Mid-State Health Network

Board of Directors Meeting ~ May 3, 2022 – 5:00 p.m.

Board Meeting Agenda

THIS MEETING WILL BE HELD AT A PHYSICAL LOCATION WITH APPROPRIATE SOCIAL DISTANCING AND/OR MASKING REQUIREMENTS

Lansing Community College West Campus
Chevrolet & Oldsmobile Rooms
5708 Cornerstone Drive
Lansing, MI 48917

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 May 3, 2022 Meeting of the MSHN Board of Directors
4. Public Comment (3 minutes per speaker)
5. **ACTION ITEM:** FY2021 Audit Presentation (*Page 6*)

   MOTION to receive and file the FY2021 Audit Report of Mid-State Health Network completed by Roslund, Prestage and Company.
6. Board Development: Harm Reduction: Reducing Stigma and Saving Lives (Page 13)
7. Chief Executive Officer's Report *(Page 30)*
8. Deputy Director's Report *(Page 55)*
9. Chief Financial Officer's Report

   Financial Statements Review for Period Ended March 31, 2022 *(Page 60)*

   ACTION ITEM: Receive and File the Statement of Net Position and Statement of Activities for the Period ended March 31, 2022, as presented.
10. **ACTION ITEM:** Contracts for Consideration/Approval *(Page 67)*

    The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2022 Contracts, as Presented on the FY 2022 Contract Listing
11. Executive Committee Report
12. 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/FY2022-MEETINGS

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Upcoming FY22 Board Meetings

Board Meetings convene at 5:00pm unless otherwise noted

July 5, 2022
Best Western Okemos/East Lansing Hotel & Suites
Stadium Room
2209 University Park Drive
Okemos, MI 48864

September 13, 2022
Okemos Conference Center
Inside Comfort Inn Okemos/East Lansing
Ballroom
2187 University Park Dr.
Okemos, MI 48864

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

13. **ACTION ITEM:** Consent Agenda

    Motion to Approve the documents on the Consent Agenda

    13.1 Approval Board Meeting Minutes 03/01/22. *(Page 70)*

    13.2 Receive SUD Oversight Policy Board Minutes 12/15/21 *(Page 75)* and 02/16/22. *(Page 79)*

    13.3 Receive Board Executive Committee Minutes 04/15/22. *(Page 83)*

    13.4 Receive Policy Committee Minutes 04/05/22. *(Page 85)*

    13.5 Receive Operations Council Key Decisions 02/28/22 *(Page 87)* and 03/21/22 *(Page 89)* and 4/18/22. *(Page 93)*

    13.6 Approve the following policies:

    13.6.1 Access System *(Page 95)*

    13.6.2 Utilization Management *(Page 105)*

    13.6.3 Level of Care System for Parity *(Page 113)*

    13.6.4 Retrospective Sampling for Acute Services *(Page 115)*

14. Other Business

15. Public Comment (3 minutes per speaker)

16. Adjourn

MSHN
Mid-State Health Network

FY22 MSHN Board Roster

Last Name	First Name	Email 1	Email 2	Phone 1	Phone 2	Appointing CMHSP	Term Expiration
Anderson	Jim	jdeweya@yahoo.com		989.667.1313	989.327.0734	BABHA	2022
Bohner	Brad	bbohner@tds.net		517.294.0009		LifeWays	2025
Brehler	Joe	jbrehler@sprynet.com		517.882.7491	517.230.5911	CEI	2025
Cadwallender	Bruce	bcadwall@umich.edu		517.703.4223		Shia Health & Wellness	2024
Cierzniewski	Michael	mikecierzniewski@yahoo.com		989.493.6236		Saginaw County CMH	2023
Colton	Craig	johnniec15@hotmail.com		989.912.0312		HBH	2023
DeLaat	Ken	kdelaat1@aol.com		231.414.4173		Newaygo County MH	2023
Griesing	David	davidgriesing@yahoo.com		989.823.2687		TBHS	2024
Grimshaw	Dan	midstatetitlesvcs@mstsinc.com		989.823.3391	989.823.2653	TBHS	2023
Hicks	Tina	tmhicks64@gmail.com		989.576.4169		GIHN	2024
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2024
Ladd	Jeanne	stixladd@hotmail.com		989.634.5691		Shia Health & Wellness	2024
Matelski	Rhonda	rhondam2374@gmail.com		989.269.2374		HBH	2023
McFarland	Pat	pjmcfarland52@gmail.com		989.225.2961		BABHA	2023
McPeek-McFadden	Deb	deb2mcmail@yahoo.com		616.794.0752		The Right Door	2024
Mitchell	Ken	kmitchellcc@gmail.com		517.899.5334	989.224.5120	CEI	2025
Nyland	Gretchen	gretchen7080@gmail.com		616.761.3572		The Right Door	2025
O'Boyle	Irene	irene.oboyle@cmich.edu		989.763.2880		GIHN	2023
Peasley	Kurt	peasleyhardware@nethawk.com		989.560.7402	989.268.5202	MCN	2024
Phillips	Joe	joe44phillips@hotmail.com		989.386.9866	989.329.1928	CMH for Central	2023
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
Twing	Susan	set352@hotmail.com		231.335.9590		Newaygo County MH	2025
Woods	Ed	ejw1755@yahoo.com		517.392.8457		LifeWays	2024

MSHN
Mid-State Health Network

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

1115: Reference is to the "1115 Waiver" which is a section of the Social Welfare Act (federal) under which the Secretary of Health and Human Services has legal authority to waive certain provisions of the act.

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

BHDDA: Behavioral Health and Developmental Disabilities Administration

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 Compliance Officer
Chief Clinical Officer

CFR: Code of Federal Regulations

CFAP: Conflict Free Access and Planning (Replacing CFCM)

CFCM: Conflict Free Case Management

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

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

DMC: Delegated Managed Care (site visits/reviews)

DRM: Disability Rights Michigan

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

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

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)

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

MSHN
Mid-State Health Network

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

LTSS: Long Term Supports and Services

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

MAT: Medication Assisted Treatment (see MOUD)

MCBAP: Michigan Certification Board for Addiction Professionals

MCO: Managed Care Organization

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

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

NMRE: Northern Michigan Regional Entity (PIHP Region 2)

OC: Operations Council

OHCA: Organized Health Care Arrangement

OIG: Office of Inspector General

OMT: Opioid Maintenance Treatment - Methadone

OP: Outpatient

OROSC: Office of Recovery Oriented Systems of Care (State SUD Office)

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

PS: Protective Services

PTSD: Post-Traumatic Stress Disorder

QAPIP: Quality Assurance and Performance Improvement Plan

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

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

SIS: Supports Intensity Scale

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

TANF: Temporary Assistance to Needy Families

UR/UM: Utilization Review or Utilization Management

VA: Veterans Administration

WM: Withdrawal Management (formerly "detox")

YTD: Year to Date

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

MSHN
Mid-State Health Network

FY2021 FINANCIAL AUDIT REPORT

Background

Pre-Paid Inpatient Health Plans (PIHPs) must have an annual financial review by an independent auditing firm and must comply with the laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not limited to: the Medicaid Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP). The independent auditing firm is retained by and responsible to the Board of Directors. The auditing firm's responsibility is to express an opinion on whether MSHNs financial statements are free from material misstatement.

The Financial Audit was conducted in January 2022 for fiscal year 2021 by Roslund Prestage & Company. The report is due to MDHHS by March 31, 2022.

The opinion rendered by Roslund Prestage & Company, is that MSHNs financial statements present fairly, in all material respects, the respective financial position of the business-type activities, each major fund, and the aggregate remaining fund information of the Entity, as of September 30, 2021, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Recommended Motion:

The MSHN Board of Directors receives and files the Fiscal Year 2021 Financial Audit of Mid-State Health Network completed by Roslund, Prestage and Company.

May 3, 2022

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

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

Independent Auditor's Report

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

Report on the Financial Statements

We have audited the accompanying financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Mid-State Health Network (the Entity), as of and for the year ended September 30, 2021, and the related notes to the financial statements, which collectively comprise the Entity's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinions

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities, each major fund, and the aggregate remaining fund information of the Entity, as of September 30, 2021, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the required supplementary information, as identified in the table of contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in

Mid-State Health Network
Statement of Net Position
September 30, 2021

	Enterprise	Internal Service	
	Behavioral Health Operating	Medicaid Risk Reserve	Total Proprietary Funds
Current assets			
Cash and cash equivalents - unrestricted	$ 56,763,617	$ -	$ 56,763,617
Cash and cash equivalents - restricted	-	42,959,798	42,959,798
Investments - restricted	-	2,998,332	2,998,332
Due from affiliate partners and other agencies	43,747,787	-	43,747,787
Due from MDHHS	14,191,489	-	14,191,489
Due from other funds	-	4,604,800	4,604,800
Prepaid expenses	69,085	-	69,085
Total current assets	114,771,978	50,562,930	165,334,908
Noncurrent assets			
Capital asset being depreciated, net	176,388	-	176,388
Total noncurrent assets	176,388	-	176,388
Total assets	114,948,366	50,562,930	165,511,296
		PY Total assets	134,987,014
Current liabilities			
Accounts payable	6,101,372	-	6,101,372
Accrued wages and related liabilities	109,611	-	109,611
Due to affiliate partners	115,059	-	115,059
Due to MDHHS	39,170,875	-	39,170,875
Due to other funds	4,604,800	-	4,604,800
Unearned revenue	59,003,074	-	59,003,074
Compensated absences	347,825	-	347,825
Total current liabilities	109,452,616	-	109,452,616
		PY Total liabilities	84,312,049
Net position			
Net investment in capital assets	176,388	-	176,388
Restricted for risk management	-	50,562,930	50,562,930
Restricted local - PBIP	5,335,083	-	5,335,083
Unrestricted	(15,721)	-	(15,721)
Total net position	$ 5,495,750	$ 50,562,930	$ 56,058,680
PY Total net position	4,738,812	45,936,153	50,674,965

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

Mid-State Health Network
Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended September 30, 2021

	Enterprise	Internal Service	
	Behavioral Health Operating	Medicaid Risk Reserve	Total Proprietary Funds
Operating revenues			
State funding			
Medicaid capitation	$ 505,664,866	$ -	$ 505,664,866
Healthy Michigan	109,599,268	-	109,599,268
Autism	59,047,434	-	59,047,434
PA2 revenues	3,678,138	-	3,678,138
DHS incentive	2,489,140	-	2,489,140
Incentive payments	6,314,893	-	6,314,893
Community grant - Substance use disorder	1,279,766	-	1,279,766
Total State funding	688,073,505	-	688,073,505
Federal funding			
Community grant	5,522,820	-	5,522,820
Prevention	1,960,036	-	1,960,036
State Opioid Response II	676,602	-	676,602
Michigan State Opioid Response	769,775	-	769,775
SUD - Tobacco	3,792	-	3,792
Partnerships for Success 2015-2020	43,972	-	43,972
Block grants	146,842	-	146,842
Total Federal funding	9,123,839	-	9,123,839
Contributions - Local match drawdown	3,140,208	-	3,140,208
Other operating revenues	53,200	-	53,200
Total operating revenues	700,390,752	-	700,390,752
		PY Operating revenues	633,065,951
Operating expenses			
Contractual obligations			
Funding for affiliate partners	616,270,761	-	616,270,761
HRA and IPA taxes	20,696,872	-	20,696,872
Local match expense	3,140,208	-	3,140,208
Total other contractual obligations	640,107,841	-	640,107,841
		PY Contractual obligations	571,832,931
Substance use services			
Prevention	4,227,043	-	4,227,043
Outpatient	11,217,572	-	11,217,572
Recovery Support	5,022,370	-	5,022,370
Medication-Assisted Treatment	4,968,280	-	4,968,280
Withdrawal management	2,821,172	-	2,821,172
Residential	13,669,108	-	13,669,108
Women's Specialty	3,981,459	-	3,981,459
Other contractual agreements	1,357,592	-	1,357,592
Total substance use services	47,264,596	-	47,264,596
		PY Substance use services	51,207,586
Administrative expense			
Board per diem	26,460	-	26,460
Depreciation expense	81,927	-	81,927
Dues and memberships	4,730	-	4,730
Insurance	29,425	-	29,425
Other	3,563	-	3,563
Professional contracts	717,504	-	717,504

Mid-State Health Network
Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended September 30, 2021

	Enterprise	Internal Service	
	Behavioral Health Operating	Medicaid Risk Reserve	Total Proprietary Funds
Rent and utilities	$ 80,790	$ -	$ 80,790
Salaries and fringes	5,642,873	-	5,642,873
Software maintenance	914,045	-	914,045
Supplies	143,458	-	143,458
Travel and training	18,862	-	18,862
Total administrative expense	7,663,637	-	7,663,637
		PY Administrative expense	7,655,098
Total operating expenses	695,036,074	-	695,036,074
Operating income (loss)	5,354,678	-	5,354,678
Non-operating revenues (expenses)			
Interest income	7,060	22,568	29,628
Investment income	-	(591)	(591)
Non-operating income (loss)	7,060	21,977	29,037
Income before transfers	5,361,738	21,977	5,383,715
Transfers in (out)	(4,604,800)	4,604,800	-
Change in net position	756,938	4,626,777	5,383,715
PY Change in net position	229,150	2,292,374	2,521,524
Net position, beginning of year	4,738,812	45,936,153	50,674,965
Net position, end of year	$ 5,495,750	$ 50,562,930	$ 56,058,680
PY Net position, end of year	4,738,812	45,936,153	50,674,965

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

NOTE 8 - UNEARNED REVENUE

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

Description	Amount
Medicaid Savings Carryforward	50,563,013
PA2 Carryforward	9,120,783
Medicaid Savings Carryforward Adjusted	(680,722)
Total	59,003,074

NOTE 9 - NET INVESTMENT IN CAPITAL ASSETS

As of September 30th, the composition of net investment in capital assets was comprised of the following:

Net investment in capital assets	Amount
Capital asset being depreciated, net	176,388

NOTE 10 – RETIREMENT AND OTHER POST EMPLOYMENT BENEFIT PLANS

Defined Contribution Retirement Plan – 401(a)

Plan Description

The Entity offers all employees a retirement plan created in accordance with the Internal Revenue Code, Section 401(a). The assets of the plan were held in trust for the exclusive benefit of the participants (employees) and their beneficiaries. MERS acts as the custodian for the plan and holds the custodial account for the beneficiaries of this Section 401(a) plan.

The assets may not be diverted to any other use. MERS are agents of the employer for purposes of providing direction to the custodian of the custodial account from time to time for the investment of the funds held in the account, transfer of assets to or from the account and all other matters. Plan balances and activities are not reflected in the Entity's financial statements.

Plan provisions are established or amended by Board resolution. This plan is funded by both employer and employee contributions.

Eligibility

All full time employees are eligible (excluding leased, independent contractors and part time employees).

Contributions

The Entity contributes 10% of the employee's compensation (defined as W2 wages) regardless of the employee contribution.

Normal Retirement Age & Vesting

Retirement age as defined by the plan is 60 years of age. Contributions are 100% vested immediately.

Forfeitures

Contributions are 100% vested immediately therefore there are no forfeitures of contributions.

Funding

For the year ended September 30th, employer contributions amounted to $411,045 and employee contributions amounted to $149,400. The outstanding liability to the plan at year-end was $0.

Deferred Compensation Retirement Plan – 457(b)

Plan Description

The Entity offers all employees a deferred compensation plan created in accordance with the Internal Revenue Code, Section 457. The assets of the plan were held in trust, as described in IRC Section 457(b) for the exclusive benefit of the participants (employees) and their beneficiaries. MERS acts as the custodian for the plan and holds

years.

The Entity's coverage limits are $10,000,000 for general liability, $10,000,000 for public officials' liability, and approximately $1,260,075 for personal property.

Medicaid Risk Reserve
The Entity covers the costs up to 105% of the annual Medicaid and Healthy Michigan contract. The entity and MDHHS equally share the costs between 105% to 110% of the contract amounts. Costs in excess of 110% of the contract are covered entirely by MDHHS.

The Entity has established a Medicaid Risk Reserve Fund, in accordance with Michigan Department of Health and Human Services guidelines, to assist in managing risk under the terms of its contract with the MDHHS.

NOTE 14 – CONTINGENT LIABILITIES

Under the terms of various federal and state grants and regulatory requirements, the Entity is subject to periodic audits of its agreements, as well as a cost settlement process under the full management contract with the State of Michigan. Such audits could lead to questioned costs and/or requests for reimbursement to the grantor or regulatory agencies. Cost settlement adjustments, if any, as a result of compliance audits are recorded in the year that the settlement is finalized. The amount of expenses which may be disallowed, if any, cannot be determined at this time, although the Entity expects such amounts, if any, to be immaterial.

NOTE 15 – ECONOMIC DEPENDENCE

The Entity receives over 90% of its revenues from the State of Michigan directly from MDHHS.

NOTE 16 - UPCOMING ACCOUNTING PRONOUNCEMENTS

GASB Statement No. 87, *Leases*, was issued by the GASB in June 2017 and will be effective for the Entity's fiscal year September 30, 2022. The objective of this Statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. This Statement increases the usefulness of governments' financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this Statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities.

GASB Statement No. 96, *Subscription-based Information Technology Arrangements,* was issued by the GASB in May 2020 and will be effective for the Entity's fiscal year ending September 30, 2023. This Statement provides guidance on the accounting and financial reporting for subscription-based information technology arrangements (SBITAs) for government end users (governments). This Statement (1) defines a SBITA; (2) establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability; (3) provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA; and (4) requires note disclosures regarding a SBITA. To the extent relevant, the standards for SBITAs are based on the standards established in Statement No. 87, *Leases,* as amended.

Harm Reduction:

Reducing Stigma & Saving Lives

May 3, 2022

Dani Meier, PhD, MSW, MA
Chief Clinical Officer

MSHN
Mid-State Health Network

Historical Context: The War on Drugs

- Criminalization & stigmatization of a disease.
- Militarization of local & federal police forces.
- Social programs including treatment defunded.
- Mandatory sentencing disparities (5 years for 5 gr. crack & 500 gr. powder cocaine)
- Racially disparate mass incarceration from 350,000 in 1970s to 2.3 million in 2017.

And yet...

- American cities are not safer.
- U.S. overdose deaths increased **over 100,000** annually.
- Overdose deaths rising fastest for **Black Americans** & other POC.
- As marijuana's decriminalized, cannabis arrests remain **3.8X higher** for Black Americans.
- Jail/prison left millions with criminal history excluding them from opportunities in education, the workforce, housing, etc.

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What's Harm Reduction?

"Harm reduction is an *evidence-based approach* to reduce the negative ... public health impacts of behavior associated with alcohol and other substance use *at both the individual and community levels*."

Principles of Harm Reduction

Treat people who use drugs (PWUD) with dignity, not shame.

Accept that drug use may occur despite risk.

Avoid pre-defined outcomes (like abstinence).

Promote connection & hope.

Focus on reducing harm & loss of life.

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Tools of Harm Reduction

- Education on SUD, safe use & infectious disease risks
- Offer links to SUD treatment and/or primary care
- Provide Narcan & fentanyl strips
- Syringe service programs (SSPs)
- Overdose Prevention Centers (OPCs)

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Harm Reduction (SSPs & OPCs)

MYTHS:

1. MYTH: Harm Reduction "encourages" drug use.
2. MYTH: Harm reduction programs increase danger to nearby residents.
3. MYTH: SSPs/OPCs increase crime in neighborhoods where they are located.
4. MYTH: It costs taxpayers too much.

FACTS:

1. FACT: SSP users are 5X more likely to enter SUD treatment & 3X more likely to stop using drugs. OPC users are 30% more likely to enter treatment.
2. FACT: OPCs reduce public use & reduce used needles discarded in public areas.
3. FACT: There's no documented increase in crime. NIMBY objections evaporate.
4. FACT: Studies show that for every dollar spent on harm reduction, >$2 is saved in public health costs

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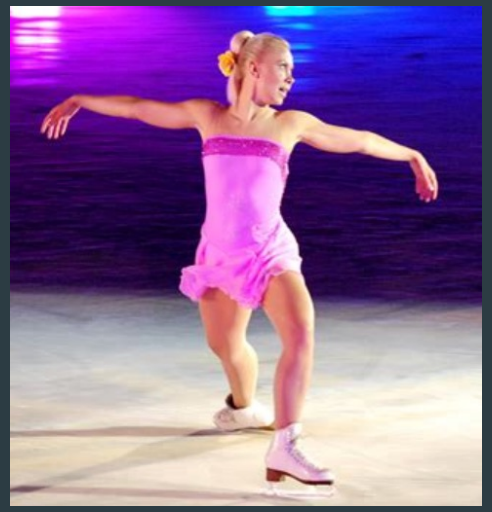
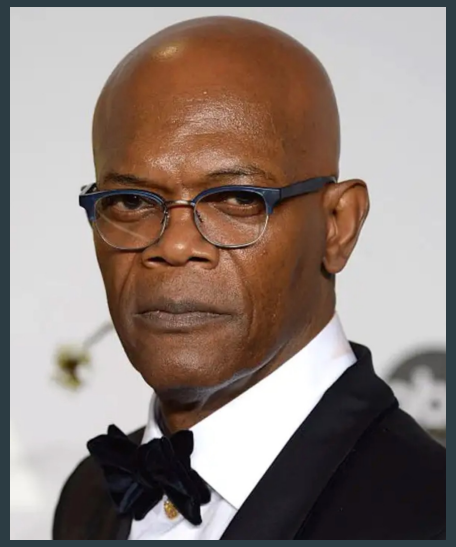
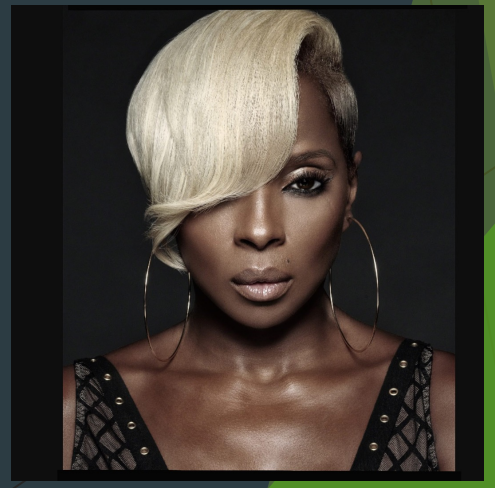
Cost Savings & Years of Life Saved: A 10-year Assessment in Vancouver

- Impact on survival, rates of HIV & hep C infection, referrals to MAT & costs:
  - 10 year estimated cost savings to Vancouver
    - **>$18 million**
  - 10 year estimate of life-years saved
    - **1,175 years**

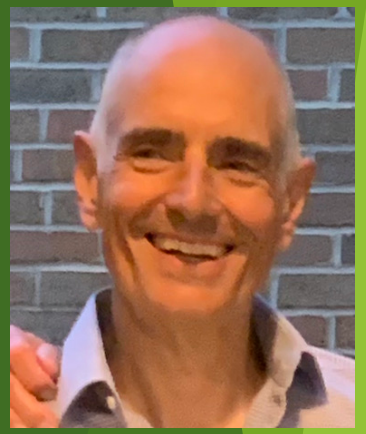
Harm reduction allows people to recover, live productively & share their talents...

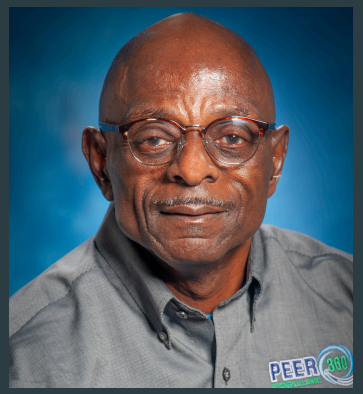






In our region, people recover to share their gifts with loved ones & their communities ...











