Mid-State Health Network

Board of Directors Meeting ~ November 10, 2020 ~ 5:00 p.m.

Board Meeting Agenda

Video Conference: Click HERE; Meeting ID: 379 796 5720
If prompted for a password, enter: 2269274
Meeting URL: https://zoom.us/j/3797965720
Teleconference: Call 312.626.6799; Meeting ID: 379 796 5720
(You do not need to call in if you are using computer audio to participate)

PUBLIC NOTICE

This meeting of the Mid-State Health Network Board of Directors is being held virtually under 2020 PA 228 to protect the health and safety of the board, staff and members of the public that participate in this meeting of this public body. The technology used for this meeting should permit two-way communication for everyone that want to participate in this meeting. If special accommodations are needed, please contact Mid-State Health Network as soon as possible.

1. Call to Order

2. Roll Call

3. **ACTION ITEM:** Approval of the Agenda

   MSHN 20-21-001: **Motion to approve the agenda for the November 10, 2020 meeting of the MSHN Board of Directors** (No Roll Call)

4. Public Comment (3 minutes per speaker)

5. **ACTION ITEM:** MSHN External Compliance Examination Report Presentation (Derek Miller, Audit Partner, Roslund, Prestage & Company) (Item 5.1 and 5.2, Pages 4-33)

   MSHN 20-21-002: **Motion to receive and file the "Report on Compliance" of Mid-State Health Network for the year ended September 30, 2019.** (Roll Call Vote)

6. **ACTION ITEM:** Confirmation of Municipal Employees Retirement System Plan Addendum (Item 6, Page 34)

   MSHN 20-21-003: **The MSHN Board of Directors approves the confirmation of said MERS Defined Contribution Plans (Employees and CEO dormant plan) and the Social Security opt out Adoption Agreement Addendum effective January 1, 2021.** (Roll Call Vote)

7. **ACTION ITEM:** MSHN Compliance Plan Update for Approval (Item 7, Pages 35 - 65)

   MSHN 20-21-004: **Motion to approve the 2021 MSHN Corporate Compliance Plan and acknowledge receipt of plan.** (Roll Call Vote)

8. Chief Executive Officer's Report (Item 8, Pages 66-80)

9. Deputy Director's Report (Item 9, Pages 81-83)

MSHN

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***

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Zoom Meeting Info:

Video Conference:
Zoom Link: *Click* ***HERE***
Meeting ID: *379 796 5720*
Password If Needed: *2269274*

Teleconference:
Call: *312.626.6799*
Meeting ID: *379 796 5720*

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Upcoming FY21 Board Meetings

Board Meetings convene at 5:00pm unless otherwise noted

January 12, 2021
VIDEOCONFERENCE IF PERMITTED
GIHN - 608 Wright Avenue, Alma

March 2, 2021
VIDEOCONFERENCE IF PERMITTED
GIHN – 608 Wright Avenue, Alma

10. Chief Financial Officer's Report (Item 10, Page 84 – See the following note)

NOTE: In order to present the most accurate and up to date financial information for the year ended 09/30/2020, MSHN has not included interim financial reports in this packet. The financial reports will be sent to MSHN Board members between November 4 and 6 and will be displayed during the meeting for board members and participating members of the public.

MSHN 20-21-005: **The MSHN Board of Directors receives and files the Preliminary Statement of Net Position and Statement of Activities for the Period ended September 30, 2020 as presented.** (Roll Call Vote)

11. **ACTION ITEM:** Contracts for Consideration/Approval (Item 11.1 and 11.2, Pages 85 -87)

MSHN 20-21-006: **The MSHN Board approves and authorizes the Chief Executive Officer to sign and fully execute the contracts as presented on the Contract Listing.** (Roll Call Vote)

12. Executive Committee Report

13. Chairperson's Report

14. **Action Item:** Consent Agenda

MSHN 20-21-007: **Motion to Approve the documents on the Consent Agenda** (Roll Call Vote)

14.1 Approval of the September 1, 2020 Board Meeting Minutes (Item 14.1, Pages 88 - 93)
14.2 Receive the October 6, 2020 Board Policy Committee Meeting Minutes (Item 14.2, Pages 94- 95)
14.3 Receive October 16, 2020 Board Executive Committee Minutes (Item 14.3, Pages 96 - 97)
14.4 Receive Operations Council Key Decisions for September 21, 2020 and October 19, 2020 (Item 14.4.1 and 14.4.2, Pages 98 - 102)
14.5 Approve MSHN Policies, as Recommended by Board Policy Committee: (Item 14.5, Pages 103 - 159)

Item	Policy Chapter	Policy Title
14.5.1	Service Delivery	Children's Home and CBS Waiver
14.5.2	Service Delivery	Severe Emotional Disturbance Waiver
14.5.3	General Mgt	Population Health Integrated Care
14.5.4	Quality	Regional Provider Monitoring and Oversight
14.5.5	Quality	MMBPIS
14.5.6	Service Delivery	Autism Spectrum Disorder Benefit
14.5.7	Service Delivery	Cultural Competency
14.5.8	Service Delivery	Drug Screen Coverage
14.5.9	Service Delivery	Electroconvulsive Therapy (ETC)
14.5.10	Service Delivery	HCBS Compliance Monitoring
14.5.11	Service Delivery	Habilitation Supports Waiver
14.5.12	Service Delivery	Indian Health Services
14.5.13	Service Delivery	Inpatient Psychiatric Hospitalizations Standards
14.5.14	Service Delivery	Out of State Placements
14.5.15	Service Delivery	Service Philosophy & Treatment
14.5.16	Service Delivery	Standardized Assessment
14.5.17	Service Delivery	Supports Intensity Scale
14.5.18	Service Delivery	Supports Intensity Scale Quality Lead
14.5.19	Service Delivery	Telemedicine
14.5.20	Service Delivery	Trauma Informed Care

13. Other Business

14. Public Comment (3 minutes per speaker)

15. Performance Evaluation of the Chief Executive Officer

Note: A summary of the Chief Executive Officer's performance review will be emailed to MSHN Board members on 11/10/2020. The summary will be displayed during this meeting and reviewed in detail by Irene O'Boyle, MSHN Board Vice-Chairperson.

MSHN 20-21-008: **Motion to receive and file the 2020 performance evaluation of the Chief Executive Officer.** (Roll Call Vote)

16. Adjourn

The **mission** of Mid-State Health Network is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members.
The **vision** of Mid-State Health Network is to continually improve the health of our communities through provision of premiere behavioral healthcare and leadership. Mid-State Health Network 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 most vulnerable citizens in our region.

Background

The Compliance Examination was conducted by Roslund Prestage and Company (RPC) firm for the fiscal year ending September 30, 2019. The intent of the review is for auditors to express an opinion on the PIHP's compliance with the Medicaid Contract. In addition to the tests performed at the PIHP level, the process also includes incorporation of each CMHSP's Compliance Examination results. RPC's auditor presented the report results and allowed questions from board members. MSHN did receive minor findings and implemented corrective action to address issues.

Recommended Motion:

Motion to receive and file the "Report on Compliance" of Mid-State Health Network for the year ended September 30, 2019.

Report on Compliance

Mid-State Health Network

September 30, 2019

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

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

Mid-State Health Network
Table of Contents
September 30, 2019

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT ACCOUNTANT'S REPORT ON COMPLIANCE

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

Report On Compliance
We have examined Mid-State Health Network's (the PIHP) compliance with the requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to its Medicaid Contract, General Fund (GF) Contract, Community Mental Health Services (CMHS) Block Grant, and Substance Abuse Prevention and Treatment (SAPT) Block Grant programs for the year ended September 30, 2019.

Management's Responsibility
Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its Medicaid Contract, GF Contract, CMHS Block Grant, and SAPT Block Grant programs.

Independent Accountants' Responsibility
Our responsibility is to express an opinion on the PIHP's compliance with the Medicaid Contract, GF Contract, CMHS Block Grant, and SAPT Block Grant programs based on our examination of the compliance requirements referred to above.

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

An examination involves performing procedures to obtain evidence about the PIHP's compliance with the specified requirements referred to above. The nature, timing, and extent of the procedures selected depend on our judgement, including an assessment of the risk of material noncompliance, whether due to fraud or error.

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

Opinion on Each Program
In our opinion, the PIHP complied, in all material respects, with the specified requirements referred to above that are applicable to its Medicaid Contract, GF Contract, CMHS Block Grant, and SAPT Block Grant programs for the year ended September 30, 2019.

Other Matters
The results of our examination procedures disclosed instances of noncompliance, which are required to be reported in accordance with Compliance Examination Guidelines, and which are described in the accompanying Comments and Recommendations as items 2019-01. Our opinion is not modified with respect to these matters.

The PIHP's responses to the noncompliance findings identified in our examination are described in the accompanying Comments and Recommendations. The PIHP's responses were not subjected to the examination procedures applied in the examination of compliance and, accordingly, we express no opinion on the responses.

Purpose of this Report
This report is intended solely for the information and use of the board and management of the PIHP and the Michigan Department of Health and Human Services, and is not intended to be, and should not be, used by anyone other than these specified parties.

Roslund, Prestage & Company, P.C.

Roslund, Prestage & Company, P.C.
Certified Public Accountants

June 26, 2020

Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract, General Fund Contract, and/or Community Mental Health Services Block Grant Program(s):

None

Material noncompliance with the provisions of laws, regulations, or contracts related to the Medicaid Contract, General Fund Contract, and/or Community Mental Health Services Block Grant Program(s):

None

Known fraud affecting the Medicaid Contract, General Fund Contract, and/or Community Mental Health Services Block Grant Program(s):

None

MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES
CONCURRENT WAIVER PROGRAMS
EXAMINED MEDICAID CONTRACT SETTLEMENT WORKSHEET
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP: Mid-State Health Network - Region 5

FISCAL YEAR: FY 18 / 19

1. Specialty Managed Care - Medicaid		Medicaid (Incl Autism & HRA)	HMP (Incl Autism & HRA)	HSW	DHIP	Total	FY Indicator
a.	Current Fiscal Year - Medicaid Revenue rec'd thru 9/30	415,815,416	68,336,066	90,640,003	931,903	$ 575,723,388	FY 19
b.	Current Fiscal Year - Medicaid Revenue Accruals			723,547	929,255	$ 1,652,802	FY 19
c.	Sub-Total Current Fiscal Year Medicaid Revenue:	$ 415,815,416	$ 68,336,066	$ 91,363,550	$ 1,861,158	$ 577,376,190	FY 19
d.	Prior Fiscal Year 1 - Accrual Adjustment - Net			35,171		$ 35,171	FY 18
e.	Prior Fiscal Year 2 - Accrual Adjustment - Net					$ -	FY 17
f.	Other Adjustments (DHHS Approval Required)					$ -	Describe Below
g.	Sub-Total - Prior Year Accrual Adjustments:	$ -	$ -	$ 35,171	$ -	$ 35,171	
h.	Total Medicaid Revenue - Current Year Settlement:	$ 415,815,416	$ 68,336,066	$ 91,398,721	$ 1,861,158	$ 577,411,361	
i.	Total Current Fiscal Year Performance Bonus Incentive Pool (PBIP) Withheld (enter as a positive amount)	3,360,831	454,525	692,337		$ 4,507,693	
j.	Explanation of Accrual Adjustments						

2. Forced Lapse to MDHHS		Amount	Examination Adjustments	Examined Totals
a.	Medicaid Specialty Managed Care Forced Lapse (enter as negative)			$ -
1.	Explanation of Forced Lapse and Explanation of Examination Adjustments:			

3. Medicaid Savings / Medicaid Lapse Calculation			Amount	
a.	Specialty Managed Care - Medicaid Capitation (incl Autism)		581,919,054	
1.	Band # 1 (95 - 100%)	5%	29,095,953	PIHP retains
2.	Band # 2 (90 - 95%)	5%	29,095,953	Shared PIHP / MDHHS
b.	Balance Available for Savings (from Medicaid FSR)		5,219,588	
b1.	Balance Available for Savings (from Healthy Michigan FSR)		-	
b2.	Total Available for Savings		5,219,588	

			Total Lapse	Total Earned Savings	Total Savings Corridor
c. 1.	Band # 1	5,219,588		5,219,588	5,219,588
2.	Sub-Total - Band # 1	-			
3.	Band # 2	-	-	-	-
4.	Sub-Total - Band # 2	-			
5.	Band # 3	-	-		-
6.	Totals		$ -	$ 5,219,588	$ 5,219,588

4. Summary of Total Savings / Lapse		Total Lapse	Total Earned Savings	Total Savings Corridor	% of Savings by Funding
1.	Total Disposition of Medicaid Savings / Lapse		5,219,588	5,219,588	100%
2.	Total Disposition of Healthy Michigan Savings / Lapse			-	0%
3.	Total Savings / Lapse	$ -	$ 5,219,588	$ 5,219,588	100%

5. Medicaid Savings - Prior Year Earnings to Expend		FY2018	FY	FY	FY	Total
a.	Prior Year Medicaid Savings Earned - Medicaid	7,503,360				7,503,360
b.	Current Year Expenditures - Medicaid	7,503,360				7,503,360
c.	Prior Year Medicaid Savings Earned - HMP					-
d.	Current Year Expenditures - HMP					-
e.	Balance of Medicaid Savings:	$ -	$ -	$ -	$ -	$ -

6. Narrative: Both CRCS and Contract Settlement Worksheet

Preparer's note: The amounts shown as submitted amounts throughout this examined FSR are based on the FSR that was submitted by MSHN to MDHHS on 03-26-20. The changes between the 02-28-20 FSR and the 03-26-20 FSR are not shown as examination adjustments in this report as the 03-26-20 FSR was accepted as the final FSR by MDHHS.

An examination adjustment was made to Row 4.1 (Total Earned Savings) to decrease earned savings to correspond with other examination adjustments that were made.
Row 4.1 was decreased from $5,233,920 to $5,219,588; a difference of $(14,332)

MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES
CONCURRENT WAIVER PROGRAMS
EXAMINED MEDICAID/HMP CONTRACT RECONCILIATION AND CASH SETTLEMENT
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP: Mid-State Health Network - Region 5

	1. Medicaid Services - Available Resources	**PIHP Contract Cost Settled**
a.	Total Managed Care Capitation (Medicaid & Healthy Michigan Plan)	$ 577,411,361
b.	1st & 3rd Party Collections - Medicaid (FSR A 121)	-
c.	1st & 3rd Party Collections - HMP (FSR AI 121)	-
d.	Prior Year Medicaid Savings (FSR A 123 + FSR AI 123)	7,503,360
e.	ISF Abatement - Medicaid / HMP(FSR A 124 + FSR AI 124)	-
f.	Redirected FROM CMHSP to CMHSP Contracts (FSR A 302 + FSR AI 302)	-
g.	Redirected FROM Non-MDHHS Earned Contracts (FSR A 303 + FSR AI 303)	-
h.	Redirected FROM Restricted Fund Balance (FSR A 315 + AI 315 + AK 315)	-
i.	Sub-Total Other Medicaid Services - Resources	$ 7,503,360
j.	Total Medicaid Services - Available Resources	$ 584,914,721

	2. Medicaid Services - Expenditures	
a.	PIHP Insurance Provider Assessment (IPA) Tax (FSR A 201 + FSR AI 201)	5,334,964
b.	Medicaid Services (FSR A 202 - A 122 - A 325)	483,822,631
b.1	Healthy Michigan Plan Services (FSR AI 202 - AI 122 - AI 325)	72,332,034
b.2	MI Health Link Medicaid Services (FSR A 205)	-
c.	Deposits - ISF Medicaid / HMP (FSR A 203 + FSR AI 203)	376,000
d.	Psych Hospital HRA (FSR A 204 + FSR AI 204)	17,829,504
e.	Sub-Total Medicaid Services - Expenditures	$ 579,695,133
f.	Redirected TO CMHSP to CMHSP Contracts (FSR A 301 + FSR AI 301)	-
h.	Redirected TO MI Health Link (FSR A 301c)	-
i.	Sub-Total Medicaid Services - Redirected Expenditures	$ -
j.	Total Medicaid Services - Expenditures	$ 579,695,133

	3. Net Medicaid Services Surplus / (Deficit)	
a.	Medicaid Funding Surplus / (Deficit)	5,219,588
b.	Less: Forced Lapse to MDHHS (Medicaid worksheet 2.a)	-
c.	Net Medicaid Services Surplus / (Deficit)	$ 5,219,588

	4. Disposition		**Amount**
a.	Surplus		
	1.	Transfer to Fund Balance - Medicaid Savings Earned	(5,219,588)
	2.	Lapse to MDHHS - Contract Settlement	-
	3.	Total Disposition - Surplus	$ (5,219,588)
b.	Deficit		
	1.	Redirected from General Fund (FSR A 331 + AI 331 + AK 331)	-
	2.	Redirected from Local (FSR A 332 + AI 332 + AK 332)	-
	3.	Redirected Risk Corridor - PIHP Share (FSR A 333 + AI 333)	-
	4.	Redirected Risk Corridor - MDHHS Share (FSR A 334 + AI 334)	-
	5.	Redirected from Restricted Fund Balance (FSR A 335 + AI 335 + AK 335)	-
	6.	Total Disposition - Deficit	$ -

4.1 Medicaid Savings Transferred To/From		**Amount**
	PIHP receiving transferred Medicaid savings	**Total Transferred**
a.		
b.		
c.		
d.		
e.		
f.	Total	$ -

5. Cash Settlement: (Due MDHHS) / Due PIHP		**Amount**
a.	Forced Lapse to MDHHS	-
b.	Lapse to MDHHS - Contract Settlement	-
c.	Risk Corridor - MDHHS Share	-
d.	Return of Prior Year Medicaid Savings	
e.	Misc (please explain)	
f.	Misc (please explain)	
g.	Total Cash Settlement: (Due MDHHS) / Due PIHP	$ -

6. Medicaid MDHHS Commitment		**Amount**
a.	MDHHS / PIHP Medicaid Funded Expenditures	572,191,773
b.	Earned Medicaid Savings	5,219,588
c.	Sub-Total MDHHS Commitment	$ 577,411,361
d.	Risk Corridor - MDHHS Share	-
e.	Total MDHHS Medicaid Commitment	$ 577,411,361
f.	General Fund Supplement for Unfunded Medicaid	-

7. Report Certification

	Cash Settlement	**Savings**
Examined	$ -	5,219,588
Original Settlement	0	5233920
Increase (Decrease)	-	(14,332)

Comments:

MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED FINANCIAL STATUS REPORT - MEDICAID page 1
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP:		Mid-State Health Network - Region 5	YEAR TO DATE REPORTING										
			A	B	C	D	E	F	G	H	I		
			Regional Authority / Reporting Board	CMHSP							PIHP Grand Total page 1 & 2	Examination Adjustments	Examined Totals
				# 1	# 2	# 3	# 4	# 5	# 6	# 7			
1		PIHP or CMHSP	MSHN	Bay	CEI	Central	Gratiot	Huron	Ionia	Lifeways			
A		MEDICAID SERVICES - PIHP USE ONLY											
A	100	REVENUE											
A	101	Specialty Managed Care Medicaid Revenue	509,075,295								509,075,295		509,075,295
A	115	Medicaid Managed Care - Affiliate Contracts	(467,717,038)	43,342,220	100,985,701	87,894,033	13,748,401	9,461,676	13,417,403	63,517,166	-	-	-
A	120	**Subtotal - Current Period Medicaid Services Revenue**	41,358,257	43,342,220	100,985,701	87,894,033	13,748,401	9,461,676	13,417,403	63,517,166	509,075,295	-	509,075,295
A	121	1st & 3rd Party Collections - Medicare/Medicaid Consumers - Rpting Bd									-		-
A	122	1st & 3rd Party Collections - Medicare/Medicaid Consumers - Affiliate		64,286	1,309,858	362,286	-	55,637	10,800	130,584	2,030,141		2,030,141
A	123	Prior Year Medicaid Savings (Funding Current Year Expenses)	7,503,360								7,503,360		7,503,360
A	124	ISF Abatement									-		-
A	140	**Subtotal - Other Medicaid Revenue**	7,503,360	64,286	1,309,858	362,286	-	55,637	10,800	130,584	9,533,501	-	9,533,501
A	190	**TOTAL REVENUE**	48,861,617	43,406,506	102,295,559	88,256,319	13,748,401	9,517,313	13,428,203	63,647,750	518,608,796	-	518,608,796
A	200	**EXPENDITURE**											
A	201	PIHP Insurance Provider Assessment (IPA) Tax	3,864,460								3,864,460		3,864,460
A	202	Medicaid Services (incl Autism)	16,105,593	43,406,506	102,295,559	88,256,319	13,748,401	9,517,313	13,428,203	63,647,750	485,852,772		485,852,772
A	203	Payment into Medicaid ISF	376,000								376,000		376,000
A	204	Psych Hospital Rate Adjuster (HRA)	10,968,804								10,968,804		10,968,804
A	205	MI Health Link - Medicaid Services									-		-
A	290	**TOTAL EXPENDITURE**	31,314,857	43,406,506	102,295,559	88,256,319	13,748,401	9,517,313	13,428,203	63,647,750	501,062,036	-	501,062,036
A	295	**SUBTOTAL NET MEDICAID SERVICES SURPLUS (DEFICIT)**	17,546,760	-	-	-	-	-	-	-	17,546,760	-	17,546,760
A	300	**Redirected Funds (To) From**											
A	301	(TO) CMHSP to CMHSP Earned Contracts - **J304**	-								-		-
A	301b	(TO) Healthy MI Plan - **AI310**	(12,327,172)								(12,327,172)		(12,327,172)
A	301c	(TO) MI Health Link Services (Medicare) - **AK310**	-								-		-
A	302	FROM CMHSP to CMHSP Earned Contracts - **J301** (explain - section AB)									-		-
A	303	FROM Non-MDHHS Earned Contracts - **K301** (explain - section AB)									-		-
A	310a	FROM Healthy MI Plan - **AI301a**									-		-
A	315	FROM Restricted Fund Balance - **RES 1.c**	-								-		-
A	325	Info only - Affiliate Total Redirected Funds - **I390**									-		-
A	330	**Subtotal Redirected Funds rows 301 - 325**	(12,327,172)	-	-	-	-	-	-	-	(12,327,172)	-	(12,327,172)
A	331	FROM General Fund - Redirected to Unfunded Medicaid Costs - **B301**									-		-
A	332	FROM Local Funds - **M301**									-		-
A	333	FROM Risk Corridor - PIHP Share - **N301**	-								-		-
A	334	FROM Risk Corridor - MDHHS Share - **N302**									-		-
A	335	FROM Restricted Fund Balance - Risk Financing **RES 1.c**	-								-		-
A	390	**Total Redirected Funds**	(12,327,172)	-	-	-	-	-	-	-	(12,327,172)	-	(12,327,172)
A	400	**BALANCE MEDICAID SERVICES**	5,219,588	-	-	-	-	-	-	-	5,219,588	-	5,219,588

AB		**REMARKS**
AB		Remarks may be added about any entry or activity on the report for which additional information may be useful.
AB		An examination adjustment was made to adjust the amounts reported by Mid-State to the examined amounts reported by the following CMHSPs:
AB		Row A115 - Montcalm from $15,505,198 to $15,519,530, an increase of $14,332
AB		Row A202 - Montcalm from $15,505,198 to $15,519,530, an increase of $14,332

MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED FINANCIAL STATUS REPORT - MEDICAID page 2
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP:		Mid-State Health Network - Region 5	YEAR TO DATE REPORTING								
			J	K	L	M	N	O	P	Q	R
			CMHSP								
			# 8	# 9	# 10	# 11	# 12	# 13	# 14	# 15	# 16
1		PIHP or CMHSP	**Montcalm**	**Newaygo**	**Saginaw**	**Shiawassee**	**Tuscola**				
A		**MEDICAID SERVICES - PIHP USE ONLY**									
A	100	**REVENUE**									
A	101	Total Specialty Managed Care Medicaid Revenue									
A	115	Medicaid Managed Care - Affiliate Contracts	15,519,530	12,534,919	70,033,239	18,965,976	18,296,774				
A	120	**Subtotal - Current Period Medicaid Services Revenue**	15,519,530	12,534,919	70,033,239	18,965,976	18,296,774	-	-	-	-
A	121	1st & 3rd Party Collections - Medicare/Medicaid Consumers - Rpting Bd									
A	122	1st & 3rd Party Collections - Medicare/Medicaid Consumers - Affiliate	-	-	-	-	96,690				
A	123	Prior Year Medicaid Savings (Funding Current Year Expenses)									
A	124	ISF Abatement									
A	140	**Subtotal - Other Medicaid Revenue**	-	-	-	-	96,690	-	-	-	-
A	190	**TOTAL REVENUE**	15,519,530	12,534,919	70,033,239	18,965,976	18,393,464	-	-	-	-
A	200	**EXPENDITURE**									
A	201	PIHP Insurance Provider Assessment (IPA) Tax									
A	202	Medicaid Services (incl Autism)	15,519,530	12,534,919	70,033,239	18,965,976	18,393,464				
A	203	Payment into Medicaid ISF									
A	204	Psych Hospital Rate Adjuster (HRA)									
A	205	MI Health Link - Medicaid Services									
A	290	**TOTAL EXPENDITURE**	15,519,530	12,534,919	70,033,239	18,965,976	18,393,464	-	-	-	-
A	295	**SUBTOTAL NET MEDICAID SERVICES SURPLUS (DEFICIT)**	-	-	-	-	-	-	-	-	-
A	300	**Redirected Funds (To) From**									
A	301	(TO) CMHSP to CMHSP Earned Contracts - **J304**									
A	301b	(TO) Healthy MI Plan - **AI310**									
A	301c	(TO) MI Health Link Services (Medicare) - **AK310**									
A	302	FROM CMHSP to CMHSP Earned Contracts - **J301** (explain - section AB)									
A	303	FROM Non-MDHHS Earned Contracts - **K301** (explain - section AB)									
A	310a	FROM Healthy MI Plan - **AI301a**									
A	315	FROM Restricted Fund Balance - **RES 1.c**									
A	325	Info only - Affiliate Total Redirected Funds - **I390**									
A	330	**Subtotal Redirected Funds rows 301 - 325**	-	-	-	-	-	-	-	-	-
A	331	FROM General Fund - Redirected to Unfunded Medicaid Costs - **B301**									
A	332	FROM Local Funds - **M301**									
A	333	FROM Risk Corridor - PIHP Share - **N301**									
A	334	FROM Risk Corridor - MDHHS Share - **N302**									
A	335	FROM Restricted Fund Balance - Risk Financing **RES 1.c**									
A	390	**Total Redirected Funds**	-	-	-	-	-	-	-	-	-
A	400	**BALANCE MEDICAID SERVICES**	-	-	-	-	-	-	-	-	-

MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED FINANCIAL STATUS REPORT - Healthy Michigan page 1
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP:		Mid-State Health Network - Region 5	YEAR TO DATE REPORTING										
			A	B	C	D	E	F	G	H	I		
			Regional Authority / Reporting Board	CMHSP							PIHP Grand Total page 1 & 2	Examination Adjustments	Examined Totals
				# 1	# 2	# 3	# 4	# 5	# 6	# 7			
1		PIHP or CMHSP	MSHN	Bay	CEI	Central	Gratiot	Huron	Ionia	Lifeways			
AI		HEALTHY MICHIGAN SERVICES - PIHP USE ONLY											
AI	100	REVENUE											
AI	101	Healthy Michigan Plan	68,336,066								68,336,066		68,336,066
AI	115	Healthy Michigan Managed Care - Affiliate Contracts	(53,015,278)	4,051,383	13,648,939	8,506,309	986,561	1,174,448	1,743,827	8,645,489	-	-	-
AI	120	**Subtotal - Current Period Healthy Michigan Services Revenue**	15,320,788	4,051,383	13,648,939	8,506,309	986,561	1,174,448	1,743,827	8,645,489	68,336,066	-	68,336,066
AI	121	1st & 3rd Party Collections - HMP Consumers - Rpting Bd									-		-
AI	122	1st & 3rd Party Collections - HMP Consumers - Affiliate									-		-
AI	123	Prior Year Healthy MI Plan Savings (Funding Current Year Expenses)	-								-		-
AI	124	ISF Abatement HMP									-		-
AI	140	**Subtotal - Other Healthy Michigan Revenue**	-	-	-	-	-	-	-	-	-	-	-
AI	190	**TOTAL REVENUE**	15,320,788	4,051,383	13,648,939	8,506,309	986,561	1,174,448	1,743,827	8,645,489	68,336,066	-	68,336,066
AI	200	**EXPENDITURE**											
AI	201	PIHP Insurance Provider Assessment (IPA) Tax Healthy Michigan Plan	1,470,504								1,470,504		1,470,504
AI	202	Healthy Michigan Plan Services (incl Autism)	19,316,756	4,051,383	13,648,939	8,506,309	986,561	1,174,448	1,743,827	8,645,489	72,332,034		72,332,034
AI	203	Payment into Healthy Michigan Plan ISF	-								-		-
AI	204	Psych Hospital Rate Adjuster (HRA)	6,860,700								6,860,700		6,860,700
AI	290	**TOTAL EXPENDITURE**	27,647,960	4,051,383	13,648,939	8,506,309	986,561	1,174,448	1,743,827	8,645,489	80,663,238	-	80,663,238
AI	295	**SUBTOTAL NET HEALTHY MICHIGAN SERVICES SURPLUS (DEFICIT)**	(12,327,172)	-	-	-	-	-	-	-	(12,327,172)	-	(12,327,172)
AI	300	**Redirected Funds (To) From**											
AI	301	(TO) CMHSP to CMHSP Earned Contracts - **J304.1**	-								-		-
AI	301a	(TO) Medicaid - **A310a**	-								-		-
AI	302	FROM CMHSP to CMHSP Earned Contracts - **J301.1** (explain - section AJ)									-		-
AI	303	FROM Non-MDHHS Earned Contracts - **K301.1** (explain - section AJ)									-		-
AI	310	FROM Medicaid - **A301b**	12,327,172								12,327,172		12,327,172
AI	315	FROM Restricted Fund Balance - **RES 1.g**	-								-		-
AI	325	Info only - Affiliate Total Redirected Funds - **I390**									-		-
AI	330	**Subtotal Redirected Funds rows 301 - 325**	12,327,172	-	-	-	-	-	-	-	12,327,172	-	12,327,172
AI	331	FROM General Fund - Redirected to Unfunded Healthy Michigan Costs - **B301.1**									-		-
AI	332	FROM Local Funds - **M301.1**									-		-
AI	333	FROM Risk Corridor - PIHP Share - **N301.1**	-								-		-
AI	334	FROM Risk Corridor - MDHHS Share - **N302.1**									-		-
AI	335	FROM Restricted Fund Balance - Risk Financing **RES 1.g**	-								-		-
AI	390	**Total Redirected Funds**	12,327,172	-	-	-	-	-	-	-	12,327,172	-	12,327,172
AI	400	**BALANCE HEALTHY MICHIGAN PLAN SERVICES**	-	-	-	-	-	-	-	-	-	-	-

AJ		REMARKS
AJ		Remarks may be added about any entry or activity on the report for which additional information may be useful.
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MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED FINANCIAL STATUS REPORT - Healthy Michigan page 2
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP:		-	YEAR TO DATE REPORTING								
			J	K	L	M	N	O	P	Q	R
			CMHSP								
			# 8	# 9	# 10	# 11	# 12	# 13	# 14	# 15	# 16
1		PIHP or CMHSP	**Montcalm**	**Newaygo**	**Saginaw**	**Shiawassee**	**Tuscola**	**-**	**-**	**-**	**-**
AI		**HEALTHY MICHIGAN SERVICES - PIHP USE ONLY**									
AI	100	**REVENUE**									
AI	101	Healthy Michigan Plan									
AI	115	Healthy Michigan Managed Care - Affiliate Contracts	2,577,041	1,693,756	6,962,397	1,755,458	1,269,670				
AI	120	**Subtotal - Current Period Healthy Michigan Services Revenue**	2,577,041	1,693,756	6,962,397	1,755,458	1,269,670	-	-	-	-
AI	121	1st & 3rd Party Collections - HMP Consumers - Rpting Bd									
AI	122	1st & 3rd Party Collections - HMP Consumers - Affiliate									
AI	123	Prior Year Healthy MI Plan Savings (Funding Current Year Expenses)									
AI	124	ISF Abatement HMP									
AI	140	**Subtotal - Other Healthy Michigan Revenue**	-	-	-	-	-	-	-	-	-
AI	190	**TOTAL REVENUE**	2,577,041	1,693,756	6,962,397	1,755,458	1,269,670	-	-	-	-
AI	200	**EXPENDITURE**									
AI	201	PIHP Insurance Provider Assessment (IPA) Tax Healthy Michigan Plan									
AI	202	Healthy Michigan Plan Services (incl Autism)	2,577,041	1,693,756	6,962,397	1,755,458	1,269,670				
AI	203	Payment into Healthy Michigan Plan ISF									
AI	204	Psych Hospital Rate Adjuster (HRA)									
AI	290	**TOTAL EXPENDITURE**	2,577,041	1,693,756	6,962,397	1,755,458	1,269,670	-	-	-	-
AI	295	**SUBTOTAL NET HEALTHY MICHIGAN SERVICES SURPLUS (DEFICIT)**	-	-	-	-	-	-	-	-	-
AI	300	**Redirected Funds (To) From**									
AI	301	(TO) CMHSP to CMHSP Earned Contracts - **J304.1**									
AI	301a	(TO) Medicaid - **A310a**									
AI	302	FROM CMHSP to CMHSP Earned Contracts - **J301.1** (explain - section AJ)									
AI	303	FROM Non-MDHHS Earned Contracts - **K301.1** (explain - section AJ)									
AI	310	FROM Medicaid - **A301b**									
AI	315	FROM Restricted Fund Balance - **RES 1.g**									
AI	325	Info only - Affiliate Total Redirected Funds - **I390**									
AI	330	**Subtotal Redirected Funds rows 301 - 325**	-	-	-	-	-	-	-	-	-
AI	331	FROM General Fund - Redirected to Unfunded Healthy Michigan Costs - **B301.1**									
AI	332	FROM Local Funds - **M301.1**									
AI	333	FROM Risk Corridor - PIHP Share - **N301.1**									
AI	334	FROM Risk Corridor - MDHHS Share - **N302.1**									
AI	335	FROM Restricted Fund Balance - Risk Financing **RES 1.g**									
AI	390	**Total Redirected Funds**	-	-	-	-	-	-	-	-	-
AI	400	**BALANCE HEALTHY MICHIGAN PLAN SERVICES**	-	-	-	-	-	-	-	-	-

MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED FINANCIAL STATUS REPORT - Health Home Services
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP:		Mid-State Health Network - Region 5	YEAR TO DATE REPORTING										
			A	B	C	D	E	F	G	H	I		
			Regional Authority / Reporting Board	CMHSP							PIHP Grand Total page 1 & 2	Examination Adjustments	Examined Totals
				# 1	# 2	# 3	# 4	# 5	# 6	# 7			
1		PIHP or CMHSP	MSHN	Bay	CEI	Central	Gratiot	Huron	Ionia	Lifeways			
AG		**Health Home Program - PIHP USE ONLY**											
AG	100	**REVENUE**											
AG	101	Revenue - Health Home Services									-		-
AG	115	Affiliate Contracts	-								-		-
AG	190	**TOTAL REVENUE**	-	-	-	-	-	-	-	-	-	-	-
AG	200	**EXPENDITURE**											
AG	201	PIHP Insurance Provider Assessment (IPA) Tax									-		-
AG	202	Expenditure - Health Home Services									-		-
AG	204	Surplus Funding Retained									-		-
AG	290	**TOTAL EXPENDITURE**	-	-	-	-	-	-	-	-	-	-	-
AG	295	**SUBTOTAL NET HEALTH HOME SERVICES SURPLUS (DEFICIT)**	-	-	-	-	-	-	-	-	-	-	-
AG	300	**Redirected Funds (To) From**											
AG	315	FROM Restricted Fund Balance - **RES 1.f**	-								-		-
AG	325	Info only - Affiliate Total Redirected Funds - **IC390**									-		-
AG	330	**Subtotal Redirected Funds rows 301 - 325**	-	-	-	-	-	-	-	-	-	-	-
AG	331	FROM General Fund - **B301.4**									-		-
AG	332	FROM Local Funds - **M301.4**									-		-
AG	335	FROM Restricted Fund Balance - Risk Financing **RES 1.f**	-								-		-
AG	390	**Total Redirected Funds**	-	-	-	-	-	-	-	-	-	-	-
AG	400	**BALANCE HEALTH HOMES BEHAVIORAL HEALTH SERVICES**	-	-	-	-	-	-	-	-	-	-	-

AH		**REMARKS**
AH		Remarks may be added about any entry or activity on the report for which additional information may be useful. Please note risk management arrangement between PIHP and Affiliates.
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MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED FINANCIAL STATUS REPORT - Opioid Health Home Services
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP:	Mid-State Health Network - Region 5		YEAR TO DATE REPORTING										
			A	B	C	D	E	F	G	H	I		
			Regional Authority / Reporting Board	CMHSP							PIHP Grand Total page 1 & 2	Examination Adjustments	Examined Totals
				# 1	# 2	# 3	# 4	# 5	# 6	# 7			
1		PIHP or CMHSP	MSHN	Bay	CEI	Central	Gratiot	Huron	Ionia	Lifeways			
AE		**Opioid Health Home Program - PIHP USE ONLY**											
AE	100	**REVENUE**											
AE	101	Revenue - Opioid Health Home Services									-		-
AE	115	Affiliate Contracts	-								-		-
AE	190	**TOTAL REVENUE**	-	-	-	-	-	-	-	-	-	-	-
AE	200	**EXPENDITURE**											
AE	201	PIHP Insurance Provider Assessment (IPA) Tax									-		-
AE	202	Expenditure - Opioid Health Home Services									-		-
AE	204	Surplus Funding Retained									-		-
AE	290	**TOTAL EXPENDITURE**	-	-	-	-	-	-	-	-	-	-	-
AE	295	**SUBTOTAL NET OPIOID HEALTH HOME SERVICES SURPLUS (DEFICIT)**	-	-	-	-	-	-	-	-	-	-	-
AE	300	**Redirected Funds (To) From**											
AE	315	FROM Restricted Fund Balance - **RES 1.e**	-								-		-
AE	325	Info only - Affiliate Total Redirected Funds - **IB390**									-		-
AE	330	**Subtotal Redirected Funds rows 301 - 325**	-	-	-	-	-	-	-	-	-	-	-
AE	331	FROM General Fund - **B301.3**									-		-
AE	332	FROM Local Funds - **M301.3**									-		-
AE	335	FROM Restricted Fund Balance - Risk Financing **RES 1.e**	-								-		-
AE	390	**Total Redirected Funds**	-	-	-	-	-	-	-	-	-	-	-
AE	400	**BALANCE OPIOID HEALTH HOME SERVICES**	-	-	-	-	-	-	-	-	-	-	-

AF		**REMARKS**
AF		Remarks may be added about any entry or activity on the report for which additional information may be useful. Please note risk management arrangement between PIHP and Affiliates.
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MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED FINANCIAL STATUS REPORT - MI Health Link page 1
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP:	Mid-State Health Network - Region 5	YEAR TO DATE REPORTING										
		A	B	C	D	E	F	G	H	I		
		Regional Authority / Reporting Board	CMHSP							PIHP Grand Total page 1 & 2	Examination Adjustments	Examined Totals
			# 1	# 2	# 3	# 4	# 5	# 6	# 7			
1	PIHP or CMHSP	MSHN	Bay	CEI	Central	Gratiot	Huron	Ionia	Lifeways			
AK	MI HEALTH LINK SERVICES - PIHP USE ONLY											
AK	100 REVENUE											
AK	101 MI Health Link									-		-
AK	102 ICO - Risk Financing / (ICO - Shared Savings)									-		-
AK	115 MI Health Link - Affiliate Contracts	-								-	-	-
AK	120 **Subtotal - Current Period MI Health Link Services Revenue**	-	-	-	-	-	-	-	-	-	-	-
AK	121 1st & 3rd Party Collections - MI Health Link Consumers - Rpting Bd									-		-
AK	122 1st & 3rd Party Collections - MI Health Link Consumers - Affiliate									-		-
AK	140 **Subtotal - Other MI Health Link Revenue**	-	-	-	-	-	-	-	-	-	-	-
AK	190 **TOTAL REVENUE**	-	-	-	-	-	-	-	-	-	-	-
AK	200 **EXPENDITURE**											
AK	202 MI Health Link Services									-		-
AK	290 **TOTAL EXPENDITURE**	-	-	-	-	-	-	-	-	-	-	-
AK	295 **SUBTOTAL NET MI HEALTH LINK SERVICES SURPLUS (DEFICIT)**	-	-	-	-	-	-	-	-	-	-	-
AK	300 **Redirected Funds (To) From**											
AK	301 (TO) CMHSP to CMHSP Earned Contracts - **J304.3**	-								-		-
AK	302 FROM CMHSP to CMHSP Earned Contracts - **J301.3** (explain - section AL)									-		-
AK	303 FROM Non-MDHHS Earned Contracts - K301.3 (explain - section AL)									-		-
AK	310 FROM Medicaid - **A301c**									-		-
AK	315 FROM Restricted Fund Balance - **RES 1.h**	-								-		-
AK	325 Info only - Affiliate Total Redirected Funds - **ID390**									-		-
AK	330 **Subtotal Redirected Funds rows 301 - 325**	-	-	-	-	-	-	-	-	-	-	-
AK	331 FROM General Fund - Redirected to Unfunded MI Health Link Costs - **B301.5**									-		-
AK	332 FROM Local Funds - **M301.5**									-		-
AK	335 FROM Restricted Fund Balance - Risk Financing **RES 1.h**	-										-
AK	336 (TO) Local funds - **M313.3**	-								-		-
AK	390 **Total Redirected Funds**	-	-	-	-	-	-	-	-	-	-	-
AK	400 **BALANCE MI HEALTH LINK SERVICES (must = 0)**	-	-	-	-	-	-	-	-	-	-	-

AL		REMARKS
AL		Remarks may be added about any entry or activity on the report for which additional information may be useful.
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MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED FINANCIAL STATUS REPORT - MI HEALTH LINK page 2
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP:		Mid-State Health Network - Region 5	YEAR TO DATE REPORTING								
			J	K	L	M	N	O	P	Q	R
			CMHSP								
			# 8	# 9	# 10	# 11	# 12	# 13	# 14	# 15	# 16
1		PIHP or CMHSP	**Montcalm**	**Newaygo**	**Saginaw**	**Shiawassee**	**Tuscola**	**-**	**-**	**-**	**-**
AK		**MI HEALTH LINK SERVICES - PIHP USE ONLY**									
AK	100	**REVENUE**									
AK	101	MI Health Link									
AK	102	FROM ICO - Risk Financing / (TO) ICO - Shared Savings									
AK	115	MI Health Link - Affiliate Contracts									
AK	120	**Subtotal - Current Period MI Health Link Services Revenue**	-	-	-	-	-	-	-	-	-
AK	121	1st & 3rd Party Collections - MI Health Link Consumers - Rpting Bd									
AK	122	1st & 3rd Party Collections - MI Health Link Consumers - Affiliate									
AK	140	**Subtotal - Other MI Health Link Revenue**	-	-	-	-	-	-	-	-	-
AK	190	**TOTAL REVENUE**	-	-	-	-	-	-	-	-	-
AK	200	**EXPENDITURE**									
AK	202	MI Health Link Services									
AK	290	**TOTAL EXPENDITURE**	-	-	-	-	-	-	-	-	-
AK	295	**SUBTOTAL NET MI HEALTH LINK SERVICES SURPLUS (DEFICIT)**	-	-	-	-	-	-	-	-	-
AK	300	**Redirected Funds (To) From**									
AK	301	(TO) CMHSP to CMHSP Earned Contracts - **J304.3**									
AK	302	FROM CMHSP to CMHSP Earned Contracts - **J301.3** (explain - section AL)									
AK	303	FROM Non-MDHHS Earned Contracts - **K301.3** (explain - section AL)									
AK	310	FROM Medicaid - **A301c**									
AK	315	FROM Restricted Fund Balance - **RES 1.h**									
AK	325	Info only - Affiliate Total Redirected Funds - **ID390**									
AK	330	**Subtotal Redirected Funds rows 301 - 325**	-	-	-	-	-	-	-	-	-
AK	331	FROM General Fund - Redirected to Unfunded MI Health Link Costs - **B301.5**									
AK	332	FROM Local Funds - **M301.5**									
AK	335	FROM Restricted Fund Balance - Risk Financing **RES 1.h**									
AK	336	(TO) Local funds - **M313.3**									
AK	390	**Total Redirected Funds**	-	-	-	-	-	-	-	-	-
AK	400	**BALANCE MI HEALTH LINK SERVICES (must = 0)**	-	-	-	-	-	-	-	-	-

MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED FINANCIAL STATUS REPORT - Substance Use Disorder Services - Page 1
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP: Mid-State Health Network - Region 5

YEAR TO DATE REPORTING

			A	B	C	D	E	F	G	H	I		
				CMHSP									
			Regional Authority / Reporting Board	# 1	# 2	# 3	# 4	# 5	# 6	# 7	PIHP Grand Total page 1 & 2	Examination Adjustments	Examined Totals
1		PIHP or CMHSP	MSHN	Bay	CEI	Central	Gratiot	Huron	Ionia	Lifeways			
AC		**Substance Use Disorder (SUD) Services - PIHP USE ONLY**											
AC	100	**REVENUE**											
AC	101	Revenue - SUD Agreement	17,072,564								17,072,564		17,072,564
AC	115	Affiliate Contracts	(1,567,112)	127,277	1,297,451	828	17,176	3,345	16,868	9,612	-	-	-
AC	120	**Subtotal SUD Agreement Revenue**	15,505,452	127,277	1,297,451	828	17,176	3,345	16,868	9,612	17,072,564	-	17,072,564
AC	121	Fees & Collections - Rpting Bd	319,348								319,348		319,348
AC	122	Fees & Collections - Affiliate		-	231,692	-	-	-	-	-	231,692	-	231,692
AC	140	**Subtotal - Other Revenue**	319,348	-	231,692	-	-	-	-	-	551,040	-	551,040
AC	190	**TOTAL REVENUE**	15,824,800	127,277	1,529,143	828	17,176	3,345	16,868	9,612	17,623,604	-	17,623,604
AC	200	**EXPENDITURE**											
AC	201	Expenditure - SUD Services	19,218,914	127,277	2,429,018	828	25,764	3,345	16,868	9,612	21,926,181		21,926,181
AC	290	**TOTAL EXPENDITURE**	19,218,914	127,277	2,429,018	828	25,764	3,345	16,868	9,612	21,926,181	-	21,926,181
AC	295	**SUBTOTAL NET SUD SERVICES SURPLUS (DEFICIT)**	(3,394,114)	-	(899,875)	-	(8,588)	-	-	-	(4,302,577)	-	(4,302,577)
AC	300	**Redirected Funds (To) From**											
AC	301	(TO) CMHSP to CMHSP Earned Contracts - **J304.2**	-								-		-
AC	302	FROM CMHSP to CMHSP Earned Contracts - **J301.2** (explain section AD)									-		-
AC	303	FROM Non-MDHHS Earned Contracts - **K301.2** (explain section AD)									-		-
AC	315	FROM Restricted Fund Balance - **RES 1.d**	4,860,468								4,860,468		4,860,468
AC	325	Info only - Affiliate Total Redirected Funds - **IA390**		-	899,875	-	8,588	-	-	-	908,463		908,463
AC	330	**Subtotal Redirected Funds rows 301 - 325**	4,860,468	-	899,875	-	8,588	-	-	-	5,768,931	-	5,768,931
AC	331	FROM General Funds - Redirected to Unfunded SUD Costs - **B301.2**									-		-
AC	332	FROM Local Funds - **M301.2**	523,045								523,045		523,045
AC	335	FROM Restricted Fund Balance - Risk Financing **RES 1.d**	-								-		-
AC	390	**Total Redirected Funds**	5,383,513	-	899,875	-	8,588	-	-	-	6,291,976	-	6,291,976
AC	400	**BALANCE SUD Services**	1,989,399	-	-	-	-	-	-	-	1,989,399	-	1,989,399

AD		**REMARKS**
AD		Remarks may be added about any entry or activity on the report for which additional information may be useful. Please note risk management arrangement between PIHP and Affiliates.
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MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED FINANCIAL STATUS REPORT - Substance Use Disorder Services - Page 2
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP:		Mid-State Health Network - Region 5	YEAR TO DATE REPORTING								
			J	K	L	M	N	O	P	Q	R
			CMHSP								
			# 8	# 9	# 10	# 11	# 12	# 13	# 14	# 15	# 16
1		PIHP or CMHSP	**Montcalm**	**Newaygo**	**Saginaw**	**Shiawassee**	**Tuscola**	**-**	**-**	**-**	**-**
AC		**Substance Use Disorder (SUD) Services - PIHP USE ONLY**									
AC	100	**REVENUE**									
AC	101	Revenue - SUD Agreement									
AC	115	Affiliate Contracts	73,965	171	17,560	1,331	1,528				
AC	120	**Subtotal SUD Agreement Revenue**	73,965	171	17,560	1,331	1,528	-	-	-	-
AC	121	Fees & Collections - Rpting Bd									
AC	122	Fees & Collections - Affiliate									
AC	140	**Subtotal - Other Revenue**	-	-	-	-	-	-	-	-	-
AC	190	**TOTAL REVENUE**	73,965	171	17,560	1,331	1,528	-	-	-	-
AC	200	**EXPENDITURE**									
AC	201	Expenditure - SUD Services	73,965	171	17,560	1,331	1,528				
AC	290	**TOTAL EXPENDITURE**	73,965	171	17,560	1,331	1,528	-	-	-	-
AC	295	**SUBTOTAL NET SUD SERVICES SURPLUS (DEFICIT)**	-	-	-	-	-	-	-	-	-
AC	300	**Redirected Funds (To) From**									
AC	301	(TO) CMHSP to CMHSP Earned Contracts - **J304.2**									
AC	302	FROM CMHSP to CMHSP Earned Contracts - **J301.2**									
AC	303	FROM Non-MDHHS Earned Contracts - **K301.2**									
AC	315	FROM Restricted Fund Balance - **RES 1.d**									
AC	325	Info only - Affiliate Total Redirected Funds - **IA390**									
AC	330	**Subtotal Redirected Funds rows 301 - 325**	-	-	-	-	-	-	-	-	-
AC	331	FROM General Funds - Redirected to Unfunded SUD Costs - **B301.2**									
AC	332	FROM Local Funds - **M301.2**									
AC	335	FROM Restricted Fund Balance - Risk Financing **RES 1.d**									
AC	390	**Total Redirected Funds**	-	-	-	-	-	-	-	-	-
AC	400	**BALANCE SUD Services**	-	-	-	-	-	-	-	-	-

MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED SUPPLEMENTAL FINANCIAL STATUS REPORT - SUD SERVICES
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP: Mid-State Health Network - Region 5

			EXPENDITURES													
	Fund Source	Budgeted Revenue	General Admin	Access Mgt Sys	Treatment	Womens Specialty	Prevention	PFS 2015-2020	State Targeted Response (STR) GY1: 10/1/18-4/30/19	State Targeted Response (STR) GY 2: 5/1/19-9/30/19	Gambling Disorder Prevention	Other (DHHS Approval Required)	Total	Examination Adjustments	Examined Totals	Balance
A	**State Agreement**	A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.	L.			M.
1	Community Grant												-		-	-
1.a	- General Admin	202,500	200,831										200,831		200,831	1,669
1.b	- Access Management System	235,200		184,675									184,675		184,675	50,525
1.c	- Treatment	8,372,811			8,389,313								8,389,313		8,389,313	(16,502)
1.d	- Women's Specialty Services (WSS)	1,072,088	24,618			1,028,528							1,053,146		1,053,146	18,942
1.e	- Other (DHHS Approval required)												-		-	-
1.f	**Subtotal - Community Grant**	9,882,599	225,449	184,675	8,389,313	1,028,528	-	-	-	-	-	-	9,827,965		9,827,965	54,634
2	Prevention	2,549,468	60,724				2,384,952						2,445,676		2,445,676	103,792
3	State Disability Assistance												-		-	-
4	Partnership For Success (2015-2020)	152,045						152,045					152,045		152,045	-
5	State Targeted Response	4,299,378	60,140						1,458,610	1,053,991			2,572,741		2,572,741	1,726,637
6	Gambling Disorder Prevention	189,074	1,981								82,757		84,738		84,738	104,336
8	**Subtotal - State Agreement**	17,072,564	348,294	184,675	8,389,313	1,028,528	2,384,952	152,045	1,458,610	1,053,991	82,757	-	15,083,165		15,083,165	1,989,399
B	**Medicaid**															
1	Medicaid	12,105,413	272,324	455,673	9,026,508	2,350,908							12,105,413		12,105,413	-
2	Healthy MI Plan	16,460,858	454,747	221,517	14,093,063	1,691,531							16,460,858		16,460,858	-
3	Medicaid- Savings / ISF	1,540,592		1,540,592	-	-							1,540,592		1,540,592	-
4	Healthy MI Plan - Savings / ISF	3,414,025		199,807	3,214,218								3,414,025		3,414,025	-
5	**Subtotal - Medicaid**	33,520,888	727,071	2,417,589	26,333,789	4,042,439	-	-	-	-	-	-	33,520,888	-	33,520,888	-
C	**MI Health Link (Medicare)**															
1	MI Health Link (Medicare)												-		-	-
2	**Subtotal - Medicare**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
D	**Local & Other**															
1	Restricted Fund Balance	4,860,468			2,403,759		2,452,904	1,722		2,083			4,860,468		4,860,468	-
2	Fees & Collections	551,040			536,830		14,210						551,040		551,040	-
3	Other Contracts & Sources	-											-		-	-
4	Other Local	1,431,508			1,242,129		189,379						1,431,508		1,431,508	-
5	**Subtotal - Local & Other**	6,843,016	-	-	4,182,718	-	2,656,493	1,722	-	2,083	-	-	6,843,016	-	6,843,016	-
E	**Grand Total**	57,436,468	1,075,365	2,602,264	38,905,820	5,070,967	5,041,445	153,767	1,458,610	1,056,074	82,757	-	55,447,069	-	55,447,069	1,989,399

F	**Local Match Computation**	Funds Subject to Match											Total Match Funds (Local & Other - D1+D2+D4)		Examined Totals	Match Percentage
		21,926,181	348,294	184,675	12,572,031	1,028,528	5,041,445	153,767	1,458,610	1,056,074	82,757	-	6,843,016		6,843,016	31.21%

G	**REMARKS**										
G	Remarks may be added about any entry or activity on the report for which additional information may be useful.										
G		Expenditure Category Detail	Amount	Expenditure Category Detail	Amount	Expenditure Category Detail					Amount
G		STR - Strengthening Families	$ 68,999	Saginaw Odyssey House (1.d.)	$ 401,220						
G											
G		STR - Red Project	$ 481,374								
G											
G		STR - Motivational Interviewing	$ 166,841								
G											
G		STR - MAT Enhancements	$ 1,456,556								
G											
G		STR - Project ASSERT	$ 338,831								
G											
G		STR - Administration	$ 60,140								
G											
G											
G											
G		Total	$ 2,572,741	Total	$ 401,220	Total					$ -

MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED RESTRICTED FUND BALANCE ACTIVITY
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP: Mid-State Health Network - Region 5

1.	Restricted Fund Balance Activity	PA2	PA2 - (Risk Financing)	Performance Bonus Incentive Pool (PBIP)	Performance Bonus Incentive Pool (PBIP) - (Risk Financing)	Restricted Fund Balances / Current Activity
a.	Restricted Fund Balance @ Beginning of Fiscal Year	$ 13,382,975				$ 13,382,975
b.	Current Period Deposits	$ 3,149,556		$ 4,218,615		$ 7,368,171
c.	Current Period Financing Medicaid					$ -
d.	Current Period Financing SUD Non-Medicaid	$ (4,860,468)				$ (4,860,468)
e.	Current Period Financing Opioid Health Homes Behavioral Health					$ -
f.	Current Period Financing Health Homes Behavioral Health					$ -
g.	Current Period Financing Healthy MI Plan					$ -
h.	Current Period Financing MI Health Link					$ -
i.	Current Period Financing Behavioral Health System			$ (4,218,615)		$ (4,218,615)
j.	Restricted Fund Ending Balance	$ 11,672,063		$ -		$ 11,672,063

Explanation of Examination Adjustme

MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT
EXAMINED INTERNAL SERVICE FUND
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP: Mid-State Health Network - Region 5

1. Internal Service Fund Fiscal Year Activity		ISF Balance @ Beginning of Fiscal Year	Current Period ISF Contributions Interest Earned	Current Period ISF Contributions Deposits	Current Period ISF Reduction (Abatement)	Current Period ISF Financing Medicaid (Risk)	Current Period ISF Financing HMP (Risk)	ISF Ending Balance
a.	ISF Balances / Current Activity	$ 43,054,074	$ 213,704	$ 376,000	$ -	$ -	$ -	$ 43,643,778
b.	Specialty Managed Care	$ 37,162,462	$ 183,398	$ 376,000	$ -			$ 37,721,860
c.	Healthy Michigan Plan	$ 5,891,612	$ 30,306	$ -	$ -			$ 5,921,918

1.1	PIHP Transferred To/From ISF balances	Total Transferred
a.		
b.		
c.		
d.		
e.		
f.	Total Transferred to/from PIHPs	$ -
g.	Final balance after transfers	$ 43,643,778
h.	Specialty Managed Care portion of balance	$ 37,721,860
i.	Healthy Michigan Plan portion of balance	$ 5,921,918

2. PIHP Maximum Allowable Funding of ISF		Amount
a.	Specialty Managed Care - Medicaid Capitation (FSR Medicaid - A 120 + FSR HMP - AI 120 + Medicaid Worksheet - 1.i PBIP Withhold)	$ 581,919,054
b.	% of Current Year Medicaid Capitation	7.5%
c.	Maximum Allowable Funding of Med ISF	$ 43,643,929

3. Disposition of ISF Ending Balance		Amount	Narrative of Resolution if ISF Over Funded
a.	Maximum Allowable Funding of Medicaid ISF	$ 43,643,929	
b.	Medicaid ISF Ending Balance	$ 43,643,778	
c.	Within Maximum Allowable Limit / (Overfunded)	$ 151	
Explanation of Examination Adjustments			

MDHHS/PIHP MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAM CONTRACT
EXAMINED SHARED RISK CALCULATION & RISK FINANCING
FOR THE YEAR ENDED SEPTEMBER 30, 2019

PIHP: Mid-State Health Network - Region 5

1. Shared Risk Calculation			Medicaid Amount	HMP Amount	PBIP Amount	Total Amount
a1.	Specialty Managed Care - Medicaid Capitation (FSR Medicaid - A 120 + FSR HMP - AI 120 + Medicaid Worksheet - 1.i PBIP Withhold)		$ 509,075,295	$ 68,336,066	$ 4,507,693	$ 581,919,054
a2.	Band # 1 (100 - 105%)	5%			29,095,953	Full PIHP Responsibility
a3.	Band # 2 (105 - 110%)	5%			29,095,953	Shared State / PIHP Responsibility
b.	Total Risk				-	

		State Risk	Local Risk	Total Risk Corridor
c1.	Band # 1 Liability		-	-
c2.	Sub-Total - Band # 1	-		
c3.	Band # 2 Liability	-	-	-
c4.	Sub-Total - Band # 2	-		
c5.	Band # 3 Liability	-		-
c6.	Total Risk Responsibility	$ -	$ -	$ -

2. Disposition of Risk		State Risk	Local Risk	Total Risk Corridor
a.	Stop/Loss Insurance (FSR - Non-Medicaid Line N 101)		-	-
b.	Medicaid / HMP for PIHP Share Risk Corridor (FSR - Non-Medicaid Line N 102)		-	-
c.	Local Funds / Local Fund Balance - Medicaid / HMP Services (FSR - Non-Medicaid Line M 301, M 301.1)		-	-
d.	Restricted Funds / Restricted Fund Balance - Medicaid / HMP Services (FSR - Non-Medicaid Line N 104)		-	-
e.	General Fund Redirect for Unfunded Medicaid / HMP Costs - MDHHS Approved ONLY (FSR - Non-Medicaid Line B 301, B301.1)		-	-
f.	Due PIHP From MDHHS (FSR - Non-Medicaid Line N 103)	-		-
g.	Total Risk Corridor Funding	$ -	$ -	$ -

3. Summary of Total Risk / Funding		State Risk	Local Risk	Total Risk Corridor
a.	Total Risk	-	-	-
b.	Total Disposition of MDHHS / Local Risk - Medicaid			-
b1.	Total Disposition of MDHHS / Local Risk - Healthy Michigan Plan			-
c.	Balance of Risk Corridor (Must = $0)	$ -	$ -	$ -

Explanation of Examination Adjustments

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
EXAMINED FINANCIAL STATUS REPORT - ALL NON MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2019

CMHSP: Mid-State Health Network - Region 5

			REPORTED	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
A		MEDICAID SERVICES - Summary From FSR - Medicaid			
A	190	TOTAL REVENUE	516,578,655	-	516,578,655
A	290	TOTAL EXPENDITURE	499,031,895	-	499,031,895
A	295	NET MEDICAID SERVICES SURPLUS (DEFICIT)	17,546,760	-	17,546,760
A	390	Total Redirected Funds	(12,327,172)	-	(12,327,172)
A	400	BALANCE MEDICAID SERVICES	5,219,588	-	5,219,588
AC		SUD NON-MEDICAID SERVICES - Summary From FSR - SUD			
AC	190	TOTAL REVENUE	17,391,912	-	17,391,912
AC	290	TOTAL EXPENDITURE	20,786,026	-	20,786,026
AC	295	NET SUD NON-MEDICAID SERVICES SURPLUS (DEFICIT)	(3,394,114)	-	(3,394,114)
AC	390	Total Redirected Funds	5,383,513	-	5,383,513
AC	400	BALANCE SUD NON-MEDICAID SERVICES	1,989,399	-	1,989,399
AE		OPIOID HEALTH HOME SERVICES - Summary From FSR - Opioid Health Home Services			
AE	190	TOTAL REVENUE	-	-	-
AE	290	TOTAL EXPENDITURE	-	-	-
AE	295	NET SURPLUS (DEFICIT)	-	-	-
AE	390	Total Redirected Funds	-	-	-
AE	400	BALANCE OPIOID HEALTH HOME SERVICES	-	-	-
AG		HEALTH HOME SERVICES - Summary From FSR - Health Home Services			
AG	190	TOTAL REVENUE	-	-	-
AG	290	TOTAL EXPENDITURE	-	-	-
AG	295	NET HEALTH HOME SERVICES SURPLUS (DEFICIT)	-	-	-
AG	390	Total Redirected Funds	-	-	-
AG	400	BALANCE HEALTH HOME SERVICES	-	-	-
AI		HEALTHY MICHIGAN SERVICES - Summary From FSR - Healthy Michigan			
AI	190	TOTAL REVENUE	68,336,066	-	68,336,066
AI	290	TOTAL EXPENDITURE	80,663,238	-	80,663,238
AI	295	NET HEALTHY MICHIGAN SERVICES SURPLUS (DEFICIT)	(12,327,172)	-	(12,327,172)
AI	390	Total Redirected Funds	12,327,172	-	12,327,172
AI	400	BALANCE HEALTHY MICHIGAN SERVICES	-	-	-
AK		MI HEALTH LINK SERVICES - Summary From FSR - MI Health Link			
AK	190	TOTAL REVENUE	-	-	-
AK	290	TOTAL EXPENDITURE	-	-	-
AK	295	NET MI HEALTH LINK SERVICES SURPLUS (DEFICIT)	-	-	-
AK	390	Total Redirected Funds	-	-	-
AK	400	BALANCE MI HEALTH LINK SERVICES	-	-	-
RES		RESTRICTED FUND BALANCE ACTIVITY			
RES	180	Beginning Restricted Fund balance	13,382,975		
RES	190	TOTAL REVENUE (Deposits)	7,368,171		
RES	290	TOTAL EXPENDITURE (PBIP only)	4,218,615		
RES	390	Total Redirected Funds	(4,860,468)		
RES	400	BALANCE RESTRICTED FUND	11,672,063		
B		GENERAL FUND			
B	100	REVENUE			
B	101	CMH Operations			-
B	120	Subtotal - Current Period General Fund Revenue	-	-	-
B	121	1st & 3rd Party Collections (Not in Section 226a Funds) 100% Services			-
B	122	1st & 3rd Party Collections (Not in Section 226a Funds) 90% Services			-
B	123	Prior Year GF Carry Forward			-
B	140	Subtotal - Other General Fund Revenue	-	-	-
B	190	TOTAL REVENUE	-	-	-
B	200	EXPENDITURE			
B	201	100% MDHHS Matchable Services / Costs			-
B	202	100% MDHHS Matchable Services Based on CMHSP Local Match Cap	-	-	-
B	203	90% MDHHS Matchable Services / Costs - REPORTED			
B	204	90% MDHHS Matchable Services / Costs - EXAMINATION ADJUSTMENTS			
B	205	90% MDHHS Matchable Services / Costs - EXAMINED TOTAL $ -	-	-	-
		Intentionally left blank			
		Intentionally left blank			
B	290	TOTAL EXPENDITURE	-	-	-
B	295	NET GENERAL FUND SURPLUS (DEFICIT)	-	-	-
B	300	Redirected Funds (To) From			
B	301	(TO) Medicaid - Redirected for Unfunded Medicaid Costs - **A331** (PIHP use only)	-	-	-
B	301.1	(TO) Healthy Michigan - Redirected for Unfunded Healthy Michigan Costs - **AI331** (PIHP use only)	-	-	-
B	301.2	(TO) SUD Non-Medicaid - Redirected for Unfunded SUD Non-Medicaid Services **AC331** (PIHP use only)	-	-	-
B	301.3	(TO) Opioid Health Home Services - Redirected for Unfunded Opioid Health Home Services **AE331** (PIHP use only)	-	-	-
B	301.4	(TO) Health Home Services - Redirected for Unfunded Health Home Services **AG331** (PIHP use only)	-	-	-
B	301.5	(TO) MI Health Link - Redirected for Unfunded MI Health Link Costs - **AK331** (PIHP use only)	-	-	-
B	304	(TO) Targeted Case Management - **D301**	-	-	-
B	305	(TO) GF Cost of SED - **E301**	-	-	-
B	306	(TO) GF Cost of SED - Not SED Waiver eligible - **E303**	-	-	-
B	308	(TO) GF Cost of Children's Waiver - **F301**	-	-	-
B	309	(TO) Allowable GF Cost of Injectable Medications - **G301**	-	-	-
B	310	(TO) PIHP to Affiliate Medicaid Services Contracts - **I304**	-	-	-
B	310.1	(TO) PIHP to Affiliate SUD (Non-Medicaid) Services Contracts - **IA304**	-	-	-
B	310.2	(TO) PIHP to Affiliate Opioid Health Home Services Contracts - **IB304**	-	-	-

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
EXAMINED FINANCIAL STATUS REPORT - ALL NON MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2019

CMHSP: Mid-State Health Network - Region 5

			REPORTED	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
B	310.3	(TO) PIHP to Affiliate Health Home Services Contracts - **IC304**	-	-	-
B	310.4	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID304**	-	-	-
B	312	(TO) CMHSP to CMHSP Earned Contracts - **J305** (explain - section Q)	-	-	-
B	313	FROM CMHSP to CMHSP Earned Contracts - **J302**			-
B	314	FROM Non-MDHHS Earned Contracts - **K302**			-
B	330	**Subtotal Redirected Funds rows 301 - 314**	-	-	-
B	331	FROM Local Funds - **M302**			-
B	332	FROM Risk Corridor - **N303**			-
B	390	**Total Redirected Funds**	-	-	-
B	400	**BALANCE GENERAL FUND (cannot be < 0)**	-	-	-

OTHER GF CONTRACTUAL OBLIGATIONS					
C		**INTENTIONALLY LEFT BLANK**			
C	100	**Revenue**			
C	170				
C	180				
C	190	**Total Revenue**	-	-	-
C	290	Expenditure			
C	295	**NET SURPLUS (DEFICIT)**	-	-	-
C	300	**Redirected Funds (To) From**			
C	301				
C	302				
C	390	**Total Redirected Funds**	-	-	-
C	400	**BALANCE (cannot be < 0)**	-	-	-
FEE FOR SERVICE MEDICAID					
D		**TARGETED CASE MANAGEMENT - (GHS Only)**			
D	190	Revenue			-
D	290	Expenditure			-
D	295	**NET TARGETED CASE MANAGEMENT (cannot be > 0)**	-	-	-
D	300	**Redirected Funds (To) From**			
D	301	FROM General Fund - **B304**			-
D	302	FROM Local Funds - **M304**			-
D	303	(TO) CMHSP to CMHSP Earned Contracts - **J304.4**	-	-	-
D	304	FROM CMHSP to CMHSP Earned Contracts - **J303.4**			-
D	390	**Total Redirected Funds**	-	-	-
D	400	**BALANCE TARGETED CASE MANAGEMENT (GHS Only) (must = 0)**	-	-	-
E		**SED WAIVER**			
E	100	**REVENUE**			
E	101	FFS Medicaid - SED-Trad			-
E	102	FFS Medicaid - SED-DHS			-
E	190	**TOTAL REVENUE**	-	-	-
E	200	**EXPENDITURE**			
E	201	Expenditure - Traditional - Federal Reimbursable			-
E	202	Expenditure - Traditional - Not SED waiver eligible			-
E	203	Expenditure - SED-DHS - Federal Reimbursable			-
E	204	Expenditure - SED-DHS - Not SED waiver eligible			-
E	290	**TOTAL EXPENDITURE**	-	-	-
E	295	**NET SED WAIVER (DEFICIT)**	-	-	-
E	300	**Redirected Funds (To) From**			
E	301	FROM General Fund - **B305**			-
E	302	FROM Local Funds - **M305**			-
E	303	FROM General Fund - Not SED Waiver eligible - **B306**			-
E	304	FROM Local Funds - Not SED Waiver eligible - **M306**			-
E	390	**Total Redirected Funds**	-	-	-
E	400	**BALANCE SED WAIVER (must = 0)**	-	-	-
F		**CHILDREN'S WAIVER**			
F	190	Revenue			-
F	290	Expenditure			-
F	295	**NET CHILDREN'S WAIVER (cannot be > 0)**	-	-	-
F	300	**Redirected Funds (To) From**			
F	301	FROM General Fund - **B308**			-
F	302	FROM Local Funds - **M308**			-
F	303	FROM Activity not otherwise reported - **O301**			-
F	390	**Total Redirected Funds**	-	-	-
F	400	**BALANCE CHILDREN'S WAIVER (must = 0)**	-	-	-
G		**INJECTABLE MEDICATIONS**			
G	190	Revenue			-
G	290	Expenditure			-
G	295	**NET INJECTABLE MEDICATIONS (cannot be > 0)**	-	-	-
G	300	**Redirected Funds (To) From**			
G	301	FROM General Fund - **B309**			-
G	302	FROM Local Funds - **M309**			-
G	390	**Total Redirected Funds**	-	-	-
G	400	**BALANCE INJECTABLE MEDICATIONS (must = 0)**	-	-	-

