Mid-State Health Network

Board of Directors Meeting ~ November 12, 2024 ~ 5:00 p.m.

Board Meeting Agenda

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

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

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

   Motion to Approve the Agenda of the November 12, 2024 Meeting of the MSHN Board of Directors
4. Public Comment (3 minutes per speaker)
5. **ACTION ITEM:** MSHN External Compliance Examination Report Presentation *(Page 6)*

   Motion to receive and file the Report on Compliance of Mid-State Health Network for the year ended September 30, 2023.
6. Chief Executive Officer's Report *(Page 12)*
7. Deputy Director's Report *(Page 30)*
8. Chief Financial Officer's Report
   A. Update on FY 25 Revenues/Expenditures
   B. Financial Statements Review for Period Ended September 30, 2024 *(Page 33)*

   ACTION ITEM: Receive and File the Preliminary Statement of Net Position and Preliminary Statement of Activities for the Period ended September 30, 2024, as presented
9. **ACTION ITEM:** Contracts for Consideration/Approval
   A. ACTION ITEM: FY24 Contract Listing for Consideration/Approval *(Page 43)*

   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
   B. ACTION ITEM: FY25 Contract Listing for Consideration/Approval *(Page 45)*

   The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2025 Contracts, as Presented on the FY 2025 Contract Listing
10. Executive Committee Report
11. Chairperson's Report

MSHN
Mid-State Health Network

Our Mission:

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

Our Vision:

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

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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/fy2025-meetings

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Upcoming FY25 Board Meetings

Board Meetings convene at 5:00pm unless otherwise noted

January 7, 2025
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

March 4, 2025
MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

May 6, 2025
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

12. **ACTION ITEM:** Consent Agenda

Motion to Approve the documents on the Consent Agenda

12.1 Approval Board Meeting Minutes 09/10/2024 *(Page 47)*

12.2 Approval Public Hearing Meeting Minutes *(Page 52)*

12.3 Receive SUD Oversight Policy Board Meeting Minutes 08/21/2024 *(Page 54)*

12.4 Receive Board Executive Committee Minutes 10/18/2024 *(Page 58)*

12.5 Receive Policy Committee Meeting Minutes 10/01/2024 *(Page 60)*

12.6 Receive Operations Council Key Decisions 09/23/2024 *(Page 62)* and 10/28/24 *(Page 66)*

12.7 Approve the following policies:

12.7.1 Children with Severe Emotional Disturbances Home and Community Based Waiver *(Page 69)*

12.7.2 Children's Home and Community Based Services Waiver (CWP) *(Page 74)*

12.7.3 Community-Based Independent Living Placement *(Page 78)*

12.7.4 Electroconvulsive Therapy (ECT) *(Page 81)*

12.7.5 Emergency & Post-Stabilization Services *(Page 83)*

12.7.6 Evidence Based Practices *(Page 88)*

12.7.7 Habilitation Supports Waiver (HSW) *(Page 91)*

12.7.8 Home and Community Based Services Compliance Monitoring *(Page 94)*

12.7.9 Indian Health Services *(Page 95)*

12.7.10 Inpatient Psychiatric Hospitalization Standards *(Page 98)*

12.7.11 Out of State Placements *(Page 102)*

12.7.12 Standardized Assessment *(Page 105)*

12.7.13 Substance Use Disorder Services-Medication for Opioid Use Disorder *(Page 107)*

12.7.14 Substance Use Disorder Services-Out Of Region Coverage *(Page 109)*

12.7.15 Substance Use Disorder Services-Telemedicine *(Page 111)*

12.7.16 Substance Use Disorder Services-Women's Specialty Services *(Page 113)*

12.7.17 Trauma-Informed Systems of Care *(Page 116)*

12.7.18 Procurement *(Page 118)*

13. Other Business
14. Public Comment (3 minutes per speaker)
15. Adjourn

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FY25 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
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	tinamariemshn@outlook.com		989.576.4169		GIHN	2027
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2027
McFarland	Pat	pjmcfarland52@gmail.com		989.225.2961		BABHA	2026
McPeek-McFadden	Deb	deb2mcmail@yahoo.com		616.794.0752	616.343.9096	The Right Door	2027
O'Boyle	Irene	irene.oboyle@cmich.edu		989.763.2880		GIHN	2026
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
Purcey	Linda	dpurcey1995@charter.net		616.443.9650		The Right Door	2025
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
Vacant	Vacant					HBH	2026
Vacant	Vacant					Shia Health & Wellness	2027
Williams	Joanie	joanie.williams@leonagroupmw.com		989.860.6230		Saginaw County CMH	2026
Woods	Ed	ejw1755@yahoo.com		517.392.8457		LifeWays	2027

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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)

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Background

The Compliance Examination was conducted by Roslund Prestage and Company (RPC) firm for the fiscal year ending September 30, 2023. The intent of the review is for auditors to express an opinion on the PIHP's compliance with the Medicaid Contract. In addition to the tests performed at the PIHP level, the process also includes incorporation of each CMHSP's Compliance Examination results. RPC's auditor presented the report results and allowed questions from board members. MSHN did receive minor findings and implemented corrective action to address issues.

Recommended Motion:

Motion to receive and file the "Report on Compliance" of Mid-State Health Network for the year ended September 30, 2023.

Report on Compliance

Mid-State Health Network

September 30, 2023

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT ACCOUNTANT'S REPORT ON COMPLIANCE

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

Report On Compliance
We have examined Mid-State Health Network's (the PIHP) compliance with the compliance requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to the Medicaid Contract and/or General Fund (GF) Contract for the year ended September 30, 2023.

Management's Responsibility
Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to the Medicaid Contract and/or GF Contract.

Independent Accountants' Responsibility
Our responsibility is to express an opinion on the PIHP's compliance with the Medicaid Contract and/or GF Contract based on our examination of the compliance requirements referred to above.

Our examination of compliance was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the PIHP complied, in all material respects, with the compliance requirements referred to above.

An examination involves performing procedures to obtain evidence about the PIHP's compliance with the specified compliance requirements referred to above. The nature, timing, and extent of the procedures selected depend on our judgement, including an assessment of the risk of material noncompliance, whether due to fraud or error. The nature, timing and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the compliance requirements described in the *Compliance Examination Guidelines* issued by the Michigan Department of Health and Human Services.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to the engagement.

We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion. However, our examination does not provide a legal determination of the PIHP's compliance.

Opinion on Each Program
In our opinion, the PIHP complied, in all material respects, with the specified compliance requirements referred to above that are applicable to the Medicaid Contract and/or GF Contract for the year ended September 30, 2023.

Other Matters
The results of our examination procedures disclosed instances of noncompliance, which are required to be reported in accordance with Compliance Examination Guidelines, and which are described in the accompanying Comments and Recommendations as item 2023-01. Our opinion is not modified with respect to these matters.

Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract and/or General Fund Contract:

None

Material noncompliance with the provisions of laws, regulations, or contracts related to the Medicaid Contract and/or General Fund Contract:

None

Known fraud affecting the Medicaid Contract and/or General Fund Contract:

None

During our compliance audit, we may have become aware of matters that are opportunities for strengthening internal controls, improving compliance, and increasing operating efficiency. These comments and recommendations are expected to have an impact greater than $25,000, but not individually or cumulatively be material weaknesses in internal control over the Medicaid Contract and/or General Fund Contract. Furthermore, we consider these matters to be immaterial deficiencies, not findings. The following comments and recommendations are in regard to those matters.

2023-01 FSR Examination Adjustments

Criteria or specific requirements:
The Contractor must provide the financial reports to the State as listed in the Medicaid Contract. Forms, instructions and other reporting resources are posted to the MDHHS website. (Contract Schedule E)

Condition:
The PIHP is not in compliance with FSR instructions.

Examination adjustments:
Examination adjustments were made to sections of the FSR. See detailed descriptions of these examination adjustments in the Explanation of Examination Adjustments section of this report.

Context and perspective:
Context and perspective have been included in the description shown on the Explanation of Examination Adjustments page of this report.

Effect:
See detailed descriptions of these examination adjustments in the Explanation of Examination Adjustments section of this report.

Recommendations:
The PIHP should review its current policies and procedures regarding the preparation and review of the Financial Status Report to assure that all amounts are reported in compliance with the reporting instructions. Specifically, a review of the final draft should be performed by a knowledgeable person who is independent from the original preparation of the report(s).

Views of responsible officials:
Management is in agreement with our recommendation.

Planned corrective action:
Mid-State Health Network will continue to review instructions and verify reported information with each individual CMHSP prior to submission of the final Financial Status Report.

Responsible party:
Amy Keinath, Finance Manager

Anticipated completion date:
February 28, 2025

Decrease in CCBHC Base Capitation

An examination adjustment was made to decrease the amount of CCBHC base capitation (CEI) which also impacted the CCBHC Base Capitation for the PIHP:

- Medicaid FSR Row A310a FROM Healthy MI Plan – A1301a was decreased from $42,517,877 to $39,955,357, a difference of ($2,562,520)
- CCBHC FSR Row AC 102 Medicaid CCBHC Base Capitation was decreased from $63,872,046 to $61,309,526, a difference of ($2,562,520)
- CCBHC FSR Row AC 103 Medicaid CCBHC Base - Affiliate Contracts (CEI) was decreased from $37,460,709 to $34,898,189, a difference of ($2,562,520)
- CCBHC FSR Row AC 105 Medicaid CCBHC Supplemental - Affiliate Contracts (CEI) was increased from $8,922,359 to $11,484,879, a difference of $2,562,520
- CCBHC FSR Row AC 122 Healthy Michigan CCBHC Base was decreased from $8,799,718 to $8,485,663, a difference of ($314,055)
- CCBHC FSR Row AC 123 Healthy Michigan CCBHC Base Affiliate Contracts (CEI) was decreased from $4,591,070 to $4,277,015, a difference of ($314,055)
- CCBHC FSR Row AC 125 Healthy Michigan CCBHC Supplemental - Affiliate Contracts (CEI) was increased from $5,905,741 to $6,219,796, a difference of $314,055

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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

FY 2024 Board Officers

Ed Woods
Chairperson

Irene O'Boyle
Vice-Chairperson

Deb McPeek-McFadden
Secretary

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
September/October 2024

- Dalontrius Acacya (MSHN Home and Community Based Services (HCBS) Waiver Coordinator) and Tori Ellsworth (MSHN Waiver Coordinator) delivered a well-prepared and well-received presentation on "The Impact of HCBS Services and Ongoing Monitoring Solutions" at the Community Mental Health Association of Michigan (CMHAM) Fall Conference in Traverse City. Our entire staff was represented so well by these staff, and we offer our congratulations and thanks for work well done (and well shared with conference-goers).
- Dani Meier, Ph.D., MSHN's Chief Clinical Officer delivered two important and well-received presentations. The 10/15/24 presentation on "Using Art to Disrupt Stigma and Bias Toward People Living with SUD" was sponsored by Corewell Health and took place in Montcalm County. The second was presented at the University of Michigan's Addiction Care Research and Education program on 10/19/24 titled "Equity Upstream: Moving from Knowledge to Action to Reduce Health Disparities in the Overdose Epidemic." Congratulations and thanks to Dr. Meier for representing MSHN and this region so well.
- Sarah Andreotti, MSHN Prevention Administrator, was named by Michigan Department of Health and Human Services (MDHHS) as "Preventionist of the Year." Sarah was honored at the 25th Annual Michigan Substance Use and Co-Occurring Disorders Conference in mid-September. In recognizing Sarah, MDHHS stated:

  "Sarah is the Substance Use Disorder Prevention Administrator for Mid-State Health Network, Region 5 PIHP. She is an active participant in the state level Behavioral Health Prevention Workgroup and Prevention Program Requirements Workgroup where she is willing to share her knowledge and experience to benefit all workgroup members. Additionally, she is willing to distribute and share created prevention documents for replication in other regions or communities. Sarah is an excellent liaison between Region 5's Prevention Provider network and MDHHS, including getting questions answered, applying for prevention certification waivers, and clarifying information to be included in the Michigan Prevention Data System. She stays up to date with substance misuse prevention knowledge, skills, and abilities and has become a facilitator of the SAPST (Strategic Prevention Framework Application for Prevention Success Training). She partners with MDHHS to provide SAPST for prevention providers across the state. Sarah embodies the important characteristics of a Prevention Coordinator, and it is an honor to award her with Preventionist of the Year."

PIHP/REGIONAL MATTERS

1. **Bill Providing Remote Option for Those With Disabilities Reported:**

   (Excerpt from Gongwer News Service, 10/02/24): Legislation allowing members of boards who have a disability to attend meetings remotely was reported Wednesday (10/02/24) by a Senate panel.

Republicans on the Senate Civil Rights, Judiciary and Public Safety Committee raised questions over the proposal prior its being reported Wednesday.

Under SB 870 , language is added to the Open Meetings Act to allow individuals with a disability to participate remotely in public hearings.

An S-1 substitute was adopted for SB 870 that clarifies that the bill would not apply to a meeting of the Legislature where a formal vote is taken. The bill, members were told, would also apply to local elected governments.

Sen. Ruth Johnson (R-Groveland Township) raised concerns over this, saying her concern was that it could prevent residents from having access to their local officials, pointing to examples in her district.

"I've seen it happen on a number of occasions, so it happens," Johnson said. "Most of us would be here, but some people wouldn't, and it takes away people's rights for everything when we can't have that one-on-one."

Johnson offered an amendment that would require those who participate in a meeting remotely due to a disability to be physically located in the state while participating in the meeting. Another provision was that there be documentation for the person's reason to be participating remotely. It failed 2-5 along party lines.

Sen. Jim Runestad (R-White Lake) said his understanding prior to Wednesday's meeting was that the bill would only deal with appointed boards, expressing concerns about the change in the bill's interpretation.

He also said it appeared that there could be a large number of ways that a local elected official could use the change to participate remotely.

Members reported SB 870 by a 5-0 vote, with Johnson and Runestad abstaining.

Reported by unanimous votes was SB 922 , SB 923 , SB 924 and SB 925 , which would provide additional protections for vulnerable adults against abuse and financial exploitation.

Prior to being reported, an S-1 substitute was adopted for SB 922 that made two changes. The first was to add a reference to corrections officers to a section of the bill so it would correspond to provisions elsewhere in the legislation. The other was the inclusion of language clarifying the definition of "vulnerable adult" as defined elsewhere in statute to provide for consistency.

Collectively, the bills would enhance penalties for abuse and financial exploitation of vulnerable adults. Further protections, including personal protection orders, would be created for those situations.

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

Please refer to my previous board reports for additional background if needed. As the MSHN Board is aware, Michigan Department of Health and Human Services (MDHHS) has stated its expectation that Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs) will come into compliance with the CFAP requirements (separation of entity conducting service planning from entity responsible for service delivery). Several waiver renewals have been submitted by MDHHS to Centers for Medicare and Medicaid Services (CMS) that include this compliance requirement. MDHHS has stated to the PIHP Chief Executive Officers (CEOs) that CMS requested a CFAP-specific meeting with MDHHS that at the

time was in the process of being scheduled. MDHHS has also stated that the 10/01/2024 implementation date has been rescinded, but a new compliance date has not yet been established.

MDHHS scheduled a November 1, 2024, meeting with PIHPs on CFAP. That meeting was cancelled and has not been rescheduled, citing ongoing conversations with CMS. The field continues to await official written communications from MDHHS both in response to questions raised by the field and any formal notice of what will be required, timelines, etc.

Meanwhile, under the leadership of Amanda Ittner, MSHN Deputy Director, we have been gathering information on regional "current state" to assist the region with planning when the time comes (and we believe it will).

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

Please see my previous board reports for additional background information if needed. Work to plan implementation of partial centralization of access for withdrawal management ("detox"), residential treatment, and recovery housing continues. Information Technology (IT) systems are being updated to incorporate the change in regional practices. MSHN Providers are aware of the forthcoming changes and more information will be provided during our regional SUD provider meeting on September 19, 2024. MSHN intends to make a downward adjustment to financing at CMHSPs for 24/7/365 access in light of this partial centralization. MSHN is also asking CMHSPs to consider establishing one CMHSP as the after hours call center for MSHN SUD access.

This implementation has been based on data submitted by our CMHSPs and SUD Provider Network that seriously underreported the call/screening volume. MSHN is making adjustments to how we've engineered this project and is working continuously to improve the process. Many thanks for our access, utilization management, and treatment team and other team members for pitching in to ensure all who contact our office receive a timely response.

4. **MSHN By-Laws:**

The following information was previously reported. As of October 18, five of twelve CMHSP Participants have adopted the proposed revisions briefly highlighted below. A few other minor edits were desired by some members of the MSHN Operations Council. About 6 months ago, a subcommittee of the Operations Council met to ask the MSHN attorney for advice on several proposed changes. Following is a brief summary of proposed changes:

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

MSHNs Board of Directors does NOT have a vote on the bylaws. Two-thirds of the region's CMHSP Participants must approve any changes to the bylaws for them to be effective and applicable to MSHN. My office has provided a customizable resolution and a tracked changes version of the bylaws for member

CMHSP board action. I have asked the region's CMHSP Participants to complete these resolutions by December 31, 2024. Final copies will be provided to the MSHN board when available.

5. **Annual Board Self-Evaluation**

Approximately one year ago, and more recently at its October 18. 2024 meeting, the Executive Committee was presented with a recommendation from our internal Inclusion, Diversity, Equity, and Accessibility (IDEA) Workgroup to include several new questions in the board self-evaluation beginning in FY 25.

The board self-evaluation usually begins in January and is reported to the board in March. New questions as recommended by our IDEA Workgroup include:

1. As a board member, I have a deep level of understanding of the health equity work of the agency.
2. As a board member, I deliberately establish consistent communication channels and bring the perspectives, feedback, needs and priorities of diverse communities, especially those affected by health disparities, into board decisions.
3. As a board member, I have a deep level of understanding of the diversity, equity and inclusion work of the agency.
4. The board ensures principles of diversity, equity and inclusion are incorporated into all MSHN policies.
5. The board ensures the agency actively engages people affected by health disparities in developing, planning and implementing health equity activities.

These new questions on board self-assessment views will be included in all future board self-evaluations. I want to acknowledge our internal team and our Executive Committee for the support provided throughout this process.

6. **Regional Financial Position:**

Our office circulated a message to our regional partners and the MSHN Board on 10/11/2024 noting that the (very late) September FY 24 rate adjustment and the new FY 25 rates improved the region's financial position.

FY 24 amended budget – The FY 24 amended budget highlighted the Region planned to overspend its operational revenue by $27 M. In late September, MSHN received amended MDHHS rates and processed those revenue figures. Results of the new rates are projected to improve the Region's fiscal position by $8 M – which means the new revenue shows the overspend has decreased to $19 M.

FY 25 original budget – The FY 25 original budget highlighted the Region planned to overspend its operational revenue by $29 M. In late September, MSHN received final MDHHS rates and processed those revenue figures. In addition, CMHSPs updated expense figures based on a few categories included in the final revenue rates. Results of the final MDHHS revenue rates are projected to improve the Region's fiscal position by $19 M – which means the new revenue shows the overspend has decreased to $10 M.

7. **Interim Contract Signed for Michigan Health Endowment Fund (MHEF):**

Deputy Director Ittner, on behalf of MSHN, completed and submitted a grant application for $300,000 to support our predictive analytics platform development to the MHEF. We were notified by the MHEF that our proposal is funded in its entirety, and MHEF followed with a contract (required to implement the grant and receive funding). Her report contains additional details.

Current MSHN policy limits my authority to sign revenue contracts to those with MDHHS where the due date for the contract to be returned occurs before the next scheduled board meeting. Thus, I sought and received consent from the Board Executive Committee to execute this revenue contract. Current MSHN policy also requires that I report such instances to the full board, which is accomplished with this note.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

8. **MSHN/MDHHS "Master Contract" for FY 25:**

I provided a summary of issues in my September Board Report and recommended that the Board authorize signing the contract (notwithstanding the issues noted therein). The board did authorize that contract to be signed.

Three (of ten) PIHPs signed the MDHHS/PIHP Contract (Mid-State Health Network, Southwest Michigan Behavioral Health, and Detroit Wayne Integrated Health Network). The remaining seven PIHPs initiated many edits (called "redlines") and signed the contract inclusive of those self-initiated, non-negotiated edits. Those seven PIHPs reportedly received communications (which I have seen) from MDHHS reminding them of their two-year transition responsibilities under the contract termination section of the FY 24 agreement.

MDHHS met with the seven PIHPs to clarify what exactly the issues those PIHPs were expressing. MDHHS was reportedly very clear that this meeting "was not a negotiation." MDHHS also met with the three PIHPs that signed the contract without redlines and reiterated that their meeting with the seven was not a negotiation. In this meeting with the three PIHPs that signed, MDHHS stated they had given the seven PIHPs until close of business 10/31/24 to sign a "clean" contract. When asked what the "or else" is, MDHHS responded that they were not ready to discuss as that and related matters were still under study by MDHHS legal and program leadership.

Our office will keep the MSHN board informed if developments occur that warrant an update.

9. **Michigan Submits New Reentry Services Demonstration Waiver:**

Michigan submitted a request for a new Medicaid section 1115 demonstration entitled "Reentry Services Demonstration." The demonstration includes a Reentry demonstration that requests coverage for certain pre-release services to eligible individuals who are incarcerated in state prisons, local county jails, and/or juvenile facilities and who are returning to the community. A copy of the application is available at this link.

10. **Michigan Expands Credentials Required for Crisis Professionals:**

Excerpted from the MDHHS Memo to the Field (10/03/24): The Michigan Department of Health and Human Services (MDHHS) has been developing a statewide crisis system model. As part of this process, we have reviewed all regulatory documents, ensuring alignment with our proposed model. MDHHS recognizes the national and state-specific mental health workforce shortages. In response to feedback from the field, MDHHS is broadening the type of degreed staff who can provide crisis services. Service quality will be maintained through a requirement for skills-based crisis training.

Beginning October 1, 2024, H2011 will be billable by Crisis Professionals, which are a new provider type created by MDHHS. Crisis Professionals are inclusive of individuals who have a master's- or bachelor's-level degree from a human services field and two years of relevant experience in behavioral health services for bachelor's, one-year relevant experience for master's. Additionally, T1023 language in the code chart is being changed to align with the Michigan Mental Health code. Preadmission screenings can be performed by a Mental Health Professional or licensed bachelor's social worker, as per 1978 PA 368, MCL 330.1409.

11. **Detroit Wayne Integrated Health Network Names New Chief Executive Officer:**

October 16, 2024 03:20 PM Dustin Walsh, Crain's Detroit Business: Detroit Police Chief James White is leaving his department to become the next CEO of the state's largest mental health service provider.

White was selected in a unanimous vote by the board of the Detroit Wayne Integrated Health Network (DWIHN) to lead the organization. He replaces Eric Doeh in the role, who resigned in June after accepting a job as the Michigan market CEO and plan president for insurance giant Humana Inc.

White was selected from seven finalists for the role.

"We are very pleased with the choice of Mr. White to continue leading DWIHN and we feel confident that he is the right person for the critical job of leading this organization as we enter this next phase of growth to help our region's most vulnerable citizens," DWIHN board chair Dr. Cynthia Taueg said in a press release.

White has served as the top cop for the Detroit Police Department (DPD) since June 2021 and has been with the department for more than 20 years. He also formerly served as executive director for the Michigan Department of Civil Rights.

White earned a bachelor's degree in sociology from Wayne State University and a master's degree in mental health counseling from Central Michigan University.

At DWIHN, he'll lead the organization that serves 123,000 people in Wayne County with behavioral health services.

The DPD and DWIHN have been working together for years, including a co-response project under White where professionals from DWIHN train DPD's crisis intervention team, which sends a specialized unit armed with non-lethal weapons to mental distress calls. Behavioral specialists are also embedded in the department's 911 communications center.

More than 16,000 911 calls in the city of Detroit last year involved someone in mental distress — or more than 43 calls per day.

A start date for White has not yet been determined and a replacement for White at the DPD has also not been announced.

FEDERAL/NATIONAL UPDATES AND ACTIVITIES

12. Senate comments on Children's Residential Treatment Facilities (RTFs):

In a report in the 09/03/2024 Washington Post, it is noted that today (September 3) Senator Wyden, Chairman of the Senate Finance Committee, will write to CMS and the Administration for Children and Families (ACF) outlining "immediate actions he says the agencies should take to improve care for minors. They include issuing joint guidance to states prioritizing community-based behavioral health and prevention services, clarifying and streamlining federal oversight requirements for RTFs and boosting engagement with youths in congregate care programs." He wishes a written update on actions the agencies have taken to implement the recommendations and their plans by October 7.

In June 2014, the Senate Finance Committee released a report summarized below:

- "The Committee's investigation into four major RTF operators revealed that children in these facilities are regularly subjected to physical, sexual, and verbal abuse; inappropriate restraints and seclusions; unsafe and unsanitary conditions; and lack of necessary behavioral health care.
- The report, which examined conditions at RTFs run by Universal Health Services (UHS), Acadia Healthcare, Devereux Advanced Behavioral Health, and Vivant Behavioral Healthcare, found that these harms are not isolated exceptions, but inherent to a model that incentivizes maximizing profits at the expense of providing high-quality care to children – and often paid for with taxpayer dollars, including Medicaid and child welfare funding.
- RTFs are intended to provide temporary, stabilizing care for children with acute behavioral health needs. Yet, for decades, journalists and government oversight agencies have found that the RTF industry attracts profit-motivated actors who abandon their duty to provide children with high-quality care. Children that enter these facilities often leave even more traumatized than when they arrived. In the most extreme cases, some children have died, including by suicide, because of the harms they experience in these facilities and the lack of care they have been provided for their intensive needs.
- Due to the patchwork system of oversight and accountability, RTF providers have evaded enforcement and accountability for years. The current system fails to effectively identify and address the harms, allowing deficiencies to persist for years. The full report, "*Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities*" is available at https://www.finance.senate.gov/imo/media/doc/rtf_report_warehouses_of_neglect.pdf.

