From the MSHN Board of Directors Chairperson

Edward Woods
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Michigan's Public Behavioral Health System Should Be Preserved – and Better Supported

Recently, some people within our state have suggested that Michigan should abandon its public specialty behavioral health managed care structure, led by regional entities known as "PIHPs" (Prepaid Inpatient Health Plans) and replace it with an Administrative Services Only (ASO) structure, as used in Connecticut.

In Michigan, PIHPs primarily ensure medically necessary services and supports are available and delivered to people with the most severe forms of mental illness, substance use disorders, and intellectual/developmental disabilities and are overwhelmingly financed by Medicaid. PIHPs do this through collaboration with Community Mental Health Services Programs and networks of providers across the regions they are responsible for. While not perfect, these organizations are lean, efficient, accountable, transparent, and effective. Hundreds of thousands of Michigan residents receive publicly managed, publicly funded, lifesaving, quality supports and services every single year.

The Connecticut ASO model does not come without complexities in terms of providing comprehensive care and bureaucratic hurdles for the agencies that interact with them. The experiences of Connecticut under their ASO model should make us slow down, take a breath, and analyze the comparative data of the two states before we make such a significant change in our state.

Connecticut's population is about 3.6 million and the geography is 5,000 square miles with 169 municipalities. In comparison, Michigan's population is a little over 10 million and large geographically as well as very diverse. Michigan has 96,713 square miles, 1,773 municipalities, and is the tenth largest state in population. I go into all these details because it is effective when figuring out a design for managing care across the state. So much

of Michigan is very rural and what works in the UP is likely not going to work in Detroit or the other population centers. Even if the system in Connecticut works well for them, it does not mean it would work well in Michigan.

The Connecticut Department of Mental Health decided to create local mental health authorities (LMHA's) to manage a system of services in specific geographical areas. Half of the LMHAs were private non-profits and half were state operated.

Connecticut's journey through the tumultuous 1990s, marked by the transition to capitated contracts and the later carve-out for behavioral health, serves as a cautionary tale. While Connecticut's system has seen some positive transformations, it is far from a utopia and is slowly migrating towards the loss of local control. Local control is a key characteristic of PIHPs that were created by the Community Mental Health Services Programs here in Michigan.
A brief breakdown of the Connecticut experience shows that in the early to mid-1990's all of Medicaid services were put out to bid under capitated contracts. Capitated contracts are financing methods where the entity is paid a standard rate, usually in advance, and must cover all medically necessary services and supports for all eligible beneficiaries.

At the time, there were 11 companies that did business in Connecticut. Most, if not all of them, contracted out for behavioral health benefits management which was carved out of the general medical benefit.

The result in Connecticut was an unmitigated disaster for behavioral health outpatient, inpatient and child residential, which was mostly Medicaid reimbursed at the time. There were high levels of service authorization denials, delayed payments to providers, provider rate reductions, inadequate funding, and many quality concerns. It took a lawsuit to stop it.

From about 1991 - 2005 lots of new services for adults with mental health conditions were funded with Connecticut state grant resources, not Medicaid. This is important, because, unlike Michigan, Connecticut's system is still heavily supported by state funding, not Medicaid. Also, unlike Michigan, which has one of the best behavioral health service arrays in the country, Connecticut's service array was primarily focused on outpatient, psychiatric inpatient, a tiny amount of case management, and a handful of other services. Connecticut has never maximized Medicaid as a source of funding like Michigan has. The Connecticut LMHAs are still in existence today, although they have not been adequately funded for a long time.

The current PIHP boards in Michigan are mostly made up of persons served, or their family members, individuals with lived experiences of mental health, developmental disabilities, and addiction issues along with other stakeholders (such as County Commissioners). These volunteers prove the importance of keeping local control and community-based services and solutions accessible where they live and work.

As we navigate the future of Medicaid and public behavioral health services, it is crucial to learn from these examples and advocate for policies that prioritize the well-being of the residents of our state and their unique circumstances, needs, and communities. As the chairman of a PIHP Board, I am concerned when I hear PIHPs blamed for things that are beyond their control, are not their responsibility, or that may be required of them by state and federal policies. Let us have a conversation about what the PIHPs are and how to improve them.