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
EXAMINED FINANCIAL STATUS REPORT - ALL NON MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2019

CMHSP: Mid-State Health Network - Region 5

			REPORTED	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
OTHER FUNDING					
H		**MDHHS EARNED CONTRACTS**			
H	100	**REVENUE**			
H	101	PASARR			-
H	102	DHHS Block Grants for CMH services	84,266		84,266
H	103	DD Council Grants	-		-
H	104	PATH/Homeless	-		-
H	105	Prevention	-		-
H	106	Aging	-		-
H	107	HUD Shelter Plus Care	-		-
H	108	Multicultural Integration	-		-
H	109	DHHS Block Grants for SUD services	445,269		445,269
H	150	Other MDHHS Earned Contracts (describe):			-
H	151	Other MDHHS Earned Contracts (describe):			-
H	190	**TOTAL REVENUE**	529,535	-	529,535
H	200	**EXPENDITURE**			
H	201	PASARR			-
H	202	DHHS Block Grants for CMH services	84,266		84,266
H	203	DD Council Grants	-		-
H	204	PATH/Homeless	-		-
H	205	Prevention	-		-
H	206	Aging	-		-
H	207	HUD Shelter Plus Care	-		-
H	208	Multicultural Integration	-		-
H	209	DHHS Block Grants for SUD services	445,269		445,269
H	250	Other MDHHS Earned Contracts (describe):			-
H	251	Other MDHHS Earned Contracts (describe):			-
H	290	**TOTAL EXPENDITURE**	529,535	-	529,535
H	400	**BALANCE MDHHS EARNED CONTRACTS (must = 0)**	-	-	-

I		**PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS - CMHSP USE ONLY**			
I	100	**REVENUE**			
I	101	Revenue - from PIHP Medicaid (incl Autism)			-
I	104	Revenue - from PIHP Healthy Michigan Plan (incl Autism)			-
I	122	1st & 3rd Party Collections - Medicare/Medicaid Consumers - Affiliate			-
I	123	1st & 3rd Party Collections - Healthy Michigan Plan Consumers - Affiliate			-
I	190	**TOTAL REVENUE**	-	-	-
I	201	Expenditure - Medicaid (incl Autism)			-
I	202	Expenditure - Healthy Michigan Plan (incl Autism)			-
I	203	Expenditure - MI Health Link (Medicaid) Services			-
I	290	**TOTAL EXPENDITURE**	-	-	-
I	295	**NET PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS SURPLUS (DEFICIT)**	-	-	-
I	300	**Redirected Funds (To) From**			
I	301	(TO) CMHSP to CMHSP Earned Contracts - **J306**	-	-	-
I	302	FROM CMHSP to CMHSP Earned Contracts - **J303**			-
I	303	FROM Non-MDHHS Earned Contracts - **K303**			-
I	304	FROM General Fund - **B310**			-
I	306	FROM Local Funds - **M309.1**			-
I	390	**Total Redirected Funds**	-	-	-
I	400	**BALANCE PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS (must = 0)**	-	-	-

IA		**PIHP to AFFILIATE SUBSTANCE USE DISORDER (NON-MEDICAID) CONTRACTS - CMHSP USE ONLY**			
IA	100	**REVENUE**			
IA	101	Revenue - SUD Non-Medicaid - from PIHP			-
IA	122	Revenue - Fees & Collections - Affiliate			-
IA	190	**TOTAL REVENUE**	-	-	-
IA	200	**EXPENDITURE**			
IA	201	Expenditure			-
IA	290	**TOTAL EXPENDITURE**	-	-	-
IA	295	**NET PIHP to AFFILIATE SUD (NON-MEDICAID) SERVICES CONTRACTS SURPLUS (DEFICIT)**	-	-	-
IA	300	**Redirected Funds (To) From**			
IA	301	(TO) CMHSP to CMHSP Earned Contracts - **J306.2**	-	-	-
IA	302	FROM CMHSP to CMHSP Earned Contracts - **J303.2**			-
IA	303	FROM Non-MDHHS Earned Contracts - **K303.2**			-
IA	304	FROM General Fund - **B310.1**			-
IA	306	FROM Local Funds - **M309.2**			-
IA	390	**Total Redirected Funds**	-	-	-
IA	400	**BALANCE PIHP to AFFILIATE SUD (NON-MEDICAID) SERVICES CONTRACTS (must = 0)**	-	-	-

IB		**PIHP to AFFILIATE OPIOID HEALTH HOME SERVICES CONTRACTS - CMHSP USE ONLY**			
IB	190	Revenue - Medicaid Opioid Health Home Services - from PIHP			-
IB	290	Expenditure - Medicaid Opioid Health Home Services			-
IB	295	**NET PIHP to AFFILIATE OPIOID HEALTH HOME SERVICES CONTRACTS SURPLUS (DEFICIT)**	-	-	-
IB	300	**Redirected Funds (To) From**			
IB	304	FROM General Fund - **B310.2**			-
IB	306	FROM Local Funds - **M309.3**			-
IB	390	**Total Redirected Funds**	-	-	-
IB	400	**BALANCE PIHP to AFFILIATE OPIOID HEALTH HOME SERVICES CONTRACTS (cannot be < 0)**	-	-	-

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
EXAMINED FINANCIAL STATUS REPORT - ALL NON MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2019

CMHSP: Mid-State Health Network - Region 5

			REPORTED	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
IC		**PIHP to AFFILIATE HEALTH HOME SERVICES CONTRACTS - CMHSP USE ONLY**			
IC	190	Revenue - Medicaid Health Home Services - from PIHP			-
IC	290	Expenditure - Medicaid Health Home Services			-
IC	295	**NET PIHP to AFFILIATE HEALTH HOME SERVICES CONTRACTS SURPLUS (DEFICIT)**	-	-	-
IC	300	**Redirected Funds (To) From**			
IC	304	FROM General Fund - **B310.3**			-
IC	306	FROM Local Funds - **M309.4**			-
IC	390	**Total Redirected Funds**	-	-	-
IC	400	**BALANCE PIHP to AFFILIATE HEALTH HOME SERVICES CONTRACTS (cannot be < 0)**	-	-	-

ID		**PIHP to AFFILIATE MI HEALTH LINK SERVICES CONTRACTS - CMHSP USE ONLY**			
ID	100	**REVENUE**			
ID	101	Revenue - MI Health Link - from PIHP			-
ID	122	1st & 3rd Party Collections - MI Health Link Consumers - Affiliate			-
ID	190	**TOTAL REVENUE**	-	-	-
ID	200	**EXPENDITURE**			
ID	201	Expenditure			-
ID	290	**TOTAL EXPENDITURE**	-	-	-
ID	295	**NET PIHP to AFFILIATE MI HEALTH LINK SERVICES CONTRACTS SURPLUS (DEFICIT)**	-	-	-
ID	300	**Redirected Funds (To) From**			
ID	301	(TO) CMHSP to CMHSP Earned Contracts - **J306.3**	-	-	-
ID	302	FROM CMHSP to CMHSP Earned Contracts - **J303.3**			-
ID	303	FROM Non-MDHHS Earned Contracts - K303.3			-
ID	304	FROM General Fund - **B310.4**			-
ID	306	FROM Local Funds - **M309.5**			-
ID	390	**Total Redirected Funds**	-	-	-
ID	400	**BALANCE PIHP to AFFILIATE MI HEALTH LINK SERVICES CONTRACTS (must = 0)**	-	-	-

J		**CMHSP to CMHSP EARNED CONTRACTS**			
J	190	Revenue			-
J	290	Expenditure			-
J	295	**NET CMHSP to CMHSP EARNED CONTRACTS SURPLUS (DEFICIT)**	-	-	-
J	300	**Redirected Funds (To) From**			
J	301	(TO) Medicaid Services - **A302** (PIHP use only)	-	-	-
J	301.1	(TO) Healthy Michigan - **AI302** (PIHP use only)	-	-	-
J	301.2	(TO) SUD (Non-Medicaid) Services Contracts - **AC302** (PIHP use only)	-	-	-
J	301.3	(TO) MI Health Link - **AK302** (PIHP use only)	-	-	-
J	302	(TO) General Fund - **B313**	-	-	-
J	303	(TO) PIHP to Affiliate Medicaid Services Contracts - **I302**	-	-	-
J	303.2	(TO) PIHP to Affiliate SUD (Non-Medicaid) Services Contracts - **IA302**	-	-	-
J	303.3	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID302**	-	-	-
J	303.4	(TO) Targeted Case Management - **D304**	-	-	-
J	304	FROM Medicaid Services - **A301** (PIHP use only)			-
J	304.1	FROM Healthy Michigan - **AI301** (PIHP use only)			-
J	304.2	FROM SUD (Non-Medicaid) Service Contracts - **AC301** (PIHP use only)			-
J	304.3	FROM MI Health Link - **AK301** (PIHP use only)			-
J	304.4	FROM Targeted Case Management - **D303**			-
J	305	FROM General Fund - **B312**			-
J	306	FROM PIHP to Affiliate Medicaid Services Contracts - **I301**			-
J	306.2	FROM PIHP to Affiliate SUD (Non-Medicaid) Services Contracts - **IA301**			-
J	306.3	FROM PIHP to MI Health Link Services Contracts - **ID301**			-
J	307	FROM Local Funds - **M310**			-
J	390	**Total Redirected Funds**	-	-	-
J	400	**BALANCE CMHSP to CMHSP EARNED CONTRACTS (must = 0)**	-	-	-

K		**NON-MDHHS EARNED CONTRACTS**			
K	190	Revenue	152,450		152,450
K	290	Expenditure	152,450		152,450
K	295	**NET NON-MDHHS EARNED CONTRACTS SURPLUS (DEFICIT)**	-	-	-
K	300	**Redirected Funds (To) From**			
K	301	(TO) Medicaid Services - **A303** (PIHP use only)	-	-	-
K	301.1	(TO) Healthy Michigan - **AI303** (PIHP use only)	-	-	-
K	301.2	(TO) SUD (Non-Medicaid) Services Contracts - **AC303** (PIHP use only)	-	-	-
K	301.3	(TO) MI Health Link - **AK303** (PIHP use only)	-	-	-
K	302	(TO) General Fund - **B314**	-	-	-
K	303	(TO) PIHP to Affiliate Medicaid Services Contracts - **I303**	-	-	-
K	303.2	(TO) PIHP to Affiliate SUD (Non-Medicaid) Services Contracts - **IA303**	-	-	-
K	303.3	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID303**	-	-	-
K	304	(TO) Local Funds - **M315**	-	-	-
K	305	FROM Local Funds - **M311**			-
K	390	**Total Redirected Funds**	-	-	-
K	400	**BALANCE NON-MDHHS EARNED CONTRACTS (must = 0)**	-	-	-

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
EXAMINED FINANCIAL STATUS REPORT - ALL NON MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2019

CMHSP: Mid-State Health Network - Region 5

			REPORTED	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
L		**Intentionally left Blank**			
L	100	**REVENUE**			
L	101				
L	102				
L	190	**TOTAL REVENUE**	-	-	-
L	200	**EXPENDITURE**			
L	201				
L	202				
L	290	**TOTAL EXPENDITURE**	-	-	-
L	295	**NET SURPLUS (DEFICIT)**	-	-	-
L	300	**Redirected Funds (To) From**			
L	300.3				
L	300.5				
L	301				
L	302				
L	390	**Total Redirected Funds**	-	-	-
L	400	**BALANCE (must = 0)**	-	-	-

M		**LOCAL FUNDS**			
M	100	**REVENUE**			
M	101	County Appropriation for Mental Health			-
M	102	County Appropriation for Substance Abuse - Non Public Act 2 Funds			-
M	103	Section 226 (a) Funds	-	-	-
M	104	Affiliate Local Contribution to State Medicaid Match Provided from CMHSP (PIHP only)	3,934,868		3,934,868
M	105	Medicaid Fee for Service Adjuster Payments			-
M	106	Local Grants			-
M	107	Interest	1,032		1,032
M	109	SED Partner			-
M	110	All Other Local Funding	523,045		523,045
M	111	Performance Bonus Incentive Pool (PBIP) Restricted Local Funding			-
M	190	**TOTAL REVENUE**	4,458,945	-	4,458,945
M	200	**EXPENDITURE**			
M	201	GF 10% Local Match	-	-	-
M	202	Reported Local match cap amount			
		Examination Adjustment Local match cap amount			
		Examinted Total Local match cap amount $ -			
M	203	GF Local Match Capped per MHC 330.1308	-	-	-
M	204	Local Cost for State Provided Services			-
M	205	Local Contribution to State Medicaid Match (CMHSP Contribution Only)			-
M	206	Local Contribution to State Medicaid Match on Behalf of Affiliate (PIHP Only)	3,934,868		3,934,868
M	207	Local Match to Grants and MDHHS Earned Contracts			-
M	209	Local Only Expenditures			-
M	290	**TOTAL EXPENDITURE**	3,934,868	-	3,934,868
M	295	**NET LOCAL FUNDS SURPLUS (DEFICIT)**	524,077	-	524,077
M	300	**Redirected Funds (To) From**			
M	301	(TO) Medicaid Services - **A332** (PIHP use only)	-	-	-
M	301.1	(TO) Healthy Michigan - **AI332** (PIHP use only)	-	-	-
M	301.2	(TO) SUD (Non-Medicaid) Services - **AC332** (PIHP use only)	(523,045)	-	(523,045)
M	301.3	(TO) Opioid Health Home Services - **AE332** (PIHP use only)	-	-	-
M	301.4	(TO) Health Home Services - **AG332** (PIHP use only)	-	-	-
M	301.5	(TO) MI Health Link - **AK332** (PIHP use only)	-	-	-
M	302	(TO) General Fund - **B331**	-	-	-
M	304	(TO) Targeted Case Management - **D302**	-	-	-
M	305	(TO) SED Waiver - **E302**	-	-	-
M	306	(TO) SED Waiver - Not SED Waiver eligible - **E304**	-	-	-
M	308	(TO) Children's Waiver - **F302**	-	-	-
M	309	(TO) Injectable Medications - **G302**	-	-	-
M	309.1	(TO) PIHP to Affiliate Medicaid Services Contracts - **I306**	-	-	-
M	309.2	(TO) PIHP to Affiliate SUD (Non-Medicaid) Services Contracts - **IA306**	-	-	-
M	309.3	(TO) PIHP to Affiliate Opioid Health Home Services Contracts - **IB306**	-	-	-
M	309.4	(TO) PIHP to Affiliate Health Home Services Contracts - **IC306**	-	-	-
M	309.5	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID306**	-	-	-
M	310	(TO) CMHSP to CMHSP Earned Contracts - **J307**	-	-	-
M	311	(TO) Non-MDHHS Earned Contracts - **K305**	-	-	-
M	313	(TO) Activity Not Otherwise Reported - **O302**	-	-	-
M	313.3	FROM MI Health Link (Medicare) - **AK336** - (PIHP use only)			-
M	315	FROM Non-MDHHS Earned Contracts - **K304**			-
M	390	**Total Redirected Funds**	(523,045)	-	(523,045)
M	400	**BALANCE LOCAL FUNDS**	1,032	-	1,032

N		**RISK CORRIDOR**			
N	100	**REVENUE**			
N	101	Stop/Loss Insurance			-
N	102	Medicaid ISF for PIHP Share Risk Corridor	-		-
N	103	MDHHS for MDHHS Share of Medicaid Risk Corridor			-
N	104	Restricted Fund balance for PIHP Share Risk Corridor	-		-
N	190	**TOTAL REVENUE**	-	-	-
N	300	**Redirected Funds (To) From**			
N	301	(TO) Medicaid Services - PIHP Share - **A333** (PIHP use only)	-	-	-
N	301.1	(TO) Healthy Michigan - PIHP Share - **AI333** (PIHP use only)	-	-	-
N	301.2	(TO) Restricted Fund balance for PIHP Share - **A335 & AI335** (PIHP use only)	-	-	-
N	302	(TO) Medicaid Services - MDHHS Share - **A334** (PIHP use only)	-	-	-
N	302.1	(TO) Healthy Michigan - MDHHS Share - **AI334** (PIHP use only)	-	-	-
N	303	(TO) General Fund - **B332**	-	-	-
N	390	**Total Redirected Funds**	-	-	-
N	400	**BALANCE RISK CORRIDOR (must = 0)**	-	-	-

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
EXAMINED FINANCIAL STATUS REPORT - ALL NON MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2019

CMHSP: Mid-State Health Network - Region 5

			REPORTED	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
O		**ACTIVITY NOT OTHERWISE REPORTED**			
O	100	**REVENUE**			
O	101	Other Revenue (describe):			-
O	102	Other Revenue (describe):			-
O	103	Other Revenue (describe):			-
O	190	**TOTAL REVENUE**	-	-	-
O	200	**EXPENDITURE**			
O	201	Other Expenditure (describe):			-
O	202	Other Expenditure (describe):			-
O	203	Other Expenditure (describe):			-
O	290	**TOTAL EXPENDITURE**	-	-	-
O	295	**NET ACTIVITY NOT OTHERWISE REPORTED SURPLUS (DEFICIT)**	-	-	-
O	300	**Redirected Funds (To) From**			
O	301	(TO) Children's Waiver - **F303**	-	-	-
O	302	FROM Local Funds - **M313**			-
O	390	**Total Redirected Funds**	-	-	-
O	400	**BALANCE ACTIVITY NOT OTHERWISE REPORTED**	-	-	-

P		**GRAND TOTALS**			
P	190	**GRAND TOTAL REVENUE**	614,815,734	-	614,815,734
P	290	**GRAND TOTAL EXPENDITURE**	609,316,627	-	609,316,627
P	390	**GRAND TOTAL REDIRECTED FUNDS (must = 0)**	-	-	-
P	400	**NET INCREASE (DECREASE)**	5,499,107	-	5,499,107

Q		**REMARKS**
Q		This section has been provided for the CMHSP to provide narrative descriptions as requested in the FSR instructions or where additional narrative would be meaningful to the CMHSP / MDHHS.
Q		Preparer's note: There is a $395,085 difference between the $3,934,868 reported by the PIHP on Row M104 Affiliate Local Contribution to State Medicaid Match Provided and the $3,539,783 reported by the CMHSPs (in total for all 12 Affiliates) on Row M206 Local Contribution to State Medicaid Match. This difference relates to Bay's actual Local Match Drawdown of $545,160 (actual) and the $150,075 which is reported on M206.
Q		
Q		
Q		
Q		
Q		
Q		
Q		

Examined Medicaid Contract Settlement Worksheet

An examination adjustment was made to Row 4.1 (Total Earned Savings) to decrease earned savings to correspond with other examination adjustments that were made.

- Row 4.1 was decreased from $5,233,920 to $5,219,588; a difference of $(14,332)

Examined Financial Status Report – Medicaid

An examination adjustment was made to adjust the amounts reported by Mid-State to the examined amounts reported by the following CMHSPs:

- Row A115 - Montcalm from $15,505,198 to $15,519,530, an increase of $14,332
- Row A202 - Montcalm from $15,505,198 to $15,519,530, an increase of $14,332

During our compliance audit, we may have become aware of matters that are opportunities for strengthening internal controls, improving compliance and increasing operating efficiency. These matters are not individually or cumulatively material weaknesses in internal control over the Medicaid Contract, General Fund Contract, and/or Community Mental Health Services Block Grant program(s). Furthermore, we consider these matters to be immaterial deficiencies, not findings. The following comments and recommendations are in regard to those matters.

2019-01 FSR Examination Adjustments

Criteria or specific requirements:
The FSR must include revenues and expenditures in proper categories and follow the reporting instructions. (Contract Section 7.8)

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

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

Context and perspective:
The examination adjustments that were made to the PIHP's FSR were the result of adjustments made to participant CMHSPs' examined FSRs.

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

Recommendations:
The PIHP should ensure that participant CMHSPs have appropriate controls in place regarding the preparation and review of the Financial Status Report to assure that all amounts are reported in compliance with the reporting instructions.

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

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

Responsible party:
Amy Keinath, Finance Manager

Anticipated completion date:
February 28, 2021

Background:

Mid-State Health Network (MSHN) currently offers three Michigan Employees Retirement Savings (MERS) Programs for MSHN employees; (1) Defined Contribution (2) Social Security Opt Out and (3) 457 Plan.

> Defined Contribution Plan: MSHN contributes a flat percentage to all full-time employees; Employees have the option to elect their own withholdings into the plan.
>
> Social Security Opt Out Plan: Replacement plan for social security tax withholdings by employees as MSHN has opted out of participation in social security. Employees do not have social security tax withheld but MSHN contributes the federal match into the plan.
>
> 457 Plan: Optional plan for employees to participate and invest funds. MSHN does not contribute to this plan.

In addition, MSHN has a dormant Defined Contribution Plan only applicable to the CEO that was utilized as a supplement in replace of Health Insurance. This plan is still in place should or when it would be negotiated in a future CEO contract.

MERS recently announced they took a comprehensive look at the plan provisions and processes through review of industry best practices and trends and revised policies and procedures for all plans. The following was further clarified in plan documents:

- Plan Eligibility (Full-time, Part-time, Temporary)
- Service Credit (vesting years)
- Leaves of Absence (qualify towards final average compensation)
- Compensation Definition (bonus, incentive, gross wages)
- Employee Contributions (define contribution rate on record)

MSHN has reviewed the plan documents as developed and authorized by the board in 2013 and determined no change is required based on the new policies. However, MERS requires confirmation of such through a Plan Adoption Agreement that would be effective January 1, 2021 along with Board of Directors approval via signed minutes by the Board Secretary.

Note: MERS only requires the addendum for the Defined Contribution and the Social Security Opt Out.

Recommended Motion:

The MSHN Board of Directors approves the confirmation of said MERS Defined Contribution Plans (Employees and CEO dormant plan) and the Social Security opt out Adoption Agreement Addendum effective January 1, 2021.

Background

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

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

The attached 2021 Corporate Compliance Plan was revised through a review by the MSHN Compliance Committee, Regional Compliance Committee and the Operations Council with recommendation for approval to the MSHN Board of Directors. The attached Summary of Recommended Changes to the 2021 Corporate Compliance Plan provides an overview of the recommended revisions to the plan. In addition, the Corporate Compliance Plan as proposed is in compliance with and supports the MSHN Policy: General Management - Compliance and Program Integrity.

Recommended Motion:

The MSHN Board approves the 2021 Corporate Compliance Plan and acknowledges receipt of said plan.

Summary of Recommended Changes to the 2021 Corporate Compliance Plan

The following is a summary of the recommended changes, per section, to the 2021 Compliance Plan.

KEY: No Revisions = no changes recommended; No Substantive Revisions = only minor additions/deletions not affecting intent

I. OVERVIEW/MISSION STATEMENT

- No Revisions

II. VALUE STATEMENT

- No Revisions

III. SCOPE OF PLAN

- No Revisions

IV. DEFINITIONS

- No Revisions

V. COMPLIANCE PROGRAM

- No Revisions

VI. STRUCTURE OF THE COMPLIANCE PROGRAM

- No revisions

VII. COMPLIANCE STANDARDS

A. Standards of Conduct and Ethical Guidelines

- No Revisions

B. Legal and Regulatory Standards

The following changes are being recommended:

- State and Federal Laws and Rules: Removed "Other Statutes Related to Municipal Organizations and Operations
- Federal Medicaid Law, Regulations and Related Items: Added "42 CFR Part 2 Confidentiality of Alcohol and Drug use Patient Records and "Affordable Care Act"
- Other Relevant Legislation: Added "American with Disabilities Act of 1990"

C. Environmental Standards

- No Revisions

D. Workplace Standards of Conduct

- No Revisions

E. Contractual Relationships

- No Revisions

F. Purchasing and Supplies

- No Revisions

G. Marketing

- No Revisions

H. Financial Systems Reliability and Integrity

The following changes are being recommended:

- Added "claims" prior to documentation to clarify that this is not clinical documentation

I. Information Systems Reliability and Integrity

- No Revisions

J. Confidentiality and Privacy

The following changes are being recommended:

- Addition of Qualified Service Organization Agreement (QSOA)

VIII. AREAS OF FOCUS

- No Revisions

IX. TRAINING

A. MSHN Employees and Board Members

- No Revisions

B. MSHN Provider Network

The following changes are being recommended:

- Changed "Annual Training Plan" to "Regional Training Requirement"

X. COMMUNICATION

- No Revisions

XI. MONITORING AND AUDITING

The following changes are being recommended:

- Financial and Billing Integrity: Added "Fiscal Monitoring reviews for all SUD providers"
- Clinical/Quality of Care: Removed "and Provider Network staff" from the second and third bullet points and removed the fifth bullet point
- Additional Internal Monitoring and Auditing Analysis: Added "Contract Expense Monitoring"

XII. REPORTING AND INVESTIGATIONS

- No Revisions

XIII. Corrective Actions and Prevention

- No Revisions

XIV. Submission of Program Integrity Activities

- No Revisions

XV. References, Legal Authority and Supporting Documents

- No Revisions

ATTACHMENT A

- No Revisions

ATTACHMENT B

The following changes are being recommended:

- Added "ad Hoc" to the Medical Director and Corporate Counsel positions for the MSHN Corporate Compliance Committee membership

ATTACHMENT C

The following changes are being recommended to the area of focus chart:

- Separated Autism Requirements and Credentialing into two separate areas of focus
- Added section for COVID-19 and added Telehealth Requirements

ATTACHMENT D

The following changes are being recommended:

- Updated compliance officer contact information

ATTACHMENT E

- No Revisions

ATTACHMENT F

- No Revisions

CORPORATE COMPLIANCE PLAN
2021

Mid-State Health Network, Corporate Compliance Committee: August 13, 2020
Mid-State Health Network, Regional Compliance Committee: August 21, 2020
Mid-State Health Network, Operations Council Approved: September 21, 2020
Mid-State Health Network PIHP Board Adopted:

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I. OVERVIEW/MISSION STATEMENT

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid-State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Community Health as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, The Right Door (formerly Ionia County CMH), Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness and Tuscola Behavioral Health Systems. As of October 1, 2015, MSHN took over the direct administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers.

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

II. VALUE STATEMENT

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

III. SCOPE OF PLAN

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

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

Failure by MSHN staff to adhere to the requirements in the Compliance Plan could result in disciplinary action, up to and including termination of employment depending on the seriousness of the offense.

Failure by the Provider Network to adhere to the standards within MSHN's Compliance Plan could result in remediation or further contract action depending on the seriousness of the offense.

Failure by Board Members to adhere to the requirements in the Compliance Plan will be addressed following the standards within the MSHN By-Laws.

IV. DEFINITIONS

These terms have the following meaning throughout this Compliance Plan.

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

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

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

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

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

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

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

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

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

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

V. COMPLIANCE PROGRAM

A. Compliance Policies

While the Compliance Plan provides the framework of the Compliance Program, the Compliance Policies provide more specific guidance. Refer to **Attachment A** for a list of the Policy and Procedure categories that are part of the Compliance Program.

B. Compliance Plan

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

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

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

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

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

VI. STRUCTURE OF THE COMPLIANCE PROGRAM

A. General Structure

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

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

- *Compliance Officer:* The MSHN Compliance Officer has primary responsibility for ensuring that MSHN maintains a successful Compliance Program. In particular, the Compliance Officer oversees the implementation and effectiveness of the Compliance Plan and Compliance Policies, serves as the Chair of the Regional Compliance Committee and MSHN Compliance Committee, provides consultative support to the provider network and has responsibility for the day-to-day operations of the compliance program.

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

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

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

B. MSHN Compliance Officer

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

- Oversight of internal (PIHP Audits) and external provider network audits (MDHHS Audit and EQR Audit) and monitoring activities outlined in the compliance plan.
- Directs and is accountable for the implementation and enforcement of the Compliance Plan.
- Serves as chair of the MSHN's Corporate Compliance Committee and Regional Compliance Committee and provides leadership to MSHN compliance activity and consultative support to CMHSP Participants/SUD Providers.
- Responsible for oversight of MSHN efforts to maintain compliance with federal and state regulations and contractual obligations.
- Serves as the Privacy Officer for MSHN.
- Ensures that effective systems are in place by which actual or suspected compliance violations are reported in a timely manner to appropriate governing bodies.
- Reviews all reports of actual or suspected compliance violations received by MSHN from any source and ensures that effective investigation and/or other action is taken.
- Completes investigations referred by, and under the direction of, the Office of Inspector General
- Monitors changes in federal and state health care laws and regulations applicable to MSHN operations and disseminate to the region.
- Works collaboratively with other MSHN employees and CMHSP Participants/SUD Providers to ensure that auditing and monitoring protocols are designed to detect and deter potential compliance violations.
- Coordinates compliance training and education efforts for MSHN staff and Board Members
- Ensures that performance improvement plans are adequate to ensure compliance and assures effective implementation of corrective action occurs to reduce risk of future occurrences.
- Prepares and submits the quarterly Office of Inspector General program integrity report
- Prepares and delivers an annual compliance report to the MSHN Board covering the fiscal year, including:
    - A summary of trends in the frequency, nature and severity of substantiated compliance violations;
    - A review of any changes to the Compliance Plan or program; and
    - An objective assessment of the effectiveness of the Compliance Plan and Program.

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

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

C. Regional Compliance Committee

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

- Advising the MSHN Compliance Officer and assisting with the development,

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

D. MSHN Corporate Compliance Committee

The MSHN Corporate Compliance Committee meets quarterly and its responsibilities include:

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

VII. COMPLIANCE STANDARDS

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

A. Standards of Conduct and Ethical Guidelines

MSHN and its Provider Network are committed to conducting the delivery of services and business operations in an honest and lawful manner and consistent with its Vision, Mission, and Values. As such, MSHN minimally establishes the following Standards of Conduct to clearly delineate the philosophy and values concerning compliance with the laws, regulations, contractual obligations, government guidelines and ethical standards applicable to the delivery of behavioral health care.

- Provide through its Provider Network, high quality services consistent with MSHN Vision, Mission, and Values;
- Dedicated to ensuring that equality in voice and governance exists, and that the benefit to the citizens meets Medicaid standards while being provided in ways that reflect the needs and resources of the communities in which each CMHSP Participants/SUD Providers operate;

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

These Standards of Conduct provide guidance for MSHN Board members and employees, as well as the provider network in performing daily activities within appropriate ethical and legal standards and establish a workplace culture that promotes prevention, detection, and resolution of instances of conduct that do not conform with applicable laws and regulations. While the above standards are expected to be a framework for compliance, the issues addressed are not exhaustive. Therefore, MSHN Board Members, employees and its provider network staff are responsible for conducting themselves ethically in all aspects of business avoiding even the appearance of impropriety and in accordance with established policies and procedures.

B. Legal and Regulatory Standards

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

State/Federal Laws and Rules

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

Federal Medicaid Law, Regulations and Related Items

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

Other Relevant Legislation

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

C. Environmental Standards

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

D. Workplace Standards of Conduct

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

1. Confidentiality: MSHN is committed to protect the privacy of its consumers. MSHN Board members, employees, and contractual providers are to comply with the Michigan Mental Health Code, Section, 330.1748, Code of Federal Regulations (CFR), Title 42 and all other privacy laws as specified under the Confidentiality section of this document.
2. Drug and Alcohol: MSHN is committed to maintain its property and to provide a drug-free work environment that is both safe for our employees and visitors, as well as conducive to efficient and productive work standards.
3. Harassment: MSHN is committed to maintaining a work environment free of harassment for Board members, employees, and contractual providers. MSHN will not tolerate harassment based on sex, race, color, religion, national origin, disability, citizenship,

chronological age, sexual orientation, union activity, or any other condition, which adversely affects their work environment.

4. Conflict of Interest: MSHN Board members, employees, and contractual providers shall avoid any action that conflicts with the interest of the organization. All Board members, employees, and contractual providers must disclose any potential conflict of interest situations that may arise or exist in accordance with established policies and procedures.
5. Reporting Suspected Fraud: MSHN Board, employees, and contractual providers shall report any suspected or actual "fraud, abuse or waste" of any funds, including Medicaid funds, to the organization.
6. Solicitation and Acceptance of Gifts: MSHN Board members, employees and contractual providers shall not solicit gifts, gratuities or favors. MSHN Board members, employees and contractual providers will not accept gifts worth more than $25, gratuities or favors of any kind from any individual, consumer, or organization doing business or seeking to do business with MSHN.
7. Workplace Bullying: MSHN defines bullying as "repeated" inappropriate behavior, either direct or indirect, whether verbal, physical, or otherwise, conducted by one or more persons against another or others, at the place of work and/or during the course of employment. Such behavior violates MSHN Code of Ethics, which clearly states that all employees will be treated with dignity and respect.
8. Workplace Violence and Weapons: MSHN takes violence and threats of violence extremely seriously. Any act or threat of violence by or against any employee, customer, supplier, partner, or visitor is strictly prohibited.
9. Political Contributions: MSHN shall not use agency funds or resources to contribute to political campaigns or activities of any political party.

E. Contractual Relationships

MSHN shall ensure that all contractual arrangements with providers are structured in accordance with federal and state laws and regulations and are in the best interest of the organization and the consumers served. In order to ethically and legally meet all standards, MSHN will strictly adhere to the following:

1. MSHN and its Provider Network shall not pay or accept payment of any tangible or intangible kind for referrals. Consumer referrals and intakes will be accepted based on the consumer's needs, eligibility, and the ability to provide the services needed. No organization, or employee, covered by this plan who is acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of consumers. Similarly, when making consumer referrals to another healthcare provider, MSHN and the Provider Network will not take into account the volume or value of referrals that the provider has made (or may make).
2. The Provider Network shall not enter into financial arrangements with physicians that are designed to provide inappropriate remuneration to the organization in return for the physician's ability to provide services to federal health care program beneficiaries at MSHN.
3. MSHN does not enter into contractual relationships with individuals or agents/agencies that have been convicted of a criminal offense related to health care or that are listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in federal health care programs. Reasonable and prudent background investigations will be completed prior to entering into contractual relationships with all individuals and agents/agencies.

