Mid-State Health Network

Board of Directors Meeting ~ May 7, 2024 ~ 5:00 p.m.

Board Meeting Agenda

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

MEMBERS OF THE PUBLIC AND OTHERS UNABLE TO ATTEND IN PERSON CAN PARTICIPATE IN THIS MEETING VIA TELECONFERENCE
Teleconference: (Call) 1.312.626.6799; Meeting ID: 379 796 5720

1. Call to Order
2. Board Member Ten Year Service Recognitions
3. Roll Call
4. **ACTION ITEM:** Approval of the Agenda

   Motion to Approve the Agenda of the May 7, 2024 Meeting of the MSHN Board of Directors
5. Public Comment (3 minutes per speaker)
6. **ACTION ITEM:** FY2023 Audit Presentation (*Page 6*)

   Motion to receive and file the FY2023 Audit Report of Mid-State Health Network completed by Roslund, Prestage and Company.
7. **ACTION ITEM:** FY2023 Board Self-Assessment (Page 13)

   Motion to receive and file the FY2023 Board Self-Assessment report
8. Network Adequacy Assessment Presentation (Page 17)
9. **ACTION ITEM:** Conflict Free Access and Planning (*Page 32*)

   Motion to approve and communicate to policy makers the resolution of the MSHN Board of Directors to oppose the conflict free access and planning implementation decisions on MDHHS and to request that MDHHS reconsider its decision(s).
10. Chief Executive Officer's Report (*Page 38*)
11. Deputy Director's Report (*Page 55*)
12. Chief Financial Officer's Report

    Financial Statements Review for Period Ended March 31, 2024 (*Page 58*)

    ACTION ITEM: Receive and File the Preliminary Statement of Net Position and Statement of Activities for the Period ended March 31, 2024, as presented
13. **ACTION ITEM:** Contracts for Consideration/Approval (*Page 67*)

    The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2024 Contracts, as Presented on the FY 2024 Contract Listing

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/FY2024-MEETINGS

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Upcoming FY24 Board Meetings
Board Meetings convene at 5:00pm unless otherwise noted

July 2, 2024
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

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

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

14. Executive Committee Report
15. Chairperson's Report
16. **ACTION ITEM:** Consent Agenda

Motion to Approve the documents on the Consent Agenda

16.1 Approval Board Meeting Minutes 03/05/2024 *(Page 69)*

16.2 Receive SUD Oversight Policy Board Meeting Minutes 02/21/2024 *(Page 73)*

16.3 Receive Board Executive Committee Minutes 04/19/2024 *(Page 77)*

16.4 Receive Policy Committee Minutes 04/02/2024 *(Page 79)*

16.5 Receive Operations Council Key Decisions 02/26/2024 *(Page 80)* and 03/18/2024 *(Page 82)* and 04/15/2024 *(Page 85)*

16.6 Adopt the Resolution to appoint an alternate member representative to the Michigan Consortium for Healthcare Excellence *(Page 87)*

16.7 Approve the following policies:

16.7.1 Access System *(Page 88)*

16.7.2 Level of Care System *(Page 91)*

16.7.3 Retrospective Sample Review – Acute Care Services *(Page 93)*

16.7.4 Utilization Management *(Page 95)*

17. Other Business
18. Public Comment (3 minutes per speaker)
19. Adjourn

MSHN
Mid-State Health Network

FY24 MSHN Board Roster

Last Name	First Name	Email 1	Email 2	Phone 1	Phone 2	Appointing CMHSP	Term Expiration
Bohner	Brad	bbohner@tds.net		517.294.0009		LifeWays	2025
Brehler	Joe	jbrehler@sprynet.com		517.230.5911		CEI	2025
Brodeur	Greg	brodeurgreg@gmail.com		989.413.0621		Shia Health & Wellness	2027
DeLaat	Ken	kend@nearnorthnow.com		231.414.4173		Newaygo County MH	2026
Gibb	Bruce	brucegibb@gmail.com		989.975.0156		HBH	2026
Griesing	David	davidgriesing@yahoo.com		989.823.2687		TBHS	2027
Grimshaw	Dan	midstatetitlesvcs@mstsinc.com		989.823.3391	989.823.2653	TBHS	2026
Hicks	Tina	tmhicksmshn64@gmail.com		989.576.4169		GIHN	2027
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2027
Ladd	Jeanne	stixladd@hotmail.com		989.634.5691		Shia Health & Wellness	2027
McFarland	Pat	pjmcfarland52@gmail.com		989.225.2961		BABHA	2026
McPeek-McFadden	Deb	deb2mcmail@yahoo.com		616.794.0752	616.343.9096	The Right Door	2027
Nyland	Gretchen	gretchen7080@gmail.com		616.761.3572		The Right Door	2025
O'Boyle	Irene	irene.oboyle@cmich.edu		989.763.2880		GIHN	2026
Palmer	Paul	ppalmer471@ymail.com		517.256.7944		CEI	2025
Pawlak	Bob	bopav@aol.com		989.233.7320		BABHA	2025
Peasley	Kurt	peasleyhardware@gmail.com		989.560.7402	989.268.5202	MCN	2027
Phillips	Joe	joe44phillips@hotmail.com		989.386.9866	989.329.1928	CMH for Central	2026
Raquepaw	Tracey	tl.raquepaw@icloud.com	raquepawt@michigan.gov	989.737.0971		Saginaw County CMH	2025
Scanlon	Kerin	kscanlon@tm.net		502.594.2325		CMH for Central	2025
Swartzendruber	Richard	rswartzn@gmail.com		989.269.2928	989.315.1739	HBH	2026
Twing	Susan	set352@hotmail.com		231.335.9590		Newaygo County MH	2025
Williams	Joanie	jkwms1@gmail.com		989.860.6230		Saginaw County CMH	2026
Woods	Ed	ejw1755@yahoo.com		517.392.8457		LifeWays	2027

Administration:

Last Name	First Name	Email 1	Email 2	Phone 1	Phone 2
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

MSHN
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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
CQS: – Comprehensive Quality Strategy
CRU: Crisis Residential Unit
CS: Customer Service
CSAP: Center for Substance Abuse Prevention (federal agency/SAMHSA)
CSAT: Center for Substance Abuse Treatment (federal agency/SAMHSA)
CW: Children's Waiver
DAB: Disabled and Blind
DEA: Drug Enforcement Agency
DECA: Devereux Early Childhood Assessment
DMC: Delegated Managed Care (site visits/reviews)
DRM: Disability Rights Michigan
DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
D-SNP: Dual Eligible Special Needs Plan
EBP: Evidence-Based Practices
EEO: Equal Employment Opportunity
EMDR: Eye Movement & Desensitization Reprocessing therapy
EPSDT: Early and Periodic Screening, Diagnosis and Treatment
EQI: Encounter Quality Initiative
EQR: External Quality Review (federally mandated review of PIHPs to ensure compliance with BBA standards)
FC: Finance Council
FI: Fiscal Intermediary
FOIA: Freedom of Information Act
FSR: Financial Status Report
FTE: Full-time Equivalent
FQHC: Federally Qualified Health Centers
FY: Fiscal Year (for MDHHS/CMHSP runs from October 1 through September 30)
GAIN: Global Appraisal of Individual Needs assessment for adolescents with SUD needs.
GF/GP: General Fund/General Purpose (state funding)
HB: House Bill
HCBS: Home and Community Based Services
HHP: Health Home Provider
HIPAA: Health Insurance Portability and Accountability Act
HITECH: Health Information Technology for Economic and Clinical Health Act
HMP: Healthy Michigan Program
HMO: Health Maintenance Organization
HRA: Hospital Rate Adjuster
HSAG: Health Services Advisory Group (contracted by state to conduct External Quality Review)
HSW: Habilitation Supports Waiver
ICD-10: International Classification of Diseases – 10th Edition
ICO: Integrated Care Organization (a health plan contracted under the Medicaid/Medicare Dual eligible pilot project)
ICTS: Intensive Community Transitions Services
I/DD: Intellectual/Developmental Disabilities
IDDT: Integrated Dual Diagnosis Treatment
IOP: Intensive Outpatient Treatment
ISF: Internal Service Fund
IT/IS: Information Technology/Information Systems
KPI: Key Performance Indicator
LBSW: Licensed Baccalaureate Social Worker
LEP: Limited English Proficiency
LLMSW: Limited Licensed Masters Social Worker
LMSW: Licensed Masters Social Worker
LLPC: Limited Licensed Professional Counselor
LPC: Licensed Professional Counselor
LOCUS: Level of Care Utilization System
LTSS: Long Term Supports and Services
MAHP: Michigan Association of Health Plans (Trade association for Michigan Medicaid Health Plans)
MAT: Medication Assisted Treatment (see MOUD)
MCBAP: Michigan Certification Board for Addiction Professionals

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

MCO: Managed Care Organization

MDHHS: Michigan Department of Health and Human Services

MDOC: Michigan Department of Corrections

MEV: Medicaid Event Verification

MHP: Medicaid Health Plan

MI: Mental Illness
Motivational Interviewing

MichiCANS: Michigan Child and Adolescent Needs and Strengths

MiHIA: Michigan Health Improvement Alliance

MiHIN: Michigan Health Information Network

MLR: Medical Loss Ratio

MMBPIS: Michigan Mission Based Performance Indicator System

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

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

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

MPHI: Michigan Public Health Institute

MRS: Michigan Rehabilitation Services

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

NAMI: National Association of Mental Illness

NASMHPD: National Association of State Mental Health Program Directors

NCQA: National Committee for Quality Assurance

NCMW: National Council for Mental Wellbeing

OC: Operations Council

OHCA: Organized Health Care Arrangement

OHH: Opioid Health Home

OIG: Office of Inspector General

OMT: Opioid Maintenance Treatment - Methadone

OP: Outpatient

OTP: Opioid Treatment Provider (formerly methadone clinic)

PA: Public Act

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

PAC: Political Action Committee

PASARR: Pre-Admission Screening and Resident Review

PCP: Person-Centered Planning
Primary Care Physician

PEP: Performance Enhancement Plan

PFS: Partnership for Success

PEO: Professional Employer Organization

PEPM: Per Eligible Per Month (Medicaid funding formula)

PI: Performance Indicator

PIP: Performance Improvement Project

PIHP: Prepaid Inpatient Health Plan

PMV: Performance Measure Validation

PN: Prevention Network

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

PRTF: Psychiatric Residential Treatment Facility

PS: Protective Services

PTSD: Post-Traumatic Stress Disorder

QAPIP: Quality Assessment and Performance Improvement Program

QAPI: - Quality Assessment Performance Improvement

QHP: Qualified Health Plan

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

QRT: Quick Response Team

RCAC: Regional Consumer Advisory Council

REMI: MSHN's Regional Electronic Medical Information software

RES: Residential Treatment Services

RFI: Request for Information

RFP: Request for Proposal

RFQ: Request for Quote

RHC: Rural Health Clinic

RR: Recipient Rights

RRA: Recipient Rights Advisor

RRO: Recipient Rights Office/Recipient Rights Officer

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

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

SARF: Screening, Assessment, Referral and Follow-up

SCA: Standard Cost Allocation

SDA: State Disability Assistance

SED: Serious Emotional Disturbance

SB: Senate Bill

SIM: State Innovation Model

SMI: Serious Mental Illness

SPMI: Severe & Persistent Mental Illness

SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income (Social Security)

SSN: Social Security Number

SUD: Substance Use Disorder

SUD OPB: Substance Use Disorder Regional Oversight Policy Board

SUGE: Bureau of Substance Use, Gambling and Epidemiology

TANF: Temporary Assistance to Needy Families

THC: Tribal Health Center

UR/UM: Utilization Review or Utilization Management

VA: Veterans Administration

VBP: Value Based Purchasing

WM: Withdrawal Management (formerly "detox")

WSA: Waiver Support Application

WSS: Women's Specialty Services

YTD: Year to Date

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

Full report in Board Member folders. For those members not present and would like a copy mailed to them, please contact MSHN Executive Support Specialist, Sherry Kletke.

Mid-State Health Network

Financial Statements

September 30, 2023

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

Independent Auditor's Report

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

Report on the Audit of the Financial Statements

Opinions
We have audited the accompanying financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Mid-State Health Network (the PIHP), as of and for the year ended September 30, 2023, and the related notes to the financial statements, which collectively comprise the PIHP's basic financial statements as listed in the table of contents.

In our opinion, the financial statements referred to above 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 PIHP, as of September 30, 2023, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions
We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the PIHP and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements
Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the PIHP's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions.

Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

Mid-State Health Network
Statement of Net Position
September 30, 2023

	Enterprise Behavioral Health Operating	Internal Service Medicaid Risk Reserve	Total Proprietary Funds
Current assets			
Cash and cash equivalents - unrestricted	$ 30,662,846	$ -	$ 30,662,846
Cash and cash equivalents - restricted	-	7,472,644	7,472,644
Investments - unrestricted	58,498,864	-	58,498,864
Investments - restricted	-	45,225,203	45,225,203
Due from affiliate partners and other agencies	3,897,855	-	3,897,855
Due from MDHHS	39,408,906	-	39,408,906
Due from other funds	-	3,242,570	3,242,570
Prepaid expenses	201,932	-	201,932
Total current assets	132,670,403	55,940,417	188,610,820
Noncurrent assets			
Capital asset being depreciated, net	75,585	-	75,585
Total noncurrent assets	75,585	-	75,585
Total assets	132,745,988	55,940,417	188,686,405
		PY Total assets	216,808,234
Current liabilities			
Accounts payable	23,517,378	-	23,517,378
Accrued wages and related liabilities	155,978	-	155,978
Due to affiliate partners	49,022,045	-	49,022,045
Due to MDHHS	35,532,209	-	35,532,209
Due to other funds	3,242,570	-	3,242,570
Unearned revenue	12,110,751	-	12,110,751
Compensated absences	453,466	-	453,466
Direct borrowing, due within one year	38,269	-	38,269
Total current liabilities	124,072,666	-	124,072,666
Noncurrent liabilities			
Direct borrowing, due beyond one year	39,748	-	39,748
Total noncurrent liabilities	39,748	-	39,748
Total liabilities	124,112,414	-	124,112,414
		PY Total liabilities	156,365,601
Net position			
Net investment in capital assets	(2,432)	-	(2,432)
Restricted for risk management	-	55,940,417	55,940,417
Restricted local - PBIP	5,521,205	-	5,521,205
Restricted local - CCBHC QBP	2,087,774	-	2,087,774
Unrestricted	1,027,027	-	1,027,027
Total net position	$ 8,633,574	$ 55,940,417	$ 64,573,991
PY Total net position	8,830,786	51,611,847	60,442,633

The notes to the financial statements are an integral part of this statement.

Mid-State Health Network
Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended September 30, 2023

	Enterprise Behavioral Health Operating	Internal Service Medicaid Risk Reserve	Total Proprietary Funds
Operating revenues			
Medicaid capitation	$ 616,707,578	$ -	$ 616,707,578
Healthy Michigan	125,825,551	-	125,825,551
Autism	53,074,371	-	53,074,371
PA2 revenues	4,283,289	-	4,283,289
DHS incentive	1,600,651	-	1,600,651
CCBHC	32,414,548	-	32,414,548
Behavioral health home	281,168	-	281,168
Opioid health home	574,056	-	574,056
State and federal grants	12,533,875	-	12,533,875
Incentive payments	7,769,759	-	7,769,759
Contributions - Local match drawdown	1,550,876	-	1,550,876
Other operating revenues	19,950	-	19,950
Total operating revenues	856,635,672	-	856,635,672
		PY Operating revenues	757,093,688
Operating expenses			
Contractual obligations			
Funding for affiliate partners	760,814,152	-	760,814,152
HRA and IPA taxes	22,216,802	-	22,216,802
Local match expense	1,550,876	-	1,550,876
Total contractual obligations	784,581,830	-	784,581,830
		PY Contractual obligations	694,347,040
Substance use services			
Prevention	5,329,017	-	5,329,017
Outpatient	10,240,637	-	10,240,637
Recovery Support	5,612,534	-	5,612,534
Medication-Assisted Treatment	9,774,821	-	9,774,821
Withdrawal management	2,921,767	-	2,921,767
Residential	18,020,071	-	18,020,071
Opioid health home	438,828	-	438,828
Women's Specialty	4,799,160	-	4,799,160
Other contractual agreements	4,043,870	-	4,043,870
Total substance use services	61,180,705	-	61,180,705
		PY Substance use services	50,821,782
Administrative expense			
Board per diem	27,370	-	27,370
Depreciation expense	84,861	-	84,861
Dues and memberships	6,723	-	6,723
Insurance	21,799	-	21,799
Professional contracts	681,173	-	681,173
Rent and utilities	8,607	-	8,607
Salaries and fringes	6,478,337	-	6,478,337
Software maintenance	948,856	-	948,856
Supplies	217,315	-	217,315
Travel and training	101,945	-	101,945
Total administrative expense	8,576,986	-	8,576,986
		PY Administrative expense	7,522,148
Total operating expenses	854,339,521	-	854,339,521
Operating income (loss)	2,296,151	-	2,296,151

The notes to the financial statements are an integral part of this statement.

Mid-State Health Network
Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended September 30, 2023

	Enterprise Behavioral Health Operating	Internal Service Medicaid Risk Reserve	Total Proprietary Funds
Non-operating revenues (expenses)			
Interest income	$ 883,955	$ 1,058,400	$ 1,942,355
Interest expense	(2,155)	-	(2,155)
Gain (loss) on disposal of capital assets	(104,993)	-	(104,993)
Non-operating income (loss)	776,807	1,058,400	1,835,207
Income before transfers	3,072,958	1,058,400	4,131,358
Transfers in (out)	(3,270,170)	3,270,170	-
Change in net position	(197,212)	4,328,570	4,131,358
PY Change in net position	3,335,036	1,048,917	4,383,953
Net position, beginning of year	8,830,786	51,611,847	60,442,633
Net position, end of year	$ 8,633,574	$ 55,940,417	$ 64,573,991
PY Total net position	8,830,786	51,611,847	60,442,633

NOTE 7 - DUE TO AFFILIATE PARTNERS

Due to affiliate partners as of September 30th consists of the following:

Description	Amount
Bay-Arenac Behavioral Health	5,928,699
Community Mental Health for Central Michigan	4,979,384
Gratiot Integrated Health Network	2,453,015
Huron Behavioral Health	2,936,061
Ionia County Community Mental Health	1,607,051
LifeWays Community Mental Health Authority	13,996,774
Montcalm Care Network	557,228
Newaygo County Mental Health	524,827
Saginaw County Mental Health Authority	14,480,280
Shiawassee Health and Wellness	1,527,128
Tuscola Behavioral Health Systems	31,598
Total	49,022,045

NOTE 8 - DUE TO MDHHS

Due to MDHHS as of September 30th consists of the following:

Description	Amount
Insurance Provider Assessment (IPA)	1,701,013
Prior Year Cost Settlements	33,831,196
Total	35,532,209

NOTE 9 - UNEARNED REVENUE

The amount reported as unearned revenue represents revenues received in advance of the period earned as follows:

Description	Amount
Medicaid Savings Carryforward	5,745,330
PA2 Carryforward	7,385,468
Medicaid Savings Carryforward Adjusted	(1,020,047)
Total	12,110,751

NOTE 17 - UPCOMING ACCOUNTING PRONOUNCEMENTS

GASB Statement No. 100, *Accounting Changes and Error Corrections*, was issued by the GASB in June 2022 and will be effective for the PIHP's fiscal year September 30, 2024. The primary objective of this Statement is to enhance accounting and financial reporting requirements for accounting changes and error corrections to provide more understandable, reliable, relevant, consistent, and comparable information for making decisions or assessing accountability.

This Statement prescribes the accounting and financial reporting for 1) each type of accounting change and 2) error corrections. This Statement requires that (a) changes in accounting principles and error corrections be reported retroactively by restating prior periods, (b) changes to or within the financial reporting entity be reported by adjusting beginning balances of the current period, and (c) changes in accounting estimates be reported prospectively by recognizing the change in the current period.

GASB Statement No. 101, *Compensated Absences*, was issued by the GASB in June 2022 and will be effective for the PIHP's fiscal year September 30, 2025. The objective of this Statement is to better meet the information needs of financial statement users by updating the recognition and measurement guidance for compensated absences. That objective is achieved by aligning the recognition and measurement guidance under a unified model and by amending certain previously required disclosures.

This Statement requires that liabilities for compensated absences be recognized for (1) leave that has not been used and (2) leave that has been used but not yet paid in cash or settled through noncash means. A liability should be recognized for leave that has not been used if (a) the leave is attributable to services already rendered, (b) the leave accumulates, and (c) the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means. This Statement requires that a liability for certain types of compensated absences—including parental leave, military leave, and jury duty leave—not be recognized until the leave commences. This Statement also establishes guidance for measuring a liability for leave that has not been used, generally using an employee's pay rate as of the date of the financial statements.

MSHN
Mid-State Health Network

FY2023 Board of Directors Self-Assessment Report

Background

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

Recommended Motion:

Motion to receive and file the FY2023 MSHN Board of Directors Self-Assessment report.

May 7, 2024

FY 23 Response Rate: 87.5% (21 out of 24 standing members)

MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY19-FY23)

Section	Item	Yes					No					Needs Improvement					Unsure				
		18/19	19/20	20/21	21/22	22/23	18/19	19/20	20/21	21/22	22/23	18/19	19/20	20/21	21/22	22/23	18/19	19/20	20/21	21/22	22/23
Mission, Vision and Strategic Direction	1. The Board participates in strategic planning	93%	95%	86%	95%	81%	0%	0%	0%	0%	0%	7%	5%	5%	0%	19%	0%	0%	9%	5%	0%
	2. The Board has a clear sense of needs and priorities for the region	77%	82%	71%	89%	67%	0%	5%	5%	0%	0%	23%	5%	14%	11%	24%	0%	8%	10%	0%	9%
	3. MSHN has a clear sense of direction	92%	86%	86%	100%	76%	0%	0%	0%	0%	0%	8%	5%	5%	0%	10%	0%	9%	9%	0%	14%
	4. The Board is advised on national, state and local trends for their effect on behavioral health services	93%	100%	90%	84%	86%	0%	0%	0%	0%	0%	7%	0%	10%	5%	14%	0%	0%	0%	11%	0%
	5. The Board is presented with information about the strengths and weaknesses of MSHN	85%	86%	85%	74%	66%	0%	0%	0%	0%	10%	15%	14%	5%	5%	10%	0%	0%	10%	21%	14%
	6. The Board receives adequate information, analysis, plans, proposals and background materials that enable decision making	100%	86%	95%	89%	71%	0%	0%	0%	0%	5%	0%	9%	5%	0%	10%	0%	5%	0%	11%	14%
	7. MSHN's strategic priorities are clear, specific and measurable	69%	73%	86%	74%	86%	0%	0%	5%	0%	4%	7%	9%	5%	10%	5%	24%	19%	4%	16%	5%
	8. The Board evaluates progress of opportunities for improvement that are identified	69%	77%	67%	74%	62%	0%	5%	5%	5%	9%	0%	5%	19%	16%	5%	0%	13%	9%	5%	24%
	Comments: 1)Area of strength. 2)I believe that the board could benefit from more local SUD related initiatives and issues as presented at SUD oversight. 3)Joe does an excellent job with his CEO detailed report and updates at the board meeting. 4)The board is guided and educated very well on the mission vision and strategic direction of MSHN. 5)Planning has taken place, however then state has made many decisions which makes planning more difficult. 6)Success and failures need more time at meetings. Metrics could be revised to show incremental changes. 7)I think all their values are met and above average.																				
CEO/Board Roles & Responsibilities	10. The Board asks "What" and "Why" and Expects the CEO to provide the "How"	93%	86%	90%	100%	81%	0%	5%	5%	0%	0%	7%	9%	5%	0%	14%	0%	0%	0%	0%	5%
	11. There is a mutual respect and open discussion between the Board and the CEO	93%	100%	100%	100%	100%	0%	0%	0%	0%	0%	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	12. Board communication to staff and providers is channeled through the CEO	93%	91%	86%	90%	100%	0%	0%	0%	0%	0%	7%	0%	0%	5%	0%	0%	9%	14%	5%	0%
	13. Revisions to all policies are reviewed and approved by the Board	93%	100%	95%	95%	90%	0%	0%	0%	5%	0%	0%	0%	0%	0%	10%	7%	0%	5%	0%	0%
	14. The Board receives timely and accurate communication	79%	86%	95%	100%	95%	0%	0%	0%	0%	0%	21%	9%	5%	0%	0%	0%	1%	0%	0%	5%
	Comments: 1)No problems here. 2)Continuing the practice of inviting staff to observe board meetings is very helpful and positive. 3)Joe does an excellent job communicating with the board. 4)CEO does a wonderful job of keeping the board informed and following the wishes of the board as long as the board is following the rule of law and health code. 5)We are made aware of changes State has been making both in and out of board meetings. 6)I have only been on the board a short time. My experience is very limited. 7)MSHN does an excellent job keeping board informed. 8)This is an outstanding strength of MSHN.																				
Resource Utilization & Risk Management	16. Board members are advised of key laws, rules and regulations and the implications for MSHN	69%	91%	100%	100%	81%	0%	0%	0%	0%	0%	31%	9%	0%	0%	5%	0%	0%	0%	0%	14%
	17. The Board has established policies, by-laws and operating agreements to reduce the risk of liability for the Board and MSHN	100%	91%	90%	89%	86%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	9%	10%	11%	14%
	18. Annually, or more often, the Board establishes priorities for the use of resources	93%	77%	95%	79%	71%	0%	9%	5%	0%	5%	7%	9%	0%	10%	10%	0%	5%	0%	11%	14%
	19. The Board receives routine financial reports including investment and risk management strategies	100%	100%	100%	95%	90%	0%	0%	0%	0%	0%	0%	0%	0%	5%	5%	0%	0%	0%	0%	5%
	20. The Board has an approved compliance plan and receives routine updates of compliance monitoring activities	93%	91%	95%	94%	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	7%	9%	5%	6%	5%
	21. The Board receives regular reports of external quality review, audits and other monitoring activities inclusive of planned corrective action	93%	95%	95%	94%	86%	7%	0%	0%	6%	5%	0%	0%	0%	0%	0%	0%	5%	5%	0%	9%
	Comments: 1)Staff keeps the Board well informed. 2)Although discussions around the ISF are frequent, it would be beneficial to new and experienced members to have additional background on the legal & contractual limits and expectations of the ISF. 3)Good. 4)Joe provides all new updates the State has made regarding payments and tries to make the most of what future will look like and how we can make changes to stay above board. 5)Board needs to be included more when setting priorities in the use of resources. 6)Board is well informed. 7)We have a strong																				

MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY19-FY23)

Section	Item	Yes 18/19	Yes 19/20	Yes 20/21	Yes 21/22	Yes 22/23	No 18/19	No 19/20	No 20/21	No 21/22	No 22/23	Needs Improvement 18/19	Needs Improvement 19/20	Needs Improvement 20/21	Needs Improvement 21/22	Needs Improvement 22/23	Unsure 18/19	Unsure 19/20	Unsure 20/21	Unsure 21/22	Unsure 22/23
Public Trust	23. The public has opportunities to address concerns to the Board	100%	95%	100%	95%	90%	0%	0%	0%	0%	0%	0%	5%	0%	0%	10%	0%	0%	0%	5%	0%
	24. Public requests for action/change are addressed as appropriate	77%	68%	81%	89%	76%	0%	0%	5%	0%	0%	0%	0%	0%	0%	5%	23%	32%	14%	11%	19%
	25. Board members provide information and support Board positions with the media, key local/ state decision makers and legislators	62%	59%	71%	68%	65%	16%	5%	0%	5%	0%	0%	9%	10%	0%	5%	16%	27%	19%	27%	30%
	26. The Board reviews customer satisfaction feedback and evaluates concerns	93%	59%	57%	79%	71%	0%	0%	5%	5%	0%	0%	14%	19%	5%	5%	7%	27%	19%	11%	24%
	Comments: 1)Hard work is done in this area. Would like to see more public at Board meetings. 2)The public trust is the foundation of local control. MSHN has honored and respected those boundaries. 3)I haven't seen much of public requests as it directly affects this board. 4)#25-I have been under the impression that board members are not to be involved with the media. 5)No concerns here.																				
Boardmanship	28. Members refrain from intruding on administrative issues that are the responsibility of the Mid- State Health Network CEO/staff except to monitor results and prohibit methods that conflict with policy	62%	77%	90%	100%	81%	0%	0%	5%	0%	0%	28%	18%	5%	0%	9%	10%	5%	0%	0%	10%
	29. Members do not exercise authority apart from the authorization of the full Board	77%	64%	95%	95%	90%	0%	0%	5%	5%	0%	8%	5%	0%	0%	0%	8%	32%	0%	0%	10%
	30. Members serve the best interest of Mid-State Health Network rather than personal or other professional interests	93%	77%	90%	95%	86%	7%	0%	0%	0%	0%	0%	18%	5%	0%	9%	0%	5%	5%	5%	5%
	31. Members are respectful of one another	100%	100%	95%	100%	90%	0%	0%	0%	0%	0%	0%	0%	5%	0%	10%	0%	0%	0%	0%	0%
	32. I am satisfied with the personal contribution I make to the Board	69%	55%	67%	79%	67%	7%	5%	0%	0%	5%	14%	32%	33%	21%	29%	0%	8%	0%	0%	0%
	Comments: 1)Appropriate in this area. 2)MSHN Directors have always been open and honest about administrative concerns or matters of governance. Speaking up has helped he board to ensure independence and accountability. 3)Some members tend to dominate conversations at meetings, but as a whole it is a good, respectful board. 4)Last calendar year I had to miss several meetings for illness and work, so I hope to improve that this calendar year. 5)Sometimes difficult to make contribution as those with more experience seem to dominate the discussions. Does make those with less knowledge apprehensive about giving input. 6)I believe in general that this area is a strength of the MSHN board.																				
Board Evaluation of Support Staff	34. I am satisfied that meetings are set up efficiently and in a timely manner	100%	100%	100%	100%	86%	0%	0%	0%	0%	0%	0%	0%	0%	0%	9%	0%	0%	0%	0%	5%
	35. I am satisfied that Board Packets are sent in a timely and complete manner and copies are made accessible	100%	86%	95%	100%	95%	0%	9%	0%	0%	0%	0%	5%	0%	0%	0%	0%	0%	5%	0%	5%
	36. Responsiveness to information requested is adequate, of good quality and timely	100%	100%	100%	100%	86%	0%	0%	0%	0%	0%	0%	0%	0%	0%	5%	0%	0%	0%	0%	9%
	37. Board member requests are handled in a polite, friendly and professional manner	100%	100%	95%	100%	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	5%	0%	5%
	38. Board meeting minutes are accurate and presented in a timely manner	100%	100%	95%	100%	95%	0%	0%	0%	0%	0%	0%	0%	5%	0%	0%	0%	0%	0%	0%	5%
	Comments: 1)Excellent. 2)The assistant has streamlined and modernized board communication and board administration. We are grateful for her professionalism. 3)Sheryl does a fabulous job preparing the board packet. She is always very timely in her responses. She is an outstanding asset to MSHN. 4)Sherry is awesome at her job. 5)Good. 6)Sheri does a phenomenal job. 7)I feel well supported by staff. Have more contact with Sheryl and she is on top of everything, always pleasant, helpful, and caring. 8)Do to my lack or experience with Mid State I currently have little knowledge of this area. 9)Very good. 10)Thanks for a great performance in this area.																				

