Mid-State Health Network

Board of Directors Meeting ~ January 12, 2021 ~ 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) 1. 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 254 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 is intended to permit two-way communication for all meeting participants. 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 20-21-012: Motion to Approve the Agenda of the January 12, 2021 Meeting of the MSHN Board of Directors
4. Public Comment *(3 minutes per speaker)*
5. Board Self Evaluation: *15-minute allowance for board members to complete the board self-evaluation available at this link.*
6. **ACTION ITEM:** Direct Care Worker Premium Pay Extension *(Items 6.1-6.2, Pages 3-7)*

   MSHN 20-21-013: Motion to Approve the Extension of Direct Care Worker Premium Pay for the Second and Third Quarters of FY 2021
7. **ACTION ITEM:** Regional Crisis Residential Unit (CRU) Service Procurement *(Items 7.1-7.2, Pages 8-18)*

   MSHN 20-21-014: Motion to Approve Forward Movement for Development of a Crisis Residential Unit Within the MSHN Region
8. Chief Executive Officer's Report *(Item 8, Pages19-35)*
   - Block Grant Presentation
9. Deputy Director's Report *(Item 9, Pages 36-37)*
10. **ACTION ITEM:** Chief Financial Officer's Report *(Items 10.1-10.2, Pages 38-46)*

    MSHN 20-21-015: The MSHN Board of Directors Receives and Files the Preliminary Statement of Net Position and Statement of Activities for the Period Ended November 30, 2020, as Presented
11. **ACTION ITEM:** Contracts for Consideration/Approval *(Items 11.1-11.2, Pages 47-48)*

    MSHN 20-21-016: The MSHN Board Approves and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2021 Contracts, as Presented on the FY 2021 Contract Listing

MSHN
Mid-State Health Network

Our Mission:

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

Our Vision:

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

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Board of Directors Meeting Materials:

Click HERE
or visit MSHN's website at:
https://midstatehealthnetwork.org/stakeholders-resources/board-councils/board-of-directors/FY2021-meetings

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Upcoming FY21 Board Meetings

Board Meetings convene at 5:00pm unless otherwise noted

March 2, 2021
VIDEOCONFERENCE/ZOOM
Meeting Link and Logistics will be available one week prior to the meeting date.

May 4, 2021
*STRATEGIC PLANNING DAY
CMH for Central Michigan
301 S. Crapo Street, Mt. Pleasant
*Day-long Strategic Planning session followed by Regular Business Meeting at 5:00 p.m.

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Policies and Procedures

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

12. Executive Committee Report

- Appointment of Acting Secretary
- Appointment to Board Policy Committee
- Board Self Evaluation
- CEO Contract

13. Chairperson's Report

- SUD Oversight Policy Advisory Board Member Update

14. **Action Item:** Consent Agenda *(Items 14.1 to 14.6R, Pages 49-114)*
MSHN 20-21-017: Motion to Approve the Documents on the Consent Agenda, as Presented

14.1 Approval Board Meeting Minutes of November 10, 2020 Regular Business Meeting
14.2 Receive SUD Oversight Policy Advisory Board Minutes of August 19, 2020
14.3 Receive Board Policy Committee Meeting Minutes of December 1, 2020
14.4 Receive Board Executive Committee Minutes of December 18, 2020
14.5A/B Receive Operations Council Key Decisions of November 16, 2020 and December 14, 2020
14.6A/R Approve MSHN Policies, as Recommended by Board Policy Committee:

Item	Policy Chapter	Policy Title
14.6A	Provider Network Mgmt.	SUD Service Provider Procurement
14.6B	Quality	Administrative & Retained PIHP Functions Contract Monitoring and Oversight
14.6C	Quality	Behavior Treatment Plan Review Committees
14.6D	Quality	Consumer Satisfaction Surveys
14.6E	Quality	Critical Incidents
14.6F	Quality	Clinical Practice Guidelines and Evidence-Based Practices
14.6G	Quality	Incident Review for SUD Providers
14.6H	Quality	Medicaid Event Verification
14.6I	Quality	Monitoring and Oversight
14.6J	Quality	Performance Improvement
14.6K	Quality	Quality Management
14.6L	Quality	Research
14.6M	Quality	Sentinel Events
14.6N	Service Delivery System	Behavioral Health Recovery-Oriented System of Care (ROSC)
14.6O	Service Delivery System	Person/Family Centered Plan of Service
14.6P	Service Delivery System	SUD Services: Medication Assisted Treatment (MAT) Inclusion
14.6Q	Service Delivery System	SUD Services: Out-of-Region Coverage
14.6R	Service Delivery System	SUD Services: Women's Specialty Services

15. Other Business

16. Public Comment (3 minutes per speaker)

17. **Action Item:** Consideration of the Board's Employment Contract with the MSHN Chief Executive Officer

Mr. Sedlock will request closed session for the board to discuss this personnel matter.

18. Adjourn

Please direct questions and/or concerns pertaining to the MSHN's Board of Directors to Joseph Sedlock, Chief Executive Officer, at 517.657.3036

RECOMMENDATION FOR BOARD APPROVAL TO CONTINUE DIRECT CARE WORKER PREMIUM PAY INITIATIVE

Background

Mid-State Health Network and all Michigan Pre-Paid Inpatient Health Plans (PIHPs) are contractually required to maintain a comprehensive provider network. The COVID-19 pandemic has required countless adaptations by the region and its providers. In many cases, service utilization went down causing severely reduced revenues that threatened the provider's ability to continue operations. In other cases, utilization went up. In almost all cases, unforeseen additional expenses were incurred. The MSHN region committed in mid-April to covering these kinds of expenses. On May 27, MDHHS required a regional provider network stabilization plan, which was ultimately approved and is being implemented region-wide effective June 17.

Perhaps more than any other specific service, residentially based services have been the most challenging to maintain. In early April, MSHN developed regional guidance on Direct Care Worker (DCW) Premium Pay to be financed through existing CMHSP revenue/budgets. Shortly thereafter (5/12/20), MDHHS issued policy directives that required premium pay increases of $2/hour (plus 12% tax and fringes) to certain DCW's providing a specific set of services retroactive to April 1 and continuing through June 30. The legislature subsequently passed, and the Governor signed, legislation requiring the continuation of the premium pay through September 30. MSHN has received funding adjustments from MDHHS to cover the costs of the DCW Premium Pay requirements.

Even with the premium pay in place, turnover and staffing in residential settings in much of the region has been extremely problematic. The DCWs are caring for beneficiaries that are in the high-risk categories for contracting the virus, have been challenged with caring for individuals who have tested positive and risk taking the virus to their families, have unprecedented challenges to go to the residential site while their children remain at home, have not had sufficient supplies of PPE and so many more challenges. Some have left employment due to these health hazards; some have left employment due to higher unemployment compensation than their take-home pay; some have left employment due to short staffing and overwhelming demands on them at work. An additional challenge is recruiting, training and deploying new employees in the current pandemic circumstances.

At its' September meeting, the MSHN Board of Directors authorized Mid-State Health Network's continuation of the DCW Premium Pay initiative through 01/09/21. At the time of that approval, there were no state appropriations to continue the initiative, however, the Michigan legislature ultimately provided the funding necessary to continue the DCW Premium Pay through 12/31/20.

It is imperative that we be able to retain and, when necessary replace, direct care workers and keep the provider network financially stable. MSHN and our regional CMHSP Participants propose to continue the DCW Premium Pay initiative for another two quarters (six months – through July 9, 2021). MSHN may propose extension through 09/30/21 at the July 6 MSHN board meeting, but that recommendation, if any, will be developed for board consideration in June 2021).

- Attached to this motion summary is a fiscal analysis demonstrating that MSHN projected prior year savings is about $33.8M. This is the revenue available without affecting MSHN appropriations to CMHSP Participants and our SAPT provider system.
- Anticipated DCW Premium Pay expenditures for the proposed two quarters of continuation total about $12.3M.
    - NOTE that the Michigan legislature has appropriated funds to continue DCW premium pay through the months of January and February 2021 (revenue estimate is about $2.3M). This reduces the MSHN outlay from prior year savings, if approved, to ~$3.9M for the second quarter; or a total of ~$10M combined for the second and third quarters).
- For illustration purposes, we have shown provider stabilization payments of about $4.4M per quarter (~$8.8M over two quarters). Note, however, that provider stabilization payments are made by

CMHSPs and MSHN out of existing revenue (not savings) and are typically offset by lower provider billings.

- MSHN has sufficient prior year savings to pay for both the DCW Premium Pay extension and provider stabilization (if the stabilization payments being made out of savings were to become necessary).

Revised January 4, 2021

Recommended Motion:

Motion to authorize Mid-State Health Network's continuation of the DCW Premium Pay initiative for the second and third quarters of fiscal year 2021 (through July 9, 2021).

FISCAL YEAR (FY) 2021 DIRECT CARE WORKER (DCW) PREMIUM PAY ANALYSIS		
FY 20 DATA - 4.1.20 - 9.30.20 (Source Interim Financial Status Report (FSR))		
MDHHSDCW Revenue	A	19,762,087
Regional DCW Expense	B	12,309,457
Excess lapse to MDHHS	C (A - B)	7,452,630
FY 20 Savings (Medicaid/HMP) - Interim FSR	D	33,802,006

		DCW					
FY 21 Estimates		Qtr 1		Qtr 2*	Qtr 3	Qtr 4	
MDHHS Revenue	E	10,000,000		2,300,000			Anticipate No Additional MDHHS Revenue
MSHN Prior Year Savings				3,854,729	6,154,729	6,154,729	FY 20 Savings Use H
Anticipated Expense	F (B/2)	6,154,729		6,154,729	6,154,729	6,154,729	Anticipated Expense I (B/2)
Lapse to MDHHS	G (E - F)	3,845,272		-	-	-	Difference J (H- I)
Total FY 21 DCW Expense	K (B*2)	24,618,914					

Qtr 2* - Revenenue covers Jan-Feb 2021

FISCAL YEAR (FY) 2021 PROVIDER STABILIZATION ANALYSIS

Provider Stabilization 4.1.20 - 9.30.20 (Source Prov Stab Report submitted Oct 2020)		
CMHSP	A	7,403,412
SUD	B	1,353,332
Total	C (A + B)	8,756,744
FY 20 Savings (Medicaid/HMP) - Interim FSR	D	33,802,006

PROVIDER STABILIZATION ONLY

		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Quarterly Provider Stab from FY 20 Savings	E (C/2)	4,378,372	4,378,372	4,378,372	4,378,372
Total Provider Stabilization	F (C*2)	17,513,488			

FISCAL YEAR (FY) 2021 DIRECT CARE WORKER (DCW) PREMIUM PAY AND PROVIDER STABILIZATION SUMMARY

DCW/PROVIDER STABILIZATION IMPACT TO SAVINGS - SUMMARY	
FY 20 Savings	33,802,006
DCW Q1	0
DCW Q2	3,854,729
DCW Q3	6,154,729
DCW Q4	6,154,729
Provider Stabilization Q1	4,378,372
Provider Stabilization Q2	4,378,372
Provider Stabilization Q3	4,378,372
Provider Stabilization Q4	4,378,372
Total Funding Need	33,677,674
FY 20 Remaining Savings*	**124,333**

FY 20 Remaining Savings* - MSHN estimates a portion of Provider Stabilization Funds can be covered with current year revenue based on the FY 21 Budget

Background:

Crisis Residential Units (CRU) are a Medicaid-reimbursable service providing treatment to individuals as a diversion or as a stepdown from psychiatric hospitalization for adults experiencing a behavioral health crisis. CRUs provide comparable treatment to psychiatric hospitals. Mid-State Health Network (MSHN) identified a trend in the lack of inpatient psychiatric bed availability. Over a 17-month period from 2016 to 2017:

- There were over 31,000 psychiatric inpatient denials of 1,676 unique individuals reported in the MSHN region.
- This was an average of 19 denials per individual.

The development of a CRU offers a safe alternative to psychiatric hospitalization and an opportunity to alleviate the denial issue

High-cost behavioral health services like emergency room visits ($525 per visit) and psychiatric hospitalization ($6,400 per 8.7-day average length of stay) are of concern to Community Mental Health (CMH) providers and utilizing less costly and less restrictive alternatives is often appropriate clinically and fiscally. In 2018:

- MSHN CMHs spent $26.3 million on inpatient psychiatric hospitalization for adults and
- Comparatively MSHN spent $3.6 million on crisis residential services.
- Of the 5,235 referrals to emergency psychiatric beds, only 1,121 (21%) were referred to crisis residential services.
- An annual savings of approximately $1.9 million could be realized if total CRU referrals rose to 33%.

MSHN CMHs that have a CRU in their catchment area show a greater utilization of the CRU service relative to psychiatric beds. In 2018 in the MSHN region:

- CRU utilization ranged from 15%-29% where a CRU was present, compared to those MSHN CMHs where there was no CRU.
- CMHs where there was no CRU had a utilization range of 0%-14%.
- Five MSHN CMHs would benefit from proximal CRU service.
- When a CRU is unavailable, the CMH has no alternative to offer except the higher-cost inpatient psychiatric service.
- Northern Lakes Community Mental Health (NLCMH), a CMH partner of Northern Michigan Regional Entity (NMRE) Pre-Paid Inpatient Health Plan (PIHP), has expressed interest in a possible partnership to utilize bedspace in a CRU facility with MSHN. Their utilization of the CRU service has ranged from 25%-37% over the last 5 years.

CMH for Central Michigan had originally started work with TBD Solutions on assessing the feasibility of bringing a CRU into their catchment area. As this work progressed, it was apparent that there were broader implications and needs for the beneficiaries of the MSHN region. CMH for Central Michigan recommended remanding responsibility of the project to MSHN for a broadened regional focus and analysis, with supported being received from all MSHN CMHs. In 2019, Mid-State Health Network contracted with TBD Solutions to further assess the feasibility of assisting in the development of a CRU facility.

MSHN analyzed the number of referrals needed, comparison of CMH inpatient utilization to crisis residential utilization (i.e., clinical eligibility drivers), external partner participation (i.e., Northern Lakes), and the ability to realize regional annual savings from less restrictive/costly care. With historical crisis residential utilization and a projected utilization range of 282 to 310 referrals (6.7-day average length of

stay) annually, there would be a projected savings of $830,000 to $990,000, at 85% to 100% occupancy, respectively.

The attached CRU Development Brief and Analysis was presented to the Operations Council in December with full support to move forward with a request for proposal, selection of a vendor and implementation of a MSHN contract for regional service delivery.

Recommended Motion:

The MSHN Board of Directors approves MSHN to move forward with issuing a Request for Participation (RFP) to pursue a contract for the development of a Crisis Residential Unit within the MSHN region.

Note: Once a vendor is selected, the contract will be presented to the Board for approval.

Mid-State Health Network Crisis Services

Crisis Residential Expansion

The content in this document was created to summarize the existing regional need and to provide a clinical and cost-effective alternative option to inpatient hospitalization and to address the Quintuple Aim. This updated crisis residential development brief was reviewed at the November 19, 2020 Clinical Leadership Committee-Utilization Management Committee combined meeting and subsequent recommendations are provided.

Background

The CRU project began out of a Community Mental Health for Central Michigan (CMHCM) analysis of 404 Data, comparing the utilization of inpatient hospitalizations to crisis residential utilization and found inpatient costs to be roughly twice as high as the state average and crisis residential costs below the state average. CMHCM sought to promote the effective utilization of crisis intervention services and completed a utilization assessment, crisis residential feasibility assessment, gap analysis of crisis services and care coordination, and facilitation of crisis services meetings to address cost-efficient access to crisis services.

TBD Solutions facilitated the CRU project and Bay-Arenac, Gratiot, Montcalm, Newaygo, and Shiawassee, as well as an external CMH, Northern Lakes, were included in discussions based on locale and feasibility. The work with the potential vendor reached an impasse when they asserted a need to have a minimum occupancy percentage to provide a rate reasonable enough for CRU services. CMHCM and MSHN discussed the possibility of the CRU project becoming regional and prompted MSHN to continue moving the CRU project forward to further explore opportunities.

MSHN began the process by establishing a contract with TBD Solutions and reinitiated the work plan, established a project timeline, and completed a revised feasibility study summary. The North Michigan Regional Entity Medical Director, Dr. Curtis Cummins was also contacted to ensure that Northern Lakes CMH was still interested. Dr. Cummins reiterated interest on the part of Northern Lakes CMH and likely other parts of NMRE.

The COVID-19 pandemic delayed the pace of the CRU project progress, but MSHN and TBD met with the original vendor regarding the likelihood continued interest to move forward with CRU development. The vendor provided a revised list of daily rates based on percent of facility occupancy. The daily rate ranged from $768.00 to $577.00, based on 75% to 100% occupancy, respectively. The revised and notably increased rates were more aligned with the cost of a hospital bed day, which was not the intent of the project to ensure there was an option for acute-level services as a clinical and cost-effective *alternative* to inpatient hospitalization. This pricing was no longer adequate to move forward with the vendor's plan.

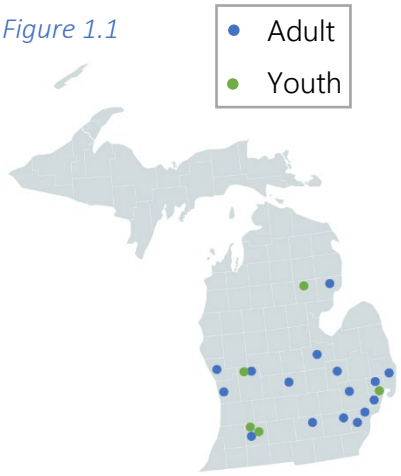
Summary of Project and Conclusion

As a result, MSHN revised the CRU development plan to first address specific questions regarding calculated "likelihoods." The likelihoods examined included number of referrals needed, comparison of CMHSP inpatient utilization to crisis residential utilization (i.e., clinical eligibility drivers), external partner participation (i.e., Northern Lakes), and the expectations necessary to realize a minimum annual savings of $500,000. Based on historical crisis residential utilization and a projected utilization range of 282 to 310 referrals (6.7-day average length of stay) annually, as identified in previous crisis residential development efforts in the MSHN region, there would be a projected savings of $830,000 to $990,000, at 85% to 100% occupancy, respectively. CLC was provided with this progress report and asked to recommend next steps. Please see the subsequent TBD analysis that helped inform the decision-making process and recommendations.

TBD Solutions Analysis

What are Crisis Residential Units?

Figure 1.1

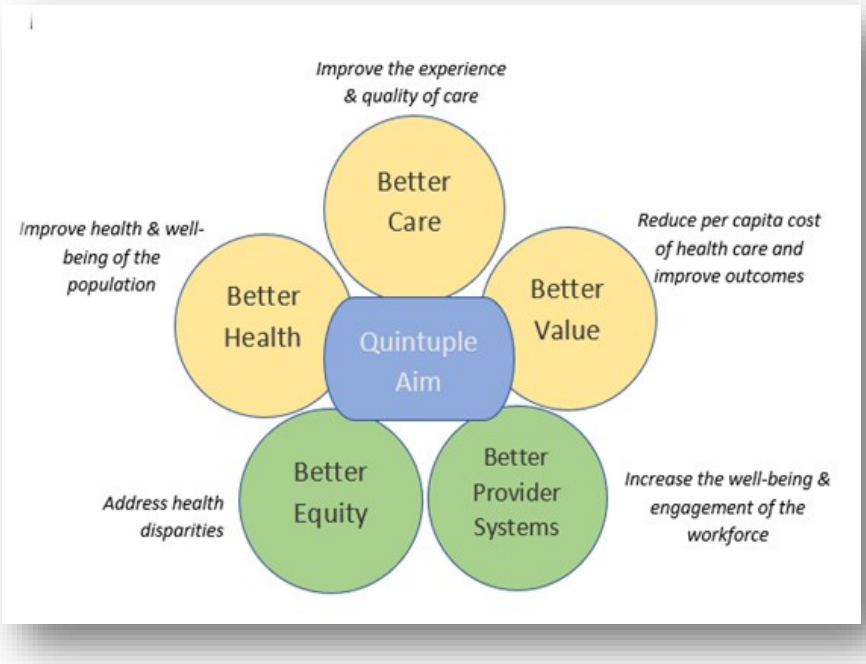


According to the Michigan Medicaid Provider Manual, Crisis Residential Units (CRUs) are "intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis."[1] These services can be used as a diversion from an inpatient psychiatric admission or a stepdown from inpatient hospitalization to shorten the length of the inpatient stay. The Crisis Residential Model is designed to serve either adults or youth.

Crisis Residential Services in Michigan

Michigan has 22 CRUs (15 adult and 5 youth), with 148 total beds. Adult CRUs range in size from 6 to 16 beds, and youth CRUs range in size from 4 to 6 beds.[2] All CRUs are in the Lower Peninsula.

Figure 1.2



Why CRUs Matter

CRUs have a 40-year research history of achieving Triple Aim goals of Better Outcomes, Better Client Satisfaction, and Lower Cost compared to inpatient psychiatric hospitalization. Practically, this means when individuals in crisis have timely access to the mental

[1] Medicaid Provider Manual. Michigan Department of Health and Human Services, p.47. October 1, 2020. http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

[2] A 6-bed youth CRU will be opening in Ingham County in Fall 2020.

health services and support, they are less likely to use more costly services like Emergency Departments or psychiatric hospitals.

CRUs also have the potential to actualize goals of better equity and better provider systems that make up MSHN's Quintuple Aim (see Figure 1.2). When individuals in crisis have better access to an array of crisis services, they are not forced into the most restrictive levels of care, keeping people closer to their support system, and not enforcing involuntary holds. When run properly, CRUs create a space for passionate mental health professionals to support persons in crisis, with opportunities for career advancement from direct support professional to clinician or supervisor.

Figure 1.3

MSHN Crisis Residential: At-A-Glance[3]	
# of adult CRU beds	30
CRU Average Cost/Day	**Region: $480** State: $405
Inpatient Average Cost/Day	**Region: $738** State: $740
CRU Average Length of Stay (in days)	Region: 6.7 State: 9.4
MSHN CRU Total Spent	**$3,627,572**
MSHN Inpatient Total Spent	$26,271,340

CRU: Return on Investment

In FY2018, CMHSPs in the MSHN region spent **$26.3 million on inpatient psychiatric hospitalization** for Mentally Ill Adults (MIA) and **$3.6 million on crisis residential services**. **Of the 5,235 referrals to emergency psychiatric beds, only 1,121 (21%) were referred to crisis residential services. If the same number of total referrals remained the same, but 33% of potential psychiatric hospital referrals were diverted to crisis residential, this would result in a savings of approximately $1.9 million annually**.

In addition, offering **an expedited referral source for individuals presenting to the Emergency Department in a psychiatric crisis can save money and resources while minimizing the amount of time a person has to spend waiting in the ED. Reducing ED boarding by diverting 175 ED and psychiatric hospital-bound individuals per year would save an estimated $525,000**.

Regional Crisis Residential Utilization

MSHN CMHSPs tend to use crisis residential services at a much lower rate than CMHSPs in- and outside the MSHN region that have a crisis residential unit. Figure 1.4 includes the prospective CMHSPs that would utilize a new CRU in the MSHN region, and their historical crisis residential utilization compared to overall emergency bed utilization (crisis residential + psychiatric hospitalization). **In 2018, Northern Lakes CMH closed its crisis residential unit which it had utilized**

[3] All data from FY2018 MDHHS 404 Report

frequently to divert people from psychiatric hospitalization. Considerable utilization of CRU services by Northern Lakes CMH is expected if the new CRU is in proximity.