The public behavioral health system in Michigan is not now, nor should it become some ubiquitous health care ASO. Michigan's public behavioral health system is governed by persons with lived experience, committed to local service, accountable to our community members who worship together, shop at the same places, and attend high school football games together. Every PIHP board member has a story of why they do this work and those that criticize PIHPs are welcome to get more directly involved to learn about its value to the beneficiaries that we are blessed to serve. I challenge all involved parties to engage in beneficiary focused improvements and to work together to develop plans that work best in Michigan.

We are not conflicted in our interests! To the contrary – our highest priority interest is in ensuring that the best possible supports and services that the people in our communities need are available to them. Michigan's current PIHP boards are advocates for beneficiaries and we are committed to continuing this important work.

From the Chief Executive Officer's Desk

Joseph Sedlock

On February 28, 2025 the Michigan Department of Health and Human Services (MDHHS) issued a press release indicating a competitive procurement process for the state's Pre-Paid Inpatient Health Plan (PIHP) contracts. There was no prior communication with PIHPs about this, and there have been no official communications since. All that is known for sure is what was in the press release.

Bidder qualifications, including whether Mid-State Health Network (MSHN) can participate in the process, bid scale and operational requirements, and all other pertinent details are not known. Nonetheless, MSHN will be taking steps to position itself to successfully participate in the procurement process.

MSHN has a contract with MDHHS that must be fulfilled no matter the internal or external environment, especially in light of the uncertainties this announcement introduced. The past success of MSHN, and our future success, depends on our employees and our regional partners.

There are many important principles that have guided us over the past decade, and they will continue to guide our work through whatever this procurement process brings. We emphasize the following two principles:

- **Performance Matters!** MSHN has a long history of achieving high levels of performance against established standards and benchmarks, of leading a variety of initiatives in our region and across the state

and achieving positive outcomes in our operations and for beneficiaries and communities in our 21-county region.

Our organization is committed to continued strong performance in all areas of operations and will continue to strive for excellence in all that the organization does, especially focusing on positive beneficiary and community impacts. The region will continue to focus on its mission, vision, performance, quality, and compliance.

- **Relationships Matter!** MSHN has a long history of effective collaboration and engagement with our MDHHS colleagues, with our Community Mental Health Service Program (CMHSP) participants, with our Provider Network, with other stakeholders, and with the communities within which we operate.

  Our organization is committed to continued effective collaboration and engagement across all areas of operations and will continue to create, develop, and maintain effective relationships with all stakeholders.

Our mission remains unchanged: to ensure access to high quality, locally-delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members.

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

NAMI Honors MSHN Board of Directors Chairperson Edward Woods

National Alliance on Mental Illness (NAMI) Michigan Honors is an annual black-tie gala held in honor of those who have made a difference in mental health. NAMI Honors seeks to turn attention to what works in Michigan's mental health system, and to shine a spotlight on exemplary individuals and organizations, who all too often do vital work that improves the lives of many people without receiving due recognition.

Edward Woods is serving his fifth consecutive term since 2015 as Board Chair of Mid-State Health Network. He is also the current Board Chair of the National Council for Mental Wellbeing (since 2023), impacting policy, supporting services to individuals as well as Diversity, Equity and Inclusion efforts.

In 2010 Mr. Woods was elected to serve as president of the Michigan Association of Community Mental Health Boards (which became Community Mental Health Association of Michigan [CMHA]), is an active member of the CMHA Executive committee and is Chairperson of the CMHA Cultural Diversity Committee.

Mr. Woods serves on local boards as well, being appointed to the Board of Directors for LifeWays in 1990 by the Jackson County Board of Commissioners for nine consecutive and has served on the local boards of the Jackson County, including: Chamber of Commerce, Jackson County Community Foundation, The Enterprise Group, Jackson Area Manufacturers Association, Jackson County Foster Care Review Board, National Association of Foster Care Reviewers, Allegiance Health Quality Council and Catholic Charities.

Mr. Woods dedication to the individuals served is evident in every conversation. He CARES about individuals and keeps that in front of every board and policy decision. He understands the complexity of Medicaid policy yet able to correlate the implications to individuals living with mental illness.

Personally, I've been impacted as the Deputy Director for MSHN by Ed beginning from early in my career back in 2000, observing his leadership and guidance, listening to his stories on how his own family members have been impacted by mental illness and deploying his strategies to encourage our coordination with Michigan legislation, national impacts on policy, and to always remember why we are here and the purpose of our calling to support whole health care!