4. MSHN and its contractual providers, as well as the Provider Network and its contractors, are responsible for properly conducting credentialing and re-credentialing in accordance with State Policy and the MSHN policies and procedures. The Provider Network and contractual providers are responsible for reporting suspected fraud, abuse and licensing violations to MSHN as soon as suspected.
5. The Provider Network and its contractors shall be responsible, and held accountable, to provide accurate and truthful information in connection with treatment of consumers, documentation of services, and submission of claims.

F. Purchasing and Supplies

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

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

G. Marketing

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

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

H. Financial Systems Reliability and Integrity

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

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

In accord with the 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005) MSHN’s processes shall monitor for actions by contractual providers of Medicaid services to prevent fraud, abuse, and waste, or are likely to result in unintended expenditures.

I. Information Systems Reliability and Integrity

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

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

J. Confidentiality and Privacy

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

- MSHN will follow the HIPAA requirements, as well as all applicable federal and state requirements, for the use of protected health data and information.
- MSHN will immediately report to the MDHHS any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements.
- Any breach of protected health information shall result in notification of the affected individuals as well as the HHS Secretary and the media in cases where the breach affects more than 500 individuals.
- Privacy Notice - MSHN will have a notice of privacy practices.
- Authorization - If protected mental health information is shared to an entity outside of MSHN for any purpose other than coordination of care, treatment, or payment of services, a signed authorization will be obtained from the consumer prior to sharing information. If substance use treatment information is being shared, for any purpose, to an entity outside of MSHN, a signed authorization, by the consumer, will be obtained. The Michigan Behavioral Health Consent Form will be utilized for obtaining authorizations.
- MSHN will perform any necessary internal risk analyses or assessments to ensure compliance.
- Physical and electronic safeguards shall be in place for MSHN employees and premises, including, but not limited to, door locks, unique logins and secure passwords, firewall and virus protection, disaster recovery mechanisms, and secure email.
- Business Associate Agreement – MSHN will obtain assurances with all Business Associates that protected health care information shared with them, will be protected and appropriately safeguarded consistent with all applicable State and Federal laws and requirements.
- Qualified Service Organization Agreement (QSOA) - Third-party service providers must become qualified to service Part 2 Programs. This is achieved through the entity entering into a written agreement with the Part 2 Program in which it acknowledges that it is bound by the Part 2 confidentiality regulations and agrees to resist in judicial proceedings any efforts to

obtain unauthorized access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment that may come into its possession.

VIII. AREAS OF FOCUS

The MSHN Compliance Officer under the direction of the MSHN Board of Directors, MSHN Corporate Compliance Committee and the MSHN Regional Compliance Committee, will identify strategic areas of focus developed from a risk analysis that will guide the direction of MSHN compliance activities (**Attachment C**).

IX. TRAINING

A. MSHN Employees and Board Members

All MSHN Employees and Board members shall receive a copy of the MSHN Compliance Plan and training on the MSHN Compliance Plan, Compliance Policies and Standards of Conduct. Additional training may be required for employees involved in specific areas of risk or as new regulations are issued. Records shall be maintained on all formal training and educational activities. The Compliance Officer must receive training by an entity other than himself/herself. Training is considered a condition of employment and failure to comply will result in disciplinary action up to and including termination.

Training will be provided upon hire for new employees and during orientation for new Board Members. All current staff and Board Members will receive annual training.

The Compliance Officer will provide ongoing information and education on matters related to health care fraud and abuse as disseminated by the Office of Inspector General, Department of Health and Human Services or other regulatory bodies.

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

B. MSHN Provider Network

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

X. COMMUNICATION

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

- There shall be access to the MSHN Compliance Officer for clarification on specific standards, policies, procedures, or other compliance related questions that may arise on a day-to-day basis.
- Access to a dedicated toll-free compliance line
- Utilization of interpreter where capacity in the area has been identified
- Information will be shared regarding the results of internal and external audits, reviews, and site visits, utilization data, performance and quality data, and other information that may facilitate understanding of regulations, and the importance of compliance.
- Information may be communicated through a variety of methods such as formal trainings, e-mails, newsletters, intranet resource pages, or other methods identified that facilitate access to compliance related information as a preventative means to reduce the potential for fraud and abuse.
- Compliance contact information shall be available to stakeholders through a variety of methods such as the MSHN & CMHSP Participants/SUD Provider customer service handbook, websites, posters, and/or other methods (or processes) identified consistent with standards associated with MSHN Policies.

XI. MONITORING AND AUDITING

Monitoring and auditing of MSHN's operations is key to ensuring compliance and adherence to policies and procedures. Monitoring and auditing can also identify areas of potential risk and those areas where additional education and training is required. Results of the below activities will be communicated through the Quality Improvement Council and summarized results to the Operations Council, MSHN Corporate Compliance Committee, MSHN Regional Compliance Committee and MSHN Board of Directors through the Annual Compliance Report.

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

<u>Financial and Billing Integrity</u>
- An independent audit of financial records each year;
- An independent compliance examination in accordance with the MDHHS guidelines (if applicable);
- Contractual providers have signed contracts and adhere to the contract requirements;
- Fiscal Monitoring reviews for all SUD providers
- Explanation of benefits (annually to 5% of the consumers receiving services)
- Medicaid Event Verification (The frequency and quantity of audits performed will be dependent on the number of fraud, waste and abuse complaints received as well as high risk activities identified through means such as data mining and analysis of paid claims)

<u>Information Systems Reliability and Integrity</u>
- MSHN Information System employees and Provider Network staff monitor the reliability and integrity of the information system and data;
- Assure appropriate security and redundancies are in place to address loss of information and that provide sufficient disaster recovery plans; and
- MSHN employees and Provider Network staff are trained on use of information systems and provided access based on role and job function.

<u>Clinical/Quality of Care</u>
- Performance indicators are monitored and reviewed in an effort to continually improve services;
- MSHN employees are evaluated in writing on their performance and are provided with detailed job descriptions;
- MSHN employees are hired through a detailed pre-employment screening and hiring process and complete a comprehensive orientation program;

- Assuring qualification and competency of organizational and practitioner credentialing and privileging directly operated by or under sub-contract with the Provider Network;

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

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

Quality and Utilization Reviews
- Review of delegated managed care functions (as identified in the MSHN/CMHSP Medicaid Subcontract);
- Review of SUD Provider Network in accordance with contracted functions
- Review of adherence and compliance with Quality Assurance and Performance Improvement Program (QAPIP) Plan; and
- Review of adherence and compliance with the Utilization Management (UM) Plan.

Additional Internal Monitoring and Auditing Activities
- Assessment of initial capacity and competency to perform delegated PIHP functions;
- Consumer Satisfaction Surveys;
- Review of MSHN contracts for administrative services;
- Contract Expense Monitoring;
- Monitor capacity and demand for services in the PIHP region through the Assuring Network Adequacy contract;
- Review of Policies and Procedures for any needed revisions or development of new ones
- Questionnaires to poll staff and the provider network regarding compliance matters including effectiveness of training/education and related policies and procedures
- Exit interviews with departing staff (Issues related to Compliance)
- Periodic interviews with staff at MSHN regarding their perception of compliance within their departments or agencies

Additional External Monitoring and Auditing Activities:
- External Quality Reviews
- CMS Site Visits
- MDHHS Site Visits
- Independent Financial Audits
- Independent Compliance Examinations
- Accreditation Surveys

XII. REPORTING AND INVESTIGATIONS

MSHN and its Provider Network shall follow established disciplinary guidelines for their respective employees who have failed to comply with the standards of conduct, policies, and procedures, federal and state law, or otherwise engage in wrongdoing. The guidelines shall be consistently enforced at all levels of the organization.

A. Reporting of Suspected Violations and/or Misconduct

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

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

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

Violations Involving Suspected Fraud, Waste or Abuse:

- MSHN board members, employees, contractual providers and the provider network will report all suspected fraud and abuse to the MSHN Compliance Officer. The report will be submitted in writing utilizing the Office of Inspector General Fraud Referral Form (**Attachment E**).
- The MSHN Compliance Officer will complete a preliminary investigation, as needed, to determine if a suspicion of fraud exists.
- If there is suspicion of fraud, the MSHN Compliance Officer will report the suspected fraud and abuse to the MDHHS Office of Inspector General.
- The MSHN Compliance Officer will inform the appropriate provider network member when a report is made to the MDHHS Office of Inspector General.
- MSHN will follow the guidance/direction provided by the MDHHS Office of Inspector General regarding investigation and/or other required follow up.
- MSHN and the provider network will cooperate fully with investigations involving the MDHHS Office of Inspector General and/or the Department of Attorney General and adhere to any subsequent legal action that may result from such investigation.

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

- MSHN employees will report all suspected violations or misconduct (not involving suspected fraud or abuse) directly to the MSHN Compliance Officer for investigation. If the suspected violation involves the MSHN Compliance Officer, the report will be made to the MSHN Chief Executive Officer. Information provided shall at a minimum include the following:
    - Provider Information, if applicable (Name, Address, Phone Number, NPI Number, Email)
    - Complainant Information (Name, Address, Phone Number, NPI number [if applicable], Medicaid ID # [if applicable], Email)

    - Consumer Information, if applicable (Name, Address, Phone Number, Email)
    - Summary of the violation and/or misconduct
    - Date(s) of the violation and/or misconduct
    - Supporting documentation, if any (i.e. claims data, audit findings, etc.)
    - Action, if any, taken prior to submitting the violation
- Any suspected violations regarding the MSHN Chief Executive Officer will be reported to the MSHN Compliance Officer and/or the MSHN Board Chairperson/Executive Committee for investigation.
- CMHSP Participant/SUD Provider staff with firsthand knowledge of activities or omissions that may violate applicable laws and regulations (not involving suspected fraud or abuse) are required to report such wrongdoing to the MSHN Compliance Officer or to the CMHSP Participant/SUD Provider Compliance Officer. The CMHSP Participant/SUD Provider Compliance Officer will review reported violations to determine the need to report to the MSHN Compliance Officer. The review will be based on but not limited to: external party involvement, Medicaid recipient services, practices and/or system-wide process applicability.
- The Provider Network (CEO)/Executive Director(ED) and/or designee, shall inform, in writing, the MSHN Chief Executive Officer (CEO) of any material notice to, inquiry from, or investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory (excluding Recipient Rights related to non-PIHP activities), prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of a recipient of Medicaid services. The Provider Network CEO/ED shall inform, in writing, the MSHN CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.
- Reports of suspected violations or misconduct may be made on a confidential basis to the extent possible.

B. Process for Investigation

All reports involving suspected fraud, waste and abuse will follow the guidance/direction of the MDHHS Office of Inspector General for any required investigation.

All reports of suspected wrongdoing, not involving fraud or abuse, shall be investigated promptly following the process outlined in the MSHN Compliance Investigation, Resolution and Documentation Process (**Attachment F**). 'Prompt response" is defined as action taken within 15 business days of receipt by the PIHP of the information regarding a potential compliance problem.

The investigation process and outcome will be documented and will include at a minimum the following (as identified on the required OIG report template):

- Date of Complaint
- Consumer Name (if applicable)
- Provider Name (if applicable)
- Source of the Complaint/Activity (Identify how the report was received such as phone, hotline, anonymous, etc)
- Activity Type (audit, complaint, referral, etc.)
- Medicaid ID# (if applicable)
- Target of Activity (indicate whether the report involves a provider, consumer, etc.)
- Provider Type (Group home, Facility, etc.)

- Time Period Covered (enter a date range that the activity occurred)
- Summary of the Complaint/Activity
- Codes Involved in Complaint/Activity (If Applicable)
- Total Amount Paid Relating to Activity (If Applicable)
- Overpayment Identified (If Applicable)
- Date the Initial Review was Completed (for determining if further action is needed such as reporting to OIG)
- Was Potential Fraud Identified (Yes or No)
- Date Referred to MDHHS OIG (If Applicable)
- Date Final Notice sent to Provider (If Applicable for matters of overpayment, etc.)
- Total Overpayment Amount Identified (If Applicable)
- Total Number of Paid Claims Related to Overpayment (If Applicable)
- Total Collection Amount (If Applicable)
- Date the Complaint was Resolved
- Summary of the Findings

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

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

XIII. Corrective Actions and Prevention

Where an internal investigation substantiates a reported violation, corrective action will be initiated as identified within MSHN policies and procedures and the MSHN subcontracts with the CMHSP Participant/SUD Providers including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, the provision of a corrective action plan from the designated Provider Network member (as necessary) including follow-up monitoring of adequate implementation, and implementing system changes to prevent a similar violation from recurring in the future.

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

Depending on the seriousness of the offense, the resulting action for MSHN staff could include additional training, written reprimand, suspension or termination of employment. The resulting action for the provider network would also depend on the seriousness of the offense and could include additional training, letter of contract non-compliance and termination of contract.

XIV. Submission of Program Integrity Activities

The PIHP, and the provider network will log and track all program integrity activities performed. The provider network will utilize the program integrity activities performed template to report quarterly to the PIHP. The PIHP will report the program integrity activities to the MDHHS Office of Inspector General, on a quarterly basis, using the provided template.

The program integrity activities will include, but limited to, the following:

- Tips/Grievances received
- Data mining and analysis of paid claims, including audits performed based on the results
- Audits performed
- Overpayments collected
- Identification and investigation of fraud, waste and abuse
- Corrective action plans implemented
- Provider dis-enrollments
- Contract terminations

XV. References, Legal Authority and Supporting Documents

1. Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans, Medicaid Alliance for Program Safeguards, May 2002
   http://ahca.myflorida.com/medicaid/managed_care/pdf/federal_cms_guidelines_constructing_compliance_program.pdf

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

3. False Claims Act
   https://oig.hhs.gov/fraud
   http://www.legislature.mi.gov

4. 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005)
   http://www.cms.hhs.gov/deficitreductionact

5. Michigan Mental Health Code
   http://michigan.gov/documents/mentalhealthcode_113313_7.pdf

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

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

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

ATTACHMENT A

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

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

Policy and Procedure Categories Include:

Compliance

Customer Service

Finance

General Management

Human Resources

Information Technology

Provider Network

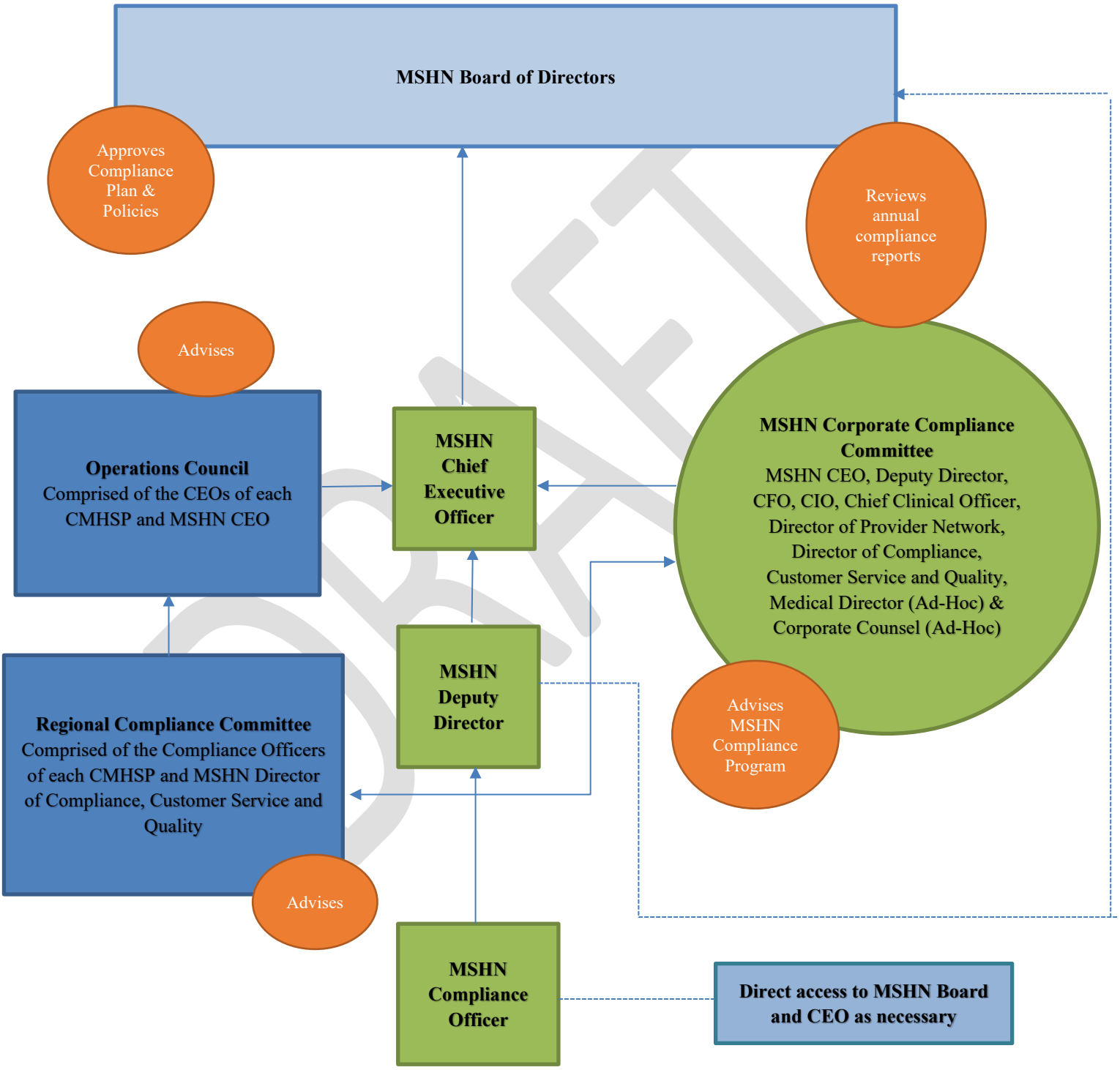
Quality

Service Delivery System

Utilization Management

ATTACHMENT B

Mid-State Health Network Compliance Process/Governance



ATTACHMENT C

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

Area of Focus	Responsible Party	Task
CMHSP Participants/ SUD Providers		
OIG Reporting Requirements	MSHN/Provider Network	Implement the quarterly reporting requirements as identified by the OIG
Medicaid Event Verification (MEV) audits	MSHN/Provider Network	Examine trends among the findings and implement processes/training to address identified issues
Autism Requirements	MSHN/Provider Network	Monitor for compliance with state contract requirements
Credentialing and Provider Qualifications	MSHN/Provider Network	Develop processes and monitoring to ensure compliance with state contract requirements
Health Services Advisory Group (HSAG) Site Review Findings and Recommendations	MSHN/Provider Network	Implement any required findings involving non-compliance with state and federal requirements
COVID-19 Changes		
Telehealth Requirements	MSHN/Provider Network	Monitor for compliance with rules outlined during the state of emergency and those continued past the state of emergency
Waiver Changes		
HCBW Planning and implementation of changes	MSHN / CMHSP	Review capacity, changes in waiver requirements and implementation to meet compliance
Children's Waiver (CW) and Serious Emotional Disturbance (SED) Waivers Certification Process for B3 Services	MSHN	Review capacity, changes in waiver certification requirements and implementation to meet compliance

ATTACHMENT D

MID-STATE HEALTH NETWORK

CONTACT INFORMATION FOR SUSPECTED COMPLIANCE VIOLATIONS

Please report suspected compliance violations to _____

In person:

By phone:

By email:

By mail:

Reports can also be made to MSHN Compliance Officer:

Kim Zimmerman
530 W. Ionia Street, Suite E
Lansing, MI 48933
P: 517.657-3018 C: 616-648-0485
kim.zimmerman@midstatehealthnetwork.org

MSHN COMPLIANCE LINE 1-844-793-1288

Or to:

CMHSP Compliance Officers (or designee):

Bay Arenac Behavioral Health,	Janis Pinter, 989.895.2760, jpinter@babha.org
CMH for Central Michigan,	Bryan Krogman, 989.772.1380, bkrogman@cmhcm.org
Clinton, Eaton, Ingham CMH,	Stefanie Zin, 517.346-8193, zinst@ceicmh.org
Gratiot County CMH,	Taylor Hirschman, 989.466.4108, thirshman@gihn-mi.org
Huron Behavioral Health,	Levi Zagorski, 989.269.9293, levi@huroncmh.org
The Right Door,	Susan Richards, 616.527.1790, srichards@rightdoor.org
LifeWays CMH,	Ken Berger, 517.789.2526, ken,berger@LifeWayscmh.org
Montcalm Care Network	Sally Culey, 989.831.7523, sculey@montcalmcare.net
Newaygo CMH,	Andrea Fletcher, 231.689.7542, afletcher@newaygocmh.org
Saginaw County CMH,	Richard Garpiel, 989.797.3539, Rmgarpiel@sccmha.org
Shiawassee County CMH,	Dirk Love, 989.723.0762, dlove@shiabewell.org
Tuscola Behavioral Health Systems	Michael Swathwood, 989.672.3014, mswathwood@tbhs.net

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

MDHHS Medicaid Fraud Hotline: 1.855.MI.FRAUD (643.7283)
HHS/OIG Hotline: 1.800.HHS.TIPS (447.8477)

ATTACHMENT E

MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES
INSPECTOR GENERAL ADMINISTRATION
INTEGRITY DIVISION
MCO – FRAUD REFERRAL

MCO Details:			
MCO Name:		**Date of Referral:**	
Referrer's Name:		**Referrer's Phone:**	
Referrer's Title:		**Referrer's Email:**	
Suspect Provider(s) Details:			
Provider Name:		**Provider Phone #:**	
Provider NPI #:		**Provider Type:**	
Provider Address:		**Provider Email:**	
Facility Owner Name:		**Owner Phone #:**	
Complainant(s) Details:			
Complainant Name:		**Complainant Phone #:**	
Complainant Address:		**Complainant Email:**	
Medicaid ID #:		**DOB:**	
Suspected Fraud Referral Details:			
Summarize the Suspected Fraudulent Activity:			
Estimated Fraud Amount:			
Date(s) of conduct:			
Document the specific laws, rules, regulations, policies, etc. that were violated:			
Supporting Documentation:	*Attach any and all documentation, data, or records obtained, reviewed, or relied on by the auditor leading to the suspicion of fraud including but not limited to:* ⇒ *Beneficiary/patient files and/or relevant medical records* ⇒ *Audit reports and findings* ⇒ *Provider Enrollment Agreements* ⇒ *Relevant fee schedules* ⇒ *Relevant provider policy manual* ⇒ *Provider education letters* ⇒ *Interview transcripts* ⇒ *Encounter claims data*		

	Label attachments 1-10, as applicable. *All submissions must be (1) zipped, encrypted, and sent to MDHHS-OIG@michigan.gov or (2) submitted via the secure File Transfer Protocol (FTP) to the OIG area specific to your MCO.*
Action Taken:	*Document the status of the current audit.* *NOTE – Do not make a fraud complaint if corrective action has been taken against the suspect provider (e.g., recoupment, contract termination, prepayment review, etc.).*
Record Review Results:	
Describe Record Selection Methodology:	*Include sample size and how the sample was selected (e.g., statistical vs nonstatistical, judgmental, etc.)*
Describe Record Review Results:	
Interview Results:	
Summarize Interviews:	*List all communications, chronologically, between the MCO and complainant, member and/or provider concerning the suspected fraud.*
Audit History:	
Document Suspect Provider(s) prior Audit History and Action Taken:	

ATTACHMENT F

MID-STATE HEALTH NETWORK

Compliance Investigation, Resolution and Documentation Process

I. Investigation

- Participant CMHSPs and SUD providers will report suspected compliance issues within ten business days of discovery to the MSHN Compliance Officer when there is suspected fraud, abuse or waste.
- Within five business days of receiving a report, the MSHN Compliance Officer shall provide a written acknowledgment of receipt to the individual making the report (if known) and conduct an initial assessment to determine whether the report has merit and warrants further investigation.
- If it is determined that the matter does not constitute a violation of any applicable laws or regulations and warrants no further action, the issue will be closed following the appropriate documentation and reporting by the MSHN Compliance Officer.
- If it is determined that the matter does not constitute a violation of any applicable laws or regulations but does identify an area for improvement or raises concern for potential future violations, the matter will be referred to the MSHN Quality Improvement Council for appropriate discussion, assignment and follow up action if appropriate.
- If it is determined that the matter requires further investigation, the MSHN Compliance Officer will first review the information and assess if immediate reporting to the MDHHS OIG should take place. The MSHN CO shall take the necessary steps to assure that documents or other evidence are not altered or destroyed through the following means, as applicable:
  - Suspending normal record/document destruction procedures;
  - Taking control of the files of individuals suspected of wrongdoing;
  - Limiting access of files, computers, and other sources of documents by individuals suspected of wrongdoing; and/or
  - Taking additional action as necessary to ensure the integrity of the investigation that could include temporary suspension, or temporary re-assignment of duties, of involved individuals.
- If the MSHN Compliance Officer concludes that reporting to a government agency (CMS, OIG, and DOJ) or a third party may be appropriate, the MSHN CO shall report to the government agency(s) within five business days following the receipt of the violation report. The MDHHS OIG Fraud Referral Form will be used for reporting. If necessary, the appropriate CMHSP Participant/SUD Provider Compliance Officer will be notified.
- No further investigation shall occur until the MSHN CO has confirmed with the MDHHS OIG to proceed. However, appropriate steps shall be taken to ensure consumer safety.
- Once confirmation from the MDHHS OIG is obtained, the MSHN CO shall provide direction to the appropriate staff and/or provider(s) based on the guidance/direction given by the MDHHS OIG.
- If MDHHS OIG confirmation is not obtained and/or MDHHS OIG instructs MSHN to not conduct any further investigation, the MSHN CO shall document the MDHHS OIG communication and follow up with the MDHHS OIG within thirty (30) days to obtain an update on the case.

II. Resolution

- Following the investigation, the MSHN Compliance Officer will document and report a summary of the findings to the MSHN CEO and the MSHN Corporate Compliance Committee. In cases where actions of the MSHN CEO are investigated, the report of findings is made to the Executive Committee of the MSHN Board of Directors.
- If the occurrence involved a MSHN employee, disciplinary action will be taken in accordance with MHSN's policies and procedures and Personnel Manual.
- If the occurrence involved a CMHSP Participant/SUD Provider, the CMHSP Participant/SUD Provider shall submit a remedial action plan to address any confirmed violations or address areas of concerns raised during the investigation.

III. Documentation

- A record will be maintained by the MSHN Compliance Officer and/or the CMHSP Participant/SUD Provider Compliance Officer or designee for all reports of potential/alleged violations to include at a minimum the information identified in section XII.B. The record may also include copies of interview notes and documents reviewed and any other documentation as appropriate.
- Records will be maintained in accordance with the "State of MI, Department of History, Arts and Libraries – Record Management – Records Retention and Disposal Schedule". http://www.michigan.gov/documents/hal/mhc_rm_gs20_195724_7.pdf

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
September/October 2020

Along with Deputy Director Amanda Ittner and the MSHN Leadership Team, I want to acknowledge with gratitude the ongoing efforts of our staff, our CMHSP partners, our SAPTR provider partners, and our MDHHS/BHDDA colleagues in meeting the challenges of supporting beneficiaries, stakeholders, and our provider system workforce from the very beginning of our pandemic response. Our staff and partners have remained engaged, committed and highly effective in supporting beneficiaries, our PIHP and our region. Services and supports to individuals, their families and supports, and communities across the region could not continue to be provided without the dedication and commitment of everyone involved.

PIHP/REGIONAL MATTERS

1. **COVID-19 MSHN Internal Operations Status:**

- In recent days, Michigan has reported record new daily infection rates, surpassing previous records set in April 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 one employee who has been assigned for office-based work.
- Work volume for most MSHN direct-employed personnel has increased due to the COVID-19 response. PIHP activities that can be carried out by remote means or that can be delayed to a future date have been adjusted. PIHP activities that can be done by phone or videoconferencing capability have also been similarly adjusted.
- MSHNs suite of three offices within the Michigan Optometric Association building have been closed since March 16, 2020.
- 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 have assigned one employee to office-based work. Away from office (remote) work arrangements were mandatory beginning on March 16, 2020 and shall continue until further notice, except as provided for in the MSHN COVID-19 Pandemic Response and Preparedness plan. In light of the recent increase in cases, an email was sent to all MSHN staff to this effect.

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 reengagement. Most are continuing with a blend of telehealth and in-person services.

- SUD Prevention, Treatment and Recovery Providers: All SUD *Treatment* providers remain functional and capable of delivering all essential services and supports to beneficiaries, families and communities. Prevention providers are delivering services within the limits of current social distancing amid the closures of schools, community-centers, etc. 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 Direct Care Worker (DCW) Premium Pay:**

MSHN has continued implementation of premium pay for direct care workers and extended this initiative through January 9, 2021. After MSHN took this action, as authorized by the MSHN Board at its September 2020 meeting, the Michigan Legislature extended (and funded) an extension through 12/31/20. Michigan's PIHPs are expected to continue the DCW premium pay, and MDHHS will include the payment in our November payments via an actuarial rate adjustment. Note that any unused portion of the premium pay increase must be returned to MDHHS. MSHN and our regional partners are very concerned about potential future cessation of the premium pay initiative and the effects this will have on our workforce and ability to continue providing necessary services and supports. MSHN continues to advocate for DCW Premium Pay continuation, and will evaluate our regional ability to continue into the second quarter (and/or beyond) in December and may bring a recommendation for continuation to the MSHN board at the January 2021 MSHN Board Meeting.

4. **Provider Stabilization Update:**

On May 27, the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) required a regional provider stabilization plan to be submitted by June 4. MSHN, in partnership with our CMHSP Participants, developed our plan, which was approved for implementation by MDHHS on June 16 and published for regional implementation on June 17. It is important to note that the MSHN region acted before the regional implementation plan was approved and implemented. The regional plan is located on the MSHN Coronavirus Page at this link.

Through September 30, 2020, the MSHN region has provided $7,403,412 in provider stabilization assistance to 79 regional specialty behavioral health providers (number of providers may be duplicated due to service delivery in multiple categories). The top few provider types to receive provider stabilization assistance include vocational providers ($3.010M), community living supports providers ($1,049M), applied behavior analysis services providers ($1,026M), and skill building service providers ($560,000). Many additional providers and provider types in the specialty behavioral health system have been assisted with regional support. All requests received for stabilization assistance have been approved.

Through September 30, 2020, the MSHN region has provided an additional $1,3653,332 in provider stabilization assistance to 29 substance abuse treatment and recovery providers. Residential treatment providers, including residential withdrawal management services providers, were supported with $418,246 in stabilization payments and outpatient services providers were assisted with $935,066 in stabilization support. All requests for stabilization assistance have been approved.

5. **Regional Implementation of SUD Treatment Services for Individuals Under the Supervision of the Michigan Department of Corrections (MDOC):**

   MSHN is reporting that it has now fully implemented, region-wide, SUD treatment access for parolees under the supervision of MDOC. MSHN has expanded the number of SUD treatment providers serving these individuals (all in-region providers) well beyond MDOC's small, previously existing network in the MSHN region. About 90% of individuals re-entering community life from prison are covered by Medicaid or Healthy Michigan. Severely impacted by the COVID-19 pandemic response, the MSHN implementation team led by Cammie Myers, Utilization Management Specialist, reports completion of the implementation plan and successful operations. Additional implementation team members to recognize include: Recognize: Amy Keinath, Forest Goodrich, Kyle Jaskulka, Melissa Davis, Skye Pletcher, Steve Grulke, Trisha Thrush, Dani Meier, Kim Zimmerman, and Shannon Myers. Congratulations and gratitude to Cammie and the Implementation Team members on this achievement!

6. **Partnership between MSHN, Michigan State University (MSU) and MDHHS:**

   Barb Groom, Waiver Coordinator, Katy Hammack, Waiver Manager, and Kara Hart, HCBS Waiver Coordinator have been key in a partnership between MSHN, MSU and MDHHS. As a result, several very positive developments have occurred:

   - One of the Applied Behavioral Analysis (ABA) providers in the region has been asked to participate in research to help guide future partnerships to improve the quality of services to individuals living on the Autism spectrum.
   - The ABA degree program at MSU is in the process of modifying its curriculum to incorporate teaching skills necessary for successful implementation of family training by BCBAs.
   - A Family Training brochure was developed and is included as an attachment to this board report.
   - Barb Groom had her article on Parent Training for Youth with Autism published in the Journal of Autism and Developmental Disorders!

7. **SUD Strategic Plan:**

   MDHHS requires region-wide strategic plans focused on substance use disorder prevention, treatment and recovery. Congratulations and gratitude to MSHN's treatment and prevention teams on MDHHS approval of the 2021-2023 SUD-Specific Strategic Plan for the region. Countless hours of work and research have gone into this effort, not to mention attention to detail, collaboration with partners, and basing our plans on the best data we can get. One of the key areas included in this plan, which will also be addressed in the master strategic plan later this fiscal year, is a focus on reducing/eliminating health disparities for individuals involved with the SUD prevention, treatment and recovery system.

8. **SAPT Block Grant:**

   MSHN has been notified of a significant reduction (38% overall - nearly $5.3M) in block grant funding for FY 21. MDHHS allocations assumes an unspent balance from the previous year. Large shirts of people moving to healthy Michigan plan from block grant – but the allocations have continued using the same formula, but without prior year savings. For the past two years, Legislature has provided additional funds to make the block grant allocation whole, but that is not an option in the current revenue climate. We will need to make significant reductions to block grant spending, and an internal MSHN team is evaluating options.

Block grant funding is used to support SUD treatment, prevention and recovery services for individual that do not qualify for Medicaid/HMP but have incomes insufficient to cover the cost of services and supports. Block grant is also used to pay for services/supports/infrastructure that cannot be covered by Medicaid or HMP funds. As a result of this significant funding reduction, MSHN announced at our recent provider meeting that it would not presently support new provider or provider service expansion initiatives in the early phases of fiscal year 2021 that began on October 1, 2020. This decision was taken out of an abundance of caution over the State of Michigan budget situation (which was not known at the time) and federal substance abuse prevention and treatment block grant availability.

MSHN anticipates sufficient fiscal year 2021 Medicaid and Healthy Michigan Program funding to meet its current obligations to provide medically necessary services and supports to covered beneficiaries. Block grant services and supports are not entitlements and MSHN must operate within available resources. As a result, MSHN must be more deliberate and conservative in evaluating these sorts of projects, especially at the beginning of the fiscal year. We anticipate revisiting this decision after results of operations from the second quarter of the new fiscal year are known.