Figure 1.4

CRU Utilization as a Percentage of Emergency BH Bed Utilization (in Days)						
FY	**Bay-Arenac**	**CMHCM**	**Montcalm**	**Northern Lakes**	**Newaygo**	**Shiawassee**
2014	7%	5%	0%	37%	9%	0%
2015	5%	7%	1%	25%	10%	0%
2016	4%	7%	2%	34%	17%	N/A
2017	4%	12%	2%	33%	12%	1%
2018	3%	12%	0%	25%	14%	0%

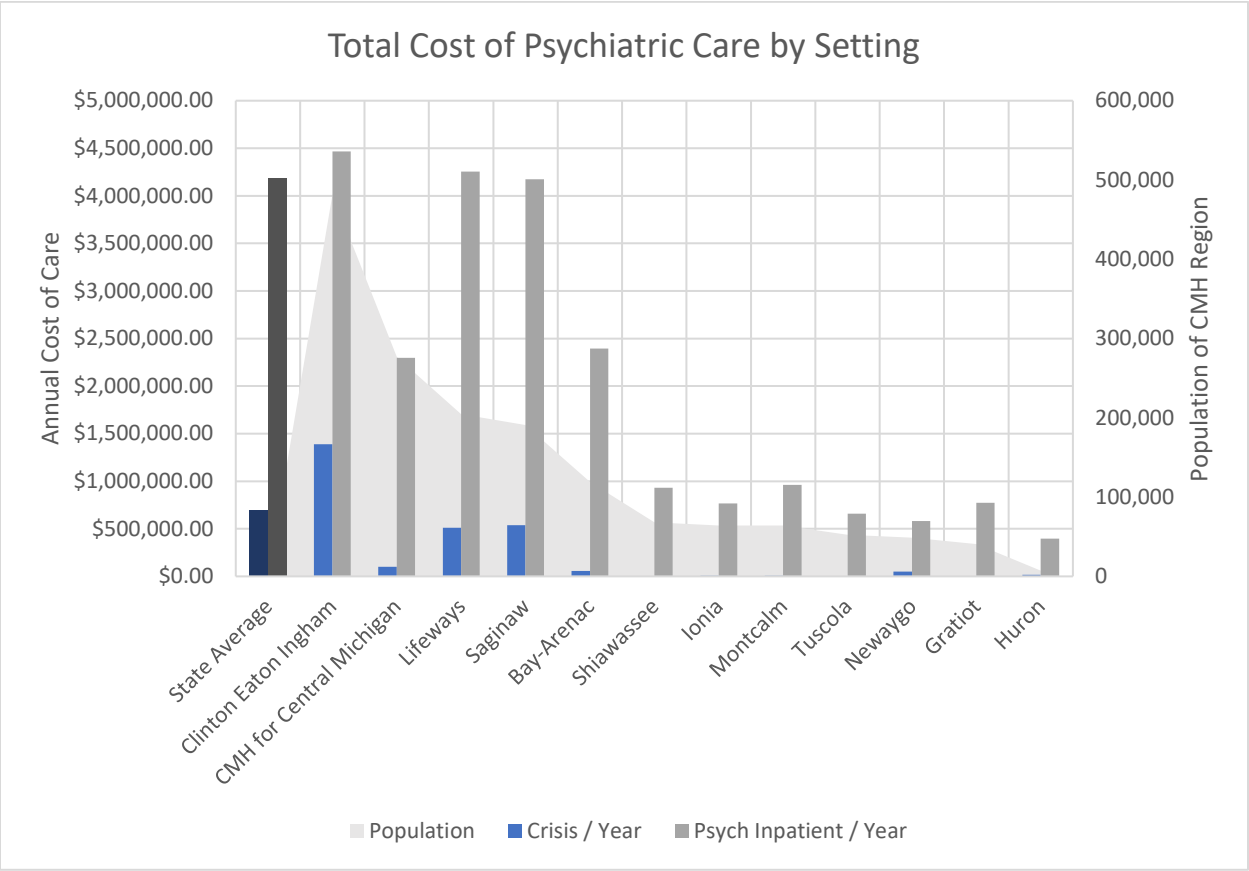
Figure 1.5 shows the CRU utilization as a percentage of emergency behavioral health bed utilization for CMHSPs who operated crisis residential programs through 2018. Utilization has been as high as 42-47% indicating that **newly developed and well-operated CRUs can achieve significant reductions in psychiatric hospital utilization**.

Figure 1.5

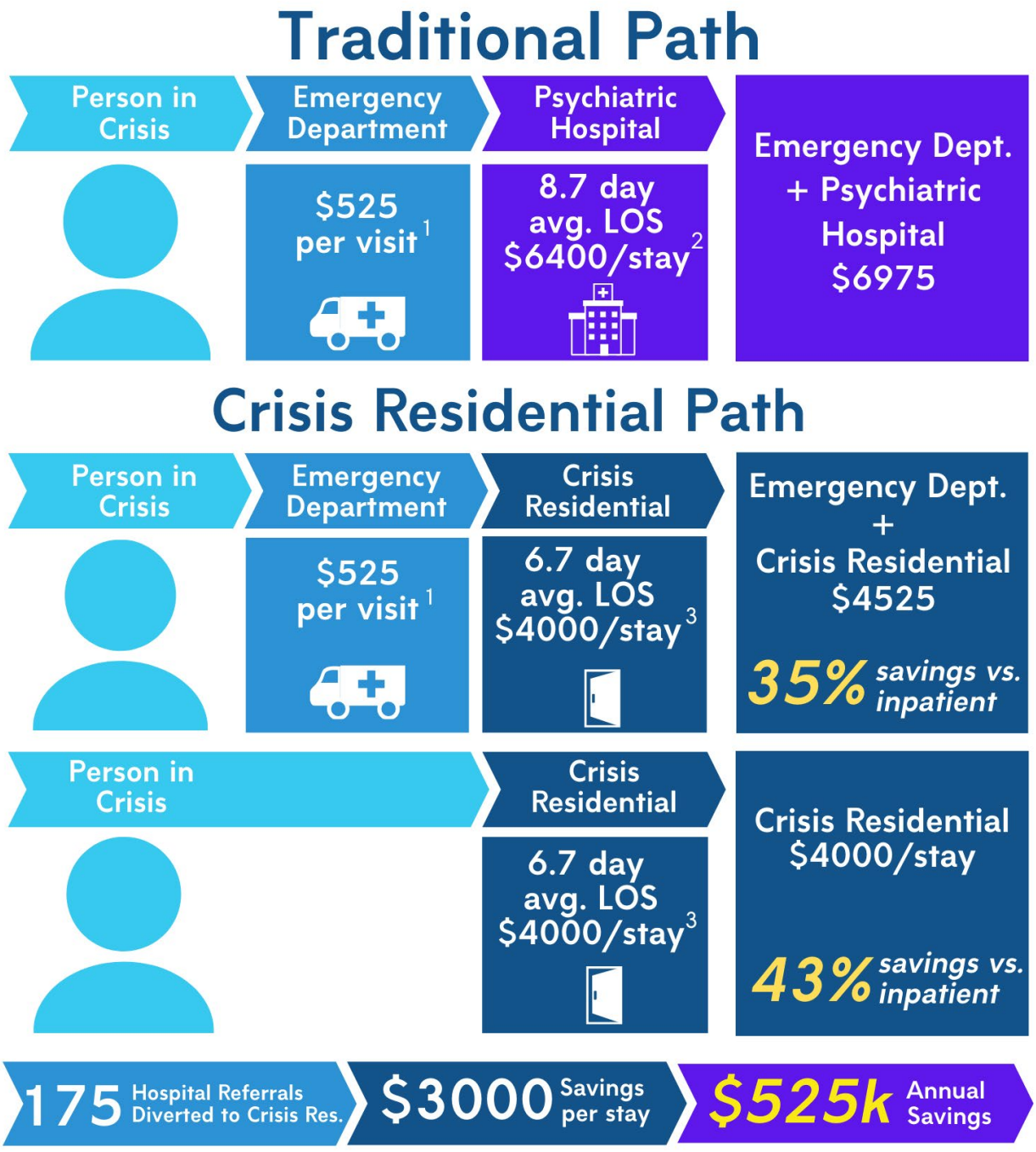
CRU Utilization as a Percentage of Emergency BH Bed Utilization (in Days)														
	AuSable Valley	**CEI**	**DWIHN**	**Genesee**	**Hiawatha**	**ISK**	**LifeWays**	**Macomb**	**network180**	**Northern Lakes**	**OCHN**	**Ottawa**	**Saginaw**	**Washtenaw**
2014	10%	N/A	2%	13%	0%	35%	17%	8%	17%	37%	0%	35%	47%	31%
2015	9%	39%	3%	13%	3%	23%	16%	9%	16%	25%	14%	38%	27%	29%
2016	22%	46%	3%	13%	12%	30%	20%	14%	19%	34%	11%	32%	25%	24%
2017	21%	42%	3%	13%	0%	28%	10%	13%	19%	33%	18%	29%	23%	21%
2018	15%	29%	6%	13%	0%	18%	15%	14%	19%	25%	35%	30%	16%	24%

Figure 1.6 compares each MSHN CMHSP region's population (shaded area), psychiatric hospital costs, and crisis residential costs.

Figure 1.6


Total Cost of Psychiatric Care by Setting
Annual Cost of Care
$5,000,000.00
$4,500,000.00
$4,000,000.00
$3,500,000.00
$3,000,000.00
$2,500,000.00
$2,000,000.00
$1,500,000.00
$1,000,000.00
$500,000.00
$0.00
Population of CMH Region
600,000
500,000
400,000
300,000
200,000
100,000
0
State Average
Clinton Eaton Ingham
CMH for Central Michigan
Lifeways
Saginaw
Bay-Arenac
Shiawassee
Ionia
Montcalm
Tuscola
Newaygo
Gratiot
Huron
Population
Crisis / Year
Psych Inpatient / Year

CRU Cost Savings

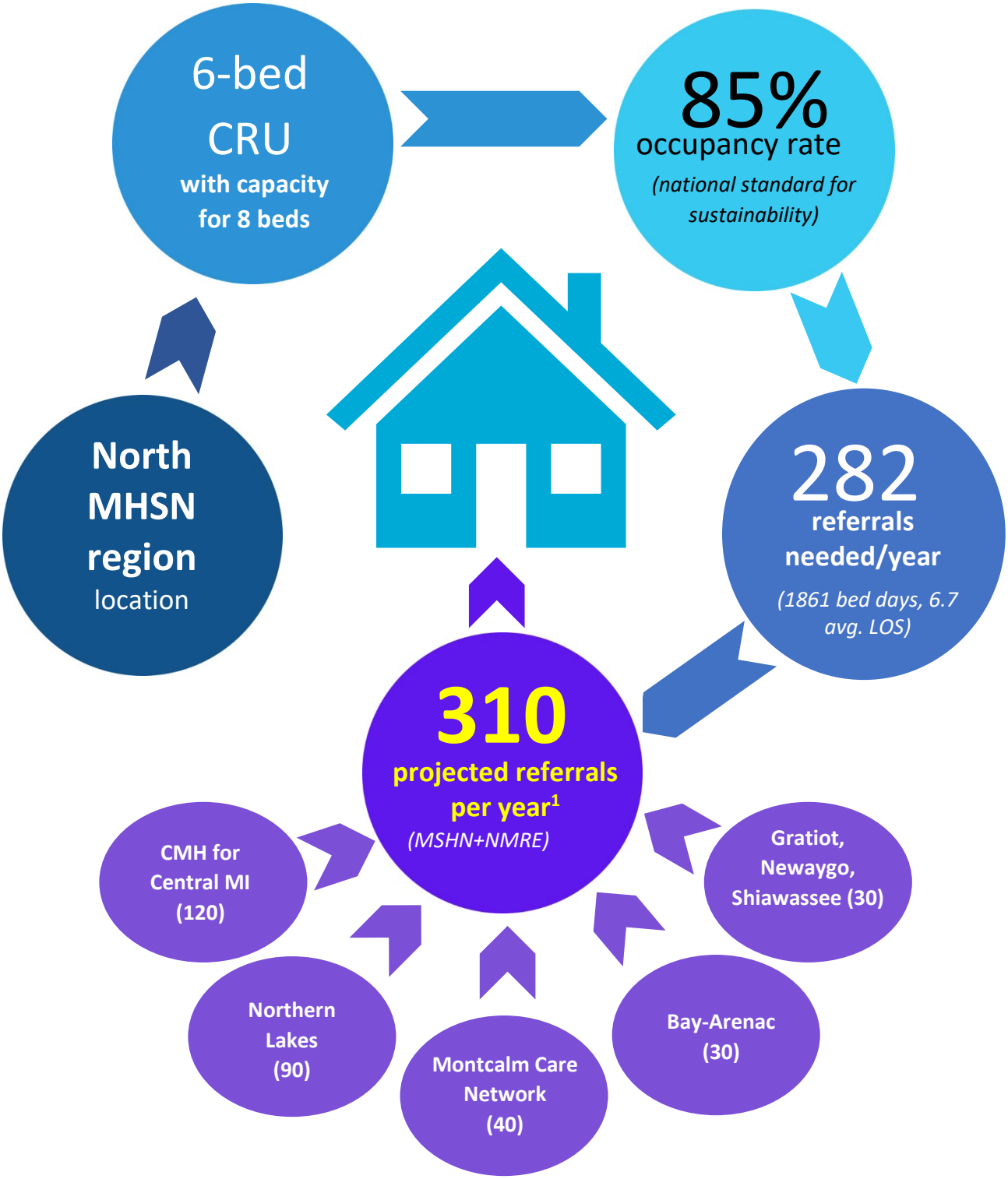


[1] Based on AHRQ's Healthcare Cost and Utilization Project report from 2017. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb257-ED-Costs-Mental-Substance-Use-Disorders-2017.pdf

[2] Based on calculations of inpatient psychiatric hospitalization utilization data for Mentally Ill Adults (MIA) in MSHN region from the MDHHS 904 Report for FY2018.

[3] Based on calculations of crisis residential utilization data for Mentally Ill Adults (MIA) in MSHN region from the MDHHS 904 Report for FY2018.

MSHN CRU Utilization



[1] Based on historical crisis residential utilization and projected utilization identified in previous crisis residential development efforts in region.

Recommendation and Outcome

1) Operations Council received this report and no CMHSP indicated interest in taking on the CRU project.
2) Operations Council (all CMHs) supported MSHN issuing an RFP on behalf of the region.

REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
November/December 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:**

- MSHNs suite of three offices within the Michigan Optometric Association building have been closed since March 16, 2020. One employee, Merre Ashley, is assigned to work in the MSHN offices to process mail, fax and packages, incoming phone calls, support MSHN staff with work that requires processing in office, and other tasks.
- 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.
- 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). 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. As noted above, one employee (Merre Ashley) has been deployed for office-based work. We remain in regular communication directly with MSHN staff and through leadership team members.

2. **MSHN Regional Operations Status:**

- CMHSPs: All CMHSPs in the region remain functional and capable of delivering all essential services and supports to beneficiaries, families, and communities. CMHSPs in the region are at various tiers and in various stages of office-based services 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:**

The status and continuation of the Direct Care Worker Premium Pay is a separate action item for the January 2021 MSHN board meeting, and we have provided information under that agenda item. Please note the related Op-Ed from Colleen Allen and Mark McWilliams attached to this report.

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. MDHHS is requiring that the PIHP Provider Network Stabilization Plans be continued through all of FY21 (through 09/30/21). The regional plan is located on the MSHN Coronavirus Page at this link.

- Through November 30, 2020 for FY 20, the MSHN region has provided $7,625,765 in provider stabilization assistance to 82 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 ($3.114M), community living supports providers ($1.060M), applied behavior analysis services providers ($1.026M), and skill building service providers ($631,079). 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 November 30, 2020 for FY 20, the MSHN region has provided an additional $1,664,942 in provider stabilization assistance to 29 substance abuse treatment and recovery providers. Residential treatment providers, including residential withdrawal management services providers, were supported with $589,706 in stabilization payments and outpatient services providers were assisted with $1.075M in stabilization support. All requests for stabilization assistance have been approved.

5. **Substance Abuse Prevention and Treatment Block Grant (SABG):**

This topic is a separate agenda item and MSHN will do a brief presentation on the causes and regional consequences of the required reduction in SABG funding that amounts to about $5.2M overall ($4.6M reduction against MSHN FY 21 SABG funding commitments).

At the request of PIHPs, MDHHS (Senior Deputy Director Allen Jansen) has issued a written statement of the cause of the SABG reduction: "*The reduction in federal Substance Abuse Block Grant (SABG) dollars to be received by Michigan's PIHPs in fiscal year (FY) 2021, from the FY 2020 funding level, is due to the fact that the Block Grant funds distributed to the PIHPs over the past several years included unspent dollars from prior*

years. Due to a number of causes – chief among them being increases in demand for Substance Use Disorder (SUD) services by persons with (sic – should be "without") Medicaid or other insurance coverage – these unspent dollars, from prior years, are not available to be included in the Community Grant dollars which include federal Block Grant and matching state General Fund dollars allocated to the State's PIHPs in FY 2021."

The memo goes on to indicate that "*In an effort to minimize the impact of the reduction in FY 2021 SABG funding to the State's PIHPs, Michigan Department of Health and Human Services (MDHHS) has increased the level of federal discretionary grant funding, such as the State Opioid Response (SOR and SOR 2) Grants, allocated to the PIHPs. As such, most PIHPs will receive a net increase in overall funding to provide SUD prevention and treatment services from federal resources. While some of the programs and costs currently supported by SABG dollars will be adversely affected, many of the programs can be now supported with SOR or SOR 2 dollars, provided the services conducted by the programs are consistent with the requirements of the SOR 2 Grant as specified in the Funding Opportunity Announcement.*"

These statements suggest that from the point of view of the state, increased resources are being provided to PIHPs to meet the demand identified in the first paragraph. MSHN acknowledges an increase in SOR and SOR II funding, but (1) the net impact is still a $2.4M reduction, not a net increase as referenced above, and (2) the increased funding under SOR is NOT – NOT – a replacement for block grant nor can it be used as a 1:1 offset to the required block grant reductions. This is a very important point. For example, the SOR grants come with their own eligibility requirements (must be directed to services for prevention and treatment of opioid and stimulant disorders only), extra administrative and reporting requirements, and a whole host of other differences. As will be noted in the presentation at this board meeting, MSHN has identified and moved eligible expenses to the SORT grants, but much remains affected by the SABG reduction.

Statewide, the SABG reductions by PIHP region are as follows:

	Current SABG amount	New SABG Amount	Block Grant Reduction	Block Grant Reduction Percent
Region 1	($3,078,265)	$1,905,910	($1,172,355)	38%
Region 2	($3,714,159)	$3,009,930	($704,229)	19%
Region 3	($8,230,968)	$6,221,409	($2,009,559)	24%
Region 4	($6,261,137)	$4,818,139	($1,442,998)	23%
Region 5	($14,452,316)	$9,168,219	($5,284,097)	37%
Region 6	($4,281,086)	$3,389,213	($891,873)	21%
Region 7	($19,411,024)	$12,718,476	($6,692,548)	34%
Region 8	($5,837,830)	$4,722,555	($1,115,275)	19%
Region 9	($5,174,463)	$3,761,232	($1,413,231)	27%
Region 10	($7,628,629)	$4,161,101	($3,467,528)	45%
Total	($78,069,877)	$53,876,184	($24,193,693)	31%

UPDATE (12/28/20): The federal consolidated appropriations act signed into law on 12/27/20 includes $1.65 Billion dollars for the Substance Abuse Prevention and Treatment Block Grant. Obviously, we'll have to wait to see what comes to Michigan, and how Michigan intends to use these funds. (It is not yet known what, if any "federal strings" may be attached).

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

6. **Open Meeting Act Statue – Virtual Meetings Extended**:

The Michigan Legislature has passed, and Governor Whitmer has signed, what is not PA 254 of 2020 which extends authorization for virtual meetings of public bodies for any reason through March 30, 2021. On and after March 31 through 12/31/21, virtual meetings are only allowed under specific circumstances. "Word" has it that the legislature will evaluate extension on a quarterly basis and will adjust as the pandemic response is assessed. The January meeting of the MSHN board is authorized under the Act as a videoconference only. MSHN will, of course, keep the board posted on any additional actions that affect in-person/virtual board meetings.

7. **COVID Dashboard:**

The Behavioral Health and Developmental Disabilities Administration (BHDDA) has released a COVID-19 dashboard organized by PIHP region and CMHSP catchment areas. The dashboard can be viewed at this link. Note that MSHN had developed a risk tracking tool prior to the dashboard created by BHDDA. The MSHN regional dashboard can be viewed at this link.

8. **Michigan Legislative Actions (COVID-Related):**

The Community Mental Health Association of Michigan (CMHAM) has released the following information specific to COVID-19 related appropriations/actions:

- Supplemental Appropriations (SB 748) [S-1]:
  - Testing of vulnerable populations in long-term care and other settings/rapid response teams ($22.5 million)
  - Purchasing of supplies and equipment to support COVID-19 testing and vaccination efforts ($15 million)
  - COVID-19 vaccine distribution efforts ($48.7 million)
  - Grants to hospitals and health systems to support temporary hospital staff ($10 million)
  - An extension of the existing wage increases for Direct Care Workers until February 28, 2021 ($26.7 million GF/$73.3 million Federal)
- SB 1185 creates the Pandemic Response Health Care Immunity Act which would provide protection from liability for health care provider and health care facilities that provided services under circumstances related to the pandemic, with some exceptions. The legislation repeals and replaces an immunity bill that passed earlier in the year and now applies to services provided from October 30-2020 through February 13, 2021. In addition, the newly created act would apply to psychiatric hospitals, psychiatric units, and nursing home care and recovery centers.
  Status: The measure will head to the Governor's desk for signature.
- SB 1253 amends the Public Health Code to limit the duration of epidemic orders to 28 days unless the legislature approves of an extension.
  Status: The measure will head to the Governor's desk for signature.

- SB 879 and 920 amends the Insurance Code and Public Health Code to provide for the temporary relaxation of regulations regarding pharmacists and prescriptions until March 31, 2021. Specifically, the bill package would, among other things, allow for emergency refills of up to a 60-day supply for covered

maintenance prescription drugs, and provides coverage for an early refill of any 30-day or 60-day covered maintenance prescription drug up to a 90-day supply.

Status: These measures head to the Governor's desk for signature.

- Senate Bill 857 repeals the 1945 Emergency Powers of the Governor Act or "Riot Act," which the Governor used as authority to issue executive orders during the early months of the pandemic. On October 2, the Supreme Court ruled that the Governor's use of the Act was unconstitutional.

  Status: The bill heads to the Governor's desk. She is expected to veto.

9. Syringe Services Programs – MDHHS Public Statement:

Signed by Dr. Joneigh Khaldun (Chief Medical Executive), Allen Jansen (Senior Deputy Director, BHDDA) and Larry Scott, Director, OROSC) and issued December 10, 2020:

This letter is to strongly state the support of the Michigan Department of Health and Human Services (MDHHS) for Syringe Services Programs (SSP) expansion in Michigan. SSPs provide vital health services to people who use substances to help them stay safe and meet people where they are without judgment. Reversing the opioid crisis in Michigan requires helping people stay safe and alive, even if they are not ready for treatment.

Syringes may be offered to the public under authorized agencies (MCL 333.7457(f)). This law negates the paraphernalia status of syringes distributed by approved programs regardless of local ordinance stating the contrary.

In 2018, the CDC identified Michigan as having one of the highest number of counties vulnerable to Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV) outbreaks among injection drug users. Incidence of HCV has been rising in young adults in Michigan. 83.7% of these cases were injection drug users. Therefore, there is a high correlation between HCV cases and injection drug use in young Michigan adults.

To counteract the rise in HCV cases, the number of SSPs has grown greatly in the last few years. SSPs have been shown to be effective in positively affecting the health of Michiganders. There are currently 64 SSP locations in Michigan which serve the purpose of treating addiction, assisting with harm reduction, and promoting drug abuse prevention through various program offerings. In Fiscal Year 2019, Michigan SSPs distributed almost 1 million syringes and 9,000 naloxone kits. These programs also referred over 2,000 Michiganders to substance use treatment and conducted HIV and HCV tests. Areas with SSP locations have lower incidence rates of HCV than do areas without SSPs. Overall, Michigan can do its part to save lives through implementing SSPs.

Due to the positive contributions SSPs can make in preventing HIV, HCV, and overdose deaths, MDHHS supports the implementation of these programs and will work with interested local communities to make this service available statewide. We encourage your organization to contact MDHHS by emailing MDHHS-syringeaccess@michigan.gov with any questions regarding SSPs.

FEDERAL/NATIONAL ACTIVITIES

10. CDC Toolkit to Build Confidence in COVID-19 Vaccinations:

CDC has "published a toolkit that medical centers, clinics, and clinicians can use to build confidence about COVID-19 vaccination among your healthcare teams and other staff. Materials include slide decks, posters,

fact sheets, FAQs, videos, and more." The toolkit is available at https://www.cdc.gov/vaccines/covid-19/health-systems-communication-toolkit.html.

11. **"Stark Law" Changes:**

The Centers for Medicare and Medicaid Services (CMS) has "finalized changes to the Physician Self-Referral Law, also known as the "Stark Law," that generally prohibits a physician from sending a patient for many types of services to a provider that the physician owns, is employed by, or otherwise receives payment from—regardless of what that payment is for. With this final rule, CMS is ensuring the regulations interpreting the Stark Law allow for changes that will help modernize the healthcare system. The rule finalizes many of the proposed policies from the notice of proposed rulemaking issued in October 2019, including:

- Finalizing new, permanent exceptions for value-based arrangements to that will permit physicians and other health care providers to design and enter into value-based arrangements without fear that legitimate activities to coordinate and improve the quality of care for patients and lower costs would violate the physician self-referral law.
- Finalizing additional guidance on key requirements of the exceptions to the physician self-referral law to make it easier for physicians and other health care providers to make sure they comply with the law.
- Finalizing protection for non-abusive, beneficial arrangements that apply regardless of whether the parties operate in a fee-for-service or value-based payment system – such as donations of cybersecurity technology that safeguard the integrity of the health care ecosystem.
- Reducing administrative burdens that drive up costs by taking money previously spent on administrative compliance and redirecting it to patient care.

