Mid-State Health Network

Board of Directors Meeting ~ September 14, 2021
Immediately Following Public Hearing

Board Meeting Agenda

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

LifeWays Community Mental Health
1200 N. West Ave
Jackson, MI 49202

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

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

   Motion to Approve the Agenda of the September 14, 2021 Meeting of the MSHN Board of Directors
4. Public Comment (3 minutes per speaker)
5. **ACTION ITEM:** Consideration of MSHN Fiscal Year 2021 Budget Amendment (*Page 5*)

   Motion to Approve the MSHN Fiscal Year 2021 Budget Amendment as presented
6. **ACTION ITEM:** Consideration of MSHN Regional Budget for Fiscal Year 2022 (*Page 7*)

   Motion to Approve the MSHN Fiscal Year 2022 Budget as presented
7. **ACTION ITEM:** Direct Care Worker Continuation (Page 10)

   Motion to authorize the continuation of the Mid-State Health Network Direct Support Professional Enhanced Compensation Program (DCW Premium Pay) through March 31, 2022 at current hourly rate levels and within regional parameters established by the MSHN Chief Executive Officer (including incorporating any changes due to MDHHS directive or legislative mandate) and, if the program is not directly funded by the State, to fund it using MSHN-managed financial resources
8. **ACTION ITEM:** FY2022-2023 Strategic Plan (*Page 11*)

   Motion to approve the FY 2022 – FY 2023 Strategic Plan Update for Mid-State Health Network and to direct the Chief Executive Officer to implement the plan
9. **ACTION ITEM:** Board Nominating Committee Report *(Page 46)*

   Motion to create up to two At Large members of the MSHN Board Executive Committee and to elect at large members of the Executive Committee during the regular board officer election timeline and process

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 FY22 Board Meetings

(Tentative until Board Approval)
Board Meetings convene at 5:00pm unless otherwise noted

November 2, 2021
Best Western Okemos
2209 University Park Drive
Okemos, MI 48864

January 11, 2022
Best Western Okemos
2209 University Park Drive
Okemos, MI 48864

March 1, 2022
Best Western Okemos
2209 University Park Drive
Okemos, MI 48864

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

10. Special Order: Board Officer Election (Page 47)

    ACTION ITEM: Election of Board Officers

    - Election of Chairperson
    - Election of Vice-Chairperson
    - Election of Secretary
    - Election of At Large Executive Committee Member(s)

11. Chief Executive Officer's Report *(Page 48)*
12. Deputy Director's Report *(Page 64)*
13. Chief Financial Officer's Report

    13.1 Financial Statements Review for Period Ended July 31, 2021 *(Page 69)*

    ACTION ITEM: Receive and File Preliminary Statement of Net Position and Statement of Activities for the Period ended July 31, 2021

    13.2 Block Grant Update *(Page 76)*

14. **ACTION ITEM:** Contracts for Consideration/Approval *(Page 79)*

    The MSHN Board of Directors Approve and Authorizes the Chief Executive Officer to Sign and Fully Execute the FY 2022 Contracts, as Presented on the FY 2022 Contract Listing

15. Executive Committee Report *(Page 83)*
16. Chairperson's Report
17. **ACTION ITEM**: Fiscal Year 2022 Board Meeting Calendar (*Page 84)*

    Motion to adopt the FY22 Mid-State Health Network Board of Directors Meeting Calendar as presented.

18. **ACTION ITEM:** Consent Agenda

    Motion to Approve the documents on the Consent Agenda

    18.1 Approval Board Meeting Minutes 07/06/21. *(Page 86)*
    18.2 Receive Board Executive Committee Minutes 08/20/21. *(Page 92)*
    18.3 Receive Policy Committee Minutes, 08/03/21. *(Page 94)*
    18.4 Receive Operations Council Key Decisions, 07/19/21 *(Page 96)* and 08/16/21. *(Page 98)*
    18.5 Receive Nominating Committee Minutes, 06/29/21 *(Page 100) and 08/20/21. (Page 102)*
    18.6 Approve the following policies:
    18.6.1 Breach Notification *(Page 103)*
    18.6.2 Disaster Recovery *(Page 105)*
    18.6.3 Information Management *(Page 106)*
    18.6.4 Record Retention *(Page 108)*
    18.6.5 Provider Network Management *(Page 110)*

19. Other Business

20. Public Comment (3 minutes per speaker)

21. Adjourn

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FY21 MSHN Board Roster

Last Name	First Name	Email 1	Email 2	Phone 1	Phone 2	Appointing CMHSP	Term Expiration
Anderson	Jim	jdeweya@yahoo.com		989.667.1313	989.327.0734	BABHA	2022
Bohner	Brad	bbohner@tds.net		517.294.0009		LifeWays	2022
Brehler	Joe	jbrehler@sprynet.com		517.882.7491	517.230.5911	CEI	2022
Cadwallender	Bruce	bcadwall@tds.net		517.703.4223		Shia Health & Wellness	2024
Cierzniewski	Michael	mikeciezniewski@yahoo.com		989.493.6236		Saginaw County CMH	2023
Colton	Craig	johnniec15@hotmail.com		989.912.0312		HBH	2023
DeLaat	Ken	kdelaat1@aol.com		231.414.4173		Newaygo County MH	2023
Griesing	David	davidgriesing@yahoo.com		989.823.2687		TBHS	2024
Grimshaw	Dan	midstatetitlesvcs@sbcglobal.net		989.823.3391	989.823.2653	TBHS	2023
Hicks	Tina	tinah600@yahoo.com		989.285.8419	989.681.5888	GIHN	2024
Holman	Dianne	dianne@workingbugs.com		517.908.9951	517.333.6880	CEI	2022
Johansen	John	j.m.johansen6@gmail.com		616.754.5375	616.835.5118	MCN	2024
Johnson	Steve	saj1950@comcast.net		231.349.6979		Newaygo County MH	2022
Ladd	Jeanne	stixladd@hotmail.com		989.634.5691		Shia Health & Wellness	2024
Matelski	Rhonda	rhondam2374@gmail.com		989.269.2374		HBH	2023
McFarland	Pat	pjmcfarland52@gmail.com		989.225.2961		BABHA	2023
McPeek-McFadden	Deb	deb2mcmail@yahoo.com		616.794.0752		The Right Door	2024
Nyland	Gretchen	gretchen7080@gmail.com		616.761.3572		The Right Door	2022
O'Boyle	Irene	irene.oboyle@cmich.edu		989.763.2880		GIHN	2023
Peasley	Kurt	peasleyhardware@nethawk.com		989.560.7402	989.268.5202	MCN	2024
Phillips	Joe	joe44phillips@hotmail.com		989.386.9866	989.329.1928	CMH for Central	2022
Raquepaw	Tracey	tl.raquepaw@icloud.com	raquepawt@michigan.gov	989.737.0971		Saginaw County CMH	2022
Scanlon	Kerin	kscanlon@tm.net		502.594.2325		CMH for Central	2022
Woods	Ed	ejw1755@yahoo.com		517.392.8457		LifeWays	2024

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Background

MSHN periodically updates its regional budget to adjust for revenue and expenditure variations throughout the fiscal year. The Fiscal Year (FY) 2021 Budget Amendment has been provided and presented for review and discussion.

Recommended Motion:

Motion to approve the FY 2021 Budget Amendment as presented.