***Note**: These photos are shared thanks to the generosity, courage & permission of the people pictured here.*

Portugal's Example of Harm Reduction

With 1% of the population addicted to heroin & one of the highest OD rates in Europe, Portugal decriminalized ALL drugs in 2001:

- Overdose deaths dropped by 80%
- No rise in overall drug use
- Drop in adolescent use
- Drop in "problematic drug use" (injecting & dependent use)
- People in SUD treatment rose 60% - 1998-2011
- New HIV cases among PWUD dropped from 1,575 in 2000 to 78 in 2013
- Decrease by 60% of drug arrests, no rise in admin. offenses 80% of which were "non-problematic"
- Decrease in prison population for drug offenses from 44 to 24%
- Increase in overall interdiction of illicit drugs

Another Myth: *"People don't recover"*

Harvard Study (2017)

- 10% of American Adults have experienced a SUD
- 9.1% of them are in recovery

CDC Study (2018)

- 3 out of 4 who have a SUD recover

Fact: Most people recover.

Harm Reduction creates opportunity: A chance for change & recovery.

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Syringe Services Programs

What is a Syringe Services Program (SSP)?

A community - based public health program that provides services to prevent drug use, HIV, and Viral Hepatitis

SSPs provide services such as:[1,2]

- Free clean needles and syringes
- Safe disposal of needles and syringes
- HIV and hepatitis testing and linkage to treatment
- Hepatitis A and B vaccination

SSPs also provide:

- Referral to substance use disorder treament
- Overdose treatment and education

Have SSPs been successful in Michigan communities?

In 2017, Michigan SSPs directly served nearly **8,000** clients

distributing over **672,000** clean needles.

Nearly **1 in 4** (24%) Michigan SSP clients referred to substance use treatment received treatment

SSPs do not increase drug use or crime

How Do SSPs Benefit Communities and Public Safety?

1 SSPs reduce needlestick injuries

SSPs **reduce needlestick injuries** among first responders and the public by providing a proper place to throw out used syringes.

After the start of a SSP in Portland, Oregon, research showed

66 % drop

in the number of syringes thrown out in an unsafe way [3]

2 SSPs Save Money

SSPs **save health care dollars** by preventing infections

Testing linked to hepatitis C treatment can save an estimated

320,000 lives. [1]

Estimated lifetime cost of treating one person living with HIV

> **$400,000** [1]

3 SSPs Reduce new HIV and Viral Hepatitis Infections [1]

SSPs **reduce new HIV and viral hepatitis infections** by decreasing the sharing of syringes and other injection tools.

New HIV infections have dropped by

80 percent

among person who inject drugs since the start of SSPs in the late 1980's [4]

SSP clients are

5 times

more likely to enter a drug treatment program than non-clients. [5]

Sources:

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MDHHS Michigan Department of Health & Human Services

Published: July 2018

Syringe Services Programs (SSPs) Fact Sheet

The opioid crisis is fueling a dramatic increase in infectious diseases associated with injection drug use.

Reports of acute hepatitis C virus (HCV) cases rose 3.5-fold from 2010 to 2016.[1]

The majority of new HCV infections are due to injection drug use.

Over 2,500 new HIV infections occur each year among people who inject drugs (PWID).[2]

Syringe Services Programs (SSPs) reduce HIV and HCV infections and are an effective component of comprehensive community-based prevention and intervention programs that provide additional services. These include vaccination, testing, linkage to infectious disease care and substance use treatment, and access to and disposal of syringes and injection equipment.

Helps prevent transmission of blood-borne infections

For people who inject drugs, the best way to reduce the risk of acquiring and transmitting disease through injection drug use is to stop injecting drugs. For people who do not stop injecting drugs, using sterile injection equipment for each injection can reduce the risk of acquiring and transmitting infections and prevent outbreaks.

SSPs are associated with an estimated 50% reduction in HIV and HCV incidence.[3] When combined with medications that treat opioid dependence (also known as medication-assisted treatment), HCV and HIV transmission is reduced by over two-thirds.[3,4]

SSPs serve as a bridge to other health services, including HCV and HIV testing and treatment and medication-assisted treatment for opioid use disorder.[5]

Helps stop substance use

The majority of SSPs offer referrals to medication-assisted treatment,[6] and new users of SSPs are five times more likely to enter drug treatment and three times more likely to stop using drugs than those who don't use the programs.

SSPs prevent overdose deaths by teaching people who inject drugs how to prevent overdose and how to recognize, respond to, and reverse a drug overdose by providing training on how to use naloxone, a medication used to reverse overdose. Many SSPs provide "overdose prevention kits" containing naloxone to people who inject drugs.[7-12]

Helps support public safety

SSPs have partnered with law enforcement, providing naloxone to local police departments to help them respond and prevent death when someone has overdosed.[13]

SSPs also protect first responders and the public by providing safe needle disposal and reducing the presence of discarded needles in the community.[14-19]

In 2015, CDC's National HIV Behavioral Surveillance System found that the more syringes SSPs distributed per the number of people who inject drugs in a geographic region, the more likely the people who inject drugs in that region were to dispose of used syringes safely.[20]

Studies in Baltimore[21] and New York City[22] have also found no difference in crime rates between areas with and areas without SSPs.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
March/April 2022

Congratulations to our partners at Newaygo County Community Mental Health on achieving renewal of their accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF).

After 30 years of public service, John Obermesik (Chief Executive Officer of Community Mental Health for Central Michigan [CMHCM]) has announced his intention to retire at the end of June 2022. John has been a strong collaborator in our region. I have deeply appreciated his contributions and partnership over the years and will miss his presence and perspectives. The CMHCM board has initiated a CEO search process.

LifeWays CMH (Jackson/Hillsdale) has announced new branding and a new website, lifewaysmi.org. Check it out!

PIHP/REGIONAL MATTERS

1. COVID-19 MSHN Internal Operations Status:

- MSHNs suite of four offices within the Michigan Optometric Association (MOA) building have been closed since March 16, 2020.
- All MSHN personnel remain engaged in the work of supporting our region, its providers, and beneficiaries. All MSHN personnel are working from remote locations 100% of the time, except for three positions that are office or field based.
- Mid-State Health Network internal operations will continue to be performed and conducted via away from office (remote) work arrangements for an indeterminate period, for all employee classifications unless specific operational or business requirements mandate that a specific employee or group of employees be deployed for in-person work at either the MSHN office location(s) or at provider or community-based site(s). We remain in regular communication directly with MSHN staff and through leadership team members.
- MSHN Leadership has prepared a Post-Pandemic Operations Plan, which is currently in draft form, and has been distributed for MSHN staff review, input and feedback. The plan contains general post-pandemic operations principles, a position-by-position analysis and post-pandemic deployment plan (many of which continue an all-remote arrangement) and revised MSHN/Employee Remote Work Agreement. The plan is based in part on information gathered from an employee and a provider survey of preferences and considerations and Leadership analysis of MSHN business requirements. MSHN is committed to providing our employees with at least 60-days' notice of change(s) in operating posture and parameters.

2. **MSHN Regional Operations Status:**

- CMHSPs: All CMHSPs in the region remain functional and capable of delivering all essential services and supports to beneficiaries, families, and communities. CMHSPs in the region are at various tiers and in various stages of office-based services re-engagement. Most are continuing with a blend of telehealth and in-person services.
- SUD Prevention, Treatment and Recovery Providers: All SUD providers remain functional and capable of delivering all essential services and supports to beneficiaries, families, and communities. In all cases, services and supports that can be delivered telephonically or by means of video or other alternatives to in-person/face-to-face have been developed and deployed (as authorized under State guidance).

3. **Regional Provider Staffing Crisis Stabilization Update:**

At its March 2022 meeting, the MSHN Board approved the allocation of up to $13M in MSHN resources for Provider Staffing Crisis Stabilization activities. MSHN's regional guidance is located on the MSHN Coronavirus website at this link. MSHN will provide a detailed summary of how these funds have been used when the program ends. As an update through March 30, 2022, MSHN's region approved requests from 18 providers totaling approximately $3.3M.

4. **Office Building Update:**

The MSHN post-pandemic operations plan referenced above will necessitate changes to how MSHN utilizes its physical space. The current lease for MSHN-occupied space terminates, if not renewed, September 2022. MSHN currently occupies four suites on two floors of the building owned by the Michigan Optometric Association (MOA). The current space is allocated among the four suites as follows: (Upper floor: Suite B = 1,200 sf, Suite C= 1,353 sf; Lower floor: Suite E = 1,320 sf, Suite F (main) = 1,500 sf) and current lease per sf cost is $13.75/sf. Given how the space is currently physically configured, it is designed for 20-25 people but currently MSHN has 43 employees. Physical (social) distancing will still be needed in a post-pandemic world and reducing the amount of space MSHN occupies would make continuation of social distancing practices (even while continuing many employees in remote or hybrid arrangements) extremely difficult. I am in discussion with MOA, MSHN's landlord, about maintaining the existing MSHN footprint for reduced monthly square footage rent. If an accommodation can be reached, MSHN will bring a proposed lease arrangement to the MSHN governing board for consideration and approval late summer or early fall.

5. **National Conference:**

MSHN sponsored the attendance of Kerin Scanlon at the National Council on Mental Wellbeing Conference in Washington, DC April 11-13. Thanks to Kerin for her representation of Mid-State Health Network in Washington!

6. **Performance Bonus Incentive Earned:**

Mid-State Health Network has been informed by the Michigan Department of Health and Human Services that it has earned a total of $5,125,371 in performance bonuses for the fiscal year that ended 09/30/2021. The performance bonus is earned through MSHN complex care collaboration with the Medicaid Health Plans (MHPs) in our region, and on joint (PIHP and MHP) performance measures along with several PIHP-only dimensions. The MSHN Operating Agreement requires that MSHN distribute 100% of the MSHN-earned performance bonus to the region's twelve CMHSPs. CMHSP distributions may be retained by CMHSPs as

restricted local funding, which increases flexibility to invest in public behavioral health services in their communities and to serve individuals not covered by Medicaid or other funding.

This accomplishment is due in large measure to the efforts of MSHN staff and to our collaborations with CMHSPs. MHPs, and other stakeholders in the region. Thank you to all involved in this achievement!

7. **Pace, Frequency, and Breadth of MDHHS Change Initiatives:**

I recently made the Executive Committee aware that the number and breadth of MDHHS-initiated change initiatives is significant and pressuring available internal resources at MSHN (and across the region). Some of these initiatives include, but are not limited to: Opioid Health Homes, Certified Community Behavioral Health Clinics, Healthcare Information Exchange, Healthcare Data Analytics, expanded MDHHS and Health Services Advisory Group Surveys, American Society of Addiction Medicine Continuum of Care Tool installation and analyses, electronic consent management development and installation, Provider Stability efforts, Conflict Free Access and Planning initiative, financial reporting requirement changes (encounter quality initiative, standard cost allocation model, tiered rates for psychiatric inpatient and specialized residential settings, and more), child and adolescent behavioral health services improvements, racial and ethnic health disparity and inequity improvements, the MICAL and national 988 crisis lines, inpatient psychiatric bed registry, MDHHS customer relationship management software implementation, and many others. MSHN continues to be heavily involved in all of these initiatives. My purpose in including this in my board report is to inform the board that, with staffing shortages and provider stabilization activities across the region, resources are wearing very thin.

8. **Southwest Michigan Behavioral Health (SWMBH) Announces Withdrawal from MI Health Link Demonstration Project:**

Southwest Michigan Behavioral Health, the PIHP covering 8 counties in southwest Michigan, has announced that it is withdrawing from the MI Health Link demonstration effective 12/31/2022. SWMBH has always and will continue to manage the Medicaid behavioral health benefits for the specialty populations with severe mental illness, serious emotional disturbance, autism spectrum disorders, intellectual and developmental disabilities, and substance use disorders after December 31, 2022. The primary reasons cited for this decision include the number and pace of MDHHS-initiated changes (also addressed for MSHN above) that require additional resources to effectively carry out, and the level of resources required in, the MI Health Link initiative to implement effectively for a very small number of beneficiaries. SWMBH was accredited by the National Committee on Quality Assurance only for their MI Health Link operations and has also decided not to pursue reaccreditation because of the resource intensity involved.

9. **Michigan Legislative System Redesign Bills - Update:**

A brief email update was provided to the MSHN Board on March 15 related to amendments to House Bills authored by Rep. Mary Whiteford. Here is a link to testimony provided by the CMH Association (which begins at about the 29:00-minute mark). Other than the update previously provided, I am not aware of any additional official actions taken up by the Legislature.

Senator Debbie Stabenow participated in an event at Clinton-Eaton-Ingham Community Mental Health where she made a public statement of opposition to the Michigan Senate proposal. Following is an article that appeared in Gongwer News Service 03/18/2022:

U.S. Sen. Debbie Stabenow is opposed to Senate Majority Leader Mike Shirkey's proposed integration of physical and mental health services legislation, saying it would upend her efforts on the national level to build up the Certified Community Behavioral Health Clinics program.

Ms. Stabenow (D-Lansing) told reporters during a Friday event in Lansing that the proposal by Mr. Shirkey (R-Clarklake) "would takes us back decades" and undermine services provided under the growing network of CCBHCs in Michigan.

"He wants to privatize mental health, basically, and have the insurance companies rather than community mental health run the services," Ms. Stabenow said. "They're very targeted only at severely mentally ill as opposed to supporting everyone in the community, whether it's children, whether it's seniors, whether it's someone with addiction."

She was referring to SB 597 and SB 598, which are awaiting a floor vote in the Senate. The bills would require the Department of Health and Human Services to develop and implement a phased-in plan to integrate the administration and provision of Medicaid physical health care service and behavioral health specialty services for behavioral health populations through the creation of specialty integrated plans. This would begin January 1, 2023 and extend through 2030.

"It is exactly the opposite approach as what I've been building now, for the last number of years," Ms. Stabenow said.

Her remarks came during a visit to the Community Mental Health Authority of Clinton, Eaton and Ingham counties. She was at the facility with officials touting $3.37 million in federal funding for a crisis stabilization unit to provide short-term behavioral health services to those in need.

The approach Mr. Shirkey is pursuing, she said, is different than CCBHC program that she has championed in Congress since the late 2000s and was signed into law in 2014.

In the 2014 act an eight-state, two-year demonstration project was established for states to develop CCBHCs.

The CCBHCs provide 24-hour crisis care, with comprehensive mental health and addiction outpatient services. The facilities are required to engage in partnerships with groups including hospitals and law enforcement agencies. They are also reimbursed based on providers' actual costs.

There are currently 33 CCBHCs in Michigan and more than 430 overall across 40 states.

"The Shirkey bill goes in the complete opposite direction," Ms. Stabenow said. "We're building ... a quality community system and crisis services, working with law enforcement and so on, and it would basically undercut all the funding."

A total of $348 million in federal funding would be provided for under SB 714 , the supplemental appropriations component to fund the proposed changes Mr. Shirkey is pushing.

Mr. Shirkey during a Monday appearance on JTV's "The Bart Hawley Show" defended his proposal, saying he hopes to bring it up for a vote soon.

"If there ever was a nonpartisan issue, it needs to be this one, and quite frankly that's why I'm holding it in the Senate," Mr. Shirkey said. "We could get it out with Republican votes, but it needs to be bipartisan."

He said he has the Republican votes in both chambers but wants to wait until there is some bipartisan support to proceed, adding he believes it is close to a vote.

Mr. Shirkey also called most of the arguments in opposition to his proposal "strawman arguments."

Supporters have said the proposed changes would simplify the process and provide care in a way that mirrors those with private insurance, while opponents have contended it would create new hurdles in obtaining care while coming up short on oversight and accountability.

Stakeholders in support have also said the changes would better reflect current times, whereas decades ago mental health was not treated with the same urgency as physical health.

Opponents have also stressed a solution should build on the existing mental health system in the state.

Ms. Stabenow's opposition was largely in line with concerns raised by opponents of Mr. Shirkey's proposal during committee hearings on the bill last year.

During her announcement, Ms. Stabenow listed statistics she said prove the effectiveness of CCBHCs.

Data from the Department of Health and Human Services stated that those who have used CCBHC services had 63.2 percent fewer emergency room visits for behavioral health problems or crises. The department also reported those utilizing the services spent 60.3 percent less time in jails and there was a 40.7 percent reduction in homelessness among such individuals.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

10. MDHHS Behavioral Health Reorganization:

MDHHS announced on 3/3/2022 (effective 3/21/22) a number of significant changes to the internal organization of Behavioral Health and Substance Abuse Services, and the current Behavioral Health and Developmental Disabilities Administration (BHDDA) is being eliminated and functions moved to other areas. The press release is at the bottom of this message.

MDHHS held a briefing for PIHPs and CMHSPs late in the day 03/02/2022, during which MDHHS stated that no BHDDA employee will lose their job but may be transferred to new/different roles within the new organizational structure. MDHHS also stated that behavioral health services are now "exactly on par with physical health services." Director Hertel stated that this reorganization has nothing to do with legislative proposals for system redesign.

Please recognize that not all answers to questions you may have are known at this time, and many questions will remain that can only be addressed as this reorganization progresses.

- Farah Hanley, who has been senior deputy of financial operations at MDHHS, has been promoted to MDHHS Chief Deputy Director for Health, replacing Dr. Joneigh Khaldun (effective Monday, March 7, 2022).

- Health and Aging Services to be renamed Behavioral and Physical Health and Aging Services Administration (BPHASA).
    - Recall that a few months ago, the Medical Services Administration (MSA) was merged with Aging Services within MDHHS, resulting in a new "Health and Aging Services Administration."
    - The current Behavioral Health and Developmental Disabilities Administration will have many of its functions distributed to other parts of MDHHS (some of which are detailed below) and management functions will be merged into the newly named Behavioral and Physical Health and Aging Services Administration.
        - Kate Massey, former MSA Director and now Director of HASA will oversee the newly named BPHASA.
        - Al Jansen will be a special advisor to MDHHS Director Hertel.
    - The state hospital administration will also be moved to the BPHASA and will continue to be led by George Mellos, MD.

- The Bureau of Children's Coordinated Health Policy and Supports was created within MDHHS, reporting to the Senior Chief Deputy Director. This Bureau will be led by Lindsay McLaughlin.
    - A number of new divisions (Office of the Advocate for Children, Youth, and Families; Contract Management and Quality Monitoring; and Service Development and Implementation) are being created.
        - Note there will be a new area focused on MI KIDS NOW (KB lawsuit settlement) implementation.
        - Note that there will be a new children's clinical review team for complex cases/care management supports to the field.
    - The Autism Council will be an advisory council to the new Bureau.
    - Pertinent BHDDA staff will be transferred to positions in the new Bureau.

- Substance Use Disorders
    - The Office of Recovery Oriented Systems of care will be eliminated.
    - Substance abuse and gambling prevention will move to the Bureau of Health and Wellness under the Division of Chronic Disease within the Public Health Administration.
    - Substance Abuse Treatment will be within the BPHASA organization. (See below)
    - OROSC Director Larry Scott is being moved to the State Hospital Administration to focus on integration of SUD treatment in the State Hospitals.

- Community Based Services (typically CMH services)
    - Bureau Director Jeff Wieferich will report to Kate Massey (currently reports to Al Jansen).
    - New "Crisis Services and Stabilization Section" to be created.
    - Adult Home and Community Based Services division (new) will be headed by Belinda Hawks.
    - Federal Compliance (Lyndia Deromedi), SUD Treatment (Angie Smith-Butterwick), and Community Based Practices and Innovation (Brenda Stoneburner) will report to Belinda Hawks unit.
    - Division of Contracts and Quality management (Jackie Sproat) will report to Jeff Wieferich.

- Behavioral Health Customer Service (Kendra Binkley) will merge with existing Customer Service Division within the Bureau of Medicaid Care Management and Customer Services (Penny Rutledge).
- A new Service Delivery Transformation Section will be organized with BPHASA under the Office of Strategic Partnerships and Medicaid Administrative Services (Erin Emerson).
  - This is where Certified Community Behavioral Health Clinics, Opioid and Behavioral Health Homes, and other initiatives will be managed from.

- Administration, quality, contracting, performance monitoring, etc.
  - No solid information released but expect many of these areas (and others) to merge with existing HASA (now BPHASA) areas, including contract negotiations and performance monitoring.
  - General statement that "certain behavioral health operations will be aligned within BPHASA to avoid duplication, including customer services, managed care contract management, site reviews and financial management."

Once again, please recognize that not all answers are known at this time, and many questions will remain that can only be addressed as this reorganization progresses. If you have specific questions or concerns, please let me know and I'll try to pursue answers. Things are understandably a bit chaotic, uncertain, and unclear at the moment.

11. Michigan Health Integration Updates:

I have been reporting on the Michigan Health Integration Activities and many other BHDDA initiatives. Please see the attached April 2022 update provided by BHDDA on the status of these many initiatives directly related to State Integration Initiatives. Also note that MSHN is directly involved in these initiatives.

12. Michigan Psychiatric Care Improvement Project:

I have been reporting on the Michigan Psychiatric Care Improvement Project and many other BHDDA initiatives. Please see the attached April 2022 update provided by BHDDA on the status of these many initiatives directly related to Psychiatric Care Improvement. Also note that MSHN is directly involved in these initiatives.

13. MDHHS Announces new Federal COVID website and guidance:

On March 30th, the United States government launched COVID.GOV. Many of the COVID-19 related resources and questions you may have are now located on one simple site. With a click of a button, you and your loved ones will be able to access:

- Latest CDC data on the level of COVID-19 in your community
- Free masks
- Locations to receive a vaccine or booster
- How to order 2 sets of 4 free at-home rapid tests
- Insurance reimbursement opportunities
- Guidance on travel
- Locations of 20,000+ free testing sites

- New test-to-treat sites, where you can get tested and if possible, get lifesaving treatments right away. There are currently 2,000 of these sites across the country, including local pharmacy clinics, community health centers and health clinics that serve veterans and families.

COVID.GOV will be available in English, Spanish, and Simplified Chinese and is accessible for those using assistive technologies.

FEDERAL/NATIONAL ACTIVITIES

14. **GAO Report on Veteran Suicides:** (Attribution to Capitoline Consultants)

The Government Accountability Office (GAO) has released a report entitled *Military Suicide: Preliminary Observations on Actions Needed to Enhance Prevention and Response Affecting Certain Remote Installations* (GAO-22-105888). The report notes that "Servicemembers assigned to remote locations outside the contiguous U.S. can experience isolation, less access to mental health resources, and other challenges that may increase their suicide risk. The DOD suicide prevention and response efforts have faced challenges, according to GAO's preliminary analysis. These include assessing suicide risk at remote installations outside the contiguous U.S. (OCONUS), implementing key prevention activities, integrating prevention in primary care, and providing response guidance and training for key personnel." The report provides the following points:

Suicide risk at remote OCONUS installations. GAO's preliminary analysis suggested that remote OCONUS installations accounted for a slightly higher proportion of reported suicide attempts, but a lower proportion of reported suicide deaths relative to the proportion of servicemembers assigned to these locations in 2016-2020. DOD and military service officials stated that suicide deaths at OCONUS installations may be lower because servicemembers assigned to installations outside the U.S. have limited access to non-military issued firearms. Separately, DOD-, service-, and installation-level officials GAO interviewed identified risk factors for suicide and related challenges at remote OCONUS installations, such as less access to mental health services and increased isolation. However, DOD has not fully assessed suicide risk at these installations. Establishing a process to do so could enhance related suicide prevention efforts.

Policies, programs, and activities. DOD and the military services have established suicide prevention policies, programs, and activities—such as training and mental health resources—for servicemembers and dependents, including those assigned to remote OCONUS installations. However, gaps exist in implementation. By establishing oversight mechanisms, these services may have greater assurance that such activities are implemented across all installations, including remote OCONUS locations.

Privacy protection and suicide prevention in primary care. DOD and the military services have established privacy protections for servicemembers and dependents seeking suicide prevention care. DOD has also taken steps to integrate suicide prevention into primary care by establishing screening requirements and embedding behavioral health personnel in some primary care clinics. However, GAO's preliminary analysis found that DOD has experienced staffing shortages for these personnel, in part because it has not developed a strategy to address hiring challenges. By developing such a strategy, DOD can enhance the provision of behavioral health care to servicemembers and dependents, including at remote OCONUS installations.