He has supported Medicaid Expansion, Certified Community Behavioral Health Clinics, Sufficient Federal and State Funding, Value Based Care, Reducing Stigma and Supporting Diversity and Healthcare Equity, addressing not only Mental Illness but Social Determinates of Health and the related impact to mental wellbeing.

I'm amazed at his ability to be a VALUABLE member by participating in local, state and national boards, dedicating his time and resources to help lead change. Citizens of Jackson County, Mid-State Health Network, State of Michigan and National Council members know they can count on Ed!

Congratulations Chairperson Woods from all of us at Mid-State Health Network!

For those wishing to join in the celebration on **April 12, NAMI Michigan Honors 2025 tickets** can be purchased here: https://namimi.org/2025-nami-honors.

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

Information Technology

Steve Grulke
Chief Information Officer

Behavioral Health Treatment Episode Data Set (BH-TEDS) is a method of reporting data to the Michigan

Department of Health and Human Services (MDHHS). BH-TEDS is an event-based capture-recapture model, where data is collected at the point of admission, annual updates and at discharge.

Anyone with mental health (MH) or substance use disorder (SUD) services paid in whole or part with State Of Michigan administered funds will have a BH-TEDS record completed, with some exceptions such as Health Homes, Recovery Housing and Peer services.

Additional considerations
Every service start (admission) must have a service end (discharge). This is the basis for the "Dangling Admissions" data clean up report that MDHHS sends to Pre-paid Inpatient Health Plans (PIHPs) quite frequently. MDHHS also produces a "missing" BH-TEDS report based on encounters (services) submitted. This report (shown below) requires that each PIHP is 95% complete. Anything that is not green is less than allowed.

If any records get submitted with incorrect data, a change record should be reported to correct the wrong data.

Data Information
At admission, additional demographic data is collected such as birthdate, gender and social security number. Other types of data that are collected at both admission and discharge include marital status, living arrangements, diagnosis, arrest data, employment and wages and school information. These data points are utilized to assess positive or negative outcomes.

Some of the data fields are required by the federal government and some of the fields have been added by the State of Michigan for local capture only.

Submission
An admission and a discharge data file are required to be submitted to MDHHS at least monthly by the PIHP. When the file is processed by MDHHS, if there are any errors in what was submitted, they are sent back to the submitter to correct the issue and resubmit.

Latest Missing BH-TEDS report from MDHHS

FY25 MH Encounters w/BH-TEDS records

Encounters: 10/01/2024 - 01/31/2025 | BH-TEDS: 07/01/2023 - 03/17/2025

Region Name	Submitter ID	Distinct Count of Individuals With: Non-H0002 & Non-Crisis, Non-OBRA Assessment & Non-Transportation	Distinct Count of Individuals With: Non-H0002, Non-Crisis, Non-Health Home, Non-OBRA Assessment & Non-Transportation Encounters But NO BH-TEDS Record Since 07/01/2023	Current Completion Rate
CMH Partnership of SE MI	00XT	8,940	154	98.28%
Detroit/Wayne	00XH	46,192	2,563	94.45%
Lakeshore Regional Entity	00ZI	15,936	427	97.32%
Macomb	00GX	11,228	126	98.88%
Mid-State Health Network	0107	33,036	1,320	96.00%
NorthCare Network	0101	4,981	21	99.58%
Northern MI Regional Entity	0108	8,417	75	99.11%
Oakland	0058	19,802	274	98.62%
Region 10	0109	17,466	120	99.31%
Southwest MI Behavioral Health	0102	20,936	75	99.64%
Statewide		186,934	5,155	97.24%

Key

95.00+ = Compliant

90.00-94.99

85.00-89.99

<85.00

*Encounters = All MH encounters **excluding**: A0080, A0090, A0100, A0110, A0120, A0130, A0140, A0170, A0425, A0427, H0002, H2011, H2034, Q3014, S0209, S0215, S0280, S0281, S9484, T1023, T1040, T2001-T2005 ,90839, 90840, 99304-99310