In addition, in the report, the Committee recommends state and local governments, federal agencies, accrediting bodies, and RTF providers immediately take the following actions:

1. Congress must legislate to improve the conditions in RTFs and the broader behavioral health landscape. It should focus its attention on the following categories: (i) raising the floor for congregate care standards (including standards that reflect active treatment and require use of evidence-based treatments), (ii) investing in community-based alternatives for care, and (iii) strengthening the oversight of congregate care facilities.
2. The companies under investigation in this report must raise standards across facilities.
3. States should use their existing authority to prioritize the availability and utilization of community-based services for children with behavioral health needs.
4. States should improve RTF oversight activities in order to compel providers to raise the bar on standards within RTFs.
5. CMS and ACF should work together to clarify and streamline federal oversight requirements for RTFs.
6. CMS and ACF can work collaboratively to center perspectives of youth with lived experience.

7. ACF should increase awareness for judges on the risks of improper placements in RTFs, the full continuum of care, and clinical best practices for treating children with behavioral health needs, particularly for children in foster care.
8. CMS and ACF can and should do more to prioritize spending on community-based behavioral health services as an alternative to placement in RTFs if possible and safe.
9. Department of Justice (DOJ) should assess RTF placements for potential Olmstead violations.
10. Accrediting bodies, such as the Joint Commission, should closely monitor facilities following the discovery of noncompliance with requirements or elements."

13. **Centers for Disease Control (CDC) Study on Reducing Suicide Risk:**

CDC notes "that a new CDC Vital Signs report highlights the role that conditions in counties, such as insurance coverage, broadband internet access, and household income, can play in lowering suicide risk. Compared to counties with the lowest levels of these factors, suicide rates were:

- 26% lower in counties with the highest health insurance coverage
- 44% lower in counties where most homes have broadband internet access
- 13% lower in counties with the most household income

These findings reinforce other studies that show that the conditions where people are born, grow, live, work, and age can play an important role in shaping suicide prevention efforts."

14. **CDC 2023 Behavioral Risk Factor Surveillance System Data Availability:**

CDC announces that "the 2023 *Behavioral Risk Factor Surveillance System* (*BRFSS*) prevalence and trends data are now available online through CDC's interactive prevalence and trend analysis tool. Celebrating 40 years of data collection this year, BRFSS is the largest continuously conducted telephone-based survey system in the world, providing timely and flexible state-level data on health-related risk behaviors, chronic health conditions, and use of preventive services."

15. **The Kennedy Forum releases Mental Health and Substance Use (MH/SUD) Workbook:**

This workbook reflects the contributions of many individuals and organizations who back a bold vision presented by The Kennedy Forum: By 2033, 90% of the population is **screened** for MH/SUD, 90% who need it receive **quality treatment**, and 90% are able to manage symptoms and achieve **recovery**.
Accurate and accessible data positions us to pursue that future, allowing visibility into multi-year trends across these three major categories:

- **Screening**
- **Treatment**
- **Recovery**

This workbook is a source of information, but it is also a call to action that can ultimately affect the millions of Americans who need MH/SUD services. All Americans deserve equitable, accessible treatment covered by insurance, as promised by the 2008 The Mental Health Parity and Addiction Equity Act (MHPAEA), co-authored by Patrick J. Kennedy. To learn more about the work to ensure mental health as essential health, visit thekennedyforum.org.

16. **988 Suicide and Crisis LifeLine:**

SAMHSA noted that the 988 Suicide & Crisis Lifeline has a "process to start routing cellular phone calls to 988 contact centers based on the caller's approximate location, versus by area code – known as

"georouting" – began Mid-September with two major U.S. wireless carriers that combined make up about half of all wireless calls to 988." More information at this link.

17. **Food and Drug Administration (FDA) Approves New Medication for Treatment of Schizophrenia :**

On 09/26/24, the U.S. Food and Drug Administration approved Cobenfy (xanomeline and trospium chloride) capsules for oral use for the treatment of schizophrenia in adults. It is the first antipsychotic drug approved to treat schizophrenia that targets cholinergic receptors as opposed to dopamine receptors, which has long been the standard of care.

"Schizophrenia is a leading cause of disability worldwide. It is a severe, chronic mental illness that is often damaging to a person's quality of life," said Tiffany Farchione, M.D., director of the Division of Psychiatry, Office of Neuroscience in the FDA's Center for Drug Evaluation and Research. "This drug takes the first new approach to schizophrenia treatment in decades. This approval offers a new alternative to the antipsychotic medications people with schizophrenia have previously been prescribed."

Schizophrenia can cause psychotic symptoms including hallucinations (such as hearing voices), difficulty controlling one's thoughts and being suspicious of others. It can also be associated with cognitive problems and difficulty with social interactions and motivation. About 1% of Americans have this illness and globally it is one of the 15 leading causes of disability. Individuals with schizophrenia are at greater risk of dying at a younger age, and nearly 5% die by suicide.

Cobenfy's effectiveness for the treatment of schizophrenia in adults was evaluated in two studies with identical designs. Study 1 and Study 2 were 5-week, randomized, double-blind, placebo-controlled, multi-center studies in adults with a diagnosis of schizophrenia according to DSM-5 criteria.

The primary efficacy measure was the change from baseline in the Positive and Negative Syndrome Scale (PANSS) total score at week 5. The PANSS is a 30-item scale that measures symptoms of schizophrenia. Each item is rated by a clinician on a seven-point scale. In both studies, the participants who received Cobenfy experienced a meaningful reduction in symptoms from baseline to Week 5 as measured by the PANSS Total Score compared to the placebo group.

The prescribing information includes warnings that Cobenfy can cause urinary retention, increased heart rate, decreased gastric movement or angioedema (swelling beneath the skin) of the face and lips. Cobenfy is not recommended for patients with mild hepatic (liver) impairment. It should not be used in patients with known hepatic impairment. There is also a risk of liver damage. Patients should stop using Cobenfy if experiencing signs or symptoms of substantial liver disease (including yellowing of the skin or the white part of the eyes, dark urine and unexplained itching). Cobenfy is substantially excreted by the kidney and is not recommended in patients with moderate to severe renal impairment.

Cobenfy should not be prescribed to patients with urinary retention, moderate or severe kidney or liver disease, gastric retention, untreated narrow-angle glaucoma or a history of hypersensitivity to either Cobenfy or its components.

The most common side effects of Cobenfy are nausea, indigestion, constipation, vomiting, hypertension, abdominal pain, diarrhea, tachycardia (increased heartbeat), dizziness and gastroesophageal reflux disease.

The approval of Cobenfy was granted to Bristol-Myers Squibb Company.

18. **CMS Guidance on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):**

CMS has "released guidance to support states in ensuring the 38 million children with Medicaid and Children's Health Insurance Program (CHIP) coverage – nearly half of the children in this country – receive the full range of health care services they need. Under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, eligible children and youth are entitled to a comprehensive array of prevention, diagnostic, and treatment services — including well-child visits, mental health services, dental, vision, and hearing services. These requirements are designed to ensure that children receive medically necessary health care services early, so that health problems are averted, or diagnosed and treated as early as possible. Because of the EPSDT requirements, Medicaid provides some of the most comprehensive health coverage in the country for children and youth. The EPSDT guidance also includes information to help address the needs of children with behavioral health conditions. The EPSDT guidance includes a series of strategies and best practices that states can use to meet children's and youth's behavioral health needs. For example, it suggests that states create a children's behavioral health benefit package and support the management of children and youth with mild to moderate behavioral health needs in primary care settings. States must provide coverage for an array of medically necessary mental health and SUD services along the care continuum – including in children's own homes, schools and communities -- in order to meet their EPSDT obligation."

19. **Mental Health and Substance Use Parity:**

On September 9th, the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury released their anticipated final rule regarding mental health and substance use parity, *Requirements Related to the Mental Health Parity and Addiction Equity Act* (MHPAEA).

This rule builds on and implements MHPAEA, providing additional protections against nonquantitative treatment limitations (NQTLs) for mental health and substance use disorder benefits as compared to medical/surgical (M/S) benefits. Examples of NQTLs include prior authorization requirements and standards related to network composition. The Departments note that the final rule will clarify and provide additional information needed for plans and issuers to meet their obligations under MHPAEA and for the Departments and states to enforce those obligations.

Highlights from the newly issued rule include:

- **Comparative Analyses:** Codification requiring health plans and issuers to conduct comparative analyses to measure the impact of NQTLs, consistent with MHPAEA, as amended by the Consolidated Appropriations Act, 2021.
- **Prohibition on Discriminatory Factors:** Prohibiting plans from using biased or non-objective information and sources that systematically, negatively impact access to mental health and substance use disorder services when applying and designing NQTLs.
- **Data Evaluation Requirements:** The requirement to evaluate data related to NQTLs placed on mental health and substance use disorder care and make changes if data suggest that they do not allow for adequate access to care.
- **Sunset of MHPAEA Opt-Out:** Implementation of the sunset provision for self-funded non-Federal governmental plan elections to opt out of complying with MHPAEA.
- **Meaningful Benefits:** Requirement that if a plan or coverage provides any benefits for a mental health or substance use condition in any benefits classification, it must provide meaningful benefits for that condition in every classification in which meaningful M/S benefits are provided.

· **Definitions:** Amendment to the terms "medical/surgical benefits," "mental health benefits," and "substance use disorder benefits" by removing a reference to state guidelines. The final rule maintains current provisions that if a plan or coverage defines what is or is not a mental health or substance use condition, the definition would need to be consistent with the most current version the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Definitions for the following terms are also included:
o "Evidentiary standards" are any evidence, sources, or standards that a plan or issuer considered or relied upon in designing or applying a factor with respect to an NQTL
o "Factors" are all information, including processes and strategies (but not evidentiary standards), that a plan or issuer considered or relied upon to design an NQTL or to determine whether or how the NQTL applies to benefits under the plan or coverage.
o "Processes" are actions, steps, or procedures that a plan or issuer uses to apply an NQTL.
o "Strategies" are practices, methods, or internal metrics that a plan or issuer considers, reviews, or uses to design an NQTL.

The final rule applies to group health plans and health insurance issuers offering group and individual health insurance coverage. The applicability date for group health plans and group health insurance coverage generally is on the first plan year beginning on or after January 1, 2025. However, the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related requirements in the provisions for comparative analyses apply on the first day of the first plan year beginning on or after January 1, 2026. The final rules apply to health insurance issuers offering individual health insurance coverage for policy years beginning on or after January 1, 2026. The rules also apply to grandfathered and non-grandfathered individual health insurance coverage for policy years beginning on or after Jan. 1, 2026. On Sept. 19, 2024, DOL will hold a compliance assistance webinar and join Treasury and HHS in providing future guidance on the rules. Until the applicability date, plans and issuers are required to continue to comply with the existing requirements, including the CAA, 2021 amendments to MHPAEA.

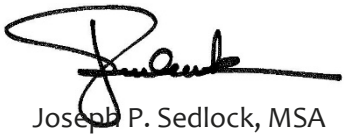
The final rule will become effective 60 days after publication in the Federal Register. Additional information can be found in DOL's news release here, factsheet here, and DOL's one-pager for providers here.

20. **Free COVID Test Kits:**

HHS has announced the reopening of COVIDTests.gov to deliver free COVID-19 tests to households. The agency's investment of $600 million to 12 domestic test manufacturers will supply 200 million home tests. Each household can order 4 free tests to detect the currently circulating COVID-19 variants.

Order your four free test kits at this link.

Submitted By:



Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 10/31/2024

Attachments:

- MSHN Michigan Legislative Tracking Summary

MSHN
Mid-State Health Network

Compiled and tracked by Sherry Kletke

Below is a list of Legislative Bills MSHN is currently tracking and their status as of October 23, 2024:

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 4169	Occupational Therapists (Rogers) Enacts occupational therapy licensure compact.	Passed in House (4/30/2024; 103-6; immediate effect)
HB 4170	Occupational Therapists (Wozniak) Modifies licensure process for occupational therapists to incorporate occupational therapy licensure compact.	Passed in House (4/30/2024; 103-6; immediate effect)
HB 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 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)
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	Introduced (6/14/2023; To Health Policy Committee)

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
	competency exams for defendants charged with misdemeanors.	
HB 4769	Gender Neutral References (Coffia) Makes certain references in the mental health code gender neutral.	Introduced (6/15/2023; To Government Operations Committee)
HB 4817	Open Meetings (Carter, B.) Modifies procedures for electronic meetings of public bodies.	Introduced (6/15/2023; To Local Government and Municipal Finance Committee)
HB 4833	Substance Use Treatment (Puri) Modifies licensure for substance use disorder service programs.	Committee Hearing in House Health Policy Committee (6/13/2024)
HB 4841	Adult Foster Care (Young) Provides for enhanced standards on adult foster care facilities.	Committee Hearing in House Families, Children and Seniors Committee (9/19/2023)
HB 4960	Employment Discrimination (Snyder) Prohibits employers and labor organizations from requesting or maintaining a record of certain criminal history information about a job applicant or employee.	Reported in Senate (4/18/2024; By Civil Rights, Judiciary and Public Safety Committee)
HB 5077	Naloxone (VanderWall) Provides distribution of naloxone under the administration of opioid antagonist act to any individual.	Committee Hearing in Senate Health Policy Committee (6/18/2024)
HB 5078	Controlled Substances (Rheingans) Provides distribution of opioid antagonists by employees and agents of agencies under the administration of opioid antagonists act.	Committee Hearing in Senate Health Policy Committee (6/18/2024)
HB 5114	Mental Health Professionals (Rheingans) Expands definition of mental health professional to include physician assistants, certified nurse practitioners, and clinical nurse specialists-certified, and allows them to perform certain examinations.	Reported in House (5/22/2024; Substitute H-3 adopted; By Health Policy Committee)
HB 5124	Controlled Substances (Bollin) Modifies crime of manufacturing, delivering, or possession of with intent to deliver heroin or fentanyl to reflect changes in sentencing guidelines.	Committee Hearing in House Criminal Justice Committee (3/12/2024)
HB 5125	Controlled Substances (Lightner) Allows probation for certain major controlled substances offenses.	Committee Hearing in House Criminal Justice Committee (3/12/2024)
HB 5126	Controlled Substances (Witwer) Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver heroin or fentanyl.	Committee Hearing in House Criminal Justice Committee (3/12/2024)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 5127	Disabled Veterans (McFall) Extends eligibility for disabled veteran registration plate to partially disabled veterans.	Passed in Senate (10/8/2024; 35-1; Earlier advanced to Third Reading.)
HB 5128	Controlled Substances (Skaggs) Modifies crime of manufacturing, delivering, or possession of with intent to deliver heroin or fentanyl to reflect changes in sentencing guidelines.	Introduced (10/12/2023; To Criminal Justice Committee)
HB 5129	Controlled Substances (Wilson) Allows probation for certain major controlled substances offenses.	Introduced (10/12/2023; To Criminal Justice Committee)
HB 5130	Controlled Substances (Filler) Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver heroin or fentanyl.	Introduced (10/12/2023; To Criminal Justice Committee)
HB 5178	Syringe Service Programs (Rheingans) Provides for syringe service programs.	Committee Hearing in House Health Policy Behavioral Health Subcommittee (6/13/2024)
HB 5179	Drug Paraphernalia (Rheingans) Modifies definition of drug paraphernalia.	Received in Senate (6/18/2024; To Health Policy 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 (6/13/2024)
HB 5185	Social Workers (Edwards) Modifies social work licensure requirements and includes licensure for licensed clinical social workers.	Committee Hearing in House Health Policy Behavioral Health Subcommittee (6/13/2024)
HB 5276	Mental Health (Conlin) Establishes office of mental health within the Michigan department of military and veterans affairs.	Received in Senate (6/25/2024; To Veterans and Emergency Services Committee)
HB 5277	Mental Health (Morse) Establishes office of mental health within the Michigan veterans affairs agency.	Received in Senate (6/25/2024; To Veterans and Emergency Services Committee)
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.	Received in Senate (6/25/2024; To Veterans and Emergency Services Committee)
HB 5280	Mental Health (Bruck) Establishes Michigan azimuth bridge program for transitioning military service members' mental health.	Received in Senate (6/25/2024; To Veterans and Emergency Services Committee)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
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 Behavioral Health Subcommittee (6/13/2024)
HB 5372	Behavioral Health Clinics (Green) Provides certification for certified community behavioral health clinics.	Committee Hearing in House Health Policy Behavioral Health Subcommittee (6/13/2024)
HB 5698	Mental Health (Young) Provides for screening and treatment for post traumatic prison disorder and requires certain other mental health screening, planning, and treatment of incarcerated individuals.	Introduced (5/1/2024; To Criminal Justice Committee)
HB 5720	National Guard (Bezotte) Provides for access to resources by National Guard members.	Received in Senate (6/25/2024; To Government Operations Committee)
HB 5725	Open Meetings (Alexander) Authorizes remote meeting participation for members of a public body meeting as a board of a prepaid inpatient health plan in certain circumstances.	Introduced (5/14/2024; To Local Government and Municipal Finance Committee)
HB 5736	Veterans' Services And Benefits (Mentzer) Requires employers to post notice of veterans' services and benefits.	Received in Senate (7/30/2024; To Labor Committee)
HB 5819	Veterans (Coffia) Modifies veterans trust fund act and removes period of war service requirement.	Introduced (6/13/2024; To Military, Veterans and Homeland Security Committee)
HB 5834	Illicit Drugs (Breen) Prohibits illicit use of xylazine and provides penalties.	Introduced (6/25/2024; To Judiciary Committee)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 5835	Illicit Drug (Breen) Provides sentencing guidelines for illicit use of xylazine.	Introduced (6/25/2024; To Judiciary Committee)
SB 28	Mental Health (Anthony) Expands definition of restraint.	Introduced (1/18/2023; To Health Policy Committee)
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.	Passed in Senate (10/23/2024; 38-0; Earlier advanced to Third Reading.)
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 House Families, Children and Seniors Committee (6/18/2024)
SB 802	Mental Health (Wojno) Provides inclusion of mental health and substance use disorder services with the Michigan crisis and access line.	Introduced (3/19/2024; To Health Policy Committee)
SB 806	Mental Health (Hauck) Requires psychological evaluation on a minor in a hospital emergency room longer than a certain period of time due to a mental health episode.	Introduced (4/9/2024; To Health Policy Committee)
SB 870	Remote Meetings (McCann) Provides for remote meeting participation of certain public body members with disabilities.	Reported in Senate (10/2/2024; S-1 substitute adopted; By Civil Rights, Judiciary and Public Safety Committee)
SB 915	Mental Health (Hertel, K.) Revises person requiring treatment and modifies certain procedures for treatment.	Committee Hearing in Senate Health Policy Committee (10/9/2024)
SB 916	Mental Health (Santana) Provides outpatient treatment for misdemeanor offenders with mental health issues.	Committee Hearing in Senate Health Policy Committee (10/9/2024)
SB 917	Mental Health (Irwin) Expands hospital evaluations for assisted outpatient treatment.	Committee Hearing in Senate Health Policy Committee (10/9/2024)
SB 918	Mental Health (Wojno) Expands petition for access to assisted	Committee Hearing in Senate Health Policy Committee (10/9/2024)

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
	outpatient treatment to additional health providers.	
HCR 5	Psychological Trauma (Conlin) A concurrent resolution to urge the United States Congress, Department of Defense, and Department of Veterans Affairs to prioritize research and investment in non-technology treatment options for servicemembers and veterans who have psychological trauma as a result of military service.	Passed in Senate (9/7/2023; Voice Vote)

REPORT OF THE MSHN DEPUTY DIRECTOR
to the Board of Directors
September/October

Staffing Update

Mid-State Health Network is pleased to announce we have filled the following positions.

- Kara Laferty has accepted the Database and Report Coordinator position and joined MSHN on October 7, 2024. Kara has her master's in social work with many years of mental health experience, most recently working at Community Mental Health for Central Michigan.
- Beth LaFleche joined MSHN on October 7, 2024. Beth comes to MSHN with many years of experience working at Community Mental Health Authority of Clinton, Eaton and Ingham Counties, and most recently for Reliance Community Care Partners. Beth has a Master's in Social Work and Bachelor of Science in Psychology.
- Bo Zwingman-Dole accepted the Compliance and Quality Coordinator position and will join MSHN on December 2, 2024. Bo comes to MSHN with over ten (10) years of experience working in quality and business intelligence at Saginaw County Community Mental Health Authority.
- Bria Perkins, MSHN's Medicaid Event Internal Auditor was promoted to a Quality Assurance and Performance Improvement (QAPI) Manager. The Medicaid Event Internal Auditor functions are being combined with the QAPI Manager functions and being spread across the now three (3) QAPI Managers. This change will allow for more cross functional support within the site review team. Bria's transition was effective October 7, 2024.

Please join us in welcoming our new hires to the team and congratulations to Bria on her promotion.

MSHN is still looking to fill the **Access Specialist II, Integrated Health Administrator** and **Quality Manager positions** located on MSHN's website at: https://midstatehealthnetwork.org/stakeholders-resources/about-us/Careers.

Michigan Health Endowment Fund Award Notice

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

MSHN proposed building and deploying predictive models for improved identification and risk stratification for most at-risk populations. These models will include the following:

- Identify enrollees most likely to become the highest cost in the coming 12 months
- Identify most at-risk enrollees for substance use disorder
- Identify enrollees not diagnosed but most at risk for anxiety/depression

Vital Technologies partnered with MSHN to submit the grant proposal based on their experience and expertise with predictive modeling. MSHN is requesting Board of Directors contract approval to work with Vital Technologies under the grant parameters defined by the Michigan Health Endowment Fund and in accordance with the project implementation time frame identified.

MSHN anticipates distribution of the predictive models' outputs directly to respective Community Mental Health Service Programs (CMHSPs) in the summer of FY25. Recommended next-best action steps can be automatically triggered according to MSHN's care guidelines.

FY25 Software Project Implementation Updates

Compliance Software

Mid-State Health Network has been researching a compliance software system to transition from a manual, labor-intensive collection process to a more streamlined and automated system to report and track Michigan Department of Health and Human Services (MDHHS) and Office of Inspector General (OIG) compliance requirements for investigations of fraud, waste and abuse. Three vendors were identified as being able to meet the regional needs, and meetings to conduct software demonstrations were held in August. MSHN staff along with Pre-paid Inpatient Health Plan (PIHP) Compliance Officers, Regional Compliance Officers and others identified by the CMHSPs attended the demonstrations. Follow-up meetings were conducted with all three vendors in September to answer follow-up questions and demonstrate additional functionality available, such as policy and contract management. The results were discussed internally through the MSHN Compliance Committee and with the Regional Compliance Officers, resulting in a recommendation to utilize Healthicity as the software vendor. This decision was made due to the functionality provided by this vendor that meets the current needs for compliance documentation and reporting as well as the ability to expand to include other functions such as contract and policy management in the future. The current cost estimate provided by this vendor includes additional functionality without an additional cost. The annual cost was included in the FY25 budget for MSHN, and no cost will be passed down to the CMHSPs for use in reporting or any other additional module they select to implement. MSHN anticipates January 2025 as the kickoff for implementation, with a goal to finalize and complete testing by September 2025 allowing for reporting and tracking in FY26.

Data Analytics Software

On October 1, 2024, MSHN released a Request for Proposal (RFP) for our region's population health and data analytics. MSHN has held a contract with Zenith Technology Solutions since 2014, at which time was a joint effort with Region 10 and Lakeshore Regional Entity. Responses to the RFP are due December 31, 2024. MSHN formed a regional cross functional workgroup that includes Finance, Information Technology and Quality Improvement Council members to lead the RFP review and selection process. For more information related to the RFP, see the link on MSHN's website at: https://midstatehealthnetwork.org/stakeholders-resources/about-us/news/Request-For-Proposal-Population-Health-Management-Data-Analytics

Health Services Advisory Group (HSAG) – External Quality Reviews Update

Performance Measure Validation (PMV) Report

The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements. HSAG completed MSHN's review remotely on July 30, 2024. MSHN received the final report that indicated 100% compliance with the State's specifications and the reported rate. The HSAG PMV report is located on MSHN's website at: https://midstatehealthnetwork.org/R5-MSHN_MI2024_PIHP_PMV_Report_F1.pdf

Network Adequacy Assessment (NAA) Results

Health Services Advisory Group implemented a new review of the PIHP's Network Adequacy Validation (NAV) indicator programming logic and methodology. In 2024, HSAG focused on ensuring provider adequacy through the Time and Distance standards set by MDHHS. MSHN included this analysis in our Network Adequacy Assessment Report for 2023 that was shared with the Board of Directors during the May Board meeting. MSHN utilized TBD Solutions to conduct the analysis and has been working to address the gaps identified. HSAG initial results indicated 100% compliance in regards to the logic and methodology calculations. The final report is expected in December 2024. The NAA report is located on MSHN's website at: https://midstatehealthnetwork.org/application/files/6117/1405/4404/NAA_2023.FINAL.CLEAN_4.25.24.pdf

Encounter Data Validation Results

MDHHS implemented an additional review in FY2024 to include a validation of encounter data submitted by the PIHPs. This review will be an ongoing expectation every three years. The review purpose is to ensure that encounter documentation accurately reflects that a provider rendered a specific service under a managed care delivery system. The review included 308 files and approximately 616 encounters. Files were uploaded through the PIHP by our CMHSP partners over the late spring/early summer. An aggregated report for Michigan is expected to be sent directly to MDHHS. The expected date has not been provided to PIHPs.