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FISCAL YEAR 2021 AMENDED BUDGET

DRAFT

	FY 2021 Original Budget	FY 2021 Amended Budget	FY 2021 Budget Increase (Decrease)	Notes
REVENUES				
Prior Year Savings	$ 22,057,111	$ 33,254,471	$ 11,197,360	Budget adjusted based on final FY2020 savings
Medicaid Capitation SP/iSPA MH	372,200,501	413,815,172	41,614,671	Budget adjusted based on amended capitation rates and actual revenues received
Medicaid Capitation SP/iSPA SUD	13,411,761	14,375,672	963,911	
Medicaid Capitation HSW	92,051,210	105,963,014	13,911,804	
Healthy Michigan Plan Capitation MH	56,262,487	64,079,447	7,816,960	
Healthy Michigan Plan Capitation SUD	23,362,573	27,267,312	3,904,739	
Medicaid Autism	53,890,080	57,396,686	3,506,606	
Medicaid DHS Incentive Payment	2,358,355	2,530,970	172,614	
Hospital Rate Adjustor	16,359,552	15,022,000	(1,337,552)	Budget adjusted based on actual revenues
Performance Bonus Incentive Payment	4,583,840	5,121,730	537,890	Budget adjusted based on increased capitation revenue
Community Grant SUD	16,646,788	12,862,575	(3,784,213)	Budget adjusted based on DHHS amended amounts
PA2 Liquor Tax SUD	4,603,141	4,872,596	269,455	Budget adjusted based on OPB approved amounts
Local Match Contribution	3,140,208	3,140,208	-	
Interest Income	218,000	30,000	(188,000)	Budget adjusted for reduced interest rates
Other Grants	388,519	220,069	(168,450)	Budget adjusted based on actual revenues
Other Income	62,250	54,600	(7,650)	Budget adjusted based on actual revenues
TOTAL REVENUE BUDGET	**$ 681,596,376**	**$ 760,006,521**	**$ 78,410,145**	
EXPENDITURES				
ADMINISTRATION:				
Salaries and Wages	$ 4,799,320	$ 4,271,348	$ (527,972)	Budget adjusted for staff vacancies
Employee Benefits	1,775,693	1,497,265	(278,428)	
Other Contractual Agreements	630,615	477,500	(153,115)	Budget adjusted based on actual costs
IS Subscriptions and Maintenance	972,400	928,280	(44,120)	Budget adjusted based on actual costs
Consulting Services	130,000	90,000	(40,000)	Budget adjusted based on actual costs
Conference and Training Expense	49,820	21,850	(27,970)	Budget adjusted based on actual costs, virtual conferences
Human Resources Fees	60,040	50,240	(9,800)	Budget adjusted for staff vacancies
Mileage Reimbursement	61,395	8,450	(52,945)	Budget adjusted based on actual costs, travel restrictions
Other Expenses	220,925	240,075	19,150	Budget adjusted for Relias charges not billed to CMHSPs
Building Rent	83,131	73,131	(10,000)	Budget adjusted based on actual costs, remote work
Telephone Expense	68,100	74,375	6,275	Budget adjusted based on actual costs
Office Supplies	35,750	16,850	(18,900)	Budget adjusted based on actual costs
Printing Expense	42,000	44,750	2,750	
Meeting Expense	32,175	11,750	(20,425)	Budget adjusted based on actual costs, travel restrictions
Liability Insurance	37,433	36,800	(633)	
Depreciation Expense	81,927	81,927	-	
Audit Services	25,500	25,300	(200)	
OPB and Council Per Diems	18,060	11,270	(6,790)	Budget adjusted based on meeting attendance
Dues and Memberships	6,600	6,500	(100)	
Legal Services	5,000	5,000	-	
Equipment Rent	5,100	5,100	-	
Internet Services	2,460	2,760	300	
Subtotal Administration	**$ 9,143,444**	**$ 7,980,521**	**$ (1,162,923)**	
CMHSP and SUD EXPENSES and TAXES:				
CMHSP Participant Medicaid	$ 450,220,277	485,742,965	$ 35,522,688	Budget adjusted based on CMHSP estimated FY2021 expenses
CMHSP Participant Healthy Michigan Plan	54,431,413	53,235,155	(1,196,258)	
CMHSP Participant Medicaid Autism	47,427,267	50,567,003	3,139,736	
CMHSP Participant Other	4,830,666	4,556,244	(274,422)	
SUD Medicaid Contracts	12,300,000	10,800,000	(1,500,000)	Budget adjusted based on actual year to date utilization
SUD Healthy Michigan Plan Contracts	21,900,000	20,900,000	(1,000,000)	
SUD Community Grant	14,823,800	11,682,108	(3,141,692)	Budget adjusted based on DHHS amended amounts and actual year to date utilization
SUD PA2 Liquor Tax	4,603,141	4,872,596	269,455	Budget adjusted based on OPB approved amounts
Hospital Rate Adjustor	16,359,552	15,022,000	(1,337,552)	Budget adjusted based on actual costs
Tax Insurance Provider Assessment	5,474,045	5,477,013	2,968	
Tax Local Match Contribution	3,140,208	3,140,208	-	
Subtotal CMHSP and SUD Expenses and Taxes	**$ 635,510,368**	**$ 665,995,292**	**$ 30,484,924**	
TOTAL EXPENDITURE BUDGET	**$ 644,653,812**	**$ 673,975,813**	**$ 29,322,001**	
Revenue Over/(Under) Expenditures	**$ 36,942,564**	**$ 86,030,708**	**$ 49,088,144**	

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Background

The draft original budget for Fiscal Year (FY) 2022 was developed based on the board-approved MSHN Strategic Plan and is based on input from MSHN leadership team and staff, MSHN Finance Council and the MSHN Operations Council.

The MSHN FY 2022 budget includes projected revenues of $736,850,813 and estimated expenditures of $702,335,323. Revenue is projected to be $34,515,490 over expenditures. MSHN's revenue estimates were based on FY 2021 capitation rates without direct care worker premiums along with adjustments for anticipated declines in enrollments. Final FY 2022 capitation rates were not available at the time of budget development. PIHP Administration increased by $2,329,532 from the FY 21 Amended Budget and is 1.47% of total FY 2022 regional expenses. The increase in administration expense is related to MSHN's intention to fill previously approved Home and Community Based Services (HCBS) positions and proposed MSHN positions to carry out PIHP responsibilities associated with Certified Community Behavioral Health Centers (CCBHC). CMHSPs submitted projected expense documentation and SUD totals are based on historical spending and trended utilization.

A public hearing on the FY 2022 budget was held on September 14, 2021.

MSHN is required to operate under a board approved budget.

Recommended Motion:

Motion to approve the FY 2022 Original Budget as presented.

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FISCAL YEAR 2022 ORIGINAL BUDGET

DRAFT

	FY 2021 Original Budget	FY 2021 Amended Budget	FY 2022 Original Budget	FY 2022 Increase (Decrease) from Amended Budget	Notes
REVENUES					
Prior Year Savings	$ 22,057,111	$ 33,254,471	$ 51,407,120	$ 18,152,649	Budget based on maximum savings allowed
Medicaid Capitation SP/iSPA MH	372,200,501	413,815,172	387,375,014	(26,440,158)	Budget based on FY2021 capitation rates without direct care worker premiums along with adjustments for anticipated decline in enrollments; FY2022 capitation rates not available at the time of budget development
Medicaid Capitation SP/iSPA SUD	13,411,761	14,375,672	14,017,949	(357,724)	
Medicaid Capitation HSW	92,051,210	105,963,014	93,225,446	(12,737,568)	
Healthy Michigan Plan Capitation MH	56,262,487	64,079,447	62,976,885	(1,102,562)	
Healthy Michigan Plan Capitation SUD	23,362,573	27,267,312	26,221,167	(1,046,145)	
Medicaid Autism	53,890,080	57,396,686	55,155,351	(2,241,335)	
Medicaid DHS Incentive Payment	2,358,355	2,530,970	2,530,970	-	
Hospital Rate Adjustor	16,359,552	15,022,000	15,773,100	751,100	
Performance Bonus Incentive Payment	4,583,840	5,121,730	4,792,289	(329,441)	
Community Grant SUD	16,646,788	12,862,575	15,149,457	2,286,882	Budget based on DHHS allocations
PA2 Liquor Tax SUD	4,603,141	4,872,596	4,712,059	(160,537)	
Local Match Contribution	3,140,208	3,140,208	3,140,208	-	
Interest Income	218,000	30,000	80,000	50,000	
Other Grants	388,519	220,069	235,000	14,931	Includes Clubhouse Engagement and Veteran's Navigator
Other Income	62,250	54,600	58,800	4,200	
TOTAL REVENUE BUDGET	**$ 681,596,376**	**$ 760,006,521**	**$ 736,850,813**	**$ (23,155,708)**	
EXPENDITURES					
ADMINISTRATION:					
Salaries and Wages	$ 4,799,320	$ 4,271,348	$ 5,756,833	$ 1,485,485	Includes additional staff related to increased waiver and CCBHC responsibilities
Employee Benefits	1,775,693	1,497,265	2,082,083	584,819	Additional staff
Other Contractual Agreements	630,615	477,500	504,150	26,650	Includes ASAM Continuum training for the SUD Provider Network; also includes allowance for contracts not yet determined
IS Subscriptions and Maintenance	972,400	928,280	987,300	59,020	Includes software costs such as, but not limited to, Microsoft Office, managed care, parity, care coordination, document sharing
Consulting Services	130,000	90,000	130,000	40,000	Includes allowance for additional consulting services
Conference and Training Expense	49,820	21,850	91,545	69,695	Additional staff, in-person conferences
Human Resources Fees	60,040	50,240	64,540	14,300	Additional staff
Mileage Reimbursement	61,395	8,450	74,425	65,975	Reduced travel restrictions, in-person activities
Other Expenses	220,925	240,075	175,480	(64,595)	Includes technical support and Relias training; also includes a reduction for one-time activities grant funded in FY2021
Building Rent	83,131	73,131	73,879	748	
Telephone Expense	68,100	74,375	72,450	(1,925)	
Office Supplies	35,750	16,850	35,850	19,000	
Printing Expense	42,000	44,750	55,000	10,250	
Meeting Expense	32,175	11,750	44,575	32,825	Reduced travel restrictions, in-person activities
Liability Insurance	37,433	36,800	38,445	1,645	
Depreciation Expense	81,927	81,927	50,397	(31,530)	Software fully depreciated
Audit Services	25,500	25,300	35,500	10,200	
OPB and Council Per Diems	18,060	11,270	18,060	6,790	
Dues and Memberships	6,600	6,500	6,500	-	
Legal Services	5,000	5,000	5,000	-	
Equipment Rent	5,100	5,100	5,100	-	
Internet Services	2,460	2,760	2,940	180	
Subtotal Administration	**$ 9,143,444**	**$ 7,980,521**	**$ 10,310,053**	**$ 2,329,532**	
Percent Administration Expenses to Total Expenses	1.42%	1.18%	1.47%		