9. **Michigan Consortium for Healthcare Excellence (MCHE) Annual Meeting**:

The MCHE is an organization comprised of the boards of nine (of ten) Michigan PIHPs. Each PIHP/Regional Entity governing board has appointed its CEO to the board of the MCHE. The bylaws of the MCHE require an annual meeting, which MSHN board members are invited to attend. Please see the flyer attached to this report for more information. Participation is voluntary.

10. **PIHPs Develop Unenrolled/Complex Care Management Proposal:**

Michigan's 10 PIHPs/Regional Entities (REs) have collaborate to develop a complex care management proposal to serve individuals not enrolled in Medicaid Health Plans (MHPs) (referred to as "unenrolled"). Integrated health services to individuals not a part of the MHPs have long been a confounding variable in system reform efforts. The PIHP/RE proposal includes PIHP-managed complex care management services for Medicaid/HMP beneficiaries not enrolled in a Medicaid Health Plan under non-risk based (fee basis, case rate or other) financing. This means that the complex care management, integrated healthcare services to this population would not expose the region to any risk, would not be use or affect internal service funds (ISF's) or savings. The proposal has been reviewed and is supported by the MSHN Operations Council. The proposal is in the process of being finalized through all regions. Next step is submission to MDHHS, but the PIHPs have not put forward a target date for providing our proposal to BHDDA as of this date. If MSHN Board Members would like to see a copy of the proposal as it stands as of this writing, please send me an email and I'll get the proposal out to you.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

11. **Regular MDHHS Meetings**:

MSHN continues to collaborate with our BHDDA colleagues on at least an every other week basis (frequently more often). MDHHS/BHDDA hosts calls with all PIHPs and CMHSPs to coordinate COVID-19 pandemic response, announce policy updates, and to hear from the field about issues being confronted "on the ground." These meetings are very helpful to ensuring consistent information is distributed and discussed.

12. **MiCAL**:

This is an acronym for Michigan Crisis and Access Line. MiCAL is one statewide line that will serve as a crisis line, warm line, information and referral line for individuals in need of behavioral health and/or substance use disorder (SUD) treatment services and do not know where to go, whether that caller is the individual in need, a concerned family member, or a helping professional.

Representative Whiteford and the House CARES Task Force recommended, funded and codified the development of MiCAL to mitigate confusion in finding help within the behavioral health and substance use disorder treatment system. It was formalized into Public Act 12 of 2020 in April.

- The intention of the law is to ensure all Michiganders know where to call when they need help, regardless of the severity of symptoms or ability to pay.
- The law specifies that resource information provided is accurate and up to date, and that the system gathers data for performance purposes and population health.
- It also includes a Customer Relations Management (CRM) system to simplify various compliance processes.

MiCAL is being modeled after the Crisis Now framework and SAMHSA's National Guidelines for Behavioral Health Crisis Care which are used successfully by other states. (https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf)

According to MDHHS, MiCAL will:

- Accept calls, chats, and texts
- Include triage and de-escalation components
- Implement care coordination tools such as individual specific crisis alerts, and intervention notes sent back to ongoing clinicians
- Provide warm transfers whenever possible

MiCAL promotes early intervention by allowing callers to define a crisis by their own standards, encouraging them to reach out for help before they need to go to the Emergency Department. The line will be a resource for familiar voices who call in frequently and will be able to identify and provide consistent services for those callers and coordinate those services with their ongoing clinicians. It will also provide crisis support to people with mild to moderate behavioral health needs who are served by private providers and Medicaid, and who do not meet the threshold for severity for a given CMHSP.

MiCAL is not an authorization line. **It does not** prevent an individual from going directly to a CMHSP or another treatment provider.

- Will complement existing CMHSP crisis lines and integrate with them after hours. It **will not** replace the CMHSP access or their existing crisis phone numbers.
- The large majority of CMHSPs and PIHPs currently forward their crisis lines to a 3rd party organization after hours. CMHSPs and PIHPs will be able to forward their lines after hours to MiCAL and possibly save resources.

The MiCAL staff will have the education, credentials and the training necessary to serve the diverse consumers calling in, including training in cultural competency and de-escalation. MiCAL will meet the standards of and become a National Suicide Prevention Lifeline Affiliate, ensuring **all calls will be answered by someone in Michigan and familiar with Michigan resources.** The mission of MiCAL is to ensure that all

Michiganders receive the appropriate level of support in connecting them to the behavioral health and SUD care they need, whether that support is crisis help, a listening ear through the warm line, information and referral, or a combination of the three.

13. **Open meeting act statue changes summary**:

On 10/16/20 Governor Whitmer signed Senate Bill 1108 which codifies her previous Executive Order that allows public bodies to conduct meetings remotely during the COVID-19 pandemic. The legislation is retroactive to March 2020, which makes virtual meetings held under previous executive orders that have been nullified by the Michigan Supreme Court ruling legal (in other words, there is no need to ratify decisions taken by the Board in the May, July and September board meetings). The legislation does include some future considerations, which we summarize for your convenience below:

- Authorizes virtual/remote meetings of the public body provided that two way communication so that members of the public body can hear and be heard and so that public participants can hear members of the public body and can be heard by members of the public body during public comment period(s) and all other provisions of the open meetings act are followed, in the following circumstances:
    - Before January 1, 2021 and retroactive to March 18, 2020, any circumstances, including but not limited to, any of the circumstances requiring accommodation of absent members due to a medical condition, or a statewide or local state of emergency or state of disaster declared pursuant to law or charter by the governor or a local official or local governing body that would risk the personal health or safety of members of the public body in the meeting were held in person.
    - On and after January 1, 2021 through December 31, 2021, only those circumstances requiring accommodation of members absent due to military duty, a medical condition, or a statewide or local state of emergency or state of disaster… For the purpose of permitting an electronic meeting due to a local state of emergency or state of disaster, this… applies only as follows:
        - To permit the electronic attendance of a member of the public body who resides in the affected area;
        - To permit the electronic meeting of a public body that usually holds its meetings in the affected area.
    - After December 31, 2021, only in circumstances requiring accommodation of members absent due to military duty.
    - According to our law firm, the statue requires that if a member is absent for any purpose other than those outlined herein, the member must also identify the county, city, township, or village and state where they are participating from. The public shall be notified of the member's absence as well as how to reach the member in advance of the meeting.
    - We have attached a memorandum from Cohl, Stoker & Toskey, our law firm, which summarizes the OMA changes along with other pertinent information resulting from the nullification of the Governor's executive orders (to facilitate brevity, we have not included the attachments referenced in the memorandum. The attachments are publicly available and can be obtained from MSHN on request).

FEDERAL/NATIONAL ACTIVITIES

14. **SAMHSA Press release 9/28/20:**

While a bit lengthy, I am including a recent press release from the Substance Abuse and Mental Health Services Administration (SAMHSA):

"SAMHSA stands by its commitment to fostering and protecting the mental health of all Americans. It is vastly disappointing that the mere reference to mental health is seen as a political ploy by members of the media and even other federal agencies who purportedly exist to protect the health of Americans. SAMHSA will proudly and continually advocate for the importance of addressing mental health.

"Our fellow Americans who claim to herald science ignore that one of the main demands of science is the ability to consider multiple perspectives at once. Why have we, as a nation, accepted that the only science that exists is that which details the tragedies of the virus? For which other medical condition would this be permitted? Never would we ignore the casualties caused by heart disease to focus solely on cancer--never. Yet, the mention of mental health conditions, real medical illnesses, is automatically deemed political in today's context. The beauty of America's science and healthcare system has always been that we have understood all aspects of health and have been allowed to do so. Why is it that when someone raises a well-founded scientific claim related to a condition other than COVID-19, that claim is now, by definition, political?

"The existence of the virus has not eliminated all other health conditions. The agency funded to promote and protect mental health must be allowed to call attention to the science around this condition. And, that science paints a damning picture. That science tells us that 2,010 children lost their lives to suicide and drug overdose in 2018. Those are not SAMHSA's numbers. They are CDC's. Science tells us that 40% of Americans are experiencing mental health consequences due to the pandemic. Those are not SAMHSA's numbers. They are CDC's. So, why is it unacceptable to share these facts with Americans? Why aren't parents allowed to know what the very real and scientific consequences of school closures may be to their children's mental health?

"This agency has never called for a cavalier approach to reopening schools or society; however, we absolutely stand by our call to reopen schools with appropriate safety measures in place. The mental health of our children is not a political issue; it is a health issue. The mental health of our nation depends on our collective ability to accept all aspects of science and make informed and rational decisions based on such information. The success of our efforts cannot lie solely in the opinions of one single agency who, if challenged, calls "politics." We must be bigger than that. Members of the public and the media: you are encouraged to hold SAMHSA accountable for the information we put out. To those living with mental health conditions or those who may be first experiencing them: this agency will not stand down. We will continue to fight on your behalf no matter the criticism we take. Your lives and this mission are simply too important to ignore."

15. **Self-care for Healthcare Professionals and Responders to COVID-19:**

SAMHSA is reiterating the availability of a resource entitled *Self-care for Healthcare Professionals and Responders to COVID-19*. SAMHSA notes that "healthcare and mental health professionals, first responders, and others on the frontlines of COVID-19 response do intense, sometimes stressful work, even outside of emergencies. In an unprecedented crisis, responders may be at particular risk, and it is

even more important they take steps to ensure their physical and mental health." The resource is available at this link.

16. **My Mental Health Crisis Plan:**

SAMHSA has released a new mobile app, *My Mental Health Crisis Plan*, "which allows individuals who have serious mental illness to create a plan to guide their treatment during a mental health crisis. The app was developed through SMI Adviser, a project funded by SAMHSA and administered by the American Psychiatric Association. The app provides an easy, step-by-step process for individuals to create and share a psychiatric advance directive." Additional information is available at this link.

17. **2019 National Survey on Drug Use and Health (NSDUH):**

SAMHSA has released the *2019 National Survey on Drug Use and Health* (NSDUH). The entire report is available at this link. "The annual survey is the nation's primary resource for data on mental health and substance use among Americans. As the NSDUH demonstrates, substance misuse and mental illness continue to be major problems for Americans. These issues demand continued attention and focus across all American communities. The data also reflect impressive progress on the nation's opioid crisis. The report summarizes the following:

- Substance use (alcohol, tobacco, marijuana, cocaine, heroin, hallucinogens, and inhalants, as well as the misuse of opioids, prescription pain relievers, tranquilizers or sedatives, stimulants, and benzodiazepines)
- Initiation of substance use
- Perceived risk from substance use
- Substance use disorders
- Any mental illness, serious mental illness, and major depressive episode
- Suicidal thoughts, plans, and non-fatal attempts for adults aged 18 or older
- Substance use treatment and mental health service use"

Submitted by:

Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 10/26/2020

Attachments: MCHE Annual Meeting Flyer
Selected Pages from 10/20/20 Memorandum from Cohl, Stoker & Toskey, P.C.
MSHN/MSU/MDHHS Family Training Brochure

MCHE

MICHIGAN CONSORTIUM FOR HEALTHCARE EXCELLENCE

2020 ANNUAL MEETING

11:30 AM NOVEMBER 5, 2020

Attend via Zoom on your device:
https://us02web.zoom.us/j/84563406891?pwd=WWNmTnVjeFZjQURicW50Z05rWGl6dz09

or dial: 470-250-9358 or 646-518-9805

Meeting ID: 845 6340 6891

Passcode: 042209

Invitees are MCHE Board Members and Regional Entity and Stand-alone CMH/PIHP Board Members

Meeting Materials: MCHE.MemberMeeting2020-21 DRAFT.pptx

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Referenced Attachments
Omitted by MSHN

IMPORTANT CLIENT UPDATE

EXECUTIVE ORDER STATUS

As you are likely aware, the Michigan Supreme Court issued an opinion Friday, October 2, 2020 in which the majority of the Justices agreed that the Governor's Executive Orders issued after April 30, 2020 were invalid as the law under which they were issued allowed an unconstitutional delegation of legislative authority to the Governor.

In essence, the federal District Court from the Western District of Michigan requested Certification from the Michigan Supreme Court regarding the appropriate interpretation of Michigan law being applied in a federal case challenging the Governor's Executive Orders. The parties to the federal case disputed the impact the Executive Orders had on limiting and regulating certain medical procedures by health care professionals. Therefore, the Certification Opinion was not a direct order as to a case before the Michigan Supreme Court; rather, it provided instruction to the federal District Court on the law that the federal Judge would need to apply in that federal lawsuit.

Following the Michigan Supreme Court's Certification Opinion, the Governor's Attorneys filed motions seeking immediate clarification that the Certification Opinion would not take effect until after the 21-day period had lapsed.[1] In response, the Michigan Supreme Court entered an Order on October 12, 2020 denying the stay of precedential effectiveness of its Certification Opinion, and also entered an order in the case filed by the State Legislature that nullified the Executive Orders relying on the same reasons as set out in the majority opinion in the Certification case.[2] This Opinion was expressly given immediate effect by the Court's majority.

Michigan Executive Branch Rules

In response to the Michigan Supreme Court's nullifying all of the Governor's Executive Orders effective after April 30, 2020, the following actions by the State's Executive branch have been taken to address COVID-19 pandemic:

1) The Michigan Department of Health and Human Services (MDHHS) issued an Emergency Order Under MCL 333.2253 on October 9, 2020 adopting regulations related

[1] It is normal practice for Michigan Supreme Court decisions not to take effect for 21 days unless the Michigan Supreme Court directs the Certification Opinion to have immediate effect.

[2] *House of Representatives and Senate v Governor,* Supreme Court Docket No. 161917 (October 12, 2020)

to COVID-19 mirroring many of the provisions in the prior Governor's Executive Orders on gatherings, capacity restrictions, face coverings, food service establishments, organized sports, the protection of employees in the workplace, and facility-specific contact tracing.[3] Important for purposes of hosting public meetings, this Emergency Order permits indoor gatherings of up to 10 persons at non-residential venues, provided each person wears a face covering. For gatherings of more than 10 and up to 500 persons occurring at non-residential venues, the organizer is responsible for determining the max occupancy based on whether fixed seating is available. A copy of the Emergency Order is attached for your review as *Attachment 1*. The MDHHS Emergency Order provides that it is effective through October 30, 2020.

2) On October 14, 2020, the Michigan Department of Labor and Economic Opportunity (LEO), Michigan Occupational Safety and Health Administration filed Emergency Rules regarding COVID-19 with the Michigan Secretary of State. These Emergency Rules were promulgated by the Director of LEO to establish clear requirements for employers in an effort to control, prevent, and mitigate the spread of COVID-19 among their employees. Moving forward, employers will be required to, among other things:

    a. Evaluate their employees' routines and reasonably anticipated tasks and procedures to determine what, if any, risk or exposure the employees may face; and

    b. Develop and implement written COVID-19 preparedness and response plans in line with current CDC guidance and recommendations; and

    c. Promote basic infection prevention measures in the workplace by requiring employees to stay home and isolate if sick; establishing disinfection procedures if it is suspected or confirmed that employees, customers, or visitors have a known case of COVID-19; and creating a teleworking policy prohibiting in-person work to the extent an employee's work can be completed remotely; and

    d. Conduct daily pre-entry self-screenings of employees and contractors entering the workplace; and

    e. Designate worksite COVID-19 safety coordinators to enforce the employers' rules; and

    f. Provide personal protective equipment to employees appropriate to the exposure risk associated with their respective jobs; and

    g. Train all employees on workplace infection-control practices, proper use of personal protective equipment, notification procedures of suspected or confirmed exposure to COVID-19, and reporting unsafe working conditions; and

[3] The MDHHS initially adopted an Emergency Order under MCL 333.2253 on October 5, 2020, which has since been rescinded and replaced by the MDHHS's October 9, 2020 Emergency Order.

h. Maintain records of all trainings, screening protocols, and records of required notifications.

Most of these regulations again nearly mirror requirements in the nullified Executive Orders.[4] These new Emergency Rules are to be in effect for a six (6) month duration per their provisions.

A copy of the Emergency Rules is attached for your review as *Attachment 2*.

COVID-19 Legislation

In addition to the steps taken by the State's Executive branch, a Public Act on the Open Meetings Act, 1976 PA 267 (OMA), has been enacted by the Legislature and signed into law by the Governor since the recent Supreme Court decisions relating to COVID-19 issues; and several other COVID-19 related laws are awaiting action by the Governor. This legislation includes:

1) One of the major issues raised by the nullification of the Executive Orders after April 30, 2020, was the impact on the OMA and the provisions within the prior Executive Orders authorizing remote public meetings. On October 16, 2020, the Governor signed Senate Bill 1108 as 2020 Public Act 228, which modifies the OMA, effective immediately and retroactively, to allow the following:

   a. Absence of Members of a Public Body: Public bodies are required to establish procedures to accommodate absent members of the public body due to military duty; a medical condition; or a statewide or local state of emergency or state of disaster declared by the governor, a local official, or a local governing body that would put the personal health and/or safety of the public body or members of the public at risk if held in person. Procedures to accommodate the absent member must include providing a mechanism for 2-way communication and a requirement the absent member(s) announce at the beginning of the meeting that they will be participating remotely. If the member is absent for any purpose other than those outlined herein, the member must also identify the county, city, township, or village and state where they are participating from. The public shall be notified of the member's absence as well as how to reach the member in advance of the meeting.

   b. Electronic Public Meetings: Public bodies may hold wholly or partly electronic meetings by telephonic or video conferencing in the following circumstances:

      i. Before January 1, 2021 and retroactive to March 18, 2020 for any circumstance, including, but not limited to, the above circumstances requiring accommodation of absent members of a public body.

      ii. On or after January 1, 2021 through December 31, 2021 for only the above circumstances requiring accommodation of absent members of a public

[4] Executive Order 2020-184: *Safeguards to Protect Michigan's Workers From COVID-19*, issued September 25, 2020, was the most recent Executive Order from the Governor on these issues.

body. However, electronic meetings due to a local state of emergency or state of disaster may only be held if a member resides in the affected area or the public body at-large holds its meetings in the affected area.

iii. After December 31, 2021 only when a member is absent due to military duty.

Two-way communication is required so that members of the public body can hear and be heard by one another, and so that public participants can hear and be heard by members of the public body and other members of the public.[5] Except as otherwise provided, a physical place is not required for an electronic meeting to be held, and electronic participation by a member of a public body or member of the public is considered present and in attendance at the meeting.

Advance notice of an electronic meeting must be provided no less than 18 hours before the meeting begins, and it must explain why the meeting is being held electronically, how members of the public may participate, how members of the public may contact members of the public body to provide input before the meeting, and how persons with disabilities may participate. If there is an agenda, it must be made available to the public at least 2 hours before the electronic meeting begins, not including subsequent amendments made at the meeting. Additionally, members of the public will not be required to register or provide their name or other information as a condition precedent to attendance other than mechanisms established or required to permit the person to participate in public comment.

2) A number of other bills have been adopted by the Legislature and presented to the Governor on COVID-19 related issues that may be forthcoming in the near future, including bills related to matter previously addressed in the prior Executive Orders, such as bills on unemployment benefits (SB 0886), and liability protection for COVID-19 workers and reopening businesses (HB 6030, HB 6031, HB 6032, HB 6101, HB 6159).

Should you have questions, please do not hesitate to contact our Office.

Cohl, Stoker & Toskey, P.C.
601 N. Capitol Ave.
Lansing, MI 48933
(517) 372-9000

October 20, 2020

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[5] Members of the public will, however, be excluded from participating in a closed session of the public body held electronically if the closed session is convened and held in compliance with the OMA.

Questions to ask your service provider:

- How do you define family training?
- How can family training help me and my child?
- What are other ways I can be involved in services?
- Can other family members or caregivers be a part of this?
- What kinds of skills do you think are important for parents to learn?
- What is your approach to helping me be involved?
- Do you use a manual or specific training program?

Questions to ask yourself:

- What do I want to learn most to help my child?
- What expectations do I have about family training?
- How do I learn best?
- How can I make time to attend and practice?
- Who can support me while I am participating?

If you are having trouble, speak up!

CMH wants to know if things are not working or if you are having trouble accessing family training services.

Who should you talk to?

First, follow **informal processes** and talk to the people involved in your services:

Your ABA provider → Your case manager → The program director

If you aren't able to resolve the problem, there **are formal processes** you can use:

Mediation: Contact Michigan Protection & Advocacy Service (MPAS) or your local Community Dispute Resolution Program

Complaints: Complete a Rights Complaint form or call the Office of Recipient Rights 1-800-854-9090

Appeals: Use the Do-It-Yourself DHHS Hearing Request tool or call the Michigan Office of Administrative Hearings and Rules 1-800-648-3397

Why speak up?

- Your experiences are valuable and can be used to improve your services
- You know when something is or is not working for your family
- You have ideas for making things better
- You have the only long-term connection

Family Training

An informational guide to family training as part of your Applied Behavior Analysis (ABA) services

Developed in partnership with:

MSU autism lab

MSHN
Mid-State Health Network

MDHHS
Michigan Department of Health & Human Services

What is Family Training?

Family training relies on **collaboration** between you and your child's therapist. It is when a provider works with you **to help you feel more confident and skilled in helping your child**. While this looks different for each family, these are the **common parts**:

Collaborate	Work with you to set goals and track progress
Model	Demonstrates strategies with your child while they explain it to you
Practice	Gives you time to practice with your child during the session
Feedback	Supports you as your practice with your child during the session
Plan for Practice	Help you plan how to practice the strategies at home with your child
Problem Solving	Help when using the strategies at home is not working well
Materials and Handouts	Provides you with written materials or videos to help you learn

We surveyed 226 families and interviewed 20 families about the family training services offered as part of their child's ABA services with CMH.

Here is what we learned.

Families value their services

Families value their current ABA and support services, but are interested in how they can be more involved.

Current family services are not always "family training"

Families describe services like progress monitoring, psychoeducation, and check-ins rather than coaching in specific intervention strategies.

Participation in family training is worth the challenges

Childcare and transportation are barriers, but parents are willing to prioritize participation in active family training around specific strategies.

Turnover creates disruptions

Frequent or unexpected changes in ABA staff negatively affects both parent and child progress.

What can I expect from family training?

Learning and practicing **requires time and effort**, but it has lasting benefits for the child and family.

For family training to work best, parents **attend weekly sessions** with a therapist over several months.

Sessions **focus on teaching you** skills that support your goals for your child's development.

What are the benefits?

- Helps children transfer the skills learned during ABA to the home
- Creates more teaching and learning opportunities
- Increases parents sense of competence and skills
- Supports family quality of life

Can address many behaviors and teach new skills such as:

- Challenging behaviors
- Talking and listening
- Social skills
- Play and imitation
- Sleeping and eating
- Toilet training

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

OPERATIONAL UPDATES

Board Member Disclosures

Annually, MSHN obtains a disclosure of ownership, controlling interest, and criminal convictions statement from the MSHN board of directors in accordance with State and Federal requirements. This generally occurs during the July meeting. Due to the nature of information that must be disclosed, we opted out of using US mail to obtain the annual disclosure. As some board members may not have access to electronic signature technology and/or have easy access to print/scan documents, we also opted out of sending disclosures electronically. MSHN has contacted CMHSPs to request a copy of a current (2020) disclosure statement for our records. If a current disclosure is not available, we will ensure updated disclosures are received at the next face-to-face board meeting. We are also seeking additional methods of collecting disclosures electronically using a secure and efficient manner.

Population Health and Integrated Care Updates

As discussed in my previous reports, MSHN and the Operations Council, along with the Regional Medical Directors, Clinical Leadership Committee and the Utilization Management Committee has finalized the review and incorporated new elements in the Region's Population Health and Integrated Care Plan. The 2021-2022 plan serves several overarching purposes:

- Describe the demographic and epidemiological profile of the population served by MSHN and its CMHSP and SUDSP networks
- Identify existing population health needs and health disparities in the MSHN region using a data-informed approach
- Define MDHHS contractual requirements pertaining to integrated health and care coordination and identify regional strategies and initiatives to meet the contractual requirements
- Set regional priorities (in addition to MDHHS contractual requirements) that align with the MSHN Strategic Plan and promote the Healthcare Quintuple Aim of better care, better health, better value, better providers, and better equity

The substantive changes to the plan include additions in multiple areas to address Racial and Ethnic Disparities as well as the COVID-19 Impact & Regional Response. ***For the full report see the FY21-22 Population Health & Integrated Care Plan link below.***

Information Technology Updates & New MSHN Data Webpage Launched

The MSHN Information Technology team provides services related to technology for the region. This includes assisting and supporting the region in meeting the contractual obligations for MDHHS, supporting the participating CMHSPs and SUD providers through managed care processes, strategic direction for technology initiatives and technical assistance with the MSHN team. Over the last quarter, the team has supported the following efforts.

- Behavioral Health Admit, Discharge, and Transfer (ADT) standard template finalized
- Mental Health Parity software upgrade to version 12.4 – for the region
- MIDIGATE care coordination evaluation
- Microsoft Surface deployment completion for all MSHN Staff
- Multi-factor Authentication implementation for all MSHN Staff

In addition, as of October 1, 2020, MSHN launched the first phase of a new webpage titled: **MSHN DATA.** The webpage is designed to share graphical data related to our region such as consumers served & enrolled, provider network audit performance, key performance metrics and financial information. As MSHN Leaders will begin to develop our next phase which includes integration with data analytics platforms and additional data elements that is scheduled for release January 1, 2020. Feedback on the MSHN DATA webpage is encouraged and welcomed to be submitted to info@midstatehealthnetwork.org. ***For the Information Technology report see the link below, Information Technology Quarterly Report FY2020 Q4***

MSHN COVID WEBSITE Updates

In light of the Michigan Supreme Court ruling, MDHHS has issued several Public Health/Epidemic Orders that address and support many areas of the previous Executive Orders. MSHN is in the process of updating our COVID website page to reflect the many changes since the ruling.

- Requirements for Residential Care Facilities
  - Visitation Order Oct. 21 Infographic
  - Visitation Order Oct 21 Special Cases Grid
- UPDATED: Gathering Prohibition and Mask Order
- Reporting of Confirmed and Probable Cases of COVID-19 at Schools
- Final MDHHS congregate care and juvenile justice epidemic order
- Final MDHHS residential care epidemic order

Please visit the MDHHS Epidemic Orders website to view the most current updated versions.

Leadership 360 Evaluation Feedback Process

As a follow up to the CEO's September Board report of MSHN efforts to increase and strengthen feedback on our Executive Team members Leadership skills as well as to identify strengths and opportunities for improvement areas, a 360 degree survey monkey link will be emailed to multiple sources of stakeholders, peers, direct reports and others including CMHSPs, PIHPs and MDHHS. Board members may receive a survey to provide valuable input and feedback on our Leadership Team members. MSHN encourages all recipients to complete the survey and appreciates your time and willingness to participate.

FY20 Office of Inspector General Reporting on Program Integrity Activities

MSHN and the CMHSPs continue to report quarterly on the regions program integrity activities through a quarterly submission to the Office of Inspector General (OIG). OIG requires PIHPs to report on: Tips/grievances received, data mining and analysis of paid claims, audits performed, overpayments collected, identification and investigation of fraud, waste and abuse, corrective action plans implemented, provider dis-enrollments and contract terminations. The OIG reviews the submissions for approval with either a "pass/fail" response. To date, MSHN's received a "Pass" on all quarterly reports. Thanks to Kim Zimmerman, MSHN's Director of Compliance, Customer Service and Quality and the CMHSP's Compliance Officers for ensuring MSHN's continued compliance with data reporting requirements. Due to the nature of the data, MSHN's unable to share the reports but a summary of reporting activities is included in the FY20Q4 Report from the Director of Compliance, Customer Service and Quality. ***For the full report see the link below, Compliance, Customer Service and Quality Quarterly Report FY2020 Q4***

Health Services Advisory Group Issues Final Report on Performance Measurement Validation (PMV)

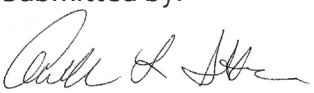
The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with PIHPs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. To meet the PMV requirements, MDHHS contracted with Health Services Advisory Group, Inc. (HSAG) to conduct the PMV for each PIHP. HSAG validated the PIHPs' data collection and reporting processes used to

calculate performance indicator rates. The purpose of performance measure validation is to assess the accuracy of performance measures reported by PIHPs and to determine the extent to which performance measures reported by the PIHPs follow state and federal specifications and reporting requirements. Once again MSHN received a score of 100% compliant/met all requirements which demonstrates our regions commitment to data accuracy and quality. MSHN appreciates the efforts of our CMHSPs and SUD Providers for their preparation and participation during the review and the ongoing commitment to quality throughout the year. A special thanks to Sandy Gettel, MSHN's Quality Manager and Forest Goodrich, MSHN's Chief Information Officer for coordinating and leading this effort for our region. ***For the full report see the SFY2020 Validation of Performance Measures link below.***

UPDATED Telehealth Service Utilization/Information (Pre-Post COVID)

In my last report to the Board of Directors, I shared the region's utilization of telehealth services since the pandemic period began in March. Our providers continue to support and ensure essential services through both face-to-face and telehealth venues. As a region since March, we noted an increase in telehealth services as expected, while just a slight decrease in individuals served. This information will be reviewed with the Operations Council in November for related follow up and action planning. ***The full report can be downloaded using the attached link below: COVID 19 Telehealth Services.***

Submitted by:



Amanda L. Ittner
Finalized: 10.28.20

Links to referenced documents:
Population Health & Integrated Care Plan 2020-2022
Information Technology Quarterly Report FY2020 Q4
SFY2020 Validation of Performance Measures
Compliance, Customer Service and Quality Quarterly Report FY2020 Q4
COVID 19 Telehealth Services

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In order to present the most accurate and up to date financial information for the year ended 09/30/2020, MSHN has not included interim financial reports in this packet, which would normally appear here.

The financial reports will be sent to MSHN Board members between November 4 and 6 and will be displayed during the meeting for board members and participating members of the public.

Please refer to the emailed documents during the meeting.

We apologize for referring you to documents outside of the packet. Our thinking is that accuracy and completeness would outweigh any inconvenience.

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 FY21 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 FY21 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2021 NEW AND RENEWING CONTRACTS
November 2020

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	ORIGINAL FY21 CONTRACT AMOUNT	FY21 TOTAL CONTRACT AMOUNT	FY21 INCREASE/ (DECREASE)
PIHP ADMINISTRATIVE FUNCTION CONTRACTS					
Allegra	Printing of 2021 Consumer Handbooks	FY2021	-	**38,000**	**38,000**
Michigan Consortium of Healthcare Excellence (MCHE)	MCG Parity Software	10.1.20 - 9.30.21	90,500	**101,670**	**11,170**
			$ 90,500	**$ 139,670**	**$ 49,170**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT SOR PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL SOR COST REIMBURSEMENT CONTRACT AMOUNT	TOTAL SOR COST REIMBURSEMENT CONTRACT AMOUNT	SOR INCREASE/ (DECREASE)
CONTRACTS LISTED IN THIS SECTION ARE ALL SOR GRANT FUNDED PROGRAMS					
Arbor Circle	SOR - MAT & Outpatient	10.1.20 - 9.30.21	-	**242,979**	**242,979**
CMH for CEI	SOR - Case Manager (for MAT) & Outpatient	10.1.20 - 9.30.21	-	**117,873**	**117,873**
McCullough Vargas & Associates	SOR-GPRA Interviews-Recovery Housing; SOR-Peer Recovery Coaches in Other Settings	10.1.20 - 9.30.21	-	**54,043**	**54,043**
Mid-Michigan Recovery Services (f.k.a.NCALRA)	SOR-GPRA Interviews-Recovery Housing	10.1.20 - 9.30.21	-	**4,226**	**4,226**
Pinnacle Recovery Services	SOR-GPRA Interviews-Recovery Housing	10.1.20 - 9.30.21	-	**11,250**	**11,250**
Randy's House	SOR-GPRA Interviews-Recovery Housing	10.1.20 - 9.30.21	-	**25,714**	**25,714**
Recovery Pathways	SOR-GPRA Interviews-Mobile Care Unit	10.1.20 - 9.30.21	339,866	**353,866**	**14,000**
Saginaw Odyssey House, Inc.	SOR-GPRA Interviews-Recovery Housing	10.1.20 - 9.30.21	-	**7,440**	**7,440**
Saginaw Psychological Services	SOR-GPRA Interviews-Recovery Housing	10.1.20 - 9.30.21	-	**47,349**	**47,349**
Sisters of Sobriety	SOR-GPRA Interviews-Recovery Housing	10.1.20 - 9.30.21	-	**24,643**	**24,643**
Ten Sixteen Recovery Network	SOR-GPRA Interviews-Recovery Housing	10.1.20 - 9.30.21	-	**5,957**	**5,957**
WAI-IAM (Rise Transitional Housing)	SOR-GPRA Interviews-Recovery Housing	10.1.20 - 9.30.21	-	**24,429**	**24,429**
			$ 339,866	**$ 919,768**	**$ 579,902**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL FY21 COST REIMBURSEMENT CONTRACT AMOUNT	FY21 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY20 INCREASE/ (DECREASE)
Arbor Circle	SUD Treatment - MAT Program	10.1.20 - 9.30.21	114,290	158,437	**44,147**
Eaton RESA	SUD Prevention - PFS (No cost extension)	11.1.20 - 9.30.21	678,278	**723,278**	**45,000**
First Ward Community Center	SUD Prevention: Coalition Responsibilities (5k of PA2)	10.1.20 - 9.30.21	255,158	**279,812**	**24,654**

CONTRACTING ENTITY	SUD PROVIDERS COST REIMBURSEMENT PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	ORIGINAL FY21 COST REIMBURSEMENT CONTRACT AMOUNT	FY21 TOTAL COST REIMBURSEMENT CONTRACT AMOUNT	FY20 INCREASE/ (DECREASE)
Saginaw Youth Protection Council	SUD Prevention: Coalition Responsibilities	10.1.20 - 9.30.21	343,776	**324,122**	**(19,654)**
Samaritas - Charlotte	SUD Treatment	10.1.20 - 3.31.21	-	**79,643**	**79,643**
Women of Colors	SUD Prevention: Coalition Responsibilities (5k of PA2)	10.1.20 - 9.30.21	227,840	**222,840**	**(5,000)**
			$ 1,619,342	**$ 1,788,132**	**$ 168,790**

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION (Revenue Contract)	CONTRACT TERM	FY21 ORIGINAL CONTRACT AMOUNT	FY21 TOTAL CONTRACT AMOUNT	FY21 INCREASE/ (DECREASE)
Michigan Department of Health & Human Services (EGrAMS)	Strategic Partnership for Success	11.1.20 - 9.30.21	-	**200,000**	**200,000**
			$ -	**$ 200,000**	**$ 200,000**

ITEM 14.1

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, September 1, 2020, 5:00 P.M.
Zoom Video/Audio Conference
Meeting Minutes

1. **Call to Order**

   Chairman Ed Woods called the meeting to order at 5:00 p.m.

2. **Roll Call**

   On behalf of Secretary Colleen Maillette, Merre Ashley, MSHN Executive Assistant, conducted the Roll Call for Board Members in attendance.