Performance Improvement Projects (PIP) Results

PIHPs are required to select a formal performance improvement project. For MSHN, our region selected the following PIP project: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population without a decline in performance for the White population. HSAG reviews the study project parameters, the methodology and the improvement initiatives. A draft report was received in late August that included low performance from our region indicating a low confidence level of the methodology and no confidence in improvement initiatives. MSHN is working now with TBD Solutions to review and update our methodology and collaborating with the CMHSPs to ensure appropriate improvement initiatives. A final report is expected anytime.

Compliance Review

MDHHS again contracts with HSAG to conduct the external quality review for compliance with the federal requirements contained 2 Code of Federal Regulations (CFR) Part 438, for Medicaid managed care programs. This review was conducted at the end of August 2024 but included many hours of preparation by multiple MSHN departments and CMHSPs. The Compliance Site Review is conducted over a period of three (3) years and includes a review of thirteen (13) different standards. FY2024 was year one of the review cycle and included review of five (5) of the thirteen (13) standards. The final report is expected in December 2024.

Submitted by:

Amanda L. Ittner
Finalized: 10.31.24

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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 Preliminary Statement of Activities for the Period Ending September 30, 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 Preliminary Statement of Activities for the Period Ending September 30, 2024, as presented.

Mid-State Health Network
Preliminary Statement of Activities
As of September 30, 2024

Rows Numbers		Columns Identifiers A	B	C	D	E (C - D)	F (C / B)	
			Budget Annual	Actual Year-to-Date	Budget Year-to-Date	Budget Difference	Actual % of Budget	
			FY24 Amended Bdgt		FY24 Amended Bdgt			
			100.00%					
1		Revenue:						
2		Grant and Other Funding	$ 371,985	274,878	371,985	(97,107)	73.89 %	1a
3		Prior FY Medicaid Carryforward	$ 7,601,858	7,601,858	7,601,858	0	100.00%	1b
4		Medicaid Capitation	868,457,818	877,982,111	868,457,818	9,524,292	101.10%	1c
5		Local Contribution	1,550,876	1,550,876	1,550,876	0	100.00%	1d
6		Interest Income	2,500,000	2,721,100	2,500,000	221,100	108.84%	1e
7		Non Capitated Revenue	21,708,490	17,061,106	21,708,490	(4,647,384)	78.59%	1f
8		Total Revenue	902,191,027	907,191,929	902,191,027	5,000,901	100.55 %	
9		Expenses:						
10		PIHP Administration Expense:						
11		Compensation and Benefits	7,529,293	7,217,764	7,529,293	(311,529)	95.86 %	
12		Consulting Services	265,300	207,818	265,300	(57,483)	78.33 %	
13		Contracted Services	145,485	155,936	145,485	10,451	107.18 %	
14		Other Contractual Agreements	349,500	307,923	349,500	(41,576)	88.10 %	
15		Board Member Per Diems	15,120	13,580	15,120	(1,540)	89.81 %	
16		Meeting and Conference Expense	134,400	111,196	134,400	(23,204)	82.74 %	
17		Liability Insurance	33,259	20,068	33,259	(13,191)	60.34 %	
18		Facility Costs	163,594	164,038	163,594	443	100.27 %	
19		Supplies	265,070	238,065	265,070	(27,005)	89.81 %	
20		Other Expenses	949,200	1,017,071	949,200	67,872	107.15 %	
21		Subtotal PIHP Administration Expenses	9,850,221	9,453,459	9,850,221	(396,762)	95.97 %	2a
22		CMHSP and Tax Expense:						
23		CMHSP Participant Agreements	792,847,472	790,113,471	792,847,472	(2,734,002)	99.66 %	1b,1c,2b
24		SUD Provider Agreements	71,739,550	61,540,520	71,739,550	(10,199,029)	85.78 %	1c,1f,2c
25		Benefits Stabilization	4,468,466	16,066,440	4,468,466	11,597,974	359.55 %	1b
26		Tax - Local Section 928	1,550,876	1,550,876	1,550,876	0	100.00 %	1d
27		Taxes- IPA/HRA	49,108,940	41,220,908	49,108,940	(7,888,033)	83.94 %	2d
28		Subtotal CMHSP and Tax Expenses	919,715,304	910,492,215	919,715,304	(9,223,090)	99.00 %	
29		Total Expenses	929,565,525	919,945,674	929,565,525	(9,619,851)	98.97 %	
30		Excess of Revenues over Expenditures	$ (27,374,498)	$ (12,753,745)	$ (27,374,498)			

Mid-State Health Network
Preliminary Statement of Net Position by Fund
As of September 30, 2024

Row Numbers		Column Identifiers A	B	C	D B + C	
1	**Assets**		**Behavioral Health Operating**	**Medicaid Risk Reserve**	**Total Proprietary Funds**	
2	**Cash and Short-term Investments**					
3	Chase Checking Account		10,700,616	0	10,700,616	1a
4	Chase MM Savings		14,863,313	0	14,863,313	
5	Savings ISF Account		0	25,992,161	25,992,161	1b
6	Savings PA2 Account		3,414,665	0	3,414,665	1c
7	Investment PA2 Account		3,499,661	0	3,499,661	1c
8	Investment ISF Account		0	31,998,687	31,998,687	1b
9	Total Cash and Short-term Investments		$ 32,478,255	$ 57,990,848	$ 90,469,103	
10	**Accounts Receivable**					
11	Due from MDHHS		49,312,624	0	49,312,624	2a
12	Due from CMHSP Participants		1,800,898	0	1,800,898	2b
13	Due from Miscellaneous		274,766	0	274,766	2c
14	Due from Other Funds		19,746,277	0	19,746,277	2d
15	Total Accounts Receivable		71,134,565	0	71,134,565	
16	**Prepaid Expenses**					
17	Prepaid Expense Insurance		71,820	0	71,820	2e
18	Prepaid Expense Rent		4,529	0	4,529	2f
19	Prepaid Expense Other		214,526	0	214,526	2g
20	Total Prepaid Expenses		290,875	0	290,875	
21	**Fixed Assets**					
22	Fixed Assets - Computers		189,180	0	189,180	2h
23	Accumulated Depreciation - Computers		(189,180)	0	(189,180)	
24	Lease Assets		203,309	0	203,309	2i
25	Accumulated Amortization - Lease Asset		(165,517)	0	(165,517)	
26	Total Fixed Assets, Net		37,792	0	37,792	
27	**Total Assets**		**$ 103,941,487**	**$ 57,990,848**	**$ 161,932,335**	
28						
29	**Liabilities and Net Position**					
30	Liabilities					
31	Accounts Payable		$ 15,569,651	$ 0	$ 15,569,651	1a
32	Current Obligations (Due To Partners)					
33	Due to State		34,120,825	0	34,120,825	3a
34	Other Payable		571,039	0	571,039	3b
35	Due to Hospitals (HRA)		8,584,554	0	8,584,554	1a, 3c
36	Due to State-IPA Tax		1,736,020	0	1,736,020	3d
37	Due to State Local Obligation		9,355	0	9,355	3e
38	Due to CMHSP Participants		23,170,582	0	23,170,582	3f
39	Due to other funds		0	19,746,277	19,746,277	3g
40	Accrued PR Expense Wages		121,975	0	121,975	3h
41	Accrued Benefits PTO Payable		453,683	0	453,683	3i
42	Accrued Benefits Other		72,174	0	72,174	3j
43	Total Current Obligations (Due To Partners)		68,840,207	19,746,277	88,586,484	
44	Lease Liability		39,748	0	39,748	2i
45	Deferred Revenue		5,916,206	0	5,916,206	1b 1c
46	Total Liabilities		90,365,812	19,746,277	110,112,089	
47	Net Position					
48	Unrestricted		13,575,675	0	13,575,675	3k
49	Restricted for Risk Management		0	38,244,571	38,244,571	1b
50	Total Net Position		13,575,675	38,244,571	51,820,246	
51	**Total Liabilities and Net Position**		**$ 103,941,487**	**$ 57,990,848**	**$ 161,932,335**	

Mid-State Health Network
Notes to Financial Statements
For the Twelve-Month Period Ended,
September 30, 2024

Please note: The Preliminary Statement of Net Position contains Fiscal Year (FY) 2024 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 projection MDHHS Financial Status (FSR) Report submitted in August 2024. Typically, projection FSR figures would not be used in Financial Statements however MSHN's fiscal position dictates a departure from that practice to ensure the reports presented illustrate the anticipated fiscal year-end standing more accurately.

Preliminary Statement of Net Position:

1. Cash and Short-Term Investments
    a) The Cash Chase Checking and Chase Money Market Savings accounts are the cash line items available for operations.
    b) The Savings Internal Service Fund (ISF) and Investment ISF reflect designated accounts to hold the Medicaid ISF funds separate from all other funding per the MDHHS contract. MSHN holds nearly $32 M in the investment account, which is about 55% 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 them 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 $3.49 M.
2. Accounts Receivable
    a) Approximately 31% 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, more than 26% of the balance is from withholds while fourth quarter Hospital Rate Adjustor (HRA) amounts account for 17% of the total. Lastly, the remaining balance stems from miscellaneous items.
    b) Due From CMHSP Participants reflect FY 2024 projected cost settlement activity. Sometime in November, MSHN will cost settle with its CMHSPs for 85% of the balance due by either party. Final cost settlements generally occur in May after the fiscal year ends and once Compliance Examination are complete.

CMHSP	Cost Settlement	Payments/Offsets	Total
CEI	258,875.54	-	258,875.54
Shiawassee	1,542,021.89	-	1,542,021.89
Total	**1,800,897.43**	**-**	**1,800,897.43**

    c) The balance in Due From Miscellaneous is equally split between monies owed for Medicaid Event Verification (MEV) findings and cash advances needed to cover operations for a small number of SUD providers.
    d) Due From Other Funds is the account used to manage anticipated ISF transfers. Approximately $19.7 M is needed to support FY 24 regional expenses in excess of revenue. This is a significant improvement as the board approved FY 24 amended

budget projected more than $27 M would be required to support FY 24 regional operations. MDHHS guidance allows PIHPs 7.5% retention of current FY revenue to manage risk. This amount is in addition to the allowable 7.5% for Savings generated when Medicaid and Healthy Michigan revenue exceed expenses.

e) Prepaid Insurance holds October 2024 fringe benefits paid in September.
f) Prepaid Expense Rent balance consists of security deposits for MSHN office suites.
g) Prepaid Expense Other primarily represents payments for Michigan Health Information Network (MiHIN – technological data exchanges) and Michigan Consortium for Healthcare Excellence (MCHE – parity software).
h) Total Fixed Assets - Computers represent the value of MSHN's capital asset net of accumulated depreciation.
i) The Lease Assets category is now displayed as an asset and liability based on a new Governmental Accounting Standards Board (GASB) 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, MDHHS recently informed MSHN that the FY 2020 $1.2 M lapse included in this balance is no longer owed as there was a change in accounting pronouncement. MSHN will consult with its auditors to determine the appropriate disposition of the liability from its general ledger.
b) This amount is related to SUD provider payment estimates and is needed to offset the timing of payments.
c) HRA is a pass-through account for dollars sent from MDHHS to cover supplemental payments made to psychiatric hospitals. HRA payments are intended to encourage hospitals to have psychiatric beds available as needed. Total HRA payments are calculated based on the number of inpatient hospital services reported.
d) Due To State - 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 advance payment made by one CMHSPs. 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 24 projected cost settlement figures based on the MDHHS Projection FSR. These amounts will be paid during the region's final cost settlements, which generally occur in May or after Compliance Examinations are complete.

CMHSP	Cost Settlement	Payments/Offsets	Total
Bay	4,868,864.89	-	4,868,864.89
Central	7,384,321.74	-	7,384,321.74
Gratiot	1,932,924.05	-	1,932,924.05
Huron	2,352,996.01	-	2,352,996.01
The Right Door	448,983.73	-	448,983.73
Lifeways	10,225,612.19	11,734,638.00	(1,509,025.81)
Montcalm	461,652.66	-	461,652.66
Newaygo	3,411,565.03	-	3,411,565.03
Saginaw	3,080,882.09	-	3,080,882.09
Tuscola	737,416.95	-	737,416.95
Total	**34,905,219.34**	**11,734,638.00**	**23,170,581.34**

g) This liability represents the anticipated ISF transfer that will be made from the Medicaid Risk Reserve fund into Behavioral Health Operations. Please see Statement of Activities 2d for more details.
h) Accrued Payroll Expense Wages represent expenses incurred in September and paid in October.
i) Accrued Benefits PTO (Paid Time Off) is the required liability account set up to reflect paid time off balances for employees.
j) Accrued Benefits Other represents retirement benefit expenses incurred in September and paid in October.
k) 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 100.00% translate to MSHN receiving less revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 100.00% show MSHN's spending is trending higher than expected. Please Note: Amounts listed in the Statement of Activities were adjusted to include figures reported on the MSHN Projection FSR submitted to MDHHS in August 2024. Typically, projection FSR figures would not be used in Financial Statements however MSHN's fiscal position dictates a departure from that practice to ensure the reports presented illustrate the anticipated fiscal year-end standing more accurately.

1. Revenue
    a) This account tracks Veterans Navigator (VN) activity and CMHSP Clubhouse Grant payments used to assist persons served with their Medicaid deductibles. The latter is responsible for the variance as spending is 100k less than the total grant amount.
    b) The region carried forward $7.6 M from FY 23 Medicaid savings. This number increased from March's Statement as a larger portion of CCBHC payments were charged to supplemental which reduced the amount paid by capitation. As a reminder, Medicaid Savings are generated when the prior year revenue exceeds expenses for the same period. In addition, A small portion of Medicaid Savings is sent to the CMHSPs as funding delegated for SUD activities which include access, prevention, and customer services. FY 2023 Medicaid Carry Forward must be used as the first revenue source for FY 2024.
    c) Medicaid Capitation – There is a positive variance in this account as it includes updated FY 24 rates sent by MDHHS in late September. The new rates increased MSHN's revenue projections by approximately $8 M. 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 are the same as FY 2023.
    e) Interest income is earned from investments and changes in principle for investments purchased at discounts or premiums. 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 as some FY 2024 budgeted positions have not been filled.
    b) CMHSP participant Agreement shows a slight variance when comparing actual to budget. As a reminder from July's statements, actual expense figures were adjusted to reflect amounts contained in the projection FSR. 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. In addition, benefit stabilization amounts are paid to CMHSP for SUD access activities plus it provides assistance for short-term cash flow needs. The short-term cash flow needs were higher than

anticipated and requested by several CMHSPs to ensure operational expenditures were covered.

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 lower than the budget although FY 24 HRA payments increased from $308 to $622. 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). Please note, revenue for this line item is included in the Medicaid capitation line and is equal to the expense.

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

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	91282CDR9	1.19.22	1.20.22	12.1.23		1,992,391.23	2,000,000.00			
UNITED STATES TREASURY BILL	91282CDR9						(2,000,000.00)			
UNITED STATES TREASURY BILL	912797FU6	6.14.23	6.15.23	12.14.23		9,746,615.56	10,000,000.00			
UNITED STATES TREASURY BILL	912797FU6						(10,000,000.00)			
UNITED STATES TREASURY BILL	912797GC5	7.12.23	7.13.23	1.11.24		19,476,648.89	20,000,000.00			
							(20,000,000.00)			
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24		13,999,344.96	14,366,000.00			
UNITED STATES TREASURY BILL	912797GM3	8.14.23	8.15.23	2.8.24			(14,366,000.00)			
UNITED STATES TREASURY BILL	912797JM0	12.12.23	12.14.23	4.9.24		9,833,206.75	10,000,000.00			
UNITED STATES TREASURY BILL	912797JM0	12.12.23	12.14.23	4.9.24			(10,000,000.00)			
UNITED STATES TREASURY BILL	912797JQ1	12.29.23	1.2.24	4.30.24		1,966,250.28	2,000,000.00			
UNITED STATES TREASURY BILL	912797JQ1	12.29.23	1.2.24	4.30.24			(2,000,000.00)			
UNITED STATES TREASURY BILL	912797HF7	1.9.24	1.11.24	4.11.24		19,998,137.44	20,261,000.00			
UNITED STATES TREASURY BILL	912797HF7	1.9.24	1.11.24	4.11.24			(20,261,000.00)			
UNITED STATES TREASURY BILL	912797GB7	4.10.24	4.11.24	7.11.24		29,998,279.23	30,395,000.00			
UNITED STATES TREASURY BILL	912797GB7	4.10.24	4.11.24	7.11.24			(30,395,000.00)			
UNITED STATES TREASURY BILL	912797KZ9	4.29.24	4.30.24	8.27.24		1,999,458.02	2,034,000.00			
UNITED STATES TREASURY BILL	912797KZ9						(2,034,000.00)			
UNITED STATES TREASURY BILL	912797MA2	7.9.24	7.11.24	11.5.24		29,999,379.63	29,999,379.63			
UNITED STATES TREASURY BILL	912797KZ9	8.26.24	8.27.24	11.21.24		1,999,307.58	1,999,307.58			
JP MORGAN INVESTMENTS							31,998,687.21			31,998,687.21
JP MORGAN CHASE SAVINGS							25,744,693.24	0.020%	247,467.43	25,992,160.67
							$ 57,743,380.45		$ 247,467.43	$ 57,990,847.88

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 September 30, 2024

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY	Chase Savings Interest	Total Chase Balance
UNITED STATES TREASURY BILL	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	3,558,000.00			
UNITED STATES TREASURY BILL	912797JZ1	2.7.24	2.8.24	6.4.24			(3,558,000.00)			
UNITED STATES TREASURY BILL	9127979LK1	6.3.24	6.4.24	10.1.24		3,499,660.72	3,499,660.72			
JP MORGAN INVESTMENTS							3,499,660.72			3,499,660.72
JP MORGAN CHASE SAVINGS							3,411,783.45	0.010%	2,882.03	3,414,665.48
							$ 6,911,444.17		$ 2,882.03	$ 6,914,326.20

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					
November 2024					
CONTRACTING ENTITY	**CMHSP SERVICE AREA**	**CONTRACT TERM**	**CURRENT FY24 CONTRACT AMOUNT**	**FY24 TOTAL CONTRACT AMOUNT**	**FY24 INCREASE/ (DECREASE)**
PIHP/CMHSP MEDICAID SUBCONTRACTS					
Montcalm Care Network	Montcalm		-	-	-
Clubhouse Spendown MOU - Amendment		10.1.23 - 9.30.24	30,000	**57,000**	**27,000**
			$ 30,000	**57,000**	**27,000**

MSHN
Mid-State Health Network

Background

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

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

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

Recommended Motion:

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

MID-STATE HEALTH NETWORK
FISCAL YEAR 2025 NEW AND RENEWING CONTRACTS
November 2024

CONTRACTING ENTITY	PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY25 COST REIMBURSEMENT CONTRACT AMOUNT	FY25 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY25 INCREASE/ (DECREASE)
PIHP ADMINISTRATIVE FUNCTION CONTRACTS					
Dr. Zakia Alavi, MD	Chief Medical Officer (Rate of $175/Hr.)	10.1.24 - 9.30.25	-	-	-
Holland Litho Printing Service	Consumer Handbooks	10.1.24 - 9.30.25	-	**48,075**	**48,075**
Kelly Services, Inc.	Tempoary Staffing	11.1.24 - 3.7.25		**50,000**	**50,000**
TBD Solutions, LLC, Ada Michigan	Ongoing Consultative Support ("Open"); per hour rate ($205 + expenses)	10.1.24 - 9.30.25	60,000	**60,000**	-
Vital Data Technology	Predictive Analytics Project	10.1.24 - 9.30.25	-	**300,000**	**300,000**
			$ 60,000	**$ 458,075**	**$ 398,075**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	CURRENT FY25 COST REIMBURSEMENT CONTRACT AMOUNT	FY25 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY25 INCREASE/ (DECREASE)
Face Addiction Now (FAN)	Harm Reduction (PA2; Saginaw)	10.1.24 - 9.30.25	-	**144,809**	**144,809**
Lansing Syringe Services	Harm Reduction (PA2; Ingham)	10.1.24 - 9.30.25	-	**95,116**	**95,116**
Peer360	CCAR Recovery Coach Training	10.1.24 - 9.30.25	1,180,850	**1,308,700**	**127,850**
Wellness, Inx	CCAR Recovery Coach Training	10.1.24 - 9.30.25	618,718	**773,926**	**155,208**
			$ 1,799,568	**$ 2,322,551**	**$ 522,983**

CONTRACTING ENTITY	SUD PROVIDERS FFS PROGRAM DESCRIPTION	CONTRACT TERM			
Isabella Citizens for Health	OHH Only Services	12.1.24 - 9.30.25	-	-	-
			$ -	**$ -**	**$ -**

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION (Revenue Contract)	CONTRACT TERM	CURRENT FY25 CONTRACT AMOUNT	FY25 TOTAL CONTRACT AMOUNT	FY25 INCREASE/ (DECREASE)
Michigan Department of Health & Human Services	Medicaid Managed Specialty Supports and Services Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs (FY25) - Change Notice #1	10.1.24 - 9.30.25	-	-	-
Michigan Health Endowment Fund (MHEF) - GRANT	Predictive Analytics Platform Development	9.12.24	-	**300,000**	**300,000**
CEO Signed on 09/19/24 after authorization by the MSHN Board Executive Committee.			-	-	-
			$ -	**$ 300,000**	**$ 300,000**

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, September 10, 2024
MyMichigan Medical Center
Meeting Minutes

1. Call to Order

Chairperson Ed Woods called this meeting of the Mid-State Health Network Board of Directors to order at 5:44 p.m. following the Public Hearing.

2. Roll Call

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

Board Member(s) Present: Greg Brodeur (Shiawassee), Ken DeLaat (Newaygo), David Griesing (Tuscola), Dan Grimshaw (Tuscola), Tina Hicks (Gratiot), John Johansen (Montcalm), Pat McFarland (Bay-Arenac), Deb McPeek-McFadden (The Right Door), Irene O'Boyle (Gratiot), Paul Palmer (CEI), Bob Pawlak (BABH), Kurt Peasley (Montcalm), Joe Phillips (CMH for Central Michigan), Linda Purcey (The Right Door), Kerin Scanlon (CMH for Central Michigan), Richard Swartzendruber (Huron), Susan Twing (Newaygo), Joanie Williams (Saginaw), and Ed Woods (LifeWays)

Board Member(s) Remote: None

Board Member(s) Absent: Brad Bohner (LifeWays), Joe Brehler (CEI), Bruce Gibb (Huron), Jeanne Ladd (Shiawassee), and Tracey Raquepaw (Saginaw)

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

3. Approval of Agenda for September 10, 2024

Board approval was requested for the Agenda of the September 10, 2024, Regular Business Meeting.

MOTION BY TINA HICKS, SUPPORTED BY DAVID GRIESING, FOR APPROVAL OF THE AGENDA OF SEPTEMBER 10, 2024, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 19-0.

The board recessed for five minutes to allow members to get refreshments and reconvened at 5:52 p.m.

4. Public Comment

Mr. Joe Sedlock discussed a letter written by Chief Executive Officer Christopher Pinter of Bay-Arenac Behavioral Health Authority to Governor Gretchen Whitmer advocating for MDHHS to address FY24 Medicaid Revenue and Expense Gaps. A copy of the letter was provided in board member folders.

5. Fiscal Year 2025 Board Meeting Calendar

Board approval was requested for the Fiscal Year 2025 Board Meeting Calendar as presented.

MOTION BY IRENE O'BOYLE, SUPPORTED BY TINA HICKS, TO ADOPT THE FISCAL YEAR 2025 MSHN BOARD OF DIRECTORS MEETING CALENDAR, AS PRESENTED. MOTION CARRIED: 19-0.

6. Consideration of MSHN Fiscal Year 2024 Budget Amendment

Ms. Leslie Thomas provided an overview and information on the Fiscal Year 2024 Budget Amendment report and recommended board approval as presented.

MOTION BY KEN DeLAAT, SUPPORTED BY DAN GRIMSHAW, FOR APPROVAL OF THE MSHN FISCAL YEAR 2024 BUDGET AMENDMENT, AS PRESENTED. MOTION CARRIED: 19-0.

7. Consideration of MSHN Regional Budget for Fiscal Year 2025

Board approval was requested for the MSHN Fiscal Year 2025 Budget as presented during the Public Hearing. Board members requested Administration send an email update to members following budget finalization once rate data is received from Michigan Department of Health and Human Services (MDHHS) and the revised budget information has been calculated and presented to the Community Mental Health Service Programs (CMHSPs).

MOTION BY KURT PEASLEY, SUPPORTED BY RICH SWARTZENDRUBER, FOR APPROVAL OF THE MSHN FISCAL YEAR 2025 BUDGET, AS PRESENTED DURING THE PUBLIC HEARING. MEMBERS ASKED FOR A ROLL CALL VOTE: VOTING IN FAVOR: GREG BRODEUR, KEN DeLAAT, DAVID GRIESING, TINA HICKS, JOHN JOHANSEN, PAT McFARLAND, DEB McPEEK-McFADDEN, IRENE O'BOYLE, PAUL PALMER, BOB PAWLAK, KURT PEASLEY, JOE PHILLIPS, LINDA PURCEY, KERIN SCANLON, RICHARD SWARTZENDRUBER, SUSAN TWING, JOANIE WILLIAMS, AND ED WOODS. VOTING IN OPPOSITION: DAN GRIMSHAW. MOTION CARRIED: 18-1.