	FY 2021 Original Budget	FY 2021 Amended Budget	FY 2022 Original Budget	FY 2022 Increase (Decrease) from Amended Budget	Notes
CMHSP and SUD EXPENSES and TAXES:					
CMHSP Participant Medicaid	$ 450,220,277	$ 485,742,965	$ 492,816,745	$ 7,073,780	Budget based on CMHSP budgeted FY2022 expenses
CMHSP Participant Healthy Michigan Plan	54,431,413	53,235,155	64,334,217	11,099,062	
CMHSP Participant Medicaid Autism	47,427,267	50,567,003	52,816,366	2,249,363	
CMHSP Participant Other	4,830,666	4,556,244	5,256,730	700,486	Includes Performance Bonus Incentive Payments and Clubhouse Engagement
SUD Medicaid Contracts	12,300,000	10,800,000	12,300,000	1,500,000	Budget based on projected utilization along with reimbursement rate increases
SUD Healthy Michigan Plan Contracts	21,900,000	20,900,000	25,200,000	4,300,000	
SUD Community Grant	14,823,800	11,682,108	9,892,900	(1,789,208)	Budget based on projected utilization and SOR grant expenditures
SUD PA2 Liquor Tax	4,603,141	4,872,596	4,712,059	(160,537)	
Hospital Rate Adjustor	16,359,552	15,022,000	15,773,100	751,100	
Tax Insurance Provider Assessment	5,474,045	5,477,013	5,782,945	305,932	Budget based on annual assessment
Tax Local Match Contribution	3,140,208	3,140,208	3,140,208	-	
Subtotal CMHSP and SUD Expenses and Taxes	**$ 635,510,368**	**$ 665,995,292**	**$ 692,025,271**	**$ 26,029,979**	
TOTAL EXPENDITURE BUDGET	**$ 644,653,812**	**$ 673,975,813**	**$ 702,335,323**	**$ 28,359,510**	
Revenue Over/(Under) Expenditures	**$ 36,942,564**	**$ 86,030,708**	**$ 34,515,490**	**$ (51,515,218)**	

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PROPOSAL FOR THE CONTINUATION OF DIRECT CARE WORKER PREMIUM PAY INTO FISCAL YEAR 2022

Background

Mid-State Health Network (MSHN) originally developed and the MSHN Board of Directors approved establishing a regional direct care worker (DCW) premium pay program in April 2020 at $2.00 per hour (with flexibility to meet local conditions up to $4/hour, with employer costs also covered). For a portion of the 2020 fiscal year, the Michigan Legislature passed bills that Governor Whitmer signed into law establishing statewide $2.00/hour direct care worker premium pay. PA2 of 2021 extended the direct care worker premium pay through September 30, 2021 (at an increased hourly wage of $2.25 + 12% employer costs). Michigan Department of Health and Human Services (MDHHS) guidance specified the services codes for which DCW premium pay would be provided. PIHP rates were adjusted to pass through appropriated funds to PIHPs, which then provided the funding via capitation payments to in-region Community Mental Health Service Providers (CMHSPs) and via MSHN directly to substance use disorder treatment providers. MSHN regional guidance has been updated several times during this period and can be found at the MSHN Website Coronavirus page. Without further legislative and gubernatorial action, the current DCW premium pay program will end September 30, 2021.

As of the date at the bottom of this page, the Michigan Legislature has not passed a FY 22 budget bill(s) for the Michigan Department of Health and Human Services (MDHHS). Of note, however, is that continuation of the direct care worker premium pay is included in the most recent drafts of MDHHS budget bills.

There is a statewide staffing crisis that is affecting the public behavioral health system's ability to provide for the health and safety of beneficiaries and to deliver needed services and supports. While the staffing crisis is broad and goes well beyond direct support professionals, the continuation of this premium pay program is one important tool that we should use to retain and attract members of the DCW workforce.

MSHN, with the unanimous support of its Operations Council, consisting of the Chief Executive Officers of its partner CMHSPs, recommends the continuation of the DCW premium pay in the MSHN region, regardless of whether the Legislature includes it in FY 22 MDHHS budget bill(s). The annual cost of providing the $2.25 (plus 12% employer costs) in the MSHN region is approximately $22M. MSHN has sufficient prior year carry forward (savings) to fund the continuation of the DCW premium pay initiative in the region. However, MSHN must remain cautious in its use of resources and recommends continuation of the DCW Program for a six-month period, and then to revisit resources and continuation of the DCW premium pay initiative for the remainder of the fiscal year at the MSHN Board level in March 2022.

Recommended Motion:

Motion to authorize the continuation of the Mid-State Health Network Direct Support Professional Enhanced Compensation Program (DCW Premium Pay) through March 31, 2022 at current hourly rate levels and within regional parameters established by the MSHN Chief Executive Officer (including incorporating any changes due to MDHHS directive or legislative mandate) and, if the program is not directly funded by the State, to fund it using MSHN-managed financial resources.

Drafted August 17, 2021

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MID-STATE HEALTH NETWORK STRATEGIC PLAN FOR 2022 THROUGH 2023

Background

The Mid-State Health Network Board of Directors is responsible for establishing the strategic direction of the organization.

The FY 2022-FY2023 Strategic Plan Update that follows has been developed with broad input from many stakeholders in the MSHN region.

Of note, the strategic priorities proposed include continuation of the four previous priorities of better health, better care, better provider systems, and better value and the adoption of a fifth strategic priority, better equity.

The MSHN Board considers and approves these strategic priorities and the strategic goals to address the priorities. MSHN management develops objectives, tasks and activities to achieve the goals.

The following motion is recommended for adoption by the MSHN Board of Directors.

Recommended Motion:

Motion to approve the FY 2022 – FY 2023 Strategic Plan Update for Mid-State Health Network and to direct the Chief Executive Officer to implement the plan.

September 14, 2021

FY 2022 – FY 2023 STRATEGIC PLAN UPDATE

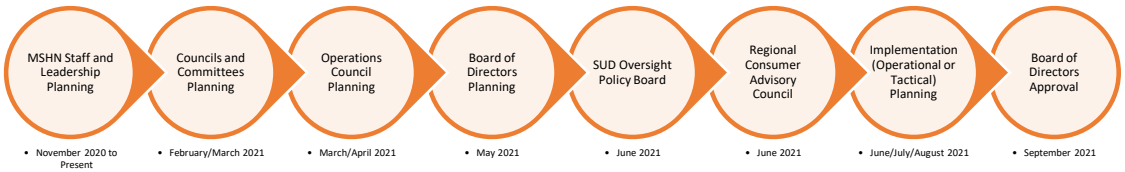
FINAL DRAFT- FOR MSHN BOARD CONSIDERATION

The pages that follow constitute the update to the Mid-State Health Network Strategic Plan covering fiscal years (FY) 2022 and 2023. This plan incorporates broad internal and external stakeholder input.