   Board Member(s) Present: Jim Anderson (Bay-Arenac), Brad Bohner (LifeWays), Joe Brehler (CEI), Bruce Cadwallender (Shiawassee), Craig Colton (Huron), Ken DeLaat (Newaygo), David Griesing (Tuscola), Dan Grimshaw (Tuscola), Diane Holmann (CEI), John Johansen (Montcalm), Steve Johnson (Newaygo), Jeanne Ladd (Shiawassee), Colleen Maillette (Bay-Arenac), Deb McPeek-McFadden (Ionia), Gretchen Nyland (Ionia), Irene O'Boyle (Gratiot), Tracey Raquepaw (Saginaw), Kerin Scanlon (CMH for Central Michigan), and Ed Woods (LifeWays)

   Board Member(s) Absent: Tina Hicks (Gratiot), Kurt Peasley (Montcalm), Joe Phillips (CMH for Central Michigan), and Leola Wilson (Saginaw)

   Staff Members Present: Joe Sedlock (CEO), Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Michael Scott (Regional Veteran's Navigator) and Merre Ashley (Executive Assistant)

3. **Approval of Agenda for September 1, 2020**

   Board approval was requested for the Agenda of the September 1, 2020 Regular Business Meeting.

   MOTION BY CRAIG COLTON, SUPPPORTED BY KEN DELAAT, FOR APPROVAL OF THE AGENDA OF THE SEPTEMBER 1, 2020 REGULAR BUSINESS MEETING, AS PRESENTED.

   Mr. Joseph Sedlock requested one administrative item be added under Agenda Item 8, specific to the Direct Care Workers Premium Pay Initiative, as outlined within documentation forwarded to board members prior to the meeting.

The Maker and Seconder amended motion to allow addition of Item 8A-1 as requested.

MSHN 19-20-036 MOTION BY CRAIG COLTON, SUPPPORTED BY KEN DELAAT, FOR APPROVAL OF THE AGENDA OF THE SEPTEMBER 1, 2020 REGULAR BUSINESS MEETING, WITH ADDITION OF ITEM 8A-1. MOTION CARREID 19-0.

4. Public Comment

There was no public comment.

5. Public Hearing

Chairman Woods called for a recess to convene the Annual Public Hearing and FY21 Regional Budget Presentation.

MSHN 19-20-037 MOTION BY JOHN JOHANSEN, SUPPORTED BY DAN GRIMSHAW TO RECESS THE MSHN BOARD OF DIRECTORS REGULAR BUSINESS MEETING FOR THE PURPOSE OF CONVENING THE ANNUAL PUBLIC HEARING. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANE HOLMANN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, TRACEY RAQUEPAW, KERIN SCANLON, ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 19-0.

The Regular Business Meeting Recessed at 5:08 p.m.

The Regular Business Meeting Reconvened at 5:20 p.m.

6. MSHN Fiscal Year 2020 Budget Amendment

Ms. Leslie Thomas provided detail and information of the 2020 budget amendment, provided within board meeting packets.

Chairman Woods called the question:

MSHN 19-20-038 MOTION BY STEVE JOHNSON, SUPPORTED BY DAVID GRIESING TO ADOPT THE FISCAL YEAR 2020 BUDGET AMENDMENT, AS PRESENTED. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANE HOLMANN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, TRACEY RAQUEPAW, KERIN SCANLON, ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 19-0.

7. MSHN Fiscal Year 2021 Regional Budget

Ms. Thomas provided detail and information on the FY21 Budget Presentation during the public hearing. Additional clarification of budget line items specific to staffing was provided by Ms. Amanda Ittner.

Chairman Woods called the question:

MSHN 19-20-039 MOTION BY JOHN JOHANSEN, SUPPORTED BY KERIN SCANLON TO ADOPT THE FISCAL YEAR 2021 REGIONAL BUDGET, AS PRESENTED. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANE HOLMANN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, TRACEY RAQUEPAW, KERIN SCANLON, ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 19-0.

8. Chief Executive Officer's Report

Mr. Sedlock provided an overview of information listed on the CEO Report and voiced acknowledgement of the excellent work done by Region 5 Providers and CMHSPs as well as MSHN staff members. Appreciation for CMHSP and MDHHS partnerships and support was expressed. He informed members remote arrangements continue for all staff except one employee; no changes are expected in the foreseeable future barring identification of operational issues. Mr. Sedlock commended the region's CMHSP staff and leadership, stating all remain open and fully functional. Other topics were covered as summarized in his written report.

Item 8A-1: Direct Care Worker Premium Care Initiative

Mr. Sedlock reviewed the information provided within documentation forwarded to board members via email and displayed on screen for the board and members of the public.

MSHN 19-20-040 MOTION BY JOE BREHLER, SUPPORTED BY COLLEEN MAILLETTE, TO AUTHORIZE MID-STATE HEALTH NETWORK'S CONTINUATION OF THE DIRECT CARE WAGE (DCW) PREMIUM PAY INTIATIVE THROUGH JANUARY 9, 2021. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANE HOLMANN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, TRACEY RAQUEPAW, KERIN SCANLON, ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 19-0.

9. Deputy Director's Report

Ms. Amanda Ittner reviewed the information included on the Deputy Director's written report and performance dashboard, provided within board meeting packet. She reported on the outcomes of the Health Services Advisory Group (HSAG) audit and offered congratulations and appreciation to regional CMHSPs and staff involved for their hard work.

10. Chief Financial Officer's Report

Ms. Leslie Thomas provided an overview of the financials included within board meeting packets, recommended for board approval to receive and file.

MSHN 19-20-041 MOTION BY TRACEY RAQUEPAW, SUPPORTED BY BRUCE CADWALLENDER, TO RECEIVE AND FILE THE STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDING JULY 31, 2020. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANE HOLMANN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, TRACEY RAQUEPAW, KERIN SCANLON, ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 19-0.

11. Contracts for Consideration/Approval

Ms. Ittner provided an overview of the FY20 contract listing provided within the board meeting packet. She stated approval of MSHN's CEO to sign and fully execute the contracts listed on the FY20 contract listing was requested.

MSHN 19-20-042 MOTION BY JOHN JOHANSEN, SUPPORTED BY DAVID GRIESING, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS LISTED ON THE FY20 CONTRACT LISTING. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANE HOLMANN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, TRACEY RAQUEPAW, KERIN SCANLON, ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 19-0.

Ms. Ittner provided an overview of the FY21 contract listing provided within the board meeting packets. She stated approval of MSHN's CEO to sign and fully execute the contracts listed on the FY21 contract listing was requested.

MSHN 19-20-043 MOTION BY KEN DELAAT, SUPPORTED BY DAN GRIMSHAW, TO AUTHORIZE ITS CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS LISTED ON THE FY21 CONTRACT LISTING. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANE HOLMANN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, TRACEY RAQUEPAW, KERIN SCANLON, ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 19-0.

12. Executive Committee Report

Chairperson Woods reported committee meeting discussions included ongoing updates and information of the efforts of MSHN's COVID-19 Response. Committee review of notes and draft agendas for today's Public Hearing and Board Meeting occurred as well.

13. Chairperson's Report

Chairperson Woods thanked the Huron Behavioral Health board for their appointment of Rhonda Matelski to the MSHN Board of Directors to fill the seat and term vacated by Mary Motts. Ms. Matelski plans to attend the November Board of Directors meeting.

14. Fiscal Year 2021 Board Meeting Calendar

Mr. Sedlock stated the board meeting calendar was revised following discussion of the July meeting to eliminate potential conflict with 2020 election night voting. Note was made to meeting locations; due to uncertainty related to social distancing requirements, physical locations are subject to change.

Chairman Woods called the question:

MSHN 19-20-044 MOTION BY JOHN JOHANSEN, SUPPORTED BY GRETCHEN NYLAND, TO ADOPT THE FY21 BOARD MEETING CALENDAR, AS PRESENTED. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANE HOLMANN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, TRACEY RAQUEPAW, KERIN SCANLON, ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 19-0.

Following board approval of the meeting calendar, Chairman Woods directed MSHN staff to distribute the board meeting calendar via email to board members.

15. Approval of Consent Agenda

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

MSHN 19-20-045 MOTION BY COLLEEN MAILLETTE, SUPPORTED BY KERIN SCANLON, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE DRAFT MINUTES OF THE JULY 7, 2020 BOARD OF DIRECTORS MEETING, RECEIVE SUD OVERSIGHT POLICY BOARD MEETING MINUTES OF JUNE 17, 2020; RECEIVE POLICY COMMITTEE MINUTES OF AUGUST 4, 2020, RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF AUGUST 21, 2020; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF JULY 20, 2020 AND AUGUST 17, 2020; AND TO ADOPT THE RECOMMENDATIONS OF THE POLICY COMMITTEE TO APPROVE THE GENERAL MANAGEMENT CHAPTER AND PROVIDER NETWORK MANAGEMENT CHAPTER POLICIES, AS PRESENTED. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANE HOLMANN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, TRACEY RAQUEPAW, KERIN SCANLON, ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 19-0.

16. Other Business

Chairman Woods stated his appreciation to members for their patience and understanding while working through the technical glitches encountered using a virtual meeting format.

17. Public Comment

There was no public comment.

18. Adjournment

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

Minutes respectfully submitted by:
MSHN Executive Assistant

ITEM 14.2

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES

TUESDAY, OCTOBER 6, 2020 (TELECONFERENCE)

Members Present: John Johansen, Irene O'boyle, Colleen Maillette and Kurt Peasley

Members Absent: N/A

Staff Present: Amanda Ittner (Deputy Director)

1. CALL TO ORDER

Chairperson 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 Colleen Maillette, to approve the October 6, 2020 Board Policy Committee Meeting Agenda, as presented. Motion Carried: 4-0.

3. NEW POLICIES

Chairperson Johansen referenced the new policies included within meeting packets and asked Ms. Amanda Ittner to provide information to the committee for each policy. Review and information included the following:

A. Children's Home and CBS Waiver

Policy specific to Children's Home and CBS Waiver at the PIHP level as it was a new requirement of the FY20 MDHHS/MSHN contract.

B. Severe Emotional Disturbance (SED) Waiver

Policy specific to SED Waiver at the PIHP level as it was a new requirement of the FY20 MDHHS/MSHN contract

MOTION by Colleen Maillette, supported by Irene O'Boyle, to approve and recommend the new policies to the full board as presented. Motion Carried: 4-0.

4. POLICIES UNDER BIENNIAL REVIEW

Chairperson Johansen invited Ms. Ittner to inform members on the revisions made to the policy being presented under biennial review. Ms. Ittner provided an overview of the substantive changes within the policies. Committee members raised no questions or comments to the eighteen (18) policies under biennial review.

A. General Management — Population Health Integrated Care
B. Quality — Regional Provider Monitoring and Oversight
C. Quality — MMBPIS
D. Service Delivery — Autism Spectrum Disorder Benefit
E. Service Delivery — Cultural Competency Policy

F. Service Delivery — Drug Screen Coverage
G. Service Delivery — Electroconvulsive Therapy (ETC)
H. Service Delivery — HCBS Compliance Monitoring Policy
I. Service Delivery — Habilitation Supports Waiver Policy
J. Service Delivery — Indian Health Services Policy
K. Service Delivery — Inpatient Psychiatric Hospitalizations Standards
L. Service Delivery — Out of State Placements
M. Service Delivery — Service Philosophy & Treatment
N. Service Delivery — Standardize Assessment
O. Service Delivery — Support Intensity Scale Policy
P. Service Delivery — Supports Intensity Scale Quality Lead Policy
Q. Service Delivery — Telemedicine
R. Service Delivery — Trauma Informed Care

MOTION by Kurt Peasley, supported by Irene O'Boyle, to approve and recommend the policies under biennial review to the full board, as presented with the following typographical edits as noted by Ms. Ittner. Motion carried: 4-0.

5. NEW BUSINESS

Ms. Ittner provided announced that the MSHN Board Executive Committee will address the appointment of additional representation to the Policy Committee in replacement of the vacancy from Mike Hamm.

6. ADJOURN

Chairperson Johansen adjourned the Board Policy Committee Meeting at 10:15 a.m.

Meeting minutes respectfully submitted by:
MSHN Deputy Director

MSHN
Mid-State Health Network

ITEM 14.3

Mid-State Health Network Board of Directors

Executive Committee Meeting Minutes

Friday, October 16, 2020, 9:00 a.m.

Members Present:	Ed Woods, Chairperson; Irene O'Boyle, Vice-Chairperson; Colleen Mailette, Secretary;
Members Absent:	Kurt Peasley, Immediate Past Officer
Staff Present:	Amanda Ittner, Deputy Director; Joe Sedlock, Chief Executive Officer
Others Present:	None

1. **Call to order:** This meeting of the MSHN Board Executive Committee was called to order by Chairperson Woods at 9:01 a.m.

2. **Approval of Agenda:** Motion by I. O'Boyle supported by C. Mailette to approve the agenda as presented. Motion carried.

3. **Board Member Comment**: None

4. **Priority Matters:**
   - 4.1. Regional/Operational COVID-19 Updates: Ms. Ittner provided a brief update on regional operations pertaining to COVID-19 pandemic response. MSHN continues to meet with MDHHS (and other PIHPs, CMHSPS) weekly. Most recent statewide concerns involve staffing and capacity issues at Adult Foster Care (AFC) facilities and difficulties encountered when staff or beneficiaries test positive for the Coronavirus in those settings. State trying to be clear internally that not all AFCs are involved with or under contract to CMHSPs/PIHPs. MSHN submitted its regional residential crisis plan and all applicable CMHSP residential crisis plans to MDHHS as requested. Statewide issues with retaining and recruiting workforce members due to burnout and exposure of the individual and potential exposure to their families. MSHN continues to meet regionally with in-region CMHSP CEOs, now on an every other week basis. Together we continue to work through issues that arise and develop regional guidance. MDHHS has indicated that it will be issuing guidance to extend current regional provider network stabilization plans at least through the second quarter of FY 21 (MSHN has already extended its Direct Care Worker Premium Pay and Provider Network Stabilization Plans through 1/9/21). The legislature has extended DCW premium pay through 12/31/20. MSHN staff continue to work remotely (with one exception, who is office based). MSHN is following its COVID preparedness and response plan, which requires daily screenings. MSHN leadership meeting with MSHN staff monthly and providing intermittent updates via email. There have been no known COVID-positive reports from among MSHN employees. MSHN working through the executive orders affected by the Supreme Court Decision and adjusting plans (if warranted) accordingly. Communications with the provider network is ongoing via Constant Contact messages and direct communications. C. Mailette raised a question about essential services, especially nursing services and the uniformity of CMHSP operations across the region.
   - 4.2. Consideration for Appointment to Policy Committee Vacancy: Ms. Ittner identified the need to replace a member that has left the MSHN Board on the Policy Committee. Discussion resulted in a recommendation to place this matter under the Executive Committee report at the 11/10/20 board meeting at which time the Chair will ask for volunteers and make an appointment.
   - 4.3. November 10, 2020 Board Meeting Draft Agendas: The draft agenda for the 11/10/20 board meeting was reviewed. The draft agenda included contingencies for ratifying actions taken at MSHN Board meetings in May, July and September in the event that the Governor's Executive Orders permitting meetings by remote means were not considered legal or replaced by legislation. On 10/13, the legislature passed SB 1108 which permits meetings of public bodies by remote means under certain circumstances for a specified

period of time (Mr. Sedlock's written board report will contain more specific information). The statue is also retroactive to March 2020, which makes the May, July and September MSHN board meetings by remote means 'legal' and nullifies the need for ratification of previous actions taken by the MSHN Board. Governor Whitmer is expected to sign the legislation but had not done so as of the date/time of this meeting.

- Board meeting logistics: The November 10, 2020 board meeting will be held by remote means (videoconference). SB 1108 specifies certain actions that MSHN must take in posting notices, ensuring two-way communication for board member and members of the public during the board meeting, permitting public access without any requirement to register or otherwise identify themselves. Of note, members of the general public may be excluded from a closed session of the public body if convened in compliance with the Open Meetings Act as applicable to a closed session.

4.4. Status Report of CEO Performance Evaluation: Ms. O'Boyle provided an update on the status of the CEO performance appraisal. 10 of 24 board members have responded by completing the review form (including all members of the Executive Committee). Discussion that evaluating the CEO is a basic board responsibility and the participation rate is concerning. Ms. O'Boyle is working with Ms. Ittner on the 360 feedback component and will be finalizing the written report before the end of the month. Mr. Sedlock reminded the board that his contract for employment expires January 31, 2021. The Committee discussed using the December Executive Committee for contract review/revision/negotiation. Mr. Sedlock will email the December Executive Committee meeting packet two weeks in advance of the 12/18/20 meeting to include a copy of the current employment contract and compensation study completed by HR Collaborative (the firm engaged by MSHN to review MSHN's compensation program. Note that the CEO compensation analysis was not included in the overall MSHN compensation review to avoid the appearance/reality of conflict of interest).

5. **Administrative Matters:**

5.1 Substance Abuse Treatment Services to MDOC parolees – update: Mr. Sedlock reported that the MSHN region has fully implemented all aspects of substance use disorder treatment services for individuals under the supervision of the Michigan Department of Corrections (MDOC). This includes expanding providers that service this population to all existing providers in the MSHN region. Mr. Sedlock recognized the leadership of Cammie Myers, a MSHN Utilization Management Specialist for her work coordinating all aspects of regional implementation. Mr. Sedlock's written board report will also include this acknowledgment and the names of other team members for board recognition. The Executive Committee requested that an expression of board appreciation be sent to the implementation team.

6. **Other:** None

7. **Board Member Comment:** None

8. **Adjourn:** This meeting was adjourned by Chairperson Woods at 9:27 a.m.

MSHN
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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: September 21, 2020
MEETING RESTRICTIONS IN EFFECT – ZOOM MEETING ONLY

ITEM 14.4.1

Members Present: Lindsey Hull; Carol Mills; Sharon Beals; Tracey Dore; Tammy Warner; Maribeth Leonard; Kerry Possehn; Michelle Stillwagon; John Obermesik; Sandy Lindsey; Chris Pinter; Sara Lurie

Members Absent:

MSHN Staff Present: Joseph Sedlock; Amanda Ittner; For Applicable Topics: Leslie Thomas;

Agenda Item	Action Required				
Consent Agenda	Item B- The MCAL Crisis line presentation indicated local crisis lines will shut down and need to use this line. This is NOT accurate and should be corrected. John will send the slide deck to MSHN for review/follow-up. Item C – Pg. 17 of packet; Question on the MI Smart project.				
	J. Obermesik will send presentation slides to J. Sedlock to follow up with MDHHS. Approved as presented	By Who	J. Sedlock	By When	9.30.20
FYE20 Savings Estimates Through July 2020	L. Thomas presented the FY20 Savings Estimates through July 2020.				
	Informational Only	By Who	N/A	By When	N/A
FY 21 Compliance Plan	A. Ittner presented the proposed changes to the FY21 Compliance Plan				
	Endorsed the changes as presented and support moving to the MSHN Board of Directors for final approval	By Who	K. Zimmerman	By When	11.15.20
ORR Monitoring of Licensed Psychiatric Hospitals/Units	S. Lurie discussed CEI's position on MDHHS ORR Monitoring of LPHU; brought up in their RR committee and other rights directors in the state are concerned about accountability for rights in the inpatient units. State was open to this as well. No objection to moving forward with Sarah's suggestion to work with advocates and others to move the proposal forward. Will be discussed as well at the PIHP inpatient reciprocity workgroup.				
	Operations Council supports and asks that CEI keep the group informed especially if additional support is needed.	By Who	N/A	By When	N/A
Parity: MCG Upgrade	A. Ittner provided updates regarding MCG and the PIHP Parity Workgroup: • Indicia: 24th guideline edition was released and to be confirmed in test environment by leads/tech & clinical - via test case; Region requires use of 24th edition by October 1, 2020. • Indicia report training – CMH leads indicate staff attendance in August/September MCG webinars. MSHN/MCG Project Managers have scheduled the final customized webinar training for October 20. • Belinda Hawks was assigned to PIHP Parity Workgroup – She is working through the states plan and related CMS requirements of standardized LOC and assessment tools.				

Agenda Item	Action Required				
	Informational Only	By Who	N/A	By When	N/A
2020-09 Deputy Director Board Report	A. Ittner reviewed the report including links to full reports available if needed.				
	Informational Only	By Who	N/A	By When	N/A
PIHP Complex Care Management/Unenrolled Design Document	J. Sedlock reviewed the background that lead to the proposals included in the packet. Along with waiting on next steps until further clarification is received from MDHHS on system design. No assumed risk by PIHP or CMHs is in the proposal. Seeking conceptual support and/or questions on the proposal.				
	Operations Council supports the proposal as presented. J. Sedlock will represent regional support and will keep the Operations Council apprised of next steps when known or taken.	By Who	J. Sedlock	By When	As needed
COVID-19 Coordination Items	Support to moving Friday COVID meetings every two weeks – avoid on the Friday before a scheduled Operations Council (regular) meeting. MSA20-58 Specialty Behavioral Health Supports and Services. Still waiting on CLS and school guidance from the state Regional Medical Directors working mask guidance and should be out next week.				
	J. Sedlock will send out revised meeting calendar invites for COVID Coordinating Calls	By Who	J. Sedlock	By When	9.30.20
FY 21 Operations Council Meeting Calendar	J. Sedlock reviewed the proposed calendar				
	Approved with moving the December meeting to the week prior (12/14 instead of 12/21); MSHN will send out calendar invites	By Who	J. Sedlock	By When	9.30.20
CEICM Questions:	S. Laurie DOL change to definition of healthcare and allowed to exempt healthcare workers but not administrative staff (related to FFFCRA). Board reviewed MSHN's Population Health and Integrated Improvement Plan; EPSTD for children – lacking; Care coordination for children and if MSHN shouldn't be pushing more for inclusion of children.				
	Discussion Only	By Who	N/A	By When	N/A
MSHN Impact Report	MSHN Impact report is final and will be sent out in the next week or two; asking CMHs to distribute to their network, stakeholders, boards, legislators, etc.				

Agenda Item		Action Required			
	CMHs to distribute Impact Report	By Who	CMH CEOs	By When	10.31.20
Operations Council Meeting packet	Reduced packet by combing 2 pages per sheet; feedback?				
	Worked for everyone, okay to continue	By Who	N/A	By When	N/A

MSHN
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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: October 19, 2020
MEETING RESTRICTIONS IN EFFECT – ZOOM MEETING ONLY

ITEM 14.4.2

Members Present: Lindsey Hull; Carol Mills; Sharon Beals; Tracey Dore; Tammy Warner; Maribeth Leonard; Kerry Possehn; Michelle Stillwagon; John Obermesik; Sandy Lindsey; Chris Pinter; Sara Lurie

Members Absent:

MSHN Staff Present: Joseph Sedlock; Amanda Ittner; For Applicable Topics: Skye Pletcher, Carolyn Tiffany;

Agenda Item	Action Required				
Consent Agenda	No questions or discussions.				
	Approved as stands including edits to charters	By Who	MSHN Leadership	By When	11.1.20
COFR Decision Points and Recommendations	S. Pletcher reviewed the background regarding COFR's including UMC and Finance Council. Discussion took place to leave it as current policy – Option A; which doesn't preclude the CMHs from not utilizing a COFR. S. Pletcher reviewed the draft procedure for the COFRs. Support for in-region work towards resolution but for out-region, the CMH would have the ability to involve both the PIHPs. No procedure needed.				
	Support for Option A in regard to the Policy. No support for procedure.	By Who	S. Pletcher	By When	11.1.20
FY 21-22 Population Health and Integrated Care Plan	S. Pletcher reviewed the changes to the Population Health and Integrated Care Plan with the major changes that include Racial and Ethnic Disparities.				
	Approved as presented	By Who	S. Pletcher	By When	11.1.20
FY 21 Delegated Managed Care Review	C. Tiffany reviewed the changes/additions to the FY21 Delegated Managed Care Review tools				
	Approved as presented for Calendar Year 2021	By Who	C. Tiffany	By When	11.1.20
MSHN Region Volunteer for Bed Registry Pilot	Bed registry work was a result of this regions effort to collect inpatient denial data. Still a concern today for bed availability. Now the State seeking participation in the pilot. Maribeth would like our region to be in the pilot and is seeking regional support. There is concern about staff and ability to participate right now with COVID and other priorities.				
	J. Sedlock will discuss with MDHHS our support but with reason/discussion.	By Who	J. Sedlock	By When	11.15.20
Video During Regional Meetings	L. Hull discussed the use of video during regional meetings and if any procedures or policies have been developed for this purpose. Shiawassee has developed a policy regarding this and has been perceived positively. Recommends that all regional meetings be mandated video on but at a minimum Ops Council will support the use of video.				

Agenda Item	Action Required				
	Shiawassee will share their information. MSHN and CMHs to discuss locally and this topic will be brought up next meeting	By Who	L. Hull J. Sedlock	By When	11.2.20 11.15.20
CCBHC Discussion	Webinar tomorrow – Table till November or when further information is received				
	Tabled till November	By Who	J. Sedlock	By When	11.1.20
COVID-19 Regional Updates/Coordination	A. Ittner provided updates on COVID: MIOSHA guidance, MDHHS update, and Regional Risk Stratification Available. Ops requested updated telehealth use updates by region and CMH. Saginaw – Available CARES act funding update; MSHN still waiting on feedback from MDHHS.				
	A. Ittner to provide updated telehealth vs. non-telehealth information.	By Who	A. Ittner	By When	11.15.20
MIOSHA Regulation	C. Mills discussed concerns about rules directing remote work where feasible. Behavioral Health services and face to face defined as unable to be conducted remotely should be included in the agency COVID plan. Saginaw CMH agreed to share their remote policy and oversight of workplace/HIPAA/etc. S. Lindsey indicated they also extended their hours.				
	Saginaw o share their remote policy	By Who	S. Lindsey	By When	11.1.20
Operations Council Annual Report	J. Sedlock reviewed the Operations Council Annual Report that will be included in the QAPIP.				
	Approved as presented	By Who	J. Sedlock	By When	11.1.20
		By Who		By When	
		By Who		By When	

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Children's Home and Community-Based Services Waiver (CWP) Policy		
Policy: ☒ Procedure: ☐ Page: 1 of 3	Review Cycle: Annually Author: Waiver Coordinator	Adopted Date: Review Date: 11.10.2020	Related Policies:

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Purpose

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

Policy

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

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

C. CWP beneficiaries must be enrolled through the Michigan Department of Health and Human Services (MDHHS) enrollment process by the Prepaid Inpatient Health Plan (PIHP) designee. The enrollment process must include verification that the beneficiary meets all of the follow eligibility criteria:
   a. The child must have a developmental disability (as defined in Michigan state law), be less than 18 years of age, and in need of habilitation services.
   b. The child must reside with his birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.
   c. The child is at risk of being placed into an ICF/IID facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/IID facility but, with appropriate community support, could return home.
   d. The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).
   e. The child's intellectual or functional limitations indicate that he/she would be eligible for health, habilitative, and active treatment services provided at the ICF/IID level of care.
   f. The child must meet the disability criteria for Social Security.

D. CWP beneficiaries must receive at least one children's waiver service per month in order to retain eligibility. Children's waiver services include the following:
   a. Community Living Supports (CLS)
   b. Enhanced Transportation
   c. Environmental Accessibility Adaptations (EAAs)
   d. Family Training
   e. Non-Family Training
   f. Fencing
   g. Financial Management Services/Fiscal Intermediary Services
   h. Respite Care

i. Specialized Medical Equipment and Supplies
j. Specialty Services
k. Overnight Health and Safety Support

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

F. MSHN shall establish adequate procedures to assure effective administration of the program across the region including:
   a. Prescreen, Initial Application, and Eligibility
   b. Annual Recertification
   c. Disenrollment and Transfer
   d. Prior Review and Approval Request
   e. Specialized Medical Equipment and Supplies
   f. Clinical Review Team

Applies to

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

Definitions

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

1. If applied to an individual older than 5 years, a severe, chronic condition that meets all of the following requirements:

a. Is attributable to a mental or physical impairment or a combination of mental and physical impairments
b. Is manifested before the individual is 22 years old
c. Is likely to continue indefinitely
d. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
    i. Self-care
    ii. Receptive and expressive language
    iii. Learning
    iv. Mobility
    v. Self-direction
    vi. Capacity for independent living
    vii. Economic self-sufficiency
e. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

2. If applied to a minor, birth to age 5, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (1) if services are not provided.

Other Related Materials
N/A

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

Change Log:

Date of Change	Description of Change	Responsible Party
07.2020	NEW Policy	Chief Behavioral Health Officer

POLICIES AND PROCEDURE MANUAL

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

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Purpose

This policy sets forth the guidelines and expectations for Mid-State Health Network's (MSHN) administration of the Severe and Emotional Disturbance Waiver (SEDW) program.

Policy

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

I. Eligibility

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

A. Meet the current MDHHS contract criteria for the state psychiatric hospital (Hawthorn Center) and be at risk of hospitalization.
B. Demonstrate serious functional limitations that impair their ability to function in the community. The functional criteria will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®).
C. The Preschool and Early Childhood Functional Assessment Scale (PECFAS) will be required for any child 4-6 years old (Intake, quarterly and at exit from CMHSP). For children 3-4 years old in SED Waiver and Wraparound PECFAS is required.
D. CAFAS will be required for any child 7-17 years old (Intake, quarterly and at exit from CMHSP) For youth aged 18-21 that are involved in the SED Waiver and Wraparound the CAFAS is required
E. CAFAS®/PECFAS score of 90 or greater for children age 12 or younger; or
F. CAFAS® score of 120 or greater for children age 13 to 18;
G. Be under the age of 21;
H. Reside with his/her birth or adoptive parents(s), or
I. In the home of a relative who is the child's legal guardian, or
J. In foster care or therapeutic foster care, with a permanency plan to return home.
K. Be financially eligible for Medicaid when viewed as a family of one (i.e., when parental income and assets are waived);
L. Be in need of waiver services in order to remain in the community
M. SEDW beneficiaries must receive at least one SEDW service per month in order to maintain eligibility. The beneficiary's services and supports must be specified in the individual's plan of services developed through the person-centered planning process that must be specific to:

    1. Medical necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.

Definitions (cont.)
Provider Network: refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through CMHSP subcontractors.
REMI: Regional Electronic Medical Information (MSHN's Managed Care Information System)
SUD: Substance Use Disorder

Other Related Materials
The MMBPIS Description of Project Study
The MMBPIS Detail Data Collection Instructions

References/Legal Authority
Medicaid Managed Specialty Supports and Services Contract, Attachment P7.9.1 and P.7.7.1.1
FY20_PIHP_PI_Code Book

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer
11.2015	Annual review and update to MDHHS	Director of Compliance, Customer Service and Quality Improvement
08.2016	Annual Review	Director of Compliance, Customer Service and Quality Improvement
03.2017	Annual Review	Director of Compliance, Customer Service and Quality
03.2018	Annual Review	Director of Compliance, Customer Service and Quality
03.2019	Annual Review	Director of Compliance, Customer Service and Quality
04.2020	Deleted Indicator 2 and 3. Replaced with new Indicators 2, 2a, and 3.	Director of Compliance, Customer Service and Quality

POLICIES AND PROCEDURE MANUAL

Chapter:	General Management		
Title:	**Population Health & Integrated Care**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Annually **Author:** Deputy Director	**Adopted Date:** 07.05.2016 **Review Date:** 11.10.2020	**Related Policies:**

Purpose

Mid-State Health Network (MSHN) is committed to increasing its understanding of the health needs of individuals within its 21-county service region and finding innovative ways to achieve the goals of better health, better care, better value, better provider systems, and better equity by utilizing informed population health and integrated care strategies. This policy exists to establish regional guidance and best practices in the areas of population health and integrated care as well as to o ensure MSHN maintains compliance with the care coordination and integrated health requirements as defined per the contract with the Michigan Department of Health and Human Services (MDHHS).

Policy

It is the policy of Mid-State Health Network, (MSHN) as a Prepaid Inpatient Health Plan (PIHP) responsible for services to individuals enrolled in Medicaid, to coordinate care provided to individuals with the Medicaid Health Plan (MHP) also managing services for those individuals. It is further the policy of MSHN to work cooperatively with other MHPs and PIHPs to jointly identify priority need populations for purposes of care coordination and population health activities including but not limited to:

A. Development of individualized care plans for persons with complex physical and behavioral health needs
B. Partnering with MHPs to manage transitions of care between hospital and community-based settings and prevent avoidable hospital readmissions
C. Identifying health disparities and engaging in practices that promote health equity for all Medicaid enrollees
D. Implementing and monitoring joint quality health metrics

In support of this policy, MSHN shall work to secure appropriate consents, share necessary electronic data, implement population health protocols, and conduct routine care coordination activities.

In furtherance of this policy, we will:

A. At least monthly, identify which members are assigned to a MHP and have sought services through the PIHP
B. Receive information from electronic sources
C. Participate in MiHIN
D. Provide notification to the MHP within 5 business days when a mutual member experiences a psychiatric inpatient admission
E. Implement approved population health clinical protocols in all local Community Mental Health Service Provider (CMHSP) organizations for designated high-risk populations

Applies to

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

Definitions

CMHSP: Community Mental Health Service Provider

Health Disparities: preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities

Health Equity: the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. All persons have a fair and just opportunity to be as healthy as possible.

MDHHS: Michigan Department of Health and Human Services

MHP: Medicaid Health Plan

MiHIN: Michigan Health Information Network

MSHN: Mid-State Health Network

PIHP: Prepaid Inpatient Health Plan

Related Materials

Mid-State Health Network Population Health and Integrated Care Plan

References/Legal Authority

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY19

Change Log:

Date of Change	Description of Change	Responsible Party
05.05.2016	New Policy	Deputy Director
01.31.2017	Annual Review	Deputy Director
02.28.2018	Annual Review	Deputy Director
01.29.2019	Annual Review	Deputy Director
07.21.2020	Biannual Review; incorporated health disparities and health equity	Director of Utilization and Care Management

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POLICY AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	Regional Provider Monitoring and Oversight		
Policy: ☑ Procedure:☐ Page: 1 of 4	**Review Cycle:** Biennial **Author:** Director of Provider Network Management Systems	**Adopted Date:** 11.07.2017 **Review Date:** 11.10.2020	**Related Policies:** Quality Management

Purpose

To establish guidelines for Mid-State Health Network and Community Mental Health Service Program (CMHSP) Participants when conducting regional monitoring and oversight of its provider network when regional provider performance monitoring has been implemented (e.g. Fiscal Intermediary Services, Psychiatric Inpatient Hospitals/Units, Applied Behavior Analysis/ABA, etc.), or when statewide reciprocity arrangements between PIHPs have been enacted pursuant to contractual MDHHS Reciprocity & Efficiency Policy, and to ensure compliance with federal and state regulations, and contractual obligations and to establish standardized, regional processes.

Policy

MSHN on behalf of the CMHSP participants shall create, implement, and maintain a published process to monitor and evaluate its provider network to ensure compliance with federal and state regulations and contractual requirements as it applies to collective services designated by the Operations Council. This includes protocols for monitoring and oversight and protocols to ensure regional reviewers are appropriately managing its charged responsibilities.