8. Chief Executive Officer's Report

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

- PIHP/Regional Matters

- MSHN releases 2024 Impact Report
- Conflict Free Access and Planning (CFAP) Update
- MSHN Cost Containment Plan – Partial Access Centralization
- MSHN Bylaws
- Regional Financial Position

- State of Michigan/Statewide Activities
  - MSHN/MDHHS "Master Contract" for FY25

9. Deputy Director's Report

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

- Staffing Update
- Performance Bonus Incentive Payment (PBIP) for Housing & Employment
- Credentialing Committee Updates
- Information Technology Report FY24Q3
- Utilization Management Department Update

10. Chief Financial Officer's Report

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

MOTION BY PAT McFARLAND, SUPPORTED BY DAVID GRIESING, TO RECEIVE AND FILE THE STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDED JULY 31, 2024, AS PRESENTED. MOTION CARRIED: 19-0.

11. Contracts for Consideration/Approval

A. FY24 Contract Listing 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 PAUL PALMER, SUPPORTED BY RICH SWARTZENDRUBER, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY24 CONTRACT LISTING. MOTION CARRIED: 19-0.

B. FY25 Contract Listing for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2025 contract listing provided in the meeting packet and requested the board authorize MSHN's CEO to sign and fully execute the contracts listed on the FY2025 contract listing.

MOTION BY DAVID GRIESING, SUPPORTED BY PAUL PALMER, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY25 CONTRACT LISTING. MOTION CARRIED: 19-0.

12. Executive Committee Report

Mr. Ed Woods informed board members the Executive Committee met on August 16, 2024, and reviewed the agendas for the Public Hearing and the Board Meeting and the FY25 meeting calendars for the Board and Executive Committee. Mr. Woods informed board members that Ms. Irene O'Boyle was appointed as Chair of the upcoming CEO performance review process and asked Ms. O'Boyle to provide an update.

Ms. Irene O'Boyle informed board members of the upcoming annual performance review process of the Chief Executive Officer explaining that she will be working with Ms. Amanda Ittner and Ms. Sherry Kletke to identify peers, stakeholders and employees to receive a 360-degree feedback survey. Board members will also receive a performance evaluation to complete through Survey Monkey following the November board meeting. Mr. Woods expressed his appreciation to Ms. O'Boyle for taking on the role of the Evaluation Chair.

13. Chairperson's Report

Mr. Ed Woods mentioned today is Suicide Prevention Day and asked for a moment of silence to reflect on all those affected by suicide.

14. Approval of Consent Agenda

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

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY RICH SWARTZENDRUBER, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE JULY 2, 2024 BOARD OF DIRECTORS MEETING; RECEIVE SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD MINUTES OF APRIL 17, 2024 AND JUNE 26, 2024; RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF JUNE 21, 2024 AND AUGUST 16, 2024; RECEIVE POLICY COMMITTEE MEETING MINUTES OF AUGUST 6, 2024; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF JULY 15, 2024 AND AUGUST 19, 2024; AND TO APPROVE ALL THE FOLLOWING POLICIES: TRAVEL, CONTROLLED ACCESS AND LEAST PRIVILEGE, DATA ENCRYPTION, REMOVABLE MEDIA, HEALTH HOME PROVIDER, APPOINTED COUNCILS, COMMITTEES AND WORKGROUP, BOARD GOVERNANCE, BOARD MEMBER CONDUCT AND MEETINGS, BOARD MEMBER DEVELOPMENT, BYLAWS

REVIEW, COMMUNITY MENTAL HEALTH SERVICE PROGRAM (CMHSP) APPLICATION, CONFLICT OF INTEREST, CONSENT AGENDA, DELEGATION TO THE CHIEF EXECTUVE OFFICER & EXECUTIVE LIMITATIONS, FREEDOM OF INFORMATION ACT (FOIA) REQUEST, GENERAL MANAGEMENT, LEGISLATIVE AND PUBLIC BODY ADVOCACY, MONITORING CHIEF EXECUTIVE OFFICER PERFORMANCE, NEW BOARD MEMBER ORIENTATION, OFFICE CLOSURE POLICY, POLICY AND PROCEDURE DEVELOPMENT AND APPROVAL, AND POPULATION HEALTH INTEGRATED CARE. MOTION CARRIED: 19-0

15. Other Business

Mr. Ed Woods expressed his appreciation to board members for taking the time to serve on the board and for taking on the responsibility as a board member. Mr. John Johansen wished to also express appreciation to the MSHN staff for all the work they do.

16. Public Comment

There was no public comment.

17. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 6:43 p.m.

Mid-State Health Network (MSHN) Board of Directors Public Hearing

Tuesday, September 10, 2024

MyMichigan Medical Center

Meeting Minutes

1. **Call to Order**

   Chairperson Ed Woods called this Public Hearing of the Mid-State Health Network Board of Directors to order at 5:01 p.m. Mr. Woods reminded members that those participating by phone may not vote on matters before the board and the Board Member Conduct Policy. Mr. Woods called on Ms. Amanda Ittner to introduce MSHN new staff member, Cari Patrick, Substance Use Disorder Prevention Specialist.

2. **Roll Call**

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

Board Member(s) Present:	Greg Brodeur (Shiawassee), Ken DeLaat (Newaygo), David Griesing (Tuscola), Dan Grimshaw (Tuscola), Tina Hicks (Gratiot), John Johansen (Montcalm), Pat McFarland (Bay-Arenac), Deb McPeek-McFadden (The Right Door), Irene O'Boyle (Gratiot), Paul Palmer (CEI), Bob Pawlak (BABH)-joined at 5:06 p.m., Kurt Peasley (Montcalm), Joe Phillips (CMH for Central Michigan), Linda Purcey (The Right Door), Kerin Scanlon (CMH for Central Michigan)-joined at 5:08 p.m., Richard Swartzendruber (Huron), Susan Twing (Newaygo), Joanie Williams (Saginaw)-joined at 5:15 p.m., and Ed Woods (LifeWays)
Board Member(s) Remote:	None
Board Member(s) Absent:	Brad Bohner (LifeWays), Joe Brehler (CEI), Bruce Gibb (Huron), Jeanne Ladd (Shiawassee), and Tracey Raquepaw (Saginaw)
Staff Member(s) Present:	Joseph Sedlock (Chief Executive Officer), Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Sherry Kletke (Executive Support Specialist), and Cari Patrick (Prevention Specialist)

3. Approval of Agenda for September 10, 2024

Board approval was requested for the Agenda of the September 10, 2024, Public Hearing.

MOTION BY PAUL PALMER, SUPPORTED BY TINA HICKS FOR APPROVAL OF THE AGENDA OF SEPTEMBER 10, 2024, PUBLIC HEARING, AS PRESENTED. MOTION CARRIED: 16-0.

4. Fiscal Year 2025 Budget Presentation

Ms. Leslie Thomas presented the FY2025 MSHN Regional Budget as distributed at the time of the meeting and answered questions posed by board members.

5. Public Comment

There was no public comment.

6. Board Comment

There was no board comment.

7. Adjournment

The MSHN Public Hearing adjourned at 5:43 p.m.

Mid-State Health Network SUD Oversight Policy Advisory Board
Wednesday, August 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 Meeting to order at 4:05 p.m. Mr. Glaser reminded members participating virtually may not participate in or vote on matters before the board. Mr. Glaser welcomed Charlie Mahar as the new member serving as alternate from Montcalm County and Karen Link as the new member from Huron County.

Board Member(s) Present:	Irene Cahill (Ingham)-joined at 4:06 p.m., Bruce Caswell (Hillsdale), Steve Glaser (Midland), Charlean Hemminger (Ionia)-joined at 4:06 p.m., John Hunter (Tuscola), Bryan Kolk (Newaygo), John Kroneck (Montcalm)-joined at 4:06 p.m., Karen Link (Huron), Jerrilynn Strong (Mecosta), Kim Thalison (Eaton), Dwight Washington (Clinton), and Ed Woods (Jackson)
Board Member(s) Remote:	Nichole Badour (Gratiot), and Jim Moreno (Isabella)
Board Member(s) Absent:	Lisa Ashley (Gladwin), Lori Burke (Shiawassee), George Gilmore (Clare), Christina Harrington (Saginaw), Robert Luce (Arenac), Justin Peters (Bay), and David Turner (Osceola)
Alternate Member(s) Present:	Charlie Mahar (Montcalm), and Simar Pawar (Ingham)-joined at 4:15 p.m.
Alternate Member(s) Remote:	Margery Briggs (Ionia)
Staff Members Present:	Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Dr. Dani Meier (Chief Clinical Officer), Dr. Trisha Thrush (Director of Substance Use Disorder Services and Operations); and Sherry Kletke (Executive Support Specialist)

Staff Members Remote: Sarah Andreotti (SUD Prevention Administrator), Sherrie Donnelly (Treatment and Recovery Specialist), Kate Flavin (Treatment Administrator), Sarah Surna (Prevention Specialist), Jodie Smith (Data and Grant Coordinator)

2. Roll Call

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

3. Approval of Agenda for August 21, 2024

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

   MOTION BY BRYAN KOLK, SUPPORTED BY JOHN HUNTER, FOR APPROVAL OF THE AUGUST 21, 2024 REGULAR BUSINESS MEETING AGENDA, AS PRESENTED. MOTION CARRIED: 12-0.

4. Approval of Minutes from the June 26, 2024 Regular Business Meeting

   Board approval was requested for the draft meeting minutes of the June 26, 2024 Regular Business Meeting.

   MOTION BY JERRILYNN STRONG, SUPPORTED BY BRYAN KOLK, FOR APPROVAL OF THE MINUTES OF THE JUNE 26, 2024 MEETING, AS PRESENTED. MOTION CARRIED: 12-0.

5. Public Comment

   There was no public comment.

6. Board Chair Report

   Chairperson Steve Glaser introduced Charlie Mahar, recently appointed as the alternate member from Montcalm County and Karen Link, recently appointed as the member from Huron County.

   Mr. Glaser called for discussion and approval of the Fiscal Year 2025 Oversight Policy Board meeting calendar as presented.

   MOTION BY JOHN HUNTER, SUPPORTED BY JOHN KRONECK, FOR APPROVAL OF THE FISCAL YEAR 2025 SUD OVERSIGHT POLICY BOARD MEETING CALENDAR, AS PRESENTED. MOTION CARRIED: 12-0.

7. 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:

   <u>Regional Matters</u>:

   - MSHN Impact Report for 2024

- 25th Annual Substance Use and Co-Occurring Disorder Hybrid Conference
- Annual Disclosure of Ownership, Controlling Interest, and Criminal Convictions
- Provider Updates

State of Michigan/Statewide Activities

- Michigan Department of Health and Human Services (MDHHS) Director Hertel visits Detroit Recovery Project to Discuss Nearly $300 Million in FY 2025 Budget to Address Substance Use Disorder (SUD)

Federal/National Activities

- A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During the Unwinding of Continuous Enrollment and Beyond

8. 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 June 2024

9. Substance Use Disorder PA2 Contract Listing

A. 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 IRENE CAHILL, SUPPORTED BY KIM THALISON, FOR APPROVAL OF THE FY24 SUBSTANCE USE DISORDER (SUD) PA2 CONTRACT LISTING, AS PRESENTED. MOTION CARRIED: 12-0.

B. FY25 Substance Use Disorder PA2 Contract Listing

Ms. Leslie Thomas provided an overview and information on the FY25 Substance Use Disorder (SUD) PA2 Contract Listing as provided in the packet.

MOTION BY JOHN KRONECK, SUPPORTED BY JERRILYNN STRONG, FOR APPROVAL OF THE FY25 SUBSTANCE USE DISORDER (SUD) PA2 CONTRACT LISTING, AS PRESENTED. MOTION CARRIED: 10-1 AND 1 ABSTENTION

10. SUD Operating Update

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

- Team staffing update
- Synar Check Compliance Results
- Peer 360 acknowledgement in article published by Clinical Simulation in Nursing
- Opioid Task Force Treatment Sub-Committee work on Medication First Principles

11. Other Business

There was no other business, however Administration will take into consideration OPB member discussions regarding Marijuana use and the effects on adults and children and changes in trends since legalization as well as the Medication First Principle supported by the Opioid Task Force and include a board development presentation on these topics at a future meeting.

12 Public Comment

There was no public comment.

13. Board Member Comment

Board members shared local stigma reduction and prevention efforts.

14. Adjournment

Chairperson Steve Glaser adjourned the MSHN SUD Oversight Policy Advisory Board Meeting at 5:15 p.m.

Meeting minutes submitted respectfully by:
MSHN Executive Support Specialist

MSHN
Mid-State Health Network

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

Friday, October 18, 2024 - 9:00 a.m.

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

Other Board Members Present: None

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

1. Call to order: Chairperson Woods called this meeting of the Mid-State Health Network (MSHN) Board Executive Committee to order at 9:00 a.m.

   - Informational Enclosure: Legislation allowing members of boards who have a disability to attend meeting remotely.

2. Approval of Agenda: Motion by I. O'Boyle supported by D. Griesing to approve the agenda for this meeting. Motion Carried.

3. Guest MSHN Board Member Comments: None

4. Board Matters
   - 4.1 Draft November 12, 2024 Governing Board Meeting Agenda: The draft agenda for the November 12, 2024 Board Meeting was reviewed with no changes recommended. Committee notes that the board agenda is not final until approved by the board.
   - 4.2 Status Update: CMHSP Participant Adoption of MSHN Revised Bylaws: J. Sedlock stated that five of 12 CMHSPs have adopted the proposed revisions to the MSHN Bylaws. CHMSPs were asked to have their boards consider the proposed bylaws revisions by 12/31/2024.
   - 4.3 Successor for Jeanne Ladd on MSHN Board Policy Committee: MSHN was informed that Jeanne Ladd resigned from her home board, Shiawassee Health and Wellness (SHW). SHW is in the process of identifying and appointing a successor. This results in a vacancy on the MSHN Board Policy Committee. A. Ittner will develop a written communication to the full board to be distributed on behalf of Mr. John Johannsen and Mr. Woods. Mr. Woods and/or Mr. Johannsen will follow-up requesting volunteers to fill the vacancy at the November board meeting.
   - 4.4 Annual Board Self-Evaluation – Adding DEI-related questions: The internal inclusion, diversity, equity, and accessibility staff workgroup (IDEA) and our regional equity advisory committee for health (REACH) have recommended the inclusion of five DEI-related questions to the board self-evaluation. The Executive Committee discussed and recommends that these be added to the annual board self-assessment. J. Sedlock will include a short summary in his November board report.
   - 4.5 Annual CEO Performance Review Update (If Any) (I. O'Boyle): I. O'Boyle updated the Executive Committee on the progress with the annual review. At this time, 360 surveys have been sent and many are being returned. I. O'Boyle will prompt board members at the November meeting to complete the performance review, a link to which will be provided shortly after the board meeting.
   - 4.6 Other (if any): None

5. Administration Matters
   - 5.1 PIHP/MDHHS Contract Update: Seven of ten PIHPs did not sign their FY 25 base contacts with MDHHS. MDHHS responded by citing transition responsibilities under the termination section of the FY 24 contract and requiring signing before the October 10 first FY 25 payment date. MDHHS scheduled a meeting with the seven PIHPs for today to address the issue. J. Sedlock will provide additional information when received and confirmed, including a written update in his November board report.

5.2 Conflict Free Access and Planning Update (Brief): MDHHS scheduled a meeting with PIHPs for November 1, 2024. That meeting was cancelled in early October with the explanation that the meeting will be rescheduled after further work with CMS is completed. Administration has no other updates.

5.3 FY 24 Revenue and FY 25 Rates/Revenue Update – details emailed: J. Sedlock reiterated information that was distributed to the full board by email, as follows:

FY 24 amended budget – The FY 24 amended budget highlighted the Region planned to overspend its operational revenue by $27 M. In late September, MSHN received amended MDHHS rates and processed those revenue figures. Results of the new rates are projected to improve the Region's fiscal position by $8 M – which means the new revenue shows the overspend has decreased to $19 M.

FY 25 original budget – The FY 25 original budget highlighted the Region planned to overspend its operational revenue by $29 M. In late September, MSHN received final MDHHS rates and processed those revenue figures. In addition, CMHSPs updated expense figures based on a few categories included in the final revenue rates. Results of the final MDHHS revenue rates are projected to improve the Region's fiscal position by $19 M – which means the new revenue shows the overspend has decreased to $10 M.

6. Other
   - 6.1 Any other business to come before the Executive Committee: None
   - 6.2 Next scheduled Executive Committee Meeting: 12/20/2024, 9:00 a.m.

7. Guest MSHN Board Member Comments: None

8. Adjourn: This meeting was adjourned at 9:22 a.m.

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, OCTOBER 1, 2024 (VIDEO CONFERENCE)

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

Members Absent: John Johansen and Jeanne Ladd

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

1. CALL TO ORDER

Mr. David Griesing called the Board Policy Committee meeting to order at 10:03 a.m.

2. APPROVAL OF THE AGENDA

MOTION by Kurt Peasley, supported by Irene O'Boyle, to approve the October 1, 2024, Board Policy Committee Meeting Agenda as presented. Motion Carried: 3-0.

3. POLICIES UNDER DISCUSSION

There were no policies under discussion.

4. POLICIES UNER BIENNIAL REVIEW

Mr. David Griesing invited Ms. Amanda Ittner to provide a review of the substantive changes within the policies listed below. Ms. Ittner provided an overview of the substantive changes within the policies. The Service Delivery Chapter was reviewed by MSHN Leadership, Clinical Leadership Committee and Operations Council. The Procurement policy was reviewed by the Chief Financial Officer and MSHN Leadership.

CHAPTER: SERVICE DELIVERY

1. CHILDREN WITH SEVERE EMOTIONAL DISTURBANCES HOME AND COMMUNITY-BASED WAIVER
2. CHILDREN'S HOME AND COMMUNITY BASED SERVICES WAIVER (CWP)
3. COMMUNITY-BASED DEPENDENT LIVING PLACEMENT
4. ELECTROCONVULSIVE THERAPY (ECT)
5. EMERGENCY & POST-STABILIZATION SERVICES
6. EVIDENCE BASED PRACTICES
7. HABILITATION SUPPORTS WAIVER (HSW)
8. HOME AND COMMUNITY BASED SERVICES COMPLIANCE MONITORING
9. INDIAN HEALTH SERVICES
10. INPATIENT PSYCHIATRIC HOSPITALIZATION STANDARDS
11. OUT OF STATE PLACEMENTS
12. STANDARDIZED ASSESSMENT
13. SUBSTANCE USE DISORDER SERVICES-MEDICATION FOR OPIOID USE DISORDER
14. SUBSTANCE USE DISORDER SERVICES-OUT OF REGION COVERAGE

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15. SUBSTANCE USE DISORDER SERVICES-TELEMEDICINE
16. SUBSTANCE USE DISORDER SERVICES-WOMEN'S SPECIALTY SERVICES
17. TRAUMA-INFORMED SYSTEMS OF CARE

CHAPTER: FINANCE

1. PROCUREMENT

MOTION by Irene O'Boyle, supported by Kurt Peasley, to approve and recommend the policies under biennial review as presented. Motion carried: 3-0.

5. NEW BUSINESS

There are no chapters scheduled for policy review at the December 3, 2024, policy committee meeting, however Administration will know after the November Operations Council meeting if there will be any policies needing review that will need to be presented to the policy committee. Administration will notify policy committee members the status of the December 3, 2024 meeting, following the November Operations Council meeting.

6. ADJOURN

Mr. David Griesing adjourned the Board Policy Committee Meeting at 10:14 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: 09/23/2024

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

Members Absent:

MSHN Staff Present: Joseph Sedlock; Amanda Ittner; Leslie Thomas, Skye Pletcher, and Todd Lewicki, per agenda items

Agenda Item	Action Required				
CONSENT AGENDA	HSW slot graph on the MDHHS reallocation doesn't add up – pg 44. Joe will reach out to clarify, but MSHN in total went down 60 slots. Consent agenda received and no further discussion				
	Received and acknowledged	By Who	N/A	By When	N/A
REGIONAL FINANCIAL POSITION AND COST CONTAINMENT STRATEGY	Joe Sedlock reviewed the financial position and deficit expected that would zero out the ISF by the end of FY25 if nothing changes. Leslie Thomas reviewed the cost containment strategy discussion in Finance Council and the status of those strategies. CMHs reporting that other increases in cost are offsetting the reduction strategies. ISF can only be funded with excess surplus at year-end. Montcalm numbers need to be updated with most current savings projection. MCN and CMHCM are not filling vacant positions. Discussed FY25 salary increases; increased benefit cost; Newaygo using PA's, mid-level as opposed to psychiatrist, Residents, etc. Hospital Rate negotiations – see below. HBH specialized residential and community placements are very costly LifeWays reported Autism, inpatient, CLS and residential increases. Reviewing out-of-county placements, budget reductions by 5%. Reduced overtime cost for on-call. Evaluating defined pension vs opting back into social security. GHIN – 30% increase in health cost; evaluate contracting out PERS (personnel emergency response system) Consideration of ABA contracts being handled regionally. Leslie sent out a survey for CMHs to consider and respond. Some CMHs direct hire behavior techs. Saginaw supportive of this review and consideration. Joe suggested we discussed PBIP local funds and how that would be distributed if we have a regional deficit. Bigger question of local to support the anticipated deficit. CCBHC rates came out on Friday, do we know yet how much is coming from capitation? It was not included. It may be included in the final rate certification document (not yet received). PIHPs/MSHN requested the MDHHS rates be reflective of more current expenditures. Leslie reviewed the feedback she worked with Wakley and 2 other CFO's to give to MDHHS. There is a discussion at MDHHS on when/if rates will be adjusted for FY24.				

Agenda Item	Action Required				
	Most PIHPs are anticipating deficits and use of ISF but not depleting it like MSHN expects. No consensus on strategy but will keep this item on the agenda for discussion each month. Leslie will work with CFO's to keep the cost containment strategy updated. Saginaw, LifeWays, BABH, CMCHM keeping no provider rate increases (CLS, Residential) Out of County seem to have strong hold on their rate increase (i.e. hope network)				
	MSHN will keep this item on the agenda for discussion. Leslie will work with CFOs to update cost containment strategy. Recommendation to come up with regional strategy with MDHHS if a significant increase doesn't materialize in the rates. CMHSPs asked to send Joe a note if interested in pursuing mid-levels/residents for employment.	By Who	N/A	By When	N/A
PIHP/MHP CARE COORDINATION OVERVIEW	Skye presented an update on PIHP/MHP Care coordination efforts and related PBIP metrics. Questions regarding Wayne County Medicaid assignments and if that affects MSHN metric performance if a CMH is involved in coordination.				
	Discussion and informational	By Who	N/A	By When	N/A
HUMANA HIDE SNP UPDATE	Last discussed was a time for Humana to come to Ops Council meeting. MSHN has offered dates but Humana hasn't responded.				
	Update only	By Who	N/A	By When	N/A
CONFLICT FREE ACCESS AND PLANNING **-DATA GATHERING** **-FOIA** **-PIHP/MDHHS MEETING SCHEDULED**	Amanda reviewed the status of the CFAP Data Gathering, still missing about half of the CMHs. CMHs indicated no issues/concerns and will plan to have this completed. FOIA information received from the association with 300 plus pages. Sandy will request association provide a summary. PIHP/MDHHS meeting scheduled for November 1. No further information provided by MDHHS. Waiver applications receiving questions from CMS. Due to questions, MDHHS will request extension of the current waivers with 90 days expected.				
	Informational Only	By Who	N/A	By When	N/A
REGIONAL PSYCHIATRIC INPATIENT RATE WORKGROUP UPDATE	Joe reported on almost every case the leads discussed with the hospitals are reporting increases in rates. Sparrow now that bought by UofM asking for an outrageous increase. The spreadsheet was reviewed on rates. Joe will ensure Ops has access to the report.				