This strategic plan update represents a continuation of the strategic priorities of Mid-State Health Network to align with the "Quintuple Aim". The Quintuple Aim is the national framework for healthcare reform. This framework may be stated differently in the literature. For the Mid-State Health Network region, the quintuple aim includes these five strategic priorities: "*Better Health*", "*Better Care*", "*Better Value*", "*Better Provider Systems*" and new for this plan, "*Better Equity.*" These are referred to throughout the remainder of this document as our *strategic priorities*.

Of note, the previous MSHN regional strategic plan was extended for FY 21 due to the Coronavirus pandemic.

As depicted below, strategic priorities, strategic goals, and strategic objectives were discussed and developed with input from MSHN staff, various councils and committees, the MSHN Regional Consumer Advisory Council, the MSHN Operations Council, the MSHN SUD Oversight Policy Board, the MSHN Governing Board and the Michigan Department of Health and Human Services. Meetings and other activities to gather this broad input occurred from November 2020 through July 2021.



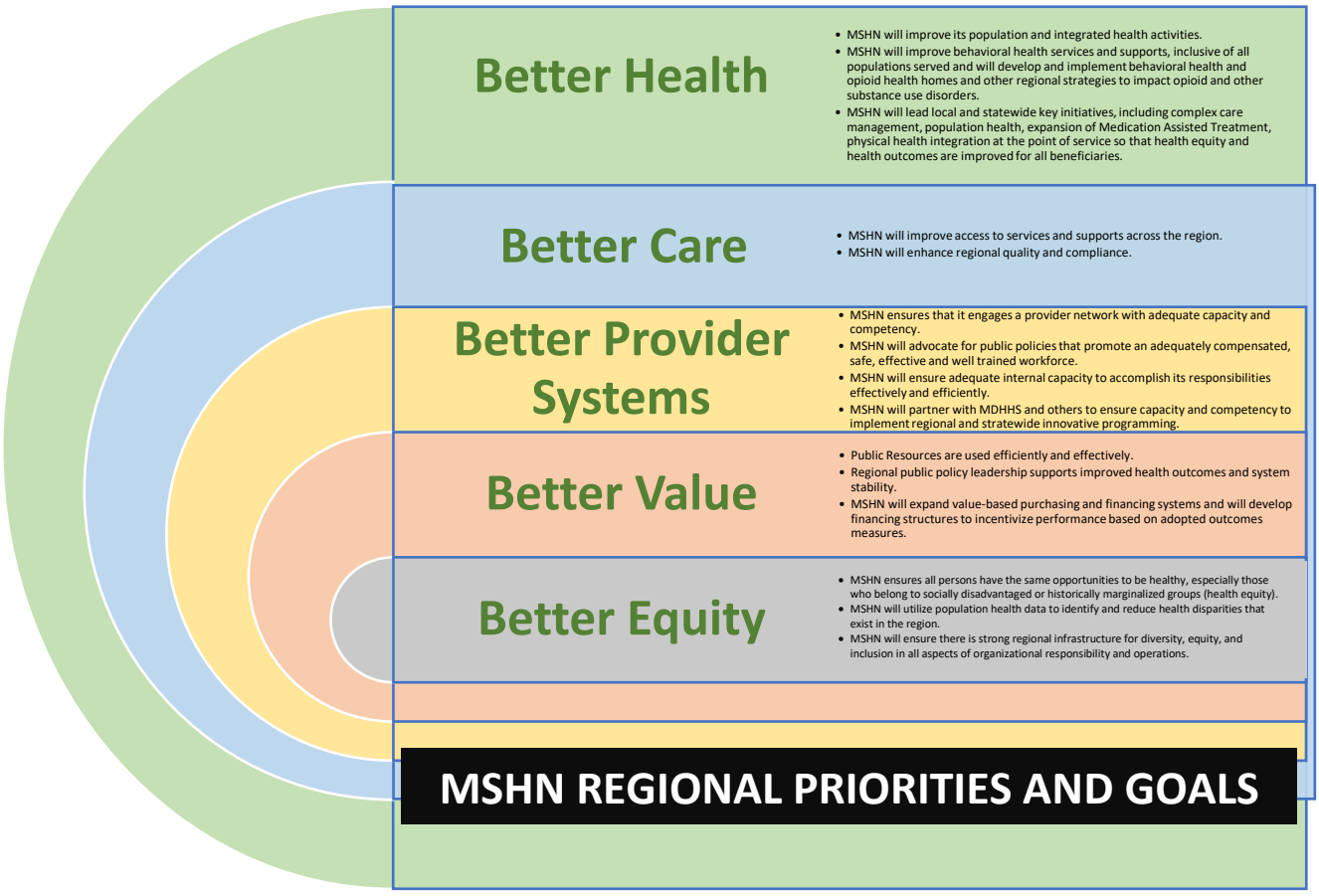
Based on this broad input, MSHN executive leadership extracted the strategic goals that emerged around common themes and which accurately correspond with its view of the accountabilities of the Mid-State Health Network, current environmental opportunities and threats, and its mission to support services within the 21-county region which best meet the needs of Medicaid, Healthy Michigan, Substance Abuse Prevention and Treatment (SAPT) Block Grant and Liquor Tax-Funded beneficiaries. MSHN's strategic goals and related strategic objectives are shown within the strategic priorities framework.

Our strategic plan is based on our *founding principles*, which include cooperative, open, and frank discussion of the strengths, weaknesses, and capacities of MSHN and each CMHSP partner as well as partnership with our SUD provider network; planning and operations that reflect a realistic evolutionary process; flexible and robust managed care operations not favoring any provider or any particular CMHSP or CMHSP service model; and many others. In partnership, MSHN and its CMHSP participants are committed to effective health integration activities, equity, and accountability.[1]

[1] Extracted from "Principles to Guide the New PIHP", MSHN Operations Council, December 13, 2012

The following pages present the strategic plan elements for fiscal years 2022 and 2023. These include new priorities, goals, and objectives developed in the process described above and continued or revised strategies from the previous MSHN Strategic Plan.

The MSHN Strategic Plan is based on the Strategic Priorities identified in the graphic below. The MSHN Strategic Goals are identified on the right of this graphic. The remainder of this document includes this material as well as strategic objectives for the region.



There is a significant amount of crossover among the strategic goals that are placed within the strategic priorities framework. Assignment of a strategic goal to a particular strategic priority is therefore somewhat arbitrary but has been mostly guided by the expected outcome of achieving the strategic goal.

Significant themes have emerged in the process of strategic planning, in particular the need to *improve consistency*, *improve standardization*, and *improve cost-effectiveness*. We have used these themes as guideposts in our development of regional and MSHN-specific strategic goals, as we have since our inception.