A. MSHN, on behalf of its CMHSP's, shall conduct a full monitoring and evaluation process of contracted providers once every two (2) years. This process will consist of utilizing uniform standards and measures to assess compliance with federal and state regulations, and regional contractual requirements. An interim year review will focus on any elements of the previous year's findings in which compliance standards were determined to be partially or not fully met and new standards effective since the previous full review.
   1. Regionally approved provider performance monitoring standards and protocols shall be exclusively used.
   2. Statewide approved provider performance monitoring standards and protocols shall be exclusively used and shall supersede any regionally developed/approved performance standards and protocols.
   3. CMHSPs may prefer to facilitate reviews and should work with the assigned MSHN Lead to coordinate. Coordinated review teams will determine task responsibilities based on content expertise and other mitigating factors.

B. The monitoring and evaluation process may consist of the following components:
   1. ***Desk Audit****:* This component will consist of a pre-review of select policies, protocols, documents and other resource materials submitted by the provider to the designated secure web-based document management system for site review team access and review prior to an on-site visit.
   2. ***On-Site Audit****:* This component will consist of an on-site visit to the provider, if site-based services are provided or site-based records access is required, to review and validate process requirements. This component may include staff interviews. This function will typically be the responsibility of a MSHN-coordinated site review team on behalf of the CMHSP Participants holding the contract responsibility.
   3. ***Consumer File Review****:* Prior to the visit, MSHN shall extract a random 5% sample of consumer record identifiers to ensure compliance with specific program requirements. The random sample will include a sample of consumers from all CMHSP's who contract

with the provider. The sample will include at least one (1) record from each of the regional CMHSPs who hold a contract with the provider. Sample sizes will be no less than two (2) and no more than (12). This function will typically be completed by a MSHN-coordinated site review team on behalf of the contracted CMHSPs. Note: The review team has the right to request additional files should there be justification to do so. As long as each contracting CMHSP is represented in the record review, the review team may complete less reviews than the original sample identified.

4. ***Personnel File Review:*** This component includes analysis of the personnel records of employees assigned to the selected consumers. On-site review will typically be completed by a MSHN-coordinated site review team on behalf of the CMHSP Participants holding the contract responsibility.
    i. For Fiscal Intermediary audits, a minimum of ten (10) and a maximum oftwenty-five (25) employee personnel files shall be reviewed which will include a sample of all employee types including aide level.
    ii. For inpatient unit reviews, an audit of personnel credentialing records may be waived upon verification of current accreditation and review of credentialing policies and procedures demonstrate compliance with *Department of Community Health Behavioral Health and Developmental Disabilities Administration Credentialing and Re-credentialing Processes.*
    iii. For Autism audits, personnel file review includes actively employed (current) staff engaged with the client.

5. ***Recipient Rights Specific Review***: For the Recipient Rights portions of the review(s) the following information is relevant:
    i. IPHU Rights reviews occur, onsite, no less than every 365-days
    ii. IPHU Policy reviews are to occur no less than every 3-years and are conducted by the CMHSP Rights Officers

6. Consumer and personnel records and other information/data that will be reviewed will include the time period from the date of the last site review to current (or the prior 24 months). The designated review team does reserve the right to request information/data prior to the last 24 months as deemed necessary.

7. Overall responsibility for regional monitoring and evaluation process and updating of the monitoring evaluation tools shall rest with the MSHN Quality Assurance and Performance Improvement (QAPI) Manager, in concert with the Provider Network Management Committee (PNMC) and/or designees. Annually, monitoring tools shall be reviewed to ensure functional utility and updated as necessary due to changing regulations, contract terms and operational feedback. Edits will be submitted to the MSHN Quality Improvement Council for review and feedback. In the case of statewide provider performance monitoring protocols, suggestions for edits/updates shall be submitted through the standing statewide PIHP process.
    a. MSHN Regional Recipient Rights Staff shall have an opportunity to review and provide recommended alterations/updates to any related source materials, e.g. regional IPHU standardized contract.
        i. PNMC and MSHN Regional Rights Officer Committee will be responsible for sharing information.

8. Site review teams shall consist of a sufficient number of CMHSP representatives to ensure an efficient and effective review with minimal disruption to provider operations. CMHSP representatives will be identified on a voluntary basis.
    a. CMHSP staffing/support should efficiently cover all review responsibilities and

account for time, content expertise, review-related tasks. MSHN support is available as needed and requested. If CMHSP volunteers are not identified, the QAPI manager shall recruit a team representative(s) through direct contact with the CMHSP.

b. At least one of the CMHSP representatives shall be from the CMHSP within which the provider's primary service site (or administrative site) is located unless an alternate plan was agreed upon.

c. A recipient rights staff from the CMHSP within which the provider's primary service site is located shall be a part of the site review team and shall conduct the Recipient Rights Review on behalf of the region.

   i. Only the recipient rights staff can review rights-related standards.

   ii. Only the recipient rights staff have authority to approve submitted rights-related corrective action.

   iii. The Rights Staff oversee all matters related to Rights and will ensure the information is shared with the review team, including the Lead, for purpose of carrying out reciprocity plan in which multiple elements / functions are reviewed for compliance during one (1) general review of a unit.

d. MSHN's QAPI manager will be responsible for coordinating a uniform and consistent review process in the region. This includes coordinated communications between MSHN, the CMHSPs and MSHN councils and committees, as necessary.

9. Annually, the MSHN QAPI manager, in concert with CMHSP review teams and, if applicable, other PIHPs, shall create its annual monitoring schedule, based on the calendar year, and notify providers at least ninety (90) days in advance of the scheduled review. Special considerations may include:
   - Ensuring coordination with other PIHPs to support regional monitoring and reciprocity.
   - Avoiding the months of January through April for reviews of Fiscal Intermediaries.

10. Following the on-site review, the review team lead, shall develop a Contract Monitoring & Evaluation Report detailing the results of its monitoring review. The monitoring report shall include the following:
    i. A summary report detailing the overall review process and findings;
    ii. Detailed findings pertaining to each standard audited/reviewed;
    iii. Quality Improvement (QI) recommendations; and
    iv. Corrective Actions (if applicable) pertaining to any finding that requires remedial action.

11. The review team lead shall submit the monitoring report to the provider within thirty (30) days of the conclusion of the review. Final reports and related documents will be uploaded to applicable file sharing protocol sites (e.g. Box, Groupsite) for contracting CMHSP's within the MSHN region to access.

12. MSHN review team(s) will adhere to all MDHHS guidance, including but not limited to, timeliness requirements.

13. The provider shall submit a corrective action plan within thirty (30) days of the monitoring review report date, for any item not meeting the compliance standard. The provider may also present information that demonstrates compliance with the

standard(s) at the time of the review. The MSHN QAPI Manager, in consultation with the CMHSP Participants holding the contract responsibility shall determine if the new information results in a change to the final report/score. The corrective action plan shall include:

i. A detailed action plan which addresses steps to be taken to assess and improve performance;
ii. Measurement criteria (i.e. how will the review team know the objective/outcome will be achieved); and
iii. Timeframes for completing each improvement plan.

14. If, during an on-site visit, the site review team member identifies an issue(s) that places a consumer in imminent risk to health, safety or welfare, both the MSHN and CMHSP representatives will initiate coordinated action in a manner consistent with federal, state and ethical requirements based on the severity of the issue(s).
15. Corrective Action Plans not submitted within the required time frame will be reported to the MSHN Director of Provider Network and the Provider Network Director of the CMHSP Participants holding the contract responsibility for resolution submission.
16. The review team will review the corrective action plan and issue a response within thirty (30) days of receiving required information from the provider. The Corrective Action Plan shall be provided, as applicable, to other PIHPs and to the contracting CMHSPs within the MSHN region through identified FTP sites.
17. The MSHN QAPI Manager and CMHSP representatives will take steps to monitor the providers implementation of the corrective action plan as part of performance monitoring, with an interim year follow up review. Monitoring activities will include review team member's organizations or other CMHSPs in the region. Based on the severity of the issue(s) requiring a corrective action, a focused review will be conducted, at a timeframe determined by the review team, to ensure remediation.
18. If the provider and review team cannot reach mutual agreement on a finding or on required corrective action, the provider may submit an appeal of finding and conflict resolution to the CMHSP Participants holding the contract responsibility. NOTE: Recommendations do not qualify under the appeal and resolution process as they are recommendations only and do not require a corrective action plan. A final determination will be coordinated by the review team and forwarded to the provider in accordance with provider appeal procedures. The review team shall adjust and reissue the monitoring report as an outcome of either an informal or formal appeal that changes the report results.
19. Report summary findings on provider monitoring activities shall be shared with the contracting CMHSP's, Provider Network Management Committee, and other MSHN councils or committees as appropriate.

Applies to:

☐ All Mid-State Health Network Staff
☒ Selected MSHN Staff, as follows: QAPI, Provider Network, Compliance
☒ MSHN's Participants: ☐ Policy Only ☒ Policy and Procedure
☒ Other: Subcontracted Providers

Definitions:
CMHSP: Community Mental Health Service Program
FI: Fiscal Intermediary; services that assist the adult beneficiary, or a representative identified in the beneficiary's individual plan of services manage and distribute funds contained in the individual budget.
MSHN: Mid-State Health Network, Region 5 Pre-Paid Inpatient Health Plan
PIHP: Prepaid Inpatient Health Plan
PNMC: Provider Network Management Committee
Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through CMHSP subcontractors.
QAPI Manager: MSHN's Quality Assurance and Performance Improvement Manager
QI: Quality Improvement
Review Team: shall consist of a sufficient number of CMHSP representatives to ensure an efficient and effective review with minimal disruption to provider operations

Other Related Materials:
1. Regional Monitoring Tools
2. MSHN Provider Appeals Procedure

References/Legal Authority:
1. The Code of Federal Regulations (CFRs)
2. PIHP managed care administrative delegations made to the CMHSP
3. PIHP/CMHSP contract
4. PIHP policies, standards and protocols, including both MDHHS and PIHP 'practiceguidelines.
5. Medicaid Provider Manual
6. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program (which includes attachment P7.3.1.1)
7. MDHHS Reciprocity Guidelines
8. MDHHS Self-Determination Implementation Technical Advisory
9. MDHHS Self-Determination Policy and Practice Guideline
10. MDHHS Fiscal Intermediary Technical Requirement

Change Log

Date of Change	Description of Change	Responsible Party
08.2017	New Policy	Director Provider Network Management
03.2018	Annual Review	Director of Compliance, Customer Service and Quality
03.2019	Annual Review	Director of Compliance, Customer Service and Quality
06.2020	Updated to include current practice for oversight including addition of Recipient Rights specific review language	Director of Compliance, Customer Service and Quality

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	Michigan Mission Based Performance Indicator System		
Policy: ☒ Procedure: ☐ Page: 1 of 3	Review Cycle: Biennial Author: Chief Compliance Officer	Adopted Date: 09.02.2014 Review Date: 11.10.2020	Related Policies: Quality Management Required Reporting

Purpose

To clearly delineate the dimensions of quality that must be addressed by the Public Mental Health System (inclusive of Substance Use Disorder Programs) as reflected in the Mission statement, in Delivering the Promise, and in the needs and concerns expressed by consumers and the citizens of Michigan. Those domains are Access, Efficiency, and Outcomes.

A. To develop a statewide aggregate status report, to address issues of public accountability for the public mental health system, to provide a data-based mechanism, and to assist the Michigan Department of Health and Human Services (MDHHS) in the management of Pre-Paid Inpatient Health Plan (PIHP) contracts that impact the quality of the service delivery system statewide.
B. To the extent possible, facilitate the development and implementation of local quality improvement systems, link with existing healthcare planning efforts, and establish a foundation for future quality improvement monitoring within a managed health care system for consumers of public mental health services in the state of Michigan. (Medicaid Managed Specialty Supports and Services Contract: Attachment P7.7.1.1)

Policy

A. The Provider Network is responsible for collecting and reporting to Mid-State Health Network (MSHN) all performance indicators as specified in the MDHHS Medicaid Specialty Supports and Services Contract.
B. The Provider Network reports the performance indicator data as required to MSHN for analysis. MSHN then reports to the MDHHS the performance indicator data as required and in accordance with the Medicaid Managed Specialty Supports and Services Contract.
C. MSHN will provide a summary report/analysis demonstrating performance to each Provider Network participant following the submission of the Michigan Mission Based Performance Indicator System (MMBPIS) to MDHHS. All Provider Network participants who exhibit performance below the standard for an indicator during the reported quarter will be subject to an improvement plan. The Provider Network is responsible for ensuring a process is in place to implement corrective action plans and quality improvement processes to improve the access, efficiency, and outcomes of services provided by the Provider Network participant as monitored through the performance indicator system. It is an expectation that the Provider Network manage their subcontractors to ensure compliance and to provide evidence of the reported data.
D. Noncompliance with the above indicators and related improvement plans will be addressed per the contract provisions.
E. Oversight and monitoring will be conducted by MSHN through the review of reports and analysis by the Quality Improvement Council and provider network monitoring desk audit and site reviews.
F. The Performance Indicators as defined by MDHHS:

1. Access:

1. The percent of all Medicaid adults and children beneficiaries that receive a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three (3) hours*.
2. The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. (MI Adults, MI Children, DD Adults, DD Children) *

2. (b) The percentage of new person during the quarter receiving a face to face service for treatment or supports within the 14 calendar days of anon-emergency request for service

for persons with Substance use Disorders (Persons approved for SUD services) **

3. The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. (MI Adults, MI Children, DD Adults, DD Children).
4. (a) The percent of discharges from psychiatric inpatient unit who are seen for follow-up care within seven (7) days (All children and all adults (MI, DD).
   (b) The percent of discharges from a substance use disorder detox unit who are seen for follow-up care within seven (7) days (All Medicaid SUD*).
5. The percent of Medicaid recipients having received PIHP managed services (MI adults/MI children/DD Adults/DD children, and SUD).**

2. Adequacy/Appropriateness:

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one (1) HSW service per month that is not support coordination. **

3. Efficiency:

7. The percent of total expenditures spent on managed care administrative function for PIHPs. **

4. Outcomes:

8. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who are in competitive employment. **
9. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who earn minimum wage or more from employment activities (competitive, supported employment, or sheltered workshop). **
10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within thirty (30) days of discharge.
11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and DD served in the categories of Abuse I and II and Neglect I and II.
12. The percent of adults with developmental disabilities served who live in a private residence alone or with spouse or non-relative(s). **
13. The percent of adults with serious mental illness served who live in a private residence alone or with spouse or non-relative(s). **
14. Percentage of children with developmental disabilities (not including children in the Children Waiver Program) in the quarter who receive at least one service each month other than Case Management and Respite. **

* Calculated by the PIHP from REMI.

** MDHHS Calculates. The PIHP does not submit data through this process.

Applies to:

☒All Mid-State Health Network Staff

☐ Selected MSHN Staff, as follows:

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

☒Other: Sub-contract Providers

Definitions:

CMHSP: Community Mental Health Service Plan
DD: Developmental Disability
HSW: Habilitation Supports Waiver
MDHHS: Michigan Department of Health and Human Services
MI: Mental Illness
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
MMBPIS: Michigan Mission Based Performance Indicator System

2. Amount: The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.
3. Scope: The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.
4. Duration: The parameters within which the service will be provided, including Who (e.g., professional, paraprofessional, aide supervised by a professional); How (e.g., face-to-face, telephone, taxi or bus, group or individual); and Where (e.g., community setting, office, beneficiary's home).

II. Caregiver Roles and Expectations

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

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

III. Administration of the SEDW

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

A. Initial Screening, Application and Service Start,
B. Annual Recertification,
C. SEDW Slot Transfer, and
D. SEDW Financial Monitoring.

Applies to

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

Definitions

CAFAS: Child and Adolescent Functional Assessment Scale
IPOS: Individual Plan of Service
MDHHS: Michigan Department of Health and Human Services
PECFAS: Preschool and Early Childhood Functional Assessment Scale
PIHP: Pre-Paid Inpatient Health Plan
SEDW: Waiver for Children with Serious Emotional Disturbance

Other Related Materials

N/A

References/Legal Authority

Medicaid Managed Specialty Supports and Services FY20 MDHHS/PIHP Contract
Michigan Medicaid Provider Manual

Change Log:

Date of Change	Description of Change	Responsible Party
07.2020	NEW Policy	Chief Behavioral Health Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Autism Spectrum Disorder Benefit**		
Policy: ☑ **Procedure:** ☐ **Page:** 1 of 10	**Review Cycle:** Biennial **Author:** Waiver Coordinator and Autism Workgroup	**Adopted Date:** 04.07.2015 **Review Date**: 11.10.2020	**Related Policies:**

Purpose

To ensure Mid-State Health Network (MSHN) and its Provider Network comply with the requirements for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age with Autism Spectrum Disorder (ASD) under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

Policy

MSHN staff and the MSHN Provider Network shall fully comply with the requirements set forth in the EPSDT benefit and the Michigan Medicaid Manual. This includes, but is not limited to:

Screening

The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well-child visit with the child's primary care provider (PCP). EPSDT well-child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well-child evaluation is also designed to rule out medical or behavioral conditions other than ASD and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.

Referral

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the CMHSP directly to arrange for a follow-up evaluation. The PCP must refer the child to the CMHSP in the geographic service area for Medicaid beneficiaries. The CMHSP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each CMHSP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed. After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the CMHSP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including BHT) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD that do not meet the eligibility requirements for developmental disabilities by the CMHSP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

While screening for ASD typically occurs during an EPSDT well-child visit with the child's PCP, there is no "wrong door" for a referral for further evaluation of the child. PCP's are responsible for screening the child for ASD and for providing a full medical and physical examination to rule out other medical or behavioral conditions other than ASD. If a beneficiary is self-referred, or is without a PCP, and contacts the PIHP/CMH regarding the need for ASD services, the PIHP/CMH may initiate the eligibility process for services while also

making an appropriate referral to the PCP for a further screening and medical/physical examination as needed. Documentation of referrals by the CMH should be recorded in the individuals file.

Comprehensive Diagnostic Evaluations

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment. The provider who conducts the behavior assessment recommends more specific ASD treatment interventions. These evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes: a physician with a specialty in psychiatry or neurology; a physician with a sub-specialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline; a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health; a psychologist; an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health; a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or a clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD. The determination of a diagnosis by a qualified licensed practitioner is accomplished by direct observation and utilizing the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2), and by administering a comprehensive clinical interview including a developmental symptom history (medical, behavioral, and social history) such as the Autism Diagnostic Interview-Revised (ADI-R) or clinical equivalent. In addition, a qualified licensed practitioner will rate symptom severity with the Clinical Global Impression Severity Scale. Other tools may be used if the clinician feels it is necessary to determine a diagnosis and medical necessity service recommendations. Other tools may include: cognitive/developmental tests such as the Mullen Scales of Early Learning, Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV), Wechsler Intelligence Scale for Children-IV (WISC-IV), Wechsler Intelligence Scale for Children-V (WISC-V), or Differential Ability Scales-II (DAS-II); adaptive behavior tests such as Vineland Adaptive Behavior Scale-II (VABS-II), Adaptive Behavior Assessment System-III (BHTS-III), or Diagnostic Adaptive Behavior Scale (DABS), and/or; symptom monitoring such as Social Responsiveness Scale-II (SRSII), Aberrant Behavior Checklist, or Social Communication Questionnaire (SCQ).

Medical Necessity Criteria

Medical necessity and recommendation for BHT services is determined by a physician, or other licensed practitioner working within their scope of practice under state law. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B listed below; and require BHT services to address the following areas:

A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by ***all*** of the following:
    1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.
    2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.
    3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.
B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by ***at least two*** of the following:
    1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, and/or excessively circumscribed or perseverative interest).
4. Hyper- or hypo- reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures.

Determination of Eligibility for BHT

The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing the ADOS-2 and symptom rating using the Clinical Global Impression Severity Scale. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who have the developmental capacity to clinically participate in the available interventions covered by BHT services. Children who have marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder. The following requirements must be met:

1. Child is under 21 years of age.
2. Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.
3. Child is medically able to benefit from the BHT treatment.
4. Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the BHT interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social-communication, increased interactive play/age-appropriate leisure skills, increased reciprocal communication, etc.
5. Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individual Education Plan/Individual Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).
6. Services are able to be provided in the child's home and community, including centers and clinics.
7. Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities or may be masked by learned strategies later in life).
8. Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.
9. A qualified licensed practitioner recommends BHT services and the services are medically necessary for the child.
10. Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.

Prior Authorization

BHT services are authorized for a time period not to exceed 365 days. The 365-day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a qualified licensed practitioner working within their scope of practice under state law.

Re-evaluation

An annual re-evaluation occurring within 365 days by a qualified licensed practitioner to assess eligibility criteria must be conducted through direct observation utilizing the ADOS-2 and symptoms rated using the Clinical Global Impression Severity Scale. Additional tools may be used if the clinician feels it is necessary to determine medical necessity and recommended services. Other tools may include cognitive/developmental tests, adaptive behavior tests, and/or symptom monitoring.

Discharge Criteria

Discharge from BHT services is determined by a qualified BHT professional for children who meet any of the below criteria:

1. The child has achieved treatment goals and less intensive modes of services are medically necessary and appropriate.
2. The child is either no longer eligible for Medicaid or is no longer a State of Michigan resident.
3. The child has not demonstrated measurable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through a period of six months.
4. Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations.
5. The child no longer meets the eligibility criteria as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.
6. The child and/or parent/guardian is not able to meaningfully participate in the BHT services and does not follow through with treatment recommendations to a degree that compromises the potential effectiveness and outcome of the BHT service.

BHT Services

A. Behavioral Assessment

   Behavioral assessments must use a validated instrument and can include direct observational assessment, observation, record review, data collection, and analysis by a qualified provider. Examples of behavior assessments include function analysis and functional behavior assessments. The behavioral assessment must include the current level of functioning of the child using a validated data collection method. Behavioral assessments and ongoing measurements of improvement must include behavioral outcome tools. Examples of behavioral outcome tools include Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic Language and Learning Skills revised (ABLLS-R), and Assessment of Functional Living Skills (AFLS).

B. Behavioral Intervention

   BHT services include a variety of behavioral interventions, which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence. BHT services are designed to be delivered primarily in the home and in other community settings. Behavioral treatment intervention services include, but are not limited to, the following categories of evidence-based interventions:

   - Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis);
   - Adapting environments to promote positive behaviors and learning while discouraging negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports, stimulus fading);
   - Applying reinforcement to change behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction);
   - Teaching techniques to promote positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting, chaining, imitation);

- Teaching parents/guardians to provide individualized interventions for their child, for the benefit of the child (e.g., parent/guardian implemented/mediated intervention);
- Using typically developing peers (e.g., individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups, peer social interaction training); and
- Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software).

In addition to the above listed categories of interventions, covered BHT treatment services may also include any other intervention supported by credible scientific and/or clinical evidence, as appropriate for each individual. Based on the behavioral plan of care which is adjusted over time based on data collected by the qualified provider to maximize the effectiveness of BHT treatment services, the provider selects and adapts one or more of these services, as appropriate for each individual.

C. Behavioral Observation and Direction

Behavioral observation and direction is the clinical direction and oversight provided by a qualified provider to a lower level provider based on the required provider standards and qualifications regarding the provision of services to a child. The qualified provider delivers face–to-face observation and direction to a lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. This service is for the direct benefit of the child and provides a real-time response to the intervention to maximize the benefit for the child. It also informs of any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the behavioral plan of care.

D. Telepractice for BHT Services

All telepractice services must be prior authorized by the Michigan Department of Health and Human Services (MDHHS). Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services. Telepractice must be obtained through real-time interaction between the child's physical location (patient site) and the provider's physical location (provider site). Telepractice services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators, and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients. Qualified providers of behavioral health services are able to arrange telepractice services for the purposes of teaching the parents/guardians to provide individualized interventions to their child and to engage in behavioral health clinical observation and direction. Qualified providers of behavioral health services include Board Certified Behavior Analysts (BCBA), Board Certified Assistant Behavior Analysts (BCaBA), Licensed Psychologists (LP), Limited Licensed Psychologists (LLP), and Qualified Behavioral Health Professionals (QBHP). The provider of the telepractice service is only able to monitor one child/family at a time. The administration of telepractice services are subject to the same provision of services that are provided to a patient in person. Providers of telepractice services must be currently certified by the Behavior Analyst Certification Board (BACB), be a QBHP enrolled in a BACB degree program, be licensed in the State of Michigan as a fully licensed psychologist or be a practitioner who holds a limited license and is under the direction of a fully licensed psychologist. Providers must ensure the privacy of the child and secure any information shared via telemedicine.

The technology used must meet the requirements of audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter of the Medicaid Provider Manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual.

The patient site may be located within a center, clinic, at the patient's home, or any other established site deemed appropriate by the provider. The room must be free from distractions that would interfere

with the telepractice session. A facilitator must be trained in the use of the telepractice technology and be physically present at the patient site during the entire telepractice session to assist the patient at the direction of the qualified provider of behavioral health. Occupational, physical, and speech therapy are not covered under telepractice services. See the telemedicine database for appropriate or allowed telemedicine services that may be covered by the Medicaid Health Plan or by Medicaid Fee-forService.

BHT Service Level

BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within their community for an appropriate period of time, depending on the needs of the child and their parents/guardians. Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the child's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings, or to be provided when the child would typically be in school but for the parent's/guardian's choice to home-school their child. Each child's IPOS must document that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) that are available to the child through a local education agency. The recommended service level, setting(s), and duration will be included in the child's IPOS, with the planning team and the parent(s)/guardian(s) reviewing the IPOS at regular intervals (minimally every three months) and, if indicated, adjusting the service level and setting(s) to meet the child's changing needs. The service level includes the number of hours of intervention provided to the child. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each child and should reflect the goals of treatment, specific needs of the child, and response to treatment. It is the responsibility of MSHN's Utilization Management to authorize the level of services prior to the delivery of services.

- Focused Behavioral Intervention: Focused behavioral intervention is provided an average of 5-15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
- Comprehensive Behavioral Intervention: Comprehensive behavioral intervention is provided an average of 16-25 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
-

BHT Service Evaluation

As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement. BCBA and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the child's response to treatment and skill acquisition. Ongoing determination of the level of service (minimally every six months) requires evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated with the use of reliable and valid assessment instruments (i.e., VB-MAPP, ABLLS-R, AFLS) and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).

BHT Service Provider Qualifications

MSHN and its Provider Network Management shall ensure credentialing of roles and responsibilities of qualified providers. BHT services are highly specialized services that require specific qualified providers that are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services. BHT services must be provided under the direction of a BCBA, another appropriately qualified LP or LLP, or a Master's prepared QBHP. These services must be provided directly to, or on behalf of, the child by training their parents/guardians, behavior technicians, and BCaBAs to deliver the behavioral interventions. The BCBA and other qualified providers are also responsible for communicating progress on goals to parents/guardians minimally every three to six months, clinical skill development and supervision of BCaBA, QBHP, and behavior technicians, and collaborating with support coordinators/case managers and the

parents/guardians on goals and objectives with participation in development of the IPOS that includes the behavioral plan of care.

BHT Supervisors

- Board Certified Behavior Analyst-Doctorate (BCBA-D) or BCBAServices Provided: Behavioral assessment, behavioral treatment, and behavioral observation and direction.
    - License/Certification: Current certification as a BCBA through the BACB. The BACB is the national entity accredited by the National Commission for Certifying Agencies (NCCA). o Education and Training: Minimum of a master's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.
- Licensed Psychologist (LP): Must be certified as a BCBA by September 30, 2020 Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
    - License/Certification: LP means a doctoral level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements.
    - Education and Training: Minimum doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented ABA specific coursework at the graduate level from an accredited university in at least three of the six following areas:
        1. Ethical considerations.
        2. Definitions & characteristics and principles, processes & concepts of behavior.
        3. Behavioral assessment and selecting interventions outcomes and strategies.
        4. Experimental evaluation of interventions.
        5. Measurement of behavior and developing and interpreting behavioral data.
        6. Behavioral change procedures and systems supports.
    - A minimum of one-year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the caseload, progress, and treatment of the child with ASD.

- LLP: Must be certified as a BCBA by September 30, 2020 Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
    - License/Certification: LLP means a doctoral or master level psychologist licensed by the State of Michigan. Limited psychologist master's limited license is good for one two-year period. Must complete all coursework and experience requirements.
    - Education and Training: Minimum of a master's or doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented ABA specific coursework at the graduate level from an accredited university in at least three of the six following areas:
        1. Ethical considerations.
        2. Definitions & characteristics and principles, processes & concepts of behavior.
        3. Behavioral assessment and selecting interventions outcomes and strategies.
        4. Experimental evaluation of interventions.
        5. Measurement of behavior and developing and interpreting behavioral data.
        6. Behavioral change procedures and systems supports.
    - A minimum of one-year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the progress and treatment of the child with ASD.
- BCaBA Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
    - License/Certification: Current certification as a BCaBA through the BACB. The BACB is the national entity accredited by the NCCA.

- Education and Training: Minimum of a bachelor's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.
- Other Standard: Works under the supervision of the BCBA.

- QBHP: Must be certified as a BCBA by September 30, 2020 Services Provided: Behavioral assessment, behavioral treatment, and behavioral observation and direction. o License/Certification: A license or certification is not required but is optional.
  - Education and Training: QBHP must meet one of the following state requirements:
    - Must be a physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD.
    - Minimum of a master's degree in a mental health-related field from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. Works within their scope of practice, works under the supervision of the BCBA, and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented ABA specific coursework at the graduate level from an accredited university in at least three of the six following areas:
      1. Ethical considerations.
      2. Definitions & characteristics and principles, processes & concepts of behavior.
      3. Behavioral assessment and selecting interventions outcomes and strategies.
      4. Experimental evaluation of interventions.
      5. Measurement of behavior and developing and interpreting behavioral data.
      6. Behavioral change procedures and systems supports.

- Behavior Technician Services Provided: Behavioral intervention. o License/Certification: A license or certification is not required.
  - Education and Training: Will receive BACB Registered Behavior Technician (RBT) training conducted by a professional experienced in BHT services (BCBA, BCaBA, LP, LLP, and/or QBHP), but is not required to register with the BACB upon completion in order to furnish services.
  - Works under the supervision of the BCBA or other professional (BCaBA, LP, LLP or QBHP) overseeing the behavioral plan of care, with minimally one hour of clinical observation and direction for every 10 hours of direct treatment.
  - Must be at least 18 years of age; able to practice universal precautions to protect against the transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedure, and to report on activities performed; and be in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien). Must be able to perform and be certified in basic first aid procedures and is trained in the IPOS/behavioral plan of care utilizing the person-centered planning process.

MSHN shall maintain evidence that the child meets needs based criteria for benefit eligibility as evidenced by the above evaluation and outcomes instruments. MSHN is responsible for a utilization management function in order to ensure sufficient separation of functions and addresses:

1. Conflict of interest;
2. Service authorization;
3. Clinical service provision;
4. Oversight and approval of ABA services;
5. Number and percent of administrative hearings related to utilization management function issues (amount, scope, duration of service;)
6. ABA services during the quarter were within the suggested range for the intensity of service.

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

Definitions:
ABA: Applied Behavior Analysis
ABLLS-R: Assessment of Basic Language and Learning Skills-Revised
ADI-R: Autism Diagnostic Interview-Revised
ADOS-2: Autism Diagnostic Observation Schedule-2
ASD: Autism Spectrum Disorder
BCBA: Board Certified Behavior Analyst
BCaBA: Board Certified Assistant Behavior Analyst
BHT: Behavioral Health Treatment
CMS: Centers for Medicare & Medicaid Services
DAS-II: Differential Ability Scales-II
EPSDT: Early Periodic Screening, Diagnosis and Treatment
IPOS: Individual Plan of Service
iSPA: 1915i State Plan Amendment LP:
Licensed Psychologist
LLP: Limited Licensed Psychologist
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
Provider Network: The Community Mental Health Services Program (CMHSP) participants that hold a contract with Mid-State Health Network. QBHP: Qualified Behavioral Health Professional
VABS-2: Vineland Adaptive Behavior Scales-Second Edition
VB-MAPP: Verbal Behavior Milestones Assessment and Placement Program
WPPSI-III: Wechsler Preschool and Primary Scale of Intelligence-III
WPPSI-IV: Wechsler Preschool and Primary Scale of Intelligence-IV

Other Related Materials:
N/A

References/Legal Authority:
MDHHS Medicaid Managed Specialty Supports & Services Contract
Medical Services Administration Bulletin 15-59

Change Log:

Date of Change	Description of Change	Responsible Party
10.2014	New Policy	UM & Waiver Coordinator
06.2016	Replaces Original Policy	Waiver Coordinator
01.10.2017	Addition of referrals from outside sources	Waiver Coordinator
11.17.2017	Removed DSM IV language and added language for ABA specific coursework under BHT Supervisor credentialing requirements.	Waiver Coordinator

2.2019	Annual Review	Waiver Coordinator
08.2020	Annual Review	Waiver Coordinator

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Cultural Competency Policy**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Deputy Director	**Adopted Date:** 01.05.2016 **Review Date:** 11.10.2020	**Related Policies:**

Purpose

This policy is intended to define the expectations for Mid-State Health Network (MSHN) and its Provider Network to provide culturally competent supports and services.

Policy

It is the policy of MSHN and its Provider Network to effectively provide services to recipients of all cultures, ages, races, gender, sexual orientation, socioeconomic status, languages, ethnic backgrounds, spiritual beliefs and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each person. In addition, MSHN and its Provider Network value workforce diversity and actively engage in culturally competent employment practices.

In furtherance of this policy MSHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area.

Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

To effectively demonstrate such commitment, MSHN's Provider Network shall have five components in place:

(1) A method of community assessment;
(2) Sufficient policy and procedure to reflect the PIHP's value and practice expectations;
(3) A method of service assessment and monitoring;
(4) Ongoing training to assure that staff are aware of, and able to effectively implement, policy; and
(5) The provision of supports and services within the cultural context of the recipient.

Competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment and economic factors, etc.

Applies to:

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

Definitions:

CMHSP: Community Mental Health Service Program
Cultural Competency: is an acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of

cultural knowledge, and resources and flexibility within service models to work toward better meeting the needs of minority populations.
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
Provider Network: refers to a CMHSP Participant that is directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through CMHSP subcontractors.

Other Related Materials:
MSHN Utilization Management Plan

References/Legal Authority:
Medicaid Managed Specialty Supports and Services Contract: Concurrent 1915(B)/(c) Waiver Programs, the Health Michigan Program and Substance Use Disorder Community Grant Programs

Change Log:

Date of Change	Description of Change	Responsible Party
03.18.2015	New Policy	Deputy Director
02.28.2018	Annual Review	Deputy Director
02.28.2019	Annual Review	Deputy Director
08.31.2020	Biennial Review	Deputy Director

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Drug Screen Coverage**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 1	**Review Cycle:** Biennial **Author:** Director of Utilization and Care Management	**Adopted Date:** 07.10.2018 **Review Date:** 11.10.2020	**Related Policies:**

Purpose

The purpose of this policy is to delineate the Mid-State Health Network (MSHN) stance on MSHN-reimbursement coverage for drug screens.