FY25 Crisis Encounters w/BH-TEDS records

Encounters: 10/01/2024 - 01/31/2025** | BH-TEDS: 07/01/2023 - 03/17/2025

Region Name	Submitter ID	Distinct Count of Individuals With: Crisis Encounters	Distinct Count of Individuals With: Crisis Encounters But NO BH-TEDS Record Since 07/01/2023	Current Completion Rate
CMH Partnership of SE MI	00XT	1,287	12	99.07%
Detroit/Wayne	00XH	4,072	27	99.34%
Lakeshore Regional Entity	00ZI	3,045	141	95.37%
Macomb	00GX	747	21	97.19%
Mid-State Health Network	0107	4,837	241	95.02%
NorthCare Network	0101	723	3	99.59%
Northern MI Regional Entity	0108	1,459	32	97.81%
Oakland	0058	985	10	98.98%
Region 10	0109	1,519	8	99.47%
Southwest MI Behavioral Health	0102	1,698	0	100.00%
Statewide		20,372	495	97.57%

Key

95.00+ = Compliant

90.00-94.99

85.00-89.99

<85.00

**Encounters include H2011, S9484, T1023, 90839, 90840

FY25 SUD Encounters w/BH-TEDS records

Encounters: 10/01/2024 - 01/31/2025*** | BH-TEDS: 07/01/2023 - 03/17/2025

Region Name	Submitter ID	Distinct Count of Individuals With: Non-Health Home Encounters	Distinct Count of Individuals With: Non-Health Home Encounters But NO BH-TEDS Record Since 07/01/2023	Completion Rate
CMH Partnership of SE MI	00XT	1,783	4	99.78%
Detroit/Wayne	00XH	4,860	1	99.98%
Lakeshore Regional Entity	00ZI	3,337	95	97.15%
Macomb	00GX	2,200	7	99.68%
Mid-State Health Network	0107	5,078	92	98.19%
NorthCare Network	0101	848	17	98.00%
Northern MI Regional Entity	0108	1,864	45	97.59%
Oakland	0058	1,788	36	97.99%
Region 10	0109	3,008	22	99.27%
Salvation Army	002Y	234	47	79.91%
Southwest MI Behavioral Health	0102	2,881	171	94.06%
Statewide		27,881	537	98.07%

Key

95.00+ = Compliant

90.00-94.99

85.00-89.99

<85.00

***Encounters = All SUD encounters **excluding** H0002, H0038, H2034, S0280, S0281, & T1040

MHSN reviews this data when MDHHS reports it with the Community Mental Health Service Program Chief Information Officers to ensure the region is meeting the MDHHS standards.

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

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN's Chief Executive Officer, Deputy Director, and Chief Financial Officer conducted meetings with each Community Mental Health Service Program (CMHSP) to discuss the region's fiscal status including their contribution to that position. Based on early FY 25 indications, MSHN projects use of at least $24 M from its Internal Service Fund (ISF). If early indications hold, MSHN would nearly deplete the ISF and have no other means to manage risk (spending more than Per Eligible Per Month (PEPM) revenue). The meetings review each CMHSP's expense estimates, results of operations for the last four fiscal years, and discussion of cost containment strategies that will likely impact FY 25.

In addition to CMHSP meetings, the same MSHN staff met with Michigan Department of Health and Human Services (MDHHS) to discuss revenue concerns. MSHN presented a PowerPoint presentation which illustrated increased expenditures for Community Living Supports (CLS), Inpatient Hospitalization, and Autism services. While this meeting was specific to MSHN, Pre-paid Inpatient Health Plan (PIHP) Chief Financial Officers are also submitting fiscal data to MDHHS and working with Wakely Actuarial firm to provide feedback for the mid-year rate adjustments.

Lastly, MSHN's Finance Team is currently engaged with Roslund Prestage & Company (RPC) to complete work on MSHN's Fiscal Year (FY) 2024 Compliance Examination and Single Audit.

Compliance Examination - Compliance Examination Guidelines require that an independent Auditor examine compliance issues related to contracts between PIHPs and MDHHS to manage the Concurrent 1915(i)/(c) Medicaid, Healthy Michigan, and the Flint 1115 waiver. These Compliance Examination Guidelines, however, DO NOT replace or remove any other Audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. The main PIHP responsibilities associated with this exam are:

1. Maintain internal control over the Medicaid Contract that provides reasonable assurance that the PIHP is managing the contract in compliance with laws, regulations, and the contract provisions that could have a material effect on the contract.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not be limited to: the Medicaid Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.

In addition, MSHN's Compliance Examination completion is contingent on final CMHSP Compliance Examinations as any changes or updates from the region impact the PIHP's final report. Lastly, any adjustments/changes noted must have a plan in place to address moving forward.