Unless otherwise specified in the rule, all of the provisions in this rule will go into effect 60 days from the rule's display date in the Federal Register (which is expected to be December 2). Overall, this rule will result in better access and outcomes for patients by creating clearer paths for the providers that serve them to do so through enhanced coordinated care arrangements. We have crafted the exceptions to this rule to be narrowly tailored to allow for value-based care coordination. At this time, we have retained the strong patient protections from the original law to clearly prohibit referrals that are based solely on financial incentives to the provider." A CMS fact sheet is available at this link.

12. **CDC Health Alert: Increase in Fatal Overdoses in the US**

The CDC issued a national healthcare alert noting the following:

- substantial increases in drug overdose deaths across the United States, primarily driven by rapid increases in overdose deaths involving synthetic opioids excluding methadone (hereafter referred to as synthetic opioids), likely illicitly manufactured fentanyl.
- a concerning acceleration of the increase in drug overdose deaths, with the largest increase recorded from March 2020 to May 2020, coinciding with the implementation of widespread mitigation measures for the COVID-19 pandemic;
- the changing geographic distribution of overdose deaths involving synthetic opioids, with the largest percentage increases occurring in states in the western United States;
- significant increases in overdose deaths involving psychostimulants with abuse potential (hereafter referred to as psychostimulants) such as methamphetamine; and
- recommendations for communities when responding to the evolving overdose crisis.

NOTE: MDHHS epidemiologists have seen an increase in drug overdose deaths in Michigan during the COVID-19 pandemic. However, at this time, there is insufficient information to quantify the involvement of synthetic opioids in this increase.

13. Incoming Biden Administration:

The Kaiser Family Foundation has released an issue brief entitled *Potential Health Policy Administrative Actions Under President Biden*. The brief notes that "President-elect Joe Biden campaigned on supporting and building upon the ACA, better managing the coronavirus pandemic and lowering prescription drug costs. However, with the political balance of the Senate uncertain, some Biden proposals, like creating a new public option and lowering the Medicare age to 60, are less likely to be enacted. Even so, as president, Biden could exercise executive branch authority to move forward on a variety of policy changes he has advocated through administrative action without Congress.

I have also included a related webinar summary from our Washington DC-based partners at Capitoline, attendance at which was supported by our other two Michigan PIHP Partners (SWMBH and Region 10).

14. Coronavirus Relief Act (Federal Appropriations Act, 12/27/20)

Congress passed and the president signed (on 12/27/20) the Consolidated Appropriations Act for 2021 which includes coronavirus relief. Following are some key highlights, including allocations to SAMHSA:

ENACTED LEGISLATION: HR133, Consolidated Appropriations Act, 2021
Date: Signed into Public Law 116-TBD on December 27, 2020
General: The Act provides funding for the federal government through the remainder of fiscal year 2021. Included in the Act are Divisions M and N dealing with the nation's response to the coronavirus. A summary of those Divisions prepared by the House Committee on Appropriations is available at https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/Summary%20of%20H.R.%20133%20Coronavirus%20Relief%20Provisions.pdf.

Division M – Coronavirus Response and Relief Supplemental Appropriations Act, 2021

Agriculture-Rural Development-FDA Food and Drug Administration
$55 million for continued work on FDA efforts to facilitate the development and review, both pre-market and post-market, of medical countermeasures, devices, therapies, and vaccines to combat the coronavirus. In addition, funds will support medical product supply chain monitoring and other public health research and response investments. Labor-Health and Human Services-Education Department of Health and Human Services

$73 billion to support public health; research, development, manufacturing, procurement, and distribution of vaccines and therapeutics; diagnostic testing and contact tracing; mental health and substance abuse prevention and treatment services; childcare support; and other activities related to coronavirus, including: Centers for Disease Control and Prevention

$8.75 billion to support federal, state, local, territorial and tribal public health agencies to distribute, administer, monitor, and track coronavirus vaccination to ensure broad-based distribution, access, and vaccine coverage, including:

- $4.5 billion for State, local, Territorial, and Tribal Public Health Departments; and
- $300 million for a targeted effort to distribute and administer vaccines to high-risk and underserved populations, including racial and ethnic minority populations and rural communities.

Assistant Secretary for Preparedness and Response

$22.945 billion to respond to coronavirus, including:

- $19.695 billion for the Biomedical Advanced Research and Development Authority (BARDA) for manufacturing and procurement of vaccines and therapeutics, as well as ancillary supplies necessary for the administration of vaccines and therapeutics; and
- $3.25 billion for the Strategic National Stockpile. Public Health and Social Services Emergency Fund

$25.4 billion to support testing and contact tracing to effectively monitor and suppress COVID-19, as well as to reimburse for health care related expenses or lost revenue attributable to the coronavirus, including:

- $22.4 billion for testing, contact tracing, and other activities necessary to effectively monitor and suppress COVID-19, including $2.5 billion for a targeted effort to improve testing capabilities and contact tracing in high-risk and underserved populations, including racial and ethnic minority populations and rural communities; and
- $3 billion in additional grants for hospital and health care providers to be reimbursed for health care related expenses or lost revenue directly attributable to the public health emergency resulting from coronavirus, along with direction to allocate not less than 85 percent of unobligated funds in the Provider Relief Fund through an application-based portal to reimburse health care providers for financial losses incurred in 2020.

National Institutes of Health

$1.25 billion to support research and clinical trials related to the long-term effects of COVID-19, as well as continued support for Rapid Acceleration of Diagnostics for COVID-19.

Substance Abuse and Mental Health Services Administration

$4.25 billion to provide increased mental health and substance abuse services and support, including:

- $1.65 billion for the Substance Abuse and Prevention Treatment Block Grant;
- $1.65 billion for the Mental Health Services Block Grant;
- $600 million for Certified Community Behavioral Health Clinics;
- $50 million for suicide prevention programs;
- $50 million for Project AWARE to support school-based mental health for children;
- $240 million for emergency grants to States; and
- $10 million for the National Child Traumatic Stress Network;
- Not less than $125 million of funds provided to SAMHSA must be allocated to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes across a variety of programs.

Administration for Children and Families

$10.25 billion to support early childhood programs and childcare providers through:

- $10 billion for Child Care and Development Block Grants to provide immediate assistance to childcare providers; and
- $250 million for Head Start. Administration for Community Living

$100 million to address abuse, neglect, and exploitation of the elderly, including adult protective service and long-term care ombudsman activities.

Division N – Additional Coronavirus Response and Relief Title

I – Healthcare

- Sec. 101. Supporting Physicians and Other Professionals in Adjusting to Medicare Payment Changes During 2021. Provides for a one-time, one-year increase in the Medicare physician fee schedule of 3.75 percent, in order to support physicians and other professionals in adjusting to changes in the Medicare physician fee schedule during 2021, and to provide relief during the COVID-19 public health emergency.
- Sec. 102. Extension of Temporary Suspension of Medicare Sequestration. Provides for a three-month delay of the Medicare sequester payment reductions through March 31, 2021.

Due to the extensive nature of the provisions in the remainder of the bill, only the section titles are included below. The text of the Act may be accessed at the link provided above.

II – Assistance to Individuals, Families and Businesses
III – Continuing Paycheck Protection Program and Other Small Business Support
IV – Transportation
V – Banking
VI – Labor Provisions
VII – Nutrition and Agriculture Relief
VIII – United States Postal Service
IX – Broadband Internet Access Service
X – Miscellaneous

Submitted by:

Joseph P. Sedlock, MSA
Chief Executive Officer
Finalized: 12/24/2020
Updates: 12/28/2020 (Federal Appropriations)

Attachments: Crain's Detroit Business, 12/13/20. Crain's Forum, Colleen Allen and Mark McWilliams: Why $2-an-hour wage boost for caregivers matters to other workforce sectors.

Summary of President-Elect Biden's Healthcare Policy Agenda

CRAIN'S DETROIT BUSINESS

December 13, 2020 12:09 AM

Colleen Allen and Mark McWilliams: Why $2-an-hour wage boost for caregivers matters to other workforce sectors

Colleen Allen and Mark McWilliams

Colleen Allen (from left), the president and CEO of the Autism Alliance of Michigan, and Mark McWilliams, public policy director for Disability Rights Michigan.

MORE IN CRAIN'S FORUM

This month's Crain's Forum dives into the fragile state of the direct care industry, the disjointed payment system and some of the issues policymakers could consider to address a growing need.

In this report:

For many Michigan families, mental illness and developmental disabilities are a fact of life.

Their daily activities include providing high levels of personal care for a loved one and, very often, they find they can't do it all on their own.

That is where our state's direct care workers come in.

These 50,000 individuals provide personal care, emotional support and vocational training to more than 100,000 of Michigan's most vulnerable residents.

Their work makes it possible for family members to remain employed and contribute to the state's economy while their family members receive the support they need.

Unfortunately, Michigan's direct care workers are not compensated as well as they should be.

In fact, many of them make less than they could if they were serving fast food or restocking store shelves.

Our state's direct care workers earn an average starting wage of $10.70 per hour. With retail outlets and fast-food restaurants paying starting wages between $11 and $14 per hour, on average, we can see there is an obvious gap.

Add in a lack of health care or other benefits to many direct care workers, and it's easy to see why many leave the profession very quickly. Today, direct care worker turnover is 37 percent — and it's increasing every day.

And there couldn't be a worse time to be losing these workers. Many Michiganders are facing a higher level of mental stress due to the COVID-19 pandemic and other factors associated with the difficult year our state has experienced. We need more supports, not less.

That is why our state's leaders acted to support direct care workers this past spring.

The governor and Legislature approved a $2 hourly wage increase to help retain and boost the availability of Michigan's direct care workers, which went a long way toward helping these essential team members make ends meet. Even better, the state's 2020-21 budget sustains this temporary increase through Dec. 31.

While that's a positive action — and one for which we are immensely grateful — we are concerned about what will happen as 2020 comes to a close.

We are hopeful our state's leaders will once again act to preserve this additional direct care worker support, so Michigan's vulnerable residents and their families can continue to receive the support they need.

Our best hope lies in the passage of another major federal aid package. These additional funds are urgently needed — and sooner, rather than later — to support an extension of the $2 hourly wage increase for direct care workers.

The consequences of losing this temporary increase are immense. Families who lose their direct care workers will have to make alternative arrangements, which may include leaving the jobs they need.

Ultimately, these sorts of decisions will bring about significant local economic impact and cost the state much-needed tax revenues.

While the issues surrounding payment of direct care workers — and the strength of that particular talent pipeline — are going to require additional long-term thought and planning, there are short-term actions possible to ensure Michigan families aren't teetering on the brink of their own financial cliffs.

We urge our state and federal policy leaders to keep this vulnerable population in mind as they develop their plans for the future.

Inline Play

Source URL: *https://www.crainsdetroit.com/crains-forum/colleen-allen-and-mark-mcwilliams-why-2-hour-wage-boost-caregivers-matters-other*

To: Participating Michigan PIHPs
From: Brian Thiel
Date: December 10, 2020
Subject: Deliverable – MCOL's Healthcare Web Summit Webinar – 2021 Outlook: Biden's Policy Agenda and SDOH Investing

On December 10, 2020, Capitoline monitored MCOL's Healthcare Web Summit webinar entitled *"2021 Outlook: Biden's Policy Agenda and SDOH Investing."* John Gorman, Founder and Chairman of Nightingale Partners, presented on four key areas:

- Components of Biden's 2021 policy agenda for health programs
- Outlook for 2021 Supplemental Benefits/SDOH Services
- Current industry developments/competition on SDOH and what to expect in 2021
- SDOH Interventions as Central to Long-Term Success for MA, Medicaid, and ACA Plans

Introduction: Mr. Gorman started the presentation with a discussion of the recent elections. He highlighted that the two January 5, 2021 run-offs in Georgia will determine the Senate majority, the outcome of which is poised to affect the policies the Biden Administration can enact.

He then painted the grim picture of a nation on the precipice of increased homelessness, poverty, and greater exposure to COVID-19. Currently, 47 million Americans are unemployed. Unless Congress acts on a new stimulus package, unemployment benefits will expire for millions of Americans on December 26th, and on January 1, the eviction moratorium expires affecting up to 10 million Americans.

Biden's "Golden Age": Mr. Gorman pivoted to Biden's promise to usher in a "Golden Age" of health equity. He pointed to Biden naming Yale's Dr. Marcella Nunez-Smith as a co-chair of his COVID-19 advisory board. She is also charged to lead a new White House task force dedicated to health equity.

Mr. Gorman outlined SDOH account for 60-80% of health care spending and emphasized that addressing poverty is key to bending the curve. SDOH interventions reliably yield 3-8x ROI in reduced health care costs. He mentioned a Geisinger pilot program in Pennsylvania where $300,000+ was spent per patient each year in elderly uncontrolled diabetics. After medically appropriate meal deliveries were introduced, this number fell to $48,000 per member per year in just 14 months, representing a 35x ROI. Geisinger is expanding the pilot, one where appropriate intervention helped to reduce costs and alleviate poverty.

Biden Administration Health Priorities: Mr. Gorman stressed we are overdue for a relief package and highlighted seven of Biden's health priorities. More details are here: https://joebiden.com/healthcare/.

1. COVID-19 Response and Economic Recovery – Two of Biden's top four incoming priorities include beating the pandemic and a jobs and economic plan for working families. More information is here: https://buildbackbetter.gov/priorities/.
2. Protect and Build on the ACA – This includes increased access and choice, reduced health care costs, and a less complex health care system.

3. Re-orient Medicaid Policy – This includes reversing work requirements for Medicaid waivers.
4. Reduce Drug Prices – (e.g., targeted efforts for insulin). Biden will improve generics supply chains and repeal the law barring Medicare from negotiating lower prices with drug companies.
5. Eliminate Health Disparities in Government Programs – Biden specifically addresses how his health care plan will benefit communities of color.
6. Stop "Surprise Medical Billing" – This is important for COVID-19 testing and treatment.
7. Implement Medicare at 60 and Public Option – These were framed as "moonshots."

COVID-19 Response: Mr. Gorman outlined five areas of Biden's health care plan related to COVID-19. Additional details are here: https://buildbackbetter.gov/priorities/covid-19/.

1. Automatically Increase FMAP Funding During Crisis – This would be as part of the ACA.
2. Major public health/CDC investments – This will reverse trends of the current Administration.
3. Guaranteed Coverage – This includes access to reliable/free testing, vaccines, and treatment.
4. Expand ACA Subsidies – This includes temporary platinum-level Federal plans on the exchange.
5. Fix PPE Stockpile – This would invoke the Defense Production Act to ramp up production.

Coverage Expansion/ACA Stabilization: Mr. Gorman outlined five areas in Biden's health care plan related to expanding coverage and stabilizing the ACA:

1. Create a Public Option **–** This is a 'moonshot' and would require legislation, therefore, the to-be-determined Senate majority will play a large role**.**
2. Eliminate 400% FPL limit on Premium Subsidies **–** Biden will also lower the limit on the cost of coverage from 9.86% of income to 8.5% so families buying insurance on the individual marketplace will not spend more than 8.5% of their income on health insurance.
3. Lower Medicare age to 60 – Again, this is framed as a "moonshot."
4. Reverse Medicaid Work Requirements – This is part of "re-orienting" Medicaid policy.
5. Use Section 1332 Waivers – These waivers will help states pursue innovative strategies.

Health Equity: Mr. Gorman outlined five areas in Biden's health care plan around health equity. Additional details are here: https://joebiden.com/health-care-communities-of-color/.

1. Mandate Data-driven Strategies – Biden will ensure all Federal agencies have data-driven strategies to eliminate health disparities across their portfolios.
2. Reinvigorate CMMI SDOH Innovation – This includes re-invigorating a broad slate of pilots.
3. Improve Cultural Competence – This is particularly important for the health care workforce.
4. Eliminate Discriminatory Policies – This includes discrimination against the LGBTQ+ community.
5. New Investment: Biden will focus on major new investments in health equity research, data collection, and analytics related to the social health of underserved communities.

SDOH Supplemental Benefits: Mr. Gorman then pivoted to a discussion of SDOH and supplemental benefits. Physical environments, access to care, personal behavior, and socio-economic factors all contribute to health outcomes. Only by addressing poverty and the systemic effects of racism across the US healthcare system can millions of Americans actively participate in their health care.

There is a renewed emphasis around data collection for these factors and a recognition that big investments in effective interventions can dramatically reduce government spending. Research shows that every $1 of SDOH investment yields a 3-8X ROI of reduced health care costs over the long term.

Mr. Gorman then reviewed a summary of SDOH research and trends over the past three years. He highlighted, that for the elderly, loneliness, which often leads to depression, has been shown to have a health impact equivalent to smoking 15-20 cigarettes per day. Adequate transportation, for example, gets members to appointments, takes them to urgent care centers instead of ERs when appropriate, provides access to pharmacies for critical medication, and transports members to grocery stores if they live in a food desert. Low-cost interventions can have huge impacts on downstream health care costs.

SDOH Guiding Principles: Mr. Gorman then highlighted that SDOH benefits must be easy to understand; equitable and targeted to those who need them most; created to be easily managed and sustained; and updated and improved over time based on data and impact.

Industry Supplemental Benefits: Currently, industry is offering limited SDOH supplemental benefits. There are quite a few OTC drug benefits and meal benefits tied to episodes of care rather than to address daily food security for seniors. The need is so much greater than what is currently being provided. Transportation, for example, is a lagging benefit that is both important and impactful. Further, some of the offerings, such as fitness benefits, are not as impactful for low-income individuals.

Mr. Gorman stressed the need for comprehensive dental benefits and the epidemic of dental care needs in the elderly population. He outlined Medicaid home and community-based services designed to provide in-home support services. There are efforts to rehabilitate foreclosed houses into group homes for dual-eligible individuals and the intellectually disabled with an onsite resident community health worker. This example deconstructs the nursing home model into more livable settings for the remainder of pandemic. Mr. Gorman noted the explosion in PACE programs, which provide all-inclusive care for the elderly with a wealth of wrap-around services, in home and community-based settings.

There are also many creative SDOH supplemental benefits. Acupuncture and massage are not as impactful for low-income seniors and dual-eligible individuals. However, benefits for bathroom safety devices and pest control have been two of the most innovative supplemental benefits this year. For example, mold abatement and vermin elimination impact not only healthcare but overall member experience. SDOH interventions impact a few dozen of health plan star ratings measures so this can lead to revenue increases from star ratings measures and better engagement in risk adjustment scores.

2021 Supplemental Benefits: In the coming year, we should see a healthy increase in SDOH supplemental benefits, however they are still grossly underrepresented among health plans in industry. In-home support services, adult day health services, and home-based palliative care will increase by ~50%. Unfortunately, plans are backing off from care-giver respite benefits, which is seen as a mistake.

SSBCI Benefits: Mr. Gorman hopes to see a huge increase in SSBCI benefits in 2021 and emphasized how meaningful they are. CMS will make data on 2021 SSBCI available in the first quarter of 2021.

Next-Generation SDOH Benefits: As SDOH benefits are being designed for 2021 and beyond, Mr. Gorman hopes to see lower copays and deductibles; a tiered system that enables members to pay more at certain times, when needed; and baseline of vision, dental, hearing, and OTC benefits. Beyond 2021, he also envisions telehealth, opioid, dementia, and caregiver respite benefits, among others.

Medicaid/SDOH: Forty states are addressing SDOH through Medicaid largely through community partnerships and care coordination. A preponderance of states screen enrollees through MCOs and provide referrals to services. There is a shift from grants to billing for services through VBP contracts and an emphasis on data collection and measuring effectiveness. Michigan is one of eight states that has healthy behavior incentive programs, such as smoking cessation and substance abuse treatment.

A New Approach: We need to rethink how we approach provider engagement and network management. How do we form partnerships to provide transportation, meal support, and broad in-home services? We should have a list of vendors who do home modifications and pest control. We need contracts with clinical providers for palliative and end-of-life care. Many providers work from grants, philanthropy, and altruism, but we need to scale through value-based contracts over the long term.

Detroit Example: Mr. Gorman provided a sample network analysis of Detroit to demonstrate the challenges to fulfill desired services in vulnerable populations. With healthy food access, for example, there are two food pantries within a twenty-mile radius for diabetic members. There are, however, only one volunteer transport program and three transportation vendors who require two-day notice.

Question/Answer Session: Mr. Gorman then fielded questions.

1) Are most SDOH supplemental benefits provided through contracts or open arrangements? Are contracts common place?

Response: Contracts are not common place in Medicare Advantage but are mainstream in the daily lives of Medicaid managed care providers. WellCare, for example, recently had $45,000 in contracts. Other programs have long standing contracts with with Meals on Wheels or local affordable housing providers. These are done out of necessity because of a huge volume of activity. Many programs do not understand how to start. Step one is for provider relations and network management to come together with the care management department to understand what providers and vendors are needed most.

2) Can you describe an opportunity zone project or success?

Response: Mr. Gorman's company, Nightingale Partners, is an opportunity zone fund dedicated to large scale efforts involving health equity and SDOH. The company funds various kinds of interventions. There is work being done in Puerto Rico to increase availability of clinical and mental health services in public

housing projects. It is critical to track how money is being spent and measure success along three domains – financial, quality, and integration impact (e.g., how an intervention integrates with providers and the plan itself.) Nightingale looks, for example, to see reduced use of neonatal ICUs by mothers of color; reduced number of people who access local food banks for other benefits if they receive a food security benefit; and numbers of people who avoid eviction or homelessness. They also track all-star ratings measures and progress as plan sponsors do.

3) Does all SDOH funding flow through plans?

Response Yes, however, it is precious little. On average, plans have set aside $22 per member/month for supplemental benefits. So much more can be done.

4) Will there be efforts to help USDA and HUD safety net programs align more closely with CMS?

Response Yes, however the Biden Administration will need time to undo the damage of the current Administration. It is likely Biden will oversee the development of new programs and partnerships.

5) How do you measure the ROI on community health workers?

Response: Mr. Gorman outlined taking the baseline cost of the intervention population before intervening and checking annually to project the costs of the population going forward. Generally, community health workers have complex interventions, so he recommends a low panel size of 30-50 workers to track health care costs of populations in which you intervene to determine results such as greater attendance at appointments or better management of pharmaceutical therapies.

Mr. Gorman wrapped up by thanking the audience and closing out the webinar.

REPORT OF THE MSHN DEPUTY DIRECTOR
to the Board of Directors
November/December

OPERATIONAL UPDATES

MSHN Annual Review of Health Insurance

MSHNs pleased to announce the continuation of the health insurance benefits for employees. Currently, MSHN provides two options: Blue Cross Blue Shield PPO and Blue Care Network HMO. The renewal rates indicated a slight increase of 2.7% and 6.3% respectively and additional quotes as provided by the Professional Employment Organization (PEO), were higher cost with less coverage. MSHN utilizes the statutory cap method to determine employee cost sharing. Due to the minimal rate increase, MSHN will also be able to sustain the current minimal employee cost share for 2021; $32.00 for a single coverage, $66.92 for double coverage and $87.25 for family coverage.

Fiscal Year 2020 Annual Reports Available

As Fiscal Year 2020 ended on September 30 MSHN staff have been working to finalize the data, reporting, monitoring and summary of annual results. The below annual reports have been completed and updated with year-end activity. ***The full reports have been linked below.***

Balanced Scorecard: Report includes the Board of Directors metrics along with all the MSHN Council and Committee Metrics by MSHN Strategic Plan Priorities (Better Health, Better Care, Better Value and Better Provider Systems)

Priority Measures Report: Report includes the identified metrics by MSHN Leadership & Operations Council to focus specific efforts to improve regional rates of performance.

Medicaid Event Verification Report: Report includes a summary of the Medicaid Event Verification activities of the CMHSPs and the SUD Provider Network throughout FY2020

Satisfaction Surveys: The Executive Summary report includes a synopsis of the multiple surveys (4 total) conducted throughout FY20 for each population served in the MSHN region. Detailed reports for each population are linked below as well.

Performance Bonus Incentive Pool: Report includes activities related to integration of Behavioral Health and Physical Health as defined by MDHHS. The results of the earned bonus should be received in January 2021.

Health Services Advisory Group Issues Final Report on Performance Improvement Project (PIP)

Michigan Department of Health and Human Services (MDHHS) requires the Prepaid Inpatient Health Plan (PIHP) to participate in performance improvement projects in accordance with the Balanced Budget Act of 1997 (BBA). Health Services Advisory Group (HSAG) serves as the External Quality Review Organization contracted by MDHHS to conduct a validation process for the PIHP annual PIP submission. The validation process will result in a "Met" or "Not Met" Status based on the compliance with 30 defined elements. MSHN's study topic was "Patient(s) with schizophrenia and diabetes who had an HbA1c and LDL-C test during the report period" also known Diabetes Monitoring. MSHN demonstrated an improvement, however, did not

achieve a statistically significant improvement. Therefore, the standard of "real improvement" was not met. This resulted in a HSAG validation score of "Not Met". MSHN has presented the report to Operations Council for support in implementing regional efforts for improvement, such as reviewing Open Care Alerts provided by MSHN through data analytics to ensure screenings and monitoring of such is taking place. ***For the full report see the HSAG PIP Validation Report link below.***

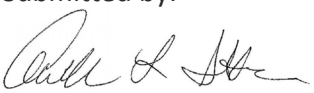
MDHHS increases State Monitoring and PIHP Report Submissions

MDHHS provided notice on December 16, 2020 indicating there will be additional state monitoring systems of managed care programs to ensure compliance with Title 42 CFR 438.66 (b) that includes the following areas:

1. Grievance and appeal system, including grievance and appeals logs
2. Medical management, including utilization management and
3. Provider network management

Therefore, MDHHS is implementing new reporting requirements for member grievances, service authorization (specifically denials), member appeals and provider credentialing. PIHPs are in the process of indicating data elements gathered on the above topics to inform MDHHS development of tools and templates, with the expectation of reporting on these elements for Fiscal Year 2021.