Guidance and training for key personnel. DOD and the military services have established some suicide response guidance and training for key personnel, but gaps exist. For example, DOD has established guidance that fully addresses commanders' response to suicide deaths, but not suicide attempts. Further, according to GAO's preliminary analysis, DOD has not established statutorily required training for commanders on responding to suicide deaths and attempts. By establishing comprehensive suicide response guidance and training for commanders, DOD can better ensure that commanders are prepared to provide support to suicide attempt survivors and the bereaved."

15. **National Prevention Week:** (Attribution to Capitoline Consultants)

SAMHSA notes that May 8-14 is National Prevention Week (NPW), and on May 9 SAMHSA will do a virtual delivery via an interactive online conference platform. Participants will "hear from prevention leaders; learn about the latest developments in the areas of mental illness and substance abuse prevention, treatment, and recovery; network with other practitioners; and sharpen your skills." Registration and additional information are available at this link.

In addition, SAMHSA has announced that "each year, NPW includes daily themes to focus on major substance use and mental health topics. The 2022 daily themes are:

- May 9: Strengthening Community Resilience: Substance Misuse and Overdose Prevention
- May 10: Preventing Substance Use and Promoting Mental Health in Youth
- May 11: Preventing Suicide: Everyone Plays a Role
- May 12: The Talent Pipeline: Enhancing the Prevention Workforce
- May 13: Prevention is Everywhere: Highlighting Efforts Across Settings and Communities
- May 14: Celebrating Prevention Heroes"

16. **National Mental Health Awareness Month: (**Attribution to Capitoline Consultants)

SAMHSA and HUD have provided "a reminder of free webinars in May to celebrate *National Mental Health Awareness Month*. The webinars will take place each Wednesday. The target audience for these webinars is HUD staff, HUD grantees, partners, and stakeholders, as well as HUD residents." The webinar dates and topics are:

- May 4: Mental Health 101 – Overview of Mental Health Issues in the Modern World [Access Code: 4670871#]
- May 11: 988 is Not a Joke – National Suicide Prevention Hotline Launch [Access Code: 8477433#]
- May 18: Get Help – Reducing Stigma Associated with Mental Health [Access Code: 5955873#]
- May 25: Now What? – Mental Health Issues in Post-COVID America [Access Code: 6268721#]

Attendee Information: All conferences begin at 1:00 PM ET; you may join the conference 10 minutes prior. Join the Webex event and follow the prompts to connect audio by computer or telephone. Need to join via phone only? (888) 251-2949 or (215) 861-0694. For assistance, contact Webex Support: (888) 793-6118.

17. **Senate Finance Committee Report: "Mental Health Care in the United States: The Case for Federal Action":** (Attribution to Capitoline Consultants)

The Senate Finance Committee in March released a document entitled *MENTAL HEALTH CARE IN THE UNITED STATES THE CASE FOR FEDERAL ACTION.* The document includes a statement by the Committee Chairman that relates in part the following:

"I am partnering with Ranking Member on a major bipartisan effort to bring behavioral health care to the forefront of the U.S. health system by leveraging the programs under this Committee's jurisdiction, including Medicare, Medicaid, and the CHIP. Ten members of the Committee – five Democrats and five Republicans – have stepped forward to lead on policy areas that will be vital for a path forward, including: Senators Debbie Stabenow and Steve Daines on the behavioral health workforce; Senators Catherine Cortez Masto and John Cornyn on care integration, coordination, and access; Senators Michael Bennet and Richard Burr on mental health parity; Senators Ben Cardin and John Thune on telehealth; and Senators Tom Carper and Bill Cassidy on improving care for children and young people…From these testimonies, and staff review of relevant research, a number of facts have come to light as presented in this report. These facts can inform the Committee's work ahead:

> First, the mental health care system needs a strong workforce able to provide appropriate care where people are—whether that's in schools for youth, community clinics, residential programs, hospitals, or virtually by telehealth.
>
> Second, reforms must connect people to the care they need at the right time. That means improving connections between Americans experiencing symptoms or crisis and mental health and substance use disorder clinicians and primary care, removing barriers to tele-mental health care, and ensuring young people and adults get care early on before conditions worsen or escalate.
>
> Third, insurance companies must be held accountable for putting mental health care on par with physical care. Medicare, Medicaid, and CHIP must also deliver on the promise of parity. There can be no cutting corners in mental health and SUD coverage. Across all of these issues, there must be a recognition of the disparities that underlie our health care system: including racial, ethnic, sexual identity, and geographic disparities. These disparities contribute to inequities in mental health and SUD outcomes. Closing these gaps requires addressing disparities in access to care and coverage, and creating a more connected, inclusive and diverse mental health workforce.

This report marks the Finance Committee's next step in the bipartisan effort to understand the behavioral health care crisis in the U.S. and, further, to craft a legislative package, which the Committee intends to consider this summer. As I see it, the Committee's lodestar must be this: every American is able to access the mental health and substance use disorder care they and their loved ones need when they need it."

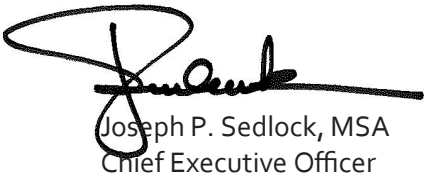
18. **National Governor's Association Report on Improving Continuum of Care for SUD and OUD:** (Attribution to Capitoline Consultants)

On March 24, the National Governors Association (NGA) released a report titled, "State Efforts To Improve The Continuum Of Care For Substance Use Disorder (SUD) And Opioid Use Disorder (OUD)." The document covers the lessons learned from the "National Governors Association Substance Use Disorder Learning

Collaborative" which was launched in June 2020. Six states participated including Kentucky, New York, Oregon, Virginia, West Virginia and Wyoming.
"States participating in the SUD Learning Collaborative shared lessons learned and best practices, which are detailed in this brief. Common strategies that emerged included:

- Maximizing resources, such as federal funding, to improve prevention, treatment and recovery activities;
- Addressing racial and ethnic disparities to promote health equity;
- Using data to improve collection and use of information on racial and ethnic disparities across systems to better target state efforts;
- Addressing stigma with the goal of creating social awareness and positive contact through intentional engagement with individuals in long-term recovery; and
- Ensuring a greater connection to SUD services for those leaving criminal justice settings."

Submitted by:



Joseph P. Sedlock, MSA
Chief Executive Officer
Mid-State Health Network
Finalized: 04/19/2022

Attachments:

- MSHN Michigan Legislative Tracking Summary, April 2022
- MDHHS Strategic Projects Update, April 2022
- Michigan Psychiatric Care Improvement Project, April 2022

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Compiled and tracked by Sherry Kletke

Below is a list of Legislative Bills MSHN is currently tracking and their status as of April 19, 2022:

BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 4075	Parking Spot Signage (LaFave) Modifies signage for parking spaces designated for persons with disabilities.	Received in Senate (10/7/2021; To Health Policy and Human Services Committee)
HB 4076	Accessibility Symbol (LaFave) Modifies symbol of accessibility.	Received in Senate (10/7/2021; To Health Policy and Human Services Committee)
HB 4925	Mental Health (Whiteford) Modifies reference to citizens mental health advisory council to behavioral health oversight council and update.	Committee Hearing in House Health Policy Committee (3/17/2022)
HB 4926	Behavioral Health Care (Hammoud) Expands use of Medicaid funds for behavioral health care services.	Committee Hearing in House Health Policy Committee (3/17/2022)
HB 4927	Mental Health (Green) Eliminates reference to "department-designated community mental health entity" in the public health code.	Committee Hearing in House Health Policy Committee (3/17/2022)
HB 4928	Mental Health (Allor) Eliminates reference to "department-designated community mental health entity" in the Michigan liquor control code of 1998.	Committee Hearing in House Health Policy Committee (3/17/2022)
HB 5163	MAT Programs (Witwer) Requires certain hospitals to provide emergency-based medication-assisted treatment (MAT) programs and provides for grants from the department of health and human services to implement the MAT programs.	Received in Senate (10/21/2021; To Health Policy and Human Services Committee)
HB 5165	Inpatient Psychiatrics Services (Whiteford) Modifies adult inpatient psychiatric services ability to pay provision.	Committee Hearing in Senate Health Policy and Human Services Committee (3/24/2022)
HB 5353	Mental Health (Whiteford) Provides revisions to the Michigan crisis and access line.	Introduced (9/30/2021; To Health Policy Committee)
HB 5354	Mental Health (Whiteford) Creates the 9-8-8 suicide prevention and mental health crisis hotline fund.	Introduced (9/30/2021; To Health Policy Committee)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
HB 5462	Medicaid (Outman, P.) Provides impact study related to eligibility for Medicaid program and provides public disclosure related to intentional program violations or fraud cases investigated.	Reported in House (2/22/2022; By Families, Children and Seniors Committee)
HB 5467	Open Meetings (Green) Provides policy related to member participation in virtual committee meetings.	Introduced (10/21/2021; To Local Government and Municipal Finance Committee)
HB 5482	Drug Court (Howell) Modifies eligibility to drug treatment courts.	Committee Hearing in House Judiciary Committee (2/22/2022)
HB 5483	Mental Health Court Participants (LaGrand) Modifies eligibility for mental health court participants.	Committee Hearing in House Judiciary Committee (2/22/2022)
HB 5484	Drug Court (Yancey) Modifies termination procedure for drug treatment courts.	Committee Hearing in House Judiciary Committee (2/22/2022)
HB 5488	Psychologists (Kahle) Modifies individuals who are authorized to engage in the practice of psychology in this state to include individuals who are authorized to practice under the psychology interjurisdictional compact.	Received in Senate (12/14/2021; To Health Policy and Human Services Committee)
HB 5489	Psychologists (Brabec) Enacts psychology interjurisdictional compact.	Received in Senate (12/14/2021; To Health Policy and Human Services Committee)
HB 5593	Mental Health (Calley) Provides community mental health oversight of competency exams for defendants charged with misdemeanors.	Introduced (12/1/2021; To Health Policy Committee)
HB 5709	Behavioral Health (Anthony) Provides equitable coverage for behavioral health and substance use disorder treatment.	Introduced (2/1/2022; To Insurance Committee)
HB 5966	MIcare Act (Rabhi) Creates MIcare act.	Introduced (3/23/2022; To Health Policy Committee)
HB 5968	Opioid Healing And Recovery Fund (Whiteford) Creates Michigan opioid healing and recovery fund.	Reported in House (4/12/2022; By Judiciary Committee)
HB 5969	Opioid Advisory Commission (Whiteford) Creates opioid advisory commission.	Reported in House (4/12/2022; By Judiciary Committee)
HB 5970	Controlled Substances (Morse) Prohibits civil lawsuits related to opioids.	Reported in House (4/12/2022; By Judiciary Committee)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
SB 101	Mental Health (McBroom) Updates provisions within the Mental Health Code by creating standards and licensing requirements for mental health transport for involuntary psych hospitalization.	Reported in Senate (10/7/2021; S-3 substitute adopted; By Health Policy and Human Services Committee)
SB 190	Psychiatric Units (VanderWall) Requires accepting public patients as a condition of licensing for psychiatric hospitals and psychiatric units.	Passed in Senate (3/24/2021; 35-0)
SB 191	Mental Health (VanderWall) Expands the definition of mental health professional to include physician assistants, certified nurse practitioners, and clinical nurse specialists-certified, and allow them to perform certain examinations.	Received in House (4/29/2021; To Health Policy Committee) Passed in Senate (4/29/2021; 35-0)
SB 321	Mental Health (Santana) Provides development or adoption of professional development standards for teachers on mental health first aid.	Passed in Senate (9/29/2021; 36-0)
SB 412 (PA 19)	Prescription Drugs (Hertel, C.) Provides exemption of certain prescription drugs from the department of health and human services Medicaid prior authorization process.	Signed by the Governor (3/10/2022; Signed: March 10, 2022, Effective: June 7, 2022)
SB 435 (PA 38)	Public Health Code (MacDonald) Expands to include mental health professionals under the definition of designated professional for the Michigan essential health provider recruitment strategy act.	Signed by the Governor (3/23/2022; Signed: March 23, 2022, Effective: March 23, 2022)
SB 578	Controlled Substances (Brinks) Allows distribution of opioid antagonists by community-based organizations under a standing order.	Introduced (10/14/2021; To Health Policy Committee) Passed in Senate (10/14/2021; 35-0)
SB 579	MAT Programs (VanderWall) Requires certain hospitals to provide emergency-based medication-assisted treatment (MAT) programs and provides for grants from the department of health and human services to implement the MAT programs.	Introduced (10/14/2021; To Health Policy Committee) Passed in Senate (10/14/2021; 35-0)
SB 597	Behavioral Health Care (Shirkey) Provides specialty integrated plan in behavioral health services.	Advanced to Third Reading in Senate (3/2/2022; Earlier committee substitute S-3 adopted.)

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BILL #	TITLE/INTRODUCER/DESCRIPTION	STATUS
SB 598	Mental Health (Bizon) Provides updates regarding the transition from specialty prepaid inpatient health plans to specialty integration plans.	Advanced to Third Reading in Senate (3/2/2022; Earlier committee substitute S-3 adopted.)
SB 705	Open Meetings (Irwin) Provides procedures for electronic meetings of public bodies.	Introduced (10/26/2021; To Local Government Committee)
SB 707	Telehealth Visits (Hollier) Requires reimbursement rate for telehealth visits to be the same as reimbursements for office visits.	Introduced (10/28/2021; To Health Policy and Human Services Committee)
SB 714	Behavioral Health (Shirkey) Provides multidepartment supplemental for behavioral health changes.	Advanced to Third Reading in Senate (3/2/2022; Earlier committee substitute S-1 adopted.)
SB 792	Open Meetings (McMorrow) Modifies circumstances permitting electronic attendance of members at meetings of public bodies.	Introduced (12/14/2021; To Local Government Committee)
SB 854	Open Meetings (McCann) Modifies procedures for electronic meetings of public bodies and expand eligibility due to a medical condition.	Introduced (2/1/2022; To Oversight Committee)
SB 855	Drug Paraphernalia (Chang) Expands definition of drug paraphernalia to include object designed for the ingestion of nitrous oxide.	Reported in Senate (3/17/2022; By Health Policy and Human Services Committee)
SB 993	Opioid Healing And Recovery Fund (MacDonald) Creates Michigan opioid healing and recovery fund.	Reported in Senate (4/14/2022; By Health Policy and Human Services Committee)
SB 994	Opioid Advisory Commission (Huizenga) Creates opioid advisory commission.	Reported in Senate (4/14/2022; S-1 substitute adopted; By Health Policy and Human Services Committee)
SB 995	Controlled Substances (Alexander) Prohibits civil lawsuits related to opioids.	Reported in Senate (4/14/2022; By Health Policy and Human Services Committee)
HR 231	Drug Paraphernalia (Slagh) A resolution to oppose the use of federal funds to purchase drug paraphernalia.	Introduced (2/16/2022)

Michigan Integration Efforts

Service Delivery Transformation

April 2022 Update

Overview

Overview
MDHHS Integration Efforts include four key initiatives: Behavioral Health Homes (BHH), Opioid Health Homes (OHH), Certified Community Behavioral Health Clinics (CCBHC) and Promoting Integration of Primary and Behavioral Health Care (PIPBHC). Each initiative seeks to improve both behavioral and physical health outcomes by emphasizing care coordination, access, and comprehensive care. These programs specifically focus on adults and children with mental health and substance use disorder needs.

Goals

1. Increase access to behavioral health and physical health services.
2. Elevate the role of peer support specialists and community health workers.
3. Improve health outcomes for people who need mental health and/or substance use disorder services.
4. Improve care transitions between primary, specialty, and inpatient settings of care.

Opportunities for Improvement

1. Improve access to care for all individuals seeking behavioral health services (SMI, SUD, SED, mild to moderate).
2. Identify and attend to social determinants of health needs.
3. Improve care coordination between physical and behavioral health services.

Behavioral Health Homes (BHH)

Overview

- Medicaid Health Homes are an optional State Plan Benefit authorized under section 1945 of the US Social Security Act.
- Behavioral Health Homes provide comprehensive care management and coordination services to Medicaid beneficiaries with select serious mental illness or serious emotional disturbance by attending to a beneficiary's complete health and social needs.
- Providers are required to utilize a multidisciplinary care team comprised of physical and behavioral health expertise to holistically serve enrolled beneficiaries.
- As of October 1, 2020, Behavioral Health Home services are available to beneficiaries in 37 Michigan counties including PIHP regions 1 (upper peninsula), 2 (northern lower Michigan), and 8 (Oakland County)

Current Activities:

- As of April 6, 2022, there are 1,117 people enrolled:
    - Age range: 7-85 years old
    - Race: 31% African American, 72% Caucasian, 2% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander
- The State of Michigan budget allocated funding to expand behavioral health homes into two new PIHP regions on May 1, 2022.
- The new regions to join the BHH are PIHP Region 6 and Region 7. This expansion will add 5 new counties and 21 BHH provider sites.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)

Certified Community Behavioral Health Clinics (CCBHC)

Overview

- MI has been approved as a Certified Community Behavioral Health Clinic (CCBHC) Demonstration state by CMS. The demonstration will launch in October 2021 with a planned implementation period of two years. 14 sites, including 11 CMHSPs and 3 non-profit behavioral health providers, are eligible to participate in the demonstration. The CCBHC model increases access to a comprehensive array of behavioral health services by serving all individuals with a behavioral health diagnosis, regardless of insurance or ability to pay.
- CCBHCs are required to provide nine core services: crisis mental health services, including 24/7 mobile crisis response; screening, assessment, and diagnosis, including risk assessment; patient-centered treatment planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family supports; and intensive, community-based mental health care for members of the armed forces and veterans.
- CCBHCs must adhere to a rigorous set of certification standards and meet requirements for staffing, governance, care coordination practice, integration of physical and behavioral health care, health technology, and quality metric reporting.
- The CCBHC funding structure, which utilizes a prospective payment system, reflects the actual anticipated costs of expanding service lines and serving a broader population. Individual PPS rates are set for each CCBHC clinic and will address historical financial barriers, supporting sustainability of the model. MDHHS will operationalize the payment via the current PIHP network.

Current Activities

- The CCBHC Demonstration has been operational since October 1, 2021. As of March 31, 2022, 25,878 Medicaid beneficiaries and 4,415 individuals without Medicaid were assigned to the 13 demonstration CCBHC sites.
- Final CCBHC certification applications have been reviewed and CCBHCs are responding to feedback, revising policies, and resubmitting documentation verifying that they meet the certification requirements. If CCBHCs have outstanding unmet certification requirements, a time-limited certification action plan will be developed and MDHHS and the PIHPs will work with clinic to address the issues.
- The MDHHS CCBHC Implementation Team has been addressing operational issues that arise as the demonstration moves forward, including assignment and transfer among CCBHCs, encounter reporting, and alignment with existing financial reporting requirements. Updates to technological systems, including the WSA and CHAMPS, are ongoing. A manual detailing metric technical specifications, requirements, and submission procedures is under development and data scoping is underway to evaluate these requirements.
- A dashboard has been finalized to assist in the monitoring of service delivery and payment distribution.
- Funding has been approved to support the costs of CCBHC services to non-Medicaid beneficiaries. CCBHCs are expected to exhaust all other revenue sources, including existing grants, sliding fees, and third-party payments, prior to utilizing MDHHS funds.
- The final CCBHC policy (MSA 21-34) and CCBHC Demonstration Handbook can be found on the CCBHC webpage MDHHS - Provider (michigan.gov). Revisions to the hand systems are ongoing.
- An MDHHS marketing campaign is under review. Marketing is intended to increase awareness of the CCBHC model, eligibility, and services among the public and other community providers. Marketing will target the sixteen counties with demonstration sites. Counties will be prioritized based on CCBHC's level of readiness to accommodate an increased volume of recipients while meeting sufficient access requirements.

Questions or Comments

- Amy Kanouse (kanousea@michigan.gov)
- Lindsey Naeyaert (naeyaertl@michigan.gov)

Opioid Health Homes (OHH)

Overview

- Medicaid Health Homes are an optional State Plan Amendment under Section 1945 of the Social Security Act.
- Michigan's OHH is comprised of primary care and specialty behavioral health providers, thereby bridging the historically two distinct delivery systems for optimal care integration.
- Michigan's OHH is predicated on multi-disciplinary team-based care comprised of behavioral health professionals, addiction specialists, primary care providers, nurse care managers, and peer recovery coaches/community health workers.
- As of October 1, 2022, OHH services are available to eligible beneficiaries in 48 Michigan counties. Service areas include PIHP region 1, 2, 6,7, 9, 10 and Calhoun and Kalamazoo counties in region 4.

Current Activities

- As of April 1, 2022, 2,052 beneficiaries enrolled in OHH services.
- MDHHS has expanded OHH services to an additional nine counties within PIHP region 6, 7, and 10 in. Existing OHH's are expanding access with new providers and growing services for more beneficiaries.
- MDHHS is working on collaborating with many state agencies such as the Maternal and Infant Health division to ensure OHH beneficiaries have wraparound support services through their recovery journey.

Questions or Comments

- Kelsey Schell (schellk1@michigan.gov)

Promoting Integration of Primary and Behavioral Health Care (PIPBHC)

Overview

- PIPBHC is a five-year Substance Abuse and Mental Health Services (SAMHSA) that seeks to improve the overall wellness and physical health status for adults with SMI or children with an SED. Integrated services must be provided between a community mental health center (CMH) and a federally qualified health center (FQHC).
- Grantees must promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental health and substance use disorders along with co-occurring physical health conditions and chronic diseases.
- MDHHS partnered with providers in three counties:
    - Barry County: Cherry Health and Barry County Community Mental Health to increase BH services
    - Saginaw County: Saginaw County Community Mental Health and Great Lakes Bay Health Centers
    - Shiawassee County: Shiawassee County Community Mental Health and Great Lakes Bay Health Centers to increase primary care

Current Activities

- Grantees are currently working toward integrating their EHR system to Azara DRVS to share patient data between the CMH and FQHC. This effort should improve care coordination and integration efforts between the physical health and behavioral health providers.
- Shiawassee and Saginaw counties are starting to see shared patient data in Azara DRVS. Implementation of the care management module is underway, and Barry County will have their kick-off in a few weeks.
- Providers are reintroducing integrated huddles between the CMH and FQHC for people enrolled in PIPBHC. Health and Wellness coaches are supporting many services that would otherwise not be possible. This includes providing cooking demonstrations, education on grocery planning, fitness plans, how to read labels, metabolic syndrome, and benefits of water and exercise. One wellness coach also meets with people at their gym to help them workout and has partnered with the YMCA to get free or discounted memberships for participants.
- CHRT has conducted in-depth interviews with each county (CMH and FQHC separately) to identify how the PIPHC integration process has been going since the beginning of the grant period. The interview summary will be shared with sites in our upcoming monthly meetings.
- MDHHS staff hosted PIPBHC sites visits in February and a cross-site call with all counties in March.

Questions or Comments

- Lindsey Naeyaert (naeyaertl@michigan.gov)

Michigan Psychiatric Care Improvement Project (MPCIP)

April 2022 Update

Overview

Michigan House CARES Task Force and the Michigan Psychiatric Admissions Discussion evolved into the Michigan Psychiatric Care Improvement Project (MPCIP).

Two Part Crisis System

1. Public service for anyone, anytime anywhere: Michigan Crisis and Access Line (MiCAL) per PA 12 of 2020, Mobile crisis*, Crisis Receiving and Stabilization Facilities [1]*

2. More intensive crisis services that are fully integrated with ongoing treatment both at payer and provider level for people with more significant behavioral health and/or substance use disorder issues

Opportunities for improvement

- Increase recovery and resiliency focus throughout entire crisis system,
- Expand array of crisis services
- Utilize data driven needs assessment and performance measures
- Equitable services across the state
- Integrated and coordinated crisis and access system – all partners
- Standardization and alignment of definitions, regulations, and billing codes

988 IMPLEMENTATION

Overview

- 988 is the new three digit dialing code for the National Suicide Prevention Lifeline.
- 988 will go live July 16, 2022.
- Michigan completed an extensive 988 Implementation planning process with stakeholder involvement which was funded by Vibrant. Michigan's Official 988 Plan was submitted to Vibrant and SAMHSA on January 21, 2022.
- The plan focuses on topics such as vision, follow up care, resources, marketing, metrics, communications, and funding.
- Marketing will start at the federal level early 2023. We have been asked to wait to market until we receive notice from Vibrant. They will send us marketing materials.
- Over the next several months to a year, Michigan will transition from a regional call coverage system to statewide call coverage through MiCAL except for Network 180 covering Kent County and Macomb CMH covering Macomb County.
- MiCAL will provide statewide text and chat coverage.