PLANNING RESPONSIBILITY AND TIMELINES CHART

MID-STATE HEALTH NETWORK LEADERSHIP TEAM

Joseph Sedlock,
Chief Executive Officer

Amanda Ittner,
Deputy Director

Todd Lewicki,
Chief Behavioral Health Officer

Forest Goodrich,
Chief Information Officer

Dani Meier,
Chief Clinical Officer

Skye Pletcher
Director of Care and Utilization Management

Kim Zimmerman,
Chief Compliance and Quality Officer

Leslie Thomas,
Chief Financial Officer

KEY ASSUMPTIONS AND KEY QUESTIONS FOR STRATEGIC PLANNING

Mid-State Health Network stakeholders developed what were considered to be important or key assumptions and questions to address in the strategic planning process. These can certainly be expanded and debated but represent the major themes revealed during the regional planning process. There were more key questions and assumptions (See Appendix 1), which have been narrowed down to the following top considerations:

KEY ASSUMPTIONS
Carve in remains a material threat even while a COVID-19 pandemic response is likely to continue well into FY 22 (and beyond). Legislation has been drafted (and introduced) that would eliminate Pre-paid Inpatient Health Plans (PIHPs) as the public managed care entities in Michigan.
By their own statements, MDHHS/BHDDA will not have the necessary staffing and other resources to drive major system reform/redesign. There continues to be legislative and advocate community desire to reform the public system. MDHHS/BHDDA wants reform, too, but is under-resourced to carry it out.
MSHN should lead reform, innovation, and collaboration efforts in the region and statewide. Unless there are changes to MSHN bylaws or regional endorsement to take on these roles, MSHN has no independent ability to pursue multi-PIHP or public/private partnerships, multi-regional or statewide opportunities.
Regional revenues will likely be pressured in future years. Revenue/Rates for FY21 and FY22 will likely be adjusted down due to low utilization during the pandemic, which should be an anomaly. • *May be offset by new federal funding under the MH and SAPT block grant and may require that the region conduct additional planning to effectively use these funds.* • *Strong commitment to Certified Community Behavioral Health Clinics (CCBHCs) and Behavioral Health Homes and Opioid Health Homes – may require additional planning to effectively implement and use these funds and may have implications for regional entity (MSHN) staffing.* • *KB lawsuit may have implications for financing and system design.* • *Post COVID utilization may increase (without necessary funding to support it).*
Performance matters. PIHP staff must be retained and MSHN must continue to fulfill (and exceed) expectations especially in light of the threat of elimination of PIHPs by the legislature/others.
Information technologies are expanding rapidly. The region may need better surveillance, awareness and participation in information sharing initiatives (such as eConsents, ADT feeds, EMR interoperability initiatives, electronic visit verification, and more).
Health integration, including behavioral/physical health integration, pressures our systems to look more like traditional healthcare delivery systems in spite of the fact that there are significant differences in the financing, delivery, and management models. Continued pressure to conform to traditional healthcare system structures and delivery modalities will have to be faced by the public behavioral health system.

KEY QUESTIONS
What is the role for MSHN and how should MSHN be preparing for CCBHC, State Innovation Model (SIM), Opioid Health Homes, Behavioral Health Homes? And to what extent does the regional delegation model impact future options and current effectiveness/efficiency?
Will MDHHS continue to seek to strengthen the existing public behavioral health system (even if "reformed") in a manner than retains the public nature of our system, keeps the county-based CMHSP structure, and the regional-entity managed substance use disorder prevention and treatment system structures largely intact?
To what extent should MSHN partner with like-minded PIHPs/Regional Entities to address key reform issues (i.e., "criticisms" upon which reform/redesign are largely based), address threats, leverage opportunities?
To what extent should MSHN position itself to partner with other entities (including Federally Qualified Health Clinics [FQHCs], Health Plans in and outside of Michigan, and other entities) in anticipation of future redesign initiatives, to address threats and leverage opportunities?
Should (National Committee for Quality Assurance, NCQA) accreditation for MSHN be revisited in light of current and predicted future environment (threats and opportunities)? (PIHPs/Regional Entities operating with accredited managed care operations include Detroit/Wayne, Southwest Michigan Behavioral Health, NorthCare, Oakland, Beacon Health Options). MSHN and CMHSPs are already stretched and should consider accreditation if it strengthens the public system and enhances support of various public system initiatives (such as CCBHCs, SIM, OHH, BHH and others).

ENVIRONMENTAL SCAN FOR STRATEGIC PLANNING

Mid-State Health Network stakeholders developed important environmental scan observations. These are arranged by strengths and weaknesses (internal-looking), threats and opportunities (external-looking). These can certainly be expanded and debated but represent the themes identified in the planning process. There are more strengths, weaknesses, opportunities, and threats that were identified (See Appendix 2), which have been narrowed down to the following considerations:

SUMMARY OF STRENGTHS AND WEAKNESSES:

Strengths:

MSHN INTERNAL STAFFING AND STRUCTURE:

- MSHN staff have a high workload capacity, are strong, dedicated, and competent who can work independently. In addition, they are highly effective in the remote work environment.

REGIONAL/STATEWIDE LEADERSHIP:

- The MSHN board has consistently demonstrated strength, fortitude and leadership, a high degree of cohesion, and a documented history of getting things done.

- MSHN maintains an excellent reputation in Michigan, is viewed as highly collaborative in-region and with external partners, and a statewide leader in many initiatives. MSHN is known to "listen" to the needs of the region and incorporate network feedback into services and operations. MSHN is a trailblazer in PIHP operations and state initiatives leading to positive impacts on people and their quality of life, health status, and more. MSHN has advanced public policy priorities as well as regional priorities to improve quality and effectiveness of services and supports.
- MSHN is developing its depth and governance in regional change management processes and communications.

MSHN OPERATIONS:

- MSHN has been a consistently high performing PIHP since its inception: Penetration rates, Medical Loss Ratio, Financial Stability and other standard performance on metrics have been exemplary; MSHN has earned 100% of its performance bonuses in all periods prior to FY 2020. Quality/performance metrics; Compliance to state requirements; and data reporting. Highly developed IT system and support infrastructure, including data analytics, have been exceptional. MSHN uses innovative techniques to accomplish objectives. Transparency in operations, providing a lot of data and metrics, and tracking a lot of data points are features of our day-to-day operations. MSHN has established an efficient administration/process. CCBHC participation in region is significant, with PIHP-level supports evolving.

PROVIDER NETWORK:

- MSHN has a strong rapport with the provider network which includes fiscal oversight, contract monitoring, and an especially strong and open communication strategy. This was noted during the COVID-19 pandemic where MSHN was envied among other regions related to a rapid response to provider needs including provider stabilization funds. In turn, MSHNs region boasts robust network adequacy.

Weaknesses:

MSHN INTERNAL STAFFING AND STRUCTURE:

- Even with a strong performance driven culture, at times, the capacity of MSHN staff is stretched due to a lean staffing model. At times, filling vacancies due to attrition can take several months as a candidate with matching credentials and experience is sought.

REGIONAL/STATEWIDE LEADERSHIP:

- MSHN endeavors to be a leading PIHP in Michigan though is not currently participating in all the possible state innovative projects and initiatives, like opioid health homes (because of State roll-out scheduling).

MSHN OPERATIONS:

- Although some see this as a strength or a feature of how MSHN was designed, MSHN lacks the ability to act independently, for example, the current provider governance model/operating agreement restricts its flexibility with financing our CMHSPs, a lack of local

PIHP funds. While this is recognized, because of lean operations we lack the required time and resources to complete change management (i.e., approval processes) in a timely manner.

- The MSHN PIHP is not accredited. (Since the NCQA readiness assessment was conducted several years ago, seeking accreditation in the near term may be more readily implemented and accepted in the region).
- There is limited CMHSP data sharing and lack of access of integrated health data within PIHPs. To that end, there is a deficiency of well-defined outcome metrics. For example, MSHN is tracking an abundance of data points without the resources to act (follow-through/monitor).
- The current MDHHS model and guidance related to CCBHCs is deficient (although a framework is expected in near future), MSHN requires additional direction related to rules and regulations and to ascertain impacts on MSHN operations (if any).

PROVIDER NETWORK:

- MSHN SUD Provider Network includes a significant level of duplication for some types of services due to delegated "no wrong door" access system. In addition, value-based purchasing (VBP) is under-developed and requires the providers understanding the concept and embracing the strategy to move in this direction. The SUD Provider network does not feel adequately compensated for the indirect/admin requirements. In addition, MDHHS encounter reporting system is not developed in this area. Case rates and other similar fiscal arrangements would be reported by the PIHP under specific Current Procedure Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) codes which would not reflect the actual "service activity". MSHN has not conducted a regional review of how to better integrate services for SAPTR at the local level.
- At MSHN, and across all providers and CMHSP Participants, staff resources are strained in providing an abundance of technical assistance to providers who have an inconsistent level of performance and depth of knowledge.
- Workforce recruitment, retention, recognition, compensation, and related factors are causing a region (and state) wide workforce crisis.

SUMMARY OF THREATS AND OPPORTUNITIES:

THREATS:

SYSTEM REFORM/REDESIGN:

- Legislative and MDHHS system reform/redesign elements include the threat of carve in (including separately carving in the SUD benefit to Medicaid Health Plans (MHPs), which will likely be addressed in the MHP contract rebid concluding 09/30/2023), elimination of the PIHPs, of which MSHN is one (of 10), all of which could affect the service array, CMHSP operations, PIHP role and operations, and requires clarity on what the MSHN Board and regional CMHSPs will support MSHN being or becoming, including which potential

partnerships with physical health payers, partnerships with other PIHPs, and other initiatives, can take place and under what conditions.