Submitted by:



Amanda L. Ittner
Finalized: 12.29.20

Links to referenced documents:

FY20 Balanced Scorecard
FY20 Priority Measures
FY20 Medicaid Event Verification
Survey Executive Summary Report
MHSIP Consumer Satisfaction for Adults with a Mental Illness
YSSF Consumer Satisfaction for Children with a Severe and Emotional Disorder
Satisfaction Survey for Individuals Receiving Substance Use Treatment
National Core Indicator Survey for IDD
Performance Bonus Incentive Report
HSAG PIP Validation Report

Background:

In accordance with the MSHN Board of Directors to review financials, at a minimum quarterly, the Preliminary Statement of Net Position and Statement of Activities for the Period Ending November 30, 2020 have been provided and presented for review and discussion.

Recommended Motion:

The MSHN Board of Directors receives and files the Preliminary Statement of Net Position and Statement of Activities for the Period Ending November 30, 2020 as presented.

Mid-State Health Network
Statement of Activities
As of November 30, 2020

	Budget Annual	Actual Year-to-Date	Budget Year-to-Date	Budget Difference	Budget Variance	
	FY 21 Original Bdgt		FY 21 Original Bdgt			
Revenue:						
Grant and Other Funding	$ 450,769	29,774	75,128	(45,354)	(60.37) %	1a
Medicaid Use of Carry Forward	$ 23,175,056	31,810,000	3,862,509	27,947,491	723.56 %	1b
Medicaid Capitation	634,480,358	119,119,136	105,746,727	13,372,409	12.65 %	1c
Local Contribution	3,140,208	760,214	523,368	236,846	45.25 %	1d
Interest Income	218,000	11,742	36,333	(24,591)	(67.68) %	1e
Change in Market Value	0	6,487	0	6,487	0.00 %	
Non Capitated Revenue	21,249,929	1,972,558	3,541,655	(1,569,097)	(44.30) %	1f
Total Revenue	682,714,320	153,709,911	113,785,720	39,924,191	35.09 %	
Expenses:						
PIHP Administration Expense:						
Compensation and Benefits	6,575,012	916,406	1,095,835	(179,429)	(16.37) %	
Consulting Services	130,000	31,155	21,667	9,488	43.79 %	
Contracted Services	96,040	7,812	16,007	(8,195)	(51.20) %	
Other Contractual Agreements	630,615	92,328	105,102	(12,774)	(12.15) %	
Board Member Per Diems	18,060	980	3,010	(2,030)	(67.44) %	
Meeting and Conference Expense	117,815	6,696	19,636	(12,940)	(65.90) %	
Liability Insurance	37,433	27,502	6,239	21,263	340.81 %	
Facility Costs	158,791	30,733	26,465	4,268	16.13 %	
Supplies	325,350	111,134	54,225	56,909	104.95 %	
Depreciation	81,927	13,655	13,655	0	0.00 %	
Other Expenses	972,400	319,182	162,066	157,116	96.95 %	
Subtotal PIHP Administration Expenses	9,143,443	1,557,583	1,523,907	33,676	2.21 %	2a
CMHSP and Tax Expense:						
CMHSP Participant Agreements	554,299,329	107,430,284	92,383,222	15,047,062	16.29 %	1b,1c
SUD Provider Agreements	53,626,941	8,282,601	8,937,823	(655,222)	(7.33) %	1c,1f
Benefits Stabilization	2,498,500	416,417	416,417	0	0.00 %	1b
Tax - Local Section 928	3,140,208	760,214	523,368	236,846	45.25 %	1d
Taxes- IPA/HRA	21,833,596	3,473,982	3,638,933	(164,951)	(4.53) %	2b
Subtotal CMHSP and Tax Expenses	635,398,574	120,363,498	105,899,763	14,463,735	13.66 %	
Total Expenses	644,542,017	121,921,081	107,423,670	14,497,411	13.50 %	
Excess of Revenues over Expenditures	$ 38,172,303	$ 31,788,830	$ 6,362,050			

Mid-State Health Network
Preliminary Statement of Net Position by Fund
As of November 30, 2020

	Behavioral Health Operating	Medicaid Risk Reserve	Total Proprietary Funds	
Assets				
Cash and Short-term Investments				
Chase Checking Account	24,860,219	0	24,860,219	1a
Chase MM Savings	5,908,940	0	5,908,940	
Savings ISF Account	0	40,795,491	40,795,491	1b
Savings PA2 Account	9,807,302	0	9,807,302	1c
Investment ISF Account	0	3,012,574	3,012,574	1b
Total Cash and Short-term Investments	$ 40,576,461	$ 43,808,065	$ 84,384,526	
Accounts Receivable				
Due from MDHHS	11,319,415	0	11,319,415	2a
Due from CMHSP Participants	28,919,765	0	28,919,765	2b
Due from CMHSP - Non-Service Related	343,854	0	343,854	2c
Due from Other Governments	75,992	0	75,992	2d
Due from Miscellaneous	242,291	0	242,291	2e
Due from Other Funds	0	2,100,000	2,100,000	2f
Total Accounts Receivable	40,901,317	2,100,000	43,001,317	
Prepaid Expenses				
Prepaid Expense Rent	4,529	0	4,529	2g
Prepaid Expense Other	6,534	0	6,534	2h
Total Prepaid Expenses	11,063	0	11,063	
Fixed Assets				
Fixed Assets - Computers	189,180	0	189,180	2i
Accumulated Depreciation - Information Tech	(162,905)	0	(162,905)	
Fixed Assets - Vehicles	251,983		251,983	2j
Accumulated Depreciation - Vehicles	(33,598)		(33,598)	
Total Fixed Assets	244,660	0	244,660	
Total Assets	**$ 81,733,501**	**$ 45,908,065**	**$ 127,641,566**	
Liabilities and Net Position				
Liabilities				
Accounts Payable	$ 14,462,318	$ 0	$ 14,462,318	1a
Current Obligations (Due To Partners)				
Due to State	11,070,975	0	11,070,975	3a
Other Payable	4,465,948	0	4,465,948	3b
Due to State HRA Accrual	2,489,100	0	2,489,100	1a, 3c
Due to State-IPA Tax	1,193,508	0	1,193,508	3d
Due to State Local Obligation	(24,838)	0	(24,838)	3e
Due to CMHSP Participants	385,522	0	385,522	3f
Due to other funds	2,100,000	0	2,100,000	3g
Accrued PR Expense Wages	90,192	0	90,192	3h
Accrued Benefits PTO Payable	345,570	0	345,570	3i
Total Current Obligations (Due To Partners)	22,115,977	0	22,115,977	
Deferred Revenue	8,847,321	0	8,847,321	1b 1c 2b 3b
Total Liabilities	45,425,616	0	45,425,616	
Net Position				
Unrestricted	36,307,885	0	36,307,885	3j
Restricted for Risk Management	0	45,908,065	45,908,065	1b
Total Net Position	36,307,885	45,908,065	82,215,950	
Total Liabilities and Net Position	**$ 81,733,501**	**$ 45,908,065**	**$ 127,641,566**	

Mid-State Health Network
Notes to Financial Statements
For the Two-Month Period Ended,
November 30, 2020

Please note: The Preliminary Statement of Net Position contains Fiscal Year (FY) 2020 cost settlement figures between the PIHP and Michigan Department of Health Human Services (MDHHS) as well as each Community Mental Health Service Program (CMHSP) Participants. CMHSP Cost settlement figures were extracted from fiscal year-end projections gathered as of November 2020. Final figures will vary.

Statement of Net Position – Preliminary:

1. Cash and Short-Term Investments
   a) The Cash Chase Checking and Chase Money Market Savings accounts is the cash available for operations. A portion of cash available for operations will be used to cover accounts payable and taxes.
   b) The Savings Internal Service Fund (ISF) and Investment ISF reflect designated accounts to hold the Medicaid ISF funds separate from all other funding per the MDHHS contract.
   c) The Savings PA2 account holds PA2 funds and is also offset by the Deferred Revenue liability account.
2. Accounts Receivable
   a) Due from MDHHS balance represents amounts owed to MSHN for HRA payments made to hospitals for the first two months and Performance Bonus Incentive Pool (PBIP). In addition, approximately 25% of the balance in this account stems from Block Grant and other various grants funds owed to MSHN.
   b) Due from CMHSP Participants reflects FY 20 preliminary cost settlement activity as well as cost settlement for other fiscal years. Note that of this $29 M, about $7.5 M is associated with unspent Direct Care Worker Premium Pay (see note 3a below).

CMHSP	Other	Cost Settlement	Payments/Offsets	Total
Bay	-	1,099,829.99	-	1,099,829.99
CEI	102,173.00	11,694,754.10	-	11,796,927.10
Central	-	4,543,999.60	-	4,543,999.60
Gratiot	-	401,171.68	-	401,171.68
Huron	-	-	-	-
The Right Door	-	1,621,959.88	-	1,621,959.88
Lifeways	-	741,085.61	-	741,085.61
Montcalm	18,941.00	1,931,282.48	918,941.00	1,031,282.48
Newaygo	-	1,105,948.92	-	1,105,948.92
Saginaw	-	4,467,902.45	-	4,467,902.45
Shiawassee	-	566,283.63	-	566,283.63
Tuscola	-	1,543,373.85	-	1,543,373.85
Total	**121,114.00**	**29,717,592.19**	**918,941.00**	**28,919,765.19**

c) Due from CMHSP – Non-Service Related reflects the balance for CMHSP FY 21 Relias billing and MSHN's performance of Supports Intensity Scale (SIS) assessment billed to CMHs in the region.
d) Due from Other Governments is the account used to track PA2 Billing to the 21 counties in MSHN's region. The amount represents dollars owed through quarter four.
e) Approximately 50% of the balance in Due from Miscellaneous represents amounts owed from providers for Medicaid Event Verification (MEV) findings. The remaining amount represents advances made to Substance Abuse and Treatment (SAPT) providers to cover operations.
f) Due from other funds is the account used to manage anticipated ISF transfers. MSHN can retain up to 7.5 % of current FY revenue to manage risk. This amount is in addition to the allowable 7.5% for savings generated when Medicaid and Healthy Michigan revenue exceed expenses.
g) Prepaid Expense Rent balance consists of security deposits for three MSHN office suites.
h) The Prepaid Expense Other represents payments made in FY 21 for FY 22 Relias training. The Relias contract cycle is November through October. MSHN has a regional contract which includes the CMHSPs and they are billed directly for their portion of Relias seats.
i) This is an account used to track Managed Care Information System (MCIS) costs associated with PCE. Amounts in this account are being depreciated.
j) Fixed Asset Vehicle contains the total cost for MSHN's Mobile Unit. The Mobile Unit will be used to provide Substance Use Disorder services and tele-psychiatry as needed. Amounts in this account are being depreciated.

3. Liabilities
   a) Due to State account balance contains the outstanding amount for FY 20 Direct Care Worker (DCW) lapse, FY 20 lapse, and an FY 2017 Autism settlement.
      - MDHHS issued revenue between April and September to cover a $2 per hour DCW premium pay for workers providing specific in-person services during COVID-19. The revenue also included 24 cents to offset administrative expenses associated with the salary increase. Based on CMHSP information collected in October, MSHN anticipates approximately $7.5 M as the DCW lapse amount. There will likely be adjustments to this projected figure as CMHSPs and MSHN finalize use of the funds during FY 20 closeout activities.
      - The FY 20 lapse of approximately $3 M is a projection based on CMHSP preliminary cost settlements. The lapse amount indicates we have a fully funded ISF and that savings will fall within the second tier (above 5%). Per contractual guidelines MDHHS will receive half of every dollar generated beyond this threshold until the PIHP's total savings reach the 7.5% maximum.
   b) This amount is related to SUD provider payment estimates and is needed to offset the timing of payments.
   c) The HRA (Hospital Rate Adjustor) is a pass-through account for dollars sent from MDHHS to cover supplemental payments made to psychiatric hospitals. The HRA payments are intended to incentivize hospitals to have available psychiatric

beds as needed. Total HRA payments are calculated based on the number of inpatient hospital services reported.

d) Due to State - IPA Tax contains funds held for tax payments associated with MDHHS Per Eligible Per Month (PEPM) funds. Insurance Plan Assessment taxes are applied to Medicaid and Healthy Michigan eligible.
e) The Local Obligation account holds funds received from CMHSPs for amounts owed to MDHHS for the quarterly Local Match Draw Down (LMDD) payment. The negative amount depicts MSHN's payment to MDHHS prior to receiving funds from one CMHSP.
f) Due to CMHSPs represent an amount a cost settlement owed to one regional partner.
g) Due to other funds is the anticipated FY 20 ISF transfer (see 2f).
h) Accrued payroll expense wages represent expense incurred in November and paid in December.
i) Accrued Benefits PTO (Paid Time Off) payable is the required liability account set up to reflect paid time off balances for employees.
j) The Unrestricted Net Position represents the difference between total assets, total liabilities, and the restricted for risk management figure.

Statement of Activities: Please Note – The Fiscal Year 2021 Original Budget approved during the September 2020 Board Meeting is displayed in this report. In addition, this report is deemed final for activity through November 2020. The Medicaid Use of Carryforward is the only estimate and will be finalized as we complete FY 20 Cost Settlement and Compliance Examinations throughout FY 21.

1. Revenue
    a) This account tracks SIS revenue earned from CMHSPs and grant revenue. Actual expenses are lower than expected as new grant activities generating revenue have yet to occur in FY 21. In addition, other existing grants have not generated the expected revenue due to ongoing pandemic concerns and stay home orders.
    b) Medicaid Use of Carry Forward represents the estimated FY 20 savings. Medicaid savings is generated when prior year revenue exceeds expenses for the same time period. A small portion of Medicaid Savings is sent to the CMHSPs as Benefit Stabilization for 24/7/365 SUD activities which include access, prevention, and customer services. FY 20 Medicaid Carry Forward must be used as the first revenue source for FY 21.
    c) Medicaid Capitation – This account's variance results from unanticipated MDHHS DCW revenue to cover the first quarter of FY 21. Medicaid Capitation is disbursed to CMHSPs based on per eligible per month (PEPM) payment files and paid to SUD providers based on service delivery
    d) Local Contribution is flow-through dollars from CMHSPs to MDHHS. Typically, revenue equals the expense side of this activity under Tax Local Section 928. Local Contributions were scheduled to reduce over the next few fiscal years until completely phased out. Legislators did not approve an FY 21 reduction thus the amounts collected from CMHSPs will be equal to those in FY 20.
    e) Interest income reflects interest earned on investments and changes in principle for investments purchased at discounts or premiums. The "change in market value" account records activity related to market fluctuations. Actual interest income is less than anticipated due to ongoing low interest rates and fewer investment opportunities to generate this revenue.
    f) This account tracks non-capitated revenue for SUD services which include Community Grant and PA2 funds. There will be a significant variance in this account based on the reduction to Community Grant funds allocation which occurred after completion and Board presentation of the FY 21 budget.
2. Expense
    a) Total PIHP Administration Expense is slightly under budget. The line items with the largest variances are compensation, supplies, and other expenses.
        - MSHN's compensation includes vacant Home and Community Based Waiver positions expected to be filled by the end of FY 2021 pending MDHHS's transfer of responsibilities to the PIHP.
        - Supplies expense has a significant variance because the FY 21 Relias seats designated for MSHN were paid in full. CMHSP Relias expense amounts are not included (Please see Statement of Net Position 2h).
        - Other expenses line item has a large variance because the full FY 21 payment of more than $100 k was made to MiHIN.
    b) IPA/HRA actual tax expenses are slightly under the budget amount however the variance is minimal. IPA estimates are impacted by variability in the number of

Medicaid and Healthy Michigan eligibles. HRA figures will vary throughout the fiscal year based on inpatient psychiatric utilization. (Please see Statement of Net Position 3c and 3d).

MID-STATE HEALTH NETWORK
SCHEDULE OF INTERNAL SERVICE FUND INVESTMENTS
As of November 30, 2020

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY
UNITED STATES TREASURY BILL	912796SP5	4.23.19	4.25.19	10.24.19	no	988,182.64	1,000,000.00	2.365%
UNITED STATES TREASURY BILL	912796SP5	4.23.19	4.25.19	10.24.19			(1,000,000.00)	
FEDERAL HOME LOAN MTG CORP	3137EAEF2	5.2.19	5.3.19	4.20.20	no	624,605.01	630,000.00	2.331%
FEDERAL HOME LOAN MTG CORP	3137EAEF2						(630,000.00)	
UNITED STATES TREASURY BILL	912796RN1	6.7.19	6.10.19	12.5.19	no	1,979,752.50	2,000,000.00	2.068%
UNITED STATES TREASURY BILL	912796RN1						(2,000,000.00)	
UNITED STATES TREASURY BILL	912796TF6	8.14.19	8.15.19	2.13.20	no	2,972,607.48	3,000,000.00	1.823%
UNITED STATES TREASURY BILL	912796TF6						(3,000,000.00)	
UNITED STATES TREASURY BILL	912796TK5	9.12.19	9.12.19	3.12.20	no	991,043.07	1,000,000.00	1.788%
UNITED STATES TREASURY BILL	912796TK5						(1,000,000.00)	
FEDERAL FARM CREDIT BANK	3133ELCD4	12.2.19	12.3.19	6.2.21	yes	2,000,092.22	2,000,000.00	1.660%
FEDERAL FARM CREDIT BANK	3133ELCD4						(2,000,000.00)	
UNITED STATES TREASURY BILL	912796UC1	2.12.20	2.13.20	1.28.21	no	2,959,268.75	2,993,114.45	
JP MORGAN INVESTMENTS							2,993,114.45	
JP MORGAN CHASE SAVINGS							39,392,950.47	0.050%
							$ 42,386,064.92	

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

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

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
January 2021

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	ORIGINAL FY21 CONTRACT AMOUNT	FY21 TOTAL CONTRACT AMOUNT	FY21 INCREASE/ (DECREASE)
PIHP ADMINISTRATIVE FUNCTION CONTRACTS					
Mary Dumas	MEV Site Reviewer/UM Authorization Reviews	10.12.20 - 3.31.21	$ 23,000	**$ 42,400**	**19,400**
			$ 23,000	**$ 42,400**	**$ 19,400**

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					
Home of New Vision	Engagement Center	10.1.20 - 9.30.21	-	**252,157**	**252,157**
			$ -	**$ 252,157**	**$ 252,157**

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)	Community Grant	10.1.20 - 9.30.21	9,450,000	**5,154,076**	**(4,295,924)**
	Michigan State Opioid Response	10.1.20 - 9.30.21	700,000	**1,804,657**	**1,104,657**
	Prevention	10.1.20 - 9.30.21	1,943,468	**2,292,055**	**348,587**
	State Opioid Response II	10.1.20 - 9.30.21	966,979	**1,091,979**	**125,000**
	SUD - Administration	10.1.20 - 9.30.21	1,854,848	**518,000**	**(1,336,848)**
	SUD - Women's Specialty Services	10.1.20 - 9.30.21	1,204,000	**1,204,088**	**88**
			$ 16,119,295	**$ 12,064,855**	**$ (4,054,440)**

Mid-State Health Network (MSHN) Board of Directors Meeting
Tuesday, November 10, 2020
Zoom Video/Audio Conference
Meeting Minutes

1. Call to Order

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

Welcome was extended MSHN Board Member Rhonda Matelski, newly appointed by Huron Behavioral Health Authority's Board of Directors.

A moment of silence was requested and observed in memory of former MSHN Board Member Mike Hamm.

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), Dianne Holman (CEI), John Johansen (Montcalm), Steve Johnson (Newaygo), Jeanne Ladd (Shiawassee), Colleen Maillette (Bay-Arenac), Rhonda Matelski (Huron), Deb McPeek-McFadden (Ionia), Gretchen Nyland (Ionia), Irene O'Boyle (Gratiot), Kurt Peasley (Montcalm), Joe Phillips (CMH for Central Michigan), Kerin Scanlon (CMH for Central Michigan), and Ed Woods (LifeWays)

Board Member(s) Absent: Tina Hicks (Gratiot), Tracey Raquepaw (Saginaw), and Leola Wilson (Saginaw)

Staff Members Present: Joe Sedlock (CEO), Amanda Ittner (Deputy Director), Leslie Thomas (Chief Financial Officer), Kim Zimmerman (Director of Quality, Compliance and Customer Service), and Merre Ashley (Executive Assistant)

3. Approval of Agenda for November 10, 2020

Board approval was requested for the Agenda of the November 10, 2020 Regular Business Meeting.

MSHN 20-21-001 MOTION BY BRAD BOHNER, SUPPPORTED BY KURT PEASLEY, FOR APPROVAL OF THE AGENDA OF THE NOVEMBER 10, 2020, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 18-0.

4. Public Comment

There was no public comment.

Ms. Kerin Scanlon and Mr. Joe Phillips joined the meeting at 5:07 p.m.
Ms. Jeanne Ladd joined the meeting 5:13 p.m.

5. MSHN External Compliance Examination Report Presentation (Roslund, Prestage and Co.) *

Mr. Bill Hirschman, Auditor, Roslund, Prestage and Co. informed and highlighted key information included the compliance examination conducted by his firm and provided within board meeting packets. Mr. Hirschman noted that the official written opinion of his firm is that MSHN complied in all material respects with specified requirements, that no control deficiencies were found, that fraud was not found, and no material non-compliance with regulations or contract provisions was identified. Members were encouraged to contact Mr. Hirschman directly with any questions or concerns related to the Compliance Examination Report.

*Connectivity issues encountered by Mr. Hirschman necessitated delay of this presentation to occur immediately following the Chief Executive Officer's Report.

MSHN 20-21-002 MOTION BY COLLEEN MAILLETTE, SUPPORTED BY JOHN JOHANSEN, TO RECEIVE AND FILE THE "REPORT ON COMPLIANCE" OF MID-STATE HEALTH NETWORK FOR THE YEAR ENDED SEPTEMBER 30, 2019. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANNE HOLMAN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, RHONDA MATELSKI, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KERIN SCANLON, ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 21-0.

6. Confirmation of Municipal Employees Retirement System (MERS) Plan Addendum

Ms. Amanda Ittner informed of the changes included within the MERS Plan Addendum in detail and provided information specific to the Defined Contribution and Social Security Opt Out Adoption Agreements. A request was made for board action to approve the confirmation of the MERS Plans and Addendum

MSHN 20-21-003 MOTION BY BRAD BOHNER, SUPPORTED BY DAVID GRIESING, TO APPROVE 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. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANNE HOLMAN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, RHONDA MATELSKI, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KERIN SCANLON, AND ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 21-0.

7. Mid-State Health Network Compliance Plan Update

Ms. Kim Zimmerman presented information specific to the changes incorporated into the 2021 Corporate Compliance Plan Update. Ms. Zimmerman encouraged members to contact her directly with any questions, concerns or to request additional information. Board action to approve the Corporate Compliance Plan and acknowledge receipt was requested.

MSHN 20-21-004 MOTION BY BRAD BOHNER, SUPPORTED BY GRETCHEN NYLAND, TO APPROVE THE 2021 MSHN CORPORATE COMPLIANCE PLAN AND ACKNOWLEDGE RECEIPT. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANNE HOLMAN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, RHONDA MATELSKI, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KERIN SCANLON, AND ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 21-0.

8. Chief Executive Officer's Report

Mr. Joseph Sedlock's CEO report included highlight of topics noted within the written report as provided within board meeting packets. He also spoke to a variety of new informational items. Active discussion around The Michigan Department of Health and Human Services' (MDHHS) recent announcement of a reduction in substance use disorder block grant resources occurred. Questions and concerns specific to actions MSHN would be required to take as a result of the funding reduction were numerous, and resulted in a call for board action to the following:

MSHN 20-21-009 MOTION BY JOE BREHLER, SUPPORTED BY DIANNE HOLMAN, TO REQUIRE A SPECIAL MEETING OF THE MSHN BOARD OF DIRECTORS IN ORDER TO REVIEW/APPROVE MANAGEMENT'S PLAN RELATIVE TO THE SIGNIFICANT CUTS IN BLOCK GRANT FUNDING WHICH WILL IMPACT THE PROVIDERS AND RESOURCES AVAILABLE TO REGION 5 CONSUMERS. VOTING IN FAVOR: JIM ANDERSON, JOE BREHLER, DAVID GRIESING, DAN GRIMSHAW, DIANNE HOLMAN; VOTING AGAINST: BRAD BOHNER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELATT, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, RHONDA MATELSKI, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KERIN SCANLON, AND ED WOODS. MOTION FAILED: 5-16.