MSHN Board of Directors Annual Self-Evaluation: Trending Report (FY19-FY23)	Yes					No					Needs Improvement					Unsure				
	18/19	19/20	20/21	21/22	22/23	18/19	19/20	20/21	21/22	22/23	18/19	19/20	20/21	21/22	22/23	18/19	19/20	20/21	21/22	22/23

Visioning

40. My dream for Mid-State Health Network is: 1)To ensure adequate funding to provide mental health services to local CMHs. 2)Continue to function and Improve. 3)To protect our public mental health system while supporting our CMH partners and theconsumers they serve. 4)To continue our financial stability in the region and provide outstanding services to theCMHSPs and consumers. 5)To advocate for and protect the public mental health care system. 6)I want to see what we can do for customers. 7)Hang in there with DHHS' ever changing bureaucratic demands. 8)To continue to be allowed to to the great work we have been doing and to advocate even morefor our consumers. 9)To continue to be able have decisions made at the local level. 10)Give great services. Be financially stable individually and as a PHIP. 11)It is to early to form any dream as I am still discovering what Mid-State is. 12)Best practice presentations. 13)Continue to exist. 14)That we continue to set the standard for all the PIHP'S. 15)To facilitate providing the needed services to clients in an efficient, respectful manner.

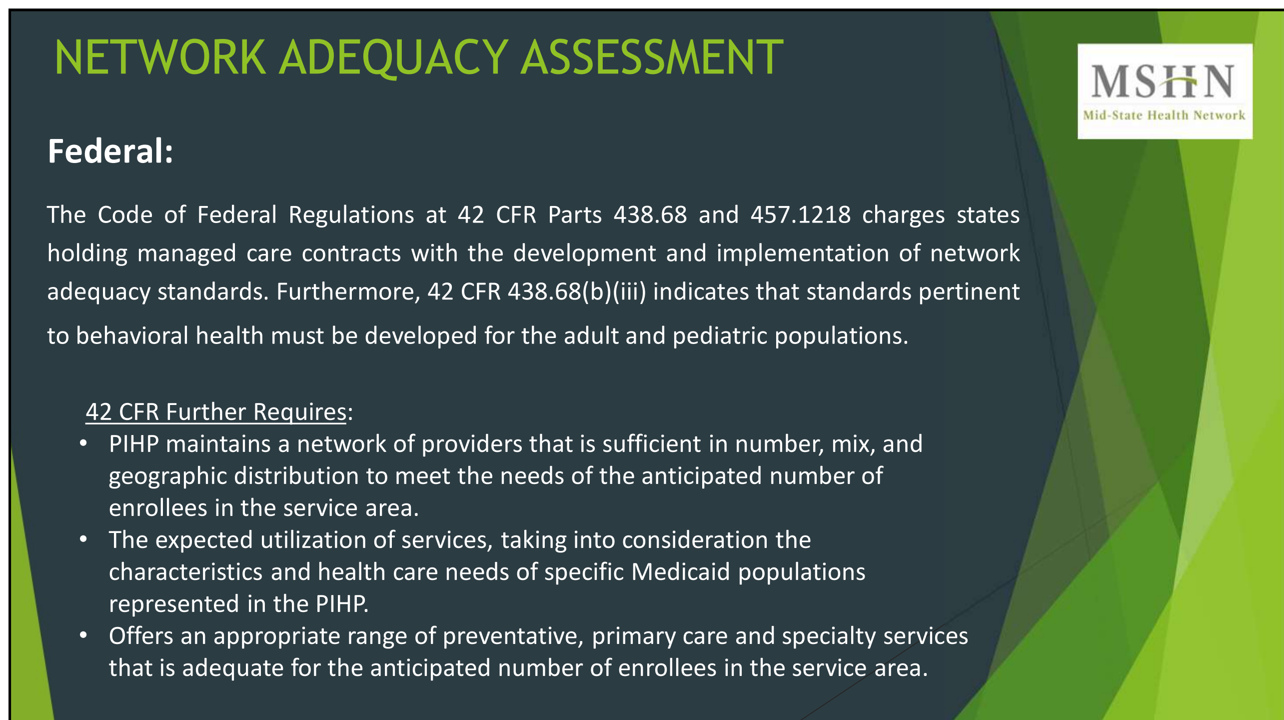
41. My greatest concern for Mid-State Health Network is: 1)Being restricted by MDHHS with unreasonable regulations that make access to mental healthservices more difficult for consumers. 2)Ignorant interference from politicians. 3)For profit entities & their supporters dividing and weakening support for the public mentalhealth system. 4)The changing environment at MDHHS. 5)To remain relevant will sacrifice the public mental health care system. 6)That the state doesn't allow it to stay in existence. 7)To have decisions made at a state level. 8)Budget overruns of members of MSHN. 9)As with HBH it is the governments apparent desire to dismantle the public mental healthsystem. 10)That the department continues to look for ways to undercut our public system. 11)Maintaining the funding for the mental health services. 12)Financial

42. With respect to Mid-State Health Network, I am proudest of: 1)Providing mental health services while being fiscally responsible. 2)The fact that all members work to improve and make us in my mind the best in the State. 3)The statewide respect that the organization receives from top to bottom. 4)Our region is a leader in Michigan and often used as a role model. 5)The professionalism. 6)The work. 7)Board's ability to listen to each other's thoughts with open mind. 8)How well we work together to help an area which may be struggling. 9)How MSHN is ranked to a higher level than others. 10)Services to our persons served. 11)It is much more organized than I imagined. 12)The entire agency et al. 13)The strength of our staff and the Executive Leadership. 14)The coordination and cooperation of MSHN and the local CMHSPs.

43. I feel that Mid-State Health Network's greatest opportunity for improvement is: 1)Not sure. 2)In house development of workforce across disciplines. 3)Help create an environment with MDHHS that best serves our consumers. 4)Help CMH's develop and maintain fiscal integrity. 5)Continue to strive for quality of care be given to the people in our representative regions. 6)Budget control. 7)To early for me to tell. 8)To continue everyday being the best that we can be and keep setting a high standard that wehave demonstrated in the past.

44. Other recommendations/feedback: 1)Continue our informed work to provide services for our customers. 2)MSHN staff are outstanding. I really enjoy working with them. 3)Continue to follow your instincts. 4)To have positive outlook in lieu of all changes. 5)It is a pleasure and rewarding to be a part of MSHN Board.

1



2

NETWORK ADEQUACY ASSESSMENT

State:
Michigan's specialty behavioral health standards reflect time/distance standards and Medicaid enrollee-to-provider ratios for services congruent with community need and statewide strategic priorities.

- Services for adults include Assertive Community Treatment, Crisis Residential Programs, Inpatient Psychiatric, Opioid Treatment Programs, and Psychosocial Rehabilitation Programs (Clubhouses).
- Services for children, include Crisis Residential Programs, Home-Based, Inpatient Psychiatric, and Wraparound Services. Time/distance standards are categorized by urban/rural and frontier status and apply to all services.

3

Michigan Specialty Behavioral Health Standards

Time and Distance Standards for Inpatient Psychiatric Services

Adults

Service	Frontier	Rural	Urban
Inpatient Psychiatric	150 minutes/125 miles	90 minutes/60 miles	30 minutes/30 miles
All Other Select Services	90 minutes/90 miles	60 minutes/60 miles	30 minutes/30 miles

Pediatrics

Service	Frontier	Rural	Urban
Inpatient Psychiatric	330 minutes/355 miles	120 minutes/125 miles	60 minutes/60 miles
All Other Select Services	90 minutes/90 miles	60 minutes/60 miles	30 minutes/30 miles

Medicaid Enrollee-to-Provider Ratio Standards for Select Services

Adult Standards

Adult Services	Standard
Assertive Community Treatment	30,000:1 (Medicaid Enrollee to Provider Ratio)
Psychosocial Rehabilitation (Clubhouses)	45,000:1 (Medicaid Enrollee to Provider Ratio)
Opioid Treatment Programs[4]	35,000:1 (Medicaid Enrollee to Provider Ratio)
Crisis Residential[5]	16 beds per 500,000 Total Population

Pediatric Standards

Children's Services	Standard
Home-Based	2,000:1 (Medicaid Enrollee to Provider Ratio)
Wraparound	5,000:1 (Medicaid Enrollee to Provider Ratio)
Crisis Residential[6]	8-12 beds per 500,000 Total Population

4

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4

Michigan Specialty Behavioral Health Standards

MDHHS Required Regional Specific Plans per 438.68(b)(3)

- MDHHS requires each PIHP to submit plans on how the standards will be effectuated by region.
- PIHPs must consider at least the following parameters for their plans:
  - 1) Maximum time and distance
  - 2) Timely appointments
  - 3) Language, Cultural competence, and Physical accessibility

5

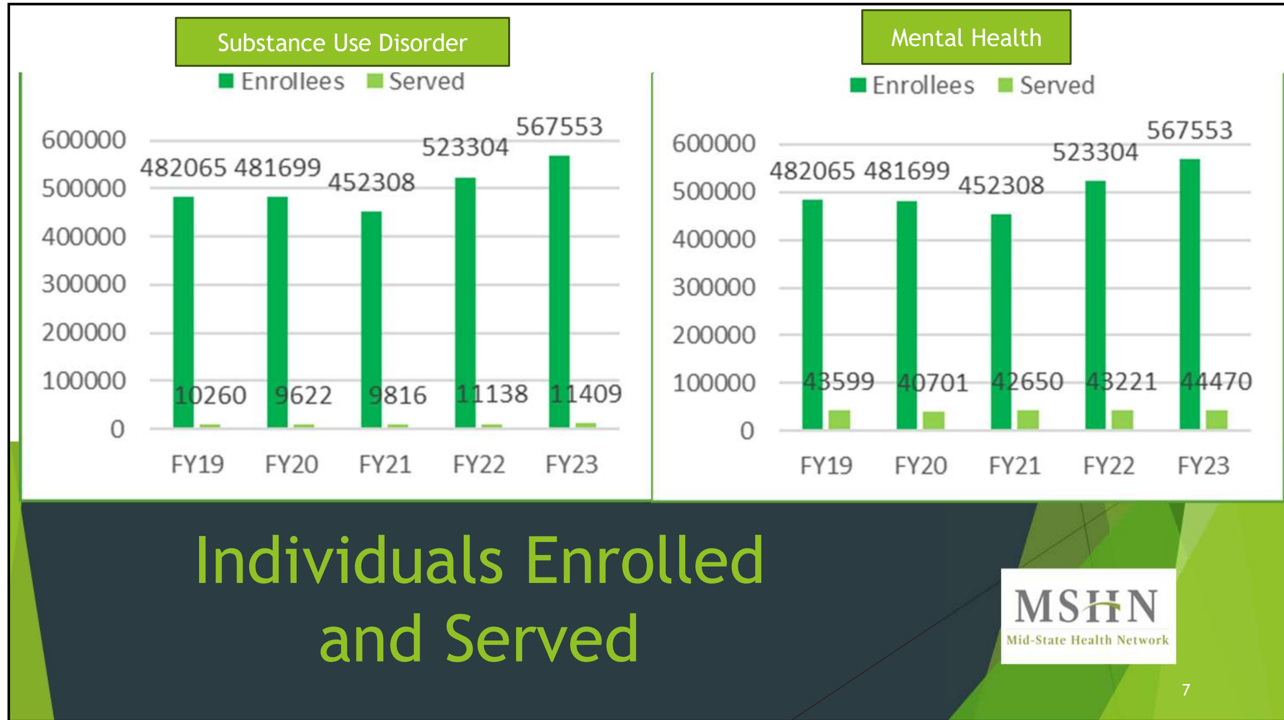
JS

5

Overview

- MSHN completed the Network Adequacy Assessment utilizing Fiscal Year 2023 data.
- Information outside of encounters, was reported directly by CMHSPs and/or MSHN Leadership.
- Geomapping was conducted utilizing a consultant and is attached to the NAA.
- Any gaps found within the assessment have a related FY24 Recommendation for implementation throughout FY25.
- NAA is reviewed by MSHN's Councils, Committees, Operations Council and Board of Directors.
- NAA is required to be submitted to MDHHS by May 31, 2024.
- This fiscal year, MDHHS utilized a template to standardize reporting by all PIHPs.

6



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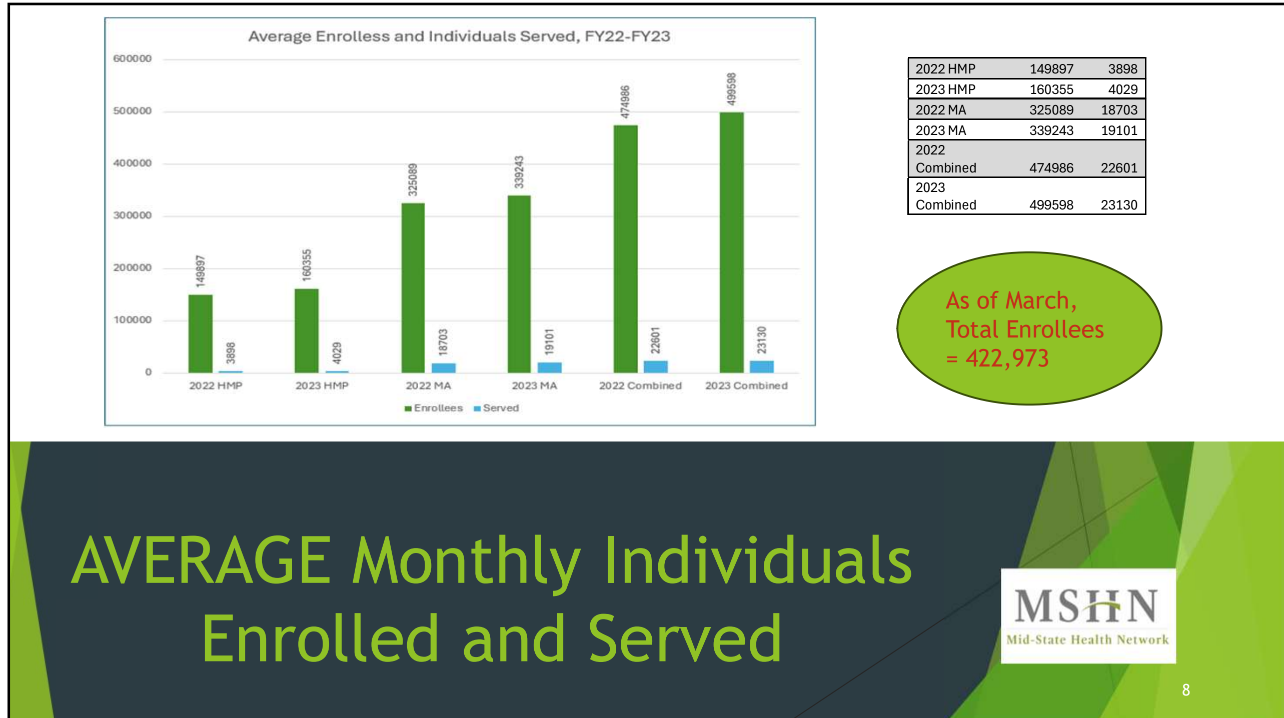
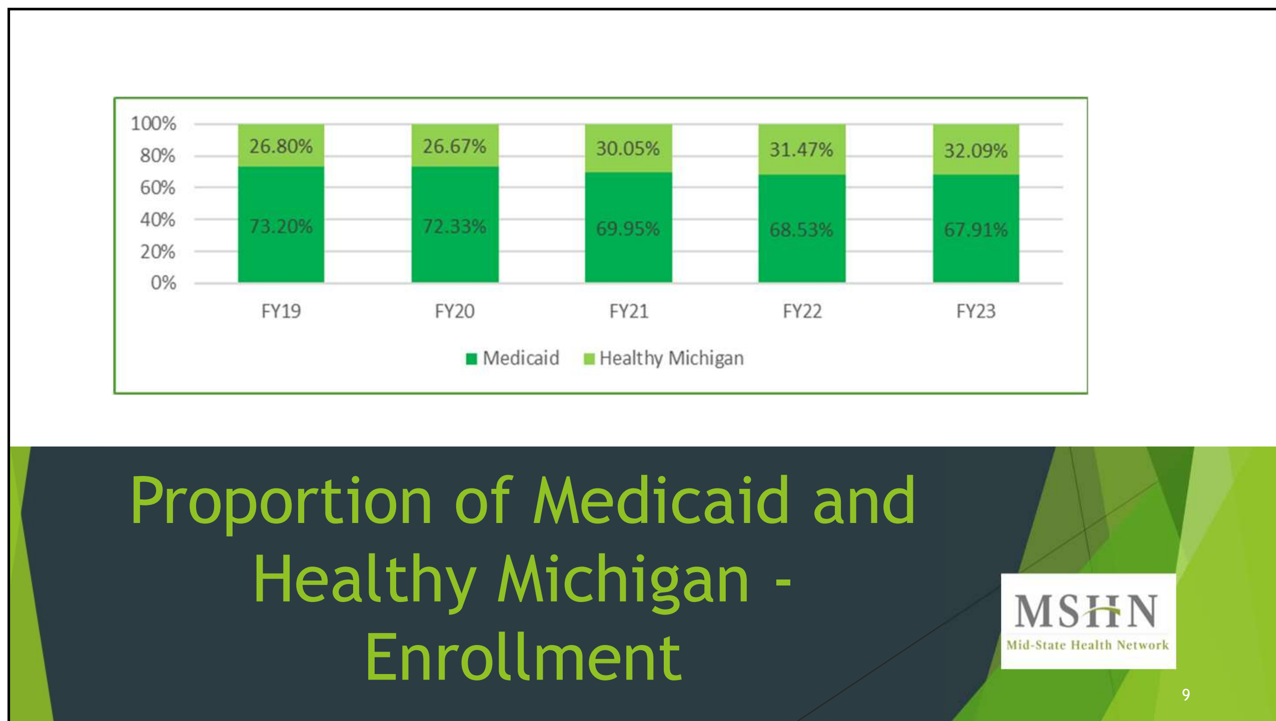


2022 HMP	149897	3898
2023 HMP	160355	4029
2022 MA	325089	18703
2023 MA	339243	19101
2022 Combined	474986	22601
2023 Combined	499598	23130

8



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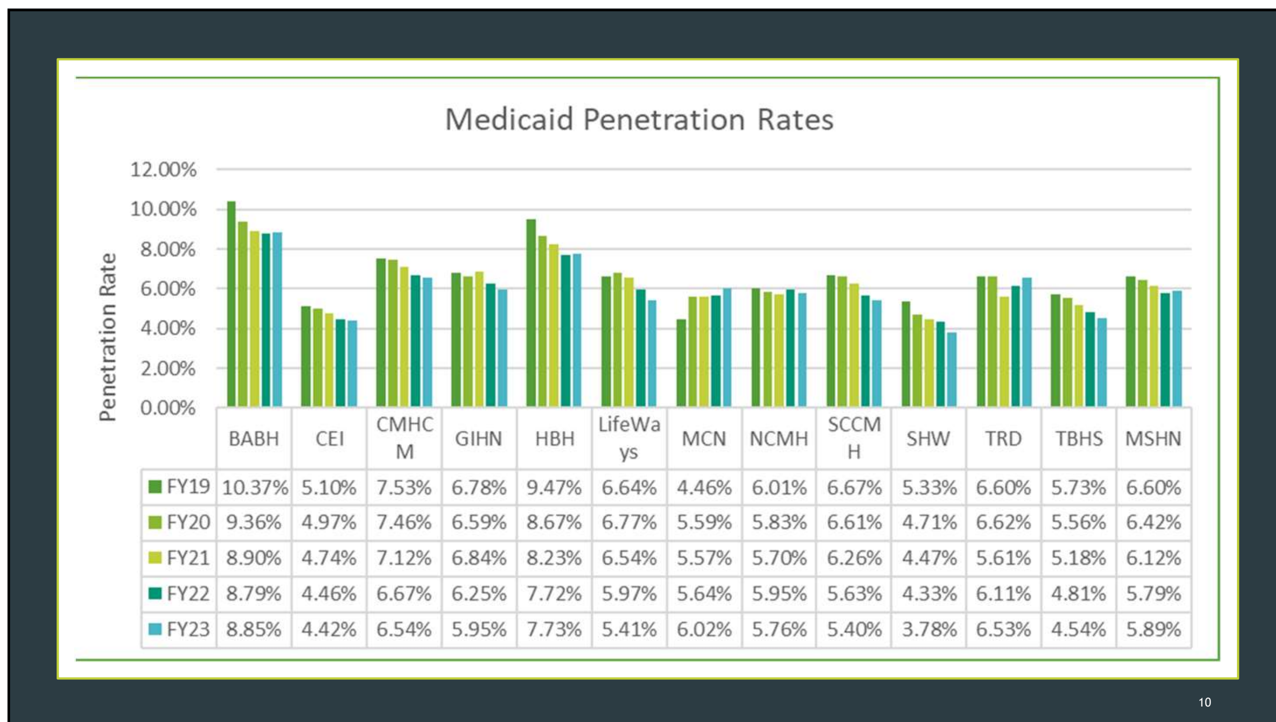
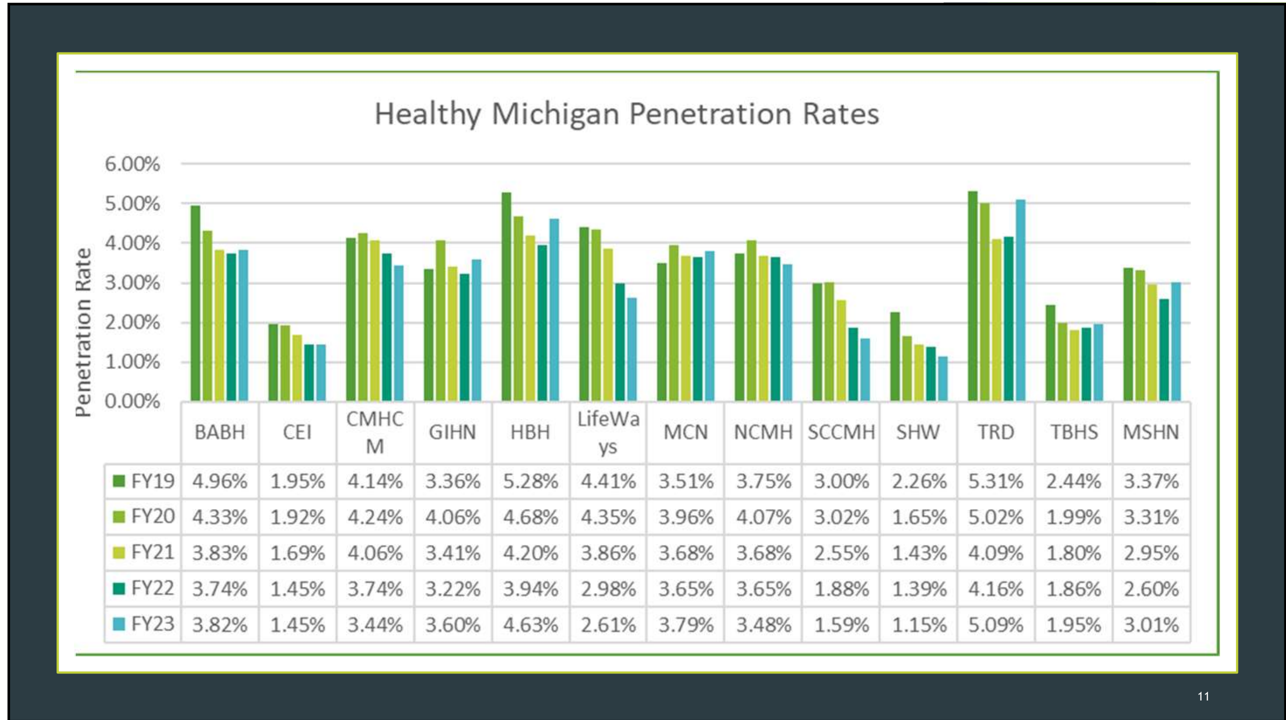