Current Activities

- NSPL/MMDHHS applied for a 988 Implementation Grant which was submitted January 31st. SAMHSA 988 Implementation grants should be awarded by the end of April. Key focus areas are: stable diversified funding, adequate statewide coverage, common practices for centers, stakeholder engagement/marketing, and 911/ 988 collaboration.
- Statewide Coverage: MiCAL is rolling out statewide. See the MiCAL section for more information.
- Stakeholder engagement: Written updates are provided every 1 to 2 months. MDHHS is developing a stakeholder engagement plan with an emphasis on marketing.
- NSPL Center Practices: Operations workgroup meetings with current NSPL centers are focused on developing common practices around Imminent Risk.
- 911/988 Collaboration: State level 911/988 workgroup is meeting to develop collaborative practices.
- Stable diversified funding: MDHHS is assessing FY 23 funding needs and exploring diverse funding sources to meet those needs.

MICHIGAN CRISIS AND ACCESS LINE (MICAL)

Legislated through PA 12 of 2020, PA 166 of 2020.

Overview

- Overall Model: One statewide line which links to local services tailored to meet regional and cultural needs.
- It will provide a clear access point to the varied and sometimes confusing array of behavioral health services in Michigan.
- Crisis triage, support, and information and referral services 24/7 via phone, text, and chat
- Predicated on Recovery & Resiliency Principles; caller-defined crisis, holistic, crisis support and triage, trauma informed, collaborative support, least restrictive, and non-judgmental.
- Supports all Michiganders with behavioral health and substance use disorder needs to locate care regardless of severity level or payer type. Warm hand-offs and follow-ups, crisis resolution and/or referral, safety assessments,24/7 warm line, and information and referral offered.
- MiCAL will not prescreen individuals. MiCAL will not directly refer people to psychiatric hospitals or other residential treatment. This will be done through PIHPs, CMHSPs, Emergency Departments, and Crisis Stabilization Units.
- Individual level performance measures.
- Opportunity for systems level change: data source for systems level needs i.e. to be addressed in collaboration with other systems including other crisis lines.
- Common Ground is the MiCAL staffing vendor.
- Target Dates: Pilot start date: Upper Peninsula and Oakland April 2021; Operational Statewide October 2022.
- Integrated with BPHASA Peer/ Recovery Coach Warm line
- Michigan Warmline is active statewide.
- MiCAL Rollout: MiCAL will rollout statewide in two phases.
    - Phase 1 FY 22: Starting in January 2022, MiCAL will rollout statewide one region at a time, providing coverage for 988 and crisis and distress support through the MiCAL number. It will not provide additional regions with CMHSP crisis after hours coverage at this time.
    - Phase 2 FY 23: CMHSP After Hours Crisis Coverage. MiCAL will provide afterhours crisis coverage for CMHSPs who currently contract with a third party for afterhours crisis coverage. Rollout will occur one PIHP at a time.
- Planned Design Activities:
    - Targeted Engagement Discussions to ensure MiCAL meets all Michiganders' needs. This process will pull together providers and people with lived experience for specific population groups to ensure that MiCAL is effectively outreaching and serving them. This will occur through 988 Implementation process.
    - Resources: Developing partnerships and technological integration with 211 and OpenBeds to ensure MiCAL has up to date resource information.
    - Ongoing small improvements to the CRM system.

Current Activities

- Frontline Strong First Responder Crisis support project called Frontline Strong in partnership with Wayne State is in development. Crisis line is estimated to go live in Summer 2022. Staff recruitment is underway.
- MiCAL and the Michigan Warmline staff have had over 55,000 encounters since April 19th (MiCAL go live); mostly calls. Over half the encounters have been on the Warmline.
- Pilot is focused on streamlining and routinizing care coordination process with CMHSPs and ensuring that CRM technology supports these processes.
- Warmline is refining data gathered during the call, i.e. reason for the call and services provided.

- Stakeholder dashboards are being developed.
- Common Ground is hiring staff in preparation for the rollout.
- MiCAL integration with OpenBeds/MiCARE is in progress.
- MiCAL/NSPL is rolling out statewide a region at a time. It is developing coordination protocols with CMHSPs and state demonstration CCBHCs as the rollout progress.
- MiCAL/NSPL is live in Prepaid Inpatient Health Plan geographic regions 1, 2, 3, 8, and 10. It will be live in Region 5 by the end of May. Map of the Prepaid Inpatient Health Plans (michigan.gov)

CRISIS STABILIZATION UNITS

Overview

- PA 402 of 2020 codifies Crisis Stabilization Units (CSUs) in the Mental Health Code. This new statute requires MDHHS to develop, implement, and oversee a certification process for CSUs. The legislation did not appropriate funding.
- MDHHS is contracting with Public Sector Consultants to help develop with the develop of a Michigan Model and certification criteria.
    - MDHHS is convening a cross sector stakeholder group to develop a Michigan model. As a group Stakeholders will review models from other states and from Michigan to make recommendations around a model that will best fit the behavioral health needs of all Michiganders. Stakeholder Workgroup has over 50 members and is inclusive of people with lived experience, Peers, and representatives from diverse disciplines and geographic regions.
- Timing: Michigan Model developed by 12/1. Draft Certification rules will be developed by summer 2022, draft administrative rules and draft Medicaid policy will be completed by September 30, 2022.

Current Activities

- Draft Certification Standards deadline is being extended to summer 2022. A small subset of the stakeholder group is developing draft certification criteria for adults. There is special attention being paid to congruency with funding requirements, licensing requirements of related services, and accreditation. PSC extensive research on best practices in other states is being incorporated in the model.
- MDHHS is exploring internal staffing necessary to certify CSUs.
- PSC is looking at available statewide data to help determine capacity needs. They are also using the new Crisis Talk Crisis Services Calculator.
- PSC is also researching funding models for this service.
- The Michigan Model is being tailored to the needs of Children and Families. Stakeholder meetings will be held in in late spring/ early summer.

MOBILE CRISIS INTERVENTION SERVICES

Overview

- Mobile crisis services are one of the three major components that SAMHSA recommends as part of a public crisis services system.
- MDHHS goal is to eventually expand mobile crisis across the state for all populations, taking advantage of the enhanced Medicaid match.

- MDHHS has contracted with PSC/HMA to develop recommendations to expand mobile crisis for adults in Michigan, with special attention on strategies for rural areas.
- There is coordination with the MDHHS staff leading the KB lawsuit around services for children.

Target Date: September 2022

Current Activities –

- Multiple parts of MDHHS are working on expanding mobile crisis services: Diversion Council, Mi Kids Now, and Bureau of Community Based Services. Internal meetings are occurring to ensure that models for children/families and adults stay aligned whenever possible.
- PA 162 and 163 of 2021 set up a Diversion Fund and pilot program for mobile crisis. MDHHS is coordinating internally around implementation plans, prior to stakeholder involvement.
- MDHHS will pursue the advanced Medicaid match and ensure that the model meets requirements.
- Public Sector Consultants is pulling together legislative and funding requirements and best practices to develop a draft model for adults.
- PSC is coordinating work with the Diversion Council and Wayne State Center for Behavioral Health Justice (CBHJ) who are also focused on looking at adult mobile crisis models.

MI-SMART (MEDICAL CLEARANCE PROTOCOL)

Overview

- Standardized communication tool between EDs, CMHSPs, & Psychiatric Hospitals to rule out physical conditions when someone in the ED is having a behavioral health emergency and to determine when the person is physically stable enough to transfer if psychiatric hospital care is needed.
- Broad cross-sector implementation workgroup.
- Implementation is voluntary for now.
- Target Date: Soft rollout has started as of August 15, 2020.
- www.mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/

Current Activities:

- Education of key stakeholders statewide; supporting early implementation sites; performance metric development.
- As of 4/1/22 Adopted/Accepted by 45 Emergency Departments, 19 Psychiatric Hospitals, 13 CMHSPs.
- 26 more facilities are pursing the implementing at their facility, including McLaren Bay Region, Beaumont Health, and UPHS Marquette.
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption
- Partnering with MHA to distribute a survey targeted to provider groups with the goal of outreach and recruitment.
- Developing a commitment letter for Psych hospitals, CMHSPs, and EDs to sign.
- Partnering with LARA to develop a crosswalk that outlines regulatory practices that MiSMART can help meet.
- Record high COVID numbers in Emergency Departments are impeding progress.

PSYCHIATRIC BED TREATMENT REGISTRY

Overview

- Legislated through PA 658 of 2018, PA12 of 2020, PA 166 of 2020.

- Electronic service registry housing psychiatric beds, crisis residential services, and substance use disorder residential services.
- The Psychiatric Bed Registry is housed in the MiCARE/ OpenBeds platform which is Michigan's behavioral health registry/ referral platform which is operated and funded by LARA.
- MiSMART will eventually house all private and public Behavioral Health Services and will have a public facing portal.
- The Psychiatric Bed Registry Advisory Group's purpose will transition from choosing a platform to supporting successful rollout and maximization of the OpenBeds platform to meet Michigan's needs.
- LARA is rolling out MiCARE regionally with a statewide completion date by early 2022.
- Target audience: Psychiatric Hospitals, Emergency Departments, CMHSP staff, PIHP staff.
  - Public and broader stakeholder access through MiCAL.
  - Broad cross-sector Advisory Workgroup.
- Target Implementation Date: Implemented statewide by January/ February 2022.

Current Activities

- LARA is in the process of rolling out MiCARE statewide a PIHP region at a time. The focus is on substance use disorders treatment services.
- Targeted rollout to psychiatric hospitals was paused due to this last wave of COVID.
- The Onboarding date was pushed back from February 2022 to June 30,2022.
- Psychiatric hospitals are being encouraged to onboard as they are able. There are 58 facilities. 70% attended the initial orientation.
- MDHHS PBR Implementation Team is developing a survey of psychiatric facilities for a status on MiCARE implementation.
- Psychiatric Bed Advisory Workgroup is providing feedback on tailoring MiCARE to Michigan, i.e. bed categorization, acuity, the rollout, and referral process.

Behavioral Health Customer Relationship Management (CRM) – Internal Business Processes

Overview

- BPHASA will transition its internal business processes to a customer relationship management (CRM) system. The Behavioral Health CRM is a customized technological platform designed to automate and simplify procedures related to the regulatory relationship between BPHASA and its customers: PIHPs, CMHSPs, CCBHCs, SUD entities, Michiganders, etc.
- The development process includes written documentation of the business process, describing the process and highlighting requirements, and the translation of the business process into technology. All this information is included in the user training.
- Stakeholders for each process are actively engaged throughout the design process and user testing.
- Training materials on the CRM and each of the business processes are housed within the CRM. Training materials include videos and written job aids.
- Virtual, synchronous training and "Learning Lab hours" are held when a business process goes live.
- Completed Processes: Customer Service Inquiry, CCBHC Certification

Current Activities

- Contract Management: Review of training materials and development of retraining plans will occur over the next few months

- Universal Credentialing (PA 282 of 2020): Stakeholder workgroup composed of representatives from CMHSPs, PIHPs, and BPHASA is meeting regularly to develop the business process for Universal Credentialing. After this step is complete then the Stakeholder group will participate in automating the business process in the CRM.
- Specialty Program Certifications: Business Process development has been completed. Requirements for CRM development is in progress. Programs included are: is starting on certification for specialty programs: homebased, ACT, intensive crisis stabilization, clubhouse, therapeutic foster care, crisis residentials, and wraparound.
- The Critical Incident Database project is in the CRM development phase. It has a go live date of October 1, 2022.
- CMHSP Certification: The CRM work is complete. Rollout plans and training are being developed.
- ASAM Level of Care Certification Development Process is live in Detroit Wayne and the Upper Peninsula.

QUESTIONS OR COMMENTS?

- Krista Hausermann (hausermannk@michigan.gov)

MSHN
Mid-State Health Network

Community Mental Health
Member Authorities

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

Board Officers

Ed Woods
Chairperson

Irene O'Boyle
Vice-Chairperson

Kurt Peasley
Secretary

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

MSHN Staffing Update

MSHN is pleased to announce that Jill Woodworth-Lackie has accepted the position of Waiver Assistant effective, April 4, 2022. Jill comes to us with many years of experience working as the Site Lead and Referral Specialist at Capital Internal Medicine Associates.

Ron Meyer has accepted the transfer from the Waiver Coordinator position to the Information Technology Department to fulfill the role of the Data and Report Coordinator effective March 21, 2022.

Please join me in welcoming Jill and congratulating Ron on his new position.

Mid-State Health Network is still looking for qualified candidates to fill the Office Assistant and Waiver Coordinator positions. Job Descriptions are located on MSHN's website at: https://midstatehealthnetwork.org/stakeholders-resources/about-us/Careers.

Annual Disclosure of Ownership, Controlling Interest, and Criminal Convictions

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

In short order, Board Members will receive an email from Sherry Kletke, with a request to complete and electronically sign a disclosure form (via DocuSign). The form can be completed on a smart phone or computer. Common questions that arise when completing the form:

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

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

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

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

COVID-19-Telehealth Report

MSHN and our Community Mental Health partners have been monitoring the regions use of telehealth over the last few years and has recently produced a three-year comparison from FY2019 through FY2021. We know our provider network has concerns and has been wondering what will happen with the flexibilities allowed during the federal Pandemic Health Emergency (PHE) declaration. MDHHS has clarified that the COVID-19 response policies will remain in effect, including the MDHHS - COVID-19 Encounter Code Chart (michigan.gov), until an appointed time which MDHHS will inform providers of in the future (as indicated in MSA 20-36). These temporary policies ARE NOT contingent upon the end of the federal PHE and will not be terminated on April 16, even if the federal PHE is not extended. Instead, MDHHS will inform providers of the end dates of those policies using our usual mechanisms for provider communication. Please see the BHDDA telemedicine database for allowable telemedicine services for once MDHHS transitions away from the temporary policies and stay tuned for further updates regarding post PHE telemedicine policies. MSHNs Telehealth report can be found here.

In addition, the General Accountability Office (GAO) has released a report entitled *Medicaid: CMS Should Assess Effect of Increased Telehealth Use on Beneficiaries' Quality of Care* (**GAO-22-104700). "**Telehealth has helped people get the health care they need while reducing their COVID-19 exposure risk. At the start of the pandemic, Medicaid data from 5 states showed exponential increases in

- the number and percentage of services delivered via telehealth
- the number of Medicaid beneficiaries receiving telehealth.

For example, from March 2020-February 2021, 32.5 million services were delivered via telehealth vs. 2.1 million services the prior year. But Medicaid hasn't collected or assessed data on the quality-of-care beneficiaries received from telehealth services. We recommended doing so." The report is available at https://www.gao.gov/assets/gao-22-104700-highlights.pdf.

Certified Community Behavioral Health Centers Update

The implementation of Certified Community Behavioral Health Centers (CCBHCs) has been going strong since Fall of 2021. All three CCBHCs in the MSHN region have been provisionally certified and have received the required corrective action plans to obtain full certification, with only minor administrative follow up required. To date MSHN has assigned 6,317 individuals with Medicaid and 297 without Medicaid to receive CCBHC services and provided 288,681 encounters. There were 40,612 consumer days (T1040's per consumer per day) that the CCBHC PPS-1 rate will be paid for totaling $23,546,511.

- CEI – $13,680,568
- TRD – $1,668,265
- Saginaw - $8,197,678

MSHN continues to meet with MDHHS and other PIHPs monthly, discussing updates to the guidance related to enrollments, financing, quality measures and reporting.

MSHN's Priority Measures FY22Q1

The selected measures for the first quarter of fiscal year 2022 have been included below in our priority measures portfolio that include:

- Follow up to Hospitalization (Adult & Child)
- Access to Primary Care (Adult & Child)
- Plan All-Cause Readmission
- Diabetes Screening and Monitoring
- Cardiovascular Screening
- Children prescribed ADHD medications (PCP follow up and Monitoring)
- Children prescribed two or more antipsychotic medications
- Initiation and Engagement of Alcohol & Other Drug Treatment

MSHN's goal is to meet or exceed the National and State benchmarks indicated in the reports. Out of the thirteen measures, MSHN exceeds in all but the Diabetes Screening (over the benchmark by 2%), Diabetes Monitoring (under by 21%) and Cardiovascular Screening (under by 21%). The three measures underperforming are required to be monitored by the Medicaid Health Plans as part of the physical health benefit under the primary care physician. MSHN is working diligently to assist and provide coordination of care for individuals through joint care plans, education on follow up care and transportation services through the local community mental health provider.

For the full report, including detailed measure descriptions and CMHSP specific performance related to information above, ***see the link below: Priority Measures FY22Q1.***

Compliance and Quality Department Report FY22Q1

Included in the Compliance and Quality Department report is the Customer Service section that details the activities related to customer inquiries. Dan Dedloff, MSHN's Customer Service and Rights Manager, provides an avenue for consumers, providers, stakeholders, and staff to request general information, technical assistance, file complaints, grievances and appeals. All requests are captured and included in a data repository for review and analysis by the regional customer services committee. The following data tables include information collected for FY22 quarter one.

CUSTOMER SERVICE CONTACTS PER PROVIDER

	Contact Type			Type of Resolution			
Provider (CMHSP & SUD)	Consumer Based Customer Service	Non-Consumer Based Customer Service	Grand Total	Immediate Resolution	Resolution In-Process	Resolution through Follow-up	Grand Total
Bear River Health	1	-	1	-	-	1	1
CMHA of Clinton, Eaton, and Ingham Counties	4	-	4	-	2	2	4
Community Mental Health for Central Michigan	3	-	3	-	-	3	3
Lansing Comprehensive Treatment Center	2	-	2	-	-	2	2
LifeWays	1	-	1	-	1	-	1
McCullough Vargas & Associates	1	-	1	-	1	-	1
Meridian Health Services	1	-	1	-	-	1	1
Victory Clinical Services	1	-	1	1	-	-	1
Grand Total	**14**	**0**	**14**	**1**	**4**	**9**	**14**

FY21 MDHHS Grievance Reporting Year Results (Q1-4)							
Grievance Category	Number of Cases Closed	Number of Cases Per 100 Members	Number of Cases Substantiated	Number of Cases Substantiated Per 100 Members	Number of Interventions	Number of Cases Resolved within 90 Calendar Days	Average Number of Days for Resolution*
QUALITY OF CARE	88	0.29	50	0.16	100	86	24
ACCESS AND AVAILABILITY	33	0.11	21	0.07	34	33	25
INTERACTION WITH PROVIDER OR PLAN	24	0.08	17	0.06	30	24	19
MEMBER RIGHTS	1	0.00	1	0.00	1	1	5
TRANSPORTATION	1	0.00	1	0.00	1	1	6
ABUSE, NEGLECT, OR EXPLOITATION	0	0.00	0	0.00	0	0	#DIV/0!
FINANCIAL OR BILLING MATTERS	1	0.00	1	0.00	1	1	0
SAFETY/RISK MANAGEMENT	3	0.01	3	0.01	3	3	13
SERVICE ENVIRONMENT	2	0.01	2	0.01	2	2	33
OTHER	3	0.01	2	0.01	3	3	10
Total	156	0.51	98	0.32	175	154	23

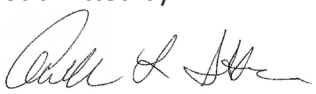
*Field will display "#DIV/0!" if there are no reported cases per category.

FY21 MDHHS Member Appeals Reporting Year Results (Q1-4)						
Grievance Category	Number of Cases Closed	Number of Cases Per 100 Members	Number of Decisions Made Timely-Standard	Number of Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited
MEDICAL NECESSITY CRITERIA NOT MET	20	0.07	20	0	0	0
NOT A PIHP-COVERED BENEFIT	0	0.00	0	0	0	0
CLINICAL DOCUMENTATION NOT RECEIVED	1	0.00	1	0	0	0
TREATMENT/SERVICE PLAN GOALS MET	1	0.00	1	0	0	0
MEMBER NOT ELIGIBLE FOR SERVICES	13	0.04	13	0	0	0
MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN	19	0.06	18	1	0	0
FAILURE OF THE PIHP/CMHSP/SUD PROVIDER TO RENDER A DECISION TIMELY	0	0.00	0	0	0	0
OTHER	13	0.04	12	0	1	0
NOT APPLICABLE	188	0.61	184	1	2	1
Total	255	0.83	249	2	3	1

FY21 MDHHS Member Appeals Reporting Year Results (Q1-4)		
	Count	Percentage
Appeals	255	N/A
Appeals Upheld	56	22%
Appeals Overturned	191	75%
Appeals Partially Upheld/Overturned	8	3%

For the full report, including follow up actions related to information above, ***see the link below: Compliance and Quality Department Report FY22Q1.***

Submitted by:



Amanda L. Ittner
Finalized: 4.19.22

Attached:

Links to Reports:
Compliance and Quality Department Report FY22Q1
Priority Measures FY22Q1

MSHN
Mid-State Health Network

Background:

In accordance with the MSHN Board of Directors to review financials, at a minimum quarterly, the Statement of Net Position and Statement of Activities for the Period Ending March 31, 2022, have been provided and presented for review and discussion.

Recommended Motion:

The MSHN Board of Directors receives and files the Statement of Net Position and Statement of Activities for the Period Ending March 31, 2022, as presented.