Agenda Item	Action Required				
	Discussion and informational	By Who	N/A	By When	N/A
FY25 PIHP CONTRACT/WASKUL, ISF	Joe sent information a week ago regarding this information Association recommended PIHPs not sign and some PIHPs are proceeding that way. MSHN recommended approval and signature to the Board and was approved. Discussion regarding other PIHP positions and why MSHN decided to sign. Operations Council members disappointed with J. Sedlock's decision to proceed without asking for their input. J. Sedlock will use this feedback to improve performance in the future.				
		By Who		By When	
OCTOBER 21 OPS MEETING-RESCHEDULE? (conflicts with Fall Conference)	Consensus to change the meeting to the week prior or the week after. Joe will work with our office to find the best time.				
	J. Sedlock with reschedule	By Who	J. Sedlock	By When	10.1.24
REMINDER TO COMPLETE ANNUAL COUNCIL EVALUATION SURVEY	Reminder to complete the survey.				
	CMHs to complete the survey	By Who	J. Sedlock	By When	11.1.24
SUD Access After Hours (24/7/365)	Skye updated the group on the SUD access and after hours. Initial discussion with CEI as the only CMH who indicated interest, occurred but more work is needed to finalize this process. Request CMHs continue current process through December 2024. Trainings in the month of October will occur and be communicated with CLC for the changes.				
	CMHSPs approved to continue through 12.31.24/holiday season.	By Who	S. Pletcher	By When	12.15.24
SUD Care Coordination Agreements - CCBHC	Sandy wanted to receive an update on the CCBHC Care Coordination Agreements. MSHN sent out last notice communication due today/tomorrow regarding execution or concerns about signing the agreement, so MSHN can send it out.				
	Informational	By Who	N/A	By When	N/A
Service Delivery Policies for Second Reading	Three service delivery policies received significant feedback after first reading and are being presented for second reading: • ECT Policy includes changes from Regional Medical Directors Committee • Person/Family Centered Procedure includes Medicaid Manual changes regarding conflict of interest with HCBS • Service Philosophy includes adherence to Practice Guidelines				

Agenda Item	Action Required				
	Ops Council approved ECT Policy for continuation to Policy Committee presentation. PCP Procure will be on hold until clarification of CFAP. Service Philosophy is being held to break out into individual policies that will be brought back for presentation to Operations Council.				
	See above for next steps related to policy and procedure	By Who	A.Ittner	By When	10.31.24

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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 10/28/2024

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

Agenda Item	Action Required				
CONSENT AGENDA	Added: Compliance Software Update Question regarding status of PIHPs negotiation with MDHHS contract. MDDHS gave the 7 PIHPs until 10.31.24 to sign a clean copy. They indicated they don't have a proposed solution if PIHPs continue to not sign. Question regarding self-determination removal from the tracking grid. There is always an option to add it back.				
	Consent items acknowledged	By Who	N/A	By When	N/A
REGIONAL FINANCIAL POSITION AND COST CONTAINMENT STRATEGY	Access to the link is limited to Finance Officers. Discussed the improved/reduced deficit with the new rates as identified by Leslie's information included in the email sent out to Ops Council. Montcalm did submit a revised cost containment plan. Saginaw has implemented additional Autism UM activities due to high volume and cost and is willing to share that with others. About 26m anticipated left in the ISF for FY25. Consideration of CCBHC application as well.				
	Discussion and follow up regarding cost containment strategies. MSHN to update permissions on the regional financial strategy/cost containment plans.	By Who	CMHSPs J. Sedlock	By When	Ongoing 10/28/2024
MSHN WRITE OFFS	MHSN has no local funds for any adjustments related to write offs. Ex: 1) provider that may owe amounts to MSHN after contract has ended (and/or provider has gone out of business), and MSHN is not able to collect. 2) provider that used grants funds and never started services, MSHN settled for about half and sent back to MDHHS, but MDHHS may send us an invoice for the other half. Question is how to address when MSHN needs local. The Operations Council has agreed that MSHN would request local funds off the top of performance bonus incentive program distributions through Ops Council to specific amounts to cover. At the point, MDHHS communicates payback, then it will come back for a formal request through a reduction of the PBIP.				
	Discussion only but MSHN will bring back if needed.	By Who	L. Thomas	By When	N/A

Agenda Item	Action Required				
CONFLICT FREE ACCESS AND PLANNING-CURRENT STATE DATA REVIEW	MDHHS had a November 1st meeting and it was canceled. Not sure when a reschedule will take place. A.Ittner reviewed the data gathering information noted areas that need follow up by the CMHs. Also discussed the volume of manual/prior authorization of services and lack of network providers.				
	MSHN will continue to keep on the agenda for planning if/when we hear from MDHHS	By Who	A.Ittner	By When	Ongoing
SUD PARTIAL ACCESS CENTRALIZATION-UPDATE/QUESTIONS	Email communication was distributed last week to update Ops Council on our SUD Access changes and agreement to continue 24/7/365 through end of December. The volume of phone calls has exceeded anticipated volume, in large part due to incomplete reporting by CMHSPs and the SUD Provider System. MSHN has pulled in support from other departments. Significant calls have come in related to referrals elsewhere. Trainings have occurred and continues for the network. MSHN will note during the trainings that this is only related to SUD providers until January 1. MSHN appreciates CMHs support during this transition.				
	Skye will clarify with her team.	By Who	S.Pletcher	By When	11.1.24
DATA ANALYTICS PROJECT AND MICHIGAN HEALTH ENDOWMENT FUND PREDICTIVE MODELING UPDATE	A.Ittner update Ops Council on the regional data analytics project as well as the Michigan Health Endowment Fund for predictive modeling.				
	Amanda will keep Ops Council updated on this project.	By Who	A.Ittner	By When	1.1.25
2024 OPERATIONS COUNCIL ANNUAL REPORT	J. Sedlock presented the draft annual report related to Operations Council that will be included in the quality assessment and performance improvement plan. Ops Council wanted one more month to review and provide feedback.				
	CMHs to review and provide feedback	By Who	J.Sedlock	By When	11/01/2024
COMPLIANCE SOFTWARE UPDATE	A.Ittner updated Ops Council on the regional project to procure compliance software. MSHN covers all cost, and no cost will be passed down to the CMH. CMHs will be able to utilize the system to report and track all compliance related matters. A vendor has been selected and MSHN will be negotiating the contract. Anticipation of implementation plan January 2025.				
	Informational – updates will be provided through Regional Compliance Committee.	By Who	A.Ittner	By When	11.30.24
COFR	UMC/CLC were not able to arrive at agreement for changes to the draft COFR policy last month and asked for an additional month so it's on the agenda again last week. Ops Council supported the elimination of COFRs about a year ago (October 2023)and requested policy come back for review. Discussion regarding requesting data, individuals, cost of services, if waiver identified, clinical/support services provided by, placed by out of state hospital, foster care.				

Agenda Item		Action Required			
	Bring back data gathering through UM and bring back to Ops when ready.	By Who	S.Pletcher	By When	11.30.24

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Children With Severe Emotional Disturbances Home and Community-Based Services Waiver (SEDW) Policy ~~Waiver (SEDW)~~		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Behavioral Health Officer	Adopted Date: 11.10.2020 Review Date: ~~11.01.2022~~06.2024	Related Policies:

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~~POLICIES AND PROCEDURE MANUAL~~

~~Chapter:~~	~~Service Delivery System~~		
~~Title:~~	~~Severe Emotional Disturbance Waiver (SEDW)~~		
~~Policy: ☒~~ ~~Procedure: ☐~~ ~~Page: 1 of 2~~	~~Review Cycle: Biennial~~ ~~Author: Chief Behavioral Health Officer~~	~~Adopted Date: 11.10.2020~~ ~~Review Date: 11.01.2022~~	~~Related Policies:~~

~~DO NOT WRITE IN SHADED AREA ABOVE~~

Purpose

This policy sets forth the guidelines and expectations for Mid-State Health Network's (MSHN) administration of the Children with Severe ~~and~~ Emotional Disturbances Home and Community-Based Waiver (SEDW) program which provides services that are enhancements or additions to Medicaid State Plan coverage for beneficiaries up to age 21 with serious emotional disturbance (SED) who are enrolled in the SEDW. Michigan Department of Health and Human Services (MDHHS) operates the SEDW through contracts with the Prepaid Inpatient Health Plans (PIHPs). The SEDW is a managed care program administered by the PIHPs in partnership with CMHSPs and other community agencies.~~Disturbance Waiver (SEDW) program.~~

Policy

MSHN shall administer the SEDW program in accordance with the Prepaid Inpatient Health Plan (PIHP) contract and the Michigan Medicaid Provider Manual (MMPM).~~.~~

I. Key Provisions

The SEDW program enables Medicaid to fund necessary home and community-based services for children up to age 21 with SED who meet the criteria for admission to a state inpatient psychiatric hospital and/or who are at risk of hospitalization without waiver services. The PIHP is responsible for assessment of potential waiver candidates.

Application for the SEDW is made through the PIHP. The PIHP is responsible for the coordination of the SEDW services. The Wraparound Facilitator, the beneficiary and their family and friends, and other professional members of the planning team work cooperatively to identify the beneficiary's needs and to secure the necessary services. All services and supports must be included in an Individual Plan of Service (IPOS).

A SEDW beneficiary must receive at least one SED waiver service, in addition to Wraparound, per month in order to retain eligibility.

The SEDW has two certification categories:

A. SEDW – Traditional: the youth resides with their legal parent(s)/guardian(s) (with or without Medicaid); this category includes private and/or internation adoptions.
B. SEDW – Department of Health and Human Services (DHHS) Project: the youth has an open foster care case through MDHHS OR the youth was adopted out of the Michigan Child Welfare System.

~~I.~~II. Eligibility

SEDW beneficiaries must be enrolled through the Michigan Department of Health and Human Services (MDHHS) enrollment process by the PIHP ~~Prepaid Inpatient Health Plan (PIHP)~~ designee. The enrollment process must include verification that the beneficiary meets the following (all must apply):

A. Reside with the birth or adoptive family or have a plan to return to the birth or adoptive home; OR reside with a legal guardian; OR
B. Reside in a foster home with a permanency plan; OR
C. Be age 18 or age 19 and live independently with supports. AND
D. Meet current MDHHS criteria for the state psychiatric hospital for children OR is at risk of hospitalization without waiver services.
    1. Medicaid Provider Manual Inpatient Admission Criteria: Children Through Age 21: (MMPM Section 8 – Inpatient Psychiatric Hospitalization Admission; 8.5.C)
        - The individual must meet all three criteria:
            - Diagnosis
            - Severity of illness
            - Intensity of services; AND
E. Meet Medicaid eligibility criteria and become a Medicaid beneficiary. Medicaid is the only funding source from the SEDW. Under Section (C) of the Social Security Act, it allows states to waive parental assets and income and make a child eligible for Medicaid as a "family of one."; AND
F. Demonstrate serious functional limitations that impair the ability to function in the community. As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®), the Preschool and Early Childhood Functional Assessment Scale (PECFAS®), or the Devereaux Early Childhood Assessment (DECA) Clinical Version scales:
    1. CAFAS score of 90 or greater for beneficiaries age 7 to 12; OR
    2. CAFAS score of 120 or greater for beneficiaries age 13 to 18; OR
    3. For beneficiaries ages 3 to 7, elevated PECFAS subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating, or behavior toward others; OR
    4. For beneficiaries ages 2 to 4, scores in the concern range DECA Clinical Version scales:
        - Protective factor scales (initiative, self-control, and attachment) that are in the Concern Range with a Total Protective Factor T-score of 40 or below and/or
        - Elevated scores on one or more of the behavioral concerns scales (attention problems, aggression, withdrawal/depression, emotional control problems) with a T-score of 60 or above; AND
G. Be under the age of 18 when approved for the waiver. If a beneficiary on the SEDW turns 18, continues to meet all non-age-related eligibility criteria, and continues to need waiver services, they can remain on the waiver up to their 21st birthday.
H. Other SEDW Eligibility Considerations:
    1. Must have a primary Serious Emotional Disturbance (SED) qualifying diagnosis
    2. Must receive at least one SEDW service (other than Wraparound) per month in order to retain eligibility
    3. Eligibility is good for one year
    4. Eligibility is reviewed annually
    5. SEDW is intended for one year, with the possibility of a second year
I. Denial of the SEDW
    1. PIHPs must provide parents with notice of denial and right to Medicaid Fair Hearing whenever the SEDW is denied. (This is delegated by MSHN to the CMHSPs.)
    2. Notice of denial must document the specific reason for the denial, based on SEDW eligibility criteria as outlined in the Medicaid Provider Manual.

3. The SEDW serves as a pathway to Medicaid, per Centers for Medicare and Medicaid Services (CMS) this pathway must not be blocked. Whenever the SEDW is specifically requested and subsequently denied, notice of denial and right to Medicaid Fair Hearing must be provided even if lesser intensive service(s) is offered.

~~A. Meet the current MDHHS contract criteria for the state psychiatric hospital for children (Hawthorn Center) and be at risk of hospitalization.~~
~~B. Demonstrate serious functional limitations that impair their ability to function in the community. The functional criteria will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS).~~
~~C. CAFAS®/ score of 90 or greater for children age7 to 12 ; or~~
~~D. CAFAS® score of 120 or greater for children age 13 to 18;~~
~~E. For children ages 3 to 7, elevated PECFAS subscale scores in at least one of these areas: self harmful behaviors, mood/emotions, thinking/communicating or behavior towards others~~
~~F. Be under the age of 18 when approved for the waiver. If a child on the SEDW turns 18, continues to meet all non-age related eligibility criteria, and continues to need waiver services, the child can remain on the waiver up to their 21st birthday~~
~~G. Reside with his/her birth or adoptive parents(s), or~~
~~H. In the home of a relative who is the child's legal guardian, or~~
~~I. In foster care or therapeutic foster care, with a permanency plan to return home.~~
~~J. Be financially eligible for Medicaid when viewed as a family of one (i.e., when parental income and assets are waived);~~
~~K. Be in need of waiver services in order to remain in the community~~
~~L. SEDW beneficiaries must receive at least one SEDW service per month in order to maintain eligibility. The beneficiary's services and supports must be specified in the individual's plan of services developed through the person-centered planning process that must be specific to:~~

~~1. Medical necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.~~
~~2. Amount: The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.~~
~~3. Scope: The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.~~
~~4. Duration: The parameters within which the service will be provided, including Who (e.g., professional, paraprofessional, aide supervised by a professional); How (e.g., face-to-face, telephone, taxi or bus, group or individual); and Where (e.g., community setting, office, beneficiary's home).~~

III. Covered Waiver Services

Each beneficiary must have a comprehensive Wraparound Plan and IPOS that specify the services and supports that the beneficiary and their family will receive. The Wraparound Plan is to be developed through the Wraparound Planning Process. Each beneficiary must have a Wraparound Facilitator who is responsible to assist the beneficiary/family in identifying, planning and organizing the Child and Family Team, developing the Wraparoun Plan, and coordinating services and supports. The Wraparound Facilitator is responsible for monitoring supports and service delivery, as well as the health and safety of the beneficiary, as part of their regular contact with the beneficiary and family.

In addition to Medicaid state plan services, beneficiaries enrolled in the SEDW may receive any of the following SEDW services as identified in the Wraparound Plan IPOS.

A. Child Therapeutic Foster Care (CTFC)
B. Community Living Supports (CLS)

C. Family Home Care Training
D. Family Support and Training
E. Fiscal Intermediary Services
F. Home Care Training, Non-Family
G. Overnight Health and Safety Support (OHSS) Services
H. Respite Care
I. Therapeutic Activities
    1. Recreation Therapy
    2. Music Therapy
    3. Art Therapy
J. Therapeutic Overnight Camp
K. Transitional Services
L. Wraparound Services (mandatory service)

~~**II. Caregiver Roles and Expectations**~~

~~If the child resides with his or her birth/adoptive family or is a temporary ward of the state, the birth/adoptive family must be willing and able to do the following:~~

~~A. Choose SEDW services as an alternative to hospitalization,~~
~~B. Participate in the development of the individual plan of service (IPOS),~~
~~C. Obtain and submit required documentation (e.g. Waiver Certification form, signed IPOS, etc.),~~
~~D. Allow services to be provided in the home setting,~~

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

CAFAS: Child and Adolescent Functional Assessment Scale
CLS: Community Living Supports
CMS: Centers for Medicare and Medicaid Services
CTFC: Child Therapeutic Foster Care
DECA: Devereaux Early Childhood Assessment
DHHS: Department of Health and Human Services
IPOS: Individual Plan of Service
MDHHS: Michigan Department of Health and Human Services
MMPM: Michigan Medicaid Provider Manual
PECFAS: Preschool and Early Childhood Functional Assessment Scale
~~DECA: Devereaux Early Childhood Assessment~~
OHSS: Overnight Health and Safety Support
PIHP: Pre-Paid Inpatient Health Plan
SED: Serious Emotional Disturbance
SEDW: Children With Severe Emotional Disturbances Home and Community- Based Services Waiver Program~~Waiver for Children with Serious Emotional Disturbance~~

Other Related Materials

Children With Severe Emotional Disturbance Home and Community-Based Services Waiver (SEDW) Disenrollment and Transfer Procedure~~N/A~~

References/Legal Authority

Medicaid Managed Specialty Supports and Services FY23~~0~~ MDHHS/PIHP Contract
Michigan Medicaid Provider Manual

Change Log:

Date of Change	Description of Change	Responsible Party
07.2020	NEW Policy	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer
02.2024	Biennial Review	Waiver Coordinator

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Children's Home and Community-Based Services Waiver (CWP) Policy		
Policy: ☒ Procedure: ☐ Page: 1 of 3	Review Cycle: Biennial Author: Waiver Administrator (Youth)	Adopted Date: Review Date: 06.2024	Related Policies:

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POLICIES AND PROCEDURE MANUAL

~~Chapter:~~	~~Service Delivery System~~		
~~Title:~~	~~Children's Home and Community-Based Services Waiver (CWP) Policy~~		
~~Policy: ☒~~ ~~Procedure: ☐~~ ~~Page: 1 of 3~~	~~Review Cycle: Biennial~~ ~~Author: Waiver Coordinator~~	~~Adopted Date:~~ ~~Review Date: 11.01.2022~~	~~Related Policies:~~

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Purpose

This policy sets forth the guidelines and expectations for Mid-State Health Network's (MSHN) administration of the Children's Home and Community-Based Waiver Program (CWP).

Policy

A. MSHN shall administer the CWP program in accordance with the Prepaid Inpatient Health Plan (PIHP) contract and the Medicaid Provider Manual.

B. This program is designed to provide in-home services and support to Medicaid-eligible children with developmental disabilities, who would otherwise be at risk of out-of-home placement into an Immediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

C. CWP beneficiaries must be enrolled through the Michigan Department of Health and Human Services (MDHHS) enrollment process by the Prepaid Inpatient Health Plan (PIHP) designee. The enrollment process must include verification that the beneficiary meets all of the follow eligibility criteria:

1. The child must have a developmental disability (as defined in Michigan state law), be less than 18 years of age, and in need of habilitation services.
2. The child must reside with his birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.
3. The child is at risk of being placed into an ICF/IID facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/IID facility but, with appropriate community support, could return home.

4. The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).

a. The child's intellectual or functional limitations indicate that he/she would be eligible for health, habilitative, and active treatment services provided at the ICF/IID level of care. Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

D. CWP beneficiaries must receive at least one of the following children's waiver services per month in order to retain eligibility.

1. Community Living Supports (CLS)
2. Enhanced Transportation
3. Family Training
4. Non-Family Training
5. Financial Management Services/Fiscal Intermediary Services
6. Respite Care
7. Specialty Services (including Music, Art, Recreation, and Massage Therapies)
8. Overnight Health and Safety Support

E. Other CWP supports/services include:

1. Environmental Accessibility Adaptations (EAAs)
2. Fencing
3. Specialized Medical Equipment and Supplies

F. The beneficiary's services and supports must be specified in the individual's plan of services developed through the person-centered planning process that must be specific to:

1. Medical necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.
2. Amount: The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.
3. Scope: The parameters within which the service will be provided, including Who (e.g., professional, paraprofessional, aide supervised by a professional); How (e.g., face-to- face, telephone, group or individual); and Where (e.g., community setting, office, beneficiary's home).
4. Duration: The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.

G. MSHN shall establish adequate procedures to assure effective administration of the program across the region including:

1. Prior Review and Approval Request (PRAR)

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

CLS: Community Living Supports
CWP: Children's Home and Community-Based Services Waiver Program
EAA: Environmental Accessibility Adaptations
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
PRAR: Prior Review and Approval Request
ICF/IID: Intermediate Care Facility for Individuals with Intellectual Disabilities – 42 CFR 435.1009 – an institution (or distinct part of an institution) that (a) is primarily for the diagnosis, treatment, or rehabilitation of people with developmental disabilities or persons with related conditions; and (b) provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.
Developmental Disability: means either of the following:

1. If applied to an individual older than 5 years, a severe, chronic condition that meets all of the following requirements:
    i. Is attributable to a mental or physical impairment or a combination of mental and physical impairments
    ii. Is manifested before the individual is 22 years old
    iii. Is likely to continue indefinitely
    iv. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
        a. Self-care
        b. Receptive and expressive language
        c. Learning
        d. Mobility
        e. Self-direction
        f. Capacity for independent living
        g. Economic self-sufficiency
    v. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
2. If applied to a minor, birth to age 5, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (1) if services are not provided.

Other Related Materials

N/A

References/Legal Authority

MDHHS – PIHP Contract;
MDHHS Medicaid Provider Manual: Section 14 – Children's Home and Community-Based Services Waiver (CWP)

Change Log:

Date of Change	Description of Change	Responsible Party
07.2020	NEW Policy	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer
06.2024	Biennial Review	Chief Behavioral Health Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery		
Title:	Community-Based Dependent Living Placement Policy		
Policy: ☒ Procedure: ☐ Page: 1 of ~~2~~3	Review Cycle: Biennial Author: MSHN Chief Behavioral Health Officer	Adopted Date: 01.12.2021 Review Date: 06.2024	Related Policies:

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Purpose

This policy exists to provide process clarification and assure ongoing regional compliance with the community-based dependent living placement process stipulated by the Michigan Administrative Rules 330.1701-1704.

Policy

A. MSHN and its Community Mental Health Service Program (CMHSP) Participants shall comply with Michigan Administrative Rules for the placement of adults who have a Mental Illness or Intellectual Disability into community based dependent living settings.

1. The Placing Agency shall, regarding ~~in regard to~~ an individual being considered for dependent living placement, be responsible for all of the following:
   i. Assess a recipient's need for placement into a dependent living setting.
   ii. Determine the type of dependent living setting required to meet the recipient's needs.
   iii. Develop the recipient's individual plan of service and supports (IPOS~~"treatment plan"~~).
   iv. Coordinate all necessary arrangements for the placement of the recipient into a dependent living setting.
   v. Monitor and evaluate the provision of services to the recipient.
   vi. Protect the rights of the recipient including informing recipient/guardian of how to file complaints against the licensee or placing agency.

2. The Placing Agency shall not place a recipient in a dependent living setting unless all ~~all of~~ the following criteria are met before placement:
   i. An IPOS ~~individual plan of~~ service has been developed for the recipient.
   ii. If a specialized program is called for in the recipient's IPOS~~individual plan of service~~, the dependent living setting is certified to provide the program.
   iii. The placing agency has made an onsite inspection, or obtained an inspection completed in the previous 12 months from another CMHSP. The placing agency has determined that the dependent living setting has sufficient resources to provide all the services that the dependent living setting is required to provide in the recipient's individual plan of service. In addition, an annual review should be completed ~~onsite~~ to ensure continued care and compliance with the treatment plan.
   iv. The consent of the recipient, and~~or~~ the recipient's guardian, has been obtained for the placement.
   v. The dependent living setting has written operating policies and procedures which are in place and enforced by the dependent living setting and which are in compliance with the laws of the State of Michigan. The dependent living setting agrees to make the operating policies and procedures available to the recipient, provide the information in alternative formats and provide assistance to the recipient with understanding the language used in the procedures, if needed.

   ~~vi.~~ The dependent living setting agrees to maintain and limit access to records that document the delivery of the services in the recipient's IPOS ~~individual plan of service~~ in accordance with ~~all~~applicable~~all~~ all applicable statutes, rules, and confidentiality provisions. The dependent living setting agrees to make recipient's record available to the recipient or their representative, provide the record in alternative format and assist the recipient with understanding the language used, if needed~~Applicable statutes, rules, and confidentiality~~

Chapter:	Service Delivery		
Title:	Community-Based Dependent Living Placement Policy		
Policy: ☒ Procedure: ☐ Page: 1 of ~~2~~3	Review Cycle: Biennial Author: MSHN Chief Behavioral Health Officer	Adopted Date: 01.12.2021 Review Date: 06.2024	Related Policies:

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~~provisions. The dependent living setting agrees to make recipient's record available to the recipient or their representative, provide the record in alternative format and assist the recipient with understanding the language used, if needed.~~

3. The Placing Agency is responsible for the development of the recipient's IPOS.~~individual plan of service~~. An initial IPOS ~~individual plan of service~~ shall be provided upon placement and a comprehensive plan developed within 30 days. The individual plan of service shall consist of a treatment plan, a support plan, or both. The IPOS ~~individual plan of service~~ shall focus on the needs and preferences of the beneficiary ~~client~~ and be developed by a planning team comprised of the following entities:
    i. The recipient
    ii. Individuals of the recipient's choosing (friends, family, relatives, natural supports)
    iii. Professionals as needed or desired

If the beneficiary~~client~~ is not satisfied with his or her individual plan of service or modifications made to the plan, the client may object and request a review of the objection by the client services manager in charge of implementing the plan. The review shall be initiated within five ~~5~~ working days of receipt of the objection. Resolution shall occur in a timely manner. If the beneficiary ~~client~~ is not satisfied with the resolution, the client may notify his or her case ~~client~~ services manager of the beneficiary's ~~client's~~ wish to appeal the resolution to the placing agency. The placing agency shall initiate a review of the appeal within five ~~5~~ working days and reach a resolution in a timely manner.

4. The placing agency shall promptly review, revise, or modify a recipient's plan of service because of any of the following:
    i. The recipient has achieved an objective set forth in the recipient's IPOS~~individual plan of service~~.
    ii. The recipient has regressed or lost previously attained skills or otherwise experienced a change in condition.
    iii. The recipient has failed to progress toward identified objectives despite consistent effort to implement the individual plan of service.

Applies to

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

Definitions

CMHSPs: Community Mental Health Service Programs
Dependent living setting –adult foster care (AFC), nursing home, or home for the aged
IPOS: Individual Plan of Service
~~MDCH: Michigan Department of Community Health~~
MSHN: Mid-State Health Network
Placing Agency: The CMHSP or agency under contract with the

Chapter:	Service Delivery		
Title:	Community-Based Dependent Living Placement Policy		
Policy: ☒ Procedure: ☐ Page: 1 of ~~2~~3	Review Cycle: Biennial Author: MSHN Chief Behavioral Health Officer	Adopted Date: 01.12.2021 Review Date: 06.2024	Related Policies:

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CMHSP ~~requesting Out-of-State Placement~~responsible for assessing need, developing IPOS, coordinating placement, and monitoring services of the recipient

-PNMC: Provider Network Management Committee

Other Related Materials

References/Legal Authority

Michigan Administrative ~~Michigan Administrative~~ Rules 330.1701-1704.