Single Audit – PIHPs that expend $750,000 or more in Federal awards during the fiscal year must obtain a Single Audit in accordance with 2 Code of Federal Regulations (CFR) 200, Subpart F. This Audit must be performed by an independent Auditor, and in accordance with Generally Accepted Government Auditing Standards (GAGAS). Federal funds referenced for Single Audit are associated with MSHN's Block Grant dollars. In recent fiscal years, various expanded Block Grant categories have been introduced (some specifically related to the Public Health Emergency). Please Note: Medicaid and Healthy Michigan reviews are handled within MSHN's financial Audit.

We anticipate completion of both reviews by June 30, 2025.

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

Behavioral Health

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

Home and Community-Based Services Update

In July 2024, the Centers for Medicare & Medicaid Services (CMS) conducted a site visit to the Michigan Department of Health and Human Services (MDHHS). The purpose of the visit was to review several settings in Michigan that were recommended by advocates and the state. These settings were identified as potentially having institutional qualities that needed to be addressed to comply with home and community-based services (HCBS) criteria. During the visit, CMS met with state officials, case managers, service providers, and individuals receiving Medicaid HCBS. The discussions focused on the strategy for implementing regulatory criteria defining a home and community-based setting and how this strategy is carried out across the HCBS system. CMS had findings that were specific to the provider as well as findings that were to be applicable to the entire HCBS system (i.e., systemic). The systemic findings resulted in an MDHHS Corrective Action Plan (CAP) that all Pre-paid Inpatient Health Plan entities (PIHPs) must address.

None of the selected settings were within the Mid-State Health Network (MSHN) region, but CMS required that the systemic findings be applied to the whole state. These systemic corrections included updating policies and procedures where necessary. Findings in this category for updating policies and procedures related to pre-planning and person-centered planning activities, community activities, training, summary of resident rights, individual control of schedule, access to common areas of a setting, compliance with individual plan of service (IPOS) modification requirements, and PIHP annual review of residential setting policies. The systemic CAP continued with a required provider training to ensure that each setting and its staff received the HCBS Rule training at hire and annually, and finally, the MSHN region's case managers and supports coordinators were to receive the HCBS Rule training at hire and annually as well.

MSHN has completed its draft policy edits, and the provider training will be addressed by MDHHS. MDHHS requires the case manager training to be completed by the PIHP during the first year of implementation and MSHN's plans are already underway to complete these within the next one to three months. The following are all parts of the MSHN case manager training plan:

- The training is required at hire and annually, with updates to MDHHS on training status.
- Approximately 700 case managers across the 12 MSHN partner Community Mental Health Service Programs (CMHSPs) will be trained via 20 initial sessions.
- Per request, several of the CMHSP trainings will include Recipient Rights staff, Behavior Treatment teams, Quality teams, and supervisors, and MSHN plans to accommodate any additional staff that wish to attend.
- MSHN will encourage all case managers to attend, even if they are not currently providing home and community-based services.
- The CMHSPs requested that their training be specific to them, when possible, so MSHN is accommodating sessions for each CMHSP.
- MSHN has received the training materials from MDHHS and is in the process of scheduling training sessions, with a mix of in-person and virtual trainings, based on CMHSP request.
- Following the completion of the initial round of trainings, MSHN will offer a monthly virtual session that will be open for any new case management staff to register for and attend, thus ensuring there is not a delay in new staff receiving the required training.
- Upon completion of the first year of PIHP training, MSHN will ensure that each CMHSP has received the training necessary to independently implement the training for their respective organizations.

The CMS CAP will further strengthen the HCBS system in Michigan and ensure that individuals receiving HCBS services have full access to the benefits of community living and the opportunity to receive services in the least restrictive and most integrated setting.

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

Population Health and Integrated Care

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

The Opioid Health Home (OHH) initiative, launched in the MSHN region on October 1, 2022 with Victory Clinical Services in Saginaw as the sole OHH provider in the MSHN region during FY23. During FY24, five additional locations received approval and certification from MSHN and Michigan Department of Health and Human Services (MDHHS) including Victory Clinic Services in Jackson, Victory Clinic Services in Lansing, Recovery Pathways in Bay City, MidMichigan Community Health Services in Houghton Lake, and Isabella Citizens for Health in Mt. Pleasant.