Mid-State Health Network
Statement of Activities
As of March 31, 2022

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	
			FY22 Amended Budget		FY22 Amended Budget			
			50.00%					
1	Revenue:							
2		Grant and Other Funding	$ 293,800	63,187	146,900	(83,713)	21.51 %	1a
3		Medicaid Use of Carry Forward	$ 51,407,120	49,882,291	25,703,560	24,178,731	97.03%	1b
4		Medicaid Capitation	733,634,419	372,457,754	366,817,209	5,640,545	50.77%	1c
5		Local Contribution	2,345,532	1,172,768	1,172,766	2	50.00%	1d
6		Interest Income	80,000	27,175	40,000	(12,825)	33.97%	1e
7		Change in Market Value	0	(49,137)	0	(49,138)	0.00%	
8		Non Capitated Revenue	19,861,516	5,392,888	9,930,758	(4,537,869)	27.15%	1f
9	Total Revenue		807,622,387	428,946,926	403,811,193	25,135,733	53.11 %	
10	Expenses:							
11		PIHP Administration Expense:						
12		Compensation and Benefits	7,838,917	2,702,737	3,919,458	(1,216,722)	34.48 %	
13		Consulting Services	130,000	50,897	65,000	(14,103)	39.15 %	
14		Contracted Services	110,540	39,328	55,270	(15,943)	35.58 %	
15		Other Contractual Agreements	504,150	180,115	252,075	(71,959)	35.73 %	
16		Board Member Per Diems	18,060	6,510	9,030	(2,520)	36.05 %	
17		Meeting and Conference Expense	172,470	28,905	86,235	(57,330)	16.76 %	
18		Liability Insurance	38,445	35,636	19,223	16,414	92.69 %	
19		Facility Costs	154,369	79,787	77,184	2,602	51.69 %	
20		Supplies	305,405	186,319	152,703	33,616	61.01 %	
21		Depreciation	50,397	25,198	25,198	0	50.00 %	
22		Other Expenses	987,300	525,959	493,650	32,309	53.27 %	
23		Subtotal PIHP Administration Expenses	10,310,053	3,861,391	5,155,026	(1,293,636)	37.45 %	2a
24		CMHSP and Tax Expense:						
25		CMHSP Participant Agreements	639,433,560	333,068,553	319,716,780	13,351,773	52.09 %	1b,1c
26		SUD Provider Agreements	55,104,959	22,989,678	27,552,480	(4,562,802)	41.72 %	1c,1f
27		Benefits Stabilization	2,351,000	1,175,500	1,175,500	0	50.00 %	1b
28		Tax - Local Section 928	2,345,532	1,172,768	1,172,766	2	50.00 %	1d
29		Taxes- IPA/HRA	21,556,045	10,649,392	10,778,023	(128,631)	49.40 %	2b
30		Subtotal CMHSP and Tax Expenses	720,791,096	369,055,891	360,395,549	8,660,342	51.20 %	
31	Total Expenses		731,101,149	372,917,282	365,550,575	7,366,707	51.01 %	
32	Excess of Revenues over Expenditures		$ 76,521,238	$ 56,029,644	$ 38,260,618			

Mid-State Health Network
Statement of Net Position by Fund As of
March 31, 2022

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		30,893,523	0	30,893,523	1a
4	Chase MM Savings		61,824,874	0	61,824,874	
5	Savings ISF Account		0	45,582,868	45,582,868	1b
6	Savings PA2 Account		8,913,257	0	8,913,257	1c
7	Investment ISF Account		0	4,946,589	4,946,589	1b
8	Total Cash and Short-term Investments		$ 101,631,654	$ 50,529,457	$ 152,161,111	
9	**Accounts Receivable**					
10	Due from MDHHS		10,521,338	0	10,521,338	2a
11	Due from CMHSP Participants		179,194	0	179,194	2b
12	Due from CMHSP - Non-Service Related		7,700	0	7,700	2c
13	Due from Other Governments		8,706	0	8,706	2d
14	Due from Miscellaneous		199,617	0	199,617	2e
15	Due from Other Funds		0	0	0	2f
16	Total Accounts Receivable		10,916,555	0	10,916,555	
17	**Prepaid Expenses**					
18	Prepaid Expense Rent		4,529	0	4,529	2g
19	Prepaid Expense Other		6,534	0	6,534	2h
20	Total Prepaid Expenses		11,063	0	11,063	
21	**Fixed Assets**					
22	Fixed Assets - Vehicles		251,983		251,983	2i
23	Accumulated Depreciation - Vehicles		(100,794)		(100,794)	
24	Total Fixed Assets		151,189	0	151,189	
25	**Total Assets**		**$ 112,710,461**	**$ 50,529,457**	**$ 163,239,918**	
26	**Liabilities and Net Position**					
27	Liabilities					
28	Accounts Payable		$ 282,203	$ 0	$ 282,203	1a
29	Current Obligations (Due To Partners)					
30	Due to State		34,022,047	0	34,022,047	3a
31	Other Payable		3,744,088	0	3,744,088	3b
32	Due to State HRA Accrual		3,878,952	0	3,878,952	1a, 3c
33	Due to State-IPA Tax		1,445,744	0	1,445,744	3d
34	Due to State Local Obligation		2	0	2	3e
35	Due to CMHSP Participants		10,098	0	10,098	3f
36	Accrued PR Expense Wages		59,252	0	59,252	3g
37	Accrued Benefits PTO Payable		347,825	0	347,825	3h
38	Accrued Benefits Other		49,507	0	49,507	3i
39	Total Current Obligations (Due To Partners)		43,557,515	0	43,557,515	
40	Deferred Revenue		7,311,877	0	7,311,877	1b 1c 2b 3b
41	Total Liabilities		51,151,595	0	51,151,595	
42	Net Position					
43	Unrestricted		61,558,866	0	61,558,866	3j
44	Restricted for Risk Management		0	50,529,457	50,529,457	1b
45	Total Net Position		61,558,866	50,529,457	112,088,323	
46	**Total Liabilities and Net Position**		**$ 112,710,461**	**$ 50,529,457**	**$ 163,239,918**	

Mid-State Health Network
Notes to Financial Statements
For the Six-Month Period Ended,
March 31, 2022

Please note: The Preliminary Statement of Net Position contains Fiscal Year (FY) 2021 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 MSHN's Financial Status Report (FSR) submitted to MDHHS in February 2022. CMHSP cost settlement activity is generally finalized in May following the fiscal-year end. Minor adjustments may occur if noted in MSHN's or any CMHSP's Compliance Examination.

Statement of Net Position:

1. Cash and Short-Term Investments
    a) The Cash Chase Checking and Chase Money Market Savings accounts is the cash available for operations. A portion of cash available for operations will be used to cover accounts payable and taxes.
    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.
    c) The Savings PA2 account holds PA2 funds and is also offset by the Deferred Revenue liability account.
2. Accounts Receivable
    a) Approximately 37% of the balance in Due from MDHHS represents amounts owed to MSHN for January through March 2022 HRA payments. Roughly 51% of the balance is owed to MSHN for the estimated FY 21 Performance Bonus Incentive Pool (PBIP) funds. The remaining amount in this account stems from Block Grant and other various grants funds owed to MSHN.
    b) Due from CMHSP Participants reflects preliminary FY 21 cost settlement activity.

CMHSP	Cost Settlement	Payments/Offsets	Total
Bay	1,192,286.76	1,020,840.00	171,446.76
CEI	19,751,454.73	21,260,518.00	(1,509,063.27)
Central	325,973.94	1,020,853.00	(694,879.06)
Gratiot	1,707,095.20	1,522,055.00	185,040.20
Huron	-	-	-
The Right Door	2,307,161.23	2,039,215.00	267,946.23
Lifeways	3,353,505.21	-	3,353,505.21
Montcalm	3,047,643.03	3,047,643.33	(0.30)
Newaygo	2,036,373.37	1,892,739.00	143,634.37
Saginaw	6,682,355.20	8,758,625.00	(2,076,269.80)
Shiawassee	1,426,828.72	1,150,658.00	276,170.72
Tuscola	517,470.17	455,807.00	61,663.17
Total	**42,348,147.56**	**42,168,953.33**	**179,194.23**

    c) Due from CMHSP – "Non-Service Related" account balance reflects MSHN's performance of Supports Intensity Scale (SIS) assessment billed to two CMHs in the region.
    d) Due from Other Governments is the account used to track PA2 billing to the twenty-one counties in MSHN's region. The balance reflects FY 21 quarter four outstanding collections due from one county.
    e) Approximately 48% of the balance in Due from Miscellaneous represents amounts owed from providers for Medicaid Event Verification (MEV) findings. The remaining amount

represents an advance made to a Substance Abuse and Treatment (SAPT) providers to cover operations.

f) Due to CMHSPs represents the amount owed to one CMHSP based on FY 21's cost settlement.
g) Prepaid Expense Rent balance consists of security deposits for three MSHN office suites.
h) The full balance in Prepaid Expense Other represents payments made in FY 22 for FY 23 Relias training. The Relias contract cycle is November through October. MSHN has a regional contract which includes the CMHSPs, and they are billed directly for their portion of Relias seats.
i) Fixed Asset Vehicle contains the total cost for MSHN's Mobile Unit. The Mobile Unit is utilized to provide Substance Use Disorder services and tele-psychiatry as needed. Amounts in this account are being depreciated.

3. Liabilities
   a) MSHN calculates an FY21 lapse of $18.6 M to MDHHS. The lapse amount indicates we have a fully funded ISF, and that savings will fall 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. In addition, MSHN will lapse approximately $14.1 M to MDHHS for unspent Direct Care Worker (DCW) premium pay funds. Lastly, MSHN owes MDHHS an FY 20 lapse amount totaling $1.2 M based on Compliance Examination adjustments.
   b) This amount is related to SUD provider payment estimates and is needed to offset the timing of payments.
   c) The HRA (Hospital Rate Adjustor) is a pass-through account for dollars sent from MDHHS to cover supplemental payments made to psychiatric hospitals. The HRA payments are intended to incentivize hospitals to have available psychiatric beds as needed. Total HRA payments are calculated based on the number of inpatient hospital services reported.
   d) Due to State - IPA Tax contains funds held for tax payments associated with MDHHS Per Eligible Per Month (PEPM) funds. Insurance Plan Assessment taxes are applied to Medicaid and Healthy Michigan eligible.
   e) Due to State Local Obligation has a negative balance from one CMHSP's immaterial overpayment.
   f) Due to CMHSP contains a balance for one FY 21 cost settlement.
   g) Accrued payroll expense wages represent expense incurred in March and paid in April.
   h) Accrued Benefits PTO (Paid Time Off) payable is the required liability account set up to reflect paid time off balances for employees.
   i) Accrued Benefits Other represents retirement benefits expense incurred in March and paid in April.
   j) The Unrestricted Net Position represents the difference between total assets, total liabilities, and the restricted for risk management figure.

Statement of Activities – PLEASE NOTE – Based on discussion during the January 2022 Board of Directors Meeting, MSHN changed the percentage calculation (column F) in the report. Column B above row one, now displays the percent of budget relative to the months presented. Since this is a statement for March 2022, the budget calculation amount is 50% which is six (6) divided by 12 months. Column F now calculates the actual revenue and expenses compared to the full year budget. Revenue accounts whose Column F percent is higher than 50% translates to MSHN receiving more revenue than anticipated/budgeted. Expense accounts with Column F amounts greater than 50% means MSHN's spending is trending higher than expected.

In addition, Medicaid Carryforward could vary pending FY 21 Cost Settlement activity.

1. Revenue
    a) This account tracks SIS revenue earned from CMHSPs, Veterans Navigator activity and other small grants. Actual revenue is lower than expected due to ongoing pandemic concerns.
    b) Medicaid Use of Carry Forward represents FY 21 savings. Medicaid savings is generated when prior year revenue exceeds expenses for the same period. A small portion of Medicaid Savings is sent to the CMHSPs as Benefit Stabilization for 24/7/365 SUD activities which include access, prevention, and customer services. FY 21 Medicaid Carry Forward must be used as the first revenue source for FY 22.
    c) Medicaid Capitation – Actual is trending higher than the amount budgeted as there is still a moratorium on Medicaid disenrollments. Medicaid Capitation dollars are disbursed to CMHSPs based on per eligible per month (PEPM) payment files 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 2022 amounts owed were nearly $800 k less than FY 21.
    e) Interest income is earned from investments and changes in principle for investments purchased at discounts or premiums. The "change in market value" account records activity related to market fluctuations. Actual interest income is less than anticipated due to ongoing low interest rates and fewer investment opportunities to generate this revenue. In addition, the other portion of interest income is amounts earned from the PA2 and General Savings accounts.
    f) This account tracks non-capitated revenue for SUD services which include Community Grant and PA2 funds. The variance may decrease over time however unspent PA2 dollars remain in the deferred revenue account and Block Grant is received based on actual expenses incurred and billed to MDHHS.
2. Expense
    a) Total PIHP Administration Expense is slightly under budget. The line item with the largest dollar amount variance is Compensation and Benefits and Other Expenses. MSHN's compensation line includes budget amounts for vacant positions and as a result, actual salary expense is lower.
    b) IPA/HRA actual tax expenses are slightly lower than the budget amount however the variance is minimal. IPA estimates are impacted by variability in the number of Medicaid and Healthy Michigan eligibles. HRA figures will vary throughout the fiscal year based on inpatient psychiatric utilization. (Please see Statement of Net Position 3c and 3d).

MID-STATE HEALTH NETWORK
SCHEDULE OF INTERNAL SERVICE FUND INVESTMENTS
As of March 31, 2022

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY
UNITED STATES TREASURY BILL	912796SP5	4.23.19	4.25.19	10.24.19	no	988,182.64	1,000,000.00	2.365%
UNITED STATES TREASURY BILL	912796SP5	4.23.19	4.25.19	10.24.19			(1,000,000.00)	
FEDERAL HOME LOAN MTG CORP	3137EAEF2	5.2.19	5.3.19	4.20.20	no	624,605.01	630,000.00	2.331%
FEDERAL HOME LOAN MTG CORP	3137EAEF2						(630,000.00)	
UNITED STATES TREASURY BILL	912796RN1	6.7.19	6.10.19	12.5.19	no	1,979,752.50	2,000,000.00	2.068%
UNITED STATES TREASURY BILL	912796RN1						(2,000,000.00)	
UNITED STATES TREASURY BILL	912796TF6	8.14.19	8.15.19	2.13.20	no	2,972,607.48	3,000,000.00	1.823%
UNITED STATES TREASURY BILL	912796TF6						(3,000,000.00)	
UNITED STATES TREASURY BILL	912796TK5	9.12.19	9.12.19	3.12.20	no	991,043.07	1,000,000.00	1.788%
UNITED STATES TREASURY BILL	912796TK5						(1,000,000.00)	
FEDERAL FARM CREDIT BANK	3133ELCD4	12.2.19	12.3.19	6.2.21	yes	2,000,092.22	2,000,000.00	1.660%
FEDERAL FARM CREDIT BANK	3133ELCD4						(2,000,000.00)	
UNITED STATES TREASURY BILL	912796UC1	2.12.20	2.13.20	1.28.21	no	2,959,268.75	3,000,000.00	
UNITED STATES TREASURY BILL	912796UC1						(3,000,000.00)	
UNITED STATES TREASURY BILL	912796C56	1.28.21	1.28.21	7.29.21	no	2,999,590.50	3,000,000.00	0.027%
UNITED STATES TREASURY BILL	912796C56	1.28.21	1.28.21	7.29.21			(3,000,000.00)	
UNITED STATES TREASURY BILL	912796k57	8.2.21	8.3.21	7.14.22		2,998,706.25	2,999,603.59	
UNITED STATES TREASURY BILL	91282CDR9	1.19.22	1.20.22	12.1.23		1,992,391.23	1,992,394.23	
JP MORGAN INVESTMENTS							4,991,997.82	
JP MORGAN CHASE SAVINGS							45,052,062.49	0.050%
							$ 50,044,060.31	

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**

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 FY22 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 FY22 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2022 NEW AND RENEWING CONTRACTS
May 2022

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	ORIGINAL FY22 CONTRACT AMOUNT	FY22 TOTAL CONTRACT AMOUNT	FY22 INCREASE/ (DECREASE)
PIHP ADMINISTRATIVE FUNCTION CONTRACTS					
Pam Fachting	MEV Site Reviewer	9.1.21 - 6.30.22	32,000	**48,000**	**16,000**
			$ 32,000	**$ 48,000**	**$ 16,000**

CONTRACTING ENTITY	CMHSP SERVICE AREA	CONTRACT TERM	ORIGINAL FY22 CONTRACT AMOUNT	FY22 TOTAL CONTRACT AMOUNT	FY22 INCREASE/ (DECREASE)
PIHP/CMHSP MEDICAID SUBCONTRACTS					
CEI Community Mental Health Authority	CCBHC Non-Medicaid Operations Grant	5.1.22 - 9.30.22	-	**351,274**	**351,274**
Saginaw County Community Mental Health Authority	CCBHC Non-Medicaid Operations Grant	5.1.22 - 9.30.22	-	**91,122**	**91,122**
The Right Door for Hope, Recovery & Wellness	CCBHC Non-Medicaid Operations Grant	5.1.22 - 9.30.22	-	**328,604**	**328,604**
			$ -	**$ 771,000**	**$ 771,000**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL FY22 COST REIMBURSEMENT CONTRACT AMOUNT	FY22 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY22 INCREASE/ (DECREASE)
Addiction Solutions Counseling Center	Technology (Isabella)	5.1.22 - 9.30.22	-	**6,365**	**6,365**
Arbor Circle	Technology (Newaygo)	5.1.22 - 9.30.22	257,255	**261,955**	**4,700**
Catholic Charities of Shiawassee & Genesee County	Technology (Shiawassee)	5.1.22 - 9.30.22	-	**17,670**	**17,670**
Child & Family Charities	SUD Prevention - Prime for Life (Ingham)	10.1.21 - 9.30.22	144,125	**226,602**	**82,477**
CMH for CEI	Technology (Ingham)	5.1.22 - 9.30.22	1,131,805	**1,134,205**	**2,400**
Cristo Rey Counseling Services	Technology (Ingham)	5.1.22 - 9.30.22	163,355	**174,140**	**10,785**
Family Services & Children's Aid	Prevention - JUMP Student Assistance; Breakout (Jackson)	10.1.21 - 9.30.22	383,352	**443,573**	**60,221**
Family Services & Children's Aid	Treatment - Technology (Jackson)	5.1.22 - 9.30.22	119,456	**123,571**	**4,115**
Huron County Health Dept.	Technology (Huron)	5.1.22 - 9.30.22	163,619	**165,589**	**1,970**
Randy's House	Technology (Montcalm)	5.1.22 - 9.30.22	23,870	**53,152**	**29,282**
Recovery Pathways	Supplies & Materials for MCU (PA2)	3.1.22 - 9.30.22	272,684	**275,434**	**2,750**
Saginaw Odyssey House, Inc.	Technology (Saginaw)	5.1.22 - 9.30.22	-	**3,610**	**3,610**
Saginaw Psychological Services	Technology (Saginaw)	5.1.22 - 9.30.22	-	**28,695**	**28,695**
Samaritas	Technology (Eaton)	5.1.22 - 9.30.22	18,000	23,880	**5,880**
Victory Clinical Services IV - Saginaw	Opioid Health Home (OHH) & Technology (Saginaw)	5.1.22 - 9.30.22	-	**206,749**	**206,749**
			$ 2,677,521	**$ 3,145,190**	**$ 467,669**

CONTRACTING ENTITY	SUD PROVIDERS FFS PROGRAM DESCRIPTION	CONTRACT TERM			
Saginaw County Community Mental Health Authority	CCBHC - Treatment	12.1.21 - 9.30.22	-	-	-
The Right Door for Hope, Recovery & Wellness	CCBHC - Treatment	10.1.21 - 9.30.22	-	-	-
			$ -	$ -	$ -

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION (Revenue Contract)	CONTRACT TERM	FY22 ORIGINAL CONTRACT AMOUNT	FY22 TOTAL CONTRACT AMOUNT	FY22 INCREASE/ (DECREASE)
Michigan Department of Health & Human Services (EGrAMS)	ARPA Prevention	5.1.22 - 9.30.22	-	**169,060**	**169,060**
	ARPA Treatment & Access	5.1.22 - 9.30.22	-	**550,000**	**550,000**
	CCBHC Non-Medicaid Operations Support	5.1.22 - 9.30.22	-	**771,000**	**771,000**
	Community Grant	10.1.21 - 9.30.22	5,154,076	**5,454,076**	**300,000**

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION (Revenue Contract)	CONTRACT TERM	FY22 ORIGINAL CONTRACT AMOUNT	FY22 TOTAL CONTRACT AMOUNT	FY22 INCREASE/ (DECREASE)
	SUD - Women's Specialty Services	10.1.21 - 9.30.22	1,204,088	**904,088**	(300,000)
	SUD Administration COVID	10.1.21 - 9.30.22	50,000	**25,000**	(25,000)
	Women's Specialty Services COVID	10.1.21 - 9.30.22	522,261	**422,261**	(100,000)
			$ 6,930,425	**$ 8,295,485**	**$ 1,365,060**

Mid-State Health Network (MSHN) Board of Directors Meeting

Tuesday, March 1, 2022

Best Western Okemos/East Lansing

Meeting Minutes

1. Call to Order

Chairperson Ed Woods called this meeting of the Mid-State Health Network Board of Directors to order at 5:00 p.m. Mr. Ed Woods reminded Board members of the Open Meetings Act change stating members participating on the phone may not vote on matters before the board. Mr. Woods asked those in attendance to take a moment of silence for the people in Ukraine fighting for their Country and for all others around the World fighting oppression.

2. Roll Call

Secretary Kurt Peasley provided the roll call for Board Members in attendance.

Board Member(s) Present: Brad Bohner (LifeWays), Joe Brehler (CEI), Bruce Cadwallender (Shiawassee), Mike Cierzniewski (Saginaw), Craig Colton (Huron), Ken DeLaat (Newaygo), David Griesing (Tuscola), Dan Grimshaw (Tuscola), John Johansen (Montcalm), Steve Johnson (Newaygo), Jeanne Ladd (Shiawassee)-joined 5:33 p.m., Pat McFarland (Bay-Arenac), Deb McPeek-McFadden (Ionia), Kurt Peasley (Montcalm), Joe Phillips (CMH for Central Michigan), Kerin Scanlon (CMH for Central Michigan), Ed Woods (Lifeways)

Board Member(s) Remote: Jim Anderson (Bay-Arenac), Tina Hicks (Gratiot), Irene O'Boyle (Gratiot), Tracey Raquepaw (Saginaw)

Board Member(s) Absent: Dianne Holman (CEI), Rhonda Matelski (Huron), Gretchen Nyland (Ionia)

Staff Members Present: Joseph Sedlock (Chief Executive Officer), Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Sherry Kletke (Executive Assistant, remote); Kim Zimmerman (Chief Compliance and Quality Officer)

3. Approval of Agenda for March 1, 2022

Board approval was requested for the Agenda of the March 1, 2022, Regular Business Meeting.

MOTION BY BRAD BOHNER, SUPPORTED BY DAVID GRIESING, FOR APPROVAL OF THE AGENDA OF THE MARCH 1, 2022, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 16-0.

4. Public Comment

There was no public comment.

5. FY2022 Quality Assessment and Performance Improvement Program (QAPIP) and the FY2021 Annual Effectiveness Evaluation

Ms. Kim Zimmerman presented an overview of the FY2022 QAPIP and the FY2021 Annual Effectiveness Evaluation included within board meeting packets and recommended for board approval.

Board Members would like to have a list of acronyms commonly used at Board meetings. MSHN Administration will provide a list of acronyms in member folders at future meetings.

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY BRAD BOHNER, FOR APPROVAL OF THE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) FOR OCTOBER 1, 2021 TO SEPTEMBER 30, 2022 AND THE ANNUAL EFFECTIVENESS AND EVALUATION REPORT FOR OCTOBER 1, 2020 TO SEPTEMBER 30, 2021. MOTION CARRIED: 16-0.

6. Provider Staffing Crisis Stabilization Program

Mr. Joseph Sedlock provided an overview of the Provider Staffing Crisis Stabilization Proposal included within board meeting packets.

Discussion on various policy and operational elements took place with many members having questions also expressing support for the proposal.

Board members requested to be provided with an itemized report containing a detailed breakdown of the expenditure categories. MSHN will provide a detailed report at the conclusion of the initiative (after 09/30/2022).

MOTION BY JOHN JOHANSEN, SUPPORTED BY DEB McPEEK-McFADDEN, TO DESIGNATE UP TO $13 MILLION (THIRTEEN MILLION DOLLARS) OF FY2022 MSHN RESOURCES FOR THE PURPOSE OF STABILIZING AND ASSISTING ELIGIBLE PROVIDER ORGANIZATIONS CONTRACTED WITHIN THE REGION IN ADDRESSING WORKFORCE/STAFFING CRISES PURSUANT TO REGIONAL GUIDELINES ESTABLISHED BY MSHN. MOTION CARRIED: 16-0.

7. FY2021 Board Self-Assessment

Ms. Irene O'Boyle summarized the FY2021 Board Self-Assessment results. The Board Self-Assessment trending report from FY2016 – FY2021 was included in board meeting packets.

Twenty-one (21) of the twenty-four (24) Board members completed the survey which equates to an 87.5% participation rate. Mr. Ed Woods expressed his appreciation to Ms. O'Boyle for taking the lead on the Board Self-Assessment project.

MOTION BY KEN DeLAAT, SUPPORTED BY DAVID GRIESING, TO RECEIVE AND FILE THE FY2021 BOARD SELF-ASSESSMENT REPORT. MOTION CARRIED: 17-0.

8. Consideration of the MSHN FY2022 Budget Amendment

Ms. Leslie Thomas provided an overview of the FY2022 Budget Amendment included within board meeting packets.

MOTION BY JOHN JOHANSEN, SUPPORTED BY DAN GRIMSHAW, TO APPROVE THE CURRENT YEAR FY2022 BUDGET AMENDMENT AS PRESENTED. MOTION CARRIED: 17-0.