RESOURCES:

- State budget shortfalls (due to COVID-19 and decreased service utilization during the pandemic response, federal changes to the ACA and/or federal appropriations), PIHP fiscal instability for some PIHPs, reductions in SUD block grant funding, lack of availability of MSHN local funds earned but fully distributed to CMHSPs per the Operating Agreement, reductions in rates associated with standard cost allocation initiative, perceived high costs, and other factors may influence how PIHP rates are set and may result in decreased revenue and pressure on the public system to drive costs down. The COVID pandemic response has increased awareness of mental health and substance abuse issues that may wane as the pandemic resolves. Funding may suffer as a result.
- Behavioral Health workforce shortages, attrition, retention, attraction and (especially with the SAPT workforce adequacy of compensation) will continue to pressure providers and resource SAPT network competency pressures to breaking points; MSHN capacity for adequate technical assistance and provider performance monitoring. An additional concern with legislative and other proposals to eliminate PIHPs is the potential for MSHN employees to leave and the ongoing ability of MSHN to carry out its responsibilities.

OPPORTUNITIES:

SYSTEM REFORM/REDESIGN

MDHHS has stated that it will not intentionally pursue system redesign, but the public system should take advantage of this opportunity to develop/implement reforms (even as legislative proposals call for elimination of PIHPs). MSHN and the region should prepare itself and delineate boundaries, if any, on MSHN latitude to pursue dialogs that may lead to partnerships that strengthen the region (such as complex care management for the unenrolled; partnerships with physical health payers, partnerships with other PIHPs and reducing health disparities). The MSHN Operations Council and the MSHN Board of Directors strongly supports MSHN continuously planning, researching, and developing strategic relationships and bringing forward proposals that would strengthen the public system, specifically CMHSPs, in the region.

RESOURCES

National healthcare reform is focused on the expansion of value-based purchasing and alternative payment models, which require the development of meaningful outcome measures associated with expanded evidence based practices, robust and inter-operable information technology and consent management systems capable of gathering and reporting data on physical and behavioral health conditions, social determinants of health, and health equity parameters and should result in a more standardized benefit, access criteria, and utilization management criteria within and between regions.

LEADERSHIP

MSHN has a history and experience being a leader on many initiatives among PIHPs in the state and should use this reputation to partner/collaborate on key initiatives, including population health, complex care management, physical health integration at the point of service, and influence the

outcomes of a variety of statewide initiatives (including but not limited to reducing health disparities and improving health outcomes for beneficiaries, collaborations with physical health payers, standard cost allocation, potential redesign/reform, expansion of Medication Assisted Treatment (MAT), Home and Community Based Services (HCBS) systems, etc.).

STRATEGIC PRIORITIES:

- MSHN has five strategic priorities. Strategic Priorities are the broadest strategic statement and require board approval:
  - Better Health

    Improve the health of the beneficiary population in the Mid-State Health Network region by supporting evidence-based interventions and other innovations to address behavioral, social, and environmental determinants of health.

  - Better Care

    Improve the overall experience of persons in services and the quality of services and supports by ensuring services and supports are person centered, family driven/youth guided, reliable, accessible, safe and effective.

  - Better Value

    Increase value for resources used by achieving balance between quality, cost, and outcomes and providing where permitted incentives to achieve better value.

  - Better Provider Systems

    Ensure availability of and beneficiary access to an adequate, competent, capable, broad, accessible, well-compensated and satisfied provider system and workforce members.

  - Better Equity

    Reduce and work toward the elimination of disparities – whatever their causes – so that communities and individuals can achieve their highest desired level of health.

STRATEGIC GOALS:

Like Strategic Priorities, Strategic Goals are board approved. The following tables are formatted to show the Strategic Priority followed by an indented Strategic Goal, followed by another indented Strategic Objective and tasks/activities. Strategic Objectives and related activities are management developed prerogatives about which the board advises.

MID-STATE HEALTH NETWORK
STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
FY 2022- FY 2023

STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
BETTER HEALTH						
	MSHN will improve its population health and integrated care activities.				Director of Utilization and Care Management	09/30/23
		MSHN will explore initiatives to address social determinants of health that contribute to undesirable health outcomes for persons served.	Director of Utilization and Care Management	MSHN will identify strategies to improve access to care such as telehealth, transportation assistance, and others.	Director of Utilization and Care Management	09/30/22
				MSHN will explore the use of geographic information systems in order to better understand neighborhood-level characteristics and areas of need.	Director of Utilization and Care Management; Chief Information Officer	09/30/22
				MSHN will work with its partner CMHSPs to develop a standardized process for collecting and sharing data related to social determinants of health.	Director of Utilization and Care Management; Chief Information Officer	09/30/23
	MSHN will improve behavioral health services and supports, inclusive of all populations served and will develop and implement behavioral health and opioid health homes and other regional strategies to impact opioid and other substance use disorders.				Chief Behavioral Health Officer	09/30/23
		MSHN will ensure regional readiness for implementation of opioid health homes.	Chief Clinical Officer	MSHN will complete a review of the requirements for opioid health homes and designate a point person to oversee the project.	Chief Clinical Officer	09/30/22
				MSHN will assess regional readiness for implementation of opioid health homes.	Chief Clinical Officer	09/30/22
				MSHN will develop a workplan for identified areas of improvement based on assessment results including meeting with Region 2 to determine implementation successes and barriers.	Chief Clinical Officer	09/30/22
				MSHN will use a procurement process to select an Opioid Health Home within the region ensuring they meet all the requirements identified by the MDHHS and SAMHSA.	Chief Clinical Officer	09/30/23

MID-STATE HEALTH NETWORK
STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
FY 2022- FY 2023

STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		MSHN will ensure regional readiness for implementation of behavioral health homes.	Chief Behavioral Health Officer	MSHN will complete a review of the requirements for behavioral health homes (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer	09/30/22
				MSHN will assess regional readiness for implementation of behavioral health homes (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer	09/30/22
				MSHN will develop a workplan for identified areas of improvement based on assessment results (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer	09/30/22
				MSHN will use a procurement process to select a behavioral health home within the region ensuring they meet all the requirements identified by the MDHHS and SAMHSA.	Chief Behavioral Health Officer	09/30/23
		MSHN will discuss and identify any other regional strategies to impact opioid and other substance use disorders.	Chief Clinical Officer	MSHN will monitor its Provider Network to ensure Evidence Based Practices are included in substance use disorder treatment as part of the annual site review process.	Chief Clinical Officer	09/30/23
				MSHN prevention team will work with community partners to increase awareness of opioid use in older adults, including risk for overdose when prescription opioids are mixed with alcohol.	Chief Clinical Officer	09/30/23
				MSHN will add information on obtaining free Naloxone and the link to order Naloxone to our website to ensure people in the region have access to life saving medication.	Chief Clinical Officer	09/30/23
				MSHN will work to increase access to re-entry services and will work with contracted providers to expand access to services within the jail setting.	Chief Clinical Officer	09/30/23

MID-STATE HEALTH NETWORK
STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
FY 2022- FY 2023

STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
	MSHN will lead local and statewide key initiatives, including complex care management, population health, expansion of Medication Assisted Treatment, physical health integration at the point of service so that health equity and health outcomes are improved for all beneficiaries.				Deputy Director	09/30/23
		MSHN will support care coordination and complex care management for the unenrolled population within the region.	Deputy Director	MSHN will develop a standard data validation and reporting on the unenrolled population, including frequency and distribution to the network via ICDP.	Chief Information Officer	09/30/22
				MSHN will review/determine risk stratification criteria and desired improvement metrics that include both process and outcome metrics.	Deputy Director	06/30/22
				MSHN will track and monitor improvement efforts, identify barriers and reassess initiatives annually through CLC, UMC and QIC.	Chief Behavioral Health Officer, Director of Utilization and Care Management, Quality Manager	03/31/22
		MSHN will review the region's Population Health via standardized, nationally recognized metrics, to update (replace, remove or add) the region's process and outcome strategies to improve access to care and overall health.	Director of Utilization and Care Management	MSHN will increase regional use of information technology data systems to support population health management.	Chief Information Officer	04/30/23
				MSHN will pursue e-consent management opportunities to improve care coordination between behavioral health, physical health, and SUD systems of care.	Chief Information Officer, Director of Utilization and Care Management	09/30/22