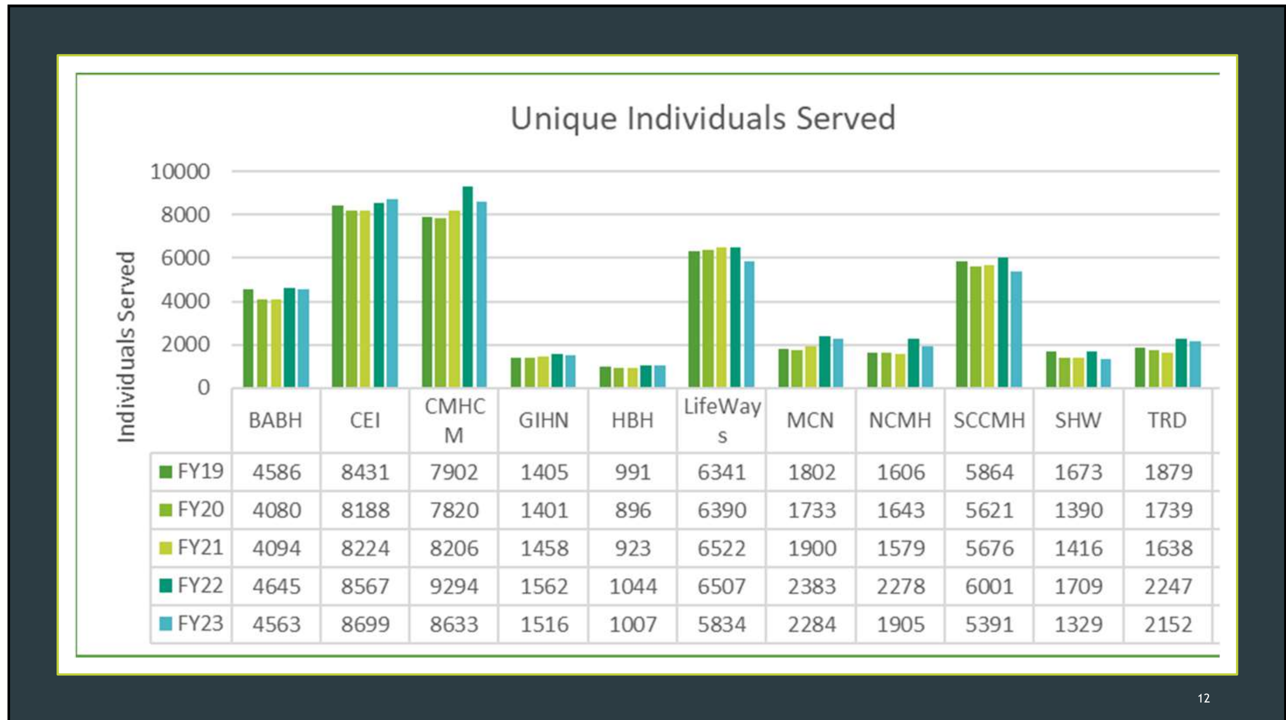
	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS	MSHN
FY19	10.37%	5.10%	7.53%	6.78%	9.47%	6.64%	4.46%	6.01%	6.67%	5.33%	6.60%	5.73%	6.60%
FY20	9.36%	4.97%	7.46%	6.59%	8.67%	6.77%	5.59%	5.83%	6.61%	4.71%	6.62%	5.56%	6.42%
FY21	8.90%	4.74%	7.12%	6.84%	8.23%	6.54%	5.57%	5.70%	6.26%	4.47%	5.61%	5.18%	6.12%
FY22	8.79%	4.46%	6.67%	6.25%	7.72%	5.97%	5.64%	5.95%	5.63%	4.33%	6.11%	4.81%	5.79%
FY23	8.85%	4.42%	6.54%	5.95%	7.73%	5.41%	6.02%	5.76%	5.40%	3.78%	6.53%	4.54%	5.89%

10



	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD	TBHS	MSHN
FY19	4.96%	1.95%	4.14%	3.36%	5.28%	4.41%	3.51%	3.75%	3.00%	2.26%	5.31%	2.44%	3.37%
FY20	4.33%	1.92%	4.24%	4.06%	4.68%	4.35%	3.96%	4.07%	3.02%	1.65%	5.02%	1.99%	3.31%
FY21	3.83%	1.69%	4.06%	3.41%	4.20%	3.86%	3.68%	3.68%	2.55%	1.43%	4.09%	1.80%	2.95%
FY22	3.74%	1.45%	3.74%	3.22%	3.94%	2.98%	3.65%	3.65%	1.88%	1.39%	4.16%	1.86%	2.60%
FY23	3.82%	1.45%	3.44%	3.60%	4.63%	2.61%	3.79%	3.48%	1.59%	1.15%	5.09%	1.95%	3.01%

11

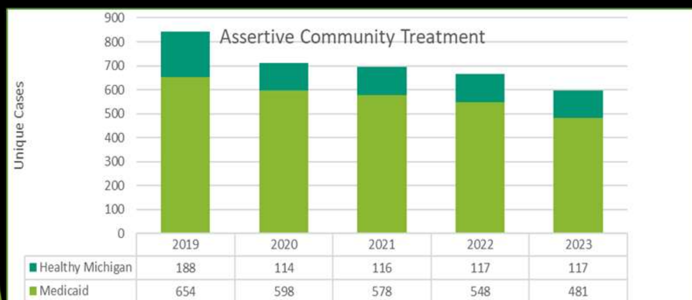


	BABH	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TRD
FY19	4586	8431	7902	1405	991	6341	1802	1606	5864	1673	1879
FY20	4080	8188	7820	1401	896	6390	1733	1643	5621	1390	1739
FY21	4094	8224	8206	1458	923	6522	1900	1579	5676	1416	1638
FY22	4645	8567	9294	1562	1044	6507	2383	2278	6001	1709	2247
FY23	4563	8699	8633	1516	1007	5834	2284	1905	5391	1329	2152

12

Medicaid to Enrollee Provider Ratio: ACT

- **Assertive Community Treatment: MDHHS has established an adequacy standard for ACT programs (30,000:1 Medicaid Enrollee to Provider Ratio).**
- **MSHN's FY23 Ratio: 567,553 Total Medicaid Enrollees to 15 providers. In order to meet the requirement, MSHN would need to have a total of 19 teams in-region, an increase of 4 teams.**
- Using average enrollees per month MSHN's FY23 Ratio 499,598/30,000 = 16.7.
- As of March 2024, MSHN's Total Enrollees = 422,973, therefore, future planning would require 14.1. MSHN's current provider capacity of 15 would be sufficient.



	2019	2020	2021	2022	2023
Healthy Michigan	188	114	116	117	117
Medicaid	654	598	578	548	481

Note: BABH and TBHS are currently not operational due to staffing; The Right Door is reviewing for implementation of ACT in FY24

13

13

Medicaid to Enrollee Provider Ratio

- **Clubhouse Psychosocial Rehab: MDHHS has established an adequacy standard for Clubhouse programs (45,000:1 Medicaid Enrollee to Provider Ratio) which requires 12.6 clubhouse programs in the region, based on the number of adult enrollees. Currently, six CMHSPs have accredited clubhouse programs, with one CMH providing 2 in their catchment area.**
- **MSHN's FY23 Ratio: 567,553 Total MH Medicaid Enrollees to 7 Providers. In order to meet the MDHHS requirements, MSHN would need to increase capacity by an additional 5 programs.**
- Using Average enrollees per month MSHN's FY23 Ratio 499,598/45,000 = 11.1.
- As of March 2024, MSHN's Total Enrollees = 422,973, therefore, future planning would require 9.4.

	2019	2020	2021	2022	2023
Healthy Michigan	104	75	78	83	86
Medicaid	518	476	404	396	400

Alternatively, ten of the twelve CMHSPs offer Drop-In Center activity with four CMHSPs offering both. For those CMHSPs without a clubhouse program six drop-in centers are offered.

14

14

Medicaid to Enrollee Provider Ratio

- **Crisis Residential Services: MDHHS has established an adequacy standard (16 adult beds per 500,000 total population and 8-12 pediatric beds per 500,000 total population). MSHN total population = 1,658,326 (2024 census), so the standard for MSHN is 53 adult beds and 26 pediatric beds (min 8 bed).**
- MSHN has an inventory of 14 contracted crisis residential providers, with a total of 145 beds. Of those in-region 18 beds are designated pediatric.
- As a result, MSHN considers its adult capacity to be compliant with the published standard but under the standard for pediatric beds.

	2019	2020	2021	2022	2023
Healthy Michigan	485	743	582	222	197
Medicaid	645	883	648	537	527

2 CRUs expected to open in 2024, adding 12 beds to the region's adult capacity.

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Medicaid to Enrollee Provider Ratio – Children Services

- **Homebased Services: MDHHS has an established adequacy standard (2,000:1 Medicaid Enrollee to Provider Ratio). Home-Based services were verified through provider enrollment information to ensure compliance with educational standards of licensure and FTE designations.**
- **MSHN DOES NOT meet the published standard with 151.85 FTEs. MSHN's FY23 Ratio: 567,553 Total MH Medicaid Enrollees to 151.85, which is under the required ratio of 283.78 FTEs.**
- Using Average enrollees per month MSHN's FY23 Ratio 499,598/2,000 = 249.80 FTEs.
- As of March 2024, MSHN's Total Enrollees = 422,973, therefore, future planning would require 211.49 FTE's.

	2019	2020	2021	2022	2023
Healthy Michigan	62	77	45	37	46
Medicaid	3217	3091	3021	2831	2422

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Medicaid to Enrollee Provider Ratio – Children Services

- **Wraparound: MDHHS has an established adequacy standard (5,000:1 Enrollee to Provider Ratio).**
- **MSHN's FY23 Ratio: 567,553 Total MH Medicaid Enrollees to 34.3 FTEs, which DOES NOT meet the required 113.51.**
- Using Average enrollees per month MSHN's FY23 Ratio 499,598/5,000 = 99.92 FTEs.
- As of March 2024, MSHN's Total Enrollees = 422,973, therefore, future planning would require 84.59 FTE's.

	2019	2020	2021	2022	2023
Healthy Michigan	0	0	0	0	0
Medicaid	342	329	318	300	333

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Medicaid to Enrollee Provider Ratio – SUD Opioid Treatment Programs and Office Based Opioid Treatment Programs

- OTPs are certified by SAMHSA under 42 CFR Part 8.11. MDHHS has an established adequacy standard (35,000:1 Medicaid Enrollee to Provider ratio). MSHN currently contracts with five (5) OTPs in the region that meet this definition.
- MSHN contracts with four (4) MOUD providers out of its geographic region for services to in-region residents. MSHN has an additional sixteen (16) contracted OBOT provider locations in region that have physicians who can prescribe naltrexone and/or buprenorphine.
- MSHN's Ratio: 567,553 Total Medicaid Enrollees to 21 providers, which is over the required 16 providers.

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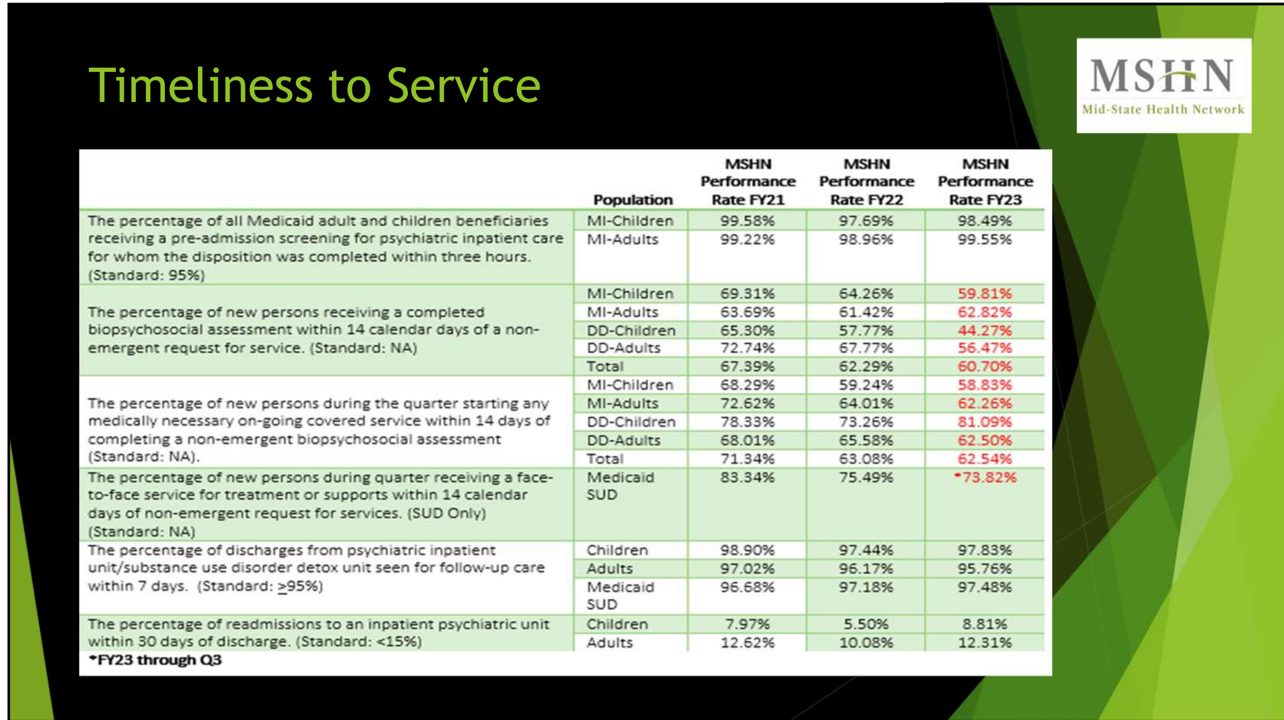

Timeliness to Service

MSHN Mid-State Health Network

	Population	MSHN Performance Rate FY21	MSHN Performance Rate FY22	MSHN Performance Rate FY23
The percentage of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (Standard: 95%)	MI-Children	99.58%	97.69%	98.49%
	MI-Adults	99.22%	98.96%	99.55%
The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergent request for service. (Standard: NA)	MI-Children	69.31%	64.26%	59.81%
	MI-Adults	63.69%	61.42%	62.82%
	DD-Children	65.30%	57.77%	44.27%
	DD-Adults	72.74%	67.77%	56.47%
	Total	67.39%	62.29%	60.70%
The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment (Standard: NA).	MI-Children	68.29%	59.24%	58.83%
	MI-Adults	72.62%	64.01%	62.26%
	DD-Children	78.33%	73.26%	81.09%
	DD-Adults	68.01%	65.58%	62.50%
	Total	71.34%	63.08%	62.54%
The percentage of new persons during quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergent request for services. (SUD Only) (Standard: NA)	Medicaid SUD	83.34%	75.49%	*73.82%
The percentage of discharges from psychiatric inpatient unit/substance use disorder detox unit seen for follow-up care within 7 days. (Standard: >95%)	Children	98.90%	97.44%	97.83%
	Adults	97.02%	96.17%	95.76%
	Medicaid SUD	96.68%	97.18%	97.48%
The percentage of readmissions to an inpatient psychiatric unit within 30 days of discharge. (Standard: <15%)	Children	7.97%	5.50%	8.81%
	Adults	12.62%	10.08%	12.31%

***FY23 through Q3**

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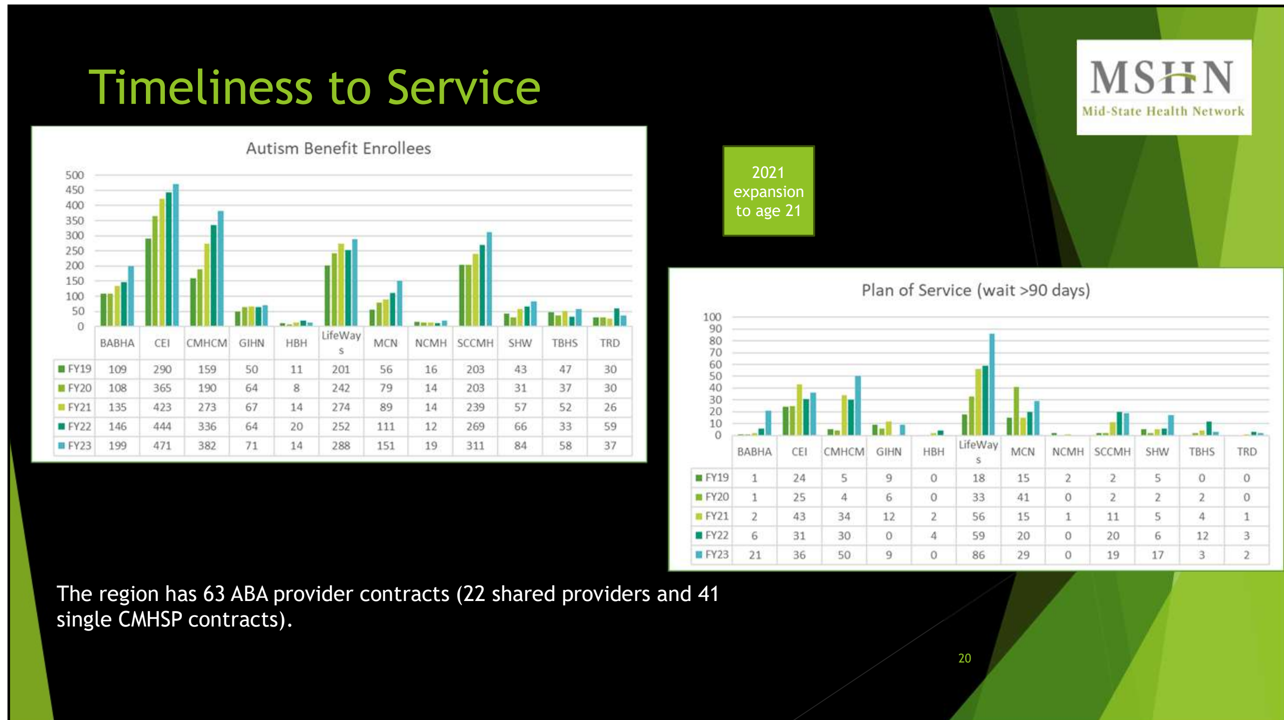

Timeliness to Service

MSHN Mid-State Health Network

Autism Benefit Enrollees

	BABHA	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TBHS	TRD
FY19	109	290	159	50	11	201	56	16	203	43	47	30
FY20	108	365	190	64	8	242	79	14	203	31	37	30
FY21	135	423	273	67	14	274	89	14	239	57	52	26
FY22	146	444	336	64	20	252	111	12	269	66	33	59
FY23	199	471	382	71	14	288	151	19	311	84	58	37

2021 expansion to age 21

Plan of Service (wait >90 days)

	BABHA	CEI	CMHCM	GIHN	HBH	LifeWays	MCN	NCMH	SCCMH	SHW	TBHS	TRD
FY19	1	24	5	9	0	18	15	2	2	5	0	0
FY20	1	25	4	6	0	33	41	0	2	2	2	0
FY21	2	43	34	12	2	56	15	1	11	5	4	1
FY22	6	31	30	0	4	59	20	0	20	6	12	3
FY23	21	36	50	9	0	86	29	0	19	17	3	2

The region has 63 ABA provider contracts (22 shared providers and 41 single CMHSP contracts).

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Time and Distance Standards

Time and Distance Standards for Inpatient Psychiatric Services

Adults

Service	Frontier	Rural	Urban
Inpatient Psychiatric	150 minutes/125 miles	90 minutes/60 miles	30 minutes/30 miles
All Other Select Services	90 minutes/90 miles	60 minutes/60 miles	30 minutes/30 miles

Pediatrics

Service	Frontier	Rural	Urban
Inpatient Psychiatric	330 minutes/355 miles	120 minutes/125 miles	60 minutes/60 miles
All Other Select Services	90 minutes/90 miles	60 minutes/60 miles	30 minutes/30 miles

	SUD Outpatient	Outpatient	Homebased	ACT	Clubhouse	Wraparound	Psych Inpatient Children	Psych Inpatient Adults	SUD Residential	SUD Withdrawal Management	Crisis Residential
Rural Stadard	60 min/60 miles	60 min/60 miles	60 min/60 miles	60 min/60 miles	60 min/60 miles	60 min/60 miles	120 min/125 miles	90 min/60 miles	90 min/60 miles	90 min/60 miles	90 min/60 miles
Urban Standard	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	60 min/60 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles	30 min/30 miles
% of Total Population Standard Met	100%	100%	100%	100%	99.63%	99.90%	86.00%	99.00%	94.90%	99.70%	95.19%

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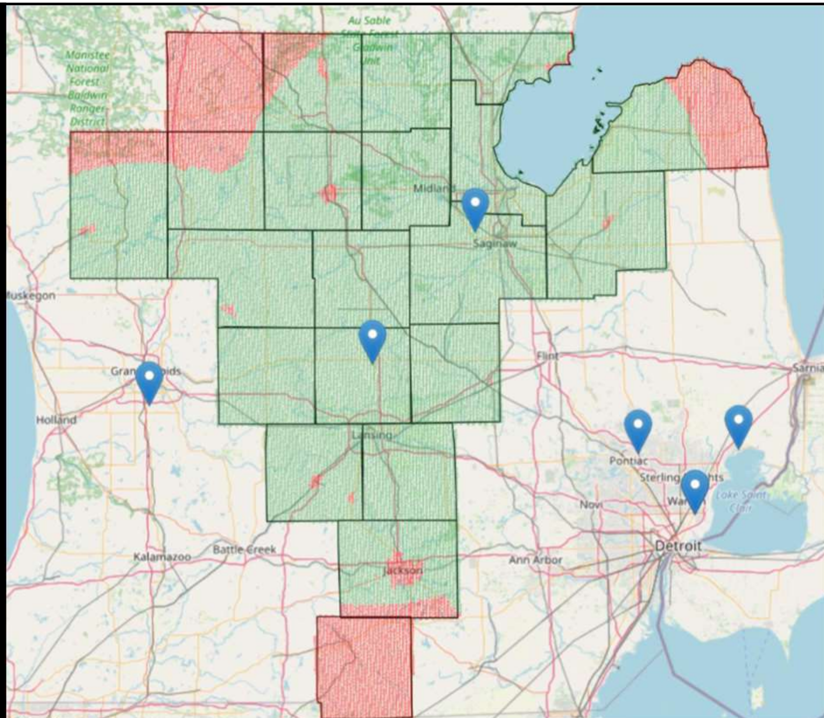
Time and Distance Standards

Child Psychiatric Inpatient – 86% of the population covered



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Time and Distance Standards

SUD Residential Treatment – 95.5% of Population Covered

SUD residential and withdrawal management services expansion was approved for Isabella County and expected to open in July of 2024 with capacity up to 75 beds.

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Time and Distance Standards

Crisis Residential – 95.19% of Population Covered

MSHN approved expansion in Gratiot County for 6 beds with anticipated opening in May 2024.

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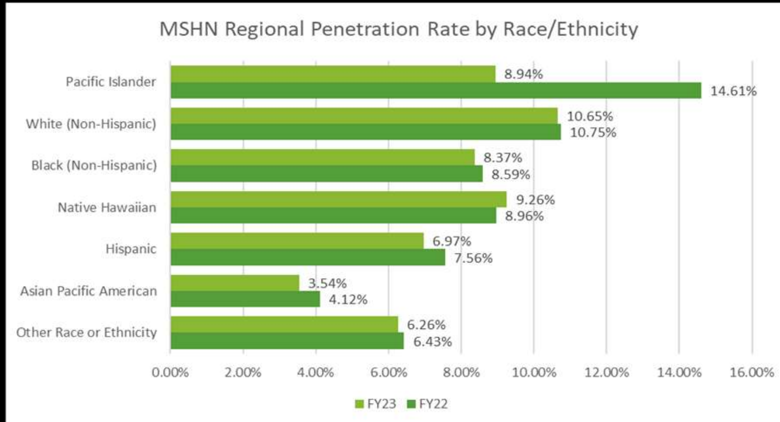
Sufficiency of Mix of Providers: Cultural Competence



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Sufficiency of Mix of Providers: Accommodations

Ingham County has 13.1% non-English speaking individuals

- All CMHSP Participants offer services in locations with physical access for Medicaid beneficiaries with disabilities . ***Out of 1,383 provider listings in the region's Provider Directory, 94.07% indicated accommodations in accordance with the American Disabilities Act.*** Delivery of services in home settings as well as telemedicine can offset barriers to physical access where present.
- The majority of the CMHSPs and SUD providers in the region ***are CARF accredited, which requires specific accommodations and accessibility*** evaluations or plans to ensure services are readily available to individuals with special needs.
- ***Interpreters and translators are available at each CMHSP for persons with Limited English Proficiency*** (individuals who cannot speak, write, read, or understand the English language at a level that permits them to interact effectively with health care providers).

County	LEP Combined	English Only	Spanish	Other Indo-European language	Asian and Pacific Islander Languages	Other languages
Arenac	1.6%	98.4%	0.9%	0.4%	0.1%	0.2%
Bay	2.0%	98.0%	1.1%	0.6%	0.3%	0.0%
Clare	5.0%	95.0%	0.5%	4.2%	0.1%	0.2%
Clinton	4.1%	95.9%	1.7%	1.1%	0.9%	0.3%
Eaton	6.5%	93.5%	2.0%	2.3%	1.3%	0.9%
Gladwin	3.8%	96.2%	0.7%	2.9%	0.1%	0.0%
Gratiot	4.0%	96.0%	2.3%	1.0%	0.5%	0.2%
Hillsdale	4.2%	95.8%	0.8%	2.9%	0.3%	0.2%
Huron	3.7%	96.3%	1.6%	1.5%	0.6%	0.1%
Ingham	13.1%	86.9%	3.4%	3.5%	4.4%	1.8%
Ionia	2.5%	97.5%	1.7%	0.5%	0.2%	0.1%
Isabella	5.7%	94.3%	1.8%	2.4%	0.9%	0.6%
Jackson	3.2%	96.8%	1.5%	0.9%	0.4%	0.3%
Mecosta	4.6%	95.4%	1.2%	2.8%	0.5%	0.0%
Midland	3.6%	96.4%	1.0%	1.3%	1.2%	0.1%
Montcalm	3.6%	96.4%	1.7%	1.3%	0.4%	0.2%
Newaygo	4.9%	95.1%	3.3%	1.2%	0.3%	0.1%
Osceola	4.1%	95.9%	0.9%	2.8%	0.2%	0.1%
Saginaw	4.3%	95.7%	2.2%	1.3%	0.5%	0.3%
Shiawassee	2.2%	97.8%	1.1%	0.6%	0.2%	0.4%
Tuscola	2.8%	97.2%	1.6%	0.9%	0.2%	0.1%

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Expansions:

- Certified Community Behavioral Health Clinics (CCBHCs) - 13,577 beneficiaries
  - Community Mental Health Authority of Clinton, Eaton and Ingham Counties
  - The Right Door for Hope, Recovery and Wellness (Ionia County)
  - Saginaw County Community Mental Health
  - LifeWays (Hillsdale, Jackson Counties)
- Opioid Health Home (OHH) - 179 beneficiaries
  - Victory Clinical Services in Saginaw County
- Behavioral Health Home (BHH) - 566 beneficiaries
  - CMH for Central MI
  - Saginaw CMH Authority
  - Montcalm Care Network
  - Newaygo CMH
  - Shiawassee Health & Wellness

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Assessment Results

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- Expand Children Services by increasing Provider Capacity:
  - Autism
  - Home Based
  - Wraparound
  - Crisis Residential
  - Inpatient Psychiatric
  - Substance Use Disorder
- MSHN will continue to work with in-region and participate in state-wide efforts to address the workforce shortage and increase timelines to services.
- Continue to expand the number of Certified Community Behavioral Health Clinics (CCBHCs), Behavioral Health Homes (BHH), and Opioid Health Homes (OHH) in the region.