9. Chief Executive Officer's Report

Mr. Joseph Sedlock announced the annual Michigan Consortium for Healthcare Excellence (MCHE) meeting is scheduled on Thursday March 3, 2022 at 12:00 p.m. The MSHN Board is a member of the MCHE, and he is the appointee of this board to the MCHE Board. Board members will receive an email containing the virtual meeting connection information on Wednesday March 2, 2022 for any member that may be interested in participating.

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

- PIHP/Regional Matters
  - COVID-19 MSHN Internal Operations Status
  - MSHN Regional Operations Status
  - Board Member Information Forms
  - MSHN Legislation Tracking Improvements
- State of Michigan/Statewide Activities
  - House Democratic Caucus Listening Tour Report
  - Current Michigan Senate legislation affecting the public behavioral health system
  - Michigan Opioid Settlement Updates

10. Deputy Director's Report

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

- Health Insurance Update
- Annual Compliance Report

- Balanced Scorecard FY2021
- Home and Community Based Services (HCBS) Rule Transition

11. Chief Financial Officer's Report

Ms. Leslie Thomas provided an overview of the financial reports included within board meeting packets for the period ended January 31, 2022.

MOTION BY MIKE CIERZNIEWSKI, SUPPORTED BY BRAD BOHNER, TO RECEIVE AND FILE THE PRELIMINARY STATEMENT OF NET POSITION AND PRELIMINARY STATEMENT OF ACTIVITIES FOR THE PERIOD ENDING JANUARY 31, 2022, AS PRESENTED. MOTION CARRIED: 17-0.

12. Contracts for Consideration/Approval

Ms. Leslie Thomas provided an overview of the FY2022 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 FY2022 contract listing.

MOTION BY DEB McPEEK-McFADDEN, SUPPORTED BY BRAD BOHNER, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS AS PRESENTED AND LISTED ON THE FY22 CONTRACT LISTING. MOTION CARRIED: 17-0.

13. Executive Committee Report

The Executive Committee reviewed the annual litigation report and MSHN is not a named party in any litigation occurring in the region.

The May 3, 2022 Board meeting will be held at Lansing Community College West Campus, 5708 Cornerstone Drive, Lansing, MI 48917.

The July 5, 2022 Board meeting will be held at the Best Western Okemos, Stadium Room, which is the same location as tonight's meeting.

The September 13, 2022 Board meeting will be held at Comfort Inn Okemos, Ballroom, which is located in the building directly behind tonight's meeting.

14. Chairpersons Report

Mr. Ed Woods thanked the Board members for their advocacy of supporting the public mental health system. Board members represent the people served and to make sure those individuals are supported. People supported are currently able to access the board members and that level of communication will go away if the system redesign passes the legislature.

15. 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 BRAD BOHNER, SUPPORTED BY KURT PEASLEY, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE JANUARY 11, 2022 BOARD OF DIRECTORS MEETING; RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF FEBRUARY 18, 2022; RECEIVE POLICY COMMITTEE MINUTES OF FEBRUARY 2, 2022; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF JANUARY 24, 2022; AND TO APPROVE ALL OF THE FOLLOWING POLICIES: CONFLICT FREE CASE MANAGEMENT, EMERGENCY AND POST-STABILIZATION SERVICES, CREDENTIALING/RE-CREDENTIALING, DISCLOSURE OF OWNERSHIP, FISCAL YEAR CONTRACT MONITORING, PROVIDER DIRECTORY, PROVIDER NETWORK, PROVIDER NETWORK RECIPROCITY, SUBSTANCE USE DISORDER DIRECT SERVICE PROVIDER PROCUREMENT, APPOINTED MEMBER COMPENSATION. MOTION CARRIED: 17-0.

16. Other Business

17. Public Comment

There was no public comment**.**

Board members expressed appreciation to the MSHN organization and its staff for their continued excellence.

18. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 6:51 p.m.

Mid-State Health Network SUD Oversight Policy Advisory Board
Wednesday, December 15, 2021, 4:00 p.m.
CMH Association of Michigan (CMHAM)

Meeting Minutes

1. Call to Order

Chairperson John Hunter called the MSHN SUD Regional Oversight Policy Board (OPB) of Directors Organizational Meeting to order at 4:28 p.m.

Board Member(s) Present: Jim Anderson (Bay), Lisa Ashley (Gladwin), Nichole Badour (Gratiot), Sandra Bristol (Clare), Bruce Caswell (Hillsdale), Steve Glaser (Midland), Susan Guernsey (Mecosta), Christina Harrington (Saginaw), John Hunter (Tuscola), Bryan Kolk (Newaygo), Robert Luce (Arenac), Jim Moreno (Isabella), Todd Tennis (Ingham), Deb Thalison (Ionia), Kim Thalison (Eaton), Dwight Washington (Clinton), Ed Woods (Jackson)

Board Member(s) Absent: Joe Murphy (Huron), Scott Painter (Montcalm), Vicky Schultz (Shiawassee), David Turner (Osceola)

Alternate Members Present: John Kroneck (Montcalm)

Staff Members Present: Amanda Ittner (Deputy Director), Joseph Sedlock (Chief Executive Officer), Sherry Kletke (Executive Assistant), Leslie Thomas (Chief Financial Officer), Dr. Dani Meier (Chief Clinical Officer), Dr. Trisha Thrush (Lead Treatment Specialist), Rebecca Emmenecker (Treatment Specialist), Sarah Andreotti (Lead Treatment Specialist), Sarah Surna (Prevention Specialist), Kari Gulvas (Prevention Specialist)

2. Roll Call

Secretary Bruce Caswell provided the Roll Call for Board Attendance.

3. Approval of Agenda for December 15, 2021

Board approval was requested for the Agenda of the December 15, 2021 Regular Business Meeting, as presented.

MOTION BY BRYAN KOLK, SUPPORTED BY BRUCE CASWELL, FOR APPROVAL OF THE DECEMBER 15, 2021 REGULAR BUSINESS MEETING AGENDA, AS PRESENTED. MOTION CARRIED: 18-0.

BOARD APPROVED APRIL 20, 2022

4. Approval of Minutes from the June 16, 2021 and October 20, 2021 Regular Business Meetings

Board approval was requested for the draft meeting minutes of the June 16, 2021 and October 20, 2021 Regular Business Meetings.

MOTION BY JIM MORENO, SUPPORTED BY TODD TENNIS, FOR APPROVAL OF THE MINUTES OF THE JUNE 16, 2021 AND OCTOBER 20, 2021 MEETINGS, AS PRESENTED. MOTION CARRIED: 18-0.

5. Public Comment

There was no public comment.

6. Board Chair Report

Board approval was requested for the FY2022 Board calendar, as presented.

MOTION BY JOHN KRONECK, SUPPORTED BY STEVE GLASER, FOR APPROVAL OF THE FY2022 BOARD CALENDAR, AS PRESENTED. MOTION CARRIED: 18-0.

Mr. John Hunter provided an overview of the SUD Oversight Policy Board Annual Report included in the board meeting packet. Commendations to the Board members for getting so much done, especially during COVID.

The annual organization meeting for the SUD Oversight Policy Board will take place at the next meeting scheduled February 16, 2022. Re-elections will take place for the Chair, Vice-Chair, and Secretary officer positions. An officer can serve for two consecutive terms. Current officers are Mr. John Hunter as Chair, Ms. Deb Thalison as Vice-Chair and Mr. Bruce Caswell as Secretary. Current officers are in their first year so each of them can run again. If anyone has interest in an office position, please contact Ms. Sherry Kletke or Ms. Amanda Ittner prior to the February meeting. A slate of officers will be put together for the February meeting and nominations can also be taken from the floor during the meeting. The question was raised if there is a training program available. All new board members receive orientation upon appointment. If a board member is interested in serving as an officer, MSHN would support that person and provide any needed training. There are also conferences available about how to be an effective officer.

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:

- Modification to the Open Meetings Act and change to the SUD OPB Bylaws: House Bill 5467 allows for remote participation; however remote participants are not allowed to vote unless they are participating remotely due to military duty, effective January 1, 2022. MSHN is seeking legal counsel and there is also lobbying efforts happening in opposition to the bill and to continue to allow remote participation voting as long as a quorum of physical

presence is reached at the meeting. MSHN is going to hold on revising the Bylaws until further information is received from legal counsel and to see if new legislation is proposed.

- Opioid Settlement: The Michigan settlement is estimated at $776 million with payments beginning as early as April 2022. Municipalities and counties must register to participate in the settlement. MDHHS has requested from the PIHPs local information on prevention activities to share with municipalities and counties in coordination of efforts when planning for use of the funds.

8. Chief Financial Officer Report

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

- FY2021 PA2 Funding and Expenditures by County
- FY2021 PA2 Use of Funds by County and Provider
- FY2021 Substance Use Disorder (SUD) Financial Summary Report as of September 2021
- Block Grant Reduction Update & Projections

FY2022 reports have not been included because there hasn't been any action on the FY2022 PA2 contracts prior to this meeting.

Suggestions were requested to change the format and font size of the Block Grant Reduction Update report to help make it easier to read.

9. FY22 Substance Use Disorder PA2 Contract Listing

Contracts are now handled by the Finance Department so Ms. Leslie Thomas will present the contracts at future meetings. However, tonight, Ms. Amanda Ittner provided an overview and information on the FY22 Substance Use Disorder (SUD) PA2 Contract listing as provided in the packet. Discussion ensued with some OPB members expressing concern with the report appearing like some counties, in particular Montcalm County and Ingham County, had a substantial funding cut. Funding allocation is based on the provider requests and availability/allowable cost to other funding sources. MSHN utilizes Medicaid and Healthy Michigan as first use of funds, along with State Opioid Response Grant. PA2 funds are allocated as last resort. MSHN will provide an additional report, as soon as it's available, with details showing other funding sources reflecting the total funding allocated for each provider. The report will also contain any funding requests that were denied, if applicable.

MOTION BY ROBERT LUCE, SUPPORTED BY JIM MORENO, FOR APPROVAL OF THE FY2022 SUBSTANCE USE DISORDER (SUD) PA2 CONTRACT LISTING, AS PRESENTED. MOTION CARRIED: 16-0. 2-ABSTAINED

10. SUD Operating Update

Dr. Dani Meier provided an overview of the written SUD Operations Report as included in the board meeting packet highlighting the addition of two new staff. Veteran's Navigator, Tammy Foster and Prevention Specialist, Sarah Surna.

Dr. Dani Meier providing a presentation on the rising rate of Methamphetamine Overdose prior to the call to order. The Power Point presentation can be viewed on the MSHN website at this link. Noting, Methamphetamine Psychosis (MAP) is when meth intoxication includes psychiatric symptoms. Placing individuals with MAP is a challenge because SUD providers are not used to psychotic behaviors and drug-induced psychosis doesn't meet eligibility for inpatient psych units. MSHN's Utilization Management department, led by Ms. Skye Pletcher Négron, is developing a clinical practice guideline for MAP. MSHN is part of a pilot Contingency Management (CM) program in recovery homes in Newaygo and Montcalm Counties.

11. Other Business

There was no other business

12. Public Comment

There was no public comment

13. Board Member Comment

Board members asked about receiving hard copies of packets similar to past practice. Now that the packet is displayed during meetings, if anyone would still like a packet mailed to them, please contact Ms. Sherry Kletke or Ms. Amanda Ittner. Members can also make a note requesting hard copies and place the note in their folder tonight.

A Board member recently learned about recovery support programs that MSHN funded at Central Michigan University, Ferris State University and Mid State College. These colleges have recovery activities on campus to engage students that are in recovery or are at-risk.

14. Adjournment

Chairperson John Hunter adjourned the MSHN SUD Oversight Policy Advisory Board Meeting at 5:26 p.m. Mr. John Hunter wished everyone Happy Holidays and wanted to thank everyone for coming to the meeting.

Meeting minutes submitted respectfully by:
MSHN Executive Assistant

BOARD APPROVED APRIL 20, 2022

Mid-State Health Network SUD Oversight Policy Advisory Board
Wednesday, February 16, 2022, 4:00 p.m.
CMH Association of Michigan (CMHAM)

Meeting Minutes

1. Call to Order

Chairperson John Hunter called the MSHN SUD Regional Oversight Policy Board (OPB) of Directors Organizational Meeting to order at 4:05 p.m.

Board Member(s) Present: Bruce Caswell (Hillsdale), Steve Glaser (Midland) joined at 4:14 p.m., John Hunter (Tuscola), Bryan Kolk (Newaygo), Vicky Schultz (Shiawassee), Jerrilynn Strong (Mecosta); Kim Thalison (Eaton)

Board Member(s) Remote: Nichole Badour (Gratiot), Sandra Bristol (Clare), Robert Luce (Arenac), Jim Moreno (Isabella), Todd Tennis (Ingham). Deb Thalison (Ionia), Ed Woods (Jackson)

Board Member(s) Absent: Jim Anderson (Bay), Lisa Ashley (Gladwin); Christina Harrington (Saginaw); Ken Mitchell (Clinton); Joe Murphy (Huron), Scott Painter (Montcalm), David Turner (Osceola)

Alternate Members Present: John Kroneck (Montcalm); Linda Howard (Mecosta)

Staff Members Present: Amanda Ittner (Deputy Director), Joseph Sedlock (Chief Executive Officer), Sherry Kletke (Executive Assistant), Leslie Thomas (Chief Financial Officer), Dr. Dani Meier (Chief Clinical Officer), Sarah Andreotti (Lead Treatment Specialist), Sarah Surna (Prevention Specialist), Kari Gulvas (Prevention Specialist); Sherrie Donnelly (Treatment & Recovery Specialist)

2. Roll Call

Secretary Bruce Caswell provided the Roll Call for Board Attendance. Only 8 represented county members were present in-person which does not meet the minimum requirement for a quorum, so no action was taken on items noted below. Items requiring action will be added to the agenda for the next meeting on April 20, 2022.

3. Approval of Agenda for February 16, 2022

No quorum was present to take action to approve the Agenda of the February 16, 2022 Regular Business Meeting, as presented.

4. Approval of Minutes from the December 15, 2021 Regular Business Meetings

No quorum was present to take action to approve the meeting minutes of the December 15, 2021 Regular Business Meeting. Board members did not note any corrections or changes needed to the December 15, 2021 meeting minutes.

5. Public Comment

There was no public comment.

6. Board Chair Report

Chairperson John Hunter extended a warm welcome to new members; Scott Painter, Ken Mitchell and Jerrilynn Strong and to the new alternate member, Linda Howard.

No quorum was present to hold the annual meeting election of Board Chairperson, Vice-Chairperson and Secretary. Annual meeting elections will be on the agenda for the next meeting on April 20, 2022.

Mr. John Hunter shared a letter that he has signed for distributing to providers in the region wishing to express admiration and deep appreciation for the courage, compassion, strength and resilience shown over the past few years during the COVID-19 pandemic. A copy of the letter was in the Board member folders and was shared on screen for those members attending virtually.

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:

- Open Meetings Act Update: Senate Bill 854 was introduced on February 1, 2022 which proposes to add back the medical condition as a circumstance for allowing remote participation in addition to military duty. MSHN is seeking legal counsel and is continuing to hold on revising the Bylaws until further information is received from legal counsel. Since this report was prepared there has been involvement with the ADA to allow for individuals with disabilities to participate remotely.

- Opioid Settlement Update: MDHHS has asked PIHPs for recommendations on projects to be supported by the settlement funding at the state level. Recommendations were due on February 11, 2022. MSHNs Substance Use Disorder team has been doing research to be prepared for programs slated to begin in FY23.

- American Rescue Plan Act (ARPA) Substance Abuse Block Grant (SABG) Appropriation
- Governor Whitmer Announces 10 Million Free KN95 Masks for Michiganders. MSHN has a supply of KN95 masks available so if any Board member hears of any resource needs, please reach out to MSHN staff.

8. Chief Financial Officer Report

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

- FY2022 PA2 Funding and Expenditures by County
- FY2022 PA2 Use of Funds by County and Provider
- FY2022 Substance Use Disorder (SUD) Financial Summary Report as of December 2021

9. FY22 Substance Use Disorder PA2 Contract Listing Report Format Changes

Ms. Leslie Thomas discussed the contract listing report format changes that arose from feedback from board members at the December 2021 meeting requesting MSHN provide an updated report with details showing other funding sources reflecting the total funding allocated for each provider. The report will also contain any funding requests that were denied, if applicable. The PA2 funding recommendations by provider is no longer broken out by county; the provider total only is reflected and a footnote added to refer to Comparison by County and Provider report for details by county. The Comparison by County and Provider report added a new column indicating if the provider is new or if the contract is a renewal. The report also adds a column to indicate date county specific coalition has or will review the new provider.

Board members wished to thank MSHN Finance staff for addressing the recommendations and making the changes to the Contract Listing reports.

10. SUD Operating Update

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

- Seeking Safety training (Evidence-based trauma training) in March 2022

Dr. Dani Meier informed the Board a provider closed yesterday after providing MSHN the required 60 days' notice and all 223 folks were transferred as of yesterday. MSHN is very grateful to all the providers and staff involved to place all 223 people.

Dr. Dani Meier also reviewed the FY2021 SUD Quarterly reports as provided in the board packet.

BOARD APPROVED APRIL 20, 2022

11. Other Business

There was no other business

12. Public Comment

There was no public comment

13. Board Member Comment

Board Members raised the question why members are unable to attend the meeting to allow for a quorum. If a Board member has any feedback allowing members to feel more comfortable attending in-person, please submit to Ms. Amanda Ittner or Ms. Sherry Kletke.

14. Adjournment

Chairperson John Hunter adjourned the MSHN SUD Oversight Policy Advisory Board Meeting at 5:07 p.m. Thank you for all that attended today in-person and for those that joined remotely.

Meeting minutes submitted respectfully by:
MSHN Executive Assistant

BOARD APPROVED APRIL 20, 2022

MSHN
Mid-State Health Network

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

Friday, April 15, 2022 - 9:00 a.m. - ZOOM VIDEO CONFERENCE

Committee Members Present:	Ed Woods, Chairperson; Irene O'Boyle, Vice-Chairperson; Kurt Peasley, Secretary; David Griesing, At Large; Pat McFarland, At Large
Staff Present:	Joseph Sedlock, Chief Executive Officer; Amanda Ittner, Deputy Director
Others Present:	Ken DeLaat; Susan Twing

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

2. **Approval of Agenda**: Motion by K. Peasley, supported by D. Griesing, to approve the agenda for the 04/15/2022 Executive Committee meeting. Motion carried.

3. **Guest Board Member Comments:** K. DeLaat introduced new MSHN board member, Sue Twing.

4. **Board Matters:**
   - 4.1 May 2022 Draft Board Meeting Agenda: The draft May 3, 2022 board meeting agenda was reviewed by the committee. J. Sedlock highlighted a few items on the agenda. There were no adjustments to the draft agenda. The Committee noted that the agenda presented is draft until finalized by administration.
   - 4.2 New Newaygo CMH Board Member Appointee Susan Twing: K. DeLaat introduced S. Twing earlier in this meeting. E. Woods informed the Executive Committee that S. Twing's board orientation was conducted in early April.
   - 4.3 Legislation Tracking Attachment to CEO Report – Feedback: J. Sedlock is seeking any feedback from the Executive Committee on the Legislation Tracking attachment to his board report. Most Executive Committee members stated that they value the report as presented and recognize the effort involved in producing it and find it highly informative and useful.
   - 4.4 Other: None

5. **Administration Matters:**
   - 5.1 System Redesign Legislation Update: J. Sedlock reported that there is no new information to provide on the House or Senate legislation.
   - 5.2 Association Representation of PIHPs: E. Woods and J. Sedlock discussed representation of PIHPs by the CMH Association and recent testimony by the Association Associate Director to the House Health Policy Committee along with recent communications from the Association. Both expressed concern that the state of CMH Association representation of PIHPs in their advocacy work around the proposed redesign legislation appears to be anti-PIHP at worst and dismissive of PIHPs roles in the public behavioral health system at best. J. Sedlock and E. Woods stated that they have expressed concern directly to the Association and have requested stronger advocacy for the *whole* public behavioral health system, including PIHPs, in public (and private) statements by the Association. E. Woods has also done so and will continue to advocate for stronger support for PIHPs in his role as a CMHAM Board Member.

5.3 MSHN Post-Pandemic Operations Plan Update: J. Sedlock reported that A. Ittner and the MSHN Leadership Team have drafted a post-pandemic operations plan. The plan is built upon the successes MSHN staff have demonstrated throughout the pandemic, a recent staff survey to gather information on issues and preferences, a recent provider/stakeholder survey to gather information on issues and preferences, MSHN business requirements and other considerations. The plan is currently under a 30-day review by MSHN staff for input and feedback, after which the proposed/draft plan will be edited and finalized. MSHN is committed to providing employees at least 60 days advance notice of its implementation. J. Sedlock is also working with the MSHN landlord to address space occupied, lease cost and related matters. The MSHN office lease expires 09/30/2022.

5.4 CCBHC Demonstration Site Updates: A. Ittner provided the Executive Committee with a briefing on the status of CCBHC demonstration implementation in the MSHN region, noting three CMHSPs are demonstration sites in the region (CEI, Saginaw, The Right Door). A. Ittner reported that the demonstration is moving forward well and that MSHN meets frequently with demonstration CCBHCs and MDHHS. Currently about 6,500 people have been enrolled at one of the three demonstration CCBHCs and approximately 300,000 CCBHC services have been delivered. A. Ittner noted ongoing workforce challenges affecting CCBHCs (and all other providers).

5.5 Pace, frequency, and breadth of MDHHS Change Initiatives: J. Sedlock made the Executive Committee aware that the number and breadth of MDHHS-initiated change initiatives is significant and pressuring available internal resources at MSHN (and across the region). Some of these initiatives include, but are not limited to: Opioid Health Homes, Certified Community Behavioral Health Clinics, Healthcare Information Exchange, Healthcare Data Analytics, expanded MDHHS and Health Services Advisory Group Surveys, American Society of Addiction Medicine Continuum of Care Tool installation and analyses, electronic consent management development and installation, Provider Stability efforts, Conflict Free Access and Planning initiative, financial reporting requirement changes (encounter quality initiative, standard cost allocation model, tiered rates for psychiatric inpatient and specialized residential settings, and more), child and adolescent behavioral health services improvements, racial and ethnic health disparity and inequity improvements, the MICAL and national 988 crisis lines, inpatient psychiatric bed registry, MDHHS customer relationship management software implementation, and many others. MSHN continues to be heavily involved in all of these initiatives. The purpose of this discussion was to inform the Executive Committee that, with MSHNs focus on services and service delivery, impact of staffing shortages and provider stabilization activities across the region, available MSHN and regional resources to attend to all of these changes are wearing very thin.

5.6 Other: None

6. Other:

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

6.2 Next scheduled Executive Committee Meeting: 05/20/2022 – The Executive Committee meeting on 05/20/2022 is cancelled due to proximity of the meeting to May 3 board meeting. The Committee can be called together if there is a need prior to the next scheduled Executive Committee meeting on June 17, 2022.

7. Guest Board Member Comments: None

8. Adjourn: This meeting was adjourned at 9:28 a.m.

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, APRIL 5, 2022 (VIDEO CONFERENCE)

***Members Present**:* Irene O'Boyle, Kurt Peasley, Jim Anderson, John Johansen

Members Absent: Jeanne Ladd

Staff Present: Amanda Ittner (Deputy Director); Sherry Kletke (Executive Assistant)

1. CALL TO ORDER

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

2. APPROVAL OF THE AGENDA

MOTION by Kurt Peasley, supported by Jim Anderson, to approve the April 5, 2022, Board Policy Committee Meeting Agenda, as presented. Motion Carried: 4-0.

3. **POLICIES UNDER DISCUSSION**:

Mr. John Johansen invited Ms. Amanda Ittner to inform members on the revisions made to the policies being presented under discussion. The Utilization Management Committee reviewed the Access System and Utilization Management policies to make them consistent with the MDHHS contract. During the first reading by the Board Policy Committee, it was recommended that there was too much detail included in each policy and the level of details should be included in procedures. These two (2) policies were revised to remove the details and make them into separate procedures. The detailed procedures were also included in the packet for Board Policy Committee reference. Committee members raised no questions or comments to the two (2) policies presented under discussion.