Seeing positive outcomes from the OHH initiative, on October 1, 2024, MDHHS transitioned the OHH initiative to the Substance Use Disorder Health Home (SUDHH) initiative. This change expanded eligibility for services to individuals with an Opioid Use Disorder, Alcohol Use Disorder, and/or Stimulant Use Disorder who were also at risk of developing mental health conditions, asthma, diabetes, heart disease, Body Mass Index (BMI) over 25 or Chronic Obstructive Pulmonary Disease (COPD).

In connection with 2024-2025 MSHN Strategic Priorities, MSHN released a Request for Interest (RFI) during Quarter 1 of FY25 to gauge provider interest in becoming SUDHH certified to serve the expanded eligible population. MSHN received responses of interest from ten (10) providers expressing interest in expanding SUDHH services at fourteen (14) unique locations in the region.

The MSHN Integrated Health team conducted a thorough review and evaluation of the provider responses utilizing specific criteria such as:

- Provider will expand or increase access to Substance Use treatment services in underserved area(s)
- Projected beneficiary enrollment and projected service utilization volume
- Provider operates an established SUD HH at a different site/location with a demonstrated history of success
- Provider holds accreditation from a nationally recognizing body specific to a health home, patient-centered medical home, or integrated care [National Committee for Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), etc.]

As a result, the Integrated Health team will be working with three (3) providers to pursue SUDHH certification and implementation planning for potential expansion of (5) new locations. Providers will participate in technical assistance meetings with the MSHN Integrated Health team to ensure they are prepared to meet SUDHH program requirements.

MSHN will present SUDHH contract recommendations to the Board of Directors in May. If approved, the expanded SUDHH locations will increase access to services in underserved areas within the region aligning with current strategic priorities.

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

Substance Use Disorder Policy, Strategy and Equity

Dani Meier, PhD, LMSW, MA
Chief Clinical Officer

Imminent Federal Cuts to Veterans' Jobs & Services

Dr. Dani Meier, Chief Clinical Officer, &
Tammy Foster, Veteran Navigator (VN)

As a National Guard & Reserve state, Michigan has no large federal active-duty bases, resulting in Michigan service members, their families, and veterans often facing limited access to essential supports and resources.

MSHN's Veteran Navigator (VN) has been working with a 100% disabled veteran who we'll call Jack. He is 30 years old and lives in the MSHN region (Region 5) in a rural motel with his wife and dog. He has a substance use disorder (SUD) and has requested SUD treatment and dental care but has no available transportation. MSHN's VN helped provide him with a tablet to facilitate virtual appointments and virtual groups with the VA. In addition to significant delays in receiving services, however, his internet service is spotty at best, so appointments are often interrupted or cancelled. His dental needs remain unaddressed due to the ongoing transportation issues.

In addition to veterans like Jack who has requested specific services, Michigan Department of Health and Human Services (MDHHS) estimates roughly 200,000 Michigan veterans, service members, and individuals with military service records have *unidentified* needs for mental health (MH) and substance use disorder (SUD) treatment. Of this population, 70,000 are likely experiencing serious mental illness (SMI), while 130,000 are dealing with mild to moderate mental health challenges. This contributes to Michigan's veteran suicides, one every 49 hours, and to the national veteran suicide rate of over 17 per day.

The proposed recent federal reductions to the Department of Veterans Affairs (VA) and other veteran services will significantly escalate the risks to the health of these Michigan veterans. We can expect that substance misuse, suicide, unemployment and homelessness will increase.

Moreover, the federal government is the U.S.'s largest employer of veterans (veterans were 30% of the federal workforce in 2023, equating to over 600,000 individuals). The proposed federal reductions will result in job instability—if not unemployment—for hundreds of thousands of veterans. This shift will undermine the federal government's history of providing post-service employment opportunities that are crucial for veterans' transition to civilian life offering them a sense of purpose, community and financial stability. Job loss is also a leading contributor to veteran homelessness which in 2023 rose to over 35,574 in the U.S. and 1,657 in Michigan.

The proposed federal VA budget cuts are anticipated to reduce access to healthcare services for veterans like Jack, resulting in as many as *30 million fewer* outpatient wellness checks, cancer screenings, mental health support, and substance use disorder treatment. Additionally, these federal cuts would lead to the loss of 81,000 jobs within the Veterans Health Administration alone, further diminishing the quality and availability of care, again precipitating increased incidence of untreated mental health conditions, higher rates of suicide and substance misuse both among those veterans who are newly unemployed as well as veterans who depend on timely services from the VA.