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Community Mental Health Member Authorities

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CMH of Clinton.Eaton.Ingham Counties

CMH for Central Michigan

Gratiot Integrated Health Network

Huron Behavioral Health

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LifeWays

Montcalm Care Network

Newaygo County Mental Health Center

Saginaw County CMH

Shiawassee Health & Wellness

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TO: Mid-State Health Network Board of Directors

FROM: Joseph P. Sedlock, Chief Executive Officer

DATE: April 24, 2024

RE: MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES REQUIREMENTS FOR IMPLEMENTATION OF CONFLICT FREE ACCESS AND PLANNING

In a March 22, 2024 meeting with Pre-Paid Inpatient Health Plans (PIHPs) and in an April 1, 2024 meeting with Community Mental Health Service Programs (CMHSPs), Michigan Department of Health and Human Services (MDHHS) announced its requirements for implementation of federal conflict free access and planning implementation. It bears noting that these meetings were captioned as "implementation meetings." On March 26, 2024, my office distributed the slide deck used by MDHHS in these meetings to the Mid-State Health Network (MSHN) Board of Directors.

PERTINENT BACKGROUND:

You will likely recall that federal regulations include provisions requiring conflict free case management for certain beneficiaries. In Michigan, this has been called "Conflict Free Access and Planning (CFAP)." The rule was enacted in 2014. The federal Home and Community Based Services (HCBS) CFAP requirements originate in the Affordable Care Act, which added to the Social Security Act a requirement that the State Medicaid Agency "establish standards for the conduct of the independent evaluation and independent assessment to safeguard against conflict of interest." Federal regulations implement this requirement not only for State plan HCBS services, but also for 1915(c) waivers. The regulation further states that "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person-centered service plan." As the State Medicaid Agency, MDHHS is responsible for compliance and determining the manner of compliance in Michigan.

In May 2023, the Mid-State Health Network (MSHN) Board of Directors passed a resolution opposing all four of the then current models MDHHS was considering to comply with the federal rule(s). MSHN executive leaders have been engaged with MDHHS on these matters for several years, including as original members of the MDHHS-sponsored CFAP workgroup. MDHHS indicated earlier this fiscal year that it would announce design decisions and implementation requirements in early 2024.

WHAT IS REQUIRED:

CMHSPs/PROVIDERS: MDHHS is requiring that providers, including CMHSPs cannot conduct or provide both HCBS service planning (defined as the case management/supports coordination function) and HCBS service delivery for the same beneficiary (unless a CMS-approved exemption is granted). MDHHS clarified that providers, including CMHSPs, can conduct both HCBS service planning and HCBS service delivery functions, but must not conduct both for the same beneficiary. MDHHS has detailed three permissible structural scenarios. The state stated its intent to require a regional implementation plan by the end of May 2024 with a "hard" implementation date of October 1, 2024.

1) The CMHSP does not conduct service planning nor service delivery, but rather contracts out both functions to providers. In this scenario, the CMHSP must ensure that a beneficiary is referred to different providers for service planning and for service delivery.

2) The CMHSP directly offers both service planning and service delivery and also contracts with providers for these functions for some beneficiaries. The CMHSP may continue to provide service planning OR service delivery to a single beneficiary but must ensure the beneficiary is referred to a separate provider for the other function.

3) The CMHSP conducts service delivery and must demonstrate it is the only willing and qualified provider available to conduct service planning for a beneficiary. These "only willing and qualified" rural exemptions must be approved by MDHHS and CMS.

PIHPs:

1) MDHHS is requiring that PIHPs conduct all utilization management operations, but has not defined those functions. It is also unclear whether related functions (such as some customer service functions which need to be performed where utilization management decisions are made) will require additional changes. The federal conflict free regulations are silent on utilization management, but the regulations at 42 CFR 438.210 describes amount, scope, duration, and appropriate limits through utilization management, medically necessary service authorizations, and adverse benefit determination notices (see this link). MSHN has been found in compliance with these regulations by the Health Services Advisory Group (HSAG), which is the MDHHS contractor that monitors PIHP managed care performance. MDHHS has stated its intention to require that PIHPs perform, and do NOT delegate utilization management functions. MDHHS has not offered a rationale for this decision, but it may be rooted in the cited regulations above.
2) MDHHS is requiring PIHPs to develop implementation plans for their regions. Early timelines indicate these plans will be due by the end of May, but their position seems to be soft because they have been unable to answer key questions needed for planning.

DISCUSSION:

In an initial meeting of the region's Operations Council, consisting of the Chief Executive Officers (CEOs) of each regional CMHSP participant, strong opposition was expressed to the announced decision – especially from the standpoint of beneficiaries because they would have to go through additional access steps and to engage at least two different organizations (one for service planning/case management/supports coordination and another for services participation), which results in the need for multiple trusting

relationships, increased chances for miscommunications, disruption to the service arrangements of thousands of beneficiaries already in services, increasing complexity for individuals and families served as well as the public, and many additional consequences.

The Community Mental Health Association of Michigan has taken a strong advocacy position against these design decisions (as it has since the outset) and has proposed a set of recommendations intended to highlight that the State is already in compliance with the federal regulations. The strongest arguments (in my view) are that CMS has already approved Michigan's 1915(i) waivers through 09/30/2027 which details existing conflict free safeguards. The design decision conflicts with statutory functions of Michigan's CMHSPs, and CCBHCs and there is no known CMS finding of Michigan non-compliance with the federal regulations. The Association is pursuing a strategy that it intends would result in dialog between CMHAM (and its member CMHSPs, PIHPs, and Providers) and MDHHS (and potentially CMS) to achieve compliance in a less disruptive way for beneficiaries and families, PIHPs, CMHSPs, and Providers.

In addition, input from many beneficiaries and their allies in MDHHS-sponsored listening sessions included:

- "I think [Separating access/planning from direct service] could be problematic due to a person having to repeat providing their info…"
- "Having to go from here, to here, to here to do it when being in a place where I need help would be a lot. It's a lot to ask one person to go through."
- "The concern is the challenge is managing [different organizations] that need to be in alignment with one another. The management now is already a concern. Does this make it worse.
- "…if no communication or miscommunication this will be hard because it will be left to person with disabilities to relay info."
- "[I have] mixed feelings. [It is] Protecting people getting these services, but I can get frantic going places to places."
- "Between the point of access and referral, things get dropped and lost."
- "It feels like the game it goes through several people and it is not the same in the end after it has moved through all the steps."

MDHHS has not released information pertinent to, and required, for effective and efficient regional planning. This includes whether or not Certified Community Behavioral Health Clinic (CCBHC) services are included in, or exempt from, the conflict free access and planning decision(s), transitions for existing beneficiaries, anticipated costs, or any other implementation guidance. MDHHS has indicated that CMS is considering the applicability of the federal regulations to CCBHC and CCBHC services and they are awaiting CMS decision(s).

There have been no official policies, contract language, memos, or other official communications to the field on these decisions. To date, MDHHS has relied on a PowerPoint slide deck to communicate its position(s).

There are differences in interpretation on applicability of the MDHHS decisions. One point of view is that it covers all HCBS services and ANY beneficiary that receives an HCBS service. Another point of view is that it covers only individuals covered by the 1915(c) waivers and the 1915(i) SPA. There are major differences in volume associated with these two opposing perspectives.

The design decisions documented above are not substantially different than the four design options offered by MDHHS last fiscal year, all four of which were opposed by resolution of the Mid-State Health Network Board.

RECOMMENDATION:

It is important that MSHN maintain solidarity with the field in advocating for reconsideration and potential reversal of MDHHS-announced design elements to comply with conflict free access and planning rules. The MDHHS announced CFAP design requirements are not substantially different in terms of impact than the four models originally presented and opposed by the MSHN Board of Directors in May 2023. MSHNs regional CMHSP Participants unanimously support continued advocacy efforts. Therefore, I am recommending that the MSHN Board of Directors and the MSHN region continue advocacy efforts directed toward MDHHS reconsideration of its decisions and to pass a resolution restating its opposition to the design decision and requesting MDHHS reconsideration. The proposed resolution is attached to this briefing memo.

RECOMMENDED MOTION:

Motion to approve and communicate to policy makers the resolution of the MSHN Board of Directors to oppose the conflict free access and planning implementation decisions of MDHHS and to request that MDHHS reconsider its decision(s).

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Secretary

RESOLUTION OF THE MID-STATE HEALTH NETWORK BOARD OF DIRECTORS OPPOSING MDHHS DECISIONS TO IMPLEMENT CONFLICT FREE ACCESS AND PLANNING IN MICHIGAN

May 7, 2024

WHEREAS the Mid-State Health Network (MSHN) is a regional entity created in 2014 by the twelve Community Mental Health Services Programs (CMHSPs) listed at left and functions as a Pre-Paid Inpatient Health Plan (PIHP) for twenty-one mid-Michigan counties under a master Medicaid specialty supports and services contract with the Michigan Department of Health and Human Services. The MSHN Board of Directors is comprised of two appointees from each of the CMH Participants in the MSHN region, half of which are primary or secondary consumers of public behavioral health services.

WHEREAS the MSHN Board recognizes and stipulates that the federal Affordable Care Act and Social Security Act mandates that States "establish standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest."

WHEREAS the MSHN Board recognizes and stipulates that federal regulations implementing these statutory requirements compel states to require that services are accessed, planned, and delivered in a conflict-free manner.

WHEREAS Michigan's public behavioral health system has been determined to already be in compliance with federal conflict free rules as evidenced by Centers for Medicare and Medicaid Services (CMS) approval of various Michigan waivers attesting to conflict free safeguards.

WHEREAS the MSHN Board recognizes and stipulates that the "conflict free access and planning" federal statutes, federal regulations, and compliance issues are complex and that State compliance with federal requirements is a responsibility of the State.

WHEREAS in May 2023, the MSHN Board passed a resolution opposing all four models proposed by MDHHS, and the recent decisions announced by MDHHS in March and April 2024 are not substantially different from those models opposed by the MSHN Board at that time.

WHEREAS MDHHS has announced its decision to require CMHSPs to separate service assessment and planning from service delivery, requiring beneficiaries to receive one service from one entity and ongoing services from another, separate entity by October 1, 2024.

WHEREAS after careful review, the conclusions of the MSHN Board are that the current decision:

- Increases barriers to effective and efficient access to specialty behavioral health services and supports;
- Seriously interrupts service planning and delivery for thousands of beneficiaries already in services;
- Is in conflict with the statutory responsibilities of CMHSPs under Michigan law;
- Erroneously implies profit driven or undue enrichment motives on the part of governmental entities (CMHSPs and PIHPs) instead of recognizing what is actually a formal transfer of governmental responsibility from the State to the Counties for the delivery of public behavioral health services;
- Is in conflict with the Certified Community Behavioral Health Clinic (CCBHC) model currently being implemented and expanded in Michigan;
- Increases system complexity and confusion of current and future beneficiaries and the public;
- Compromises the formation of the therapeutic alliance between beneficiaries and service professionals by de-emphasizing the critical role of consistency and continuity in evidence-based care;
- Unnecessarily adds costs and fiscal irresponsibility with public dollars, redundancy, duplication and ignores thoughtful application of trauma sensitive systems of care;
- Degrades quality and accountability;
- Increases marginalization of highly vulnerable populations, detrimentally affecting engagement and social determinants of health;
- Ignores, at best, and disregards, at worst, input from persons with lived experience that have consistently stated that the available procedural safeguards are preferable to systemic/structural upheaval inherent in MDHHS announced decisions;

Adopted May 7, 2024

- Ignores Michigan's current shared risk (with MDHHS) financing system which already mitigates against conflict and self-interest.

THEREFORE, BE IT UNANIMOUSLY RESOLVED THAT, i**n the strongest possible terms**, and for the reasons noted herein, the MSHN Board of Directors **opposes the MDHHS announced structural strategies** for compliance with the federal Conflict Free Access and Planning Rules.

BE IT FURTHER UNANIMOUSLY RESOLVED THAT, the MSHN Board of Directors can support, and where necessary, modifying (for the purpose of strengthening) existing procedural safeguards. The changes proposed by MDHHS are extreme, and in our view cause and create undue burdens to beneficiaries, unnecessary upheaval to an already workforce fragile service planning and service delivery system, along with increasing complexity of access for the public.

BE IT FURTHER UNANIMOUSLY RESOLVED THAT, the Mid-State Health Network Board of Directors requests MDHHS reconsideration of its current decisions and to honor CMS waiver approval of procedural mitigation of conflict, and to pursue CMS approval of strengthened procedural safeguards against conflict of interest in Michigan.

MID-STATE HEALTH NETWORK BOARD OF DIRECTORS

Pat McFarland; Bay-Arenac Behavioral Health

Bob Pawlak; Bay-Arenac Behavioral Health

Joe Phillips; Community Mental Health for Central Michigan

Kerin Scanlon; Community Mental Health for Central Michigan

Joe Brehler; Community Mental Health Authority for Clinton, Eaton and Ingham Counties

Paul Palmer; Community Mental Health Authority for Clinton, Eaton and Ingham Counties

Tina Hicks; Gratiot Integrated Health Network

Irene O'Boyle; Gratiot Integrated Health Network

Bruce Gibb; Huron Behavioral Health

Rich Swartzendruber; Huron Behavioral Health

Deb McPeek-McFadden; The Right Door for Hope, Recovery and Wellness

Gretchen Nyland; The Right Door for Hope, Recovery and Wellness

John Johansen; Montcalm Care Network

Kurt Peasley; Montcalm Care Network

Ken DeLaat; Newaygo County Mental Health Center

Susan Twing; Newaygo County Mental Health Center

Tracey Raquepaw; Saginaw County CMH

Joan Williams; Saginaw County CMH

Greg Brodeur; Shiawassee Health & Wellness

Jeanne Ladd; Shiawassee Health & Wellness

David Griesing; Tuscola Behavioral Health Systems

Dan Grimshaw; Tuscola Behavioral Health Systems

Brad Bohner; LifeWays

Ed Woods; LifeWays, Chairperson

Adopted May 7, 2024

Community Mental Health
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Saginaw County CMH

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Secretary

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
March/April 2024

- Michigan Department of Health and Human Services (MDHHS) will be conducting its review of MSHN and Community Mental Health Service Program (CMHSP) operations under performance standards for the Children's Waiver Program, Habilitation Supports Waiver, Waiver for Children with Serious Emotional Disturbance, and the 1915(j) SPA (State Plan Amendment) beginning May 28, 2024 and ending July 31, 2024.

PIHP/REGIONAL MATTERS

1. Michigan Consortium for Healthcare Excellence – Alternate Appointment Request:

The Mid-State Health Network (MSHN) board is a member of the Michigan Consortium for Health Care Excellence (MCHE), and I am the board's appointed Member Representative on the MCHE Board. Nine of Michigan's ten Prepaid Inpatient Health Plans (PIHPs) are members. The MCHE bylaws allow for the appointment of an alternate to carry out the duties of the Member Representative. Administration has written a resolution of the appointment of the MSHN Deputy Director as alternate. This is a routine matter and it has been placed into the consent agenda. Any MSHN Board Member that would like to discuss this appointment, or the resolution, can call this item out when the consent agenda is presented.

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

In recent weeks, MDHHS announced its decision to require that CMHSPs cannot conduct or provide both service planning (case management/supports coordination) and Home and Community Based Services (HCBS) delivery for the same beneficiary. CMHSPs are permitted to provide both service planning and HCBS service delivery, but not to the same beneficiary. Background on this has been provided in previous board reports and an email to all board members on March 26, 2024. MDHHS also stated it will require PIHPs to conduct all utilization management functions. MSHN has sent key questions to MDHHS about these decisions, including requesting an explanation of rationale for ruling out other options, exactly what the MDHHS intends for individuals currently in services (presumably in conflict with the announced decisions), rationale for Utilization Management decisions, exactly what is intended by way of the Utilization Management functions, and more. As of this writing, MDHHS has not responded.

The MSHN Operations Council met on April 15, 2024 on this (and other) topic. All twelve (12) CMHSP Chief Executive Officers (CEOs) oppose the conflict free access and planning design decisions announced by MDHHS. The announced decisions are not much different than the design models opposed by the MSHN board a year ago (in May 2023). The CMH Association and most (if not all) CMHSPs are engaging in advocacy to reverse or modify these decisions, including with MDHHS and the Michigan Legislature. After significant discussion, the Operations Council and MSHN agreed to propose the resolution included in this meeting packet opposing the MDHHS announced CFAP design decision. This is consistent with the May 2023 board resolution of opposition.

It is important that MSHN demonstrate solidarity with our regional partners and others to oppose the decisions as announced. This is the focus of the proposed resolution and board briefing paper included in this meeting packet.

MDHHS has notified me as Chair of the PIHP/MDHHS contract negotiations group that it intends a meeting on May 21, 2024, to lay out their contract requirements to implement CFAP. In my view, it is likely that MDHHS will reiterate its decisions and require PIHPs to develop regional implementation plans. As noted above, MDHHS has not provided sufficient information upon which to base a regional plan, nor has it issued formal (meaning state policy or contract requirements) upon which MSHN can rely to comply. Thus, implementation/compliance considerations will be taken up at a future date. While it is clear I do not require board authorization to fulfill my and MSHNs contractual/compliance obligations, there may be board-level decisions required depending on the form and nature of compliance requirements that can be taken up in a special MSHN board meeting if/as needed. If that option is to be pursued, I will work with the Board's Executive Committee on details.

3. **State Opioid Response ([SOR] Grant III) Site Review:**

MSHN has been the recipient of State Opioid Response Grants for several years. Regulations require that MDHHS conduct oversight to confirm MSHN's use of funds consistent with federal and state requirements. MDHHS conducted a review of related MSHN operations on March 27, 2024. On April 10, 2024, MDHHS released its findings noting that they determined "that Mid-State Health Network is in substantial compliance with Substance Abuse and Mental Health Services Administration's Funding Opportunity Announcements and the MDHHS contract. Currently, MSHN has all the necessary tools in place to manage, maintain and report on the SOR activities and data for their provider network."

I would like to acknowledge with gratitude Dr. Trisha Thrush, Sarah Andreotti, Jodie Smith, Amy Keinath, Leslie Thomas, Rebecca Emmenecker, Sherrie Donnelly, Kate Flavin, Kari Gulvas, Sarah Surna, and Dr. Dani Meier for their consistently excellent focus on compliance, performance, and especially quality.

4. **Behavioral Health Home (BHH) and Opioid Health Home (OHH) Potential Expansion:**

The MSHN region currently has six Behavioral Health Home partners (CMH for Central Michigan, Gratiot Integrated Health, Montcalm Care Network, Newaygo CMH, Saginaw County CMH, and Shiawassee Health and Wellness; Newaygo CMH is not yet certified). Additional CMHSPs in the region are considering establishing BHHs. The MSHN region currently has two opioid health homes operating in Saginaw and Jackson Counties and is working on expansion of that model.

MDHHS has announced plans for potential expansion of both models and is in the process of submitting documentation for the Centers for Medicare and Medicaid Services (CMS) to all counties in Michigan, and CMS authorization to add alcohol and stimulant use disorders to the OHH model (which would then become a "Substance Use Disorder Health Home" (SUDHH).

5. **COVID Un-Wind Update; Regional Revenue Impact:**

The Mid-State Health Network region has experienced a cumulative reduction of over 81,000 in the number of eligibles in the MSHN region for the period July 2023 through March 2024. This has a direct impact on regional revenues. Amanda Ittner, Deputy Director, will provide additional information in her Network Adequacy Assessment presentation.

All PIHPs are experiencing similar impacts. The Fiscal Year (FY) 24 rates developed by MDHHS and their actuary Milliman were based on significantly lower disenrollment rates. MDHHS has revised current year rates resulting in an estimated $3M additional revenue in the current year to the MSHN region. This revenue estimate is contingent on minimal fluctuations in the State's disenrollment activities.

6. **Regional Cost Containment Strategies:**

The additional revenue noted immediately above is expected to help the region's financial position at year end. In addition, MSHN and our CMHSP Participants anticipating excess costs in this fiscal year are all engaged in various, locally developed cost containment strategies. Each entity is engaged in activities intended to contain or reduce costs, and each entity is using a combination of strategies to achieve that objective. Our focus at MSHN and at the MSHN Board level is aggregated impacts and not on individual CMHSP performance.

A sampling of strategies being implemented across the region include renewed focus on eligibility determinations and medical necessity criteria (especially for high cost/high volume services), consolidating group home operations, evaluating necessity of filling open positions or hiring freezes, evaluating out of county placements for necessity, appropriateness and costs, seeking grant funding, and many more locally determined strategies. It is important to note two additional factors: reductions to beneficiary services/supports that are not medically necessary are prohibited, and there are also factors driving costs up (such as very high levels of autism eligibility/enrollment and utilization of psychiatric inpatient services). Considering all of these strategies and factors, the cost containment impact is expected to be approximately $2.7M in the current fiscal year and about $7.2M in future years. These are obviously soft estimates as some cost containment strategies may not achieve their estimated impact.

MSHN is working to implement a cost containment plan through partial centralization of some Substance Use Disorder (SUD) access processes, elimination of duplicate screenings, and better level of care determinations processes. I will provide more detail on the strategy at a future MSHN Board meeting.

7. **Certified Community Behavioral Health Clinic (CCBHC) Operations:**

There are four CCBHCs in the MSHN region (CEI CMH, Saginaw CMH, The Right Door, and LifeWays). Other regional partners are considering establishing CCBHCs in FY 25 or future years. The State of Michigan is in year two of a five-year federal demonstration. While complicated, the funding model covers all CCBHC costs using a prospective payment system (PPS) rate (a case rate per daily encounter). A portion of the PPS is covered with Medicaid capitation (from regional revenues) and the other portion is fully funded with CCBHC Supplemental funds for the mild-to-moderate population. The funding model and related formulas have shifted a couple of times over the demonstration period and are currently under review for further refinement. To the extent that the PPS payments exceed CCBHC costs, the CCBHC may retain the excess. Conversely, CCBHCs are responsible for covering their cost overruns with local or other funding dollars.

Of note, Congress has passed, and the President has signed, the Consolidated Appropriations Act of 2024 into law. One important aspect of this federal law is that it establishes the definition of CCBHCs within federal Medicaid law.

8. **MSHN Approved to Implement Recovery Incentives Pilot:**

MSHN has been approved by MDHHS to implement the recently CMS-approved Recovery Incentives Pilot. Recovery incentives are also known by the label "Contingency Management." According to the National Library of Medicaid, Contingency management is a highly effective treatment for substance use and related disorders. Contingency management refers to a type of behavioral therapy in which individuals are 'reinforced', or rewarded, for evidence of positive behavioral change. These interventions have been widely tested and evaluated in the context of substance misuse treatment, and they most often involve a provision of monetary-based (and/or non-monetary) reinforcers for submission of drug-negative urine specimens and other desirable behaviors. The reinforcers typically consist of vouchers exchangeable for retail goods and services or the opportunity to win prizes. Contingency management has a great deal of evidence supporting its efficacy. MSHN has several providers that it will partner with during the pilot period.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

9. **Medicaid Health Plan Re-Bid – MI Healthy Life Award Announcement:**

From a MDHHS press release 04/08/2024: MDHHS is pleased to announce the selection of nine Medicaid health plans for the contract period beginning October 1, 2024. The contracts are for five years with three, one-year optional extensions.

Since 2022, MDHHS has been engaged in MI Healthy Life, an initiative to strengthen Medicaid services through new Medicaid health plan contracts. Input from nearly 10,000 enrollees and family members, health care providers, health plans and other community partners informed the creation of five MI Healthy Life strategic pillars:

- Serve the Whole Person, Coordinating Health and Health-Related Needs.
- Give All Kids a Healthy Start.
- Promote Health Equity and Reduce Racial and Ethnic Disparities.
- Drive Innovation and Operational Excellence.
- Engage Members, Families and Communities.

These pillars guided the design of changes in the Medicaid health plan contract rebid, including:

- Prioritizing health equity by requiring Medicaid health plans achieve National Committee for Quality Assurance Health Equity Accreditation.
- Addressing social determinants of health through investment in and engagement with community-based organizations.
- Increasing childhood immunization rates, including increasing provider participation in the Vaccines for Children program.
- Adopting a more person-centered approach to mental health coverage.
- Ensuring access to health care providers by strengthening network requirements.
- Increasing Medicaid Health Plan accountability and clarifying expectations to advance state priorities.

The culmination of this two-year effort has resulted in contract awards to the following entities by prosperity region: (MSHN NOTE: These regions are prosperity regions and do not align with PIHP regions).

- Region 1 – Upper Peninsula Prosperity Alliance: Upper Peninsula Health Plan, LLC.
- Region 2 – Northwest Prosperity Region: Blue Cross Complete of Michigan, LLC, McLaren Health Plan, Inc., Molina Healthcare of Michigan, Inc., Priority Health Choice, Inc.
- Region 3 – Northeast Prosperity Region: Blue Cross Complete of Michigan, LLC, McLaren Health Plan, Inc., Molina Healthcare of Michigan, Inc., Priority Health Choice, Inc.
- Region 4 – West Michigan Prosperity Alliance: Blue Cross Complete of Michigan, LLC, McLaren Health Plan, Inc., Meridian Health Plan of Michigan, Inc., Molina Healthcare of Michigan, Inc., Priority Health Choice, Inc., United Healthcare Community Plan, Inc.
- Region 5 – East Central Michigan Prosperity Region: Blue Cross Complete of Michigan, LLC, McLaren Health Plan, Inc., Meridian Health Plan of Michigan, Inc., Molina Healthcare of Michigan, Inc.
- Region 6 – East Michigan Prosperity Region: Blue Cross Complete of Michigan, LLC, HAP CareSource, Inc., McLaren Health Plan, Inc., Meridian Health Plan of Michigan, Inc., Molina Healthcare of Michigan, Inc., United Healthcare Community Plan, Inc.
- Region 7 – South Central Prosperity Region: Aetna Better Health of Michigan, Inc., HAP CareSource, Inc., McLaren Health Plan, Inc., United Healthcare Community Plan, Inc.
- Region 8 – Southwest Prosperity Region: Aetna Better Health of Michigan, Inc., McLaren Health Plan, Inc., Meridian Health Plan of Michigan, Inc., United Healthcare Community Plan, Inc.
- Region 9 – Southeast Prosperity Region: Aetna Better Health of Michigan, Inc., Blue Cross Complete of Michigan, LLC, HAP CareSource, Inc., McLaren Health Plan, Inc., Meridian Health Plan of Michigan, Inc., United Healthcare Community Plan, Inc.
- Region 10 – Detroit Metro Prosperity Region: Aetna Better Health of Michigan, Inc., Blue Cross Complete of Michigan, LLC, HAP CareSource, Inc., McLaren Health Plan, Inc., Meridian Health Plan of Michigan, Inc., Molina Healthcare of Michigan, Inc., Priority Health Choice, Inc., United Healthcare Community Plan, Inc.