CHAPTER: UTILIZATION MANAGEMENT

1. ACCESS SYSTEM
2. UTILIZATION MANAGEMENT

MOTION by Irene O'Boyle, supported by Kurt Peasley, to approve and recommend the policies under discussion as presented. Motion carried: 4-0.

Board Policy Committee Members expressed appreciation of the explanations and agreeing to divide out the policies and procedures for the policies under discussion. Policy Committee members also appreciated the quick turnaround time to remove the details into separate procedures. Policy Committee members wished to thank Ms. Irene O'Boyle for responding back with the edit requests and in a timely fashion as always.

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

4. POLICIES UNDER BIENNIAL REVIEW

Mr. John Johansen invited Ms. Amanda Ittner to inform members on the revisions made to the policies being presented under biennial review. Ms. Ittner provided an overview of the substantive changes within the policies. The Utilization Management chapter has been reviewed by the Utilization Management Committee and the Operations Council. Committee members raised no questions or comments to the two (2) policies presented under biennial review.

CHAPTER: UTILIZATION MANAGEMENT

1. LEVEL OF CARE SYSTEM FOR PARITY
2. RETROSPECTIVE SAMPLING FOR ACUTE SERVICES

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

5. NEW BUSINESS

There was no new business.

6. ADJOURN

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

Meeting Minutes respectfully submitted by:
MSHN Executive Assistant

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

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 02/28/2022

Members Present: Chris Pinter; Lindsey Hull; Carol Mills; Sharon Beals; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; John Obermesik; Sandy Lindsey;
Members Absent: Maribeth Leonard; Sara Lurie
MSHN Staff Present: Joseph Sedlock; Amanda Ittner; for applicable areas: Kim Zimmerman and Todd Lewicki

Agenda Item	Action Required				
CONSENT AGENDA	No discussion				
	Consent agenda items approved	By Who	N/A	By When	N/A
FY2021 Annual Compliance Summary and Report	K. Zimmerman reviewed the FY21 Annual Compliance Summary and Report				
	Ops Council received and supports efforts included	By Who	N/A	By When	N/A
FY2021 QAPIP Report, FY2022 QAPIP Plan and Summary	K. Zimmerman reviewed the FY21 Annual QAPIP Summary and Report				
	Ops Council approved the FY21 QAPIP report and FY22 Plan	By Who	N/A	By When	N/A
1915(i) Update	T. Lewicki provided an update on the 1915(i) workgroup and related initiatives.				
	Ops Council supports implementation as presented	By Who	N/A	By When	N/A
North Shores Crisis Residential Contract	T. Lewicki gave an update on the progress with development plan on the crisis residential services with North Shores. A. Ittner reviewed the contract template with North Shores; North Shores supports the contract language with no changes; CMHs that want to utilize the service should review the contract template, provide feedback and then final version will be sent out for signature.				
	Ops Council to review the contract, provide feedback, edits within two weeks and indication if they will be participating in the contract	By Who	CMHSP CEOs	By When	3.14.22
Provider Staffing Crisis Stabilization Initiative – Application Form	J. Sedlock reviewed the guidance and application form with edits as requested. The standardized regional provider communication release was presented that will be distributed by end of week after Board approval. Joe reviewed the recommendations from Sandy Lindsey and will incorporate the changes.				
	Ops Council supported and Joe will send out documents after Board approval	By Who	J. Sedlock	By When	3.4.22

Agenda Item	Action Required				
Regional COVID Related updates/planning (if any)	Discussed the vaccination mandate and any updated guidance.				
	Discussion Only	By Who		By When	
System Redesign – Ongoing Dialog/Discussion/Regional Strategies	Discussed the current Shirkey and Whiteford proposal indicated possible vote on Wednesday				
	Discussion Only	By Who		By When	
Salary and Wage Survey	M. Stillwagon wanted feedback and requested our region's approach to submission of the survey both from an internal agency perspective and with distribution and submission from the network. MSHN's perspective is the survey is under the PIHPs contract via policy and allowability of MDHHS to request information. CMHSPs have communicated the survey out to providers with questions being directed to Milliman. CMHSPs also plant to submit information related to direct operated services.				
	Discussion Only	By Who	N/A	By When	N/A

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 03/21/2022

Members Present: Lindsey Hull; Maribeth Leonard; Carol Mills; Sharon Beals; Tracey Dore; Tammy Warner; Kerry Possehn; Michelle Stillwagon; John Obermesik; Sandy Lindsey; Sara Lurie
Members Absent: Chris Pinter (bereavement)
MSHN Staff Present: Joseph Sedlock; for relevant portions: Todd Lewicki (MiCAL/9-8-8 Rollout); Kim Zimmerman (FMS and Self-Determination items)

Agenda Item	Action Required				
CONSENT AGENDA					
	Items on the consent agenda considered; no further discussion; all consent agenda items recommended for approval.	By Who	N/A	By When	N/A

MiCAL/9-8-8 Rollout – MDHHS Guests Presenting for Region 5	Elizabeth DeJongh, Krista Hausermann, Karen Everett and Natalie McQueary gave a presentation on MiCAL and 9-8-8 rollout. Soft rollout by region (11/2021 to 10/2022). Of note:
	• Not a replacement for CMHSP crisis/access lines – it is supplemental and supportive.
	• No one will be required to call 9-8-8 or the MiCAL system
	• Provides support for individuals in crisis, information and referral
	• 9-8-8 is not new – it is an expanded service for the National Suicide Prevention Lifeline (NSPL). (NSPL direct dial numbers will not go away)
	• No additional face-to-face services are required in relation to the implementation of either line.
	• Will activate emergency services but will not dispatch mobile teams or anyone else. Described as a warm handoff to the local CMHSP/service provider.
	• Warm line is open now, available between 10 am and 2 am 7 days per week. – This is a separate line from MiCAL and 988 – staffed by peer support specialists. If crisis services needed, someone is available in the same location to assist the peer support specialist and caller.
	• 80% of NSPL lines must be handled in State of origin by July 2022. (Michigan goal is 90%)
	  ○ Chats and texts will be added after voice calls at a later date.
	• 988 won't be advertised until the end of 2022 or the beginning of 2023 – there will be a national strategy and a state strategy.
	• Michigan plans to transition from a regional call line system to a statewide call line system over the next year or so. Need to stay in alignment with Michigan statue that requires a statewide crisis and access line.
	• There will be Letters of Agreement with each CMHSP/PIHP/Emergency Services provider.
	  ○ As rollout occurs, existing call volume to NSPL is not very frequent, a nod to the effectiveness of current crisis and access lines across the state.
	  ○ Once 988 goes live, additional call volume is anticipated (early 2023 and beyond).				

Agenda Item	Action Required				
	• Coordination requirements were reviewed – including Crisis and Access services and information, referrals, activation of face-to-face crisis services, encounter reports and crisis alerts. ○ MDHHS will work with each entity on all of these coordination aspects/requirements • Schedule of training reviewed. • Target MSHN Region go-live date is May 30. • MSHN will collect information staff key contacts and trainees from regional CMHSPs via Clinical Management Committee (due 3/31) and submit to MDHHS				
	Clinical Leadership Committee to gather required staff training/contact information and submit on behalf of the region to MDHHS	By Who	Todd Lewicki	By When	03/31/2022
FY22 Savings Estimates	Savings estimates reviewed				
	MSHN region continues to be in a health financial position.	By Who	N/A	By When	N/A
FMS/Self-Determination Review/Workgroup Request	A) K. Zimmerman requested that regional CMHSPs identify a lead organization for a Financial Management Services provider performance review B) Request to create a short-term Self-Determination focused workgroup to address changes to the MDHHS Self-Determination Technical Requirement and standardize approach for consistency across the region.				
	A) CMHCM and SCCMHA will consult with their internal teams and advise K. Zimmerman by 03/31/2022 B) Operations Council support the creation of a limited (6 meetings max) self-determination focused regional workgroup. If more time is needed, Operations Council requests that the workgroup reapproach with rationale for additional time.	By Who	John Obermesik Sandy Lindsey	By When	03/31/2022
Check in: MDHHS Reorganization • **Regional Approach to orient/level-set with MDHHS?**	Discussion of MDHHS reorganization and whether to approach new MDHHS leadership to highlight this region's effectiveness, collaborations, successes, etc.				
	Operations Council supports a meeting with incoming MDHHS leadership at some future date if the region believes that would be in our interests and we have specific items to communicate. Hold for now.	By Who	N/A	By When	N/A
Check in: MSHN Regional Provider Staffing Crisis Stabilization Initiative • **Applications received; Issues?**	S. Lindsey advised the group that MALA is making grants of up to $700/bed available for COVID-related costs not covered by other initiatives or fund sources. Region will not request disclosure of provider receipt of these funds, but individual CMHSPs may do so as they determine best for local decision-making/circumstances.				

Agenda Item	Action Required				
Provider Questions? • **Regional Guidance-any edits needed?**	SCCMHA raised a few questions for the group to ensure regional consistency in administering the Provider Staffing Crisis Stabilization Initiative. A) Recommended and Operations Council agreed to ask the Finance Council to develop a recommended upper range for provider retention/sign-on incentives, noting these ranges would help ensure some regional consistency and also noting they should not be published in the regional guidance. B) Deadlines for applications: J. Sedlock noted that the regional guidance did not require submission of applications by any date because it will take providers time to comply with the requirement to secure governing body authorization. MSHN released guidance to the SAPTR system with a notation that applications are open through the rest of the FY or as funds remain available, noting that early application is encouraged. C) Discussion of providers under contract with multiple CMHSPs in the region, submitting the CMHSP that represents highest dollar volume, then designating support to another part of the region (but not in the catchment area of the funding CMHSP). D) J. Sedlock described his understanding of process to be used by finance council to track applications (spreadsheet in MSHN Box System) for funding and discuss some applications to help promote regional consistency (CMHSPs are free to make decisions for their networks within the guidelines established in the regional guidance document).				
	A) J. Sedlock to request L. Thomas to address via Finance Council B) SCCMHA CFO to bring this issue to the Finance Council for discussion and any ensuing recommendations to be brought to Operations Council	By Who	J. Sedlock S. Lindsey	By When	03/25/2022 3/31/2022
Regional COVID related updates/planning (if any)	CMHSP Participants discussed various operational issues to inform one another on COVID-related issues they are dealing with				
	No further action needed.	By Who	N/A	By When	N/A
System Redesign-Ongoing Dialog/Discussion/Regional Strategies (if any)	Some discussion of points not being addressed by the Association (designated entity language)				
	No further action needed.	By Who	N/A	By When	N/A
MSHN Operations Council Meetings (in-person/virtual)?	Discussion of future in-person meetings.				
	MSHN to arrange for in-person meetings through the rest of the current fiscal year when (1) agenda is substantial and expected to involve substantial dialog; (2) agenda includes longer strategic discussion.	By Who	J. Sedlock	By When	As Needed

Agenda Item		Action Required			
	For FY 23 venue planning (which is typically done in August/September for the following fiscal year), the Operations Council will consider alternating between virtual and in-person meetings [every other month or quarterly basis]		J. Sedlock		When FY 23 Meeting Schedule is presented (August or September)

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: 04/18/2022

Members Present: Chris Pinter; Sara Lurie; Maribeth Leonard; Carol Mills; Sharon Beals; Tracey Dore; Tammy Warner; John Obermesik; Sandy Lindsey
Members Absent: Michelle Stillwagon; Lindsey Hull; Kerry Possehn
MSHN Staff Present: Joseph Sedlock; Amanda Ittner;

Agenda Item	Action Required				
CONSENT AGENDA	K. Conflict Free Case Management: T. Lewicki to be requested to a future Ops meeting G. Question on the SIS data, HBH will send info to Amanda for follow				
	No further follow up or questions	By Who	J. Sedlock A. Ittner	By When	4.30.22
Staff Qualifications Advocacy Opportunity	Included as a handout; Crisis Service Qualifications request (Gratiot) and discussion to support regional communication to MDHHS with urgency for consideration.				
		By Who		By When	
Check In: MSHN Regional Provider Staffing Crisis Stabilization Initiative • **Applications received; Issues? Provider Questions?** • **Regional Guidance-any edits needed?**	Discussed the applications received and rationale by each CMH and MSHN MSHN: 5-6 from SUD residential and outpatient, totals seemed reasonable				
	No further discussion	By Who	N/A	By When	N/A
Regional COVID related updates/planning (if any)	Discussed masks guidance across the region Some CMHs tracking percent vaccinated Discussed in person training				
	Discussion Only	By Who	N/A	By When	N/A
System Redesign – ongoing dialog/discussion/regional strategies (if any)	Extended discussion around system redesign and system improvements MSHN and/or PIHPs collectively can take. Not an all-inclusive list, the following were discussed at length: Representation of PIHPs by the Association, including that PIHPs have been asked by the Association to indicate the value of the PIHPs. Discussed the Whiteford and Shirkey Bills and implications for regional entity, PIHPs, CMHSPs and actions this region (in partnership with others or even other stakeholders) can take to improve and not maintain status quo. Support for moving the systems towards efforts such as CCBHC, OHH, BHH, etc.; probably need fewer PIHPs Impact with current state lead initiatives and keeping up with the pace of change				

Agenda Item	Action Required				
	Is there space for our PIHPs/regions to conduct some consolidation or operate more similarly Discuss where can PIHPs/CMHs find some relief in administrative burdens: skinny record, PCP				
	Bring forward a recommendation for skinny record for CCBHC services Sedlock adding information for the value add of PIHPs Sedlock will connect with MDHHS structure related to PCP follow up as it relates to Mild to Moderate Review the Risk Based Performance Monitoring Strategy	By Who	CCBHC sites J. Sedlock A. Ittner	By When	5.30.22

POLICIES AND PROCEDURE MANUAL

Chapter	Utilization Management		
Title:	Access System Policy		
Policy: ☒ Procedure:☐ Page: 1 of 38	Review Cycle: Biennial An Author: UM Director & UM Committee	Adopted Date: 11.22.2013 Review Date: 07.07.2020 02.24.2022 Revision Eff. Date: 04.2020	Related Policies: Service Delivery System: Service Philosophy Utilization Mgmt: Utilization Management

Purpose

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

Policy

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

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

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

The access system performs the following key functions:

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

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

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

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

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

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

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

~~intellectual I~~

~~Access System Management:~~

~~MSHN shall create, implement and maintain access system standards that are uniform throughout the region. The MSHN provider network shall develop written policies, procedures and plans demonstrating the capability of its access system to comply with those standards.~~

- ~~MSHN will ensure that screening/outcomes tools and admission criteria are based on eligibility criteria established in contract and regulations are reliably and uniformly administered. The MSHN UM Plan is designed to integrate system review components that include PIHP contract requirements and CMHSPs' roles and responsibilities concerning UM/quality assurance/improvement issues.~~
- ~~CMHSP Participants within the MSHN region will manage all requests with prompt, consistent screening and assessment for Medicaid eligible adults and children requesting service.~~
- ~~MSHN has delegated its access system to CMHSP Participants. Each CMHSP Participant shall adopt access policies and procedures that assure compliance with MSHN's policy and provide for efficient and effective access practices.~~
- ~~MSHN and the CMHSP Participants shall determine the individual's eligibility for Medicaid specialty services and supports, Healthy Michigan Plan, Substance Abuse Block Grant (SABG) or, for those who do not have any of these benefits as a person whose presenting needs for behavioral health services make them a priority to be served.~~
- ~~The access system shall operate or arrange for an access line that is available 24 hours per day, seven days per week; including in-person and by-telephone access for hearing impaired individuals.~~
- ~~CMHSP Participants are responsible to ensure appropriate treatment, supports, and services to Medicaid beneficiaries through the use of a review/authorization process. The system also provides crisis screening and authorization for high urgent/emergent services (inpatient, crisis residential, and crisis stabilization).~~
- ~~Beneficiaries with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR 438.208(c)(4). This standard does not apply to SUD Community Grant services.~~
- ~~MSHN shall assure, through delegation monitoring reviews, that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, is made by a health care professional who has appropriate clinical licensure and expertise in treating the beneficiary's condition.~~
- ~~The access system shall provide information regarding confidentiality (42 CFR) and recipient rights of substance use disorder clients to all individuals requesting services.~~
- ~~Should a Medicaid beneficiary not meet criteria for the priority population and/or requested service, referring the responsible CMHSP Participant shall provide timely written notice to the individual of the adverse action. Written notice shall include the reason for the action and the beneficiary's options for appealing the action. CMHSP Participant referring subcontractors shall be notified of the authorization disposition at the time of the denial.~~

- When a clinical screening is conducted, the access system shall provide a written (hard copy or electronic) screening decision of the person's eligibility based upon established admission criteria. The written decision shall include:
  - Presenting problems and needs for services and supports,
  - Initial identification of the population group that qualifies the person for services and supports,
  - Legal eligibility and priority criteria (where applicable),
  - Urgent and emergent needs including how linked for crisis services,
  - Screening deposition, and
  - Rationale for admission or denial.
- No individual meeting eligibility and medical necessity criteria for specialty mental health services shall be denied service solely because of individual/family income or third-party payer sources.
- Individuals with behavioral health needs but who are not eligible for Medicaid or Healthy Michigan may be referred to other community services or placed on a waiting list with a written explanation related to the individual's service needs, consistent with MDHHS Waiting List guidelines.
- MSHN is responsible for maintaining an SABG waiting list by contacting clients who are placed on it every 30 days to check their status/well-being and continued interest in services until they are linked with the appropriate level of care. Attempts and contacts shall be documented to ensure that the list is properly maintained. Those clients who are not able to be contacted, or who do not respond after 90 days, may be removed.
  - SABG priority population clients placed on a waiting list are required to be offered interim services. Interim services must minimally include:
    a. Counseling and education about the human immunodeficiency virus (HIV) and tuberculosis (TB).
    b. The risks of needle sharing.
    c. The risks of transmission to sexual partners, infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
    d. HIV or TB treatment service referrals.
    e. Counseling on the effects of alcohol and drug use on a fetus and referral for prenatal care are required for pregnant women.
- MSHN CMHSP Participants shall assure that an individual who has been discharged back into the community from outpatient services and is requesting entrance back into the CMHSP or provider, within one year, will not have to go through a duplicative screening process.

Eligibility Determination:
MSHN's provider network shall serve individuals with serious mental illness, serious emotional disturbance, substance use disorders, and intellectual/developmental disabilities, giving priority to persons with the most serious forms of illness and those in urgent and emergent situations. Once the needs of these individuals have been addressed, MDHHS expects that individuals with other diagnoses of mental disorders with a diagnosis found in the most recent Diagnostic and Statistical Manual of Mental Health Disorders (DSM), will be served based upon agency priorities and within the funding available.
The determination of eligibility will be based upon the target populations as provided in the MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract. This includes persons who may be eligible for the Habilitation Supports Waiver (HSW) and/or the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit that further delineates eligibility for autism services (also referred to as the expanded Autism Benefit). The HSW and EPSDT policies are referenced in the subsequent References/Legal Authority Section.

Mental Illness:
- The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities.

- The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist, and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse.
- The beneficiary has been treated by the health plan for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year.

Serious Emotional Disturbance:

- A minor that possesses a diagnosable mental, behavioral, or emotional disorder that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association.
- Functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities.
- The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:
  (a) A substance abuse disorder.
  (b) A developmental disorder.
  (c) "V" codes in the diagnostic and statistical manual of mental disorders.

Intellectual/Developmental Disability: If applied to an individual older than 5 years, a severe, chronic condition that meets all of the following requirements:

- Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
- Is manifested before the individual is 22 years old.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in three (3) or more of the following areas of major life activity: Self-care, Receptive and Expressive language, Learning, Mobility, Self-direction, Capacity for Independent Living, Economic Self-sufficiency.
- 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.

Substance Use Disorder:

- Determination of medical necessity.
- A diagnosis of one or more substance use disorders found in the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Determination of the initial level of care (LOC) based on the most current edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC), including:
  1. Dimension 1 – Alcohol Intoxication and/or Withdrawal Potential.
  2. Dimension 2 – Biomedical Conditions and Complications.
  3. Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications.
  4. Dimension 4 – Readiness to Change.
  5. Dimension 5 – Relapse, Continued Use or Continued Problem Potential.
  6. Dimension 6 – Recovery Environment.
- Determination of priority population status-priority population client must be admitted to services as follows:

Population	**Admission Requirement**	**Interim Service Requirement**

Pregnant Injecting Drug User	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential Offer admission within 24 business hours. Other Levels or Care Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. d) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Pregnant Substance Use Disorders	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential Offer admission within 24 business hours. Other Levels or Care Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) HIV and TB. b) Risks of transmission to sexual partners and infants. c) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 hours – maximum waiting time 120 days:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. 2. Early intervention clinical services.
Parent At Risk of Losing Children	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 business hours:* Early intervention clinical services.
Individuals Under Supervision of MDOC and Referred by MDOC or Individuals Being Released Directly from an MDOC Without Supervision and Referred by MDOC	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 hours:* Early intervention clinical services Recovery Coach services
All Others	Screened and referred within seven calendar days. Capacity to offer admission within 14 days.	Not required.

The MSHN region will operate within a common definition of medical necessity for service entry, which must be consistently applied region-wide according to the Medicaid Provider Manual. The eligibility/coverage determination decision shall be the result of integrating eligibility criteria and clinical needs with current insurance benefits.

Eligibility determinations occur at initial entry into an episode of care, and on an ongoing basis during an episode of care. Initial eligibility is determined through the Access screening process that occurs as the individual/family requests services to determine the likelihood of a mental illness, serious emotional disturbance, substance use disorder, or intellectual/developmental disability. The screening process shall be used to determine the coverage eligibility that

qualifies individuals for services and authorizes their initial entry into the publicly- funded mental health system for a clinical assessment. Ongoing eligibility is determined by provider clinical reviews and/or UM- continued stay reviews. Ongoing eligibility reviews shall be used to ensure that the individual continues to qualify for ongoing services. Components that go into eligibility decisions include, but are not limited to:

- Data from the practitioner's comprehensive clinical interview and complete mental status examination
- Past clinical history (medical and psychiatric, including response to medication)
- Assessment of the current support system available to the patient including resources, individual's strengths and resources, financial, housing, government programs, community treatment facilities, etc. that are available
- Family history
- Current medical status
- Comprehensive risk assessment, including consideration of relevant demographic factors (age, ethnicity), comorbid substance use, medical conditions and support system, among other factors

Regarding eligibility for SUD services, MSHN may not limit access to the programs and services funded only to the residents of the MSHN's region, because the funds provided by MDHHS come from federal and statewide resources. Members of federal and state-identified priority populations must be given access to screening and to assessment and treatment services, consistent with the requirements, regardless of their residency. However, for non-priority populations, MSHN may give its residents priority in obtaining services when the actual demand for services by residents eligible for services exceeds the capacity of the agencies.

MSHN is committed to culturally competent service delivery acknowledging enrollee rights and responsibilities as established in Federal and State law. To ensure and monitor consumer rights, each Medicaid Service Provider will maintain an Office of Recipient Rights that is in substantial compliance with the requirements of Chapter 7 of the Michigan Mental Health Code.

Medical Necessity Determination:
The following medical necessity criteria apply to the MSHN Medicaid behavioral health and substance use disorder supports and services.

- Necessary for screening and assessing the presence of a mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder and/or
- Required to identify and evaluate a mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or intellectual/developmental disabilities, based on person-centered planning, and for beneficiaries with substance disorders, individualized treatment planning that directs the provision of supports and services to be provided; and
- Made by appropriately licensed and trained mental health, intellectual/developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose;

- Based on documented evidenced-based criteria for determination of scope, duration and intensity; and
- Documented in the individual plan of service.