Mr. Sedlock reiterated that MSHN administration will keep the MSHN Board informed regarding recommendations relative to the block grant funding reduction(s) along with any anticipated ramifications to programs and services resulting from those recommendations.

Chairman Woods thanked members for their dialogue which provided the CEO with clear direction and indication of what the board wants; interactions such as this, and a sharing of ideas on every issue is the reason this is the best board and PIHP in the state.

Mr. Sedlock added information to the following topics, included within his written report:

- Complex Care Management for the Unenrolled Population: Not a risk based financial arrangement, if approved, should not affect CMHSPs of the region. Members should contact MSHN administration if they would like to receive additional information/copy.
- MiCAL: Administration can arrange to have an individual attend an upcoming meeting to provide more information if desired by the MSHN Board.
- Change in Open Meetings Act (OMA) and Virtual Meetings: Due to recent change in the OMA board meetings can be held virtually without question through 12.31.20. The board executive committee and MSHN administration will evaluate future virtual meetings under the current law. Should future meetings need to occur via video conference to keep people healthy and safe, a communication will be released to members well in advance of meeting date(s).

9. Deputy Director's Report

Ms. Amanda Ittner highlighted elements and provided information on topics of her written report, provided in board meeting packets. She also referenced board member Conflict of Interest forms, of which update/maintenance is a requirement, saying MSHN is working with each of the region's CMHSPs to obtain the information. Should additional information be needed, member(s) will be contacted. Acknowledgement and appreciation to CMHSP staff was made relevant to collaboration during recently completed HSAG Performance Measure Validation audit which culminated in a 100% compliance score for MSHN.

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 20-21-005 MOTION BY KURT PEASLEY, SUPPORTED BY DIANNE HOLMAN, TO RECEIVE AND FILE THE STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDING SEPTEMBER 30, 2020, AS PRESENTED. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANNE HOLMAN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, RHONDA MATELSKI, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KERIN SCANLON, AND ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 21-0.

11. Contracts for Consideration/Approval

Ms. Ittner referenced Amendment #1 of the MDHHS-PIHP contract sent via email prior to the board meeting and provided an overview of the FY21 contract listing provided within the board meeting packet. She requested approval for MSHN's CEO to sign and fully execute the contracts listed on the FY21 contract listing, as well as Amendment #1 of the MDHHS-PIHP contract.

MSHN 20-21-006 MOTION BY BRAD BOHNER, SUPPORTED BY DAVID GRIESING, TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE MDHHS-PIHP CONTRACT AMENDMENT #1 AND 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, DIANNE HOLMAN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, RHONDA MATELSKI, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KERIN SCANLON, AND ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 21-0.

12. Executive Committee Report

Chairperson Woods expressed his thanks to MSHN staff for their work with the Michigan Department of Corrections (MDOC). Notice that one additional member is needed to fill a vacancy on the Board Policy Committee was made. Members who are interested should email Mr. Woods.

13. Chairperson's Report

Chairperson Woods reiterated the importance of responding to 360-Degree Leadership feedback surveys if they are received from MSHN. The information provided is used in the performance evaluation process to improve management performance.

14. Approval of Consent Agenda

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

MSHN 20-21-007 MOTION BY IRENE O'BOYLE, SUPPORTED BY GRETCHEN NYLAND, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE DRAFT MINUTES OF THE SEPTEMBER 1, 2020 BOARD OF DIRECTORS MEETING; RECEIVE POLICY COMMITTEE MINUTES OF OCTOBER 6, 2020, RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF OCTOBER 16, 2020; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF SEPTEMBER 21, 2020 AND OCTOBER 19, 2020; AND TO ADOPT THE RECOMMENDATIONS OF THE POLICY COMMITTEE TO APPROVE THE SERVICE DELIVERY CHAPTER AND QUALITY CHAPTER POLICIES, AS PRESENTED. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANNE HOLMAN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, RHONDA MATELSKI, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KERIN SCANLON, AND ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 21-0.

15. Other Business

16. Public Comment

There was no public comment

17. Performance Evaluation

Mr. Sedlock requested the Board handle this matter in closed session.

MSHN 20-21-010 MOTION BY JIM ANDERSON, SUPPORTED BY DIANNE HOLMAN, TO ENTER INTO CLOSED SESSION TO ADDRESS THE CEO PERFORMANCE EVALUATION. VOTING IN FAVOR: JIM ANDERSON, BRAD BOHNER, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAVID GRIESING, DAN GRIMSHAW, DIANNE HOLMAN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, RHONDA MATELSKI, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KERIN SCANLON, AND ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 21-0.

The MSHN Board of Directors entered into Closed Session at 6:35 p.m. to address the CEO performance evaluation.

Mr. Brad Bohner and Mr. David Griesing disconnected at approximately 6:45 p.m.

MSHN 20-21-011 MOTION BY JIM ANDERSON, SUPPORTED BY DIANNE HOLMAN, TO ADJOURN THE CLOSED SESSION AND RECONVENE THE BOARD OF DIRECTORS REGULAR BUSINESS MEETING. VOTING IN FAVOR: JIM ANDERSON, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAN GRIMSHAW, DIANNE HOLMAN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, RHONDA MATELSKI, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KERIN SCANLON, AND ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 19-0.

The MSHN Board of Directors resumed its regular business meeting to address the CEO performance evaluation on the public record.

MSHN 20-21-008 MOTION BY DEB MCPEEK-MCFADDEN, SUPPORTED BY KURT PEASLEY, TO RECEIVE AND FILE THE 2020 PERFORMANCE EVALUATION OF THE CHIEF EXECUTIVE OFFICER. VOTING IN FAVOR: JIM ANDERSON, JOE BREHLER, BRUCE CADWALLENDER, CRAIG COLTON, KEN DELAAT, DAN GRIMSHAW, DIANNE HOLMAN, JOHN JOHANSEN, STEVE JOHNSON, JEANNE LADD, COLLEEN MAILLETTE, RHONDA MATELSKI, DEB MCPEEK-MCFADDEN, GRETCHEN NYLAND, IRENE O'BOYLE, KURT PEASLEY, JOE PHILLIPS, KERIN SCANLON, AND ED WOODS. VOTING AGAINST: N/A. MOTION CARRIED: 19-0.

18. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 6:53 p.m.

Minutes respectfully submitted by:
MSHN Executive Assistant

Colleen Maillette, MSHN Board Secretary

November 25, 2020
Date

Mid-State Health Network SUD Oversight Policy Advisory Board
Wednesday, August 19, 2020, 4:00 p.m.
Virtual Meeting with Zoom

Meeting Minutes

1. Call to Order

Chairperson Debbie Thalison called the MSHN SUD Regional Oversight Policy Board of Directors Organizational Meeting to order at 4:00 p.m.

Board Member(s) Present: Nichole Badour (Gratiot), Bruce Caswell (Hillsdale), Dick Gromaski (Bay), Susan Guernsey (Mecosta), John Hunter (Tuscola), Jerry Jaloszynski (Isabella), Bryan Kolk (Newaygo), John Kroneck (Montcalm), Deb Thalison (Ionia), Kim Thalison (Eaton), Ed Woods (Jackson), Steve Glaser (Midland), Tom Lindeman (Montcalm), and Dwight Washington (Clinton)

Board Member(s) Absent: John Bodis (Huron), Christina Harrington (Saginaw), Vicky Schultz (Shiawassee) Leonard Strouse (Clare), Carol Koenig (Ingham), Larry Emig (Osceola, Robert Luce (Arenac), and Lisa Ashley (Gladwin)

Alternate Members Present: John Kroneck (Montcalm) and Ken Mitchell (Clinton)

Staff Members Present: Amanda Ittner (Deputy Director), Joe Sedlock (CEO), Dr. Dani Meier (Chief Clinical Officer), Carolyn Tiffany (Director of Provider Network Management Systems), Leslie Thomas (Chief Financial Officer), Dr. Trisha Thrush (Lead Treatment Specialist), (Merre Ashley (Executive Assistant), Kari Gulvas (Prevention Specialist), Jennifer McCoy (Office Assistant) and Jill Worden (Lead Prevention Specialist)

2. Roll Call

Ms. Merre Ashley provided the Roll Call for Board Attendance.

3. Approval of Agenda for August 19, 2020

Board approval was requested for the Agenda of the August 19, 2020 Regular Business Meeting, as presented.

ROPB 19-20-014 MOTION BY BRUCE CASWELL, SUPPORTED BY STEVE GLASER, FOR APPROVAL OF THE AGENDA OF THE AUGUST 19, 2020, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 14-0.

4. Approval of Minutes from the JUNE 17, 2020 Regular Business Meeting

Board approval was requested for the draft meeting minutes of the June 17, 2020 Regular Business Meeting.

ROPB 19-20-015 MOTION BY DICK GROMASKI FOR MINUTES TO STAND AS CORRECTED, SUPPORTED BY JOHN HUNTER. CORRECTION MADE BY JERRY JALOSZYNSKI FOR LOCATION OF BOARD MEETING TO REFLECT THAT IT WAS A VIRTUAL MEETING, FOR APPROVAL OF THE MINUTES OF THE JUNE 17, 2020 MEETING. MOTION CARRIED: 14-0.

5. Public Comment

There was no public comment.

6. Board Chair Report

Chairperson Debbie Thalison informed the board that travel vouchers were not required to be filled out and submitted. MSHN would document their attendance at virtual meetings and fill out towards their travel.

A. FY21 Board Calendar

FY21 Board Calendar – Chairperson Thalison stated that the meeting location will be determined by MSHN based on COVID-19 protocols to either remain virtual or go back to face to face. It was noted that the dates were incorrect and will be updated to reflect the correct 2021 dates.

7. Deputy Director Report

Ms. Amanda Ittner referenced and provided information on the following items:

A. FY2020 PA2 Funding and Expenditures by County
B. FY2020 PA2 Use of Funds by County and Provider
C. FY2020 SUD Financial Summary Report of June 2020

8. ACTION ITEM: FY20 Substance Use Disorder (SUD) PA2 Contract Listing

Ms. Carolyn Tiffany, Provider Network Management Director, referenced and provided an overview of the FY20 contract listing, recommended for board approval.

Chairperson Thalison expressed concern regarding the authorization to use PA2 for Ionia County without prior review at the Ionia Coalition.

ROBP 19-20-16 MOTION BY BRUCE CASWELL, SUPPORTED BY DICK GROMASKI, TO APPROVE ITEM 8A THE FY20 SUD CONTRACT LISTING, ROLL CALL VOTE: YES: NICHOLE BADOUR, BRUCE CASWELL, STEVE GLASER, DICK GROMASKI, SUSAN GUERNSEY, JERRY JALOSZYNSKI ABSTAINING: DEB THALISON, VOTING NO: BRIAN KOLK. MOTION CARRIED: 6-1-1

With the motion carrying, Ms. Ittner will ensure staff follow up with the Ionia Coalition for feedback prior to presentation to the full MSHN Board of Directors for approval.

9. ACTION ITEM: FY21 Substance Use Disorder PA2 Contract Listing

Ms. Carolyn referenced and provided an overview of the FY21 contract listing, recommended for board approval.

ROBP 19-20-17 MOTION BY JERRY JALOSZYNSKI, SUPPORTED BY BRUCE CASWELL, TO APPROVE THE FY21 SUD CONTRACT AS PRESENTED. ROLL CALL VOTE: YES: NICHOLE BADOUR, BRUCE CASWELL, DICK GROMASKI, SUSAN GUERNSEY, JERRY JALOSZYNSKI, BRYAN KOLK, STEVE GLASER, TOM LINDERMAN. ABSTANING: DEB THALISON AND JOHN KRONECK. NO: N/A. MOTION CARRIED: 9-0

10. Operating Update

Dr. Dani Meier provided information and updates on the following:

A. Chief Clinical Officer Update

- COVID-19 testing with MSHN's mobile unit has taken place in Ingham County in collaboration with the Ingham County Health Department in August with the focus on methadone providers. The mobile care unit has also completed COVID-19 testing at a methadone clinic in Saginaw and will now be deployed to offer COVID-19 testing in Bay County once PPE supplies are available. Once

completed in Bay County the mobile care unit will then be deployed to Arenac County.

- MDHHS requested all PIHP's submit SUD specific strategic plans for FY21-FY23. MSHN has submitted their draft plan and is awaiting a response. Once MSHN receives the plan back, it will be presented to the SUD OPB board for review and feedback.
- Key elements of strategic plan: *Prevention side*: reducing underage drinking, marijuana use, tobacco/nicotine (vaping) use, opioid prescription uses and reducing substance abuse disorder in older adults. *Treatment side*: expanding access to treatment services such as MAT's, stimulant use, Women's Specialty services, jail-based services, and trauma informed care. The strategic plan also addresses health disparities as a result of COVID-19 crisis.
- August 31, 2020 is International Overdose Awareness Day and all the PIHP's are involved with distributing naloxone – an overdose response medication. The state has created a portal that orders go through to be distributed to communities, coalitions, and public health departments. MSHN has a supply that is available to our 21 counties as well.

B. Achieving Equity in Opioid Use Disorder Treatment

Dr. Meier presented and provided background information on Achieving Equity in Opioid Use Disorder Treatment: Confronting Racism's Impact on Access & Quality Care with a power point presentation.

Board discussion took place regarding MSHN's use of data with Health and Racial Disparities and seeking community and stakeholder feedback.

11. FY21 Budget Presentation

Ms. Leslie Thomas, Chief Financial Officer referenced and presented an overview on the FY21 Budget for Substance Abuse Prevention and Treatment (SAPT). The MSHN budget will be presented to the MSHN's Board of Directors in September.

12. Other Business

Chairperson Thalison reminded the board members of the next SUD OPB board meeting scheduled for October 14, 2020 at 4:00 pm with location to be determine. The board meeting will most likely be held virtual but MSHN will confirm.

13. Public Comment

There were no public comments

14. Board Member Comment

There were no board comments

15. Adjournment

Chairperson Thalison adjourned the August 19, 2020, MSHN SUD Oversight Policy Advisory Board Meeting at 5:16 p.m.

Meeting minutes submitted respectfully by:
MSHN Office Assistant

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES

TUESDAY, DECEMBER 1, 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 Irene O'Boyle, supported by Kurt Peasley, to approve the December 1, 2020 Board Policy Committee Meeting Agenda, as presented. Motion Carried: 4-0.

3. POLICY FOR DISCUSSION Ms. Amanda Ittner reviewed the recommended change to the fifth bullet based off feedback from the first reading by the Policy Committee.

A. Provider Network Management: SUD Direct Service Provider Procurement: Policy amended to ensure inclusion/exclusion of providers to the MSHN SUD Provider Panel based on service demand.

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. Quality: Administrative and Retained PIHP Functions
B. Quality: Behavior Treatment Plan Review Committees
C. Quality: Consumer Satisfaction Surveys
D. Quality: Critical Incidents
E. Quality: Incident Review for SUD Providers
F. Quality: Medicaid Event Verification
G. Quality: Monitoring and Oversight
H. Quality: Performance Improvement
I. Quality: Quality Management
J. Quality: Research
K. Quality: Sentinel Events
L. Service Delivery System: Behavioral Health Recovery-Oriented System of Care
M. Service Delivery System: Clinical Practice Guidelines and Evidence-Based Practices
N. Service Delivery System: Medication Assisted Treatment Inclusion
O. Service Delivery System: Person/Family Centered Plan of Service
P. Service Delivery System: Out of Region Coverage

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Q. Service Delivery System: Women's Specialty Services

MOTION by Kurt Peasley, supported by Colleen Maillette, to approve and recommend the policies under biennial review and the policy under discussion to the full board, as presented. Motion carried: 4-0.

5. NEW BUSINESS

A. Ms. Ittner discussed the value/need for the MSHN Board of Directors first and second reading. First reading occurs via email to all Board members seeking input/review of said policies. If no feedback is received, the policies are included in the MSHN Board of Directors packet for second reading. It is very rare to receive feedback from a board member during the first reading and requires staff resources to combine the packet. Therefore, MSHN recommends eliminating the first reading by MSHN Board of Directors but continue to include the policies for approval in the MSHN Board of Directors packet. Ms. Ittner will include the recommended edits to the General Management: Policy and Procedure Policy to the next Policy Committee meeting.

MOTION by Irene O'Boyle, supported by Colleen Maillette, to remove the second readings for the Board of Directors and only include a first reading during the board packet distribution. Motion Carried: 4-0.

B. Colleen Mailette announced today would be her last Policy Committee meeting as she now has a conflict with the MSHN Board meeting dates. Ms. Mailette thanked Mr. Johansen for his leadership and participation in the policy committee. The members of the policy committee thanked Ms. Mailette for her service and dedication to the board and policy committee.

6. ADJOURN

Chairperson Johansen adjourned the Board Policy Committee Meeting at 10:18 a.m.

Meeting minutes respectfully submitted by:
MSHN Deputy Director

Mid-State Health Network Board of Directors

Executive Committee Meeting Minutes

Friday, December 18, 2020, 9:00 a.m.

Members Present: Ed Woods, Chairperson; Irene O'Boyle, Vice-Chairperson; Colleen Mailette, Secretary; Kurt Peasley, Ex Officio Member

Others Present: Ken DeLaat

Staff Present: Joseph Sedlock, MSHN Chief Executive Officer

1. **Call to order:** This meeting of the MSHN Board Executive Committee was called to order by Chairperson Woods at 9:00a.m.

2. **Approval of Agenda:** Motion by I. O'Boyle supported by K. Peasley to approve the agenda for this meeting. Motion carried.

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

4. **Board Matters:**
   - 4.1. January 12, 2021 Board Meeting - Draft Agenda: The committee reviewed the draft board agenda for January 12, 2021 board meeting. Mr. Sedlock mentioned the addition of two items: Proposal for MSHN to conduct a request for proposals for a crisis residential unit, and then hold the contract, for benefit of the region and Direct Care Worker Premium Pay extension through June 30, 2021. Committee members discussed both items in some detail. No other adjustments to the draft board agenda were made. The Committee notes that the agenda is draft until the final packet is prepared and may be changed as items for inclusion in the meeting warrant.
   - 4.2. Board Self Evaluation: The board self-evaluation uses the same questions and format as have been used for the past five years. Due to low response rates in the past, Administration recommends that time be set aside in the January 12, 2021 board meeting for members to complete the survey. Executive Committee asks that administration convert the current survey to a "survey monkey" format to improve the ease of completion, and to include on the board agenda a 10-15-minute period for board members to complete the board self-evaluation survey during the board meeting itself (in order to improve response rate). Absent members or others that do not complete the survey will receive one email follow-up as a reminder, after which time the survey response window will close and the results tabulated. Results will be included for the current survey and the past several years and will be available for board consideration at the March 2021 board meeting.
   - 4.3. Policy Committee Vacancies: The chair notes that Jim Anderson and Jeanne Ladd have requested consideration for appointment to the two vacancies on the Policy Committee. Chair will make these appointments after calling for any additional nominations at the January 2021 board meeting.

     It was also noted that Colleen Mailette will be stepping away from her MSHN Board Member appointment due to her election to a local body. Executive Committee discussed the appointment of an Acting Secretary to fill Ms. Mailette' s term (officer elections typically follow board reappointments in April and usually occur at the July board meeting). The chair will approach an identified potential candidate to ascertain willingness to serve and will finalize with the board at the January board meeting.

5. **Administrative Matters:**
   - 5.1. Block Grant Reductions – Status, Next Steps, Member Comments: Mr. Sedlock provided a brief summary

of MSHN actions taken since the distribution of the block grant reduction strategy to the governing and oversight policy boards on 12/05/2020. Mr. Sedlock is planning a presentation to include recent updates at the January board meeting under his regular report. Executive Committee concurs.

6. **Personnel Matters:**
   6.1. Consideration of recommendation(s) to the MSHN Board of Directors regarding the employment contract with the Chief Executive Officer: Mr. Sedlock was excused from this meeting so that the Executive Committee could consider the board's employment contract with him as MSHN Chief Executive Officer. Committee discussed proposed changes to employment contract in private. After discussion, motion by K. Peasley, supported by I. O'Boyle that the Executive Committee recommend the proposed employment contract to the full MSHN Board for adoption/approval as presented. Motion Carried. (Mr. Sedlock was invited to rejoin the meeting). Mr. Sedlock was informed of the motion just passed by the Committee. Mr. Sedlock noted that his intention is to request consideration of the employment contract (a personnel matter for which closed session is permitted) in closed session. The Executive Committee directed that the board chair prepares a memorandum to the board disclosing the details of proposed changes to the employment contract for distribution to all MSHN board members prior to the board meeting. This memorandum will also be displayed for board member viewing during closed session at the January virtual board meeting. The Executive Committee noted that Mr. Sedlock was present for the closed session the last time his contract was renewed three years ago, and the Executive Committee anticipates that will also be the case at the January board meeting. However, if the board wishes to excuse Mr. Sedlock so that private conversation can take place, arrangements were made to facilitate that event.

7. **Other**:
   7.1. Next Executive Committee Meeting: scheduled for Friday, January 15, 2021 – As this will be only three days after the January 12, 2021 Board Meeting, administration recommends cancellation. Executive Committee concurs.
   7.2. Any other business to come before the Executive Committee: None

8. **Guest Board Member Comments:** Appreciation expressed for work of MSHN leadership and staff. Happy holiday greetings expressed.

9. **Adjourn**: 9:59 AM

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: November 16, 2020
MEETING RESTRICTIONS IN EFFECT – ZOOM MEETING ONLY

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: Carolyn Tiffany, Leslie Thomas, Kim Zimmerman

Agenda Item	Action Required				
Consent Agenda	Requested minutes from PIHP/MDHHS notes for October that were missing from this month's packet (will be included next month). • CEO Report: ○ Question on DCW and concern about the DCW beyond January 9; If the region is prepared to make a continuation recommendation, it will be brought to the January Board Meeting after financial review in December ○ Unenrolled population proposal – Refresher on how this works and related to Mild to Moderate and the CCBHC – Only includes SMI and will add to future Ops packet again (was distributed in September)				
	Approved as presented	By Who	N/A	By When	N/A
Stay Well Brochures/24 Hour Crisis	S. Lindsey brought up the zoom call in the eastern region related to FEMA grant documents – MDHHS Tool Kits Documents – Informational and distributed to the group – includes crisis line numbers for each CMH.				
	Informational Only – CMHSPs to confirm accuracy of crisis line numbers	By Who	CMHSPs	By When	11.20.20
FY 21 Consumer Handbook Edits	K. Zimmerman reviewed the summary of changes in the consumer handbook for FY21				
	Approved as presented	By Who	K. Zimmerman	By When	11.30.20
FY 20 Savings Estimates As Of 09/30/20	L. Thomas reviewed the FY20 Savings Estimates as of 9.30.20				
	Informational Only	By Who	N/A	By When	N/A
MSHN Block Grant Allocation – • 50% cut by OROSC • Net 37% Reduction - ~$5.2M	J. Sedlock reviewed the reduction to the regions SUD Block Grant funds. This will be an ongoing reduction in our allocation. MSHN has a task force working on identifying reductions. Would CMHSPs entertain a proposal for utilizing a portion of performance bonus incentive fundings earned by the region to cover any overage? If yes, MSHN would bring a proposal to a future date. • Operations Council is open to MSHN bringing forward the proposal with the preamble of the identified efforts to reduce allocations in current year.				
	Discussion Only	By Who	N/A	By When	N/A

Agenda Item	Action Required				
Network Adequacy Assessment – FY 21	C. Tiffany reviewed the changes to the Network Adequacy Assessment for FY21				
	Ops Council to review and provide input/feedback by 12.18.20	By Who	C. Tiffany	By When	12.18.20
Temporary Moratorium on Specialized Residential Site Review Activity	Per email forwarded by J. Sedlock: Providers are struggling with audits, HCBS oversight, MEV reviews, etc. If items can be delayed, please take that approach to support the providers in our region.				
	Discussion, support, and support to pursue with MDHHS for formal request to not have compliance issues if postponed.	By Who	J. Sedlock	By When	11.30.20
FY 20 Q3 MMBPIS Summary Report	K. Zimmerman reviewed the summary report for MMBPIS including the new indicators/changes to indicators and exceptions and related reduction in performance.				
	Discussion Only	By Who	N/A	By When	N/A
Default to "Video On" for Regional Meetings	J. Sedlock reviewed the discussion at the last Ops Council meeting to support for default to "video on" for regional meetings.				
	MSHN will develop regional statement/communication for our leaders to distribute and CMHSPs to distribute	By Who	J. Sedlock	By When	11.30.20
Group Home COVID Testing	S. Lurie discussed this item during the other COVID meeting, so all set.				
	Informational Only	By Who	N/A	By When	N/A
Deputy Director's Report	A. Ittner reviewed her board report inclusive of MSHN data web page, PMV and telehealth.				
	Informational Only	By Who	N/A	By When	N/A
CMHSP SUD Transportation Technical Advisory Revision	A. Ittner reviewed the Technical Advisory – Questions should be directed to Skye Pletcher. This guidance may be limited by block grant reductions.				
	Informational Only	By Who	N/A	By When	N/A
WHAM Promo – Peer Training Availability	A. Ittner reviewed the WHAM Promo – Encouraged region to attend/register – Grant funded				
	Informational Only	By Who	N/A	By When	N/A
FY 21 PIHP/MHP Shared Metrics Specifications	A. Ittner reviewed the Metrics including the reference to disparities. Meeting with MDHHS today to review the metrics and regional performance.				