Our state and our region faces a multifaceted threat to our already vulnerable veteran community. MSHN will continue to work on expanding awareness of the profound implications of these federal reductions and we encourage advocacy for policies that uphold the well-being and dignity of those who have served our nation, often at great cost to themselves and their families.

Resources:

- "*Ongoing Veteran and Military Family Challenges in the Walking With Warriors Veteran and Military Family Strategic Plan for 2025-2030*," published by MDHHS/Brian Webb, Brenda Stoneburner (March 2025) – Not on MDHHS website yet
- https://www.mentalhealth.va.gov/docs/data-sheets/2023/2023-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf
- https://ourpublicservice.org/fed-figures/a-profile-of-the-2023-federal-workforce/
- https://www.pbs.org/newshour/politics/trump-has-moved-to-slash-the-federal-government-heres-what-the-data-shows-about-its-workforce
- https://www.pbs.org/newshour/politics/trump-has-moved-to-slash-the-federal-government-heres-what-the-data-shows-about-its-workforce
- https://news.va.gov/126913/veteran-homelessness-increased-by-7-4-in-2023/
- https://www.michigan.gov/mvaa/news/2024/03/06/$2-million-in-state-grants-to-help-homeless-veterans

Contact Dani with questions, comments or concerns related to the above and/or MSHN SUD Treatment and Prevention at Dani.Meier@midstatehealthnetwork.org

Substance Use Disorder Providers and Operations

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

Michigan's Opioid Healing & Recovery Fund

The opioid epidemic has resulted in close to a million deaths in the U.S. since 1999. Because of the pharmaceutical and adjacent industries' role in precipitating the crisis, lawsuits have generated billions of dollars for states, counties and local governments. With the passage of MCL 12.253 in 2022, Michigan's state legislature established the Opioid Healing and Recovery Fund (OHRF) designed to manage the financial resources derived from opioid settlement funds. Approximately half of these settlement funds are channeled into the OHRF which are managed by the Michigan Department of Health and Human Services (MDHHS) while the other half is distributed directly to counties and municipalities and are intended to offer communities support to address the opioid epidemic.

In fiscal year 2025, MDHHS received $100 million for the OHR Fund, and designated $10 million for equal distribution among MSHN and the state's other nine Prepaid Inpatient Health Plans (PIHPs). The guidelines set by MDHHS were narrow (especially in contrast to the broader parameters allowed for counties and local municipalities). The categories for PIHP allocations were built around investment in community engagement and infrastructure focused on combating the impacts of opioid use.

MSHN has embraced its responsibility to utilize the $1 million grant effectively by fostering community collaboration and transparency. To generate insights from the MSHN region (Region 5) stakeholders, MSHN organized two virtual public listening sessions that attracted nearly 100 stakeholders from the 21 counties within Region 5. These sessions provided a platform for community members to voice their opinions and share their unique experiences related to opioid use and are posted on MSHN's website. These engagements helped inform the needs and gaps in services within the region. MSHN will continue hosting listening sessions throughout the fiscal year and will post recordings on our website along with links to additional relevant state and federal resources.

MSHN's commitment to transparency means that community members will have regular opportunities to provide feedback, ask questions, and stay informed about how the opioid settlement funds are being allocated. Furthermore, all upcoming sessions will be publicly announced on MSHN's website and communicated through various channels, making it easier for the community to engage.

To distribute Region 5's $1 million grant award in FY25, MSHN established a provider proposal process that detailed MDHHS' parameters for use of OHR funds. Upon receipt of multiple proposals, MSHN's Substance Use Disorder (SUD) Clinical Team did a thorough review to ensure compliance with MDHHS requirements, and then as an additional safety measure, MDHHS did their own review of proposals we approved. These allocations will be posted on MSHN's opioid transparency page as well.

Since 2015, MSHN has supported prevention, treatment and recovery of Substance Use Disorders (SUD)—and Opioid Use Disorders (OUD) in particular. Through the disbursement of the $1 million MSHN received in FY25, MSHN is also able to support infrastructure for long-term recovery for affected OUD-impacted individuals and families throughout MSHN's 21 counties.