10. <u>Family Treatment Court Laws Enacted:</u>

From a Gongwer News Services article, 03/13/2024: A family treatment court that can address substance abuse and child safety was signed into law by Governor Gretchen Whitmer on Tuesday.

HB 4522 and HB 4524 (Public Acts 15 and 14, respectively) would create the family treatment and expand eligibility for drug treatment courts.

"Every year, the statistics tell us that treatment courts solve problems and save lives," Supreme Court Justice Kyra Harris Bolden said in a statement. "Now, experienced trial courts judges who lead family treatment courts will be able to do even more to solve problems and save lives by supporting families who need help and children who need safe, nurturing homes."

11. <u>MSU Receives DHHS Grant to Address Direct Care Worker Shortage:</u>

From Gongwer News Service article, 03/06/24: Michigan State University has received a $25 million grant from the Department of Health and Human Services aimed at fixing issues within Michigan's direct care workforce, the university announced Wednesday.

The grant will help establish a Direct Care Career Center, which MSU said in a statement would aspire to "increase pathways into the field and transform the public view to one that recognizes the workforce as a respected profession."
In recent years, the state's direct care workforce has seen a shortage that experts say can lead to longer periods of hospitalization, higher costs for people with disabilities and reliance on less-qualified family members for medical support. IMPART Alliance, MSU's research hub for direct care work, has been trying to address the issues within the profession that leads to a shortage of DCWs.

"The U.S. and Michigan's populations are rapidly aging, which is creating a greater demand for high-quality, lower cost supports and services at home, where most people prefer to live for as long as possible in their later years," Clare Luz, IMPART Alliance executive director and faculty researcher, said in a statement.

DCWs in Michigan often face low pay and few job benefits or paid time off, leading to high turnover rates and providers cutting back on direct care services overall. Luz said that the grant from DHHS will help MSU researchers find solutions to these problems and make action recommendations to the Legislature.

"We need more DCWs, but we also want competent DCWs who know how to provide support safely and with respect and who like their job and plan to stay in it," Luz said. "Evidence clearly shows that a stable, trained, professional direct care workforce can result in higher worker satisfaction, lower turnover rates and better health outcomes including fewer falls and emergency department visits."

The grant comes from the DHHS Home and Community Based Services Spending Plan, with funds supported by the American Rescue Plan. Programs to recruit and credential DCWs, assist the existing workforce with childcare, tuition and transportation costs and evaluate successes and areas for improvement yearly will exist within the Direct Care Career Center.

"Strengthening the direct care workforce has been a focus of the state for several years," said DHHS Director Elizabeth Hertel. "These dedicated individuals assist with daily tasks that enhance the quality of life for those they serve including personal care, household and clinical tasks and even companionship. We look forward to the Direct Care Career Center helping increase the number of workers.

FEDERAL/NATIONAL ACTIVITIES

12. Public Opinion Poll on Medicaid:

The Kaiser Family Foundation has published the results of polling as 5 *Charts About Public Opinion on Medicaid.* "A quick look at the public's view of Medicaid, the government health insurance and long-term care program for low-income adults and children, from recent KFF polling.

#1: Most Americans Have Some Connection To Medicaid

Two-thirds of adults in the U.S. say they have had some connection to the Medicaid program, including health insurance (59%), pregnancy-related care, home health care, or nursing home care (31%), coverage for a child (31%), or to help pay for Medicare premiums (23%).

#2: Public Holds Favorable Views Of Medicaid

Large majorities of the public hold favorable views of the Medicaid program. The March 2023 KFF Health Tracking Poll found three-fourths of the public say they have an either "very favorable" (29%) or "somewhat favorable" (47%) view of the program, while one-fifth say they have an unfavorable view. A majority of Democrats (89%), independents (75%), and Republicans (65%) view the program favorably.

#3: Most Think Medicaid Works Well For Lower-Income People

Most Americans say the current Medicaid program is working well for most low-income people covered by the program. More than two-thirds of the public overall (69%) say the program is working well, as do large majorities of independents (63%), Republicans (69%), and Democrats (76%). Three-fourths of people who have a connection to Medicaid, either through themselves, a family member, or a close friend receiving benefits (two-thirds of all adults), say the program is working well.

#4: Views Of Whether Medicaid Is Health Insurance Or Welfare Vary By Partisanship

When asked whether Medicaid is primarily a government health insurance program or a government welfare program, a larger share of the public (61%) as well as six in ten independents and eight in ten Democrats (79%) say Medicaid is primarily a health insurance program. A small majority of Republicans (54%) say Medicaid is primarily a welfare program.

#5: Medicaid Expansion Is Popular In Non-Expansion States

Two-thirds of the people living in states that have not expanded their Medicaid programs under the Affordable Care Act to cover more low-income adults say they want to see their Medicaid programs expand. This is nearly twice the share who say they want the program to stay as it is today (34%)."

13. Federal Office of Inspector General (OIG) Report on Behavioral Health Access:

In March, the Health and Human Services (HHS) Office of Inspector General released a report entitled *A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care*.

Why OIG did this review:

- Almost half of all Americans will experience a behavioral health condition—which includes mental health disorders and substance use disorders—in their lifetime.
- Without enough behavioral health providers willing to participate in Medicare and Medicaid, enrollees may experience difficulty accessing providers or delays in care and may even forgo treatment altogether.
- OIG is conducting this review, in part, because of congressional interest in ensuring that enrollees have access to behavioral health services in traditional Medicare, Medicare Advantage, and Medicaid managed care (hereafter referred to as "Medicaid").

What OIG found:

- Overall, there were few behavioral health providers in the selected counties who actively served Medicare and Medicaid enrollees.
- These providers represented about one-third of the total behavioral health workforce in the counties.
- Despite unprecedented demand for behavioral health services, treatment rates in all three programs remained relatively low.
- Most enrollees saw their behavioral health providers in person; however, many enrollees traveled long distances to see them.

What OIG Recommends: OIG recommends that CMS:

1. Take steps to encourage more behavioral health providers to serve Medicare and Medicaid enrollees.
2. Explore options to expand Medicare and Medicaid coverage to additional behavioral health providers.
3. Use network adequacy standards to drive an increase in behavioral health providers in Medicare Advantage and Medicaid.
4. Increase monitoring of Medicare and Medicaid enrollees' use of behavioral health services and identify vulnerabilities.

14. **Continued and Expanding Federal Program Integrity Initiatives:**

The Government Accountability Office (GAO) has released a report entitled *Medicare and Medicaid: Additional Actions Needed to Enhance Program Integrity and Save Billions* (GAO-24-107487). "HHS has estimated a combined total of over $100 billion in improper payments in the Medicare and Medicaid programs in fiscal year 2023. This represents 43 percent of the government-wide total of estimated improper payments that agencies reported for that year. CMS has taken several steps in response to GAO recommendations to help reduce improper payments in Medicare and Medicaid. These actions have resulted in billions of dollars in federal savings. For example:

- Improved fraud prevention in Medicare. CMS implemented capabilities that automatically stopped payments of certain improper and non-payable claims. These improvements generated an estimated almost $2 billion in savings over a 5-year period.
- Improved Medicaid managed care oversight. CMS worked with states and audit contractors to improve oversight. This included an exponential increase in investigations of managed care providers, from 16 in 2016 through 2018 to 893 in 2019 through 2021. Preliminary results indicate that the audits are identifying overpayments.
- Provider screening and enrollment**.** GAO recommended CMS expand its review of states' implementation of provider screening and enrollment requirements in Medicaid, and monitor progress when states are not fully compliant. For Medicare, GAO recommended that CMS implement a risk-based plan for revalidating enrollment for Medicare providers after pauses during the COVID-19 pandemic.
- Prepayment claim reviews in Medicare. GAO recommended that CMS seek legislative authority to allow Recovery Auditors to conduct prepayment claim reviews, which are generally more cost effective than post-payment reviews in preventing improper payments.
- Equalizing certain Medicare payments**.** GAO recommended that Congress take action to address that Medicare pays more for certain services based on where they are provided. Congress has taken some actions. For example, this committee proposed and the House passed legislation to equalize payments for certain drug administration services. Taking additional steps to equalize payments has been estimated to save Medicare $141 billion over 10 years.
- Telehealth**.** In response to the COVID-19 pandemic, HHS temporarily waived certain Medicare restrictions on telehealth and use increased dramatically. We recommended CMS comprehensively assess the quality of telehealth services in Medicare, which is needed to ensure those services are medically necessary, among other things.
- Medicaid demonstrations**.** In response to GAO recommendations, CMS has made changes to its policies for ensuring that demonstrations do not increase federal spending, reducing federal liabilities by over $120 billion. Additional action by CMS and Congress could result in further savings.
- State auditors**.** State auditors play an important role in Medicaid oversight and have identified improper payments and other deficiencies through their reviews. GAO recommended that CMS use trends in state auditor findings to inform its Medicaid oversight and share information on the status of actions to address findings with state auditors.

Recommendations: CMS has implemented dozens of GAO recommendations to improve Medicare and Medicaid. As of March 2024, over 100 recommendations to CMS remain unimplemented, including 15 related to improper payments."

15. **Waivers to Improve Services to Incarcerated Individuals:**

The Kaiser Family Foundation has released an Explainer entitled *How States Are Using Medicaid Waivers to Help Incarcerated Individuals Get Care and Transition Back into Their Communities.* "KFF examines a new

waiver opportunity that allows states to request a partial waiver of the inmate exclusion policy from CMS to help smooth individuals' transitions back into the community with "reentry services." These services aim to improve health care transitions, increase continuity of health coverage, reduce disruptions in care, improve health outcomes, and reduce recidivism rates. KFF explains the current landscape of "pre-release" waivers across states. The explainer also provides background on the demographic characteristics and health needs of people who are incarcerated. Among the key takeaways:
About 1.2 million people were incarcerated in federal and state prisons as of the end of 2022, and 660,000 people were held in local jails as of mid-year 2022. Millions more interact with the correctional system each year.

- Individuals who are incarcerated have higher rates of chronic diseases such as hypertension, tuberculosis, hepatitis, and HIV/AIDS than the general population and also have significant behavioral health needs. An estimated 65% of people incarcerated in prisons nationally have an active substance use disorder.
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- Three states (California, Montana, and Washington) have approval to provide pre-release services to certain incarcerated, Medicaid-eligible individuals as of April of this year. California estimates that approximately 200,000 people each year will be eligible to receive pre-release services, and Washington estimates 4,000 people per year will receive them. Nineteen additional states have waiver requests pending with CMS.
- Pre-release services vary by state but include (at a minimum) case management (to assess health and social needs and to assist individuals in obtaining services both pre- and post-release), medication-assisted treatment and counseling for substance use disorders, and a 30-day supply of prescription medications upon release."

16. **Voter Guide for Individuals Living With Behavioral Health Conditions:**

Mental Health America has released a voter guide that "will help ensure that people with mental health and substance use conditions feel empowered and able to vote, that candidates at the federal, state, and local levels are considering the concerns of the mental health community, and that all voters are encouraged to vote like your mental health depends on it.

This guide is non-partisan, and provides information and tools for:

- Voter registration
- Voting rights
- Making an elections action plan
- Questions to ask candidates
- Writing a letter to the editor
- Understanding major party platforms
- Sharing on social media
- Caring for your mental health
- And more!"

17. **State Medicaid Directors Letter to Assist States in Addressing the Mental Health Crisis:**

CMS has "released new guidance to State Medicaid Directors to better support states in addressing the nation's mental health crisis.

- First, today's guidance expands the pool of behavioral health care providers eligible for enhanced Medicaid dollars to include Master of Social Work and other master's-level behavioral health care providers, such as marriage and family therapists as well as mental health counselors. During a time when the country is facing an unprecedented behavioral health crisis, it is essential that state Medicaid agencies have every tool available to meet the needs of their beneficiaries. This policy will support states in hiring and maintaining the specialized expertise needed to administer a robust Medicaid program that can meet beneficiaries' behavioral health care needs.
- Second, the guidance allows for federal funds to support Nurse Advice Lines as part of the continuum of supports available for Medicaid beneficiaries. Nurse Advice Lines can help support states to expand workforce capacity and provide access to an initial source of non-emergency care, including for behavioral health. Nurse Advice Lines can provide high quality responses informed by evidence-based models of clinical practice, including for mental health and substance use needs. Following the COVID-19 Public Health Emergency and particularly in rural areas, Nurse Advice Lines can be an important tool to support ongoing access to care."

18. **<u>Summary of Changes to 42 Code of Federal Regulations (CFR) Part 2, Confidentiality of SUD Records:</u>**

The U.S. Department of Health & Human Services through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office for Civil Rights announced on February 8, 2024, a final rule that modifies the Confidentiality of Substance Use Disorder (SUD) Beneficiary Records regulations at 42 CFR Part 2 ("Part 2"). The final rule becomes effective April 16, 2024, and entities will have until February 16, 2026, to be in compliance. The changes were made in an attempt to better align Part 2 with the Health Insurance Portability and Accountability Act (HIPAA) regulations around consent, civil penalties and breaches.

The following is a summary of the major changes of the final rule.

- Adoption of HIPAA's deidentification standards that permit Part 2 programs to disclose de-identified data to public health authorities
- Beneficiary Consents:
  - Aligns requirements for Part 2 written consent to use or disclose Part 2 records with most of the content requirements for a valid HIPAA authorization
  - A single consent can be used for treatment, payment and health care operations (TPO)
  - Unless revoked, a recipient Part 2 program, HIPAA covered entity, or business associate receiving Part 2 records under such a consent may use and redisclose those records for TPO as permitted by HIPAA
- New definition for SUD clinician's notes documenting or analyzing the conversation in an SUD counseling session that can be maintained separately from the rest of the beneficiary's SUD treatment record (this would require a specific consent for disclosure)
- Permission to use or disclose Part 2 records must be given on separate consent form:
  - Prohibits combining consent for the use and disclosure of records for civil, criminal, administrative, or legislative proceedings with beneficiary consent
  - Requires a separate beneficiary consent for the use and disclosure of SUD counseling notes
  - Copy of consent or a clear explanation of scope of the consent must be provided with the record(s) being disclosed
  - Clarifies how beneficiaries (by name or "class of persons", etc.) may be designated in a consent to use and disclose Part 2 records

- Permits Part 2 programs to disclose to public health authorities (without need for beneficiary consent) deidentified beneficiary information that meets the HIPAA standards for de-identification

- Aligns Part 2 beneficiary notice requirements with the requirements of the HIPAA Notice of Privacy Practices
- Adds civil money penalties for violations of Part 2 (same as HIPAA violations)
- Restricts the use of records and testimony in civil, criminal, administrative, and legislative proceedings against beneficiaries, absent beneficiary consent or a court order
- HIPAA Breach Notification Rule has been adopted and applies to Part 2
- The Qualified Service Organization definition was modified to include HIPAA business associates when the Part 2 program is also a HIPAA covered entity
- New definitions were added, and some modified, to align with existing HIPAA terms

The following has not changed in Part 2:

- SUD treatment records cannot be used to investigate or prosecute the beneficiary without written consent or a court order
- Records from an audit or evaluation cannot be used to investigate or prosecute a beneficiary without written consent or a court order

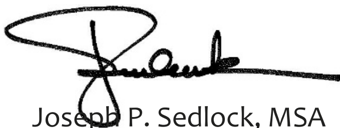
You can find more information on the final rule in the HHS press release and final rule fact sheet, as well as SAMHSA's FAQ webpage.

19. National Strategy for Suicide Prevention; First-Ever Federal Action Plan:

On April 23, 2024, the Biden Harris Administration, through the U.S. Department of Health and Human Services (HHS) released the 2024 National Strategy for Suicide Prevention (National Strategy) and accompanying Federal Action Plan. The Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Disease Control and Prevention (CDC), in partnership with the National Action Alliance for Suicide Prevention (Action Alliance), led the development of these critical deliverables which support the Biden-Harris Administration's priorities to address the overdose and mental health crises, key pillars of the Biden-Harris Unity Agenda. An Interagency Work Group (IWG), comprised of over 20 agencies in 10 federal departments across the government, contributed to the development of the *National Strategy*.

Suicide is an urgent and growing public health crisis. More than 49,000 people in the United States died by suicide in 2022. That's one death every 11 minutes. Addressing this crisis requires a bold new strategy, and the first-ever *Federal Action Plan* to put the strategy into action and drive results. The *National Strategy* is a comprehensive, whole-of-society approach to suicide prevention.

Submitted by:



Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 04/24/2024

Attachments:

- MSHN Michigan Legislative Tracking Summary

Compiled and tracked by Sherry Kletke

Below is a list of Legislative Bills MSHN is currently tracking and their status as of April 22, 2024:

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 4131	Health Insurers (Liberati) Modifies coverage for health care services provided through telemedicine.	Advanced to Third Reading in Senate (4/17/2024; With committee substitute S-2 adopted.)
HB 4169	Occupational Therapists (Rogers) Enacts occupational therapy licensure compact.	Reported in House (10/12/2023; With substitute H-1; By Health Policy Committee)
HB 4170	Occupational Therapists (Wozniak) Modifies licensure process for occupational therapists to incorporate occupational therapy licensure compact.	Reported in House (10/12/2023; With substitute H-1; By Health Policy Committee)
HB 4201	Liquor Licenses (Grant) Eliminates sunset of carryout sales and delivery of alcoholic liquor by an on-premises licensee.	Received in Senate (5/3/2023; To Regulatory Affairs Committee)
HB 4213	Telemedicine (Morse) Provides definition of distant site for a telemedicine visit.	Advanced to Third Reading in Senate (4/17/2024; With committee substitute S-1 adopted.)
HB 4498	Disabilities Discrimination (Bierlein) Requires pre-suit notice of civil actions under the persons with disabilities civil rights act and provides an opportunity to comply.	Introduced (5/2/2023; To Judiciary Committee)
HB 4523	Mental Health Court (Hope) Modifies violent offender eligibility for mental health court.	Returned from Senate (2/22/2024) Passed in Senate (2/22/2024; 34-3; immediate effect)
HB 4524 (PA 14)	Drug Treatment Courts (Andrews) Modifies termination procedure for drug treatment courts.	Signed by the Governor (3/12/2024; Signed: March 12, 2024, Effective: June 9, 2024)
HB 4525	Drug Treatment Court (Filler) Modifies violent offender eligibility for drug treatment court.	Returned from Senate (2/22/2024) Passed in Senate (2/22/2024; 32-5; immediate effect)
HB 4576	Behavioral Health Services (VanderWall) Provides specialty integrated plan for in behavioral health services.	Introduced (5/16/2023; To Health Policy Committee)
HB 4577	Mental Health (VanderWall) Provides updates regarding the transition from specialty prepaid inpatient health plans to specialty integration plans.	Introduced (5/16/2023; To Health Policy Committee)
HB 4690	Substance Abuse (Coffia) Modifies notice of a defendant's right to secular substance abuse disorder treatment.	Committee Hearing in House Judiciary Committee (6/21/2023)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 4693	Open Meetings (Fitzgerald) Allows nonelected and noncompensated public bodies to meet remotely.	Introduced (5/30/2023; To Local Government and Municipal Finance Committee)
HB 4707	Health Insurers (Brabec) Modifies coverage for intermediate and outpatient care for substance use disorder.	Advanced to Third Reading in House (10/24/2023)
HB 4745	Mental Health (BeGole) Expands petition for access to assisted outpatient treatment to additional health providers.	Introduced (6/14/2023; To Health Policy Committee)
HB 4746	Mental Health (Steele) Provides outpatient treatment for misdemeanor offenders with mental health issues.	Introduced (6/14/2023; To Health Policy Committee)
HB 4747	Mental Health (Kuhn) Expands hospital evaluations for assisted outpatient treatment.	Introduced (6/14/2023; To Health Policy Committee)
HB 4748	Mental Health (Tisdel) Allows use of mediation as a first step in dispute resolution.	Introduced (6/14/2023; To Health Policy Committee)
HB 4749	Community Mental Health (Harris) Provides community mental health oversight of competency exams for defendants charged with misdemeanors.	Introduced (6/14/2023; To Health Policy Committee)
HB 4769	Gender Neutral References (Coffia) Makes certain references in the mental health code gender neutral.	Introduced (6/15/2023; To Government Operations Committee)
HB 4817	Open Meetings (Carter, B.) Modifies procedures for electronic meetings of public bodies.	Introduced (6/15/2023; To Local Government and Municipal Finance Committee)
HB 4841	Adult Foster Care (Young) Provides for enhanced standards on adult foster care facilities.	Committee Hearing in House Families, Children and Seniors Committee (9/19/2023)
HB 4960	Employment Discrimination (Snyder) Prohibits employers and labor organizations from requesting or maintaining a record of certain criminal history information about a job applicant or employee.	Reported in Senate (4/18/2024; By Civil Rights, Judiciary and Public Safety Committee)
HB 5077	Naloxone (VanderWall) Provides distribution of naloxone under the administration of opioid antagonist act to any individual.	Advanced to Third Reading in House (4/18/2024)
HB 5078	Controlled Substances (Rheingans) Provides distribution of opioid antagonists by employees and agents of agencies under the administration of opioid antagonists act.	Advanced to Third Reading in House (4/18/2024)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 5114	Mental Health Professionals (Rheingans) Expands definition of mental health professional to include physician assistants, certified nurse practitioners, and clinical nurse specialists-certified, and allows them to perform certain examinations.	Committee Hearing in House Health Policy Committee (3/5/2024)
HB 5124	Controlled Substances (Bollin) Modifies crime of manufacturing, delivering, or possession of with intent to deliver heroin or fentanyl to reflect changes in sentencing guidelines.	Committee Hearing in House Criminal Justice Committee (3/12/2024)
HB 5125	Controlled Substances (Lightner) Allows probation for certain major controlled substances offenses.	Committee Hearing in House Criminal Justice Committee (3/12/2024)
HB 5126	Controlled Substances (Witwer) Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver heroin or fentanyl.	Committee Hearing in House Criminal Justice Committee (3/12/2024)
HB 5128	Controlled Substances (Skaggs) Modifies crime of manufacturing, delivering, or possession of with intent to deliver heroin or fentanyl to reflect changes in sentencing guidelines.	Introduced (10/12/2023; To Criminal Justice Committee)
HB 5129	Controlled Substances (Wilson) Allows probation for certain major controlled substances offenses.	Introduced (10/12/2023; To Criminal Justice Committee)
HB 5130	Controlled Substances (Filler) Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver heroin or fentanyl.	Introduced (10/12/2023; To Criminal Justice Committee)
HB 5184	Social Workers (Brabec) Modifies social work licensure requirements and includes licensure for licensed clinical social workers.	Committee Hearing in House Health Policy Behavioral Health Subcommittee (11/9/2023)
HB 5185	Social Workers (Edwards) Modifies social work licensure requirements and includes licensure for licensed clinical social workers.	Committee Hearing in House Health Policy Behavioral Health Subcommittee (11/9/2023)
HB 5276	Mental Health (Conlin) Establishes office of mental health within the Michigan department of military and veterans affairs.	Introduced (10/26/2023; To Military, Veterans and Homeland Security Committee)
HB 5277	Mental Health (Morse) Establishes office of mental health within the Michigan veterans affairs agency.	Introduced (10/26/2023; To Military, Veterans and Homeland Security Committee)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 5278	Mental Health (Bezotte) Establishes veteran service officer mental health training program.	Introduced (10/26/2023; To Military, Veterans and Homeland Security Committee)
HB 5279	Mental Health (Brabec) Establishes office of mental health peer mentorship program within the Michigan department of military and veterans affairs.	Introduced (10/26/2023; To Military, Veterans and Homeland Security Committee)
HB 5280	Mental Health (Bruck) Establishes Michigan azimuth bridge program for transitioning military service members' mental health.	Introduced (10/26/2023; To Military, Veterans and Homeland Security Committee)
HB 5343	Mental Health Professionals (Arbit) Requires insurance providers to panel a mental health provider within a certain time period of application process.	Committee Hearing in House Health Policy Committee (2/6/2024)
HB 5344	Health Benefits (Brabec) Requires nonprofit health care corporation to panel a mental health provider within a certain time period of the application process.	Committee Hearing in House Health Policy Committee (2/6/2024)
HB 5345	Mental Health Parity (Arbit) Provides mental health parity and addiction equity compliance.	Committee Hearing in House Health Policy Committee (2/6/2024)
HB 5346	Mental Health Parity (Coffia) Requires certain annual reports of health insurers relating to mental health parity.	Committee Hearing in House Health Policy Committee (2/6/2024)
HB 5347	Health Insurers (Mentzer) Requires certain annual reports of nonprofit health care corporations.	Committee Hearing in House Health Policy Committee (2/6/2024)
HB 5371	Behavioral Health Clinics (Brabec) Provides certification and funding for certified community behavioral health clinics.	Committee Hearing in House Health Policy Committee (2/6/2024)
HB 5372	Behavioral Health Clinics (Green) Provides certification for certified community behavioral health clinics.	Committee Hearing in House Health Policy Committee (2/6/2024)
SB 27	Health Insurance (Anthony) Provides equitable coverage for behavioral health and substance use disorder treatment.	Committee Hearing in House Insurance and Financial Services Committee (4/18/2024)
SB 28	Mental Health (Anthony) Expands definition of restraint.	Introduced (1/18/2023; To Health Policy Committee)
SB 57 (PA 18)	Drug Paraphernalia (Chang) Prohibits sale of nitrous oxide devices.	Signed by the Governor (3/12/2024; Signed: March 12, 2024, Effective: June 9, 2024)
SB 58 (PA 19)	Drug Paraphernalia (Bellino) Provides penalties for sale of nitrous oxide devices.	Signed by the Governor (3/12/2024; Signed: March 12, 2024, Effective: June 9, 2024)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
SB 227	Child Protection (Lauwers) Modifies emergency safety intervention in a children's therapeutic group home.	Defeated in House (1/17/2024; 52-52; Bill earlier returned from the Senate as requested and earlier vote to pass reconsidered with floor substitute H-1 adopted.)
SB 399	Mental Health (Bellino) Modifies competitive grant program.	Introduced (6/21/2023; To Appropriations Committee)
SB 499	Controlled Substances (Irwin) Exempts conduct associated with entheogenic plants and fungi from criminal penalties in certain circumstances.	Introduced (9/14/2023; To Regulatory Affairs Committee)
SB 540	Veterans (Hertel, K.) Creates Michigan veterans coalition grant program.	Introduced (10/3/2023; To Veterans and Emergency Services Committee)
SB 541	Veterans (Hauck) Creates Michigan veterans coalition fund.	Introduced (10/3/2023; To Veterans and Emergency Services Committee)
SB 542	Controlled Substances (Hertel, K.) Allows choice of formulation, dosage, and route of administration for opioid antagonists by certain persons and governmental entities if department of health and human services distributes opioid antagonists free of charge.	Introduced (10/3/2023; To Health Policy Committee)
SB 546	Liquor Licenses (Hauck) Modifies license to sell alcoholic liquor for consumption on the premises of a certain conference centers.	Received in House (3/19/2024; To Regulatory Reform Committee) Passed in Senate (3/19/2024; 37-0; Earlier advanced to Third Reading.)
SB 574	Veteran Benefits (Singh) Creates Tricare premium reimbursement program.	Introduced (10/10/2023; To Appropriations Committee)
SB 641	Open Meetings (McBroom) Revises provisions of open meetings act relating to virtual attendance and participation of members of public bodies at public meetings.	Introduced (11/7/2023; To Oversight Committee)
SB 647	Tobacco Products (Shink) Eliminates preemption of local ordinances pertaining to the sale of tobacco products or the licensure of distributors.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 648	Tobacco Products (Chang) Creates excise tax on e-cigarettes and certain other tobacco products.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 649	Tobacco Products (Cherry) Prohibits advertising for sale, displaying for sale,	Introduced (11/9/2023; To Regulatory Affairs Committee)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
	marketing, or selling a nicotine or tobacco product that has characterizing flavor.	
SB 650	Tobacco (Cherry) Revises reference to 1915 PA 31 in the age of majority act of 1971.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 651	Tobacco Products (Singh) Requires license to sell a nicotine or tobacco product at retail.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 652	Tobacco (Singh) Revises reference to 1915 PA 31 in the age of majority act of 1971.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 653	Tobacco (Cavanagh) Revises reference to 1915 PA 31 in the age of majority act of 1971.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 654	Youth Tobacco Act (Wojno) Sunsets criminal penalties and civil sanctions for minors that purchase, possess, or use tobacco products, vapor products, or alternative nicotine products.	Introduced (11/9/2023; To Regulatory Affairs Committee)
SB 695	Adult Foster Care (Singh) Modifies definitions and licensing provisions under adult foster care facility licensing act.	Committee Hearing in Senate Oversight Committee (2/7/2024)
SB 802	Mental Health (Wojno) Provides inclusion of mental health and substance use disorder services with the Michigan crisis and access line.	Introduced (3/19/2024; To Health Policy Committee)
SB 806	Mental Health (Hauck) Requires psychological evaluation on a minor in a hospital emergency room longer than a certain period of time due to a mental health episode.	Introduced (4/9/2024; To Health Policy Committee)
HCR 5	Psychological Trauma (Conlin) A concurrent resolution to urge the United States Congress, Department of Defense, and Department of Veterans Affairs to prioritize research and investment in non-technology treatment options for servicemembers and veterans who have psychological trauma as a result of military service.	Passed in Senate (9/7/2023; Voice Vote)

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Community Mental Health Member Authorities

Bay Arenac Behavioral Health
·
CMH of Clinton.Eaton.Ingham Counties
·
CMH for Central Michigan
·
Gratiot Integrated Health Network
·
Huron Behavioral Health
·
The Right Door for Hope, Recovery and Wellness (Ionia County)
·
LifeWays CMH
·
Montcalm Care Center
·
Newaygo County Mental Health Center
·
Saginaw County CMH
·
Shiawassee Health and Wellness
·
Tuscola Behavioral Health Systems

Board Officers

Ed Woods
Chairperson

Irene O'Boyle
Vice-Chairperson

Deb McPeek-McFadden
Secretary

REPORT OF THE MSHN DEPUTY DIRECTOR
to the Board of Directors
March/April

Annual Disclosure of Ownership, Controlling Interest, and Criminal Convictions

MSHN is contractually responsible for monitoring ownership and control interests within its provider network and disclosing criminal convictions of any staff member, director, or manager of MSHN, any individual with beneficial ownership of five percent or more, or an individual with an employment, consulting, or other arrangement with MSHN. Therefore, Board of Directors must complete an annual disclosure statement that ensures MSHNs compliance with the contractual and federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions.