Change Log:

Date of Change	Description of Change	Responsible Party
01.2015	New Policy	C. Mills, PNMC
01.2017	Review	Waiver Coordinator
03.2019	Annual Review	Director of Provider Network Management Systems
09.2020	Annual Review	Director of Provider Network Management Systems
08.2022	Biennial Review	Chief Behavioral Health Officer; Clinical Leadership Committee
06.2024	Biennial Review	Chief Behavioral Health Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery**		
Title:	**Electroconvulsive Therapy (ECT)**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 1	**Review Cycle:** Biennial **Author:** Chief Medical Officer	**Adopted Date:** 03.05.2019 **Review Date:** 06.2024	**Related Policies:**

~~**POLICIES AND PROCEDURE MANUAL**~~

~~**Chapter:**~~	~~**Service Delivery**~~		
~~**Title:**~~	~~**Electroconvulsive Therapy (ECT)**~~		
~~**Policy:** ☒~~ ~~**Procedure:** ☐~~ ~~**Page:** 1 of 1~~	~~**Review Cycle:** Biennial~~ ~~**Author:** Chief Medical Officer~~	~~**Adopted Date:** 03.05.2019~~ ~~**Review Date:** 11.10.2020~~	~~**Related Policies:**~~

Purpose

This policy was developed to describe the funding, authorization and approval process associated with providing adults, children and adolescents with Electroconvulsive Therapy (ECT) ~~ECT~~ and/or any procedure intended to produce convulsions when such procedures are clinically justified.

Policy

It is the policy of Mid-State Health Network (MSHN) that ECT (which can be provided on an inpatient, partial, or outpatient basis, as clinically determined) and ancillary charges will only be authorized and funded by each Community Mental Health Services Program (CMHSP) ~~CMHSP~~ for persons who are not covered by insurance, who have Medicaid, or Medicaid as secondary coverage, when it is clinically justified. The ECT clinical justification process for prior authorization will be outlined in the procedure document.

Applies to:

☐All Mid-State Health Network Staff

☐Selected MSHN Staff, as follows:

☒MSHN CMHSPs ☐Policy Only ☒Policy and Procedure

☐Other: Sub-contract Providers

Definitions:

CMHSP: Community Mental Health Service Program

Electro-Convulsive Therapy (ECT): According to the American Psychiatric Association (APA), ECT involves a brief electrical stimulation of the brain while the patient is under anesthesia. It is typically administered by a team of trained medical professionals that includes a psychiatrist, an anesthesiologist, and a nurse or physician assistant.

MSHN: Mid-State Health Network

Other Related Materials:

N/A

References/Legal Authority:
Michigan Mental Health Code 330.1717

Change Log:

Date of Change	Description of Change	Responsible Party
11.2018	New Policy	MSHN Medical Director
08.2020	Biennial Review	Chief Behavioral Health Officer
06.2024	Biennial Review	Chief Behavioral Health Officer

MID-STATE HEALTH NETWORK
POLICIES MANUAL

Chapter:	**Service Delivery System**		
Title:	**Emergency & Post-Stabilization Services**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 45	**Review Cycle:** Biennial **Author:** Clinical Leadership and Utilization Management Committee	**Adopted Date: 03.01.2022** **Review Date: 06.2024~~11.01.2022~~**	**Related Policies:** Inpatient Psychiatric Hospitalization Standards

Purpose

Federal and State legal authorities require Medicaid managed care entities, including Prepaid Inpatient Health Plans (PIHPs), to provide coverage and payment for emergency services and post-stabilization care services. The definition and descriptions of emergency medical conditions, emergency services, and care services focus heavily on physical health and serious bodily impairment. However, the same coverage provisions and requirements for emergency services and post-stabilization care services are still applicable to the PIHP for the scope of services which it is responsible to provide to Medicaid and Healthy Michigan Plan beneficiaries. The purpose of this policy is to provide clarity and definition to the scope of behavioral health and substance use disorder (SUD) emergency services and post-stabilization care services covered by Mid-State Health Network (MSHN) and furnished through its Community Mental Health Service Program (CMHSP) Participants.

Policy

Emergency Medical Condition/Emergency Situation

The definition of emergency medical condition found in 42 Code of Federal Regulations (CFR) 438.114(a) is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

For the purpose of this policy in the context of behavioral health emergencies, MSHN and its CMHSP Participants use the definition of emergency situation found in Section 300.1100(a)(25) of the Michigan Mental Health Code to be synonymous with the Federal definition of emergency medical condition. An emergency situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a minor is experiencing a serious emotional disturbance, and one ~~1~~ of the following applies:

a. The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally.
b. The individual is unable to provide himself or herself food, clothing, or shelter or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
c. The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

MSHN does not limit what constitutes an emergency situation on the basis of specific diagnoses or symptoms. To assure understanding of the problem from the point of view of the person who is seeking help,
methods for determining emergent situations must incorporate consumer or family-defined crisis situations.

Emergency Services

Emergency services are covered inpatient and outpatient services that are as follows:

a. Furnished by a provider that is qualified to furnish these services
b. Needed to evaluate or stabilize an emergency medical condition/emergency situation

MSHN, via delegation to its CMHSP Participants, provides the following types of emergency services described in the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental
Disability Supports and Services Chapter:

- Crisis Intervention - Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy. Crisis intervention may occur in a variety of settings, including but not limited to the CMHSP offices, hospital emergency department, beneficiary home, schools, jails, and other community settings.
- Crisis Residential – Services are designed for individuals who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/Family Driven, Youth Guided, and recovery/resiliency-oriented approach. Services must be designed to resolve the immediate crisis and improve the functioning level of the individual to allow them to return to less intensive community living as soon as possible.
- Inpatient Psychiatric Hospital Pre-Admission Screening - Pre-admission screening to determine if an individual requires psychiatric inpatient hospitalization or whether alternative services are appropriate and available to treat the individual's needs. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Inpatient pre-screening services must be available 24-hours-a-day/7-days-a-week. Pre-admission screenings most often occur in hospital emergency departments although they can take place in other settings such as CMHSP offices, jails, or other community settings.
- Intensive Crisis Stabilization Services - Intensive crisis stabilization services (ICSS) are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated. ICSS may be provided where necessary to alleviate the crisis situation, and to permit the beneficiary to remain in, or return more quickly to, his usual community environment. ICSS can also be used for post-stabilization care once the immediate crisis situation has been addressed. Most ICSS are delivered by a mobile crisis team and typically occur at the beneficiary's home or other community settings where the beneficiary is located.
- Outpatient Partial Hospitalization – Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the individual does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the individual's present treatment needs. The Severity of Illness/Intensity of Service criteria for admission assume that the individual is displaying signs

and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Coverage and Payment: Emergency Services

The Michigan Mental Health Code 330.1206 (1) (a) requires that all Community Mental Health Service Programs must provide 24/7 crisis emergency service and stabilization for persons experiencing acute emotional, social, or behavioral dysfunctions. These services are funded through the per eligible per month (PEPM) sub-capitation~~subcapitation~~ payment the CMHSP receives from the PIHP. There is never a cost to the beneficiary for emergency services provided by the PIHP and its CMHSP Participants. No prior authorization is needed.

When necessary, a beneficiary may seek services through the hospital emergency room. Disposition of the psychiatric emergency will be the responsibility of the PIHP (via delegation to its CMHSP Participants).
The PIHP is involved in resolving the psychiatric aspect of the emergency situation. Any medical treatment including medical clearance screening, stabilization and emergency physician services needed by the beneficiary while in the emergency room is beyond the contractual requirements of the PIHP (Michigan Medicaid Provider Manual Hospital Chapter, Section 3.14.D Psychiatric Screening and Stabilization Services).

MSHN and its CMHSP Partners adhere to the MDHHS County of Financial Responsibility (COFR) Technical Requirements when a beneficiary requires emergency services from a different PIHP or CMHSP provider outside of the MSHN PIHP region.

Post-stabilization Care Services

Post-stabilization care services means covered services, related to an emergency medical condition/emergency situation that are provided after an individual is stabilized to maintain the stabilized condition or to improve or resolve the individual's condition. MSHN, via delegation to its CMHSP Participants, provides the following types of post-stabilization care services as described in the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter:

- Inpatient Psychiatric Hospital Admission- Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness/Intensity of Service criteria for admission are based upon the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.
- Crisis Residential – Services are designed for individuals who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/Family Driven, Youth Guided~~Youth Guided~~, and recovery/resiliency-oriented approach. Services must be designed to resolve the immediate crisis and improve the functioning level of the individual to allow them to return to less intensive community living as soon as possible.

- Outpatient Partial Hospitalization – Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the individual does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the individual's present treatment needs. The Severity of Illness/Intensity of Service criteria for admission assume that the individual is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Coverage and Payment: Post-stabilization Care Services

The Michigan Medicaid Provider Manual requires prior authorization for post-stabilization psychiatric services from the PIHP or CMHSP for all Medicaid beneficiaries who reside within the service area covered by the PIHP. The following sections of the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter contain specific prior authorization requirements and provider qualifications for each type of post-stabilization care service:

Section 6.3 - Crisis Residential
Sections 8.1 and 8.2 - Inpatient Psychiatric Hospital Admissions
Section 9.1.A - Intensive Crisis Stabilization Services
Section 10 - Outpatient Partial Hospitalization Services

The MSHN Finance Claims Procedure includes provision for reimbursement of claims for emergency and post-stabilization services provided to beneficiaries of the MSHN region if the provider is not contracted with the PIHP/CMHSP and/or if prior authorization was not obtained but it can be determined that, but for the urgency of the need, the service would have been pre-authorized by MSHN or the CMHSP.

Applies to

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

Definitions/Acronyms:
CFR: Code of Federal Regulations
CMHSP: Community Mental Health Service Programs
COFR: County of Financial Responsibility
Consumers/Beneficiaries: Refers to those individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PEPM: Per Eligible Per Month
PIHP: Prepaid Inpatient Health Plan
SUD: Substance Use Disorder

References/Legal Authority
1. Medicaid Managed Specialty Supports and Services MDHHS/PIHP Contract
2. 42 CFR 438.114(a-f)
3. Michigan Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter

Change Log:

Date of Change	Description of Change	Responsible Party
01-2022	New policy	Director of Integrated Care and Utilization Management
09.2022	Biennial Review	Chief Behavioral Health Officer
06.2024	Biennial Review	Chief Behavioral Health Officer

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POLICY & PROCEDURE MANUAL

Chapter:	Service Delivery		
Title:	Clinical Practice Guidelines and Evidence-Based Practices		
Policy: ☒ Procedure: ☐ Page: 1 of 3	Review Cycle: Biennial Author: Chief Compliance Officer	Adopted Date: 11.04.2014 Review Date: 06.2024	Related Policies: Quality Management

~~POLICY & PROCEDURE MANUAL~~

~~Chapter:~~	~~Service Delivery~~		
~~Title:~~	~~Clinical Practice Guidelines and Evidence-Based Practices~~		
~~Policy: ☒~~ ~~Procedure: ☐~~ ~~Page: 1 of 2~~	~~Review Cycle: Biennial~~ ~~Author: Chief Compliance Officer~~	~~Adopted Date: 11.04.2014~~ ~~Review Date: 11.01.2022~~	~~Related Policies:~~ ~~Quality Management~~

Purpose

To establish service provision parameters and expectations of the Community Mental Health Services Program(CMHSP) Participants and the Substance Use Disorder Prevention and Treatment Provider System of the Mid-State Health Network (MSHN) region regarding the network-wide use of nationally accepted or mutually agreed upon clinical practice guidelines and evidence-based practices (EBP).

Policy

MSHN supports and requires the use of nationally accepted and mutually agreed upon clinical practice guidelines including EBPs to ensure the use of research-validated methods for the best possible outcomes for service recipients as well as best value in the purchase of services and supports. Practice guidelines include clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served.

While MSHN does support the use of promising and emerging practices, interventions that are considered experimental or indicate risk of harm to human subjects are not supported within the Pre-paid Inpatient Health Plan (PIHP) region unless approved in accordance with MSHN's Research Policy and by the Michigan Department of Health and Human Services (MDHHS).

Standards:

A. CMHSP Participants and the Substance Use Disorder Prevention and Treatment Provider System under contract to provide prevention and/or treatment services for mental health and/or substance use disorders will deliver services in a manner which reflects the values and expectations contained in nationally accepted or mutually agreed upon practice guidelines.
    a. The guidelines should include but are not limited to the following practice guidelines:
        i. Access Standards
        ii. Behavior Treatment Plans Technical Requirement
        iii. Inclusion Practice Guideline
        iv. Housing Practice Guideline
        v. Consumerism Practice Guideline
        vi. Personal Care in Non-specialized Residential Settings
        vii. Family Driven and Youth Guided Policy and Practice Guideline
        viii. Employment Works! Policy
        ix. Person-Centered Planning ~~Practice Guideline~~Policy
        x. School to Community Transition
        ~~Self-Determination Practice & Fiscal Intermediary Guideline~~

xi. ~~Self-Direction Technical Requirement Implementation Guide~~Self-Directed Services Technical Requirements
xii. Technical Requirement for Infants, Toddlers, Children, Youth, and Young Adults with Serious Emotional Disturbance (SED) Children and Intellectual and/or Developmental Disabilities (I/DD)
xiii. Trauma Policy

b. Adoption, development, and implementation of practice guidelines
   i. Key concepts of recovery and resilience, wellness, person-centered planning/individual treatment planning and choice, self-determination, and cultural competency are critical to the success of implementation of practice guidelines or treatment.
   ii. Practices will appropriately match the presenting clinical and/or community needs as well as demographic and diagnostic characteristics of the individuals to be served.
   iii. Programs will ensure the presence of foundational practice skills including motivational interviewing, trauma informed care, and positive behavioral supports.
   iv. Practices which are not evidence-based should be replaced with practices that are, where feasible.
   v. Promising or emerging EBPs may be conditionally explored or supported where appropriate to meet the needs of person served.
   vi. CMHSP Participants and Substance Use Disorder Service Providers (SUDSP) will review service and clinical practices for EBP endorsement, offering an array of EBPs which best meet the needs of the persons served.
   vii. Evidence for EBP prevention programs must come from one of these sources: a) Federal Registries; b) Peer Reviewed Journals; c) Community Based Process Best-Practices; or d) Other sources of documented effectiveness.

c. Monitoring and Evaluation
   i. Oversight of practice guidelines and EBPs will be provided by the responsible contractor and will be reviewed as part of the MSHN site review and monitoring process.
   ii. Contractors must report to MSHN any practices being used to support and/or provide clinical interventions for/with individuals.
   iii. Evidence-based practices will be monitored, tracked, and reported, including summary information provided to MSHN through the annual assessment of Network Adequacy.
   iv. Requisite staff training, supervision/coaching, certifications and/or credentials for specific clinical practices as needed will be required, verified, and sustained as part of the credentialing, privileging and/or contracting processes.
   v. Fidelity reviews shall be conducted and reviewed as part of local quality improvement programs or as required by MDHHS

d. Communication
   i. Persons served as well as other key stakeholders will be routinely provided with practice guidelines relevant for their services and supports.
   ii. Practice Guideline expectations will be included in contracts.

Applies to:

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

Definitions:

Clinical Practice Guidelines: The Institute of Medicine (IOM) defines clinical practice guidelines

as "statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."
CMHSP: Community Mental Health Services Program; A program operated under Chapter 2 of the Michigan Mental Health Code-Act 258 of 1974 as amended.
Evidence Based Practices (EBP): treatments that have been researched academically or scientifically, been proven effective, and replicated by more than one investigation or study
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network; A regional entity formed for the purpose of carrying out the provisions of Section 1204b of the Mental Health Code relative to serving as the prepaid inpatient health plan to manage Medicaid specialty supports and services.
PIHP: An organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR part 401, as amended, regarding Medicaid managed care.

References/Legal Authority:
Medicaid Managed Specialty Supports and Services Contract
MDHHS Quality Assessment and Performance Improvement Program for Specialty Prepaid Inpatient Health Plans Technical Requirement

Change Log:

Date of Change	Description of Change	Responsible Party
11.2014	New Policy	Chief Compliance Officer
11.2015	Policy Review	Chief Clinical Officer
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service and Quality
03.2019	Annual Review	Quality Manager
10.2020	Biennial Review	Quality Manager
09.2022	Biennial Review	Chief Behavioral Health Officer
06.2024	Biennial Review	Chief Behavioral Health Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Habilitation Supports Waiver Policy**		
Policy: ☒ **Procedure:** ☐ **Version:** **Page: 1 of 3**	**Review Cycle: Biennial** **Author:** HCBS ~~Manager~~ Administrator (Adults)	**Adopted Date: 7.1.2024** **Review Date:** ~~11.01.2022~~06.2024 **Revision Eff. Date:**	**Related Policies:** Philosophy & Treatment

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Purpose

This policy sets forth the guidelines and expectations for Mid-State Health Network's (MSHN) administration of the Habilitation Supports Waiver (HSW) program.

Policy

MSHN shall administer the HSW program in accordance with the Prepaid Inpatient Health Plan (PIHP) contract and the Medicaid Provider Manual.

HSW beneficiaries must be enrolled through the Michigan Department of Health and Human Services (MDHHS) enrollment process by the Prepaid Inpatient Health Plan (PIHP) designee. The enrollment process must include verification that the beneficiary (all must apply):

1. Has a developmental disability (as defined in Michigan Mental Health Code MCL 330.1100 (20))
2. Is Medicaid-eligible
3. Is residing in a community setting (12 beds or less)
4. If not for HSW services, would require Intermediate Care Facility/for Individual with Intellectual Disabilities (ICF/IID) level of care services;
5. Chooses to participate in the HSW in lieu of ICF/IID services;
6. Habilitation services under the HSW are not otherwise available to the individual through a local educational agency.
7. HSW beneficiaries must receive at least one HSW habilitative service per month in order to maintain eligibility. Habilitative services include Community Living Supports, Out-of-Home Non-Vocational Habilitation, Prevocational Services, and Supported Employment

The beneficiary's services and supports must be specified in the individual's plan of services developed through the person-centered planning process that must be specific to:

1. Medical necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.
2. Amount: The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.

3. Scope: The parameters within which the service will be provided, including Who (e.g., professional, paraprofessional, aide supervised by a professional); How (e.g., face-to-face, telephone, taxi or bus, group or individual); and Where (e.g., community setting, office, beneficiary's home).
4. Duration: The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.

MSHN shall establish adequate procedures to assure effective administration of the program across the region including:

1. Initial Application and Eligibility;
2. Annual Recertification,
3. Disenrollment and Transfer Procedure

Applies to

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

Definitions

CMHSP: Community Mental Health Service Provider
HSW: Habitation Support Waiver
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
ICF/IID: (Intermediate Care Facility for Individuals with Intellectual Disabilities 42 CFR 435.1009) Institution for individuals with developmental disabilities or persons with related conditions means an institution (or distinct part of an institution) that (a) Is primarily for the diagnosis, treatment, or rehabilitation of people with developmental disabilities or persons with related conditions; and (b) Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.
Developmental Disability: means either of the following:

1. If applied to an individual older than 5 years, a severe, chronic condition that meets all of the following requirements:
    i. Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
    ii. Is manifested before the individual is 22 years old.
    iii. Is likely to continue indefinitely.
    iv. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
        a. Self-care.
        b. Receptive and expressive language
        c. Learning.

d. Mobility.
e. Self-direction.
f. Capacity for independent living.
g. Economic self-sufficiency.

v. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

2. If applied to a minor from birth to age 5, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (a) if services are not provided.

Other Related Materials
N/A

References/Legal Authority
The MDHHS – PIHP Contract
MDHHS, Medicaid Provider Manual; Section 15 – Habilitation Supports Waiver Program for Persons with Developmental Disabilities
Intermediate Care Facility/for Individuals with Intellectual Disabilities 42 CFR 435.1009; and Michigan Mental Health Code MCL 330.1100 (20).

Change Log:

Date of Change	Description of Change	Responsible Party
April, 2014	New policy	M. Neering N. Miller
January, 2017	Reviewed policy no recommended changes	Waiver Coordinator
October, 2017	Reviewed policy no recommended changes	Waiver Coordinator
July, 2020	Biennial Review	Waiver Coordinator
09.2022	Biennial Review	Chief Behavioral Health Officer
03/2024	Biennial Review	Waiver Coordinator

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Home and Community Based Services (HCBS) Compliance Monitoring		
Policy: ☒ Procedure: ☐ Page: 1 of 1	Review Cycle: Biennial Author: HCBS Waiver Manager	Adopted Date: 07.10.2018 Review Date: ~~11.01.2022~~06.2024	Related Policies:

Purpose:
To ensure that the Mid-State Health Network (MSHN) conducts monitoring and coordination of oversight of the Provider Network with the Community Mental Health Services Program (CMHSP), specifically Home and Community Based Services (HCBS) Program Rule compliance with federal and state regulations through a collaborative, standardized procedure for conducting reviews.

Policy:
MSHN will ensure that its member CMHSPs and their contractual providers of HCBS services, including residential and nonresidential home and community-based services are compliant with the Federal HCBS Final Rule.

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

Definitions:
CMHSP: Community Mental Health Services Program
HCBS: Home and Community Based Services
MSHN: Mid-State Health Network
~~Out of Compliance: the status of a provider who has answered the HCBS survey in such a way as to require a corrective action plan to the identified area~~.
Provider: A provider, internal or external to the MSHN region, who has a current contractual agreement to provide Medicaid services to individuals the CMHSP supports.

Other Related Materials:
N/A

References/Legal Authority:
- The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s)
- ~~MSA Bulletin 17-31 Compliance with Federal Home and Community Based Services (HCBS) Final Rule by New Providers~~
- Michigan Medicaid Provider Manual, Home and Community Based Services Chapter
- MSHN Procedure–MSHN HCBS Monitoring Procedure

Change Log:

Date of Change	Description of Change	Responsible Party
03.2018	New Policy	Waiver Coordinator
02.2019	Annual Review	Waiver Coordinator
08.2020	Annual Review	HCBS Manager
07.2022	Biennial Review	HCBS Manager
06.2024	Biennial Review	Chief Behavioral Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Indian Health Services/Tribally-Operated Facility/Urban Indian Clinic Services (I/T/U)		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Behavioral Health Officer	Adopted Date: 03.06.2018 Review Date: ~~11.01.2022~~06.2024	Related Policies:

Purpose

To ensure that the Mid-State Health Network (MSHN) has a policy that standardizes the regional service coverage approach to be consistent with the requirements of the Michigan Department of Health and Human Services (MDHHS) and Pre-Paid Inpatient Health Plan (PIHP) contract.

Policy

It is the policy of MSHN to pay any Indian Health Service, Tribal Operated Facility Organization/Program/Urban Indian Clinic (I/T/U), or I/T/U contractor, whether participating in the PIHP provider network or not, for PIHP authorized medically necessary covered Medicaid managed care services provided to Medicaid beneficiary/Indian enrollees who are eligible to receive services from the I/T/U provider either at a rate negotiated between the PIHP and the I/T/U provider, or if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

General

Under the Indian Self-Determination and Education Assistance Act (Public Law 93-638), tribal facilities, including Tribal Health Centers (THCs), are those owned and operated by American Indian/Alaska Native tribes and tribal organizations under contract or compact with Indian Health Service (IHS). Mental health and substance use disorder services provided at the THC to American Indian and Alaska Native beneficiaries do not require the authorization of MSHN.

American Indians and Alaska Natives who are Medicaid beneficiaries can obtain mental health or substance abuse treatment services directly from the THC or may choose to obtain services from a PIHP program. There is a process available for Tribal Health Providers to be reimbursed using Medicaid funds for providing behavioral health services, when the Tribal Health Provider has chosen not to be part of a Medicaid Health Plan's (MHP) or PIHP's provider network. Tribal Health Providers can also be paid by the PIHPs when they provide a covered medically necessary Medicaid service to a Medicaid eligible tribal member who has a serious mental illness or a substance use disorder. THC services are not included in the MDHHS §1915(b) Managed Specialty Services and Supports Waiver for PIHPs and substance use disorder services. THCs may refer tribal members to the PIHP/Community Mental Health Service Program (CMHSP) for mental health or substance abuse treatment services not provided at the THC.

Under the Michigan Medicaid State Plan, THCs have the option of choosing from one of four ~~three~~ reimbursement mechanisms. The THC may elect to be reimbursed under only one of the options listed below, and the selected option applies to all beneficiaries receiving services at the THC.

The options are:

- A THC may choose to be certified as an IHS facility, and receive the HIS outpatient all-inclusive rate (AIR) for eligible encounters. The AIR applies to encounters for both native and non-native Medicaid beneficiaries. THCs are reimbursed at the AIR unless the THC chooses a different payment option and informs MDHHS of the choice in writing. ~~sign the~~

~~THC Memorandum of Agreement (MOA) and receive the IHS encounter rate in accordance with the terms of the MOA.~~

- ~~If a THC chooses to be reimbursed as an FQHC, the entity would be required to adhere to the same requirements specified in the Federally Qualified Health Centers chapter of the Michigan Medicaid Provider Manual.~~ ~~Upon federal approval by the Health Resources and Services Administration, THCs may be reimbursed as a Federally Qualified Health Center (FQHC) by signing the FQHC Memorandum of Agreement. THCs choosing this option will receive the FQHC encounter rate set by the State in accordance with the Michigan Medicaid State Plan and federal regulations. The FQHC encounter rate applies to encounters for both native and non-native beneficiaries. A THC electing to be reimbursed as an FQHC is not required to have a contract with the managed care entity. If a THC chooses to be reimbursed as a FQHC, the entity would be required to adhere to the same requirements specified in the FQHC Chapter of the Michigan Medicaid Manual.~~
- A Tribal facility may choose to enroll as a Tribal FQHC and be reimbursed for outpatient face-to-face visits with the FQHC scope of services provided to Medicaid beneficiaries, including telemedicine and services provided by contracted employees. Tribal FQHCs are eligible to receive the HIS outpatient AIR for eligible encounters.
- A THC may be reimbursed as a fee-for-service provider. THCs choosing this option receive payment for covered services. No additional reimbursement or settlement is made.