Supports, Services and Treatment Authorized by the PIHP (through the CMHSP Participant) must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and\
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

Using criteria for medical necessity, a PIHP (through its Provider Network) may deny services that are:

- Deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
- Experimental or investigational in nature;
- For which there exists another appropriate, efficacious, less restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

The MSHN provider network may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

MSHN assures that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

Level of Care Determination:

MSHN ensures there are sufficient and appropriate processes in place at each Network Provider for level of care determination and consistent application of eligibility criteria. Screening tools and admission criteria shall be valid, reliable and uniformly administered. The functional assessment and the Person-Centered Planning (PCP) process together should be used as a basis for identifying goals, risks, and needs; authorizing services, utilization management and review. No assessment scale or tool shall be utilized to set a dollar figure or budget that limits the person-centered planning process. Level of care criteria shall be sufficient to address the severity of illness and define the intensity of service required. CMHSP Participants shall administer level of care reviews that are structured to monitor and evaluate under/over and appropriate utilization of services provided to beneficiaries while also ensuring that consistent standards are being applied. Reviews shall match medical necessity and MSHN Practice Guidelines (Medicaid Provider Manual) to provide for appropriate amount, scope and duration of services necessary to achieve treatment outcomes and consistent with approved practice guidelines.

A. Severity of Illness: the nature and severity of the signs, symptoms, functional impairments and risk potential related to the consumer's disorder.
B. Intensity of Services: the setting of care, usually corresponding to the types and frequency, duration, restrictiveness, and level of support needed to treat the consumer.

Coordination of Care with the Court System:

The access system must be able to utilize the substance use disorder screening information and treatment needs provided by district court probation officer assessments when the probation officer has the appropriate credentialing

~~through the Michigan Certification Board for Addiction Professionals (MCBAP). A release of information form must accompany the district court probation officer referral. The information provided by the probation officer should supply enough information to the access system to apply ASAM Criteria to determine LOC and referral for placement. In situations where information is not adequate, the release of information will allow the access system to contact the district court probation officer to obtain other needed information. The access system must be able to authorize these services based on medical necessity, so PIHP funds can be used to pay for treatment.~~

~~Measurement of Outcomes:~~
~~The MSHN UM model places less emphasis or attention to the specific number, type and duration of services and units delivered; rather, MSHN focuses on the outcome/effectiveness of those services. Outcomes shall be standardized and measurable, where feasible. The MSHN UM model follows use of all contractually mandated outcomes instruments, including the Devereaux Early Childhood Assessment (DECA), Child and Adolescent Functional Assessment Scale (CAFAS), the Level of Care Utilization System (LOCUS), and the Supports Intensity Scale (SIS). Measurement of outcomes must be consistently assessed and monitored and known intervals and applied across all services and service populations. Specific outcome measures include:~~

- ~~Clinical stability~~
- ~~Effectiveness in addressing service needs~~
- ~~Psychosocial factors~~
- ~~Cost~~
- ~~Satisfaction/experience with care.~~
- ~~Individual, family, and community indicators of health and wellness, including benchmarks of quality-of-life changes for people in recovery.~~

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

Definitions/Acronyms:
42 CFR Part 2: The portion of the Code of Federal Regulations which establishes confidentiality requirements pertaining to recipients of substance use disorder treatment services
ASAM-PPC: American Society of Addiction Medicine-Patient Placement Criteria
BH-TEDS: Behavioral Health Treatment Episode Data Set
EPSDT: Early Periodic, Screening, Diagnosis, and Treatment
CAFAS: Child and Adolescent Functional Assessment Scale
CMHSP: Community Mental Health Service Program ~~(inclusive of substance Use Service Provision, coordination and administrative oversight)~~
Contractual Provider: refers to an individual or organization under contract with MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP Participants who hold retained functions contracts
Employee: refers to an individual who is employed by the MSHN PIHP
IDD: Intellectual/Developmental Disabilities
LOCUS: Level of Care Utilization System

MDHHS: Michigan Department of Health & Human Services
MI: Mental Illnesses
MIChild: a Medicaid health insurance program for uninsured children of Michigan's working families
MSHN: Mid-State Health Network
PCP: Person-Centered Plan
PIHP: Prepaid Inpatient Health Plan
Subcontractors: refers to an individual or organization that is directly under contract with CMHSP and/or MSHN to provide behavioral health services and/or supports
Provider Network: refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements
SA~~PT~~BG: Substance Abuse ~~Prevention and Treatment~~ Block Grant
SED: Serious Emotional Disturbance
SIS: Supports Intensity Scale
Staff: refers to an individual directly employed and/or contracted with a CMHSP Participant or SUD providers
SUD: Substance Use Disorder
SUDSP: Substance Use Disorder Service Provider
UMC: Utilization Management Committee

References/Legal Authority:

1. Access System Standards: MDHHS, revised~~:~~ July 29, 2020~~September 2015~~ ~~(Contract Attachment P.4.1.1)~~
~~2. Customer Service System Standards: MDHHS, 2/27/07~~
2. Appeal and Grievance Resolution Processes Technical Requirement: MDHHS, revised July 29, 2020
~~3. Early Periodic, Screening, Diagnosis, and Treatment Policy: MSHN~~
~~4. Habilitation Supports Waiver Policy: MSHN~~
~~5.~~3. 42CFR 438.206: Access Standards
~~6.~~4. 42 CFR 438.208(c)(4)
~~7.~~5. 42CFR 438.210: Enrollee Rights
~~8.~~6. Michigan Mental Health Code 330.1124: Waiting Lists for Admission
~~9.~~7. Michigan Mental Health Code 330.1208: Individuals to Whom Service is Directed
~~10.~~8. MDHHS Medicaid Provider Manual, ~~Mental Health/ Substance Abuse~~ Behavioral Health and Intellectual and Developmental Disabilities Supports and Services chapter
~~11. MDHHS Bureau of Substance Abuse and Addiction Services, Treatment Policy #07~~
~~12.~~9. ~~MDHHS~~ Person-Centered Planning Practice Guideline: MDHHS, ~~olicy~~, ~~revised June 5, 2017~~ revised July 29, 2020

Other References:

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

Change Log:

Date of Change	Description of Change	Responsible Party
11.22.2013	New Policy	UMC
09.2014	Annual Review and update of definitions and acronyms	MSHN CEO
06.2015/07.2015	Update to integrate with UMP	UMC and MSHN CEO
07.23.2015	Clarify clinical eligibility for SUD, clarify FY15 contract provisions.	UMC
04.26.2016	Differentiated SED from MI, 2015 MDHHS Access Policy, and added assessment tools and reference to HSW and EPSDT policies.	UMC

10.27.2016	Updated the policy to reflect Access Management System changes in FY17 MDHHS/PIHP contract.	UMC
10.26.2017	Updated policy to reflect the PCP policy language around assessment tools and PCP process for authorizing services	UMC
10.26.2018	Annual Review	UMC
02.27.2020	Annual Review- added MDOC priority population requirements for SUD services; added DECA as contractually mandated assessment tool	UMC
02.24.2022	Biennial Review – Updated References/Legal Authorities to current versions; Re-formatted to align with MDHHS Access Standards (Rev. January 2022); Separated content into Access Policy and Access Procedure	UMC

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Utilization Management**		
Title:	**Utilization Management Policy**		
Policy: ☒ **Procedure:**☐ **Page:** 1 of ~~48~~	**Review Cycle:** ~~Annually~~ Biennial **Author:** UM Director and UM Committee	**Adopted Date: 11.22.2013** **Review Date: ~~07.07.2020~~ 02.24.2022** **~~Revision Eff. Date:~~** ~~07.07.2020~~	**Related Policies:** Utilization Mgmt: Access Service Delivery System: Service Philosophy; Level of Care System (LOC) for Parity

Purpose

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

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

Policy

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

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

Principles~~:~~

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

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

~~Utilization Management Structure:~~

~~The UM Committee is the primary body responsible for evaluating the utilization of MSHN provider network services and making recommendations to the MSHN Chief Executive Officer (CEO), Chief Compliance Officer (CCO) and the Operations Council (OC). The UM Committee is responsible for reviewing aggregated and trend data related to the implementation and effectiveness of the UM plan.~~

- Utilization Management Committee: The UM Committee is comprised of the MSHN Director of Utilization and Care Management and the CMHSP Participants' Utilization Management staff appointed by the respective CMHSP Participant CEO/Executive Director (ED). All CMHSP Participants shall have equal representation on this committee. Retain and delegated UM functions are outlined in the MSHN Utilization Organization Chart.
- Operations Council: The Operations Council reviews reports concerning utilization and quality improvement matters as identified by the Quality Improvement Council (QIC) and UM Committee and makes recommendations for regional planning and improvement to the MSHN CEO. The Operations Council shall be comprised of the CEO/ED of each CMHSP Participant.

Utilization Management Plan:

MSHN shall create, implement and maintain a region-wide UMP that complies with applicable federal and state statutes, laws and regulations. The MSHN UMP shall adhere to regulations established by governing bodies including the Michigan Department Health & Human Services (MDHHS), Medicaid Services Administration, Centers for Medicaid and Medicare, and relevant accrediting bodies.

A. The MSHN UM Plan shall be implemented in a manner which remains true to MSHN Service Philosophies, particularly person/family centeredness, self-determination, cultural sensitivity, trauma informed/sensitive, and responsiveness to co-occurring (dual diagnoses) conditions.
B. All CMHSP Participants/Provider Network shall create policies and procedures necessary to fulfill all aspects of the CMHSP UMP that include criteria for evaluating medical necessity and processes for reviewing and approving the provision of services.
C. MSHN will monitor CMHSP Participant/Provider Network follow through, specifically evidence of local monitoring for over/under utilization, consistent and responsive to regionally identified patterns and trends.
D. All CMHSP Participants/ Provider Network shall establish procedures for prospective (preauthorization), concurrent, and retrospective authorizations. Procedures shall ensure that:
    1. Review decisions that deny or reduce services are supervised by qualified professionals who have appropriate clinical expertise.
    2. Efforts are engaged to obtain all necessary information, including pertinent clinical data and consultation with the treating physician or prescriber as appropriate for decision making.
    3. Reasons for decisions are clearly documented and readily available to service recipients.
    4. Appeals mechanisms for both providers and service recipients are well publicized and readily available. Notification of denial decisions shall include a description of how to file an appeal and shall be provided to both the beneficiary and the provider.
    5. Decisions and appeals are conducted in a timely manner as required by the exigencies of the situation.
    6. Mechanisms are implemented to evaluate the effects of the program using data related to consumer satisfaction, provider satisfaction, or other appropriate measures.

Authorization for Treatment & Support Services:

Initial and ongoing approval or denial of requested services is delegated to the local CMHSP Participants. This approval or denial includes the screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community mental health services. Communication with individuals regarding UM decisions, including adequate and advance notice, right to second opinion, and grievance and appeals shall be provided in accordance with the Medicaid Managed Specialty Supports and Services contract with the MDHHS. The reasons for treatment decisions shall be clearly documented and available to Medicaid beneficiaries. Information regarding all available appeals processes and assistance through customer services is communicated to the consumer. MSHN shall monitor affiliate authorization, second opinions and appeals processes to ensure compliance with PIHP, State and Federal requirements.

1. Utilization reviews are conducted using medical necessity criteria adopted or developed specifically to guide the level of care and appropriate care planning (Medicaid Provider Manual). This may include, but is not limited to, appropriate length of stay for each level of care according to identified needs of the beneficiary in order for payment to be authorized.

2. The responsibility for managing the utilization of clinical care resources is delegated to the MSHN provider network/professional staff members who assess the needs of and authorize care for beneficiaries receiving services funded by the PIHP.

3. Decisions regarding the type, scope, duration and intensity of services to authorize or deny must be:
    a. Accurate and consistent with medical necessity criteria;
    b. Consistent with Medicaid eligibility, entry, continuing stays and discharge criteria as applicable;
    c. Consistent with formal assessments of need and beneficiary desired outcomes;
    d. Consistent with established guidelines (Medicaid Provider Manual);
    e. Adjusted appropriately as beneficiary needs, status, and/or service requests change;
    f. Timely;
    g. Provided to the consumer in writing as to the specific nature of the decision and its reasons;
    h. As applicable, shared with affected service providers verbally or in writing as to the specific nature of the decision and its reasons if there are any concerns with decisions made;
    i. clearly documented as to the specific nature of the services authorized or denied and the reasons for denial; and
    j. Accompanied by the appropriate notice to consumers regarding their appeal rights with a copy of the notice placed in the consumer's clinical case record.

4. Timeliness of authorization decisions and issuing of appropriate notice to consumers:
    a. For a service authorization decision that denies or limits services, notice must be provided to the member within 14 days following receipt of the request for service for standard authorization decisions, or within 72 hours after receipt of a request for an expedited authorization decision.
    b. For service authorization decisions not reached within 14 days for standard request, or 72 hours for an expedited request, this constitutes a denial and thus the member must receive notice of Adverse Benefit Determination (ABD) on the date that the timeframe expires or a standardized 14 day extension notification letter.
    c. The CMHSP (by delegated function of the PIHP) may extend the standard or expedited service authorization timeframe in certain circumstances for up to an additional 14 calendar days. Circumstances in which an extension may be acceptable include: the consumer requests the extension; awaiting the results of assessment/testing that will inform service level recommendations; additional information is needed from the service provider that submitted the authorization request on behalf of the consumer in order to determine medical necessity of the services being requested; other reasons if the extension is in the best interest of the consumer. If so, the CMHSP must:
        i. Provide the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a Grievance if s/he disagrees with that decision; and
        ii. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
    d. Each CMHSP participant must ensure that it has an established policy/procedure identifying the responsible staff and the method for tracking the timeframe for issuing of an Adverse Benefit Determination (ABD) or the issuing of a standardized 14 day extension notification letter.

5. Additional mental health services (through authority of 1915(b)(3) of the Social Security Act ("B3" services) are intended to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. Authorization and use of

Medicaid funds for any B3 supports and services (including amount, scope, and duration) are dependent upon:

a. The Medicaid beneficiary's eligibility for specialty services and supports;
b. Services have been identified during person-centered planning;
c. Services are medically necessary;
d. Services are expected to achieve one or more of the goals listed in 4.
e. Decision to authorize B3 services (including amount scope and duration) must take into account MSHN's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services.

6. MSHN CMHSP Participants shall not deny the use of a covered service based on preset limits of units or duration; but instead reviews the continued medical necessity on an individualized basis.

7. MSHN assures that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

Service settings must meet the home and community-based setting requirements as specified in the SPA and in accordance with 42 CFR 441.710(a)(1) and (2).achieveparticipation
1915(i) eligibility of enrolled individuals is reevaluated at least annually
home and community-based

Oversight and Monitoring:

Annually MSHN and the UM Committee shall conduct a review of this plan and its stated priorities for action (Attachment B) to assure program effectiveness. MSHN's Medical Director shall be involved in the review and oversight of access system policies and clinical practices.

Additionally, MSHN shall provide oversight and monitoring to ensure that the CMHSP participants meet the following standards:

1. CMHSP participants shall ensure access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual, the Michigan Mental Health Code and the MDHHS/PIHP contract.
2. CMHSP participants shall ensure that there is no conflict of interest between the coverage determination and the access to, or authorization of, services.
3. CMHSP participants shall monitor provider capacity to accept new individuals and be aware of any providers not accepting referrals at any point in time.
4. CMHSP participants shall routinely measure telephone answering rates, call abandonment rates and timeliness of appointment and referrals at any point in time. Any performance issues shall be addressed through the PIHP Quality Assurance and Process Improvement Plan.
5. CMHSP participants shall assure that the access system maintains medical records in compliance with state and federal standards.
6. The CMHSP participants shall work with individuals, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation.

Applies to:

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

Definitions/Acronyms:

Adverse Benefit Determination: A decision that adversely impacts a Medicaid Enrollee's claim for services
Appeal: A review at the local level by a PIHP or CMHSP or an Adverse Benefit Determination, as defined above.
Authorization of Services: The processing of requests for initial and continuing service delivery
CMHSP: Community Mental Health Service Program (inclusive of Substance Use Service Provision, coordination and administrative oversight)

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

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

~~Employee: refers to an individual who is employed by the MSHN PIHP~~

~~Grievance: Enrollee's expression of dissatisfaction about PIHP/CMHSP service issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the Enrollee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, or an Enrollee's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision~~

MDHHS: Michigan Department of Health & Human Services

MSHN: Mid-State Health Network

PIHP: Prepaid Inpatient Health Plan

~~Subcontractors: refers to an individual or organization that is directly under contract with CMHSP and/or MSHN to provide behavioral health services and/or supports.~~

Provider Network: refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements

~~Staff: refers to an individual directly employed and/or contracted with a CMHSP Participant or SUD providers~~

~~SUD: Substance Use Disorder~~

UM: Utilization Management

UMC: Utilization Management Committee

Related Materials:

MSHN Utilization Management Plan

References/Legal Authority:

1. Appeal and Grievance Resolution Processes Technical Requirement: MDHHS, revised July 29, 2020
   ~~1. MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P.6.3.2.1:The Appeal and Grievance Resolution Processes Technical Requirement, July 2004.~~
2. ~~MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P.7.1.1:~~ Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans: MDHHS, Current Year
3. ~~MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P.6.5.1.1:~~ Michigan Mission-Based Performance Indicator System, Version 6.0 for PIHPs, Current Year
4. MDHHS Medicaid Providers Manual, ~~(c~~Current E~~e~~dition~~).~~
5. MSA Bulletin: Mental Health/Substance Abuse 04-03 (Prepaid Inpatient Health Plans)
6. ~~6.~~ 42 CFR 438.404c(5)(6)
7. Early Periodic, Screening, Diagnosis, and Treatment Policy: MSHN
8. Habilitation Supports Waiver Policy: MSHN

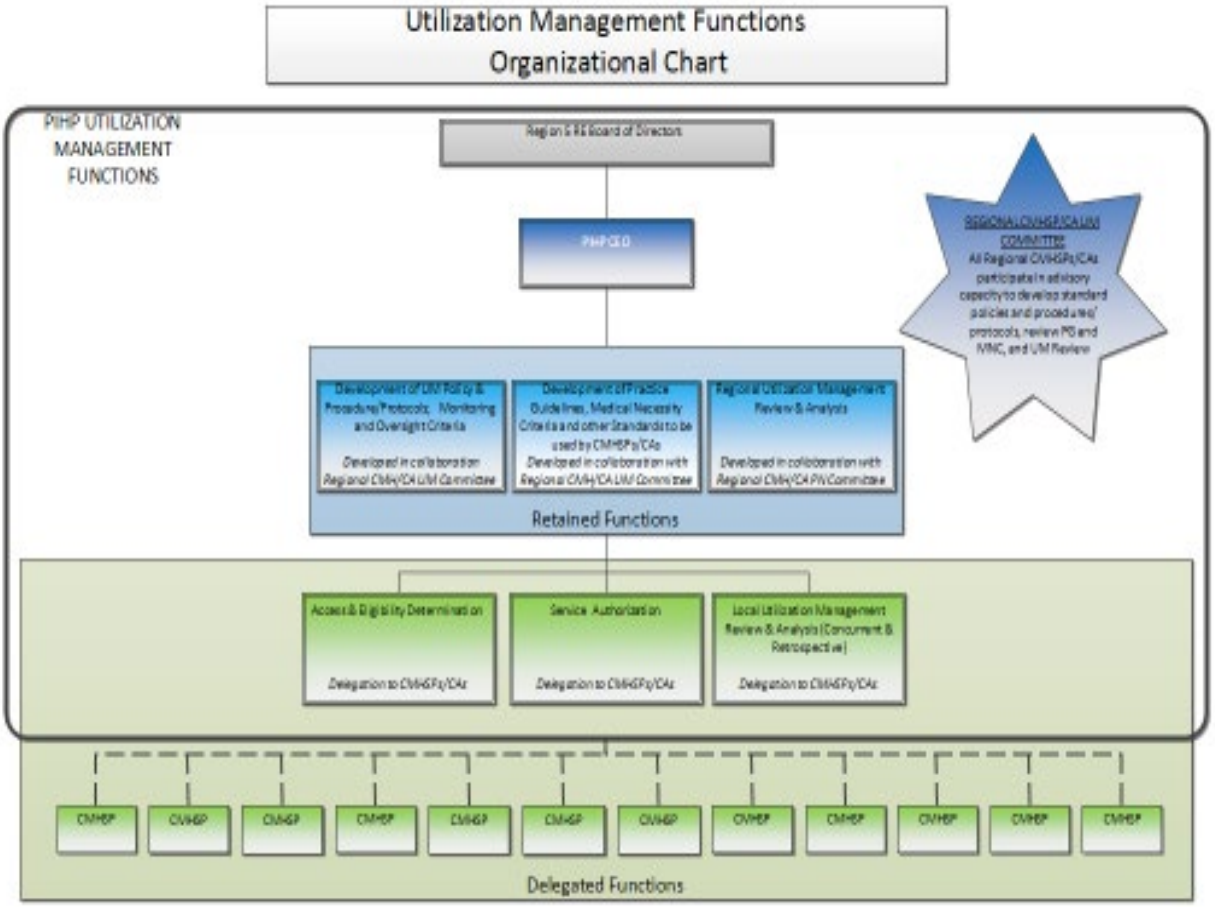
Change Log:

Date of Change	Description of Change	Responsible Party

11.23.2013	New MSHN policy	L. Verdeveld
03.14.2014	Alignment with service philosophy and addition of "prescriber."	Dr. H. Lenhart
04.09.2014	To reflect input of the Utilization Management and Substance Use Disorder Committee/Workgroup	D. McAllister
07.23.2015	UM Committee feedback on MSHN monitoring of over/under utilization; and B3 service clarification of reasonable and equitable, clarify FY15 contract provisions.	UMC
04.25.2016	Moved description of UM delegation grid to UM Policy.	UMC
10.27.2016	Annual review by UMC-no changes.	UMC
10.26.2017	Annual review by UMC-no changes.	UMC
10.26.2018	Annual review by UMC- no changes	UMC
02.27.2020	Annual review by UMC- added clarifying language regarding timeliness of authorization decisions and issuing of Adverse Benefit Determinations in response to 2018-2019 HSAG quality review findings; added corresponding definitions	UMC
02.24.2022	Biennial review by UMC- separated content into policy and procedure	UMC

Attachment A

MSHN Utilization Management Functions Organization Chart



Attachment B

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

MSHN Utilization Management Delegation Grid

MSHN
Mid-State Health Network

Chapter:	Utilization Management		
Title:	Level of Care System (LOC) for Parity		
Policy: ☒ Procedure:☐ Page: 1 of 2	Review Cycle: ~~Annually~~ Biennial Author: Chief Behavioral Health Officer; Admissions and Benefits Standardization Workgroup	Adopted Date: 03.03.2020 Review Date: 02.24.2022 ~~Revision Eff. Date:~~	Related Policies: Service Philosophy Utilization Management

Purpose

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

Policy

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

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

Applies to:

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

Definitions/Acronyms:

CAFAS: Child and Adolescent Functional Assessment Scale
CMHSP: Community Mental Health Service Program
LOC: Level of Care
LOCUS: Level of Care Utilization System
MCG: MCG Health is a software vendor who offers a proprietary product, the MCG Care Guidelines. The MCG Care Guidelines were selected by the Michigan Parity Workgroup as the tool to be utilized by all Michigan PIHPs and CMHSPs to provide care guidance for acute behavioral health services.
MSHN: Mid-State Health Network
PECFAS: Preschool and Early Childhood Functional Assessment Scale

PIHP: Prepaid Inpatient Health Plan

SIS: Supports Intensity Scale

References/Legal Authority:

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

Other References:

N/A

Change Log:

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

MSHN
Mid-State Health Network

Chapter:	Utilization Management		
Title:	Retrospective Sample Review of Acute Care Services Policy		
Policy: ☒ Procedure:☐ Page: 1 of 2	Review Cycle: ~~Annually~~Biennial Author: Director of Utilization & Care Mgmt.; UM Committee	Adopted Date: 03.05.2019 Review Date: ~~07.07.2020~~ 2.24.2022 ~~Revision Eff. Date: 07.07.2020~~	Related Policies: Service Philosophy Utilization Management

Purpose

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

Policy

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

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

Applies to:

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

Definitions/Acronyms:

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

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

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

Other References:
N/A

Change Log:

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