Included in the Board Member folders is the disclosure form required to be filled out, signed, and returned. For Board Members not in attendance, the form will be emailed/mailed directly to the member. Common questions that arise when completing the form:

- ***Do I have to provide my social security number?*** 42 Code of Federal Regulations (CFR) § 455.104 requires names, address, DOB, and Social Security numbers in the case of an individual.

- ***How will my information be kept confidential and secure?*** MSHN maintains policies and practices that protect the confidentiality of personal information, including Social Security numbers, obtained from its providers and associates in the course of its regular business functions. MSHN is committed to protecting information about its providers and associates, especially the confidential nature of their personal information. Access to this, and other confidential documentation, is limited to MSHN staff who need to access information in order to perform their duties, relative to monitoring disclosures.

- ***What does MSHN do with the information it obtains through disclosure statements?*** MSHN is required to ensure it does not have a 'relationship' with an 'excluded' individual and must search the Office of Inspector General's (OIG) exclusions database to ensure that the provider entity, and any individuals with ownership or control interests in the provider entity (direct or indirect ownership of five percent or more or a managing employee), have not been excluded from participating in federal health care programs. MSHN must search the OIG exclusions database monthly to capture exclusions and reinstatements that have occurred since the last search, or at any time new disclosure information is provided.

If Board Members have questions about the disclosures or need assistance completing the form, please feel free to reach out to Sherry or myself.

Provider Network Adequacy Assessment – Fiscal Year (FY)23

The Code of Federal Regulations (CFR) at 42 CFR Parts 438.68 and 457.1218 charges states holding managed care contracts with the development and implementation of network adequacy standards. Michigan Department of Health and Human Services (MDHHS) developed parameters for Pre-paid Inpatient Health Plans (PIHPs) to ensure compliance with CFR requirements that includes time and distance standards as well as Medicaid Enrollee-Provider

Ratio standards. MDHHS requires each PIHP to submit plans on how the standards will be effectuated by region. Understanding regional diversity, MDHHS expects to see nuances within the PIHPs to best accommodate the local populations served. PIHPs must consider at least the following parameters for their plans:

1) Maximum time and distance
2) Timely appointments
3) Language, Cultural competence, and Physical accessibility

MSHN delegates Network Management to the Community Mental Health Service Programs (CMHSPs), including assurance of sufficient capacity to meet the community needs. MSHN and the CMHSPs began assessing the adequacy of our regional network. The Network Adequacy Assessment (NAA) plan was updated with FY23 data points, including the state required analysis on the above three (3) elements. After a review of the results, MSHN developed a list of recommendations to address identified gaps, areas for improvement and future demand considerations.

The Board of Directors will receive a presentation on the results of the FY23 Network Adequacy Assessment. More detailed information including regional, Substance Use Disorder (SUD) Provider Network and CMHSP specific results, related to information above is available via ***the link below: FY23 Provider Network Adequacy Assessment.***

Population Health and Integrated Care Plan 2024-2025

As an organization, Mid-State Health Network (MSHN) is committed to increasing its understanding of the health needs of individuals within its 21-county service region and finding innovative ways to achieve the goals of better health, better care, better value, better provider systems, and better equity by utilizing informed population health and integrated care strategies. The purpose of the MSHN Population Health and Integrated Care plan is to establish regional guidance and best practices in these areas as well as describe specific population health and integrated care initiatives currently underway in the MSHN region. The Population Health and Integrated Care Plan is intended to support and advance the goals and priorities outlined in the MSHN Strategic Plan. The plan will:

- Identify the population served by MSHN and explore key population health needs.
- Identify chronic co-morbid physical health conditions that contribute to poor health and drive health costs for individuals with behavioral health disorders.
- Describe the concepts of population health, social determinants of health, health disparities, health equity, and identify specific factors that impact the population in the MSHN region.
- Examine key foundational areas necessary to support population health programs and evaluate MSHN's stage of readiness for each area.
- Describe current population health and integrated care initiatives underway by MSHN and its CMHSP partner organizations.

The summary section of the plan incorporates all the above and recommends priority steps to drive population health and integrated care efforts across the region. These include:

- Identify and address current integrated health program gap areas, if applicable.
- Advance strategic priorities for 2024-2025 related to improving health outcomes and reducing health disparities.
- Determine resource and budget requirements for effective population health and integrated care initiatives.
- Identify the role of regional Council(s) and Committee(s) relative to strategic planning, monitoring and oversight of integrated care and population health activities.

- Measure the value and effectiveness of regional population health and integrated care initiatives through quality, costs, outcomes.

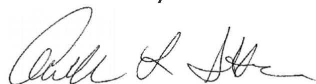
The 2024-2025 Population Health and Integrated Care Plan Summary and Recommendations include:

- Continue to explore technology platforms that leverage the use of data for predictive modeling of health outcomes.
- Fully implement the use of Admission/Discharge/Transfers (ADTs) and other CareConnect360 data with MSHN's Substance Use Disorder Service Provider (SUDSP) network.
    - Develop clinical protocols around the use of ADTs and expectations of providers relating to care coordination with physical healthcare providers.
- Continue to gather and analyze regional data on health disparities.
    - Gather stakeholder input about factors that contribute to health disparities in their communities through use of focus groups.
- Expand existing SUD Value Based Purchasing arrangements; consider use of performance metrics with all SUD providers to incentivize quality outcomes.
- Consider regional training support for CMHSP and SUDSP workforce in care management, transitions of care, and effective coordination with Medicaid Health Plans (MHPs) and physical healthcare systems.
- Develop and implement a comprehensive MSHN regional Diversity, Equity and Inclusion (DEI) Plan which also includes strategies to reduce and eliminate health disparities and promote health equity in all aspects of operations and service delivery.
- Expand availability of behavioral health services and support to residents of the MSHN region by increasing the number of Certified Community Behavioral Health Centers.
- Expand availability of health home services and support to residents of the MSHN region by increasing the number of Behavioral Health Homes, Opioid Health Homes, and SUD Health Homes.
- Develop risk stratification for Complex Care Management systems in-region to improve overall population health (e.g. unenrolled, high cost, complex physical and behavioral health.
- Develop system to monitor and support Children in Foster Care/Welfare System with joint care planning.
- Research and develop reporting system on Social Determinates of Health for individuals served, focusing on employment and housing for 2024-2025.

For the full report, see the link ***Population Health and Integrated Care Plan.***

Reporting on the population health metrics and performance is detailed in the Integrated Health Report, see the link below ***Integrated Health Quarterly Report, FY24Q1-Q2***.

Submitted by:



Amanda L. Ittner
Finalized: 4.25.24

Links to Reports:
Provider Network Adequacy Assessment FY23
Population Health and Integrated Care Plan 2024-2025
Integrated Health Quarterly Report, FY24Q1-Q2

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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 March 31, 2024, have been provided and presented for review and discussion.

Recommended Motion:

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

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

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	
		FY24 Original Bdgt		FY24 Original Bdgt			
		50%					
1	Revenue:						
2	Grant and Other Funding	$ 371,985	115,945	185,993	(70,048)	31.17 %	1a
3	Medicaid Use of Carry Forward	$ 6,930,100	4,725,283	3,465,049	1,260,234	68.18%	1b
4	Medicaid Capitation	836,629,761	404,825,396	418,314,881	(13,489,485)	48.39%	1c
5	Local Contribution	1,550,876	825,656	775,438	50,218	53.24%	1d
6	Interest Income	1,300,000	1,818,355	650,000	1,168,355	139.87%	1e
7	Non Capitated Revenue	21,631,638	7,379,242	10,815,819	(3,436,577)	34.11%	1f
8	Total Revenue	868,414,360	419,689,877	434,207,180	(14,517,303)	48.33 %	
9	Expenses:						
10	PIHP Administration Expense:						
11	Compensation and Benefits	8,053,276	3,477,227	4,026,639	(549,411)	43.18 %	
12	Consulting Services	212,800	73,463	106,400	(32,938)	34.52 %	
13	Contracted Services	131,550	50,063	65,775	(15,711)	38.06 %	
14	Other Contractual Agreements	427,000	168,560	213,500	(44,940)	39.48 %	
15	Board Member Per Diems	18,900	6,720	9,450	(2,730)	35.56 %	
16	Meeting and Conference Expense	229,275	54,281	114,637	(60,356)	23.68 %	
17	Liability Insurance	32,500	33,259	16,250	17,009	102.34 %	
18	Facility Costs	158,254	88,901	79,127	9,774	56.18 %	
19	Supplies	353,575	109,678	176,788	(67,109)	31.02 %	
20	Other Expenses	992,000	602,258	496,000	106,257	60.71 %	
21	Subtotal PIHP Administration Expenses	10,609,130	4,664,410	5,304,566	(640,155)	43.97 %	2a
22	CMHSP and Tax Expense:						
23	CMHSP Participant Agreements	774,358,597	360,934,119	387,179,298	(26,245,179)	46.61 %	1b,1c,2b
24	SUD Provider Agreements	72,537,438	31,862,157	36,268,720	(4,406,562)	43.93 %	1c,1f,2c
25	Benefits Stabilization	1,401,000	1,087,427	700,500	386,927	77.62 %	1b
26	Tax - Local Section 928	1,550,876	825,656	775,438	50,218	53.24 %	1d
27	Taxes- IPA/HRA	24,055,503	16,050,522	12,027,751	4,022,771	66.72 %	2d
28	Subtotal CMHSP and Tax Expenses	873,903,414	410,759,881	436,951,707	(26,191,825)	47.00 %	
29	Total Expenses	884,512,544	415,424,291	442,256,273	(26,831,982)	46.97 %	
30	Excess of Revenues over Expenditures	$ (16,098,184)	$ 4,265,586	$ (8,049,093)			

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

Row Numbers	A	B	C	D	
	Column Identifiers			B + C	
		Behavioral Health Operating	Medicaid Risk Reserve	Total Proprietary Funds	
1	**Assets**				
2	**Cash and Short-term Investments**				
3	Chase Checking Account	12,665,146	0	12,665,146	1a
4	Chase MM Savings	13,859,725	0	13,859,725	1a
5	Savings ISF Account	0	25,294,097	25,294,097	1b
6	Savings PA2 Account	3,356,157	0	3,356,157	1c
7	Investment PA2 Account	3,499,228	0	3,499,228	1c
8	Investment ISF Account	0	31,797,595	31,797,595	1b
9	Total Cash and Short-term Investments	$ 33,380,256	$ 57,091,692	$ 90,471,948	
10	**Accounts Receivable**				
11	Due from MDHHS	44,834,906	0	44,834,906	2a
12	Due from Miscellaneous	387,368	0	387,368	2b
13	Total Accounts Receivable	45,222,274	0	45,222,274	
14	**Prepaid Expenses**				
15	Prepaid Expense Rent	4,529	0	4,529	2c
16	Prepaid Expense Other	10,037	0	10,037	2d
17	Total Prepaid Expenses	14,566	0	14,566	
18	**Fixed Assets**				
19	Fixed Assets - Computers	189,180	0	189,180	2e
20	Accumulated Depreciation - Computers	(189,180)	0	(189,180)	2e
21	Lease Assets	203,309	0	203,309	2f
22	Accumulated Amortization - Lease Asset	(146,621)	0	(146,621)	2f
23	Total Fixed Assets, Net	56,688	0	56,688	
24	**Total Assets**	**$ 78,673,784**	**$ 57,091,692**	**$ 135,765,476**	
25					
26	**Liabilities and Net Position**				
27	Liabilities				
28	Accounts Payable	$ 8,171,372	$ 0	$ 8,171,372	1a
29	Current Obligations (Due To Partners)				
30	Due to State	33,831,196	0	33,831,196	3a
31	Other Payable	4,731,476	0	4,731,476	3b
32	Due to Hospitals (HRA)	12,882,488	0	12,882,488	1a, 3c
33	Due to State-IPA Tax	1,464,865	0	1,464,865	3d
34	Due to State Local Obligation	50,218	0	50,218	3e
35	Due to CMHSP Participants	(748,134)	0	(748,134)	3f
36	Accrued PR Expense Wages	100,173	0	100,173	3g
37	Accrued Benefits PTO Payable	453,466	0	453,466	3h
38	Accrued Benefits Other	71,024	0	71,024	3i
39	Total Current Obligations (Due To Partners)	52,836,772	0	52,836,772	
40	Lease Liability	58,978	0	58,978	2g
41	Deferred Revenue	5,858,779	0	5,858,779	1b 1c
42	Total Liabilities	66,925,901	0	66,925,901	
43	Net Position				
44	Unrestricted	11,747,883	0	11,747,883	3j
45	Restricted for Risk Management	0	57,091,692	57,091,692	1b
46	Total Net Position	11,747,883	57,091,692	68,839,575	
47	**Total Liabilities and Net Position**	**$ 78,673,784**	**$ 57,091,692**	**$ 135,765,476**	

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

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

Preliminary Statement of Net Position:

1. Cash and Short-Term Investments
   a) The Cash Chase Checking and Chase Money Market Savings accounts is the cash available for operations.
   b) The Savings Internal Service Fund (ISF) and Investment ISF reflect designated accounts to hold the Medicaid ISF funds separate from all other funding per the MDHHS contract. MSHN holds more than $31.8 M in the investment account which is about 67% of the available ISF balance. The investment percentage is less than historical amounts should the Region need to access funds for service delivery and other operational expenses. The remaining portion is held in a savings account and available for immediate use if needed. Internal Service Funds are used to cover the Region's risk exposure. In the event current Fiscal Year revenue is spent and all prior year savings are exhausted, PIHPs can transfer ISF dollars and use for remaining costs. MSHN has had a fully funded ISF which is 7.5% of Medicaid Revenue for the last several Fiscal Years.
   c) The Savings PA2 account holds PA2 funds and is also offset by the Deferred Revenue liability account and investments exceeding $3.5 M.
2. Accounts Receivable
   a) More than 45% of the balance results from Certified Community Behavioral Health Centers' (CCBHC) supplemental funding which covers all mild to moderate recipients. Supplemental funding also covers a portion of the Prospective Payment System (PPS-1) for individuals with Severe Mental Impairments (SMI)/Severe Emotional Disturbance (SED)/Substance Use Disorder (SUD). In addition, revenue withholds contribute to 18% of the balance along with 29% of October through March's Hospital Rate Adjuster (HRA) payments. Lastly, the remaining balance stems from miscellaneous items.
   b) Approximately 66% of the balance in Due from Miscellaneous represents amounts owed from providers for Medicaid Event Verification (MEV) findings. The remaining amount represents advances made to SUD providers to cover operations and other outstanding miscellaneous items.
   c) Prepaid Expense Rent balance consists of security deposits for MSHN office suites.
   d) Prepaid Expense Other represents payments for a BOX upgrade, MSHN's file storage platform.
   e) Total Fixed Assets - Computers represent the value of MSHN's capital asset net of accumulated depreciation. This item was not included in November's Financials but has been added back since the asset is still in use.
   f) The Lease Assets category is now displayed as an asset and liability based on a new Governmental Accounting Standards Board (GASB) requirement. The lease assets figure represents FY 2022 – 2025 contract amounts for MSHN's office space.
3. Liabilities
   a) MSHN estimates FY 2022 and FY 2021 lapses totaling $13.5 M and $19.1 M to MDHHS, respectively. The lapse amounts indicate the ISF was fully funded for both

fiscal years, and that savings fell within the second tier (above 5%). Per contractual guidelines MDHHS receives half of every dollar generated beyond this threshold until the PIHP's total savings reach the 7.5% maximum. Further, MSHN owes MDHHS an FY 2020 lapse amount totaling $1.2 M based on Compliance Examination adjustments.

b) This amount is related to SUD provider payment estimates and is needed to offset the timing of payments.
c) HRA is a pass-through account for dollars sent from MDHHS to cover supplemental payments made to psychiatric hospitals. HRA payments are intended to incentivize hospitals to have available psychiatric beds as needed. Total HRA payments are calculated based on the number of inpatient hospital services reported.
d) Due to State - IPA Tax contains funds held for tax payments associated with MDHHS Per Eligible Per Month (PEPM) funds. Insurance Plan Assessment taxes are applied to Medicaid and Healthy Michigan eligibles.
e) Due to State Local Obligations has a balance resulting from an advance payment from one CMHSP. MSHN submits the quarterly payment to MDHHS by the due date and then collects from the CMHSPs for their portion.
f) Due to CMHSP represents FY 23 projected cost settlement figures. During November each fiscal year, MSHN performs a preliminary settlement with its CMHSPs for 85% of the balance due by either party. The negative balance indicates MSHN's preliminary payments were higher than the projected final amounts owed to the CMHSPs listed below. These amounts will be collected during the region's final cost settlements, which generally occur in May or after Compliance Examinations are complete.

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

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

Preliminary Statement of Activities – Column F now calculates the actual revenue and expenses compared to the full year's original budget. Revenue accounts whose Column F percent is less than 50% translate to MSHN receiving less revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 50% shows MSHN's spending is trending higher than expected.

1. Revenue
    a) This account tracks Veterans Navigator (VN) activity and other small grants. The variance is expected to lessen over time as CMHSP Clubhouse Grant payments are received.
    b) The region is estimating a $4.75 M savings carry forward. Medicaid Savings are generated when the prior year revenue exceeds expenses for the same period. A small portion of Medicaid Savings is sent to the CMHSPs as funding delegated for SUD activities which include access, prevention, and customer services. FY 2023 Medicaid Carry Forward must be used as the first revenue source for FY 2024.
    c) Medicaid Capitation –The **majority** of this variance is due from MDHHS for Certified Community Behavioral Health Clinic (CCBHC) supplemental payments. Supplemental payments fully cover Prospective Payment System (PPS) rates (daily visits) for individuals classified as having mild to moderate Behavioral Health and/or SUD diagnoses. In addition, although Medicaid disenrollments exceeded numbers used in MDHHS rate setting projections, MSHN's budgeted figures for Medicaid Capitation revenue are less than a 1% variance of the actual funds received. MSHN will continue monitoring funding trends related to disenrollments and take necessary action to ensure the region's financial stability including a potential budget amendment later this fiscal year if indicated. Medicaid Capitation payment files are calculated and disbursed to CMHSPs based on a per eligible per month (PEPM) methodology and paid to SUD providers based on service delivery.
    d) Local Contribution is flow-through dollars from CMHSPs to MDHHS. Typically, revenue equals the expense side of this activity under Tax Local Section 928. Local Contributions were scheduled to reduce over the next few fiscal years until completely phased out. FY 2024 amounts owed will be the same as FY 2023.
    e) Interest income is earned from investments and changes in principle for investments purchased at discounts or premiums. Interest income is currently trending higher than budget amounts and will likely grow throughout the year. Please Note: The "change in market value" account activity has been removed for the FY 24 statements as MSHN's US treasury investments may be recorded at costs since they are held to maturity and the maturity date occurs within one year of purchase.
    f) This account tracks non-capitated revenue for SUD services which include Community Grant and PA2 funds. There is a large variance in this account because the budget amount represents the full MDHHS allocation amount regardless of planned spending. COVID dollars are the most unspent of Block Grants because of strict parameters regarding use of these funds.
2. Expense
    a) Total PIHP Administration Expense is slightly under budget. The line items with the largest dollar variances are Compensation and Benefits and Other Expenses. Other Expense balance is higher than budgeted because MiHIN's (technology provider – data exchange) entire FY 24 invoice was paid in October.
    b) CMHSP participant Agreement expenses are under budget and correlates directly to Medicaid Capitation. MSHN funds CMHSPs based on per eligible per month (PEPM) payment file. The file contains CMHSP county codes which designate where the payments should be sent. MSHN sends the full payment less taxes and affiliation fees which support PIHP operations.

c) SUD provider payments are less than anticipated and paid based on need. (Please see Statement of Activities 1c and 1f.)

d) IPA/HRA actual tax expenses are higher than the budget amount. IPA estimates are impacted by variability in the number of Medicaid and Healthy Michigan eligibles. HRA figures will also vary throughout the fiscal year based on inpatient psychiatric utilization and contribute to the variance. (Please see Statement of Net Position 3c and 3d).

MID-STATE HEALTH NETWORK
SCHEDULE OF INTERNAL SERVICE FUND INVESTMENTS
As of March 31, 2024

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	91282CDR9	1.19.22	1.20.22	12.1.23		1,992,391.23	2,000,000.00			
UNITED STATES TREASURY BILL	91282CDR9						(2,000,000.00)			
UNITED STATES TREASURY BILL	912797FU6	6.14.23	6.15.23	12.14.23		9,746,615.56	10,000,000.00			
UNITED STATES TREASURY BILL	912797FU6						(10,000,000.00)			
UNITED STATES TREASURY BILL	912797GC5	7.12.23	7.13.23	1.11.24		19,476,648.89	20,000,000.00			
							(20,000,000.00)			
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24		13,999,344.96	14,366,000.00			
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24			(14,366,000.00)			
UNITED STATES TREASURY BILL	912797JM0	12.12.23	12.14.23	4.9.24		9,833,206.75	9,833,206.75			
UNITED STATES TREASURY BILL	912797JQ1	12.29.23	1.2.24	4.30.24		1,966,250.28	1,966,250.28			
UNITED STATES TREASURY BILL	912797HF7	1.9.24	1.11.24	4.11.24		19,998,137.44	19,998,137.44			
JP MORGAN INVESTMENTS							31,797,594.47			31,797,594.47
JP MORGAN CHASE SAVINGS							25,051,117.70	0.010%	242,979.37	25,294,097.07
							$ 56,848,712.17		$ 242,979.37	$ 57,091,691.54

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 March 31, 2024

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24		3,499,349.00	3,591,000.00	912797GM3		
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24			(3,591,000.00)			
UNITED STATES TREASURY BILL	912797JZ1	2.7.24	2.8.24	6.4.24		3,499,228.51	3,499,228.51			
JP MORGAN INVESTMENTS							3,499,228.51			3,499,228.51
JP MORGAN CHASE SAVINGS							3,353,444.17	0.010%	2,712.51	3,356,156.68
							$ 6,852,672.68		$ 2,712.51	$ 6,855,385.19

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

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

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

MSHN
Mid-State Health Network

Background

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

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

Therefore, MSHN presents the attached FY24 Contract Listing for Board approval and authorization of the Chief Executive Officer to sign.

Recommended Motion:

The MSHN Board authorizes its Chief Executive Officer to sign and fully execute the contracts as presented and listed on the FY24 contract listing.

MID-STATE HEALTH NETWORK FISCAL YEAR 2024 NEW AND RENEWING CONTRACTS May 2024					
CONTRACTING ENTITY	**PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION**	**CONTRACT TERM**	**CURRENT FY24 COST REIMBURSEMENT CONTRACT AMOUNT**	**FY24 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT**	**FY24 INCREASE/ (DECREASE)**
PIHP ADMINISTRATIVE FUNCTION CONTRACTS					
Holland Litho Printing Service	FY24 MSHN Consumer Handbooks	Exp. 9.30.24	-	**48,310**	**48,310**
MacDonald Garber Broadcasting	Opioid Anti-Stigma Campaign	6.1.24 - 8.31.24	-	**150,000**	**150,000**
			$ -	**$ 198,310**	**$ 198,310**
CONTRACTING ENTITY	**SUD PROVIDERS FFS PROGRAM DESCRIPTION**	**CONTRACT TERM**			
MidMichigan Community Health Services	OHH Services	5.1.24 - 9.30.24	-	**-**	-
			$ -	**$ -**	**$ -**
CONTRACTING ENTITY	**CONTRACT SERVICE DESCRIPTION (Revenue Contract)**	**CONTRACT TERM**	**FY24 CURRENT CONTRACT AMOUNT**	**FY24 TOTAL CONTRACT AMOUNT**	**FY24 INCREASE/ (DECREASE)**
Michigan Department of Health & Human Services (EGrAMS)	Prevention II - Covid	10.1.23 - 9.30.24	424,125	**424,125**	-
	SUD Administration - COVID	10.1.23 - 9.30.24	50,000	**50,000**	-
	Treatment - COVID	10.1.23 - 9.30.24	1,443,795	**1,443,795**	-
	Women's Specialty Services - COVID	10.1.23 - 9.30.24	261,130	**261,130**	-
			$ 2,179,050	**$ 2,179,050**	**$ -**

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, March 5, 2024
Comfort Inn & Suites and Conference Center
Meeting Minutes

1. Call to Order

Chairperson Ed Woods called this meeting of the Mid-State Health Network Board of Directors to order at 5:00 p.m. Mr. Woods reminded members participating by phone may not vote on matters before the board and the Board Member Conduct Policy.

