitions:

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

Other Related Materials:

Recipient Rights definitions found within Mich Admin Code. R 325.1301

References/Legal Authority:

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

MSHN
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Change Log:

Date of Change	Description of Change	Responsible Party
12/03/18	New policy	Director of Quality, Compliance, and Customer Service
03.16.2020	Annual Review; revisions to match Mich Admin Code revisions	Customer Service Committee
11.15.2021	Bi-annual Review, minor language updates	Customer Service Committee
01.22.2024	Biennial Review, language updates based upon changes in the Administrative Code	Customer Service Committee
01.26.2026	Biennial Review, minor language updates	Customer Service Committee