The PIHP will have a designated tribal liaison who will ensure that any tribal members seeking services through the PIHP/CMHSP are able to access services efficiently and without barriers by serving as a primary point of contact in the MSHN region and by providing guidance to CMHSP and SUD service providers who perform access responsibilities on behalf of the PIHP.

Applies to

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

Definitions

CMHSP: Community Mental Health Services Program
FQHC: Federally Qualified Health Center
IHS: Indian Health Service
I/T/U: Indian Health Service, Tribal Operated Facility Organization/Program/Urban Indian Clinic
MDHHS: Michigan Department of Health and Human Services
MHP: Medicaid Health Plan
MOA: Memorandum of Agreement
MSHN: Mid-State Health Network
PIHP: Pre-Paid Inpatient Health Plan
THC: Tribal Health Center

Other Related Materials References/Legal Authority

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program/MDHHS-
PIHP Contract
Michigan Medicaid Provider Manual/Behavioral Health and Intellectual Disabilities Supports and Services

Change Log:

Date of Change	Description of Change	Responsible Party
10.29.2017	New policy	Utilization Management & Waiver Director
02.2019	Annual review	Chief Behavioral Health Officer
08.27.2020	Annual review	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer
06.2024	Biennial Review	Chief Behavioral Health Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Inpatient Psychiatric Hospitalization Standards**		
Policy: ☒ **Procedure:** ☒ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** ~~Director of Provider Network Mgmt Systems~~Chief Behavioral Health Officer	**Adopted Date:** 11.07.2017 **Review Date:** 11.01.2022	**Related Policies:** MSHN Retrospective Sampling for Acute Services Policy

Purpose

To establish a single set of psychiatric inpatient provider performance standards, including pre-admission, admission, continuing care, and discharge.

Policy

Mid-State Health Network (MSHN), Community Mental Health Service Progams (CMHSPs) and providers shall adhere to *Section 8 – Inpatient Psychiatric Hospital Admissions* within the Behavioral Health and Intellectual and Developmental Disabilities Supports and Services chapter of the Medicaid Provider Manual, the Michigan Mental Health Code, Chapter 330, Act 258 of 1974, and the Michigan Department of Health and Human Services *Michigan Prepaid Inpatient Health Plan (PIHP)/CMHSP Provider Qualifications per Medicaid Services & Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) Codes.*

A. Pre-Admission:

1. Emergency Services staff who ~~are screening~~screen children shall complete 24 hours of child-specific training annually.
2. Provider shall maintain proper documentation of clinical presentation and disposition.
3. When known to the screening unit, screening unit personnel shall coordinate care with primary care physicians, substance use disorder treatment providers, alternative service providers and other individuals or organizations having an identified role in services and supports delivery to the consumer being served.
4. The screening unit shall furnish the Inpatient Psychiatric Hospital/Unit (IPHU) with necessary clinical, social, and demographic documentation to foster the admitting and discharge process.
5. The screening unit shall provide an admissions packet to the IPHU that has agreed to provide inpatient care to the consumer being served.
6. Established pre-admission screening tools will be used by pre-admission/crisis intervention staff. MSHN and its CMHSP participants use nationally-recognized written criteria based on sound clinical evidence (MCG Behavioral Health Medical Necessity Guidelines) to verify that admission decisions for acute care services are based on medical necessity.
7. In cases when the consumer is diverted from inpatient level of care to an alternative service, a crisis/safety plan shall be established. Whenever possible, a warm handoff occurs and CMHSPs conducts wellness checks, follow-up calls, face-to-face appointments, or any other appropriate safety monitoring activities warranted.
8. CMHSPs in the MSHN region shall provide emergency services, including pre-admission screening and related follow-up activities, including identification of and placement in appropriate psychiatric inpatient or alternative service settings regardless of where the consumer resides. MSHN shall pursue payment from other PIHPs for services. In all cases, communication(s) should occur with the CMHSP or PIHP in the catchment area of the residence of the consumer served. In no case should pre-admission screening activities be delayed while waiting for a response from the CMHSP/PIHP in the catchment area where the consumer resides. Established medical necessity and service utilization criteria are the only criteria to be used in making psychiatric admission determinations. Place of residence, willingness of another CMHSP

or PIHP to authorize services, or other non-clinical factors are not pertinent to the determination of inpatient psychiatric or alternative service levels of care and related placement decisions. Arrangement for continuing stay reviews and other follow-up care should be worked out with the provider system that will be responsible for post-inpatient follow-up care.

9. Screening unit will work with MDHHS to secure consents for children/adolescents in foster care and may proceed with a verbal consent; preadmission disposition cannot be finalized until parent or guardian is present or in the case of State Wards, MDHHS has provided written authorization for psychiatric inpatient admission.
10. Assertive Community Treatment (ACT) consumers seeking psychiatric admission should be screened by an ACT team member as that team member would be in the best position to not only approve an admission but also divert it.

B. In-Region Pre-Admissions Between MSHN CMHSP Participants

In instances when a MSHN CMHSP participant (screening CMHSP) is conducting "courtesy" pre-admission screening activities for an individual that resides in the catchment of another MSHN CMHSP participant (authorizing CMHSP):

1. The screening CMHSP will initiate communication to the authorizing CMHSP as soon as possible. In no case should pre-admission screening activities be delayed while waiting for a response or authorization from the authorizing CMHSP.
2. Once a disposition recommendation has been reached the screening CMHSP is responsible for communicating the disposition recommendation and sharing all pre-admission screening documentation, lab work, additional hospital clinical records, etc. to the authorizing CMHSP.
3. The authorizing CMHSP has primary responsibility in facilitating all related follow-up activities including but not limited to: identification and placement in appropriate psychiatric inpatient unit, identification and placement in alternative service settings, development of crisis/safety plans, and discharge/transfer planning with the hospital emergency department. Exceptions may occur if the authorizing CMHSP is not responding in a timely manner or the authorizing CMHSP requests assistance from the screening CMHSP to facilitate placement. If the authorizing CMHSP requests assistance the screening CMHSP will provide support and coordination.
4. If there is disagreement regarding the disposition recommendation, consultation should be sought between the crisis services supervisors for the screening CMHSP and the authorizing CMHSP. If this is not possible or agreement is not reached, the screening CMHSP will act in the best interest of the consumer based on the clinical assessment and established medical necessity criteria. In no case should medically necessary services be delayed due to willingness of another CMHSP to authorize services.

C. Admission

1. The contractually required inpatient admission, severity of illness, and service selection criteria for both adults and children shall be the only criteria for admission to psychiatric inpatient admission and inpatient alternative service.
2. The screening unit making the determination that a consumer served meets psychiatric admission criteria shall provide an initial authorization to the psychiatric inpatient unit consistent with severity of illness, presenting problems and other clinical factors associated with the preadmission screening determination. Initial authorizations may vary between one (1) and three (3) days. Many of these elements are procedural and in the case of involuntary admissions, vary from court jurisdiction to court jurisdiction.
3. Screening unit shall ensure that emergency transportation of a consumer from the location of screening to the receiving psychiatric inpatient unit is coordinated. Safety of the consumer served, and the safety of those providing supports to the consumer, are the primary considerations in making transportation arrangement.

4. The screening unit is responsible for ensuring that families, guardians, service providers and others involved in the care, custody and service delivery of the consumer served are updated regularly on screening status, disposition, and placement efforts. Family members and others in the consumer's circle of support should receive communication as often as possible, and supportive assistance provided as needed.
5. Clinical determinations and formulations, eligibility determinations, service disposition and related information is documented per established CMHSP policies.

D. Continuing Stay

1. The Continuing Stay Criteria for Adults, Adolescents and Children shall be the only criteria used in determining authorization for continued stay in inpatient psychiatric hospitals/units. The number of days authorized for continued stay is dependent on a number of variables, including medication effectiveness, clinical progress, co-morbidities and many other factors. Continued stay authorizations range from one (1) to three (3) days. The rationale considered in making a continued stay authorization shall be documented in the clinical record of the consumer served.
2. Assessment, discharge procedures, and aftercare planning shall be conducted by the Provider's staff and the Payor's staff functioning as a multi-disciplinary treatment team. The Payor is responsible for monitoring patient progress. To the extent possible, provider will coordinate care with other entities and individuals involved with the care of the consumer that is being served.

E. Discharge

1. All discharge planning will begin immediately at admission and continue as part of the ongoing treatment planning and review process. Discharge planning will involve the consumer, the consumer's family or significant others, as desired by the consumer, and the provider's staff and the payor's staff.
2. Provider shall submit a notification of discharge at least 48 hours preceding the discharge, if possible. Special consideration shall be given to weekend discharge with regard to additional supports needed to ensure safe transition of care to include transportation from hospital to next point of care or the consumer's home. Discharge summary shall be submitted to payor within 48 hours of discharge.
3. At the time of discharge, the provider may provide a supply of medications sufficient to carry through from date of discharge to the next business day, but not less than a two (2) day supply but shall issue a prescription for not less than fourteen (14) days.
4. Provider shall notify the Payor of persons discharged to community settings who are subject to judicial orders requiring community-based treatment.

Applies to:

☐All Mid-State Health Network Staff

☐ Selected MSHN Staff, as follows:

☒MSHN CMHSP Participants: ☒Policy Only Policy and Procedure

☒Other: Sub-contract Providers

Definitions

ACT: Assertive Community Treatment
CMHSP: Community Mental Health Services Program Participant
HCPCS/CPT: Healthcare Common Procedure Coding System/Current Procedural Terminology
IPHU: Inpatient Psychiatric Hospital/Unit
MSHN: Mid-State Health Network

Payor: A person, organization, or entity that pays for the services administered by a healthcare provider
PIHP: Pre-paid Inpatient Health Plan
Provider: Licensed Inpatient Hospital/Unit
Screening Unit: CMHSP Emergency Services or other CMHSP-Operated Pre-Admission Screening Unit

References/Legal Authority

- Medicaid Provider Manual, Section 8 – Inpatient Psychiatric Hospital Admissions within the Behavioral Health and Intellectual and Developmental Disabilities Supports and Services Chapter
- Michigan Mental Health Code, Chapter 330, Act 258 of 1974
- Michigan Department of Health and Human Services Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes.
- Michigan Department of Health and Human Services Memorandum: Assertive Community Treatment (ACT) Service Clarifications

Change Log

Date of Change	Description of Change	Responsible Party
07.2017	New Policy	Director of Provider Network Management Systems
02. 2019	Annual Review	Director of Provider Network Management Systems
06.2020	Added Clarifying Language regarding pre-admission screenings	Director of Utilization and Care Management
09.2022	Biennial Review	Chief Behavioral Health Officer
06.2024	Biennial Review	Chief Behavioral Health Officer

Chapter:	Service Delivery System		
Title:	Out of State Placements		
Policy: ☒ Procedure: ☐ Page: 1 of 3	Review Cycle: Biennial Author: Clinical Leadership Committee	Adopted Date: 05.05.2015 Review Date: 06.2024	Related Policies:

Purpose

This policy is established to provide guidelines for the placement of Mid-State Health Network (MSHN)service recipients outside of the State of Michigan in accordance with the Michigan Mental Health Code and the Michigan Medicaid Provider Manual.

Policy

Mid-State Health Network and its Community Mental Health Service Program (CMHSP) Participants will comply with *Section 330.919 of the Michigan Mental Health Code Section 330.1919 - Contracts for services of agencies located in bordering states* and the Michigan Medicaid Provider Manual regarding the placement of individuals outside of the state of Michigan.

CMHSPs shall notify MSHN of their intent to place a Medicaid or Healthy Michigan Plan eligible beneficiary out of state. MSHN, in collaboration with the CMHSP, will submit a request for placement approval to the appropriate division at the Michigan Department of Health and Human Services (MDHHS). Placement shall not occur until MDHHS approves the out of state placement in writing. This policy is applicable to all out of state placements including but not limited to, specialized residential treatment and adult foster care settings.

Determination of Need

The CMHSP must make a determination that the placement is clinically appropriate. All efforts should first be made to serve the needs of individuals within the State of Michigan.

If an out of state placement is being considered, the CMHSP shall notify MSHN of its intentions and detail the history of the individual and services that have been provided, and clinical determination that needed services are not available within the State for that individual. MSHN shall submit to the State of Michigan a treatment summary, current assessment and PCP summary, discharge plan and monitoring of placement plan.

The CMHSP shall meet the requirements of the Mental Health Code and the Michigan Medicaid Provider Manual in seeking provision of out of state services.

These requirements include, but may not be limited to:

1) The CMHSP may contract as provided under section 330.1919 of the Michigan Mental Health Code with a public or private agency located in a state bordering Michigan to secure services for an individual who receives services through the county program.
2) The CMHSP may contract as provided under this section with a public or private agency located in a state bordering Michigan to provide services in an approved treatment facility in this state for an individual who is a resident of the bordering state, except that such services may not be provided for an individual who is involved in criminal proceedings.
3) An individual does not establish legal residence in the state where the receiving agency is located while the individual is receiving services

4) An individual who is detained, committed, or placed on an involuntary basis may be admitted and treated in another state. Court orders valid under the law of Michigan are granted recognition and reciprocity in the receiving state to the extent that the court orders relate to admission for the treatment or care of a mental disability. The court orders are not subject to legal challenge in the courts of the receiving state. An individual who is detained, committed, or placed under the law of Michigan and who is transferred to a receiving state continues to be in the legal custody of the authority responsible for the individual under the law of Michigan. Except in an emergency, such an individual may not be transferred, removed, or furloughed from a facility of the receiving agency without the specific approval of the authority responsible for the individual under the law of Michigan.

5) While in the receiving state, an individual is subject to all of the laws and regulations applicable to an individual detained, committed, or placed pursuant to the corresponding laws of the receiving state, except those laws and regulations of the receiving state pertaining to length of involuntary inpatient treatment, reexaminations, and extensions of involuntary inpatient treatment and except as otherwise provided by Michigan law. The laws and regulations of Michigan relating to length of involuntary inpatient treatment, reexaminations, and extensions of involuntary inpatient treatment apply.

6) If an individual receiving treatment on a voluntary basis requests discharge, the receiving agency shall immediately notify the CMHSP and shall return the individual to Michigan as directed by the CMHSP within 48 hours after the request, excluding Saturdays, Sundays, and legal holidays, unless other arrangements are made with the CMHSP.

7) If an individual leaves the receiving agency without authorization and the individual at the time of the unauthorized leave is subject to involuntary inpatient treatment under the laws of Michigan, the receiving agency shall use all reasonable means to locate and return the individual. The receiving agency shall immediately report the unauthorized leave of absence to the sending CMHSP. The receiving state has the primary responsibility for, and the authority to direct, the return of individuals within its borders and is liable for the cost of such action to the extent that it would be liable for costs if an individual who is a resident of the receiving state left without authorization.

8) An individual may be transferred between facilities of the receiving state if transfers are permitted by the contract providing for the individual's care.

9) Each contract executed for out of state services shall contain all of the following:
    a) Establish the responsibility for payment for each service to be provided under the contract. Charges shall not be more or less than the actual cost of providing the service.
    b) Establish the responsibility for the transportation of individuals to and from the receiving agency.
    c) Provide for reports by the receiving agency to the CMHSP on the condition of each individual covered by the contract.
    d) Provide for arbitration of disputes arising out of the contract that cannot be settled through discussion between the contracting parties and specify how the arbitrators will be chosen.
    e) Include provisions ensuring the nondiscriminatory treatment, as required by law, of employees, individuals receiving services, and applicants for employment and services.
    f) Establish the responsibility for providing legal representation for an individual receiving services in a legal proceeding involving the legality of admission and the conditions of involuntary inpatient treatment.
    g) Establish the responsibility for providing legal representation for an employee of a contracting party in legal proceedings initiated by an individual receiving treatment pursuant to the contract.
    h) Include provisions concerning the length of the contract and the means by which the contract can be terminated.

i) Establish the right of the CMHSP and the State of Michigan to inspect, at all reasonable times, the records of the Provider and its treatment facilities to determine if appropriate standards of care are met for individuals receiving services under the contract.
j) Require the sending CMHSP to provide the receiving agency with copies of all relevant legal documents authorizing involuntary inpatient treatment of an individual who is admitted pursuant to the laws of Michigan.
k) Require each individual who seeks treatment on a voluntary basis to agree in writing to be returned to the State of Michigan upon making a request for discharge and require an agent or employee of the sending CMHSP to certify that the individual understands that agreement.
l) Establish the responsibility for securing a reexamination for an individual and for extending an individual's period of involuntary inpatient treatment.
m) Include provisions specifying when a receiving facility can refuse to admit or retain an individual.
n) Specify the circumstances under which an individual will be permitted a home visit or granted a pass to leave the facility, or both.

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

Definitions:
CMHSP: Community Mental Health Service Program responsible for requesting and managing the Out-of-State placement
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
Receiving Agency: Organization accepting the out of state placement
Responsible Mental Health Agency: Agency responsible for payment

Other Related Materials:

References/Legal Authority:
Michigan Mental Health Code
Michigan Medicaid Provider Manual

Change Log:

Date of Change	Description of Change	Responsible Party
01.2015	New Policy	C. Mills, PNMC
05.2016	Annual Review	Director of Provider Network Management Systems, Provider Network Management Committee
02.2018	Annual Review	Director of Provider Network Management Systems, Provider Network Management Committee
03.2019	Annual Review	Director of Provider Network Management Systems, Provider Network Management Committee
07.2022	Biennial Review	Chief Behavioral Health Officer Clinical Leadership Committee
02.2023	Edited to clarify that approval is not needed for out of state inpatient psychiatric hospitalization	Chief Behavioral Health Officer, Director of Utilization & Care Management
06.2024	Biennial Review	Chief Behavioral Health Officer, Chief Population Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Standardized Assessment**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Clinical Leadership Committee; ~~Director of Utilization, and Utilization Management Committee~~Chief Behavioral Health Officer	**Adopted Date:** 04.07.2015 **Review Date:** 11.01.2022	**Related Policies:** Service Philosophy

Purpose

In accordance with best practice standards and the Mid-State Health Network (MSHN) contract with the Michigan Department of Health and Human Services (MDHHS), MSHN's provider network inclusive of Community Mental Health Service Program (CMHSP) Participants and the Substance Use Disorder (SUD) Provider Network shall administer or require administration of standardized assessments, for specific populations served, as defined by the Medicaid Managed Specialty Supports and Services Contract with the Pre-Paid Inpatient Health Plan (PIHP).

Policy

MSHN shall assure through contract, policy and procedure that regional provider network members are administering the noted standardized assessments as required. These assessments include, where clinically and contractually indicated, the American Society of Addiction Medicine (ASAM) Criteria, Global Appraisal of Individual Needs (GAIN), ~~Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS)~~Michigan Child and Adolescent Needs and Strengths (MichiCANS), Level of Care Utilization System (LOCUS), ~~the Supports Intensity Scale (SIS),~~ and the Devereaux Early Childhood Assessment (DECA). When necessary, MSHN shall work with CMHSPs and the SUD Provider Network to establish regional procedures for the administration and monitoring of standard assessment compliance.

MSHN staff or provider network members shall participate in MDHHS selection, planning and monitoring of standardized assessment administration as required.

Applies to:

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

Definitions:

ASAM: American Society of Addiction Medicine
CAFAS: Child and Adolescent Functional Assessment Scale
CMHSP: Community Mental Health Services Programs
DECA: Devereaux Early Childhood Assessment
GAIN: Global Appraisal of Individual Needs
LOCUS: Level of Care Utilization System
MDHHS: Michigan Department of Health and Human Services
MichiCANS: Michigan Child and Adolescent Needs and Strengths, effective 10/1/2024
MSHN: Mid-State Health Network
PECFAS: Preschool and Early Childhood Functional Assessment Scale

PIHP: Pre-paid Inpatient Health Plan
Provider Network: MSHN's provider network is inclusive of and limited to the CMHSPs and the SUD Provider Network; Contracted providers for the administration of services to persons with substance use disorder services.
~~SIS: Supports Intensity Scale~~

Other Related Materials:
N/A

References/Legal Authority: MDHHS –
PIHP Contract and related amendments.

Change Log:

Date of Change	Description of Change	Responsible Party
01.2015	New Policy	CEO
03.2016	Annual Review.	Director of Utilization Management and Waiver Services
02.2017	Added standardized assessments by name.	Director of Utilization Management and Waiver Services
01.2018	No changes	Director of Utilization Management and Waiver Services
02.2019	Annual Review	Chief Behavioral Health Officer; Director of Utilization Management
08.2020	Annual Review	Chief Behavioral Health Officer, Director of Utilization and Care Management
09.2022	Biennial Review	Chief Behavioral Health Officer
06.2024	Biennial Review	Chief Behavioral Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery		
Title:	SUD Services – Medications for Opioid Use Disorder (MOUD)		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Clinical Officer SUD Medical Director Medical Director	Adopted Date: 03.06.2018 Review Date: 9.06.2024	Related Policies:

Purpose

Medication for Opioid Use Disorder Treatment (MOUD) ~~Medication-Assisted Treatment (MAT)~~ is a standard of care that is broadly recognized as foundational to any comprehensive approach to the national opioid addiction and overdose pandemic. MSHN seeks to ensure therefore that no MSHN client is denied access to or pressured to reject the full array of evidence-based and potentially life-saving treatment options, including ~~MAT~~MOUD, that are determined to be medically necessary for the individualized needs of that client. Note: Supported by medical and epidemiological data, the terminology of the past, i.e., Medication-Assisted Treatment (M~~OUD~~AT) has been replaced by MOUD to reflect new standards around low-barrier access to care and Medication First Principles (see "Related materials" #1-3 on p.2).

Policy

Following the recommendations by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), the American Society for Addiction Medicine (ASAM), the National Institute for Drug Abuse (NIDA), the Michigan Department of Health and Human Services (MDDHS)'s Office of Recovery Oriented Systems of Care (OROSC) Treatment Policies #5 and #6, and other state and national directives, MSHN-contracted SUD treatment providers are expected to adopt a ~~MAT~~MOUD-inclusive treatment philosophy in which 1) the provider demonstrates willingness to serve all eligible treatment-seeking individuals, including those who are using ~~MAT~~MOUD as part of their individual recovery plan at any stage of treatment or level of care, and without precondition or pressure to adopt an accelerated tapering schedule and/or a mandated period of abstinence, 2) the provider develops policies that prohibit disparaging, delegitimizing, and/or stigmatizing of ~~MAT~~MOUD either with individual clients or in the public domain.

Abstinence-Based (AB) Providers – In the interest of offering client choice, MSHN will contract with AB providers who offer written policies and procedures stating the following:

1. If a prospective client, at the point of access, expresses his/her preference for an abstinence-based treatment approach, the access worker will obtain a signed MSHN Informed Consent form that attests that the client was informed in an objective way about other treatment options and recovery pathways including ~~MAT~~MOUD, and the client is choosing an abstinence-based provider from an informed perspective.
2. When a client already on ~~MAT~~MOUD (or considering ~~MAT~~MOUD) is seeking treatment services (counseling, case management, recovery supports, and/or transitional housing) at the point of access to an AB facility, access staff will a) be accepting towards ~~MAT~~MOUD as a choice, b) will not pressure the client to make a different choice, c) will work with that client to do a "warm handoff" to another provider of the client's choice by scheduling an appointment with the chosen provider that can provide those ancillary services while the client pursues his or her chosen recovery pathway that includes ~~MAT~~MOUD, and d) will follow up with the chosen provider to ensure client admission.
3. Providers' written policies will include language that prohibits delegitimizing, and/or stigmatizing of ~~MAT~~MOUD (e.g. using either oral or written language that frames ~~MAT~~MOUD as "substituting one addiction for another") either with individual clients, written materials for distribution to clients, or in the public domain.

Applies to:

☒All Mid-State Health Network Staff
☐Selected MSHN Staff, as follows:
☒MSHN CMHSP Participants: Policy

Definitions

AB: Abstinence-Based
ASAM: American Society for Addiction Medicine
CDC: Centers for Disease Control and Prevention
MAT: Medication-Assisted Treatment
MOUD: Medication for Opioid Use Disorder
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health and Human Services
NIDA: National Institute for Drug Abuse
OROSC: Office of Recovery Oriented Systems of Care
SAMHSA: Substance Abuse and Mental Health Services Administration
SUD: Substance Use Disorder

Other Related Materials

1. SAMHSA Advisory: Low Barrier Models Of Care For Substance Use Disorders
2. CDC Linking People with Opioid Use Disorder to Medication Treatment
3. https://www.medicationfirst.org/ Medication First Principles
~~1.~~4. SAMHSA Treatment Improvement Protocol #43 - ~~MAT~~MOUD for Opioid Addiction in Opioid Treatment Programs
~~2.~~5. U.S. Surgeon General – Treatment Options
~~3.~~6. National Institute on Drug Abuse Effective Treatment for Opioid Addiction
~~4.~~7. The Center for Disease Control "Vital Signs" – Today's Heroin Epidemic
~~5.~~8. White House Commission on Combating Drug Addiction and the Opioid Crisis White House Commission on Combating Drug Addiction and the Opioid Crisis – Letter to the President
~~6.~~9. ASAM National Practice Guideline
~~7.~~10. MDHHS ~~MAT~~MOUD Guidelines for Opioid Use Disorders
~~8.~~11. MSHN 2022 SUD Provider Manual

References/Legal Authority:

1. Behavioral Health and Developmental Disabilities Administration Treatment Policy #5
2. Behavioral Health and Developmental Disabilities Administration Treatment Policy #6

Change Log:

Date of Change	Description of Change	Responsible Party
12.2017	New Policy	Chief Clinical Officer, SUD Medical Director & Medical Director
02.2019	Annual Review	Chief Clinical Officer
10.2020	Annual Review	Chief Clinical Officer
08.2022	Biennial Review	Chief Clinical Officer
09.2024	Biennial Review	Chief Clinical Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	SUD Services – Out of Region Coverage		
Policy: ☑ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: ~~Utilization Mgmt. and Waiver Director~~Utilization Management Administrator	Adopted Date: 09.06.2016 Review Date: ~~11.01.2022~~ 08/2024	Related Policies:

Purpose

The purpose of this policy is to delineate the Mid-State Health Network (MSHN) stance on MSHN-Medicaid consumer coverage for beneficiaries who receive residential, withdrawal management, and/or ~~detoxification~~ recovery housing services outside of the MSHN region.