2. Roll Call

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

Board Member(s) Present: Joe Brehler (CEI), Ken DeLaat (Newaygo), Bruce Gibb (Huron), Dan Grimshaw (Tuscola)-arrived at 5:02 p.m., Tina Hicks (Gratiot)-arrived at 5:06 p.m., John Johansen (Montcalm), Pat McFarland (Bay-Arenac), Deb McPeek-McFadden (Ionia), Gretchen Nyland (Ionia), Paul Palmer (CEI), Bob Pawlak (Bay-Arenac), Joe Phillips (CMH for Central Michigan)-arrived at 5:15 p.m., Tracey Raquepaw (Saginaw), Kerin Scanlon (CMH for Central Michigan), Richard Swartzendruber (Huron), Susan Twing (Newaygo), and Ed Woods (LifeWays)

Board Member(s) Remote: David Griesing (Tuscola), Irene O'Boyle (Gratiot), and Kurt Peasley (Montcalm)

Board Member(s) Absent: Brad Bohner (LifeWays), Greg Brodeur (Shiawassee), Jeanne Ladd (Shiawassee), and Joanie Williams (Saginaw)

Staff Member(s) Present: Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Dr. Todd Lewicki (Chief Behavioral Health Officer), Paul Duff (Integrated Healthcare Coordinator), and Kim Zimmerman (Chief Compliance and Quality Officer)

Staff Member(s) Remote: Sherry Kletke (Executive Support Specialist)

3. Approval of Agenda for March 5, 2024

Board approval was requested for the Agenda of the March 5, 2024, Regular Business Meeting.

MOTION BY PAUL PALMER, SUPPORTED BY KERIN SCANLON, FOR APPROVAL OF THE AGENDA OF MARCH 5, 2024, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 16-0.

4. **Public Comment**

   There was no public comment.

5. **MSHN FY2024 Corporate Compliance Plan and FY2023 Compliance Report**

   Ms. Kim Zimmerman presented an overview of the FY2024 Corporate Compliance Plan and the FY2023 Compliance Report included within board meeting packet and recommend for board approval.

   MOTION BY TRACEY RAQUEPAW, SUPPORTED BY RICH SWARTZENDRUBER, TO APPROVE AND ACKNOWLEDGE RECEIPT OF THE MSHN FY2024 CORPORATE COMPLIANCE PLAN AND THE FY2023 ANNUAL COMPLIANCE SUMMARY REPORT. MOTION CARRIED: 17-0.

6. **Chief Executive Officer's Report**

   Ms. Amanda Ittner discussed several items in Mr. Joe Sedlock's absence from within the Chief Executive Officer's written report to the Board highlighting the following:

   - PIHP/Regional Matters
     - Congratulations to Sherrie Donnelly, MSHN Treatment and Recovery Specialist for coauthoring a recent article to be published in the American Journal of Drug and Alcohol Abuse.
     - Michigan Consortium for Healthcare Excellence (MCHE) Data Visualization Portfolio
     - Conflict Free Access and Planning (CFAP) Update
     - MSHN Prevention Media Campaigns
     - Regional Equity Upstream Learning Collaborative
     - COVID Un-Wind Update; Regional Revenue Impact
     - Regional Crisis Residential Unit "Healthy Transitions" to Open Soon

7. **Deputy Director's Report**

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

   - MSHN Staffing Update
   - Performance Bonus Incentive Award FY24
   - Balanced Scorecard FY2024 Measures Available

- Michigan Mission Based Performance Indicator System (MMBPIS)
- Substance Use Disorder Oversight Intergovernmental Agreement Update

8. Chief Financial Officer's Report

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

MOTION BY KEN DeLAAT, SUPPORTED BY TINA HICKS, TO RECEIVE AND FILE THE PRELIMINARY STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDED JANUARY 31, 2024, AS PRESENTED. MOTION CARRIED: 17-0.

9. Contracts for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2024 contract listing provided in the meeting packet and requested the board authorize MSHN's CEO to sign and fully execute the contracts listed on the FY2024 contract listing.

MOTION BY JOE BREHLER, SUPPORTED BY DAN GRIMSHAW, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY24 CONTRACT LISTING. MOTION CARRIED: 17-0.

10. Executive Committee Report

Mr. Ed Woods informed board members the Executive Committee met on February 16, 2024, and reviewed the following:

- March Board Meeting Agenda
- Tour of the Regional Crisis Residential Unit, Healthy Transitions, prior to this evening's meeting
- MSHN Board Member Sponsorship to NatCon 2024 will be David Griesing
- Annual Litigation Report - MSHN is not a named party in any litigation occurring in the region.
- FY2023 Board Self-Evaluation Progress. Mr. Woods invited Ms. Irene O'Boyle to provide members with an update. Ms. O'Boyle informed the board the survey results are being recorded and will be presented to the Executive Committee in April and to the full board in May.

11. Chairperson's Report

Mr. Ed Woods encouraged members to speak to their county Board of Commissioners related to the importance of the Substance Use Disorder Oversight Policy Board Intergovernmental Agreement discussed earlier under the Deputy Directors report.

12. Approval of Consent Agenda

Board approval was requested for items on the consent agenda as listed in the motion below, and as presented.

MOTION BY TINA HICKS, SUPPORTED BY TRACEY RAQUEPAW, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE JANUARY 30, 2024 BOARD OF DIRECTORS MEETING; RECEIVE SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD MINUTES OF DECEMBER 20, 2023; RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF FEBRUARY 16, 2024; RECEIVE POLICY COMMITTEE MEETING MINUTES OF FEBRUARY 6, 2024; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF JANUARY 22, 2024; AND TO APPROVE ALL THE FOLLOWING POLICIES: CREDENTIALING/RECREDENTIALING, DISCLOSURE OF OWNERSHIP, CONTROL AND CRIMINAL CONVICTIONS, FISCAL YEAR CONTRACT MONITORING, PROVIDER DIRECTORY, PROVIDER NETWORK MANAGEMENT, PROVIDER NETWORK RECIPROCITY, SUBSTANCE USE DISORDER DIRECT SERVICE PROVIDER PROCUREMENT, AND 1915(i) SPA. MOTION CARRIED: 17-0.

13. Other Business

There was no other business.

14. Public Comment

There was no public comment.

15. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 6:11 p.m.

Mid-State Health Network SUD Oversight Policy Advisory Board
Wednesday, February 21, 2024, 4:00 p.m.
CMH Association of Michigan (CMHAM)
507 S. Grand Ave
Lansing, MI 48933

Meeting Minutes

1. Call to Order

Chairperson Steve Glaser called the MSHN SUD Regional Oversight Policy Board (OPB) of Directors Organizational Meeting to order at 4:00 p.m. Mr. Glaser extended a warm welcome to new member, Alaynah Smith, alternate for Midland County.

Board Member(s) Present:	Lori Burke (Shiawassee), Irene Cahill (Ingham), Steve Glaser (Midland), Charlean Hemminger (Ionia), John Hunter (Tuscola), Bryan Kolk (Newaygo), John Kroneck (Montcalm), Jim Moreno (Isabella), Justin Peters (Bay), Jerrilynn Strong (Mecosta), Kim Thalison (Eaton), Dwight Washington (Clinton), and Ed Woods (Jackson)
Board Member(s) Remote:	Bruce Caswell (Hillsdale) and Nichole Badour (Gratiot)
Board Member(s) Absent:	Lisa Ashley (Gladwin), George Gilmore (Clare), Christina Harrington (Saginaw), Robert Luce (Arenac), Joe Murphy (Huron), and David Turner (Osceola)
Alternate Members Present:	Simar Pawar (Ingham) and Alaynah Smith (Midland)
Alternate Members Remote:	Margery Briggs (Ionia)
Staff Members Present:	Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Dr. Trisha Thrush (Director of Substance Use Disorder Services and Operations); Sherry Kletke (Executive Support Specialist), Joseph Sedlock (Chief Executive Officer), Skye Pletcher (Chief Population Health Officer), Katy Hammack (Integrated Healthcare Coordinator)
Staff Members Remote:	Sarah Andreotti (SUD Prevention Administrator), Sarah Surna (Prevention Specialist), Kari Gulvas (Prevention Specialist), and Sherrie Donnelly (Treatment and Recovery Specialist)

BOARD APPROVED APRIL 17, 2024

2. Roll Call

Secretary Dwight Washington provided the Roll Call for Board Attendance and informed the Board Chair, Steve Gleason, that a quorum was present for Board meeting business.

3. Approval of Agenda for February 21, 2024

Board approval was requested for the Agenda of the February 21, 2024 Regular Business Meeting, as presented.

MOTION BY BRYAN KOLK, SUPPORTED BY JERRILYNN STRONG FOR APPROVAL OF THE FEBRUARY 21, 2024 REGULAR BUSINESS MEETING AGENDA, AS PRESENTED. MOTION CARRIED: 13-0.

4. Approval of Minutes from the December 20, 2023 Regular Business Meeting

Board approval was requested for the draft meeting minutes of the December 20, 2023 Regular Business Meeting.

MOTION BY JIM MORENO, SUPPORTED BY JOHN HUNTER, FOR APPROVAL OF THE MINUTES OF THE DECEMBER 20, 2023 MEETING, AS PRESENTED. MOTION CARRIED: 13-0.

5. Public Comment

There was no public comment.

6. Opioid Health Home Presentation

MSHN Chief Population Health Officer, Skye Pletcher and Integrated Healthcare Coordinator, Katy Hammack provided members with a presentation about Opioid Health Homes in the MSHN region.

7. Board Chair Report

Chairperson Steve Glaser again welcomed Alaynah Smith, the alternate member from Midland County recognized earlier in the meeting. Mr. Glaser reported that prior to this meeting new member orientation was held for the four most recent new members to join the OPB.

8. Approval of the Substance Use Disorder Intergovernmental Agreement

Ms. Amanda Ittner provided an overview of the changes to the Substance Use Disorder Intergovernmental Agreement and requested board approval as presented.

MOTION BY BRYAN KOLK, SUPPORTED BY JIM MORENO FOR APPROVAL OF THE SUBSTANCE USE DISORDER INTERGOVERNMENTAL AGREEMENT, AS PRESENTED. MOTION CARRIED: 13-0.

Members requested MSHN Administration send an email notification when the Intergovernmental Agreement has been distributed to the counties for signature.

9. Deputy Director Report

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

Regional Matters:

- Substance Use Disorder (SUD) Oversight Policy Board (OPB) Intergovernmental Agreement
- Coordination with Counties Regarding Opioid Settlement Funds
- Recovery Incentive Pilot
- 2023 Annual Member Perception of Care Report
- Balanced Scorecard FY2023

State of Michigan/Statewide Activities

- Governors FY2025 Executive Budget Recommendations

10. Chief Financial Officer Report

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

- FY2024 PA2 Funding and Expenditures by County
- FY2024 PA2 Use of Funds by County and Provider
- FY2024 Substance Use Disorder (SUD) Financial Summary Report as of December 2023

11. FY24 Substance Use Disorder PA2 Contract Listing

Ms. Leslie Thomas provided an overview and information on the FY24 Substance Use Disorder (SUD) PA2 Contract Listing as provided in the packet.

MOTION BY JOHN KRONECK, SUPPORTED BY JIM MORENO, FOR APPROVAL OF THE FY24 SUBSTANCE USE DISORDER (SUD) PA2 CONTRACT LISTING, AS PRESENTED. MOTION CARRIED: 13-0.

12. SUD Operating Update

Dr. Trisha Thrush provided an overview of the written SUD Operations Report included in the board meeting packet, highlighting the below.

- Media Campaigns-Problem Gambling aimed at Older Adults and Anti-Stigma/Recovery
- All Vendor Education materials were ordered to begin Synar work
- New team member, Jodie Smith hired as the Data and Grant Coordinator
- Expansion of additional providers as part of RFP's with North Kent Guidance in Gratiot County and Ten16 in Isabella County for outpatient SUD services
- Expansion of harm reduction vending machines

- Equity Upstream Learning Collaborative-implementation of focus groups to gather specific DEI feedback
- New report included in packets showing FY23 full year information by county as a follow-up request from members

13. Other Business

Ms. Amanda Ittner informed members that she will be out of state attending a conference for the April 17, 2024 meeting and MSHN Chief Executive Officer, Joe Sedlock will be covering the meeting in her absence.

14 Public Comment

There was no public comment.

15. Board Member Comment

Board members expressed appreciation to Ms. Skye Pletcher and Ms. Katy Hammack for the Opioid Health Home presentation earlier in the meeting.

16. Adjournment

Chairperson Steve Glaser adjourned the MSHN SUD Oversight Policy Advisory Board Meeting at 4:55 p.m.

Meeting minutes submitted respectfully by:
MSHN Executive Support Specialist

BOARD APPROVED APRIL 17, 2024

MSHN
Mid-State Health Network

Mid-State Health Network Board of Directors
Executive Committee Meeting Minutes

Friday, April 19, 2024 - 9:00 a.m.

Committee Members Present: Ed Woods, Chairperson; Irene O'Boyle, Vice Chairperson; Deb McPeek-McFadden, Secretary; Kurt Peasley, Member at Large; David Griesing, Member at Large

Other Board Members Present: None

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

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

2. **Approval of Agenda**: Motion by K. Peasley supported by I. O'Boyle to approve the agenda for the 04/19/2024 Executive Committee Meeting. Motion Carried.

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

4. **Board Matters**

4.1 May 7, 2024 Draft Board Meeting Agenda: Agenda Reviewed. Motion at item #8 will be changed to reflect recommended motion in administrations revised board briefing paper on conflict free access and planning. Executive Committee agreed that resolution of appointment of the Deputy Director as alternate to the MCHE Board can remain on the consent agenda as it is a routine matter and any board member wanting to discuss has the option to remove from consent agenda for separate consideration. There were no other recommended changes.

Motion by I. O'Boyle supported by D. Griesing to base board meeting on the draft agenda, noting that the agenda is draft until approved at the meeting by the full board. Motion carried.

4.2 Board Member Recognition for 10 Years of Service on the MSHN Board: The following individuals will be recognized for 10 years of service on the MSHN Board at the May 7 board meeting:

- Joe Brehler
- Irene O'Boyle
- Gretchen Nyland
- Brad Bohner
- Ed Woods
- John Johansen
- Kurt Peasley
- Dan Grimshaw

The Executive Committee recommends a ceremony after the Board Meeting is called to order. A. Ittner noted that MSHN is preparing an updated Impact Report and MSHN would like to have a photo of the honorees to include in the updated report. MSHN will make arrangements for needed photos.

4.3 Board Self-Evaluation Update: I. O'Boyle reviewed the summary of board self-evaluation results, noting several areas for focus in the future. Administration was asked to include the results in the board meeting packet, and to annotate items under Boardsmanship for the Chair to address in his report.

4.4 Other: None

5. **Administration Matters**

5.1 Conflict Free Access and Planning – Draft Board Briefing Paper: J. Sedlock provided a substitute document for consideration by the Executive Committee. J. Sedlock explained the rationale for a substitute document and replacement recommendations. He explained the MSHN Operations Council met earlier this week on this topic, and the draft briefing paper included in the Executive Committee packet was reviewed and discussed in detail, noting that all 12 CMHSP CEOs oppose the conflict free access and planning design decisions announced by MDHHS 3/22 and 4/1. The announced decisions are not much different than the design models opposed by the MSHN board a year ago. Mr. Sedlock also noted that the CMH Association and most (if not all) CMHSPs are engaging in advocacy to reverse or modify these decisions, including with MDHHS and the Michigan Legislature. Mr. Sedlock advised that he took the counsel of the Operations Council to split the decisions into advocacy support (which is consistent with the May 2023 board resolution opposing the models) and implementation or compliance (to be determined/decided at a future date). The Executive Committee agreed with these rationales and to split these decisions into advocacy, now, and to consider compliance separately. The Executive Committee noted that if MSHN is required by contract or official state policy to comply, a special board meeting may not be required (on strength of the argument that MSHN does not need board action to carry out its responsibilities), but also noted that if there is a need for a special board meeting or if Administration wants board action on the matter, that Administration is directed to convene the Executive Committee to determine whether a special board meeting is needed and if so to set the logistics.

5.2 Resolution Appointing Deputy Director as Alternate Representative to the Michigan Consortium for Healthcare Excellence: J. Sedlock summarized rationale for appointment of an alternate to the MCHE Board. The Executive Committee supports the resolution of appointment.

5.3 Other: None

6. **Other**

6.1 Any other business to come before the Executive Committee: None

6.2 Next scheduled Executive Committee Meeting: 06/21/2024, 9:00 a.m. It was noted that an ad hoc Executive Committee meeting may be needed pursuant to the discussion of a special board meeting above.

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

8. **Adjourn:** This meeting was adjourned at 9:52 a.m.

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, APRIL 2, 2024 (VIDEO CONFERENCE)

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

Members Absent: Jeanne Ladd

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

1. CALL TO ORDER

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

2. APPROVAL OF THE AGENDA

MOTION by David Griesing, supported by Irene O'Boyle, to approve the April 2, 2024, Board Policy Committee Meeting Agenda as presented. Motion Carried: 4-0.

3. POLICIES UNDER DISCUSSION

There were no policies under discussion.

4. POLICIES UNDER BIENNIAL REVIEW

Mr. John Johansen invited Ms. Amanda Ittner to inform members of the revisions made to the policies under biennial review for the Utilization Management chapter as listed below. Ms. Ittner provided an overview of the substantive changes within the policies. The Utilization Management policies were reviewed by the Chief Population Health Officer and the Utilization Management Committee.

CHAPTER: UTILIZATION MANAGEMENT

1. ACCESS SYSTEM
2. LEVEL OF CARE SYSTEM
3. RETROSPECTIVE SAMPLE REVIEW – ACUTE CARE SERVICES
4. UTILIZATION MANAGEMENT

MOTION by David Griesing, supported by Kurt Peasley, to approve and recommend the policies under biennial review as presented. Motion carried: 4-0.

5. NEW BUSINESS

6. ADJOURN

Mr. John Johansen adjourned the Board Policy Committee Meeting at 10:04 a.m.

Meeting Minutes respectfully submitted by:
MSHN Executive Support Specialist

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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 02/26/2024

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

Agenda Item	Action Required				
CONSENT AGENDA	BHQ1 Report removed for discussion – See below				
	Consent Items received and approved	By Who	N/A	By When	N/A
Inpatient Psychiatric Tiered Rate Implementation – Regional Coordination	J. Sedlock reviewed the Inpatient Psychiatric Tiered Rate slide deck. Joe proposed to take a regional approach to negotiating the contracts to provide a standard rate across the region, understanding each CMH would sign their own contract. The rate right now included physician services and intended to be inclusive. L. Thomas has concerns with the revenue and expense tracking in FY25. Leslie recommended MDHHS should pilot this with one hospital. Not all hospitals are in the workgroup. Ops Council supports a regional approach to contract implementation.				
	CMHSPs are encouraged to give feedback to MDHHS (Jackie Sproat and Keith White) so they hear the concerns outside of the workgroup, with a copy to MSHN. Chris agreed to draft language and will share with the group Joe will request CEOs appoint a workgroup participant to negotiate rates on behalf of the region and request information of hospital relationships to share workload across the region.	By Who	CMHSPs Chris Pinter Joe Sedlock	By When	3.15.24 3.7.24 3.7.24
Regional Financial and cash Management Issues	Joe indicated MSHN has been reviewing the cash demands and cash flow projections in anticipation of possible ISF abatement. MSHN has developed an emergency cash management strategy to assist while MSHN is waiting for a rate adjustment. MSHN intends to avoid ISF abatement if at all possible, but anticipates some short term cash needs across the region. Rate adjustments are anticipated for the spring. PIHP CFOs are presenting rate analysis, including enrollee information and revenue projections to support a rate adjustment and help MDHHS understand the impact of disenrollments. It is uncertain that the rate adjustment will be to the positive but MDHHS has acknowledged the issue. At January, MSHN is $10m under revenue projections.				

Agenda Item	Action Required				
	MSHN will request of the CFOs with copy to the CEOs their cash needs for the next two-three months and the cash request from MSHN.	By Who	L. Thomas/CFO's	By When	3.11.24
Bylaws Review Plan	J. Sedlock reported Chris, Brian, Lindsey and Carol are part of the Bylaws review workgroup. The first meeting will occur after the April Ops Council meeting. CFAP may or may not affect the Bylaws, so that is why the meeting was scheduled after April. Most likely any CFAP changes will affect the delegation agreement. Others who want to participate can do so.				
	Informational Only	By Who	N/A	By When	N/A
CCBHC Expansion Plans & BHH Expansion Plans	Amanda Ittner requested information related to future expansion of CCBHC and BHH.				
	Informational Only	By Who	N/A	By When	N/A
Conflict Free Access and Planning	MDHHS sent out a survey to the PIHPs to fill out and return. The survey has been shared with Ops Council to provide any concerns and/or feedback. The focus seems to limit the areas to HCBS, 1915c and 1915i. MDHHS is still in discussion with CMS regarding the exemption of CFAP regulations for CCBHC. MDHHS indicated an announcement would be sent out this week and meet with each PIHP. The survey is now in place of that meeting, which is due later this week. C.Mills asked to reinforce rural exemptions.				
	CMHs to provide feedback by COB Tuesday	By Who	CMHSPs	By When	2.27.24
BHQ1 Report – Autism Revenue	Carol Mills discussed pulling this item out because she wanted to discuss the Autism revenue distribution. Changing this distribution process was referred to Finance Council. Leslie Thomas report FC reviewed the Autism case rate and completed the straight CAP analysis. FC voted and 10/11 wanted to remain on the enrollee process. Carol requested Ops Council revisit this distribution.				
	MSHN will add Autism Revenue and Expense Analysis to the March Agenda.	By Who	3.15.24	By When	3.15.24

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 03/18/2024

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

Agenda Item	Action Required				
CONSENT AGENDA	Add V.e under consent for further discussion – Service Use Analysis				
	Received and approved	By Who	N/A	By When	N/A
SAVINGS ESTIMATES	L.Thomas reviewed the savings estimates, noting the numbers are soft. Pg. 91 – Okay with only separating Autism and HSW. Pg. 94 – Autism expenditure over by 9m. CFO's are completing regional reporting on cost containment plans, including reporting of increased and unanticipated expenses. Due to early projections related to Q1, individual cost containment plans are not being requested. Regional strategy for cost containment is being implemented after which individual cost containment would be considered after the March 2024 financials.				
	Discussion and planning	By Who	N/A	By When	N/A
AUTISM REVENUE & SERVICE USE EVALUATION	L. Thomas reviewed the Autism revenue worksheet. Autism revenue is not dispersed as a PEPM but rather enrollment based. This decision was authorized years ago with the autism rollout and is documented in the MSHN Operating Agreement. Discussion regarding changing the revenue distribution. Cost settlement still doesn't change in terms of year end cost/Medicaid settlement with the PIHP. Any change only affects the upfront payment and potentially cash flow. Discussed looking at rates for FY25 and then discuss a process change to Autism revenue. If a change is recommended, the Operating Agreement will need to be changed.				
	MSHN to develop a smoothing plan or multi-year implementation plan for Autism revenue that may or may not include the adjusted rates.	By Who	J. Sedlock/L. Thomas	By When	4/30/24
SHORT TERM CASH FLOW ANALYSIS	J. Sedlock reviewed Leslie's verbal report on the amount of cash advances requested for March and April. Follow up was sent out to CMHs to clarify the amount. Will revisit in April, once we know the amount of rate setting adjustment.				