Agenda Item		Action Required			
	Informational Only	By Who	N/A	By When	N/A
Performance Bonus Incentive Report – FY 20	The first PBI report was sent out separately. A. Ittner reviewed the report and timeline for MDHHS to review/respond before final version for bonus approval. (There are other aspects to the performance bonus, including performance on specified metrics)				
	Informational Only	By Who	N/A	By When	N/A
OT/PT for Habilitative Services	C. Pinter raised the issue the now MHPs have this option included in the covered services.				
	Informational Only	By Who	N/A	By When	N/A
Schedule Strategic Planning "Day" (or "Days") for Operations Council	J. Sedlock discussed his thoughts to propose a couple hours during the regular scheduled meetings in March and April for strategic planning.				
	Discussion Only - Support	By Who	J. Sedlock	By When	3.1.20
NEW Epidemic Orders	S. Lurie mentioned Al send out email for any questions to be sent to him. Did we want to send a regional response with a list of questions? Discussions on rapid tests availability, inpatient availability, etc. MSHN has had 3 calls with Al on inpatient access.				
	Discussion Only	By Who	N/A	By When	N/A

MSHN
Mid-State Health Network

REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: December 14, 2020
MEETING RESTRICTIONS IN EFFECT – ZOOM MEETING ONLY

Members Present: Lindsey Hull; Carol Mills; Sharon Beals; Tracey Dore; Tammy Warner; Maribeth Leonard; Kerry Possehn; Michelle Stillwagon; John Obermesik; Sandy Lindsey; Sara Lurie
Members Absent: Chris Pinter
MSHN Staff Present: Joseph Sedlock; Amanda Ittner; For Applicable Topics: Todd Lewicki, Skye Pletcher, Leslie Thomas, Kim Zimmerman, Amy Dillon

Agenda Item	Action Required				
Consent Agenda	C. PIHP/MDHHS Operations Meeting: John questioned page 17, local crisis lines via MiCAL– (Page 4, 2c.), difficulty accepting idea to relinquish local crisis lines and seem like too many barriers, understand 2 pilots will be implemented. J. Sedlock indicated the intent was to invite an MDHHS member to the Ops Council but it was pushed to January.				
	Approved as presented On Item C – J. Sedlock to invite Jon Villasurda and Krista Hausermann to January (or future) Ops Council Meeting	By Who	N/A J. Sedlock	By When	N/A 01/11/21
FY21 Financial Management (formally Fiscal Intermediary) Contract Amendment	A. Ittner reviewed the summary and background regarding the changes to the FY21 Financial Management contract and asked Ops Council to review, provide feedback, questions, etc. by January 7 to Carolyn Tiffany (Carolyn.Tiffany@midstatehealthnetwork.org) to allow final to presented to Ops in January.				
	CMHSPs to review and provide feedback	By Who	CMHSPs	By When	1.7.21
MSHN Crisis Residential Development Analysis and Proposal	T. Lewicki reviewed the background, summary and recommendations for next steps related to developing a regional Crisis Residential contract held by MSHN for regional benefit. J. Obermesik would like the RFP to identify or weight for a vendor in a location that supports the region and makes it possible for other regions to place individuals when there isn't a MSHN-beneficiary need.				
	Operations Council fully supports MSHN moving this proposal forward to (1) conduct an RFP for the region; (2) enter into negotiations with a successful bidder; (3) present a contract to the MSHN board for Crisis Residential Services (to be held and managed by MSHN) after Board approval	By Who	T. Lewicki/J. Sedlock	By When	1.30.21
Direct Care Worker Premium Pay Continuation	L. Thomas reviewed the DCW analysis and related cost to continue the DCW. There is legislation being proposed to extend DCW Premium Pay through 3.31.21. MSHN is expected to lapse DCW Premium Pay funds in FY20 (reason is that MSHN can not retain the revenue in excess of expense per contract). FY21 revenue is expected to be sufficient to cover 1st quarter expense with an overage of 3.8m. If no revenue received in FY21 last 3 quarters, it would cost 18.3m for MSHN that could be pulled from the 33.8m estimated savings from FY20. L. Thomas also reviewed the same analysis for the provider stabilization payments. Total FY20 was 8.7m. In FY21, estimated at 17.5m.				

Agenda Item	Action Required				
	Summary: FY20 savings at 33.8m; FY21 DCW and Provider Stabilization total 36m; Over by 2.2m but expected to be able to utilize current revenue that is expected to be unspent. MSHN Proposes extending DCW and through 3rd quarter, June 30, 2021. MDHHS will require Provider Stabilization plan to be continued throughout FY 21. S. Laurie asked again to add ACT and other groups. There is concern that opening other worker categories to the DCW premium pay would create more problems than it would solve. MSHN reminded CMHSPs that, within CMH budget constraints, CMHSPs in the region could create incentives or provide premium pay to other job classifications. C. Mills asked how this would affect rates. DCW premium pay done by MSHN independent of MDHHS financial should be recognized in PIHP rate setting process, Provider Stabilization would not but need to be allocated in costs.				
	Ops Council supports DCW through 6.30.21 (actual end date to be determined by MSHN to coordinate with MSHN Board meetings), MSHN will present to the January Board meeting. MSHN has already extending PS through FYE 21. L. Thomas will follow up with Finance Council to determine fiscal impact, cash flow, etc.	By Who	J. Sedlock	By When	1.11.21
BBA Managed Care Rules Tracking Sheet	A. Ittner reviewed the new BBA Managed Care rules effective 12.14.20 with some exceptions that are effective July 1, 2021. MSHN will send out excel version for easier tracking/review. Discussed areas being monitored by MSHN and respective councils.				
	A. Ittner will send out excel BBA tracking	By Who	A. Ittner	By When	12.14.20
Diabetes Monitoring Summary Report	K. Zimmerman reviewed the PIP for FY20 – Diabetes HEDIS screening and monitoring. The baseline of calendar year 2018 did have an error related to incorrect diagnosis in specifications that dropped our rate. MSHN was not able to achieve statistical significance in FY20.				
	CMHSPs take note of local results and asked to support local change and improvements; this is important for CMHSP follow-up as it relates to health outcomes improvements for the people we support and with HSAG reviews	By Who	CMHSPs	By When	Ongoing
Health Equity Analysis Report	S. Pletcher reviewed FY21 Integrated Health Metrics Equity Analysis Plan all Cause Readmissions has been removed from PIHP performance incentive bonus Report period changed to July 1, 2020 – June 30, 2021; with comparison year - calendar year 2019 Interest in sharing the barriers identified				
	Skye will share data and barriers with Ops Council	By Who	S. Pletcher	By When	12.20.20
Complex Care Management for the Unenrolled – PIHP Proposal Questions – Follow-Up	J. Obermesik indicated they have looked at high utilizers and have saved physical health expenses by conducting complex care management; wanted to share some concerns and questions.				

Agenda Item	Action Required				
	J. Sedlock clarified there is no risk to the CMHs and that it was specifically designed to be FFS (non-risk based) with the PIHPs. There is no involvement of, no risk to, and no financial relationship to CMHSPs unless an individual is already in service, which would already be the CMHSPs responsibility. If a CMHSP is contracted to do work related to the Unenrolled under this proposal, the CMHSP would be paid for its work. If the proposal is taken up by MDHHS, PIHPs collectively will negotiate with MDHHS on savings sharing. There are many benefits to the proposal, including putting the PIHPs and our CMHSP partners in the position of solving a "headache" for MDHHS. Adopting the PIHP proposal would significantly strengthen the value proposition of the public system as well as make it more difficult for the system to be "taken apart". The proposal is specific to unenrolled – those not enrolled in a Medicaid Health Plan PIHPs have submitted to MDHHS Executive Office, which has assigned it to BHDDA; Al Jansen expected to attend a future PIHP meeting to discuss; A copy of the proposal was sent to the Association, which has referred it to a number of internal groups/committees to inform a decision on whether the Association supports or takes an alternate position.				
	Discussion and informational Only	By Who	N/A	By When	N/A
		By Who		By When	
		By Who		By When	
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Chapter:	Provider Network Management		
Title:	Substance Use Disorder Service Provider Procurement		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Annually **Author:** Director of Provider Network Management Systems, Contract Manager	**Adopted Date: 01.06.2016** **Review Date:** 01.12.2020	**Related Policies:** Provider Network Policy Provider Network Credentialing and Re-credentialing Policy

Purpose

This policy is intended to provide guidance to Mid-State Health Network (MSHN) staff involved with Substance Use Disorder provider network panel procurement and contracting.

Policy

It is MSHN's objective to acquire needed services and supports at fair and economical prices, with appropriate attention to quality of care and maintenance of existing-care relationships and service networks currently used by service recipients.

MSHN maintains a managed open Substance Use Disorder provider panel of organizational providers and/or provider network entities that are:

- Qualified: with appropriate credentials, license(s), accreditation, quality review, and meet pre- contract and ongoing site review standard(s),
- Willing: to accept contract terms, price and performance expectations, oversight activities, etc.
- Able: with a history of providing same or like services at a satisfactory level; qualified staff; satisfied fund sources,
- Competent: with administrative, clinical, billing, financial and other systems to support/produce desired outcomes,
- Needed: there exists in the MSHN region or parts of the region a documented need for the services/supports offered by the provider and sufficient projected beneficiary/service volume to justify empaneling a provider, and
- On file with MSHN after having submitted a completed Provider Network Application and Ownership & Controlling Interested Disclosure Statement.

MSHN conducts a periodic assessment of its provider network adequacy to identify underserved locales and underserved populations within the MSHN Region. As a result of the assessment, MSHN may, in its sole discretion, using any legitimate means including by way of competitive or non-competitive solicitation, empanel Licensed Independent Practitioners to provide specialized services or to improve access to services in underserved areas thus increasing consumer choice.

MSHN may, at its sole discretion, periodically review, revise, renew or update its provider network. MSHN may use a formal Request for Proposals (RFP) for provider services in circumstances where gaps exist, expansion is desirable, or service capacity is low, or for any other reason in the interests of MSHN. MSHN, in its sole discretion, may restrict or otherwise limit the number of providers that can participate in its provider network in any portion of or for all of its region. Factors that are considered in these circumstances include, but are not limited to, level(s) of utilization of the same or similar services in the geographic or sub-geographic area to be served, consumer choice considerations, quality, cost, pricing, provider saturation, other market factors or other programmatic considerations. For some market factors, such as but not limited to service cost comparison, a periodic Request for Quote (RFQ) process, annual planning process, or similar processes may be utilized when MSHN would like to obtain new or updated information.

MSHN's procurement processes shall reflect applicable State and local laws and regulations, provided that the procurements conform to applicable Federal law and the standards identified in 45 CFR 92.36.

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:
Managed Open Provider Panel: Status by which MSHN, in its sole discretion, may contract with a qualified, willing, able, and competent provider or provider entity without going through a formal RFP process, depending upon the needs of the region or a specific sub-geographical part of the region, service demand, service utilization and other market and programmatic factors identified in this policy.
Request for Proposal (RFP): A solicitation, often made through a bidding process, by an agency or company interested in procurement of a commodity, service or valuable asset, to potential suppliers to submit business proposals.
Request for Quote (RFQ): A solicitation in which an agency or company seeks outside providers or vendors to provide a cost quote for the completion of a particular project, service, or program. An RFQ is more likely to occur in situations where products and services are standardized, since this allows the soliciting agency to compare the different bids easily.
SUDSP: Substance Use Disorder Service Provider: Agency that provides prevention, early intervention, outpatient, withdrawal management, residential, recovery housing, or medication assisted treatment services.

Other Related Materials:
Procurement through Request for Proposal Procedure Procurement Technical Requirements P37.0.1

References/Legal Authority:
45 CFR 92.36

Change Log:

Date of Change	Description of Change	Responsible Party
11.2015	New Policy	Director of Provider Network Mgmt. Systems
08.2017	Annual Review/Update Language	Director of Provider Network Mgmt. Systems
10.2018	Annual Review	Director of Provider Network Management
01.2020	Annual Review	Director of Provider Network Management
09.2020	Review to included Needed Requirement	Chief Executive Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	Administrative & Retained PIHP Functions Contract Monitoring and Oversight		
Policy: ☑ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Compliance Officer	Adopted Date: 12.08.2020 Review Date: 01.12.2021 Revision Eff. Date:	Related Policies: Quality Management

Purpose

This policy is intended to establish guidelines, as the Pre-Paid Inpatient Health Plan (PIHP), for the development and implementation of the Mid-State Health Network (MSHN). To ensure compliance with federal and state regulations, and to establish standardized processes for conducting a review of performance contracts.

Policy

MSHN shall create, implement and maintain a published process to monitor and evaluate its administrative and retained PIHP function contracts to ensure compliance with federal and state regulations and to ensure compliance with the contracted scope of work.

A. MSHN shall conduct a full monitoring and evaluation process of administrative and retained PIHP function contracts at least annually prior to the expiration (or renewal) of the contract. This process will consist of utilizing a uniform contract assessment template to evaluate compliance with contractual requirements and deliverables identified in the scope of work.
B. The contract assessment process shall consist of the following components:
    1. ***Deliverables in the Contract Scope of Work****:* Identified elements for each component evaluated based on: exceeds expectations, meets contract requirements, partial met contract requirements, unmet contract deliverables.
    2. ***Customer Service/Satisfaction****:* Includes contractor performance with the Provider Network, MSHN staff and MSHN Councils and Committees.
    3. ***Contract Performance Strengths****:* Includes identification of strengths related to contract performance.
    4. ***Contract Performance Opportunities****:* Includes opportunities for improvement in current performance, consideration for future growth, and requests related to new requirements.
    5. ***Value (Price/ROI)****:* Includes an assessment based on contractor's deliverables, scope of work, contract price to determine value.
    6. ***Recommendations***: Includes recommendation to renew contract, terminate or let expire.
C. Overall responsibility for the contract monitoring evaluation process shall rest with the MSHN contract designee identified in the contract.
D. Input and feedback regarding the assessment shall be obtained from related parties as appropriate. (e.g. Provider Network, MSHN staff, MSHN Councils)
E. The contractor shall be given the opportunity to complete a self-assessment utilizing the MSHN performance contract assessment template.
F. The MSHN contract designee shall discuss and review the completed performance assessment with the contractor to provide an opportunity for collaborative review and feedback.
G. The completed assessment with the appropriate recommendation shall be forwarded to the MSHN Chief Executive Officer and MSHN Chief Financial Officer for consideration in future contracting.
H. Final contract evaluation shall be maintained in the provider's contract file.

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
MDHHS: Michigan Department of Health and Human Services
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

Performance Contract Assessment Template

References/Legal Authority

N/A

Change Log:

Date of Change	Description of Change	Responsible Party
01.26.2015	New Policy	Chief Compliance Officer
03.2016	Annual Review	Quality, Compliance and Customer Service Director
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service and Quality
03.2019	Annual Review	Quality Manager
10.2020	Biennial Review	Quality Manager

POLICIES AND PROCEDURE MANUAL

Chapter:	**Quality**		
Title:	**Behavior Treatment Plan Review Committees**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle: Annually** **Author:** Chief Compliance Officer, Quality Improvement Council	**Adopted Date: 12.08.2020** **Review Date:** 01.12.2021 **Revision Eff. Date:**	**Related Policies:** **Quality Management**

Procedure:
The purpose of this policy is to guide Mid-State Health Network (MSHN) in monitoring the delegated function of Behavior Treatment Plan (BTP) Review Committees to the CMHSP Participants in accordance with the Michigan Department of Health and Human Services (MDHHS) Medicaid Managed Specialty Supports and Services Contract.

Policy:
MSHN through delegated function to the CMHSP participants will adhere to the guidelines of the Standards for Behavior Treatment Plan Review Committees.

Each CMHSP Participant shall have a Behavior Treatment Plan (BTP) Committee to review and approve or disapprove any plan that proposes to use restrictive or intrusive interventions in accordance with the Standards.

Evaluation of the BTP Committee's effectiveness by stakeholders, individuals who have a plan, family members and advocates shall occur annually as part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP).

A. Data on the use of the intrusive and restrictive techniques will be:
   1. Evaluated by the PIHP's QAPIP and the CMHSP's QIP
   2. Available for review by the PIHP and MDHHS

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

Definitions:
Aversive Techniques: Those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant and may often generate physical painful responses in the average person or would have a specific unpleasant effect on a particular person) by staff to a recipient to achieve the management and/or control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist or other noxious substance to consequate behavior or to accomplish a negative association with target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g., exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive for purposes of this technical requirement. Otherwise, use of aversive techniques is prohibited. Disclaimer: It is the policy of the Pre- Paid Inpatient Health Plan (PIHP) that aversive interventions are prohibited by any direct or contract provider employee.

BTP: Behavior Treatment Plan
BTPRC: Behavior Treatment Plan Review Committee CMHSP: Community Mental Health Service Provider
Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self- injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.
MSHN: Mid-State Health Network
MSHN-CO: Mid-State Health Network Compliance Officer MDHHS: Michigan Department of Health and Human Services QAPIP: Quality Assessment and Performance Improvement Program QIC: Quality Improvement Council
QIP: Quality Improvement Program
Other Techniques: Those techniques that are insufficiently documented in the established literature, or evidence-based practices, related to behavior management. "Insufficient" means that in the best judgment of the BTPRC, there are too few references in commonly available literature.
Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code (MMHC) and the federal Balanced Budget Act. Examples of such techniques are limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.

Other Related Materials:
Project Description

References/Legal Authority:
1. Michigan Department of Health and Human Services
2. Michigan Mental Health Code
3. Michigan Department of Health and Human Services Standards for Behavior Treatment Plan Review Committees
4. Mid-State Health Network QAPIP Plan

Monitoring and Review Completed by:
This policy shall be reviewed annually by the MSHN Quality Manager in collaboration with CMHSP Participants. Compliance with this policy shall be ensured through the following: minimum of annual monitoring of CMHSP Participants, review of data and submitted reports, and/or on-site visits. External monitoring by MDHHS and/or accreditation bodies may also occur.

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New Policy	Chief Compliance Officer
04.2016	Annual Review	Director of Compliance, Customer Service & Quality
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service & Quality
03.2019	Annual Review	Quality Manager
10.2020	Biannual Review	Quality Manager

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POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	Consumer Satisfaction Surveys		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Compliance Officer, Quality Improvement Council	Adopted Date: 04.07.2015 Review Date: 01.12.2021 Revision Eff. Date:	Related Policies:

Purpose

To ensure Mid-State Health Network (MSHN) and its Provider Network comply with the Satisfaction Survey process and requirements as set forth in the Michigan Department of Health and Human Services (MDHHS), Medicaid Specialty Supports and Services Contract.

Policy

MSHN shall ensure satisfaction surveys of persons receiving treatment are conducted by the Provider Network at least once a year.

A. Consumers may be active consumers or consumers discharged up to 12 months prior to their participation in the survey.
   - Surveys may be conducted by mail, electronic, telephone, or face-to-face.
   - Surveys will be conducted in accordance with the forms and timelines established in the MDHHS contract reporting requirements regarding consumer satisfaction surveys.
   - Consumer satisfaction surveys shall incorporate questions that address the "welcoming" nature of the agency and its services.

B. Survey results will be aggregated and reviewed for continuous quality improvement by the Provider Network.
   - Regional survey results will be aggregated and reviewed by the Quality Improvement Council, the SUD Provider Advisory Committee, and the Regional Consumer Advisory Council for determining appropriate initiatives and areas for quality improvement.
   - MSHN will compile findings and results of client satisfaction surveys and related improvement initiatives for all providers and make findings and results, by provider, available to the public.

C. MSHN shall monitor compliance with satisfaction surveys through reporting progress and outcomes to the MSHN Quality Improvement Council, SUD Provider Advisory Council, the SUD Provider Network meeting, Regional Consumer Advisory Council, other relevant committees/councils, and Operations Council and the Board of Directors.

Applies to:

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

Definitions:

CMHSP: Community Mental Health Service Programs
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
SUD: Substance Use Disorder
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

Other Related Materials
N/A

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

Change Log:

Date of Change	Description of Change	Responsible Party
03.2015	New Policy	Chief Compliance Officer, Quality Improvement Council
03.2016	Annual Review	Quality, Compliance and Customer Svc Director
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service & Quality
03.2019	Annual Review	Quality Manager
10.2020	Biennial Review	Quality Manager

POLICIES AND PROCEDURE MANUAL

Chapter:	**Quality**		
Title:	**Critical Incidents**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle: Biennial** **Author:** Quality Improvement Council, Chief Compliance Officer	**Adopted Date: 07.01.2014** **Review Date:** 01.12.2021 **Revision Eff. Date:** 01.05.16	**Related Policies:** Quality Management Policy Sentinel Event Policy

Purpose: To ensure that the Mid-State Health Network (MSHN) pre-paid inpatient health plan is in compliance with the Michigan Department of Health and Human Services (MDHHS), Medicaid Managed Specialty Supports and Services Contract, Critical Incident Reporting System.

Policy: MSHN delegates responsibility to its Community Mental Health Services Program (CMHSP) Participants, with oversight and monitoring by MSHN, for collecting, analyzing and reporting to MSHN all critical incidents that meet the criteria as specified in the MDHHS Medicaid Specialty Supports and Services Contract.

- The CMHSP reports the critical incidents as required to MSHN for analysis andaggregation.
- Where a County of Financial Responsibility (COFR) agreement exist, the COFR shall report the critical incidents.
- MSHN reports to the MDHHS, critical incident data as required and in accordance with the Medicaid Managed Specialty Supports and Services Contract.
- For the sake of Critical Incident reporting, a consumer is considered to be actively receiving service when any of the following occur:
    1. A face-to-face intake has occurred, and the individual was deemed eligible for ongoing service, or
    2. The CMHSP/PIHP has authorized the individual for ongoing service, either through a face-to- face assessment or a telephone screening, or
    3. The individual has received a non-crisis, non-screening encounter
- The period during which the consumer is considered to be actively receiving services shall take place between the following begin date and end date, inclusively:
    1. Begin Date: Actively receiving services begins when the decision is made to start providing ongoing non-emergent services. Specifically, the beginning date shall be the first date that any of the 3 conditions referenced above occurs.
    2. End Date: When the consumer is formally discharged from services. The date the discharge takes effect shall be the end date. This should also be the date that is supplied to the consumer when the consumer is notified that services are terminated.
- The CMHSP is responsible for ensuring a process is in place to recommend and implement corrective action plans and quality improvement processes in an effort to prevent the reoccurrence of critical incidents.
- 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.

Critical incidents are defined as:

1. **Suicides*:** by any consumer actively receiving services or who received an emergent service within the last 30 days calendar days.
2. **Non-Suicide Deaths*:** by consumers who were actively receiving services at the time of their death and met any one of the 2 following conditions:

A. Living in a specialized Residential or a child-caring institution or
B. Receiving any of the following:
   - Community Living supports,
   - Supports Coordination,
   - Targeted Case management
   - ACT
   - Home-Based
   - Wrap-Around
   - Habilitation Supports Waiver (HSW)
   - Serious Emotional Disturbance (SED) Waiver Child Waiver Services (CWS)

3. **Emergency Medical Treatment due to Injury or Medication Errors**: report consumers who, at the time of event were actively receiving services and met any one of the following two conditions:
   A. Living in a 24-hour Specialized Residential setting (per the Administrative Rule R330.1801-09) or in a Child-Caring Institution, or
   B. Receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.
4. **Hospitalization due to Injury or Medication Errors**: by consumers who at the time of the event were actively receiving services and met any one of the following two conditions:
   A. Living in a 24-hour Specialized Residential setting (per the Administrative Rule R330.1801-09) or in a Child-Caring Institution, or
   B. Receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.
5. **Arrests**: of consumers who, at the time of their arrest were actively receiving services and met any one of the following two conditions:
   A. Living in a 24-hour Specialized Residential setting (per the Administrative Rule R330.1801-09) or in a Child-Caring Institution, or
   B. Receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.