Policy

It is the policy of MSHN that for individuals receiving covered residential, ~~or~~ withdrawal management, and/or recovery housing ~~detoxification~~ services in a licensed out of region provider, that providers take no action to change the Medicaid county of residence of the individual receiving services.

Additional Guidance:

MSHN has established contracts with certain out of region (i.e., outside of the MSHN 21-county area) substance use disorder (SUD) treatment providers for residential, withdrawal management, and/or recovery housing ~~and/or detoxification~~ services. In other cases, MSHN will engage in "single-consumer" letters of agreement with providers not previously empaneled in the MSHN provider network to facilitate needed care.

It has been the historical practice of some SUD ~~residential and/or detoxification~~ treatment providers to contact local Michigan Department of Health and Human Services (MDHHS) eligibility personnel to transfer the consumer's Medicaid county of residence coverage to the county in which the treatment facility exists. Per the Medicaid Services Administration (MSA), there is no type of eligibility requirement dictating such a change in address when the consumer enters any treatment program.

The unintended consequence of switching any consumer's Medicaid coverage temporarily to a non-MSHN county results in the consumer being assigned to a different Pre-Paid Inpatient Health Plan (PIHP) region. In addition, when the consumer leaves the SUD provider and returns home, he or she will not be able to get medical or other covered services in their home county until the Medicaid coverage is returned to the original PIHP (MSHN) assignment. This represents a barrier to treatment that should not exist for beneficiaries. The MSHN access management system should be service-driven and facilitate meeting the needs of the client without risking disengagement or constructing unnecessary barriers to benefit utilization.

MSHN has established rates for reimbursement to account for any benefits that the provider may use on behalf of the consumer, making a consumer address change initiated by the SUD provider unnecessary.

The MSHN region also contains Medicaid Health Plan (MHP) coverages (i.e., Medicaid Regional Prosperity Regions) that include all plans in the lower peninsula such that when the MSHN consumer participates in an out-of-region SUD program, adequate healthcare coverage continues to exist for that consumer.

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

Definitions:
CMHSP: Community Mental Health Service Program
MDHHS: Michigan Department of Health and Human Services
MHP: Medicaid Health Plan
MSA: Medicaid Services Administration
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
SUD: Substance Use Disorder

Other Related Materials:

References/Legal Authority:
MDHHS Bureaus of Substance Abuse and Addiction Services Treatment Policy #7
MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program
MDHHS Michigan Medicaid Health Plans beginning January 1, 2016
MSHN 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
08.08.2016	New Policy	Utilization Mgmt. & Waiver Director
02.28.2018	Annual Review	UM Director & Director of Provider Network Management Systems
3.2019	Annual Review	Chief Clinical Officer
10.2020	Annual Review	Chief Clinical Officer
08.2022	Biennial Review	Chief Clinical Officer
08.2024	Biennial Review – updated "detoxification" to "withdrawal management" and added recovery housing services.	Utilization Management Administrator

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POLICIES AND PROCEDURE MANUAL

Chapter	Service Delivery System		
Title:	Substance Use Disorder (SUD) Services: Telemedicine		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Behavioral Health Officer & Chief Clinical Officer	Adopted Date: 07.09.2019 Review Date: ~~11.01.2022~~9.6.2024	Related Policies:

Purpose

The purpose of this policy is to delineate the use of synchronous (i.e. real-time two-way interactivity) telemedicine services using telecommunication technology to connect a patient with a health care professional in a different location.

Policy

It is the policy of Mid-State Health Network (MSHN) to make telemedicine available through the provider system to connect the individual served with an appropriately established professional for treatment involving substance use disorder (SUD).

The following standards must be met:

A. The telecommunication technology shall be synchronous (i.e. "real-time") between the individual and the health care professional.
B. The telecommunication technology must meet requirements for audio and visual compliance in accordance with current regulations and standards for privacy and security of all information shared via telemedicine.
C. Telecommunication systems using asynchronous (i.e. "store and forward" methods like email) transmission of data are not considered to be a part of this policy.
D. The real-time interactive system shall include the originating site (location of the individual in treatment at the time the service is furnished) and the distant site (provider). Authorized originating sites include:
    1) County mental health clinic or publicly funded mental health facility
    2) Federally Qualified Health Center (FQHC)
    3) Hospital (inpatient, outpatient, or critical access hospital)
    4) Office of a physician or other practitioner (including medical clinics)
    5) Hospital-based or Critical Access Hospital (CAH)-based renal Dialysis Centers (including satellites)
    6) Rural health clinic
    7) Skilled nursing facility
    8) Tribal Health Center (THC)
    9) Mobile Health Care Unit
E. In compliance with the Michigan Insurance Code of 1956 (Act 218 of 1956), telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the individual is located.
F. The physician or practitioner at the distant site who is licensed under state law to furnish a covered telemedicine service may bill and receive payment for the service when it is delivered via a telecommunications system.
G. The provider shall have a contract with or be authorized by MSHN to perform telemedicine services and shall also be enrolled in Michigan Medicaid.
H. Providers can only bill for services listed on the Current Allowable Telemedicine Services list as appropriate.
I. The individual shall be provided and complete informed consent in verbal and written form prior to the delivery of telemedicine services.

J. The treating professional shall follow all professional licensing and ethical standards delineated by the state of Michigan related to his or her area of practice (i.e. counseling, psychology, social work, etc.) in addition to his or her governing accrediting body (i.e. American Psychological Association (APA), Commission on Rehabilitation Counselor Certification (CRCC), National Board for Certified Counselors (NBCC), National Association of Social Workers (NASW), etc.).

Applies to

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

Definitions

APA: American Psychological Association
Asynchronous communication: Also known as store and forward, any electronic communication that does not occur in real-time, such as email, texts, blogs, social media, listservs, and newsgroups.
CAH: Critical Access Hospital
CRCC: Commission on Rehabilitation Counselor Certification.
Distant Site: the location of the professional providing the telemedicine service at time of delivery.
FQHC: Federally Qualified Health Center
MSHN: Mid-State Health Network
NASW: National Association of Social Workers.
NBCC: National Board for Certified Counselors.
Originating Site: the location of the individual in treatment at the time the service is furnished.
SUD: Substance Use Disorder(s)
Synchronous Communication: any electronic communication that occurs in real-time, such as video conferencing, webcams, telemedicine.
THC: Tribal Health Center

Other Related Materials

N/A

References/Legal Authority

Michigan Department of Health and Human Services, Michigan Medicaid Provider Manual
Michigan Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing
PIHP Encounter Reporting HCPCs and Revenue Codes/Current Allowable Telemedicine Services

Change Log:

Date of Change	Description of Change	Responsible Party
02.06.2019	New policy	Chief Behavioral Health Officer & Chief Clinical Officer
08.27.2020	Biennial Review	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer
09.2024	Biennial Review	Chief Clinical Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**SUD Services-Women's Specialty Services**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** SUD Workgroup, Health Integration, Treatment & Prevention Director	**Adopted Date: 07.07.2015** **Review Date:** 09.06.2024	**Related Policies:** Service Philosophy & Treatment

Purpose

The purpose of this policy is to establish the philosophy, requirements and procedure for women's substance use disorder (SUD) treatment services (Designated women's programs and gender competent programs) within the Mid-State Health Network (MSHN) region.

Standards

A. Substance Abuse Prevention and Treatment (SAPT) Block Grant requirements; (42U.S.C.96.124 [e])
B. Michigan Public Act 368 of 1978, Part 62, Section 333.6232.
C. Federal Regulation 45 Code of Federal Regulations (CFR) Part 96.
D. Michigan Department of Health & Human Services (MDHHS), Substance Abuse Treatment Policy #12, Women's Treatment Services (October 1, 2010).
E. Michigan Department of Health & Human Services (MDHHS), Substance Abuse Treatment Technical Advisory #8, Enhanced Women's Services (January 31, 2012)

Policy

MSHN strives to provide exceptional, gender-specific SUD prevention, treatment and recovery services, using the best quality, consumer-friendly, cost-efficient means possible. Women Specialty Service providers shall adhere to the following core values in delivery of care and service:

A. Family-Centered (Family is defined by the consumer)
B. Family Involvement
C. Build on Natural and Community Supports
D. Strength-based
E. Unconditional Care
F. Collaboration Across Systems
G. Team Approach across Agencies
H. Ensuring Safety
I. Gender/Age/Culturally Responsive Treatment
J. Self-sufficiency
K. Education and Work Focus
L. Belief in Growth, Learning, and Recovery
M. Outcome Oriented Services

Consumer Eligibility Criteria

- Pregnant women
- Women with dependent children
- Women attempting to regain custody of their children and/or women whose children are at-risk of out-of-home placement due to substance abuse
- Men who are the primary caregivers of dependent children
- Men, established as primary caregiver, attempting to regain custody of their children and/or men, established as primary caregiver, whose children are at-risk of out-of-home placement due to substance abuse

MSHN requires all providers screen and/or assess for the above eligibility.

Federal Requirements

Federal requirements are contained in 45 CFR (Part 96) section 96.124, and may be summarized as:

- Providers receiving funding from the state-administered funds set aside for Women's Specialty Services (WSS) consumers must provide or arrange for the 5 types of services, as listed below. Use of state administered funds to purchase primary medical care and primary pediatric care must be approved, in writing, in advance, by the Department contract manager.

For eligible clients, the following federal services must be made available:

1. Primary medical care for women receiving SUD treatment.
2. Primary pediatric care for their children, including immunizations.
3. Gender specific SUD treatment and therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting.
4. Childcare while women are receiving these services, therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect.
5. Sufficient case management and transportation services to ensure that women and children have access to the services provided in the first 4 requirements.

The above five types of services may be provided through the MDHHS/Pre-paid Inpatient Health Plan (PIHP) agreement only when no other source of support is available and when no other source is financially responsible.

Women's Specialty Services may only be provided by providers that are designated as gender-responsive by the Michigan Department of Health & Human Services or certified as gender-competent by MSHN and that meet standard panel eligibility requirements. MSHN will maintain an accessible list of choice providers offering gender-competent treatment and identify providers that provide the additional services specified in the federal requirements.

Additional WSS information and requirements:

Providers should reference MSHN's 2022 SUD Provider Manual for additional WSS information, including:

- Encounter Reporting Requirements
- Admission Preference & Interim Services
- Access Timeliness Standards
- Admission Priority Requirements
- WSS Service Delivery Tiers
- WSS Program Structure
- WSS Treatment

Applies to:

☒All Mid-State Health Network Staff

☐Selected MHN Staff, as follows:

☐ MSHN's CMHSP Participants: ☐Policy Only ☐Policy and Procedure

☒ Other: Sub-contract Providers

Definitions:

CFR: Code of Federal Regulations

MDHHS: Michigan Department of Health and Human Services

MSHN: Mid-State Health Network

PIHP: Prepaid Inpatient Health Plan

SAPT: Substance Abuse Prevention and

Treatment
SUD: Substance Use Disorder
WSS: Women's Specialty Services

Other Related Materials:
MSHN 2022 SUD Provider Manual

References/Legal Authority:
1. MDHHS/BHDDA Substance Abuse Treatment Policy #12, Women's Treatment Services.
2. MDHHS/BHDDA Treatment Technical Advisory #08, Enhanced Women's Services

Change Log:

Date of Change	Description of Change	Responsible Party
03.03.2015	New Policy	Deputy Director
07.13.2016	Revisions	Lead Treatment Specialist
03.2017	Annual Review	Deputy Director
02.2018	Annual Review	Chief Clinical Officer
03.2019	Annual Review	Chief Clinical Officer
10.2020	Annual Review	Chief Clinical Officer
08.2022	Biennial Review	Chief Clinical Officer
09.2024	Biennial Review	Chief Clinical Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery**		
Title:	**Trauma-Informed Systems of Care**		
Policy: ☒ **Procedure:** ☐ **Page: 1 of 2**	Review Cycle: Biennial **Authors:** Chief Clinical Officer, Chief Behavioral Health Officer	**Adopted Date: 07.07.2020** **Review Date:** ~~11.01.2022~~06.2024	**Related Policies**:

Purpose:
This policy ensures that Mid-State Health Network (MSHN) and its provider network promotes an understanding of trauma and its impact, develops and implements trauma-informed systems of care, and ensures availability of trauma-specific services for all persons served.

Policy:
It is the policy that MSHN and its provider network develop a trauma-informed system of care that is inclusive of internal staff, consumers across the developmental spectrum and throughout the full array of services offered. The following elements should be included:

A. Adoption of trauma informed culture: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization.
B. An organizational self-assessment for trauma-informed care, to be updated every three years. It should a) evaluate the extent to which providers' policies and practices are trauma-informed, b) identify organizational strengths and barriers, and c) include an environmental scan to ensure that the internal culture, environment, and building(s) are safe and trauma-sensitive.
C. Inclusion of strategies to address secondary trauma for all staff, including, but not limited to opportunities for supervision, trauma-specific incident debriefing, training, self-care, and other organizational support.
D. Universal screening for trauma exposure and related symptoms for each population. The screening instrument should be culturally competent, standardized, validated, and appropriate for each population.
E. ~~There should be screening for trauma exposure and a trauma-Trauma~~Screening for trauma exposure and a trauma-specific assessment for all populations served. The assessment tool should be culturally competent, standardized, validated, and appropriate for each population.
F. Trauma-specific services for each population using evidence-based practices (EBPs) or promising practice(s) are provided in addition to EBPs when no EBP is appropriate.
G. Collaboration between MSHN, its provider networks, and community partners to support development of a trauma informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders.

Applies to:

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

Definitions:

~~Adverse Childhood Experiences (ACEs): Stressful or traumatic events that children might experience including abuse, neglect, witnessing domestic violence, incarceration of a parent, or a family member with serious mental illness and/or a substance use disorder. ACEs are strongly related to the development~~

~~and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance abuse.~~

EBP: Evidence Based Practices

MSHN: Mid-State Health Network
Populations Served: Includes children with serious emotional disturbance, adults with serious mental illness, persons with intellectual/developmental disabilities, persons with substance use disorders including co-occurring disorders.

Re-traumatization: A situation, attitude, interaction, or environment that replicates the events or dynamics of the original trauma and triggers the overwhelming feelings and reactions associated with them.

Secondary Trauma: The emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder. Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure.

Trauma: The results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or threatening and that have lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. Forms of traumatizing events include violence and assault, discrimination, racism, oppression, and poverty. These chaotic life conditions are directly related to chronic fear and anxiety and can have serious long-term effects on health and other life outcomes.

~~Trauma-informed Services: Services designed specifically to avoid re-traumatizing those who seek assistance as well as staff working in service settings. These services seek "safety first" and commit themselves to "do no harm".~~

Trauma-specific Services: Services or interventions designed specifically to address the consequences of trauma in the individual and to facilitate healing.

Other Related Materials:
N/A

References/Legal Authority:
Medicaid Managed ~~Trauma~~ Specialty Supports and Services Program,
MDHHS Trauma Policy
~~FY20, Contract Amendment #1, Attachment 7.10.6.1~~

Change Log:

Date of Change	Description of Change	Responsible Party
04.2020	New Policy	Chief Behavioral Health Officer/Chief Clinical Officer
08.2020	New Policy	Chief Behavioral Health Officer
09.2022	Biennial Review	Chief Behavioral Health Officer
06.2024	Biennial Review	Chief Behavioral Health Officer

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POLICIES AND PROCEDURES MANUAL

Chapter:	Finance		
Section:	Procurement Policy		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 4	**Review Cycle:** Biennial **Author:** Chief Financial Officer	**Adopted Date: 09.02.2014** **Review Date:** 07.11.2023	**Related Policies:** Financial Management Cash Management

Purpose

To provide guidance to Mid-State Health Network (MSHN) staff involved in purchasing goods and services to assure:

A. That the MSHN obtains the best possible price and terms for all goods and services;
B. That a wide range of qualified vendors are notified of impending purchases;
C. That specifications are not so needlessly complex or restrictive that they would exclude qualified vendors; and
D. That staff are encouraged to exercise discretion in the purchasing process.

Policy

A. Oversight and Supervision of the Purchasing Process Shall be as Follows:
   1. **$0.00 -- $1,999**: Purchase of goods or services valued within this range may be purchased without written cost quotations or proposals. The responsible staff person shall solicit verbal quotations and submit to the Chief-level administrative officer in their reporting line. If approved by the Chief, documentation should be sent to the Chief Financial Officer (CFO) who will authorize the purchase to be made from the vendor best able to provide necessary goods or services based upon price, availability of goods, and delivery schedule.
   2. **$2,000 -- $24,999**: Purchase of goods or services valued within this range shall be preceded by the solicitation of written cost proposals (or estimates), submitted to the Chief-level administrative officer in their reporting line, and if approved, sent to the Chief Financial Officer. The Chief Financial Officer shall develop a written recommendation based on written documentation and present to the Chief Executive Officer (CEO) for approval. The reasons for all purchases made where the low-cost proposal is not accepted shall be clearly documented. Approved purchases shall be made from the vendor best able to provide the necessary goods or services with price being the primary consideration. The Chief Financial Officer will forward all pertinent documentation for inclusion in the accounts payable file.
   3. **$25,000 and higher (annually for multi-year agreements)**: Purchase of goods or services valued within this range shall be preceded by the solicitation of cost proposals as described in the Procedure: Procurement through formal procurement process (such as, but not necessarily limited to requests for quote, requests for information, or requests for proposals). Agency procedures for these processes shall be followed as noted in the Substance Use Disorder (SUD) Direct Service Procurement Policy and Procurement Through Request For Proposal Procedure The purchase shall be made from the vendor best able to provide the necessary goods or services with price being the primary consideration. The Chief-level Administrative Officer responsible for the purchase shall send all pertinent documentation and recommendations to the Chief Financial Officer. The Chief Financial Officer shall develop a written recommendation based on written documentation and present to the Chief Executive Officer for approval. The reasons for all purchases made where the low-cost proposal is not accepted shall be clearly documented. Once approved by the CEO, the Chief Financial Officer, with assistance from the Chief-level administrative officer responsible for the purchase, will prepare a Board Background and Motion (BB&M) containing sufficient background information and underlying rationale to support the purchase recommendation to the Board of Directors.

Items or services previously approved by the Board shall be brought back to the Board for review and approval if there is a dollar amount variance from the original BB&M of more than $10,000.

Exceptions:

1. Properties/facilities and maintenance purchases shall be bid out when the annualized or per item cost/value exceeds $10,000.
2. Computer Hardware and Software: The purchase of computer items or services valued less than $5,000 shall not be subject to this policy / procedure. The purchase may be approved when, in the judgment of the Chief Information Officer (CIO), the purchase is made from the vendor best able to provide necessary goods or services based upon price, availability of goods, and delivery schedule. The Chief Financial Officer must approve the purchase or purchase arrangement.
3. Computer Services: The purchase of computer services valued less than $20,000 may be approved by the Chief Information Officer after consultation with the Chief Financial Officer, when the provider of that service has already been selected to provide similar services within the previous 24 months via a documented bid or cost comparison process. Such approval may be made when, in the judgment of the CIO, the vendor continues to be best able to provide necessary services based upon price, performance and schedule.
4. Computer Hardware and Software and Employee/Physician Insurances: Purchases of $25,000 and higher may not be required to adhere to formal procurement process if the responsible Administrative Officer determines a solicitation of cost proposals is more appropriate.
5. Clinical services and/or supports including Substance Use Disorder (SUD) services are excluded from this policy as these procurements are governed by MSHN's SUD Direct Service Procurement Policy.
6. The services sought are professional services of limited quantity or short duration (e.g. Psychological testing);
7. Through the person-centered planning process, the consumer has chosen a qualified non-network provider as his/her provider of choice.
8. Where, for purposes of continuity of care, an existing qualified network provider or provider panel may be selected to provide a service.

Exclusions:

1. The purchase of food and consumable supplies.
2. Goods or service contracts entered under, or based upon, the State of Michigan MI Deal program~~, or the~~ US Federal Government's General Services Administration (GSA) program(s)~~.~~, or other non-State of Michigan or non-Federal Government grants.

B. Staff shall obtain cost proposals from qualified vendors for goods and services specified in this policy. Proposals may be obtained by means of direct solicitation or by advertising through professional periodicals, or otherwise appropriate publications with the express purpose of notifying a wide range of vendors. The use of direct solicitation or published advertisements to affect an efficient and expeditious vendor response shall be left to the discretion of the Chief-level administrative officer with responsibility for department making the purchase, in consultation with the Chief Financial Officer if/as needed. Generally, the receipt of at least three cost proposals shall be required prior to authorizing a purchase, however, the receipt of fewer proposals shall be acceptable, provided that a reasonable staff effort and solicitation process is documented and approved by the Chief Financial Officer.

C. MSHNs finance department may maintain a list of qualified vendors for solicitation purposes for routine or regular purchases. This list may be developed from a variety of sources, including vendor requests, professional or trade organizations, and past MSHN experience. The qualification of vendors may include verifying appropriate insurances, licensure, past performance based upon written recommendations and comments from previous customers, and the vendor's size and experience relative to MSHN's project and needs.

D. When used, MSHN Chief-level administrative officer shall develop specifications for cost proposals that are sufficiently complete so that all vendors provide quotations that are comparable. Specifications shall not be designed to favor a particular brand or type of product, or to exclude a particular vendor, without good cause. Good cause for narrow or restrictive specifications may include, but is not limited to, compatibility with existing systems or equipment, particular or specific needs of MSHN that few vendors are capable of fulfilling, professional or technical judgment of MSHN staff, and previous MSHN experience with vendors of products. The reasons for restrictive or narrow specifications must be clearly defined and filed with all other cost and proposal documents. Staff may be authorized make purchases without obtaining cost proposals, if only one vendor or product exists, or if proposals for identified products were received within the past twelve (12) months. The Chief Financial Officer shall approve all written specifications prior to release.

E. Staff shall maintain records sufficient to detail the significant history of a procurement decision. These records shall include, but are not limited to, information pertinent to the rationale for the method of provider selection or rejection and the basis for the cost or price. The files shall be maintained with MSHN's Finance department.

F. It is the responsibility of the Chief-level administrative officer to confirm with the Chief Financial Officer or designee that funds have been allocated and are available prior to the purchase.

G. All audits required by MSHN shall be obtained by direct solicitation or by advertising, which shall adhere to the principles stated herein. The length of the initial audit period shall not exceed three years. The CFO shall approve the audit specifications and proposal process. All responses to audit cost proposals shall be reviewed and approved by the Chief Executive officer and by the Board of Directors. MSHN may authorize staff to extend audit services beyond the original audit period without soliciting additional cost proposals, provided that any extensions do not exceed three (3) years. The cost for any extension may be negotiated at the time the extension is authorized.

H. Sole Source Exceptions: Under certain circumstances, the agency may contract with vendors or providers through single-source procurement without executing a competitive bid process. These circumstances may include any one or more of the following:

1. The goods or services are available only from a single source;
2. There is an urgent or emergent need for the goods or service;
3. After solicitation through a number of sources, there is a lack of qualified provider candidates;
4. The goods or services sought are unique or highly specialized;
5. The services sought are professional services of limited quantity or short duration (e.g. Psychological testing);
6. Through the person-centered planning process, the consumer has chosen a qualified non-network provider as his/her provider of choice.
7. Resource outputs associated with potential gain of multi-source procurement are considered excessive, unreasonable, or cost prohibitive.

Single Source exceptions must be documented in writing and filed with the provider contract file (or accounts payable files) prior to execution of contract or expenditures of funds to complete the purchase.

I. For the purchases funded with federal funds, the MSHN shall be in compliance with requirements of the Davis-Bacon Act, the Copeland "Anti-Kickback" Act, and the Contract Work Hours and Safety Standards Act.

J. MSHN funds may not be utilized for the purchase of alcohol or tobacco products.

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:
Administrative Officer: MSHN officer of administrative services (Chief Executive Officer, Deputy Directory, Chief Financial Officer, Chief Information Officer, Chief Clinical Officer)
BB&M: Board of Directors' Background and Motion
CEO: Chief Executive Officer
CFO: Chief Financial Officer
CIO: Chief Information Officer
CMHSP: Community Mental Health Service Program
GSA: General Services Administration; The executive agency responsible for supervising and directing the disposal of surplus personal property
MI Deal: Extended purchasing program which allows Michigan local units of government to use state contracts to buy goods and services
MSHN: Mid-State Health Network
RFP: Request for Proposal
SUD: Substance Use Disorder

References/Legal Authority
2 CFR 200; Subpart D; Sections 318 through 326
Michigan Department of Health and Human Services Contract for Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program, and Substance Use Disorder Community Grant Programs – Procurement Technical Requirement

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Financial Officer
11.2015	Annual Review	Chief Financial Officer
03.20.17	Policy Update	Chief Financial Officer
03.2018	Annual Review	Chief Financial Officer
03.2019	Policy Update	Chief Financial Officer
01.2021	Biennial Review	Chief Financial Officer
06.2022	Policy Update	Chief Executive Officer
01.2023	Biennial Review	Chief Financial Officer
05.2023	Policy Update	Chief Financial Officer
09.2024	Policy Update	Chief Financial Officer