Resources:

- MSHN Opioid Settlement Transparency page
- KFF Opioid Settlement Tracker
- KFF Opioid Settlements
- MDHHS List of Funded Projects
- MDHHS Opioid Settlement Homepage
- MI Attorney General Opioid Settlement Homepage
- Michigan Association of Counties (MAC) Opioid Settlement Resource Center
- NPR: Opioid Settlements

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

Quality, Compliance & Customer Service

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Chief Compliance and Quality Officer

Fiscal Year 2024 Quality Monitoring and Oversight Updates

The Michigan Department of Health and Human Services (MDHHS) provides monitoring and oversight to the Pre-Paid Inpatient Health Plans (PIHPs) through the completion of several reviews each year. Included are the external quality reviews completed by the Health Services Advisory Group (HSAG) and the MDHHS waiver reviews. These reviews look at compliance with activities required by the Balanced Budget Act of 1997 (BBA), Code of Federal Regulations (CFR) and contract requirements.

MDHHS Waiver Reviews

MDHHS conducted a full review for the MSHN region May - July 2024. The purpose of the review was to ensure compliance with state and federal requirements related to the Habilitation Supports Waiver (HSW), Waiver for Children with Serious Emotional Disturbance (SEDW), Children's Waiver Program (CWP), and 1915i SPA (iSPA). MDHHS reviewed 149 clinical records and a total of 868 staff files (236 professional staff and 632 aide-level staff).

HSW: Twenty-five (25) measures were reviewed related to charts and the following trends were identified:

- Increase in Compliance: 2 measures
- Maintained Compliance: 5 measures
- Decreased Compliance: 9 measures

CWP: Twenty-seven (27) measures were reviewed related to charts/files and the following trends were identified:

- Increase in Compliance: 7 measures
- Maintained Compliance: 5 measures
- Decreased Compliance: 3 measures

SEDW: Twenty-five (25) measures were reviewed related to charts/files and the following trends were identified:

- Increase in Compliance: 7 measures
- Maintained Compliance: 3 measures
- Decreased Compliance: 4 measures

iSPA: 2024 was the first year that iSPA was reviewed. There are no trends to report.

MSHN was required to submit a plan of correction for each finding. The plan of correction was approved by MDHHS on March 7, 2025, and a follow-up review will be scheduled to review the plan of correction implementation.

HSAG Encounter Data Validation (EDV)

HSAG conducted a validation of encounter data reported by PIHPs for the purpose of ensuring encounter documentation accurately reflects the provider rendered a specific service under a managed care delivery system.

HSAG reviewed 308 files that included approximately 616 encounters. Required documentation included demographic information, provider information, service date, diagnosis code, procedure code and procedure modifiers, and charts/visit notes.

An aggregated report for Michigan is expected to be sent directly to MDHHS.

HSAG Network Adequacy Validation (NAV)

In accordance with 42 CFR §438.358(b)(1)(iv), the EQR must include validation of MCO, PIHP, or PAHP network adequacy to comply with requirements set forth in §438.68.

The focus of the review included network adequacy data collection, integration, calculation, accuracy, and reporting of indicators for each required standard. Specifically, HSAG reviewed the logic used specific to the time and distance standard.

MSHN has received approval for our process of calculating time and distance. The final report for all the elements has not yet been received.

HSAG Performance Measure Validation (PMV)

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

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

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

- Data Integration and Control - Thirteen (13) Standards: 100%
- Denominator Validation - Seven (7) Standards (2 NA): 100%
- Numerator Validation - Five (5) Standards: 100%
- Performance Measures - Fourteen (14) Measures Fully Validated: 100%

HSAG Compliance Review

The Compliance Site Review is conducted over a period of three (3) years. FY2024 was year one of the review cycle and included review of five (5) of the thirteen (13) standards. The review took place on August 26, 2024.

MSHN achieved an overall compliance score of 85%.
Standard I - Member Rights and Member Information: 76%
Standard III – Availability of Services: 100%
Standard IV- Assurances of Adequate Capacity and Services: 100%
Standard V- Coordination and Continuity of Care: 93%
Standard VI – Coverage and Authorization of Services: 68%

HSAG Performance Improvement Project (PIP)

MSHN's PIP for 2022 through 2025 is: *Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population without a decline in performance for the white population.*

Validation Rating: Design and Implementation

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

Validation Rating Outcomes

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

MSHN did not demonstrate statistically significant improvement over the baseline performance for the

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

The MSHN region will review all findings with the appropriate council to include the quality improvement council and clinical leadership committee for opportunities to identify barriers and develop quality improvement efforts.

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

Our Mission:

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

Our Vision:

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

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