Unexpected deaths who at the time of their deaths were receiving specialty supports and services, are subject to additional review and must include:

1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
2. Involvement of medical personnel in the mortality reviews
3. Documentation of the mortality review process, findings, and recommendations
4. Use of mortality information to address quality of care
5. Aggregation of mortality data over time to identify possible trends.

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 Programs
Unexpected Deaths: Deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

Other Related Materials:

References/Legal Authority:

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New Policy	Chief Compliance Officer
05.12.2015	Added COFR clarification	Chief Compliance Officer
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service & Quality
03.2019	Annual Review, added unexpected death review	Quality Manager
10.2020	Biennial Review	Quality Manager

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POLICY & PROCEDURE MANUAL

Chapter:	Quality		
Title:	Clinical Practice Guidelines and Evidence-Based Practices		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Compliance Officer	Adopted Date: 11.04.2014 Review Date: 01.12.2021 Revision Eff. Date:	Related Policies: Quality Management

Purpose

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

Policy

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

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

Standards:

A. CMHSP Participants and the Substance Use Disorder Prevention and Treatment Provider System under contract to provide prevention and/or treatment services for mental health and/or substance use disorders will deliver services in a manner which reflects the values and expectations contained in nationally accepted or mutually agreed upon practice guidelines.
    a. The guidelines should include but are not limited to the following practice guidelines:
        i. Inclusion Practice Guideline
        ii. Housing Practice Guideline
        iii. Consumerism Practice Guideline
        iv. Personal Care in Non-specialized Residential Settings
        v. Family Driven and Youth Guided Policy and Practice Guideline
        vi. Employment Works! Policy
        vii. School to Community Transition
    b. Adoption, development, and implementation of practice guidelines
        i. Key concepts of recovery and resilience, wellness, person-centered planning/individual treatment planning and choice, self-determination, and cultural competency are critical to the success of implementation of practice guidelines or treatment.
        ii. Practices will appropriately match the presenting clinical and/or community needs as well as demographic and diagnostic characteristics of the individuals to be served.
        iii. Programs will ensure the presence of foundational practice skills including motivational interviewing, trauma informed care, and positive behavioral supports.
        iv. Practices which are not evidence-based should be replaced with practices that are, where feasible.
        v. Promising or emerging EBPs may be conditionally explored or supported where appropriate to meet the needs of person served.

vi. CMHSP Participants and Substance Use Disorder Service Providers (SUDSP) will review service and clinical practices for EBP endorsement, offering an array of EBPs which best meet the needs of the persons served.
vii. Evidence for EBP prevention programs must come from one of these sources: a) Federal Registries; b) Peer Reviewed Journals; c) Community Based Process Best-Practices; or d) Other sources of documented effectiveness.

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

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

Applies to:

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

Definitions:

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

References/Legal Authority:

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

Change Log:

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

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POLICIES AND PROCEDURE MANUAL

Chapter:	**Quality**		
Title:	**Incident Review for Substance Use Disorder (SUD) Providers**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle: Biennial** **Author:** Quality Manager	**Adopted Date: 07.07.2020** **Review Date: 01.12.2021** **Revision Eff. Date:**	**Related Policies:** Quality-Sentinel Events Policy

Purpose: To ensure that the Mid-State Health Network (MSHN) pre-paid inpatient health plan is in compliance with the Michigan Department of Health and Human Services (MDHHS), Medicaid Managed Specialty Supports and Services Contract, Substance Use Disorder Incident Review for Sentinel Event Reporting

Policy: MSHN delegates responsibility to its Substance Use Disorder Providers, with oversight and monitoring by MSHN, for collecting and analyzing all incidents that meet the criteria as specified in the MDHHS Sentinel Events Data Report and the SUD Provider Manual. The SUD Provider reviews at a minimum the following incidents for those who reside in a 24-hour specialized setting or recovery housing.

- death of a recipient
- serious illness requiring admission to hospital
- accident resulting in injury to recipient requiring emergency room visit or hospital admission
- behavioral episode (serious challenging behavior)
- arrest and/or conviction
- medication error
- administration of Narcan

All incidents should be reviewed to determine if the incidents meet the criteria and definitions for a sentinel event and if they are related to practice of care. The outcome of this review is a classification of incidents as either a) sentinel events, or b) non-sentinel events.

All incidents should be reported to MSHN quarterly (January 15, April 15, July 15, October 15) as indicated in the reporting requirements. Additionally, deaths of recipients and all administrations of Narcan should be reported within 48 hours to MSHN.

Oversight and monitoring will be conducted by MSHN through the review of reports and analysis by the Quality Improvement Council/Provider Advisory Council and provider network monitoring desk audit and site reviews.

Deaths as a result of staff action or inaction, or subject to a recipient rights investigation, licensing, or police investigation requires additional information to be submitted to the Quality Manager at MSHN for reporting to MDHHS within 48 hours of the notification of an investigation occurring.

The additional information includes the following:

a. Name of beneficiary
b. Beneficiary ID number (Medicaid ID/MIChild ID)
c. Consumer ID (COND) if there is no beneficiary ID number.
d. Date, time and place of death (if a licensed foster care facility, include the license#)
e. Preliminary cause of death
f. Contact person's name and E-mail address.

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:
Death: That which is not by natural cause or does **not** occur as a natural outcome to a chronic condition (e.g. terminal illness) or old age.
Unexpected Deaths: Deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.
Sentinel Event: An "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." (JCAHO, 1998)
24-hour Specialized Setting: Means substance abuse residential treatment programs.
Injury -Injury by accident resulting in in a visit to an emergency room, medi-center and urgent care clinic/center and/or admissions to hospital
Physical illness resulting in admission to a hospital: Does **not** include planned surgeries, whether inpatient or outpatient. It also does **not** include admissions directly related to the natural course of the person's chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.
Serious challenging behaviors: Behaviors not already addressed in a treatment plan and include significant (in excess of $100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence that result in death or loss of limb or function to the individual or risk thereof. All unauthorized leaves from residential treatment are not sentinel events in every instance) Serious physical harm is defined by the Administrative Rules for Mental Health (330.7001) as "physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient."
Medication errors: Mean a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage which resulted in death or loss of limb or function or the risk thereof. It does not include instances in which consumers have refused medication.
Recovery Housing: Recovery housing provides a location where individuals in early recovery from a behavioral health disorder are given the time needed to rebuild their lives, while developing the necessary skills to embark on a life of recovery. This temporary arrangement will provide the individual with a safe and secure environment to begin the process of reintegration into society, and to build the necessary recovery capital to return to a more independent and functional life in the community. These residences provide varying degrees of support and structure. Participation is based on individual need and the ability to follow the requirements of the program. (Excerpt from the proposed Substance Use Disorder Benefit Package for the state of Michigan).

Other Related Materials:
MSHN Sentinel Event Policy
MSHN SUD Provider Manual

References/Legal Authority:
Medicaid Managed Specialty Supports and Services Program Contract. Medicaid Managed Specialty Supports and Services Program Contract SUD Non-Medicaid Reporting Instructions
MDHHS Sentinel Events Data Report
MDHHS Substance Use Disorder Benefit Package for the state of Michigan

Change Log:

Date of Change	Description of Change	Responsible Party
03.2020	New Policy to address incident review requirement	Quality Manager
10,2020	Biannual Review	Quality Manager

POLICIES AND PROCEDURE MANUAL

Chapter:	**Quality**		
Title:	**Medicaid Event Verification**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle: Biennial** **Author:** Medicaid Event Internal Auditor and Director of Compliance, Customer Service and Quality	**Adopted Date: 01.05.2016** **Review Date: 01.12.2021** **Revision Eff. Date: 12.08.2020**	**Related Policies:** Monitoring and Oversight

Purpose

To establish guidelines as the Pre-Paid Inpatient Health Plan (PIHP) for the development and implementation of the Mid-State Health Network (MSHN) process for conducting monitoring and oversight of the Medicaid, Healthy Michigan Plan and SUD Block Grant claims/encounters submitted within the Provider Network. To ensure compliance with federal and state regulations, and to establish standardized process for review of claims/encounters submitted for Medicaid, Healthy Michigan Plan and SUD Block Grant recipients in accordance with the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Attachment - Medicaid Services Verification-Technical requirements.

Policy

MSHN shall create, implement and maintain a published process to monitor and evaluate its Provider Network to ensure compliance with federal and state regulations. This includes protocol for how monitoring and oversight of any claims/encounters provided to beneficiaries of Medicaid, Healthy Michigan and SUD Block Grant services will be completed.

A. MSHN shall conduct a full monitoring and verification process on a selected sample of claims/encounters. The reviews will be completed as follows:
    1. CMHSPs bi-annually
    2. Substance Use Disorder providers annually
    3. Any provider (including subcontractors of the CMHSP and SUD providers) that represents more than 25% of MSHN claims/encounters in either unit volume or dollar value annually. The 25% of unit volume will be determined using the claims/encounters billed to MSHN with each submitted claim/encounter equaling 1 unit of claims/encounters.
    4. Any Provider that MSHN directly contracts with for services that are paid utilizing Medicaid or Healthy Michigan Plan funding,
    5. Upon termination of a Provider contract with MSHN.

MSHN reserves the right to conduct further reviews of the Provider Network on an as needed basis.

B. The claim/encounter review process may consist of the following components:
    1. Desk Audit: This component will consist of a pre-review of select policies, protocols, and documents and other resource material submitted by the Provider Network to the PIHP for review prior to the on-site visit.
    2. On-Site Audit: This component will consist of an on-site visit to the Provider Network to review and validate process requirements.
    3. Claim/Encounter Review: The PIHP shall pull a random sample of Medicaid, Healthy Michigan Plan and SUD Block Grant participants to complete verification of submitted claims/encounters.
    4. Data Review and Analysis: This component includes analysis of the Provider Network.
C. Overall responsibility for the claim/encounter verification and updating of the monitoring evaluation tool shall rest with the PIHP. The tool shall be reviewed on an annual basis to ensure functional utility; and updated as necessary due to changing regulations, new contract terms and operational feedback received.
D. MSHN shall create its verification schedule at least 45 days in advance of its review.

E. Following the review, MSHN shall develop a Medicaid Event Verification Report detailing the results of its verification review for the Provider. The Medicaid Event Verification report shall include the following:
    1. A summary detailing the PIHP's overall review process and findings;
    2. Details pertaining to each claim/encounter reviewed
    3. "Findings" (if applicable) that will require corrective action for claims/encounters that are found not to be in substantial compliance with federal and state standards.
    4. "Recommendations" (If applicable) pertaining to any quality improvement or best practice suggestions.
    5. All claims/encounters found to be invalid that will require correction either by resubmission or voiding.
    6. Recoupment of funds for any fee for service provider for any claims/encounters that are found to be invalid.

   The PIHP shall submit the verification report to the Provider within thirty (30) days of the verification audit conclusion.

F. Report summary findings of the MSHN Medicaid Event Verification audits shall be shared with MSHN Board of Directors, Corporate Compliance Committee, Operations Council, Quality Improvement Council, and other MSHN councils as appropriate.

G. MSHN will report any suspected fraud or abuse discovered during the Medicaid Event Verification Process to MDHHS-Office of Inspector General.

H. MSHN shall submit an annual report to MDHHS per the contract requirements, due December 31, covering the claims/encounter audit process.
    1. Cover letter on PIHP letterhead
    2. Description of the methodology used by the PIHP, including all required elements previously described.
    3. Summary of the results of the Medicaid event verification process performed, including: population of the providers, number of providers tested, number of providers put on corrective action plans, number of providers on corrective action for repeat/continuing issues, number of providers taken off of corrective action plans, population of claims/encounters tested (units and dollar value), claims/encounters tested (units and dollar value), and invalid claims/encounters identified (units and dollar value).

I. MSHN will maintain all documentation supporting the verification process as required by state and federal regulation.

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:

Covered Service: Any service defined by the Michigan Department of Health and Human Services as required service in the Medicaid Specialty Supports and Services benefit

CMHSP: Community Mental Health Service Program

CPT Code: Current Procedural Terminology Code (CPT) is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

Documentation: Documentation may be written or electronic and will correlate the service to the plan. Clinical documentation must identify the consumer and provider, must identify the service provided, date and time of the service. Administrative records might include monthly occupancy reports, shift notes, medication logs, personal care and community living support logs, assessments, or other records.

Finding: A federal or state standard found out of compliance. A finding requires a corrective action to ensure compliance with federal and state guidelines.

HCPCS: Healthcare Common Procedure Coding System: set of health care procedure codes based on the American Medical Associations Current Procedural Terminology (CPT)
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
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
Random Sample: A computer generated selection of events by provider and HCPCS, Revenue, or CPT Code or Code Category. The auditor then randomly picks the events to review from the list of events
Recommendation: A quality improvement suggestion that is meant to guide quality improvement discussion and change. A recommendation does not require corrective action.
Record Review: A method of audit includes administrative review of the consumer record.
Subcontractors: Refers to an individual or organization that is directly under contract with the CMHSP to provide service or supports

Other Related Materials

MSHN Medicaid Event Verification Procedure

References/Legal Authority

Medicaid Managed Specialty Supports and Services Concurrent Contract
Medicaid Services Verification-Technical Requirements

Change Log:

Date of Change	Description of Change	Responsible Party
12.2015	New Policy	Director of Compliance, CS & Quality
03.2017	Annual Review	Director of Compliance, CS & Quality
03.2018	Annual Review	Director of Compliance, CS & Quality
03.2019	Annual Review, removed monthly review of reports of claims and encounters	Quality Manager
10.2020	Biennial Review	Quality Manager

MSHN
Mid-State Health Network

POLICY & PROCEDURE MANUAL

Chapter:	Quality		
Title:	**Monitoring and Oversight**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Compliance Officer Quality Improvement Council	**Adopted Date: 11.04.2014** **Review Date:** 01.12.2021 **Revision Eff. Date:**	**Related Policies:** Quality Management

Purpose

To establish guidelines, as the Pre-Paid Inpatient Health Plan (PIHP), for the development and implementation of the Mid-State Health Network (MSHN) process for conducting monitoring and oversight of its CMHSP and SUDSP Provider Network. To ensure compliance with federal and state regulations, and to establish standardized processes for conducting review of all delegated managed care functions.

Policy

MSHN shall create, implement and maintain a published process to monitor and evaluate its provider network to ensure compliance with federal and state regulations. This includes protocols for how monitoring and oversight of any entity to which it has delegated a managed care administrative function and protocols to ensure the delegated provider is appropriately managing its charged responsibilities.

A. MSHN shall conduct a full monitoring and evaluation process of each CMHSP Participant and Substance Use Disorder (SUD) Service Provider, at a minimum once every two years. This process will consist of utilizing uniform standards and measures to assess compliance with federal and state regulations, and PIHP contractual requirements. During the interim year, the review process will focus on any elements of the previous year's findings in which compliance standards were considered to be partially or not fully met. All delegated functions will be reviewed prior to delegation occurring and every other year thereafter.

B. The contract and delegation 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 CMHSP Participant/SUDSP to the PIHP for review prior to an on-site visit.
   2. ***On-Site Audit****:* This component will consist of an on-site visit to the CMHSP Participant/SUDSP Participant to review and validate process requirements. This component may include staff interviews.
   3. ***Consumer Chart Review***: The PIHP shall pull a random sample (of consumer records to ensure compliance with specific program requirements, Person-Centered Planning requirements, enrollee rights, and documentation requirements.
   4. ***Data Review and Analysis****:* This component includes analysis of CMHSP Participant/SUDSP performance and encounter data trends.

C. Consumer charts and other information/data that will be reviewed by the PIHP will include the time period from the date of the last site review to current (or the prior 12 months). The PIHP does reserve the right to request information/data prior to the last 12 months as deemed necessary.

D. Overall responsibility for the contract monitoring evaluation process and updating of the monitoring evaluation tools shall rest with the PIHP. The tools shall be reviewed on an annual basis by the Quality Improvement Council to ensure their functional utility; and updated as necessary due to changing regulations, new contract terms and operational feedback received.

E. MSHN shall create its monitoring schedule at least ninety (90) days in advance of its review.

F. Following the review, MSHN shall develop a Contract Monitoring & Evaluation Report detailing the results of its monitoring review for each CMHSP Participant/SUDSP. The monitoring report shall include the following:

- A summary report detailing the PIHP's overall review process and findings;
- Detailed findings pertaining to each standard audited/reviewed;
- Quality Improvement (QI) recommendations; and
- "Recommendations" (if applicable) pertaining to any finding that requires remedial action.
- Sanctions as defined in the PIHP contract with the CMHSP Participant/SUDSP.

The PIHP shall submit the monitoring report to the CMHSP Participant/SUDSP within thirty (30) days of the monitoring review conclusion.

G. The CMHSP Participant/SUDSP shall submit a remedial action/quality improvement plan within thirty (30) days of the monitoring review report date, for any item not meeting the compliance standard. This plan shall include:
   1. A detailed action plan which addresses steps to be taken to assess and improve performance
   2. Measurement criteria (i.e. how will the PIHP know the objective/outcome will be achieved)
   3. Timeframes and responsible individual for completing each improvement plan.

   When access to care to individuals is a serious issue, the CMHSP Participant/SUDSP may be given a shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference. If, during a MSHN on-site visit, the site review team member identifies an issue that places a consumer in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the CMHSP Participant/SUDSP, which must be completed within seven (7) calendar days. Evidence of the review and appropriate action taken will be required to be submitted to MSHN at the time of completion. A follow up review may be conducted to ensure remediation of issues identified as out of compliance within 90 days of the approve plan of correction. Quality Improvement Plans not submitted within the required time frame will be reported to the MSHN Chief Executive Officer and the CMHSP Participant's /SUDSP's Chief Executive Officer/Executive Director for resolution and submission.

H. MSHN will review the remedial action/quality improvement plan, seek clarifying or additional information from the CMHSP Participant/SUDSP as needed, and issue a response within 15 days of receiving required information from the CMHSP Participant/SUDSP. MSHN will take steps to monitor the CMHSP Participant's/SUDSP's implementation of the remedial action/quality improvement plan as part of performance monitoring.
   1. If additional information is required, the Provider will have 7 days to respond and provide any additional information requested to MSHN. If the response requires additional follow up MSHN will have 7 days to review and respond to the Provider.
   2. It is the expectation that all corrective actions will be fully implemented within 30 days of their approval by MSHN. In special circumstances MSHN may approve an extension for the implementation to occur.
   3. Any identified health and/or safety issue will need to be corrected immediately and will require submission of evidence that the issue has been corrected within 7 days of the site review.

I. 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 per the MSHN provider appeal procedure. NOTE: Recommendations do not qualify under the appeal and resolution process as they are recommendations only and do not require a corrective action plan. After a review, the MSHN provider appeal committee shall submit to the provider a determination of the appeal and copy the review team. 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.

J. Report summary findings on PIHP monitoring activities shall be shared with the MSHN Board of Directors, Corporate Compliance Committee, Operations Council and other MSHN councils as appropriate.

Applies to:

☒All Mid-State Health Network Staff

☐ Selected MSHN Staff, as follows:

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

☒Other: SUD Providers

Definitions:
CMHSP: Community Mental Health Service Program
Finding: A federal or state standard found out of compliance. A finding requires corrective action to ensure compliance with federal and state guidelines.
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health and Human Services
PIHP: Prepaid Inpatient Health Plan
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.
QI: Quality Improvement Recommendation: A quality improvement suggestion that is meant to guide quality improvement discussion and change. A recommendation does not require a corrective action.
SUDSP: Substance Use Disorder Service Provider

Other Related Materials:
MSHN Corporate Compliance Plan

References/Legal Authority:
1. The Code of Federal Regulations (CFR)
2. PIHP managed care administrative delegations made to the CMHSP
3. PIHP/CMHSP contract
4. PIHP/SUD Provider contract
5. PIHP policies, standards and protocols, including both MDHHS and PIHP 'practice guidelines.
6. Medicaid Provider Manual
7. SUDSP Provider Manual
8. Medicaid Managed Specialty Supports and Services Concurrent Contract
9. Federal Procurement Guidelines (The Office of Federal Procurement Policy (OFPP)-Office of Management and Budget

Date of Change	Description of Change	Responsible Party
08.18.2014	New Policy	Chief Compliance Officer
11.2015	Annual Review	Director of Compliance, Customer Services & Quality
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service and Quality
03.2019	Annual Review	Quality Manager
10.2020	Biennial Review	Quality Manager

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	Performance Improvement		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: Biennial Author: Chief Compliance Officer, Quality Improvement Council	Adopted Date: 04.07.15 Review Date: 01.12.2021 Revision Eff. Date:	Related Policies:

Purpose

To ensure Mid-State Health Network (MSHN) and its Provider Network comply with the performance improvement project requirements as set forth in the Michigan Department of Health and Human Services (MDHHS), Medicaid Specialty Supports and Services Contract.

Policy

MSHN shall ensure region-wide performance improvement projects (PIP) are conducted in accordance with the following:

- Projects must address both clinical and non-clinical aspects of care.
  - Clinical areas would include, but not limited to, high-volume services, high-risk services, and continuity and coordination of care
  - Non-clinical areas would include, but not be limited to, appeals, grievances and trends and patterns of substantiated Recipient Rights complaints; and access to, and availability of, services.
- Topics will be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, MSHN's consumers; consumer demographic characteristics and health risks; and the interest of consumers in the aspect of service to be addressed.
- PIPs may be directed at state or MSHN-established aspects of care.
- MSHN will engage in at least two projects during the waiver renewal period.
- MSHN-established PIPs will be developed by the Quality Improvement Council.
- State directed PIPs will be conducted in accordance with state requirements and timelines.
- Regional performance improvement project results will be aggregated and reviewed by the Quality Improvement Council, the Regional Consumer Advisory Council, and the Medical Directors Committee when relevant, for determining appropriate initiatives and areas for continuous quality improvement.

MSHN shall monitor Provider Network compliance with the regional performance improvement projects through reporting progress and outcomes to the MSHN Quality Improvement Council, Provider Advisory Council, Regional Consumer Advisory Council, Operations Council, the Medical Directors when relevant, and the Board of Directors.

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 Programs
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
Definitions (cont.)

PIP: Performance Improvement Project
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

Other Related Materials
N/A

References/Legal Authority
Medicaid Managed Specialty Supports and Services contract, MDHHS Quality Assessment and Performance Improvement Technical Guideline

Change Log:

Date of Change	Description of Change	Responsible Party
03.2015	New Policy	Chief Compliance Officer
03.2016	Annual Review	Quality, Compliance & Customer Svc Director
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 added PAC and Medical Directors as relevant for committees to review	Quality Manager
10.2020	Biennial Review	Quality Manager

POLICIES AND PROCEDURES MANUAL

Chapter:	Quality		
Title:	**Quality Management**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle: Biennial** **Author:** QI Council and Chief Compliance Officer	**Adopted Date: 11.22.2013** **Review Date:** 01.12.2021 **Revision Eff. Date:**	**Related Policies:** General Management

Purpose

The Quality Management (QM) system of Mid-State Health Network (MSHN) is designed to monitor, evaluate, and improve the efficacy, efficiency, and appropriateness of the services provided to consumers, and the administrative functions supporting that care.

Policy

MSHN shall develop, implement and maintain a QM system which includes processes for monitoring and oversight of its provider network. The QM system shall conform to the requirements reflected in the Balanced Budget Act of 1997 and the Medicaid Specialty Supports and Services contract.

The following QM functions are retained by MSHN or delegated to Community Mental Health Service Program (CMHSP) Participants and the Substance Use Disorder (SUD) Provider Network as delineated below:

A. **Quality Assessment Performance Improvement Program (QAPIP) Plan and Report**: MSHN retains responsibility for developing, maintaining, and evaluating the annual QAPIP Plan and Report in collaboration with the CMHSP Participants. The report shall include analysis of critical incidents, risk events and sentinel events, and shall facilitate quality improvement processes. Responsibility for implementation of the QAPIP is delegated to the CMHSP Participants and the SUD Provider Network, including local analysis of risk events, critical incidents, sentinel events, and events requiring immediate notification, with oversight by MSHN.

B. **Standard Setting**: MSHN retains responsibility for establishing quality standards in collaboration with CMHSP Participants. Responsibility for implementing processes for meeting those standards is delegated to the CMHSP participants and SUD Provider Network with oversight and monitoring by MSHN.

C. **Regulatory and Corporate Compliance**: MSHN shall comply with 42 CFR Program Integrity Requirements, including designating a MSHN Compliance Officer. Responsibility for establishing processes to achieve compliance consistent with the MSHN Corporate Compliance Plan is delegated to the CMHSP participants and the SUD Provider Network, with oversight and monitoring by MSHN.

D. **Performance Assessments and Conducting Quality Reviews**: MSHN retains responsibility for assessing the performance of its provider network, including conducting reviews of performance according to established standards.

E. **External Reviews**: MSHN retains responsibility, in collaboration with the CMHSP Participants, for managing outside entity review processes, including, but not limited to, external quality review.

F. **Research**: Responsibility for assuring compliance with state and federal rules, laws and guidelines regarding conducting research consistent with MSHN policy is delegated to the CMHSP participants. MSHN retains the responsibility for assuring capacity to reach compliance within the region.