Agenda Item	Action Required				
	Discussion only	By Who	N/A	By When	N/A
BTP VS. HCBS GUIDANCE RECOMMENDATIONS	T. Lewicki reviewed the BTP & HCBS Guidance recommendations and requested support from Ops Council of the recommendations therein. Ops Council supported and added this is concern for services and revenue. Contract negotiations on both the CMH and PIHP has supported defining of BTP as a component/part of IPOS. Also add collaboration with PIHPs				
	Ops Council supported	By Who	T. Lewicki	By When	4.15.24
PSYCHIATRIC INPATIENT TIERED RATES & REGIONAL WORKGROUP	J. Sedlock reviewed the status of the workgroup, including the update of the 4th quarter implementation that the state is still trying to implement. Joe recommended an ad hoc workgroup to plan for this process. BABH shared letter directed to MDHHS regarding the concern for implementation and encouraged other CMHs to do the same. 2 CEO's to help lead this group: Chris Pinter & Carol Mills Joe will draft a charter for the workgroup				
	Ops Council supported a workgroup	By Who	J. Sedlock	By When	3.30.24
CFAP: EXPECTED MID-MARCH PIHP MEETING	J. Sedlock announced the CFAP PIHP only meeting this Friday. MDHHS scheduled a meeting with CMHs.				
	Informational Only	By Who	N/A	By When	N/A
CCBHC & BHH	Nothing to discuss today				
		By Who	N/A	By When	N/A
BY-LAWS WORKGROUP TO CONVENE	Workgroup will convene immediately after the April Operations Council.				
	Informational Only	By Who	N/A	By When	N/A
SERVICE USE ANALYSIS	J. Sedlock reminded the group that Ops Council wanted to review the service use analysis in light of cost variations and cost containments. CLS being one of the outliers. A.Ittner reported UMC has been reviewing CLS and working to bring a recommendation to Ops Council for standardization of assessment in developing rate.				
	Support from Ops to have UMC continue their work and review the CLS tools.	By Who	A.Ittner/S.Pletcher	By When	5.1.24

Agenda Item	Action Required				
May Ops Council	May Operations Council is now in conflict with the Directors Forum planning. The week after is Memorial Week.				
	Joe will send out a new calendar invite for May meeting	By Who	J. Sedlock	By When	4.15.24

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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 04/15/2024

Members Present: Chris Pinter; Lindsey Hull; Carol Mills; Julie Majeske; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; Bryan Krogman; Sandy Lindsey;
Members Absent: Maribeth Leonard; Sara Lurie
MSHN Staff Present: Joseph Sedlock; Skye Pletcher (pertinent topic); Todd Lewicki (pertinent topic)

Agenda Item	Action Required				
CONSENT AGENDA	No exceptions for discussion				
	Approved as presented.	By Who		By When	
FY24-25 POPULATION HEALTH AND INTEGRATED CARE PLAN	Skye Pletcher reviewed the Population Health and Integrated Care Plan for FY 24-25. MHP Bid awards may require that MSHN edit that portion of the plan to update. High level review of Diversity, Equity, Inclusion and Health Equity work was provided. New sections added to cover CCBHC, BHH, OHH and other integrated care initiatives. Recommendations for the plan period were reviewed in detail. Exploring possibilities for sharing SUD information consistent with recent updates at the federal level of 42CFR2. Previous reviews by CLC, Regional Medical Directors, and REACH.				
	MSHN will review table on page 37 to confirm accuracy. Operations Council approves and recommends board approval.	By Who		By When	
DRAFT REGIONAL INPATIENT TIERED RATE IMPLEMENTATION WORKGROUP CHARTER - APPROVAL	Charter approved as presented. Discussion focused on when to launch. Determination was made to launch June 2024. CMHSPs to circulate approved charter to their identified members as a heads up.				
	Charter approved; launch June 2024. J. Sedlock to send approved charter to CMHSPs for internal distribution.	By Who	J. Sedlock	By When	04/15/24
CONFLICT FREE ACCESS AND PLANNING-UPDATES/DISCUSSION	MSHN circulated a draft briefing paper and recommendation intended for the MSHN Board of Directors May meeting, which was discussed in detail. It is the unanimous recommendation of the region's CMHSP Participants to revise the briefing paper to focus on continued advocacy for reconsidering/reversing MDHHS decisions and to remove content (and recommendations) associated with compliance activity for MSHN and the region. The position of the regional CMHSPs is to keep the focus on advocacy and to deal with separately, by a special meeting of the MSHN board, if/when implementation compliance is required by MDHHS.				
	J. Sedlock will circulate a revised board briefing paper by the end of this week. Operations Council scheduled a provisional meeting for Tuesday, April 23 if further discussion seems warranted	By Who	J. Sedlock J. Sedlock	By When	04/19/24 04/15/24

Agenda Item	Action Required				
	after the revised draft is circulated. J. Sedlock to send a provisional calendar invite.				
HCBS/MDHHS REQUEST FOR CMS REVIEW	Todd Lewicki reviewed issues and recommendations around an ad hoc request from MDHHS for information not tracked by CMHSPs or MSHN. MDHHS request is intended to inform CMS site visit preparations by MDHHS. MSHN recommendation is to not comply with the request due to its breadth/scope and resources needed to comply by 05/30/24 which is not possible. MSHN will communicate this position to MDHHS.				
	CMHSP Participants agreed with MSHN recommendation; MSHN will send the original communication to HCBS leads so that CMHSP CEOs can stand down any initiated compliance activities.	By Who	T. Lewicki	By When	04/15/24
BYLAWS REVIEW SUBCOMMITTEE	C. Mills, C. Pinter, B. Krogman, L. Hull, and J. Sedlock met to conduct the policy-required review of Bylaws. Discussion occurred and was deferred to review of the Operating Agreement on SUD responsibilities of MSHN, Autism funding mechanics, and responsibility of Participating CMHSPs to participate in ISF replenishment in the event of its use.				
	Subcommittee recommendations include striking a single line in the preamble on the supremacy of the Operating Agreement if conflicts exist between it and the bylaws; evaluate whether requirements of 1204b of the mental health code are included properly in the bylaws; confirm that parliamentary procedural notations at section 5.5 and following are necessary for bylaws inclusion; and to check language at 3.13 permitting MSHN to enter into contracts "without limitation." J. Sedlock to update draft, circulate to members, take input, then provide to MSHN legal counsel.	By Who	J. Sedlock	By When	04/26/24

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Community Mental Health Member Authorities

Bay-Arenac Behavioral Health

CMH of Clinton.Eaton.Ingham Counties

CMH for Central Michigan

Gratiot Integrated Health Network

Huron Behavioral Health

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

LifeWays

Montcalm Care Network

Newaygo County Mental Health Center

Saginaw County CMH

Shiawassee Health & Wellness

Tuscola Behavioral Health Systems

Board Officers
Edward Woods
Chairperson

Irene O'Boyle
Vice-Chairperson

Deb McPeek-McFadden
Secretary

MID-STATE HEALTH NETWORK BOARD OF DIRECTORS

RESOLUTION

WHEREAS, the Mid-State Health Network Board of Directors is a member of the Michigan Consortium for Healthcare Excellence;

WHEREAS, the Mid-State Health Network Board of Directors formally adopted the bylaws of the Michigan Consortium for Healthcare Excellence by adopted resolution on September 6, 2016;

WHEREAS, the Mid-State Health Network Board of Directors formally joined the Michigan Consortium for Healthcare Excellence by adopted resolution on September 6, 2016;

WHEREAS, the Mid-State Health Network Board of Directors, as the member, formally appointed the Mid-State Health Network Chief Executive Officer as Member Representative to the Michigan Consortium for Healthcare Excellence Board of Directors;

WHEREAS, Section 7 of the bylaws of the Michigan Consortium for Healthcare Excellence permit members to appoint an alternate to carry out the duties of the Member Representative.

NOW, THEREFORE, BE IT RESOLVED that the Mid-State Health Network Board of Directors, having previously appointed its Chief Executive Officer as Member Representative, hereby appoints the Mid-State Health Network Deputy Director (or equivalent position) as an alternate to carry out the duties of the Chief Executive Officer in all matters before the Michigan Consortium for Healthcare Excellence in the absence or at the request of the Mid-State Health Network Chief Executive Officer.

RESOLUTION ADOPTED

I, Deb McPeek-McFadden, Secretary of the Mid-State Health Network Board of Directors, certify that the forgoing is a true and complete copy of the Resolution duly adopted by the Board of Directors of Mid-State Health Network at a meeting held on May 7, 2024 at which a quorum was present, and that the minutes of said meeting are kept.

____________________________________ ________________
Deb McPeek-McFadden, Secretary Date
Mid-State Health Network Board of Directors

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter	Utilization Management		
Title:	**Access System Policy**		
Policy: ☒ **Procedure:**☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** ~~UM Director~~Chief Population Health Officer & UM Committee	**Adopted Date:** 11.22.2013 **Review Date:** ~~05.03.2022~~ 02.22.2024	**Related Policies:** Service Delivery System: Service Philosophy Utilization Mgmt: Utilization Management

Purpose
Mid-State Health Network (MSHN) shall ensure regional access to public behavioral health services in accordance with the Michigan Department of Health & Human Service (MDHHS) contracts, MDHHS Access Standards, MDHHS Medicaid Provider Manual, and Michigan Mental Health Code. The purpose of this policy is to create, implement and maintain access system standards that are uniform throughout the region, MSHN has delegated its access system to its Community Mental Health Service Program (CMHSP) Participants and Substance Use Disorder Service Providers (SUDSP). The MSHN provider network shall develop written policies, procedures and plans demonstrating the capability of its access system to comply with those standards and provide for efficient and effective access practices.

Policy MSHN's provider network administers a welcoming, responsive, access system 24 hours a day, 7 days a week, 365 days a year. Individuals may contact any CMHSP seeking information, services, and/or support systems for behavioral health care needs including:

- Intellectual/ Developmental Disabilities (IDD),
- Mental Illnesses (MI),
- Serious Emotional Disturbance (SED)
- Substance Use Disorders (SUD), and/or
- Co-occurring Disorders

Additionally, it is the policy of MSHN that the regional access system incorporates a "no wrong door" approach for substance use treatment services. Individuals seeking information, services, and/or supports for substance use treatment needs may contact any CMHSP **or** any SUDSP.

The access system performs the following key functions:

1. **Welcome** all individuals by demonstrating empathy and providing opportunity for the person presenting to describe situation, problems, and functioning difficulties; exhibiting excellent customer service skills; and working with them in a non-judgmental way.

2. **Screen** individuals who approach the Access System to determine whether they are in crisis and, if so, assure that they receive timely appropriate attention.

3. **Determine** individuals' eligibility for Medicaid specialty services and supports, MIChild, Healthy Michigan Plan, Substance Abuse Block Grant (SABG) or, for those who do not have any of these benefits as a person who is presenting needs for behavioral health services, make them a priority to be served.

4. **Collect** information from individuals for decision-making and reporting purposes.

5. **Refer** individuals in a timely manner to the appropriate behavioral health practitioners for assessment, person-centered planning (PCP), and/or supports and services or, if the individual is not eligible for Prepaid Inpatient Health Plan (PIHP) or CMHSP services, to community resources that may meet their needs.

6. **Inform** individuals about all the available mental health and substance abuse services and providers and their due process rights under Medicaid, MIChild, Healthy Michigan Plan, SABG, and the Michigan Mental Health Code.

7. **Conduct outreach** to under-served and hard-to-reach populations and be accessible to the community-at-large.

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~~:
~~42 CFR Part 2: The portion of the Code of Federal Regulations which establishes confidentiality requirements pertaining to recipients of substance use disorder treatment services~~
~~ASAM-PPC: American Society of Addiction Medicine-Patient Placement Criteria~~
~~BH-TEDS: Behavioral Health Treatment Episode Data Set~~
~~EPSDT: Early Periodic, Screening, Diagnosis, and Treatment~~
~~CAFAS: Child and Adolescent Functional Assessment Scale~~
CMHSP: Community Mental Health Service Program
~~Contractual Provider: refers to an individual or organization under contract with MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP Participants who hold retained functions contracts~~
~~Employee: refers to an individual who is employed by the MSHN PIHP~~
IDD: Intellectual/Developmental Disabilities
~~LOCUS: Level of Care Utilization System~~
MDHHS: Michigan Department of Health & Human Services
MI: Mental Illnesses
MIChild: a Medicaid health insurance program for uninsured children of Michigan's working families
MSHN: Mid-State Health Network
PCP: Person-Centered Plan
PIHP: Prepaid Inpatient Health Plan
~~Subcontractors: refers to an individual or organization that is directly under contract with CMHSP and/or MSHN to provide behavioral health services and/or supports~~
Provider Network: refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements
SABG: Substance Abuse Block Grant
SED: Serious Emotional Disturbance
~~SIS: Supports Intensity Scale~~
Staff: refers to an individual directly employed and/or contracted with a CMHSP Participant or SUD providers
SUD: Substance Use Disorder
SUDSP: Substance Use Disorder Service Provider
UMC: Utilization Management Committee

References/Legal Authority:
1. Access System Standards: MDHHS, revised July 29, 2020
2. Appeal and Grievance Resolution Processes Technical Requirement: MDHHS, revised July 29, 2020

3. 42CFR 438.206: Access Standards
4. 42CFR 438.208(c)(4)
5. 42CFR 438.210: Enrollee Rights
6. Michigan Mental Health Code 330.1124: Waiting Lists for Admission
7. Michigan Mental Health Code 330.1208: Individuals to Whom Service is Directed
8. MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disabilities Supports and Serviceschapter
9. Person-Centered Planning Practice Guideline: MDHHS, , revised July 29, 2020

Other References:

MSHN Medicaid Subcontract Agreement Exhibit H: Technical Requirement: CMHSP RESPONSIBILITIES FOR 24/7/365 ACCESS FOR INDIVIDUALS WITH PRIMARY SUBSTANCE USE DISORDERS

Change Log:

Date of Change	Description of Change	Responsible Party
11.22.2013	New Policy	UMC
09.2014	Annual Review and update of definitions and acronyms	MSHN CEO
06.2015/07.2015	Update to integrate with UMP	UMC and MSHN CEO
07.23.2015	Clarify clinical eligibility for SUD, clarify FY15 contract provisions.	UMC
04.26.2016	Differentiated SED from MI, 2015 MDHHS Access Policy, and added assessment tools and reference to HSW and EPSDT policies.	UMC
10.27.2016	Updated the policy to reflect Access Management System changes in FY17 MDHHS/PIHP contract.	UMC
10.26.2017	Updated policy to reflect the PCP policy language around assessment tools and PCP process for authorizing services	UMC
10.26.2018	Annual Review	UMC
02.27.2020	Annual Review- added MDOC priority population requirements for SUD services; added DECA as contractually mandated assessment tool	UMC
02.24.2022	Biennial Review – Updated References/Legal Authorities to current versions; Re-formatted to align with MDHHS Access Standards (Rev. January 2022); Separated content into Access Policy and Access Procedure	UMC
02.22.2024	Biennial Review	UMC

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Chapter:	Utilization Management		
Title:	Level of Care System (LOC) for Parity		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: ~~Chief Behavioral Health Officer; Admissions and Benefits Standardization Workgroup~~ Chief Population Health Officer; UM Committee	Adopted Date: 03.03.2020 Review Date: ~~05.03.2022~~ 02.22.2024	Related Policies: Service Philosophy Utilization Management

Purpose

The purpose of this policy is to define the expectations for Mid-State Health Network (MSHN) and its Community Mental Health Service Program (CMHSP~~s~~) participants related to ensuring consistent application of medical necessity criteria by implementing the regional admission and service guidelines that include service code-level thresholds for individuals via a nationally recognized recommended Level of Care (LOC) instrument [~~(~~i.e. Child and Adolescent Functional Assessment Scale/ Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) or~~,~~ Level of Care Utilization System (LOCUS)~~, or SIS)~~], and person-centered planning process. This is used to address compliance with the Mental Health Parity and Addiction Equity Act of 2008.

Policy

~~Mid-State Health Network (~~MSHN~~)~~ and its provider network shall ensure that medical necessity determination decisions are informed by the MSHN Admission and Service Selection Guidelines. It is the policy of MSHN and its CMHSP participants to use objective evidence-based criteria and best practices, objective service utilization patterns and the person-centered planning process that includes consideration of the individual circumstances and the local delivery system when determining medical necessity. MSHN and its CMHSP participants use nationally-recognized criteria based on sound clinical evidence to ensure a consistent benefit across the region, (MCG Behavioral Health Medical Necessity Guidelines), need identification instruments, and the person-centered planning process to make utilization management (UM) decisions for behavioral health services as well as for agreed upon thresholds comparable to all Michigan Pre-Paid Inpatient Health Plans (PIHPs).

MSHN delegates all access, authorization and utilization management functions for behavioral health services to its CMHSP participants, which must operate in compliance with regional policy and procedure.

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~~:

CAFAS: Child and Adolescent Functional Assessment Scale
CMHSP: Community Mental Health Service Program
LOC: Level of Care
LOCUS: Level of Care Utilization System

MCG: MCG Health is a software vendor who offers a proprietary product, the MCG Care Guidelines. The MCG Care Guidelines were selected by the Michigan Parity Workgroup as the tool to be utilized by all Michigan PIHPs and CMHSPs to provide care guidance for acute behavioral health services.
MSHN: Mid-State Health Network
PECFAS: Preschool and Early Childhood Functional Assessment Scale
PIHP: Prepaid Inpatient Health Plan
~~SIS: Supports Intensity Scale~~

References/Legal Authority:

1. Mental Health Parity and Addiction Equity Act of 2008
2. MDHHS Mental Health and Substance Use Disorder Parity Assessment and Corrective Action Plan, 2018

Other References:
N/A

Change Log:

Date of Change	Description of Change	Responsible Party
07.24.2019	New Policy	Director of Utilization and Care Management
02.24.2022	Biennial Review	UM Committee
02.22.2024	Biennial Review	UM Committee

MSHN
Mid-State Health Network

Chapter:	Utilization Management		
Title:	Retrospective Sample Review of Acute Care Services Policy		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: ~~Director of Utilization & Care Mgmt.~~ Chief Population Health Officer; UM Committee	Adopted Date: 03.05.2019 Review Date: ~~05.03.2022~~ 02.22.2024	Related Policies: Service Philosophy Utilization Management

Purpose

Mid-State Health Network (MSHN) and its provider network shall ensure that medical necessity determination decisions for acute care services are conducted using defined criteria and standardized service selection guidelines. In the context of this policy acute care services include inpatient psychiatric hospitalization, crisis residential, and continuing stay reviews for inpatient psychiatric hospitalization. The purpose of this policy is to define the expectations for MSHN Community Mental Health Service Programs (CMHSPs) related to ensuring consistent application of medical necessity criteria for acute care services by implementing a sampling process to complete retrospective reviews of acute care services.

Policy

It is the policy of MSHN and its CMHSP participants to use objective and evidence-based criteria and best practices, objective data based upon typical service utilization patterns for specialty behavioral health services and taking into consideration the consumer's individual circumstances and the local delivery system when determining the medical necessity of acute care services. MSHN and its CMHSP participants use nationally-recognized written criteria based on sound clinical evidence (MCG Behavioral Health Medical Necessity Guidelines) to make Utilization Management (UM) decisions for acute care services.

MSHN delegates all utilization management functions for behavioral health services, including pre-screening and authorization for acute care services, to its CMHSP participants. It is the policy of MSHN that each CMHSP is responsible for establishing its own local policies and procedures relative to using MCG medical necessity criteria to conduct retrospective reviews for acute care services. The policy and/or procedure must include the use of a retrospective sampling process to conduct reviews of a percentage of all cases in which acute care services were received.

Applies to:

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

Definitions~~/Acronyms~~:

CMHSP: Community Mental Health Service Program
MCG: MCG Health is a software vendor who offers a proprietary product, the MCG Care Guidelines. The MCG Care Guidelines were selected by the Michigan Parity Workgroup as the tool to be utilized by all Michigan PIHPs and CMHSPs to provide care guidance for acute behavioral health services.
MDHHS: Michigan Department of Health & Human Services
MSHN: Mid-State Health Network

PIHP: Prepaid Inpatient Health Plan
~~**Definitions/Acronyms (continued)**~~
Provider Network: refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements
UM: Utilization Management

References/Legal Authority:

1. Mental Health Parity and Addiction Equity Act of 2008
2. MDHHS Mental Health and Substance Use Disorder Parity Assessment and Corrective Action Plan, 2018

Other References:
N/A

Change Log:

Date of Change	Description of Change	Responsible Party
10.22.2018	New Policy	Director of Utilization and Care Management
02.27.2020	Annual Review- no changes	UM Committee
02.24.2022	Biennial Review- no changes	UM Committee
02.22.2024	Biennial Review – no changes	UM Committee

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POLICIES AND PROCEDURE MANUAL

Chapter:	Utilization Management		
Title:	Utilization Management Policy		
Policy: ☒ Procedure: ☐ Page: 1 of 4	Review Cycle: Biennial Author: Chief Population Health Officer ~~UM Director~~ and UM Committee	Adopted Date: 11.22.2013 Review Date: ~~05.03.2022~~ 02.22.2024	Related Policies: Utilization Mgmt: Access Service Delivery System: Service Philosophy; Level of Care System (LOC) for Parity

Purpose

Mid-State Health Network (MSHN), either directly or through delegation of function to its provider network, is responsible for the region's Utilization Management (UM) system. Through contract, MSHN has identified the retained and delegated functions of the networks UM system. MSHN is responsible for oversight and monitoring of all UM functions.

UM is a set of administrative functions that assure appropriate clinical service delivery. In short, this means the "right service in the right amount to the right individuals from the right service provider". These functions occur through the consistent application of written policies and eligibility criteria

Policy

MSHN UM functions are performed in accordance with approved MSHN policies, protocols and standards and may be delegated to its provider network or directly administered by the Pre-Paid Inpatient Health Plan (PIHP). ~~(see Attachment A).~~ This includes monitoring of local prospective, concurrent and retrospective reviews of authorization and UM decisions, activities regarding level of need and level/amount of services. MSHN maintains a Utilization Management Delegation Grid (see Attachment ~~B~~A) that defines whether a utilization management function is considered retained or delegated.

MSHN provider network shall have mechanisms to identify and correct under/over-utilization of services; as well as procedures for conducting prospective, concurrent, and retrospective reviews. Qualified health professionals shall supervise review decisions. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to provide treatment in consultation with the primary care physician as appropriate. MSHN conducts data-driven analysis of regional utilization patterns, and monitoring for over-and under-utilization across the region.

Principles

Utilization management must be based on valid data in order to produce reliable reports required to analyze patterns of utilization, determine clinical effectiveness of the service delivery model and compare cost-effectiveness and outcomes of services.

- Value-based purchasing assures appropriate access, quality, and the efficient and economic provision of supports and services.
- The MSHN UM framework is not a mandate for clinical decision-making, but instead aims to define and standardize criteria, factors, and outcomes for evaluation purposes.
- The MSHN Utilization model will be consistent with Michigan Department of Health & Human Services (MDHHS) contract requirements, Balance Budget Act of 1997, and national accreditation standards.
- National standards and metrics are utilized throughout the model wherever possible (standardized tools, recognized process metrics, and outcome measures).

Applies to:

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

Other: Sub-contract Providers

Definitions/Acronyms:
CMHSP: Community Mental Health Service Program (inclusive of Substance Use Service Provision, coordination and administrative oversight)
MDHHS: Michigan Department of Health & Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
Provider Network: refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements
UM: Utilization Management
UMC: Utilization Management Committee

Related Materials:
MSHN Utilization Management Plan

References/Legal Authority:
1. Appeal and Grievance Resolution Processes Technical Requirement: MDHHS, revised July 29, 2020
2. Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans: MDHHS, Current Year
3. Michigan Mission-Based Performance Indicator System, Version 6.0 for PIHPs, Current Year
4. MDHHS Medicaid Providers Manual, Current Edition
5. MSA Bulletin: Mental Health/Substance Abuse 04-03 (Prepaid Inpatient Health Plans)
6. 42 CFR 438.404c(5)(6)
7. Early Periodic, Screening, Diagnosis, and Treatment Policy: MSHN
8. Habilitation Supports Waiver Policy: MSHN

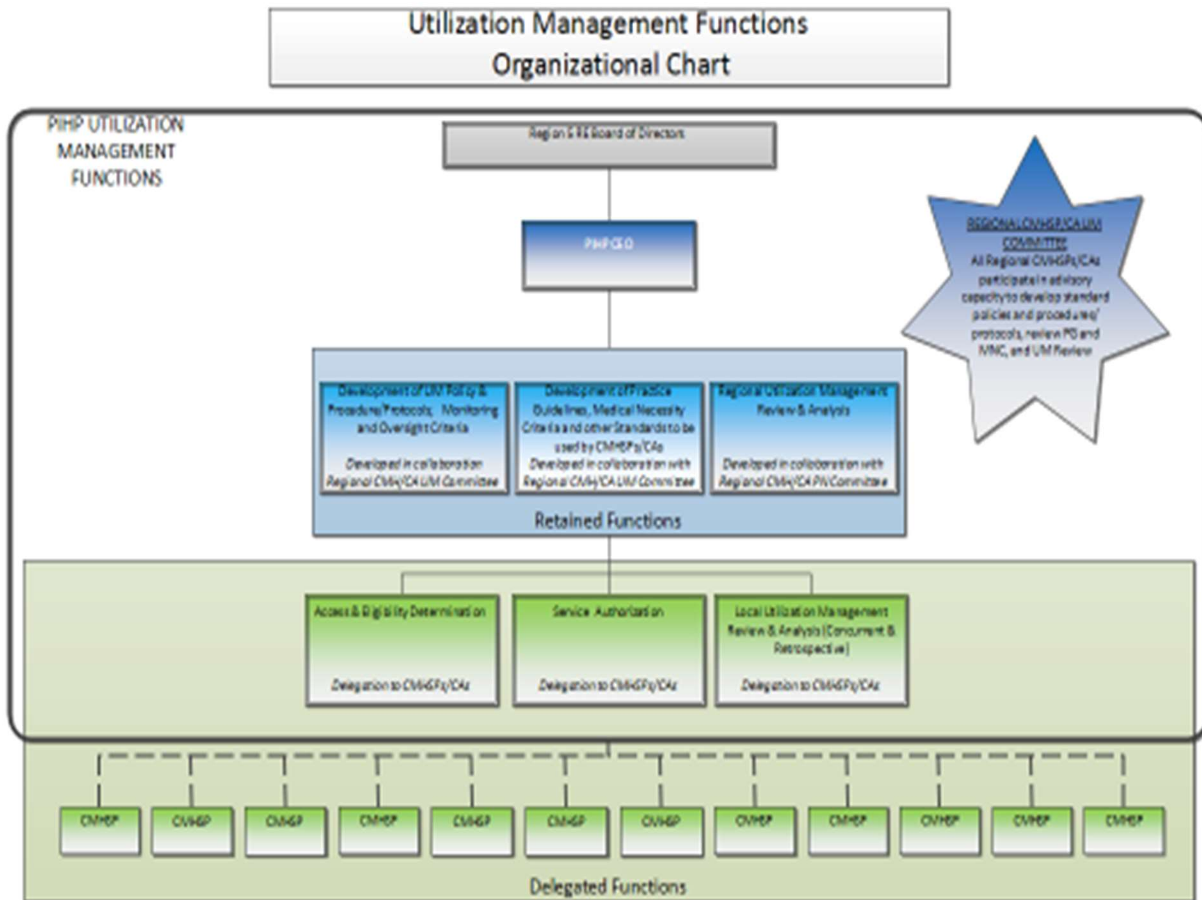
Change Log:

Date of Change	Description of Change	Responsible Party
11.23.2013	New MSHN policy	L. Verdeveld
03.14.2014	Alignment with service philosophy and addition of "prescriber."	Dr. H. Lenhart
04.09.2014	To reflect input of the Utilization Management and Substance Use Disorder Committee/Workgroup	D. McAllister
07.23.2015	UM Committee feedback on MSHN monitoring of over/under utilization; and B3 service clarification of reasonable and equitable, clarify FY15 contract provisions.	UMC
04.25.2016	Moved description of UM delegation grid to UM Policy.	UMC
10.27.2016	Annual review by UMC-no changes.	UMC
10.26.2017	Annual review by UMC-no changes.	UMC
10.26.2018	Annual review by UMC- no changes	UMC
02.27.2020	Annual review by UMC- added clarifying language regarding timeliness of authorization decisions and issuing of Adverse Benefit Determinations in response to 2018-2019 HSAG quality review findings; added corresponding definitions	UMC

02.24.2022	Biennial review by UMC- separated content into policy and procedure	UMC
02.22.2024	Biennial Review	UMC

~~Attachment A~~

~~MSHN Utilization Management Functions Organization Chart~~



Attachment ~~B~~A

PIHP Delegated Activity	**Retained or Delegated?**	**If Retained:** Conducted internally by MSHN or contracted?
Prospective approval or denial of requested service as guided by the regional Level of Care System (LOC) for parity: - Initial assessment for and authorization of psychiatric inpatient services; - Initial assessment for and authorization of psychiatric partial hospitalization services; - Initial and ongoing authorization of services to individuals receiving community-based services; - Grievance and Appeals, Second Opinion management, coordination and notification; - Communication with consumers regarding UM decisions, including adequate and advanced notice, right to second opinion and grievance and appeal	___ Retained by MSHN ☑ Delegated to local CMHs *This topic has been marked as an implementation issue requiring the development of a specific policy or procedure at the MSHN level.	☐Conducted by MSHN ☐Contracted
Local-level Concurrent and Retrospective Reviews of affiliate Authorization and Utilization Management decisions/activities to internally monitor authorization decisions and congruencies regarding level of need with level of service, consistent with PIHP policy, standards and protocols.	___ Retained by MSHN ☑ Delegated to local CMHs	☐Conducted by MSHN ☐Contracted
Persons who are enrolled on a habilitation supports waiver must be certified as current enrollees and be re-certified annually. A copy of the certification form must be in the individual's file and signed by the local CMHSP representative.	*This will be a **local responsibility** that is **prompted centrally by MSHN**. It will be a central responsibility to manage the resource of waiver slots and provide oversight.	☒Conducted by MSHN ☐ Contracted
Development, adoption and dissemination of Practice Guidelines (PGs), Medical Necessity Criteria, and other Standards to be used by the local CMHSP. 42 CFR: 438.236: Practice Guidelines	☑ Retained by MSHN ___Delegated to local CMHs	☒Conducted by MSHN ☐Contracted
Development, modification and monitoring of related PIHP UM Policy, Procedures and Annual Plan as part of the Affiliation QI Plan.	☑ Retained by MSHN ___Delegated to local CMHs	☒Conducted by MSHN ☐Contracted
Review and Analysis of the CMHSP's quarterly utilization activity and reporting of services. Annual review of each CMHSP's and the PIHP's overall Utilization Activities.	☑ Retained by MSHN ___Delegated to local CMHs	☒Conducted by MSHN ☐Contracted

MSHN Utilization Management Delegation Grid