Policy

It is the policy of MSHN that the necessary criteria must be met for drug screens to be covered by treatment funds, provided all of the following criteria are met. Note that this policy does not apply to medication assisted treatment (MAT) services.

Guidance

All following criteria must be met for drug screens to be covered by MSHN funding:

- No other responsible payment source will pay for the screens. This includes self-pay, Medicaid, and private insurance. Documentation must be in the client file;
- The screens are justified by specific medical necessity criteria as having clinical or therapeutic benefit; and
- Screens performed by professional laboratories can be paid for one time per admission to residential or detoxification services, if specially justified. Other than these one-time purchases, funds may only be used for in-house "dip stick" screens.

Applies to:

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

Definitions:

MAT: Medication-Assisted Treatment
MSHN: Mid-State Health Network

Other Related Materials:

N/A

References/Legal Authority:

Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program

Change Log:

Date of Change	Description of Change	Responsible Party
03.05.2018	New Policy	Utilization Management and Waiver Director
02.2019	Annual review	Utilization and Integrated Care Director
08.2020	Annual Review	Director of Utilization and Care Management

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

Purpose

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

Policy

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

Applies to:

☐All Mid-State Health Network Staff

☐Selected MSHN Staff, as follows:

☒MSHN CMHSPs ☐Policy Only ☒Policy and Procedure

☐Other: Sub-contract Providers

Definitions:

CMHSP: Community Mental Health Service Program

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

MSHN: Mid-State Health Network

Other Related Materials:

N/A

References/Legal Authority:

Michigan Mental Health Code 330.1717

Change Log:

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

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POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Home and Community Based Services (HCBS) Compliance Monitoring		
Policy: ☒ Procedure: ☐ Page: 1 of 1	Review Cycle: Biennial Author: HCBS Waiver Manager	Adopted Date: 07.10.2018 Review Date: 11.10.2020	Related Policies:

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

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

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

Monitoring and Review:
This policy will be reviewed annually by MSHN's HCBS Manager in collaboration with the MSHN HCBS/HSW Workgroup.

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

Other Related Materials:
N/A

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

Change Log:

Date of Change	Description of Change	Responsible Party
03.2018	New Policy	Waiver Coordinator
02.2019	Annual Review	Waiver Coordinator
08.2020	Annual Review	HCBS Manager

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Habilitation Supports Waiver Policy		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** HCBS Manager	**Adopted Date:** 7.1.2014 **Review Date:** 11.10.2020	**Related Policies:** HSW Service Philosophy

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

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

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

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

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

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

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

- Initial Application and Eligibility,
- Annual Recertification,
- Disenrollment and Transfer Procedure

Applies to

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

Definitions

HSW: Habitation Support Waiver

MDHHS: Michigan Department of Health and Human Services

PIHP: Prepaid Inpatient Health Plan

ICF/IDD: (Intermediate Care Facility/Intellectual-Developmental Disability 42 CFR 435.1009) Institution for individuals with developmental disabilities or persons with related conditions means an institution (or distinct part of an institution) that (a) Is primarily for the diagnosis, treatment, or rehabilitation of people with developmental disabilities or persons with related conditions; and (b) Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.

Developmental Disability: means either of the following:

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

    e. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
2. If applied to a minor from birth to age 5, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (a) if services are not provided.

Other Related Materials:
N/A

References/Legal Authority
The MDHHS – PIHP Contract
MDHHS, Medicaid Provider Manual; Section 15 – Habilitation Supports Waiver Program for Persons with Developmental Disabilities, January 2020
Intermediate Care Facility/Intellectual-Developmental Disability 42 CFR 435.1009; and Michigan Mental Health Code MCL 330.1100 (20).

Change Log:

Date of Change	Description of Change	Responsible Party
April, 2014	New policy	M. Neering N. Miller
January, 2017	Reviewed policy no recommended changes	Waiver Coordinator
October, 2017	Reviewed policy no recommended changes	Waiver Coordinator
July, 2020	Biennial Review	Waiver Coordinator

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Indian Health Services/Tribally-Operated Facility/Urban Indian Clinic Services (I/T/U)**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Behavioral Health Officer	**Adopted Date:** 03.06.2018 **Review Date:** 11.10.2020	**Related Policies:**

Purpose

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

Policy

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

General

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

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

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

The options are:

- A THC may choose to be certified as an IHS facility, sign the THC Memorandum of Agreement (MOA) and receive the IHS encounter rate in accordance with the terms of the MOA.
- Upon federal approval by the Health Resources and Services Administration, THCs may be reimbursed as a Federally Qualified Health Center (FQHC) by signing the FQHC Memorandum of Agreement. THCs choosing this option will receive the FQHC encounter rate set by the State in accordance with the Michigan Medicaid State Plan and federal regulations. The FQHC encounter rate applies to encounters for both native and non-native beneficiaries. A THC electing to be reimbursed as an FQHC is not required to have a contract with the managed care entity. If a THC

chooses to be reimbursed as a FQHC, the entity would be required to adhere to the same requirements specified in the FQHC Chapter of the Michigan Medicaid Manual.

- A THC may be reimbursed as a fee-for-service provider. THCs choosing this option receive payment for covered services. No additional reimbursement or settlement is made.

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

Applies to

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

Definitions

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

Other Related Materials References/Legal Authority

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

Change Log:

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

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Inpatient Psychiatric Hospitalization Standards**		
Policy: ☒ **Procedure:** ☒ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Director of Provider Network Mgmt Systems	**Adopted Date:** 11.07.2017 **Review Date:** 11.10.2020	**Related Policies:** MSHN Retrospective Sampling for Acute Services Policy

Purpose

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

Policy

MSHN, CMHSPs and providers shall adhere to *Section 8 – Inpatient Psychiatric Hospital Admissions* within the Behavioral Health and Intellectual and Developmental Disabilities Supports and Services chapter of the Medicaid Provider Manual, the Michigan Mental Health Code, Chapter 330, Act 258 of 1974, and the Michigan Department of Health and Human Services *Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes.*

A. Pre-Admission:

1. Emergency Services staff who are screening children shall complete 24 hours of child-specific training annually.
2. Provider shall maintain proper documentation of clinical presentation and disposition.
3. When known to the screening unit, screening unit personnel shall coordinate care with primary care physicians, substance use disorder treatment providers, alternative service providers and other individuals or organizations having an identified role in services and supports delivery to the consumer being served.
4. The screening unit shall furnish the Inpatient Psychiatric Hospital/Unit (IPHU) with necessary clinical, social, and demographic documentation to foster the admitting and discharge process.
5. The screening unit shall provide an admissions packet to the IPHU that has agreed to provide inpatient care to the consumer being served.
6. Established pre-admission screening tools will be used by pre-admission/crisis intervention staff. MSHN and its CMHSP participants use nationally-recognized written criteria based on sound clinical evidence (MCG Behavioral Health Medical Necessity Guidelines) to verify that admission decisions for acute care services are based on medical necessity.
7. In cases when the consumer is diverted from inpatient level of care to an alternative service, a crisis/safety plan shall be established. Whenever possible, a warm handoff occurs and CMHSPs conducts wellness checks, follow-up calls, face-to-face appointments, or any other appropriate safety monitoring activities warranted.
8. CMHSPs in the MSHN region shall provide emergency services, including pre-admission screening and related follow-up activities, including identification of and placement in appropriate psychiatric inpatient or alternative service settings regardless of where the consumer resides. MSHN shall pursue payment from other PIHPs for services. In all cases, communication(s) should occur with the CMHSP or PIHP in the catchment area of the residence of the consumer served. In no case should pre-admission screening activities be delayed while waiting for a response from the CMHSP/PIHP in the catchment area where the consumer resides. Established medical necessity and service utilization criteria are the only criteria to be used in making psychiatric admission determinations. Place of residence, willingness of another CMHSP or PIHP to authorize services, or other non-clinical factors are not pertinent to the determination of inpatient psychiatric or alternative service levels of care and related placement decisions. Arrangement for continuing stay reviews and other follow-up care should be worked out with the provider system that will be responsible for post-inpatient follow-up care.

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

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

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

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

C. Admission

1. The contractually required inpatient admission, severity of illness, and service selection criteria for both adults and children shall be the only criteria for admission to psychiatric inpatient admission and inpatient alternative service.
2. The screening unit making the determination that a consumer served meets psychiatric admission criteria shall provide an initial authorization to the psychiatric inpatient unit consistent with severity of illness, presenting problems and other clinical factors associated with the preadmission screening determination. Initial authorizations may vary between one (1) and three (3) days. Many of these elements are procedural and in the case of involuntary admissions, vary from court jurisdiction to court jurisdiction.
3. Screening unit shall ensure that emergency transportation of a consumer from the location of screening to the receiving psychiatric inpatient unit is coordinated. Safety of the consumer served, and the safety of those providing supports to the consumer, are the primary considerations in making transportation arrangement.
4. The screening unit is responsible for ensuring that families, guardians, service providers and others involved in the care, custody and service delivery of the consumer served are updated regularly on screening status, disposition, and placement efforts. Family members and others in the consumer's circle of support should receive communication as often as possible, and supportive assistance provided as needed.
5. Clinical determinations and formulations, eligibility determinations, service disposition and related information is documented per established CMHSP policies.

D. Continuing Stay

1. The Continuing Stay Criteria for Adults, Adolescents and Children shall be the only criteria used in determining authorization for continued stay in inpatient psychiatric hospitals/units. The number of

days authorized for continued stay is dependent on a number of variables, including medication effectiveness, clinical progress, co-morbidities and many other factors. Continued stay authorizations range from one (1) to three (3) days. The rationale considered in making a continued stay authorization shall be documented in the clinical record of the consumer served.

2. Assessment, discharge procedures, and aftercare planning shall be conducted by the Provider's staff and the Payor's staff functioning as a multi-disciplinary treatment team. The Payor is responsible for monitoring patient progress. To the extent possible, provider will coordinate care with other entities and individuals involved with the care of the consumer that is being served.

E. Discharge

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

Applies to:

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

Definitions

CMHSP: Community Mental Health Services Program Participant
HCPCS/CPT: Healthcare Common Procedure Coding System/Current Procedural Terminology
MSHN: Mid-State Health Network
PIHP: Pre-paid Inpatient Health Plan
Provider: Licensed Inpatient Hospital/Unit
Screening Unit: CMHSP Emergency Services or other CMHSP-Operated Pre-Admission Screening Unit

References/Legal Authority

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

Change Log

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

Chapter:	Service Delivery System		
Title:	Out of State Placements		
Policy: ☒ Procedure: ☐ Page: 1 of 3	Review Cycle: Biennial Author: Provider Network Management Committee	Adopted Date: 05.05.2015 Review Date: 11.10.2020	Related Policies: Service Delivery System

Purpose

This policy is established to provide guidelines for the placement of Mid-State Health Network (MSHN) Adult recipients outside of the State of Michigan into a community based residential dependent living setting, in accordance with the Michigan Mental Health Code and the State of Michigan Administrative Rules. Persons under the age of 18 shall not be placed out of the State of Michigan for residential care.

Policy

It is the intent of Mid State Health Network to comply with *Section 330.919 of the Michigan Mental Health Code Section 330.1919 - Contracts for services of agencies located in bordering states as well Section 330 Michigan Administrative Rules Section 330.1701 – 330.1703* regarding the placement of individuals outside of the state of Michigan.

Community Mental Health Service Programs (CMHSPs) shall notify MSHN of their intent to place a Medicaid eligible adult out of state and keep them apprised of the status of the placement approval from the Michigan Department of Health and Human Services (MDHHS).

Determination of Need

Only voluntary placements shall be considered for out of state residential services. The Provider will be the CMHSP, and act in accordance with State requirements for such placements.

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

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

Placement shall not occur until the Michigan Department of Health and Human Services approves the out of state placement in writing.

The CMHSP shall meet the requirements of the Mental Health Code and the Michigan Administrative Rules in seeking provision of out of state services.

These requirements include, but may not be limited to:

1) The CMHSP may contract as provided under this section with a public or private agency located in a state bordering Michigan to secure services under this act for an individual who receives services through the county program.

2) The CMHSP may contract as provided under this section with a public or private agency located in a state bordering Michigan to provide services under this act in an approved treatment facility in this

state for an individual who is a resident of the bordering state, except that such services may not be provided for an individual who is involved in criminal proceedings.

3) An individual does not establish legal residence in the state where the receiving agency is located while the individual is receiving services pursuant to a contract executed under this section.
4) If an individual receiving treatment on a voluntary basis pursuant to a contract executed under this section requests discharge, the receiving agency shall immediately notify the CMHSP and shall return the individual to the sending state as directed by the CMHSP within 48 hours after the request, excluding Saturdays, Sundays, and legal holidays, unless other arrangements are made with the CMHSP.
5) An individual may be transferred between facilities of the receiving state if transfers are permitted by the contract executed under this section providing for the individual's care.
6) Each contract executed for out of state residential services shall contain all of the following:
    a) Establish the responsibility for payment for each service to be provided under the contract. Charges shall not be more or less than the actual cost of providing the service.
    b) Establish the responsibility for the transportation of individuals to and from the residential facility.
    c) Provide for reports by the receiving agency to the CMHSP on the condition of each individual covered by the contract.
    d) Provide for arbitration of disputes arising out of the contract that cannot be settled through discussion between the contracting parties and specify how the arbitrators will be chosen.
    e) Include provisions ensuring the nondiscriminatory treatment, as required by law, of employees, individuals receiving services, and applicants for employment and services.
    f) Establish the responsibility for providing legal representation for an employee of a contracting party in legal proceedings initiated by an individual receiving treatment pursuant to the contract.
    g) Include provisions concerning the length of the contract and the means by which the contract can be terminated.
    h) Establish the right of the CMHSP and the State of Michigan to inspect, at all reasonable times, the records of the Provider and its treatment facilities to determine if appropriate standards of care are met for individuals receiving services under the contract.
    i) Require each individual who seeks treatment on a voluntary basis to agree in writing to be returned to the State of Michigan upon making a request for discharge
    j) Specify the circumstances under which an individual will be permitted a home visit or granted a pass to leave the facility, or both.

Applies to:

☐All Mid-State Health Network Staff

☐Selected MSHN Staff, as follows:

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

☐Other: Sub-contract Providers

Definitions:

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

Other Related Materials:
Out-Of-State Placement Procedure

References/Legal Authority:
Michigan Mental Health Code

Change Log:

Date of Change	Description of Change	Responsible Party
01.2015	New Policy	C. Mills, PNMC
05.2016	Annual Review	Director of Provider Network Management Systems, Provider Network Management Committee
02.2018	Annual Review	Director of Provider Network Management Systems, Provider Network Management Committee
03.2019	Annual Review	Director of Provider Network Management Systems, Provider Network Management Committee

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MID-STATE HEALTH NETWORK
POLICIES MANUAL

Chapter:	**Service Delivery System**		
Title:	**Service Philosophy & Treatment**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 6	**Review Cycle:** Biennial **Author:** Clinical Leadership and Utilization Management Committee	**Adopted Date:** 12.03.2013 **Review Date:** 11.10.2020	**Related Policies:** Utilization Management UM Access

Purpose

To ensure that Mid-State Health Network (MSHN) and its Community Mental Health Service Program (CMHSP) Participants have a consistent service philosophy across its network of care related to person-centered planning, integrated care, housing, employment, and self-determination. MSHN promotes a person-centered approach to all service planning and delivery of supports and services in the community, consistent with Michigan Department of Health and Human Services (MDHHS) policy direction.

Policy

A. Person-Centered/Family-Centered Planning
   1. MSHN shall be committed to ensuring that all individuals have the freedom and right to create an Individual Plan of Service that is developed through a person-centered planning process without regard to age, disability or residential setting, as required in the Michigan Mental Health Code and defined in the MDHHS Person Centered/Family-Centered Planning Policy and Practice Guideline.
   2. Standards
      i. CMHSPs Participants shall support person-centered/family-centered planning in the creation, development, and implementation of all consumer services.
      ii. MSHN shall ensure that CMHSP Participants provide comprehensive information to consumers about the risks and benefits of services including their freedom or right to participate in decision-making regarding their health, treatment options, and services that will be provided.
      iii. MSHN shall monitor the implementation of person-centered planning for adults and family-centered planning for minor children and families through an annual on-site audit of each CMHSP Participant and through consumer satisfaction surveys.

B. Integrated Care
   1. MSHN shall utilize a coordinated, person-centered/family-centered system of care that allows for comprehensive care from primary care, mental health and substance use disorder providers.
   2. MSHN shall make a coordinated approach to service delivery available to its consumers. This is an essential element of treatment and supports and produces the best outcomes for people with multiple and complex healthcare needs.
   3. Standards
      i. Coordination shall include health care providers who shall work collaboratively to improve functioning and promote recovery and resiliency.
         - The MSHN provider network will implement practices to encourage all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the consumer's Medicaid Health Plan.

         - The MSHN provider network will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to

the attention of the individual along with information about the need for intervention and how to obtain it.

ii. Consideration shall be given to system-wide, cost-effective interventions and supports that produce the highest level of outcomes.
iii. MSHN shall have written agreements with the Medicaid Health Plans in the service area.
iv. Interagency agreements shall meet the requirements in 42 CFR Part 2.
v. Outcomes that represent improvements in significant aspects of clinical services and supports will be shared among health care providers to assist in identifying over and underutilization and patterns of service delivery.
vi. Health information exchange shall be supported through the use of technology to assure timely and accurate access to pertinent clinical information consistent with related rules and regulations for protected health information and confidentiality.
    - As authorized by the consumer, MSHN provider network members will include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered plan.
    - Information sharing across the provider network will focus on essential aspects of the provision of health care and will assist with population health management as well as the coordination of individual care in accordance with requirements for confidentiality and protection of health information.

C. Collaboration with Community Agencies

MSHN through its CMHSP provider network must work closely with local public and private community-based organizations and providers to address prevalent human conditions and issues that relate to a shared customer base to provide a more holistic health care experience for the consumer. Such agencies and organizations may include local health departments, local Department of Health and Human Service, Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), community and migrant health centers, nursing homes, Area Agency and Commissions on Aging, Medicaid Waiver agents for the Home Community Based Waiver (HCBW) program, school systems, and Michigan Rehabilitation Services. Local coordination and collaboration with these entities will make a wider range of essential supports and services available to the PIHP beneficiaries. PIHPs through the region's CMHSPs will coordinate with these entities through participation in multi-purpose human services collaborative bodies, and other similar community groups.

The MSHN through its CMHSP provider network shall have written coordination agreements with each of the pertinent agencies noted above describing the coordination arrangements agreed to and how disputes between the agencies will be resolved. To ensure that the services provided by these agencies are available to all PIHP eligible consumers, an individual contractor shall not require an exclusive contract as a condition of participation with the PIHP.

Agreements shall assure that coordination regarding mutual recipients is occurring between the PIHP and/or its provider network, and primary care physicians. This policy shall minimally address all recipients of PIHP services for whom services or supports are expected to be provided for extended periods of time (e.g., people receiving case management or supports coordination) and/or those receiving psychotropic medications.

D. Housing

1. MSHN's provider network shall assist consumers/guardians with decisions about the most appropriate residential option for persons with disabilities.
2. CMHSP Participants within MSHN will maintain an established plan to work with community housing partners to promote desirable housing and residential options for persons with disabilities.
3. Standards:

i. An array of housing choices and related resources and supports shall be made available to persons served in their local communities and, whenever possible, shall allow for the individual to integrate into his/her home and community of choice.
ii. Each CMHSP Participant shall demonstrate leadership in suggesting, developing and refining local housing options to meet consumer needs and choices in their local communities.
iii. The residential option selected shall be based upon the needs and desires of the individual as part of the individual's person-centered plan.
iv. Housing options shall be based on the least restrictive setting that will best meet the needs of the individual.
v. CMHSP Participants will include cultural considerations when assisting consumers and guardians with residential options.
vi. Consumers and guardians shall be offered comparative information about housing providers whenever available.
vii. Housing options shall support consumers' plans and goals, and shall also promote overall wellness, health, safety, quality of life, meaningful community activities, and the highest possible level of independence, including within supervised settings.
viii. Respect for personal privacy for consumers shall be a priority in all housing settings.
ix. Housing settings shall be safe, habitable and affordable. Home settings of individuals served shall be monitored, by the contracting organization, on a regular basis for the purpose of consumer welfare, regardless of whether PIHP or CMHSP funds pay for the costs of the housing.
x. CMHSP Participants shall offer mandatory and elective training on a regular basis to support housing providers and staff.
xi. CMHSPs shall maintain collaborative agreements and communications with housing providers and resources in their communities, including participation in local planning groups or coalitions.
xii. Each CMHSP participant shall have and make available written policies and procedures regarding housing assistance, supports, and resources for consumer and guardian decision-making, including the on-going assessment needs in consumer housing.

E. Self Determination
1. MSHN shall ensure that all individuals served through Community Mental Health Programs are given the freedom to pursue Self Determination (SD) arrangements that provide the individual the ability to guide and direct the services and supports they receive.
2. Standards
i. A Person/Family-Centered Planning Process will be used to identify supports and services and provide information on how to participate in SD arrangements.
ii. Participation in SD arrangements shall be voluntary and shall be made available in accordance with established MDHHS best practice guidelines and state and federal regulations.

F. Employment
1. MSHN recognizes that employment is an essential element of the quality of life for most people. CMHSP Participants shall work together to achieve consistency across the region in providing competitive integrated employment services.
2. Standards
i. MSHN will assure that all recipients, including those who have advocates or guardians, have genuine opportunities for freedom of choice and self-representation.
ii. MSHN shall promote community inclusion and participation, independence and productivity throughout its provider network.

iii. Service providers within MSHN shall identify outcomes based on the individual's life goals, interests, strengths, abilities, desires, and preferences.
iv. Service providers within MSHN shall explore in the pre-planning meeting the person's options for work that include competitive employment, community group employment, self-employment, transitional employment, volunteering, education/training, and internships as a means to future competitive employment.
v. CMHSP Participants shall promote the use of best employment practices including the MDHHS adopted evidence-based practice Individual Placement and Support for employment goals for persons with mental illness.
vi. CMSHP Participants shall share and reinforce the MDHHS Employment Works! Policy across it service delivery network.
vii. Each CMHSP Participant shall designate a local staff member who will provide leadership in employment initiatives and services and shall designate at least one staff who has expertise in benefits planning or the capacity to access the information in a timely manner.
viii. CMHSP Participants shall share local best employment practices across MSHN.
ix. MSHN shall collect accurate employment outcome data and submit the data to MDHHS for review in a timely manner.
x. CMHSP Participants shall establish strategies and partnerships with Michigan Rehabilitation Services (MRS) and the Michigan Commission for the Blind (MCB) where indicated to improve consistency of MRS/MCB supports for consumers.

G. Transitions from Institutional Care (Behavioral Health Psychiatric Care)
1. MSHN shall promote and support a smooth and safe transition for each individual who is released from an institution into the community.
2. CMHSP Participants shall ensure that each individual will obtain placement appropriate to the individual's needs and will have a provider that is able to provide supports and services that enable the individual to live successfully in the community.
3. When a continuing stay review has determined that an individual no longer meets the medical necessity criteria for the institutional placement, CMHSP Participants shall seek other alternatives in the community that are available to meet the individual's treatment needs. In seeking other alternatives, the CMHSP Participant shall make every effort to ensure that the following standards have been considered.
4. Standards:
    i. An individualized discharge/transition plan shall be completed utilizing the person-centered planning process, incorporating the individual's strengths, needs, abilities, and preferences.
    ii. The discharge/transition plan shall have input and participation from the individual, family, authorized representatives, treatment team, and other community resources or supports as applicable.
    iii. The discharge/transition plan should include needed support systems and types of services that will allow for successful transition and integration into the community.
    iv. The individual and/or support people shall be educated on all options available for community support services and types of services needed for a successful transition into the community.
    v. The discharge/transition plan should address any barriers that may interfere with a successful transition. The placement should allow for freedom of choice while ensuring that resources are in place to meet the individual's basic needs and ensure that the needs of the individual are met safely.
    vi. Communication and coordination should occur for all services in the community prior to release. This includes but is not limited to coordination for continuity of medications and follow-up appointments for continuity of medical and behavioral health treatment.
    vii. Referral information and appointments scheduled should be documented and given to the individual and/or authorized representative.

viii. Discharge/transition planning will follow the standards that are included in the Housing Practice Guidelines, Person Centered Planning Policy and Practice Guideline, Consumerism Practice Guidelines, and the Inclusion Practice Guideline.

Applies to

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

Definitions/Acronyms:

CMHSP: Community Mental Health Service Programs
Consumerism: Means active promotion of the interests, service needs, and rights of consumers receiving mental health and/or substance use disorder services.
Customers/Consumers: Refers to those individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.
MCB: Michigan Commission for the Blind
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
MRS: Michigan Rehabilitation Services
PIHP: Prepaid Inpatient Health Plan
SD: Self Determination Arrangement

References/Legal Authority

1. Medicaid Provider Manual
2. Balanced Budget Act of 1997
3. MDHHS PIHP Contract – Person-Centered Planning; Cultural Competence;
4. Out of Network Responsibility; Consumerism Practice Guideline; and Inclusion Practice Guideline
5. MDHHS CMHSP Contract – Recovery Policy & Practice Advisory; Self Determination Practice & Fiscal Intermediary Guideline; QI Programs for CMHSPs; Housing Practice Guideline
6. MDHHS/PIHP Contract: Attachment 3.4.4 (The Self Determination Policy and Practice Guidelines, March 18, 2012)
7. Inclusion Practice Guideline C6.9.3.2
8. Employment Works! C6.9.8.1
9. MDHHS –PIHP Contract Collaboration with Community Agencies 7.2
10. MDHHS-PIHP Contract Integrated Physical and Behavioral health 7.4
11. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program
12. Housing Practice Guidelines (Attachment P 6.8.2.2)
13. Person Centered Planning Policy and Practice Guideline (Attachment P 3.4.1.1)
14. Consumerism Practice Guidelines (Attachment P 6.8.2.3)
15. Inclusion Practice Guideline (Attachment P 6.8.2.1)
16. 2017 Behavioral Health Standards Manual, Commission on Accreditation of the Rehabilitation Facilities (69-75), 2017.
17. Quality Improvement Data (Attachment P 6.5.1.1)
18. 42 CFR Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New policy	Customer Service Committee
04.2015	Annual review, format consistency	CEO, Utilization Management Committee and Clinical Leadership Committee
07.2015	Added Community Collaboration section to address MDHHS requirements; added integrated healthcare standards	Chief Executive Officer
03.2017	Annual Review	Chief Executive Officer
02.2018	Annual Review	Chief Clinical Officer
01.2019	Annual Review	Chief Behavioral Health Officer
08.2020	Annual	Chief Behavioral Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Standardized Assessment**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Clinical Leadership Committee and Utilization Management Committee	**Adopted Date:** 04.07.2015 **Review Date:** 11.10.2020	**Related Policies:** Service Philosophy

Purpose

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

Policy

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

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

Applies to:

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

Definitions:

ASAM: American Society of Addiction Medicine
CAFAS: Child and Adolescent Functional Assessment Scale
CMHSP: Community Mental Health Services Programs
DECA: Devereaux Early Childhood Assessment
LOCUS: Level of Care Utilization System
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PECFAS: Preschool and Early Childhood Functional Assessment Scale
PIHP: Pre-paid Inpatient Health Plan
Provider Network: MSHN's provider network is inclusive of and limited to the CMHSPs and the SUD Provider Network; Contracted providers for the administration of services to persons with substance use disorder services.
SIS: Supports Intensity Scale

Other Related Materials:
N/A

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

Change Log:

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

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Supports Intensity Scale**		
Policy: ☒ **Procedure:**☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Behavioral Health Officer	**Adopted Date:** 07.07.2015 **Review Date:** 11.10.2020	**Related Policies:** Service Delivery

Purpose

Mid-State Health Network (MSHN) shall administer the Supports Intensity Scale in accordance with the Pre-Paid Inpatient (PIHP) contract with the Michigan Department of Health and Human Services (MDHHS).

Policy

MSHN shall comply with section 7.7.3 Supports Intensity Scale of the PIHP Contract. In accordance with the contract MSHN shall:

1. Ensure that each individual age 16 and older with an Intellectual/Developmental Disability who has also received a case management, supports coordination, or respite only service, is assessed using the Supports Intensity Scale (SIS) at minimum of once every 3 years (or more or if the person experiences significant changes in their support needs). The PIHP will need to ensure that a proportioned number of assessments are completed each year to assure that all are done in the three-year cycle. Each three-year cycle will begin consecutive to the end of the previous three-year cycle. PIHPs or their designee shall continue to engage, at least annually, individuals who did not participate (or declined) in the SIS assessment, to increase their understanding of the benefits of the process and how results will be used. The SIS is an essential and valued part of service planning.

2. Ensure an adequate team of trained and American Association on Intellectual and Developmental Disabilities (AAIDD) recognized as qualified SIS assessors across its region to ensure that all individuals are assessed in the required timeframe…"

To achieve the requirement for SIS administration, each CMHSP shall designate a "clinical contact" to facilitate communication between the assigned SIS Assessor and their respective organization. Clinical contacts or their designees will be responsible for communicating with the SIS Assessor, knowing the requirements to complete a valid SIS, scheduling the assessment times, and getting the SIS report into their Electronic Medical Record (EMR).

Applies to:

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

Definitions:

AAIDD: American Association on Intellectual and Developmental Disabilities
CMHSP: Community Mental Health Service Program
EMR: Electronic Medical Record
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan

SIS: Supports Intensity Scale
UM: Utilization Management

Related Materials:
SIS Procedure
Attachment A: Reporting and billing of valid SIS Claims

References/Legal Authority:
PIHP-MDHHS Contract FY20
Supports Intensity Scale Implementation Manual, July 2020

Change Log:

Date of Change	Description of Change	Responsible Party
06.2015	New Policy	Waiver Director, Chief Compliance Officer
04.2016	Annual Review/Update	UM & Waiver Director
02.2017	Annual review	UM & Waiver Director
01.2018	Annual review	UM & Waiver Director
02.2019	Annual Review	Chief Behavioral Health Officer
08.2020	Annual Review	Chief Behavioral Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**Supports Intensity Scale Quality Lead Policy**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Behavioral Health Officer	**Adopted Date:** 07.05.2016 **Review Date:** 11.10.2020 **Revision Eff. Date:**	**Related Policies:** Support Intensity Scale Policy

Purpose

Mid-State Health Network (MSHN) shall ensure that all Supports Intensity Scale (SIS) assessors meet quality and reliability standards and allow the completion of assessments within each three-year timeframe through development of a SIS Quality Lead.

Policy

MSHN shall comply with the Michigan Department of Health and Human Services (MDHHS) section 7.7.3 Supports Intensity Scale of the PIHP Contract and the MDHHS SIS Implementation Manual by identifying, developing, and utilizing a SIS Quality Lead.

PIHP SIS Quality Lead is a SIS assessor and ensures that all SIS assessors in the MSHN region continue to meet AAIDD quality and reliability standards and allow the completion of assessments within the three-year timeframe. The PIHP SIS Quality Lead is intended to be a liaison to the SIS assessors within the MSHN region as the individual responsible for the development and maturation of the region's SIS assessor skillsets. The SIS Quality Lead shall develop and maintain the appropriate skillset and meet the following criteria:

1. Passed (at the Qualified: Excellent-Excellent or higher level) an Interviewer Reliability and Qualification Review (IRQR) conducted by an American Association on Intellectual and Developmental Disabilities (AAIDD) recognized trainer;
2. Have experience conducting assessments for a range of individuals with varying needs and circumstances;
3. Participated in regular Quality Assurance and Drift Reviews to develop his or her skills.
4. Possess the ability to transform from a skills focus while conducting assessments to a needs and supports orientation;
5. Effective communication skills;
6. Public speaking skills;
7. Ability to relate well to groups;
8. Ability to work well with people with various backgrounds;
9. Effective audience management skills;
10. Flexibility with work schedule, including commitment to completing work within designated timeframes;
11. Willingness and eagerness to participate as an internal lead;
12. Analytical skills to address difficult questions or problematic participants;
13. Ability to effectively use audio-visual equipment;
14. Effective time management skills;
15. Flexibility to modify presentation based on audience;
16. Strong organizational skills;
17. Practical knowledge of adult learning strategies;
18. Ability to deal with ambiguity (the rules will not always be clear or multiple changes may need to occur);
19. As ambassadors of the SIS implementation strategy, the person selected should present a positive view of the process and have a solid understanding of the SIS process and the tool;
20. Always seek to improve effectiveness and achieve greater efficiencies in the implementation strategy; and
21. Demonstrate a sense of humor as the ability to promote humor in a SIS training session is essential.

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

Definitions:
AAIDD: American Association on Intellectual and Developmental Disabilities
CMHSP: Community Mental Health Service Program
IRQR: Interviewer Reliability and Qualification Review
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health and Human Services
PDR: Periodic Drift Review
PIHP: Prepaid Inpatient Health Plan
QL: Quality Lead
SIS: Supports Intensity Scale
UM: Utilization Management

Other Related Materials:
N/A

References/Legal Authority:
PIHP-MDHHS Contract FY15
MDHHS SIS Implementation Manual

Change Log:

Date of Change	Description of Change	Responsible Party
04.2016	New Policy	UM & Waiver Director
02.2017	Annual review	UM & Waiver Director
01.2018	Annual review/No changes	UM & Waiver Director
02.2019	Annual Review	Chief Behavioral Health Officer
08.2020	Annual Review	Chief Behavioral Health Officer

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POLICIES AND PROCEDURE MANUAL

Chapter	**Service Delivery System**		
Title:	**Substance Use Disorder (SUD) Services: Telemedicine**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Chief Behavioral Health Officer & Chief Clinical Officer	**Adopted Date:** 07.09.2019 **Review Date:** 11.10.2020	**Related Policies:**

Purpose

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

Policy

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

The following standards must be met:

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

J. The treating professional shall follow all professional licensing and ethical standards delineated by the state of Michigan related to his or her area of practice (i.e. counseling, psychology, social work, etc.) in addition to his or her governing accrediting body (i.e. APA, CRCC, NBCC, NASW, etc.).

Applies to

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

Definitions

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

Other Related Materials

N/A

References/Legal Authority

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

Change Log:

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

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery**		
Title:	**Trauma-Informed Systems of Care**		
Policy: ☒ **Procedure:** ☐ **Page: 1 of 2**	Review Cycle: Biennial **Authors:** Chief Clinical Officer, Chief Behavioral Health Officer	**Adopted Date: 07.07.2020** **Review Date:** 11.10.2020	**Related Policies**:

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

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

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

Applies to:

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

Definitions:

Adverse Childhood Experiences (ACEs): Stressful or traumatic events that children might experience including abuse, neglect, witnessing domestic violence, incarceration of a parent, or a family member with serious mental illness and/or a substance use disorder. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance abuse.

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

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

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

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

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

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

Other Related Materials:
N/A

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

Change Log:

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