G. **Provider Education and Training**: Responsibility for providing training to providers is delegated to the CMHSP participants, with oversight and monitoring by MSHN. Assurances for uniformity and reciprocity shall be established in MSHN provider network policies and procedures.

H. Practice Guidelines: Responsibility for the adoption, development, implementation, and continuous monitoring and evaluation of practices guidelines is delegated to the CMHSP participants, with oversight and monitoring by MSHN.

Applies to:

☒All Mid-State Health Network Staff

☐ Selected MHN Staff, as follows:

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

☒Other: Sub-contract Providers

Definitions:

CARF: Commission on Accreditation of Rehabilitation Facilities

Corporate Compliance: This sort of compliance is required in the PIHP contract with MDHHS and is intended to prevent, monitor and remediate instances of abuse and fraud of public funds.

CMHSP: Community Mental Health Service Program

Critical Incidents: Specific events requiring analysis and reporting to MDHHS. These events include suicides, non-suicide deaths, emergency medical treatment or hospitalizations due to injury or medication error, and arrests of consumers. The population on which these events must be reported differs slightly by type of event (MDHHS Contract, Attachment.). Physical management and/or involvement of law enforcement, permitted for intervention in emergencies only, are considered critical events..

Joint Commission: A national organization that accredits healthcare and behavioral health.

Risk Events: Additional events that put individuals, in the same population categories as the critical events above, at risk of harm. These events minimally include actions taken by consumers that cause harm to themselves or to others, and two or more unscheduled admissions to a medical hospital, not due to planned surgery or the natural course of a chronic illness, within a 12-month period (MDHHS Contract). These events require analysis. Reporting to MDHHS occurs upon MDHHS request.

MSHN: Mid- State Health Network

MDHHS: Michigan Department of Health and Human Services

PIHP: Prepaid Inpatient Health Plan

SUD: Substance Use Disorder

SUD Provider Network: Refers to Substance Use Disorder Providers that are directly under contract with the MSHN PIHP to provide services and/or supports.

QAPIP: Quality Assessment and Performance Improvement Program

QIC: Quality Improvement Council

QM: Quality Management

Sentinel Events: Unexpected occurrences involving death, serious psychological or physical injury (specifically loss of limb or function) or the risk thereof. This includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response (CARF; Joint Commission.). Also included is injury or death that occurs as a result of the use of a behavioral intervention (MDHHS Contract.). Sentinel Events require root cause analysis and reporting to MDHHS and accrediting entities in accordance with established procedures.

References/Legal Authority:

1. BBA 438.240: Quality Assessment and Performance Improvement Program
2. Michigan Medicaid Managed Special Supports and Service Contact
3. MDHHS Quality Assessment and Performance Improvement Program Technical Requirement
4. Mid-State Health Network QAPIP Plan
5. Mid-State Health Network Compliance Plan

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New policy	QIC
01.06.2016	Annual review, format consistency	Director of Compliance, CS & Quality
03.2017	Annual Review	Director of Compliance, CS & Quality
03.2018	Annual Review	Director of Compliance, CS and Quality
03.2019	Annual Review, added risk events and immediate notification	Quality Manager
10.2020	Biennial Review	Quality Manager

Chapter:	**Quality**		
Title:	**Research**		
Policy: ☐ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle: Biennial** **Author:** Chief Compliance Officer, Quality Improvement Council	**Adopted Date: 09.02.2014** **Review Date:** 01.12.2021 **Revision Eff. Date:** 11.2015	**Related Policies:** Quality Management

Purpose:

To protect the rights and well-being of human subjects of research conducted by Mid-State Health Network (MSHN) and/or its provider network and to ensure compliance with the Protection of Human Subjects Act, 45 CFR, Part 46 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Policy:

Prior to initiation of research by MSHN and/or its provider network MSHN will submit Institutional Review Board (IRB) application material for all research involving human subjects that is conducted in programs sponsored by the Michigan Department of Health and Human Services (MDHHS) or in programs that receive funding from or through the State of Michigan. The application and approval material will be submitted to the MDHHS's IRB for review and approval or for acceptance of the review by another IRB. All such research must be approved by a federally assured IRB, but the MDHHS's IRB can only accept the review and approval of another institution's IRB under a formally approved interdepartmental agreement. The manner of the review will be agreed upon between the MDHHS's IRB Chairperson and the Contractor's IRB Chairperson or Executive Officer(s).

Research initiated prior to MSHN contracting shall be acceptable provided, upon request, the responsible CMHSP can provide evidence of appropriate MDHHS IRB or alternative review.

All research and related projects shall be conducted in such a manner as to ensure the rights, benefits, and privileges guaranteed bylaw.

All research involving MSHN consumers must be reviewed and approved by a MSHN or MSHN Contractor Research Review Committee before involvement of MSHN subjects in the project. Externally funded projects involving the use of MSHN consumers are to be approved by a MSHN Research Review Board. MSHN acknowledges that grant application time frames may require submission prior to MSHN review; however, approval by the MSHN Research Review Board is required prior to acceptance and implementation of the grant award.

The Research Review Board shall include minimally:

1. A Senior officer of MSHN or its contractors
2. A senior clinician with expertise with the identified population
3. A recipient rights officer
4. A medical director for medically related research

The Research Review Board is responsible for reviewing proposed research projects involving human subjects before submission to the MDHHS's IRB for approval of the research project to ensure that:

1. The rights and welfare of the subjects are protected;
2. Written informed consent is obtained from each subject using appropriate methods;
3. The risks and potential benefits are disclosed to participating subjects;and
4. Review completed (IRB) application material

MSHN may request additional expertise when necessary for adequate review by the Research Review Board. The research review board shall maintain a written record of all research proposals and publication submissions and report at least annually to the MSHN Operations Council.

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

HIPAA: Health Insurance Portability & Accountability Act.
Human subject (as defined by 45 CFR, Part 46.102) means a living individual about whom an investigator (whether professional or student) conducting research obtains

(1) Data through intervention or interaction with the individual, or
(2) Identifiable private information.

IRB**:** Institutional Review Board reviews, approves, and monitors research that directly or indirectly involves living persons, their issues or personal information, in order to protect the rights of the participants.
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health & Human Service
Provider Network: Refers to a Community Mental Health Services Program (CMHSP) Participant and a Substance Abuse Provider that is directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's and CA's subcontractors.
Research Review Board: A body of appointed MSHN or MSHN contractor staff with the knowledge and experience required to function as an IRB.
Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

Other Related Materials

N/A

References/Legal Authority

45 CFR 46: Human Subjects Research
Medicaid Managed Specialty Supports and Services Contract
MDHHS Quality Assessment and Performance Improvement Program for Specialty Prepaid Inpatient Health Plans Technical Requirement

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer
08.2015	Update to MDHHS and to include accommodation to research prior to	Deputy Director, Chief Executive Officer
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	Quality Manager
10.2020	Biannual Review	Quality Manager

POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	**Sentinel Events**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle: Biennial** **Author:** Quality Improvement Council, Quality Manager	**Adopted Date: 07.07.2020** **Review Date: 01.12.2021** **Revision Eff. Date:**	**Related Policies:** Critical Incident Policy Incident Review for Substance Use Providers Policy

Purpose: To ensure that the Mid-State Health Network (MSHN) pre-paid inpatient health plan is in compliance with the Michigan Department of Health and Human Services (MDHHS), Medicaid Managed Specialty Supports and Services Contract, Quality Assessment and Performance Improvement Plan related to Sentinel Event Reporting.

Policy: MSHN delegates responsibility to its Provider Network, with oversight and monitoring by MSHN, for collecting, analyzing and reporting to MSHN all incidents that meet the criteria as specified in the MDHHS Medicaid Specialty Supports and Services Contract for sentinel events.

- The Provider Network must review incidents to determine if it is a sentinel event within three (3) business days of the occurrence of the incident.
- The Provider Network must commence a root cause analysis within two (2) subsequent business days of the identification of a sentinel event.
- Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care.
- Based on the outcome of the analysis or investigation, the provider must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan.
- The Provider Network must report all sentinel events to the MSHN Quality Manager within required timeframes as specified by incident.
- The Quality Manager will notify the appropriate MSHN Staff of the event.
- The root cause analysis should be completed and be available upon request.
- The Provider Network will have a standard for the timeframe of the completion of the root cause analysis.
- MSHN will submit all sentinel events to MDHHS as required.

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 Programs
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
Provider Network: Refers to a CMHSP Participant and SUD Treatment and Recovery Providers (ie. 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.

Sentinel Events: Is an “unexpected occurrence” involving death (not due to the natural course of a health condition) or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “or risk thereof” includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome. (JCAHO, 1998) Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. (Medicaid Managed Specialty Supports and Services Program Contract)

Root Cause Analysis: A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

Other Related Materials:

N/A

References/Legal Authority:

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

Change Log:

Date of Change	Description of Change	Responsible Party
03.2020	New Policy-Sentinel Event Reporting Requirements	Quality Manager
10.2020	Biennial Review	Quality Manager

POLICIES AND PROCEDURES MANUAL

Chapter:	**Service Delivery System**		
Title:	**Behavioral Health Recovery Oriented System of Care**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Annually **Author:** SUD Workgroup and HITP Director	**Adopted Date: 1.06.2015** **Review Date:** 01.12.2021 **Revision Eff. Date:**	**Related Policies:** Service Philosophy

Purpose

To ensure that Mid-State Health Network (MSHN) and its Provider Network develop a holistic and effective behavioral health system that promotes recovery and resilience across its network of care, through adoption of the fifteen guiding principles of a Recovery Oriented System of Care (ROSC) developed by the state of Michigan. Behavioral health systems are inclusive of individuals who encompass one or more of the following disorders:

- Substance use disorders,
- Severe and persistent mental illness,
- Serious emotional disturbances,
- Autism,
- Intellectual/Developmentally disabilities and;
- Co-occurring Disorders.

Policy

MSHN and its Provider Network adopts fifteen ROSC principles to support and guide the development of behavioral health throughout the region as identified below.

A. Adequately and flexibly financed: MSHN's system will be adequately financed to permit access to a full continuum of behavioral health services, ranging from prevention, early intervention, case management, and treatment to continuing care, peer support and recovery support. In addition, MSHN will strive to make funding sufficiently flexible to enable the establishment of a customized array of behavioral health services that can evolve over time to support an individual's and a community's recovery.

B. Inclusion of the voices and experiences of recovering individuals, youth, family, and community members: The voices and experiences of all community stakeholders will contribute to the design and implementation of the system. People in recovery, youth, and family members will be included among decision-makers and have input and/or oversight responsibilities for behavioral health service provision. Recovering individuals, youth, family, and community members will be prominently and authentically represented on behavioral health advisory councils, boards, task forces, and committees.

C. Integrated strength-based services: MSHN's system will coordinate and/or integrate efforts across behavioral health service systems, particularly with primary care services, to achieve an integrated service delivery system that responds effectively to the individual's or the community's unique constellation of strengths, desires, and needs.

D. Outcomes driven: MSHN's system will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration with individuals in recovery, the Provider network and the community. Outcome measures will be diverse and encompass measures of community wellness as well as the long-term global effects of the behavioral health recovery process on the individual, family, and community – not just the remission of biomedical symptoms. Behavioral health outcomes will focus on individual, family, and community indicators of health and wellness, including benchmarks of quality-of-life changes for people in recovery.

E. Family and significant-other involvement: MSHN's system of care will acknowledge the important role that families and significant others can play in promoting wellness for all and recovery for those with behavioral health challenges. They will be incorporated, whenever it is appropriate, into needs-assessment processes, community planning efforts, recovery planning and all support processes. In addition, MSHN's system will identify and coordinate behavioral health services for the family members and significant others of people with substance use disorders.

F. System-wide education and training: MSHN's Provider Network will seek to ensure that concepts of behavioral health prevention, recovery, and wellness are foundational elements of curricula, certification, licensure, accreditation, and testing mechanisms. The workforce requires continuing education, at every level, to reinforce the tenets of ROSC. Education and training commitments are reinforced through policy, practice, and the overall service culture as identified by the state of Michigan.

G. Individualized and comprehensive services across all ages: MSHN's system of care will be individualized, person/family/community-centered, comprehensive, stage-appropriate, and flexible. It will adapt to the needs of individuals and communities, rather than requiring them to adapt to it. Individuals will have access to a menu of stage-appropriate choices that fit their needs throughout the recovery process. The approach to behavioral health care will change from an acute, episode-based model to one that helps people manage their symptoms throughout their lives. Behavioral health treatment and prevention services will be developmentally appropriate, emphasizing strengths, assets, and resiliencies; and engage the multiple systems and settings that have an impact on health and wellness. Behavioral health efforts will be individualized based on the community's needs, resources, and concerns.

H. Commitment to peer support and recovery support services: MSHN's system of care will promote ongoing involvement of peers, through peer support opportunities for youth and families and peer recovery support services for individuals with behavioral health concerns. Individuals with relevant lived experiences will assist in providing these valuable supports and services.

I. Responsive to Cultural Factors and Personal Belief Systems: MSHN's system of care will be culturally sensitive, gender competent, and age appropriate. There will be recognition that beliefs and customs are diverse and can impact the outcomes of behavioral health efforts.

J. Partnership-consultant relationship: MSHN's system will be patterned after a partnership/consultant model that focuses more on collaboration and less on hierarchy. Systems and services will be designed so that individuals, families, and communities feel empowered to direct their own journeys of behavioral health recovery and wellness.

K. Ongoing monitoring and outreach: MSHN's system of care will provide ongoing monitoring and feedback, with assertive outreach efforts to promote continual participation, re-motivation, and re-engagement of individuals and community members in behavioral health services.

L. Research based: MSHN's system will be informed by research. Additional research on individuals in recovery, recovery venues, and the processes of behavioral health recovery (including cultural and spiritual aspects) will be essential to these efforts. Published research related to behavioral health will be supplemented by the individual experiences of people in recovery. Prevention efforts will use the Strategic Prevention Framework and epidemiologically based needs-assessment approaches to identify behavioral health issues and community concerns. Individual, family, and environmental prevention strategies will be data driven.

M. Continuity of care**:** MSHN's system will offer a behavioral health continuum of care that includes prevention, early intervention, treatment, continuing care, and support throughout recovery. Individuals will have a full range of stage-appropriate behavioral health services to choose from at any point in the recovery process with the outcome of improving quality of life. Behavioral health prevention services will involve the development of coordinated community systems that provide ongoing support, rather than isolated, episodic programs.

N. Promote Community Health and Address Environmental Determinants to Health: MSHN's system will strive to promote community health and wellness through strategic behavioral health prevention initiatives that focus on building community strengths in multiple sectors of our communities.

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:
Behavioral Health Systems: The system is inclusive of individuals who encompass one or more of the following disorders: Substance use, Severe and persistent mental illness, Autism, Serious emotional disturbances, Intellectual/Developmentally disabilities and Co-occurring disorders.
MSHN: Mid-State Health Network
HITP: MSHN Health Integration, Treatment and Prevention Director
Recovery: Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential. (Substance Abuse and Mental Health Services, SAMHSA).
ROSC: Recovery Oriented System of Care; based upon significant input from stakeholders, Michigan defines a ROSC as: *Michigan's recovery-oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life-enhancing recovery and wellness for individuals, families and communities*. Adopted by the ROSC Transformation Steering Committee, September 30, 2010
SUD: Substance Use Disorder
Strategic Prevention Framework: The framework establishes the parameters within which a regional prevention plan is established and monitored.
TSC: Transformation Steering Committee – committee working under the direction of OROSC staff. Developed Michigan's ROSC – An Implementation Plan for SUD Service System Transformation.

Other Related Materials:
Michigan's Recovery Oriented System of Care–An Implementation Plan for Substance Use Disorder Service System Transformation:
http://www.michigan.gov/documents/mdch/ROSC_Implementation_Plan_357360_7.pdf
Guiding Principles and Elements of Recovery Oriented Systems: www.samhsa.gov/.../rosc_resource guide

References/Legal Authority:
2013 Application for Participation Region 5 Response:
http://www.midstatehealthnetwork.org/docs/Region5PIHP2013AFP.PDF

Change Log:

Date of Change	Description of Change	Responsible Party
01.06.2015	New Policy	SUD Workgroup and HITP Director
06.2016	Policy reviewed	Clinical Leadership Committee
03.2017	Annual Review	Clinical Leadership Committee/Deputy Director
02.2018	Annual Review	Clinical Leadership Committee / Chief Clinical Officer
03.2019	Annual Review	Chief Clinical Officer
10.2020	Annual Review	Chief Clinical Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery System		
Title:	Person/Family Centered Plan of Service		
Policy: ☒ **Procedure:** ☐ **Version:** 2.0 **Page:** 1 of 3	**Review Cycle:** Annually **Author:** Clinical Leadership Committee/Chief Clinical Officer	**Adopted Date: 01.05.2016** **Review Date:** 01.12.2021 **Revision Eff. Date:**	**Related Policies:** Service Philosophy

Purpose

To ensure that Mid-State Health Network (MSHN) and its CMHSP Participants have a consistent service philosophy across its network of care related to Person/Family Centered Planning. MSHN promotes a Person/Family Centered approach to the development of the individual plan of service and the delivery of supports and services in accordance with established state and federal regulations (reference Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program attachment P4.4.1.1).

Policy

The policy is intended to outline the required elements of Person/Family Centered Planning as required by MSHN and informed by the Medicaid Provider Manual, Section 2:

A. A preliminary plan of service is developed within seven (7) days of the commencement of services that will include a treatment plan, a support plan, or both.
B. Consumers are given information as needed on the array of mental health services, community resources and available providers.
C. Ensure that for each Person/Family Centered Plan, a pre-planning meeting is completed that includes addressing the information below. Documentation should reflect that the process took place in a timely manner (Items below are not required for those who receive short term outpatient therapy only, medication only, or those who are incarcerated)

    1. Who to invite;
    2. Where and when to have the meeting;
    3. What will be discussed, and not discussed, at the meeting;
    4. Any accommodations the consumer may need to meaningfully participate;
    5. Who will facilitate the meeting;
    6. Who will record what is discussed at the meeting; and
    7. The pre-planning meeting is to be completed with sufficient time to take all necessary/ preferred actions.

D. Provide information/education on what an Independent or External Facilitator is and how to request the use of one. Not required for consumers receiving short term outpatient therapy or medication only. Consumers must have a choice of at least two facilitators.

E. Each plan is individualized to meet the consumer's medically necessary identified needs and includes:

1. A description and documentation of the consumer's individually identified goals, preferences, strengths, abilities, and natural supports.
2. Outcomes identified by the consumer and the steps to achieve the outcomes.
3. Risk factors and measures in place to minimize them, including backup plans and strategies.
4. Services and supports needed to achieve the outcomes (including community resources and other publicly funded programs such as Home Help).
5. Amount, scope and duration of medically necessary services and supports authorized by and obtained through the CMHSP.
6. Estimated/prospective cost of services and supports authorized by the community mental health system.
7. Roles and responsibilities of the consumer, the CMHSP staff, allies, and providers in implementing the plan.
8. The plan should be written in plain language that is easily understood by the individual and others supporting him/her. The language in the service plan must also be understandable by individuals with disabilities and those with limited English proficiency, in accordance with federal law.
9. The plan should be finalized and include informed consent of the individual and his/her representative (if applicable).
10. Signatures on the plan should include the consumer, his/her representative (if applicable) and the providers responsible for the implementation of the plan (at a minimum, this includes the person or entity responsible for coordinating the individual's services and supports).

F. The plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the consumer's needs, changes in the consumer's condition as determined through the PCP process or changes in the consumer's preferences for support). A review of the plan can be requested at any time by the consumer or his/her guardian. A formal review of the plan with the consumer and his/her guardian or authorized representative shall occur at least every 12 months or more frequently if the consumer requests it or there is a change in service needs. Reviews should work from the existing plan of service to amend or update it as circumstances, needs, preferences or goals change or to develop a completely new plan if so desired by the consumer.

G. The consumer is provided a copy of the plan within 15 business days of the conclusion of the PCP process.

H. There is a process to identify and train staff at all levels on the philosophy of PCP. Staff who are directly involved in the implementation of the PCP are provided with additional training, including direct care level staff being trained on consumer specific plans of service.

Applies to:

☒All Mid-State Health Network Staff

☐Selected MSHN Staff, as follows:

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

☒Other: Sub-contract Providers

Definitions/Acronyms:

CMHSP: Community Mental Health Service Program

Consumer/Customer: Refers to 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.

Independent Facilitator: An individual chosen by the consumer to serve as the consumer's guide throughout the PCP process, assisting with pre-planning activities and co-leads any PCP meeting(s) with the consumer.

MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PCP: Person-Centered Planning

References/Legal Authority:

- Michigan Department of Health and Human Services Medicaid Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY15, including the "Person Centered Planning Policy and Practice Guideline".
- Mental Health Code, Section 330.1700(g).

Change Log:

Date of Change	Description of Change	Responsible Party
10.2015	New policy	Chief Clinical Officer
02.2017	Annual Review	Chief Clinical Officer
02.2018	Annual Review	Chief Clinical Officer
01.2019	Annual Review	Chief Behavioral Health Officer
07.2020	Annual Review	Chief Behavioral Health Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery**		
Title:	**SUD Services - Medication Assisted Treatment Inclusion**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Annually **Author:** Chief Clinical Officer SUD Medical Director Medical Director	**Adopted Date: 03.06.2018** **Review Date: 01.12.2021** **Revision Eff. Date:**	**Related Policies:** Service Philosophy

Purpose

Medication-Assisted Treatment (MAT) is a standard of care that is broadly recognized as foundational to any comprehensive approach to the national opioid addiction and overdose pandemic. MSHN seeks to ensure therefore that no MSHN client is denied access to or pressured to reject the full array of evidence-based and potentially life-saving treatment options, including MAT, that are determined to be medically necessary for the individualized needs of that client.

Policy

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

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

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

Applies to:

☒All Mid-State Health Network Staff
☐Selected MSHN Staff, as follows:
☒MSHN's Affiliates: Policy

Definitions

MAT: Medication-Assisted Treatment
MSHN: Mid-State Health Network
MDHHS: Michigan Department of Health and Human Services
OROSC: Office of Recovery Oriented Systems of Care
SUD: Substance Use Disorder

Other Related Materials

1. SAMHSA Treatment Improvement Protocol #43 - MAT for Opioid Addiction in Opioid Treatment Programs
2. U.S. Surgeon General – Treatment Options
3. National Institute on Drug Abuse Effective Treatment for Opioid Addiction
4. The Center for Disease Control "Vital Signs" – Today's Heroin Epidemic
5. White House Commission on Combating Drug Addiction and the Opioid Crisis White House Commission on Combating Drug Addiction and the Opioid Crisis – Letter to the President
6. ASAM National Practice Guideline
7. MDHHS MAT Guidelines for Opioid Use Disorders
8. MSHN 2018 SUD Provider Manual

References/Legal Authority:

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

Change Log:

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

Chapter:	**Service Delivery System**		
Title:	**SUD Services – Out of Region Coverage**		
Policy: ☑ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Annually **Author: Utilization Mgmt. and Waiver Director**	**Adopted Date: 09.06.2016** **Review Date:** 01.12.2021 **Revision Eff. Date:**	**Related Policies:**

Purpose

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

Policy

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

Additional Guidance:

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

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

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

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

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

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

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

Other Related Materials:

References/Legal Authority:
MDHHS Bureaus of Substance Abuse and Addiction Services Treatment Policy #7
MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program
MDHHS Michigan Medicaid Health Plans beginning January 1, 2016
MSHN Technical Requirement: CMHSP Responsibilities for 24/7/365 Access for Individuals with Primary Substance Use Disorders

Change Log:

Date of Change	Description of Change	Responsible Party
08.08.2016	New Policy	Utilization Mgmt. & Waiver Director
02.28.2018	Annual Review	UM Director & Director of Provider Network Management Systems
3.2019	Annual Review	Chief Clinical Officer
10.2020	Annual Review	Chief Clinical Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	**Service Delivery System**		
Title:	**SUD Services-Women's Specialty Services**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 3	**Review Cycle:** Annually **Author:** SUD Workgroup, Health Integration, Treatment & Prevention Director	**Adopted Date: 07.07.2015** **Review Date:** 01.12.2021 **Revision Eff. Date:**	**Related Policies:** Service Philosophy

Purpose

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

Standards

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

Policy

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

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

Consumer Eligibility Criteria

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

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

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

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

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

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

The above five types of services may be provided through the MDHHS/PIHP agreement only when no other source of support is available and when no other source is financially responsible.

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

Additional WSS information and requirements:
Providers should reference MSHN's 2019 SUD Provider Manual for additional WSS information, including:

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

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

Definitions:
MSHN: Mid-State Health Network
SUD: Substance Use Disorder

Other Related Materials:
MSHN 2017 SUD Provider Manual

References/Legal Authority:

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

Change Log:

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