MID-STATE HEALTH NETWORK
STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
FY 2022- FY 2023

STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
BETTER CARE						
	MSHN will improve access to services and supports across the region.				Chief Behavioral Health Officer	09/30/23
		MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region.	Chief Behavioral Health Officer	MSHN will review and determine SUD screening and access needs and recommend improvements as appropriate.	Director of Utilization and Care Management	09/30/22
				MSHN will review and address need for increasing access to children's acute care services.	Chief Behavioral Health Officer	09/30/22
				MSHN will participate in PRTF discussions through MDHHS planning workgroup as appropriate.	Chief Behavioral Health Officer	09/30/22
				MSHN will review and determine capacity needs for ABA services and work with region and providers.	Waiver Manager (BG)	09/30/22
		MSHN takes actions to improve access to psychiatric inpatient care, reduce denials and improve emergency and crisis support continuum of care available in the region and across the State.	Chief Behavioral Health Officer	MSHN to review the use of a psychiatric inpatient denial database.	Director of Provider Network Management Systems	03/01/22
				MSHN will implement a regionally-operated crisis residential unit.	Chief Behavioral Health Officer	03/01/22
				MSHN will monitor mobile crisis response (intensive crisis stabilization services) activities, and suggest process and outcomes metrics.	Chief Behavioral Health Officer; Director of Utilization and Care Management	09/30/22
				MSHN will work with MDHHS to determine readiness to bring the Michigan Crisis and Access Line (MiCAL) function to the region and establish workplan.	Chief Behavioral Health Officer; Director of Utilization and Care Management	04/30/22
				MSHN will work with MDHHS to implement relevant process and outcomes measures for MiCAL.	Director of Utilization and Care Management	12/31/22
				MSHN will monitor the number of emergency room visits and the time spent in emergency room for substance use in the Jackson community to measure the reduction of emergency room services now that the Engagement Center is open.	Chief Clinical Officer	03/31/22
				MSHN will monitor the amount of project ASSERT screenings that are completed in the emergency department that result in substance use disorder and behavioral health referrals and track the percentage of referrals that attend a referred service within the MSHN network of providers.	Chief Clinical Officer	12/31/22

MID-STATE HEALTH NETWORK
STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
FY 2022- FY 2023

STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		MSHN's network of providers establish processes to assist individuals served in establishing and maintaining eligibility for Medicaid and/or Healthy Michigan Program coverage.	Chief Compliance and Quality Officer	Coordinate a review of individuals whose services are funded by Block Grant and connect those who are not Medicaid or Healthy Michigan covered to DHHS for eligibility review.	Customer Services Specialist	09/30/22
		MSHN ensures expanded SAPT and CMHSP service access and utilization for Veterans and Military Families through implementation of the regional and statewide Veteran and Military Family Member strategic plan.	Chief Clinical Officer	Provide trainings to improve Military Cultural Competency in the provider network and reduce the stigma associated with accessing treatment services and support for behavioral health and substance use disorders.	Veteran's Navigator	09/30/23
				MSHN will increase access to services for veterans by monitoring data regarding the number of veterans in MSHN's network who connect with the Veteran Navigator and developing strategies to connect veterans to services either through the VA or MSHN's BH/SUD network.	Veteran's Navigator	09/30/23
				Reduce veteran suicide within the MSHN region through participation in local suicide prevention coalitions.	Veteran's Navigator	09/30/23
				MSHN will increase access to veteran peer specialist, veteran peer recovery coaches, and veteran recreation therapy to increase access and engagement in treatment and recovery services for veterans and military families.	Veteran's Navigator	09/30/23
	MSHN will enhance regional quality and compliance				Chief Compliance and Quality Officer	09/30/23
		MSHN will provide leadership on improving the consistency and implementation of person-centered planning, self-determination, conflict free case management, and independent facilitation in the region.	Chief Compliance and Quality Officer	PCP toolkit/training resource will be updated on a quarterly basis and made available to the provider network.	Chief Compliance and Quality Officer	06/30/22
				Identification of additional training(s) and resources will be based on findings/outcomes from annual internal (DMC) and external (MDHHS) site reviews.	Chief Compliance and Quality Officer	12/31/22
				MSHN will provide templates, formats and/or guidelines as identified through semi-annual review by CLC and QIC.	Chief Compliance and Quality Officer	03/30/23

MID-STATE HEALTH NETWORK
STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
FY 2022- FY 2023

STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		On a regional basis, effectively engage like-minded partners in leading initiatives to address system reform objectives, especially those that improve beneficiary access to and benefit from services and to promote long-term stabilization of the public behavioral health system.	Chief Behavioral Health Officer	MSHN through its CLC, UMC, and QIC, will identify relevant system reform objectives (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer; Director of Utilization and Care Management; Quality Manager	04/30/22
				MSHN will identify the group most appropriate to address system reform objectives (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer; Director of Utilization and Care Management; Quality Manager	09/30/22
				MSHN will work with its partners to establish a workplan to address system reform objectives (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer; Director of Utilization and Care	09/30/23
		Expand penetration rates in specialty populations (in particular, older adults, adolescents and veterans).	Chief Behavioral Health Officer	MSHN will establish baseline penetration rate for its specialty populations including utilization rates of SUD and BH services.	Chief Behavioral Health Officer; Chief Clinical Officer	09/30/22
				MSHN will identify strategies to address increased penetration rates for adolescents and older adults (including what, who, by when, related metrics (if any).	Director of Utilization and Care Management; Quality Manager	09/30/22
				MSHN will work with substance use disorder providers to engage community partners such as schools, senior centers, MDHHS, courts, faith-based agencies, etc. to establish a support network for adolescents and older adults in services and to build relationships to increase referrals for people who need substance use disorder services.	Lead Treatment Specialist; Lead Prevention Specialist	09/30/23
				MSHN will increase access to services for veterans by monitoring data regarding the number of veterans in MSHN's network who connect with the Veteran Navigator and developing strategies to connect veterans to services either through the VA or MSHN's BH/SUD network.	Veteran's Navigator	09/30/23

MID-STATE HEALTH NETWORK
STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
FY 2022- FY 2023

STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		MSHN will have well established compliance processes that are recurring, consistent and measurable and aimed at preventing, detecting, and deterring fraud, waste and abuse.	Director of Quality, Compliance and Customer Services	The Medicaid Event Verification site review results will be analyzed for trends of non-compliance with required standards on a quarterly basis and utilize MSHN's Compliance Committee and the Regional Compliance Committee to develop processes/education/training to promote compliance.	Chief Compliance and Quality Officer	12/31/22
				Develop a compliance webpage on MSHN's website providing current information on healthcare rules and regulations, education on current trends of non-compliance as identified through internal and external site reviews and identification of trainings on compliance related activities. The webpage will be updated as new information is available.	Chief Compliance and Quality Officer	12/31/22
				Identify trends of non-compliant activities as reported on the Office of Inspector General quarterly activity report and utilize MSHN's Compliance Committee and the Regional Compliance Committee to develop processes/education/training to promote compliance.	Chief Compliance and Quality Officer	12/31/22
				Research options and determine feasibility for the completion of a compliance risk assessment region wide.	Chief Compliance and Quality Officer	12/31/22

MID-STATE HEALTH NETWORK
STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
FY 2022- FY 2023

STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
BETTER VALUE						
	Public Resources are used efficiently and effectively.				Chief Financial Officer	09/30/23
		MSHN will participate in the State's development of various monitoring and reporting processes to ensure continual input and outcomes that are supportive to the MSHN region and its system. State-engineered systems for financing and determining value (such as Behavioral Health Fee Screens, Standard Cost Allocation Models, Rate development, and others) require full MSHN regional participation to shape them appropriately.	Chief Financial Officer	MSHN will ensure through the work of its regional Finance Council each CMHSP implements all MDHHS fiscal guidelines. Finance Council will engage in monthly discussions and problem solving to ensure standardization and consistency.	Chief Financial Officer	09/30/22
				MSHN's Fiscal Officers will ensure MDHHS feedback regarding State changes are addressed and corrected in a timely manner.	Chief Financial Officer	09/30/22
	Regional public policy leadership supports improved health outcomes and system stability.				Chief Executive Officer	09/30/23
		MSHN continues to evaluate the feasibility and appropriateness of pursuing NCQA (or other) accreditation in light of system redesign initiatives, potential for partnerships in the future and the potential for long-term value added to the region.	Deputy Director	MSHN will assess new design initiatives for application/appropriateness of accreditation of the PIHP.	Deputy Director	09/30/22
				MSHN will assess long-term planning and readiness for accreditation.	Deputy Director	03/30/23
		MSHN will ensure consistent, standardized, and cost-effective operations and will position the region for continued success regardless of payer structure – MDHHS processes for standardized cost allocation and independent rate models once promulgated will be followed to promote regional consistency.	Chief Financial Officer	MSHN will ensure through the work of its regional Finance Council each CMHSP implements all MDHHS fiscal guidelines. Finance Council will engage in monthly discussions and problem solving to ensure standardization and consistency.	Chief Financial Officer	09/30/23
				MSHN and its Regional Finance Council will monitor budget trends to evaluate cost-effectiveness.	Chief Financial Officer	09/30/22

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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		MSHN will advocate for public policies, statutes and financing necessary to advance beneficiary health outcomes improvements that demonstrate good stewardship of public resources and partnership with persons served and their advocates.	Chief Executive Officer	MSHN will participate in MDHHS and State Government meetings as necessary to ensure structured advocacy occurs for Behavioral Health and Substance Use Disorder persons served.	Chief Executive Officer	09/30/23
				MSHN will engage with providers to develop strategies to improve outcomes for persons served. The success of this task will require cross functional department efforts.	Chief Executive Officer	08/01/22
		MSHN will expand value-based purchasing and financing systems and will develop financing structures to incentivize performance based on adopted outcomes measures.	Chief Financial Officer	MSHN will expand its Value Based purchasing efforts mutually agreeable outcomes and measures are developed with providers.	Chief Financial Officer	09/30/23
				MSHN will evaluate, at least annually, existing Value Based purchasing agreements to determine efficacy and identify updates to improve persons served outcomes or better service value.	Chief Financial Officer	09/30/22
		Increase overall efficiencies and effectiveness by streamlining and standardizing business tasks and processes as appropriate.	Chief Compliance and Quality Officer	Identify capacity within REMI for building reports, data collection, and reporting.	Chief Information Officer	04/30/22
				Develop list of available reports in REMI inclusive of the purpose (what is the intended purpose, what data is included, who the intended audience is, etc.), source(s) of data, frequency data is updated, and how this will be communicated to staff.	Chief Information Officer	09/30/22
				Identify if there are similar reports that could be combined, discontinued, etc. and any needed additional reports.	Chief Information Officer	09/30/22
				Develop and implement of standardized Plans of Correction template and process.	Chief Compliance and Quality Officer	03/30/23
				Develop a process map to include how plans of correction are developed, implemented, and utilized for providers. Include required plans of corrections for internal and external reviews inclusive of DMC, department reviews, HSAG, MDHHS, etc. to eliminate/reduce duplication of plans of correction.	Chief Compliance and Quality Officer	03/30/23
				Identify a centralized place to store plan of correction that is easily accessible by MSHN staff.	Chief Compliance and Quality Officer	06/30/22
				Develop a consistent internal communication process that is meaningful and accessible.	Chief Compliance and Quality Officer	09/30/22
				Review current types of information being shared with all staff and identify if any additional types of information should be shared.	Chief Compliance and Quality Officer	09/30/22

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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
				Review current methods for sharing relevant information to MSHN Staff. Determine if information is being shared in a meaningful and easily understandable manner and determine whether other methods of disseminating information be used.	Chief Compliance and Quality Officer	12/31/22
				Review internal (DMC) site review standards.	QAPI Manger; Quality Manager	12/31/22
				Complete a crosswalk of review elements to other internal (annual plans, etc.) and external (HSAG, MDHHS, etc.) reviews to eliminate redundancies.	QAPI Manger; Quality Manager	03/30/23
				Identify content expert staff involvement per content area as well as staff responsibility for plan of correction review and approval, implementation and effectiveness.	QAPI Manger; Quality Manager	12/31/22
				Review use of management systems to increase efficiency with completing required functions.	QAPI Manger; Quality Manager	12/31/22
				Develop process for when to discontinue monitoring of a standard, how it is communicated to staff and the provider network.	QAPI Manger; Quality Manager	09/30/22
				Define internal processes that drive workflows; Develop workflows for job functions/tasks for MSHN positions, inclusive of communication lines; Identify functions to be automated for efficiency/effectiveness.	QAPI Manger; Quality Manager	06/30/23

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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
BETTER PROVIDER SYSTEMS						
	MSHN ensures that it engages a provider network with adequate capacity and competency (and addresses any network adequacy deficiencies) in partnership with its CMHSP participants and providers.				Deputy Director	09/30/22
		Ensure MSHN's network is adequate to meet consumer demand.	Deputy Director	Address recommendations from the Annual Network Adequacy Assessment (NAA) FY21.	Contracts Specialist	09/30/22
				Conduct Geomapping analysis.	Database and Reports Coordinator; Deputy Director	01/31/22
				Revise and update NAA FY22.	IT Reports Manager; Deputy Director	04/30/22
		Ensure MSHN's network is competent to provide quality services with positive outcomes for individuals served.	Deputy Director	Review quarterly/annual QAPI summary results and develop training based on low performing areas.	Chief Clinical Officer	09/30/22
				Review quarterly/annual QAPI summary results and develop performance incentives based on low performing areas.	Chief Financial Officer; Deputy Director	01/31/22
				MSHN will conduct an assessment of Certified Clinical Supervisor (CCS) capacity within the region for licensed SUD treatment programs.	Deputy Director	03/31/22
				MSHN will request feedback through the SUD Providers to develop a workplan to increase CCS capacity and competency within the region.	Deputy Director	06/30/22
		MSHN will advocate for public policies that promote an adequately compensated, safe, effective and well-trained workforce.	Chief Executive Officer	Advocate to make the direct care workforce wage increase permanent to address the long-standing staffing crisis created by low wages and high turnover among direct care workers and develop a regional strategy to address the continuation of direct care worker wage increases initiated during the COVID pandemic response and make recommendations for consideration by the regional CMHSP participants and the MSHN governing board.	Chief Executive Officer	03/01/22
				Advocate for long-term funding and other supports to reduce turnover, improve retention and ability to attract new workers into the regional workforce.	Chief Executive Officer	03/01/22
		To the extent required under or necessary to fulfill its contractual obligations, MSHN will ensure adequate internal capacity to accomplish its responsibilities effectively and efficiently.	Deputy Director	MSHN will ensure sufficient internal resources by evaluating current requirements/new requirements and external network capacity, including the proposed system redesign.	Deputy Director; Chief Executive Officer	07/01/22
				FY22 Contractual requirements will be assessed to determine implementation of 1115 Waiver responsibilities -SIS Child, Waiver Supports.	Chief Behavioral Health Officer	07/01/22
				Assess proposed system redesign for changes to the PIHP role and responsibilities, including possible closeout through staff retention planning.	Deputy Director; Chief Executive Officer	09/30/22

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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
BETTER EQUITY						
	MSHN and its regional provider and CMHSP partners ensure all persons have the same opportunities to be healthy, especially those who belong to socially disadvantaged or historically marginalized groups (health equity).				Director of Utillization and Care Management	09/30/23
		MSHN will increase access to health services for historically marginalized groups by monitoring penetration rate data and developing initiatives around outreach and engagement to underserved individuals & communities.	Director of Utilization and Care Management	MSHN will identify other underserved populations for which penetration rate data is not currently collected/monitored and develop strategies to obtain data that more accurately represents diverse populations in our region.	Director of Utillization and Care Management	04/30/22
				MSHN will obtain input from the affected populations around barriers to engaging in treatment and effective outreach strategies.	Director of Utillization and Care Management	09/30/22
		MSHN will plan and develop a regional Health Equity Advisory Committee to guide its health equity and inclusion activities.	Chief Clinical Officer	Consult with other stakeholders in the region who have existing Diversity, Equity, Inclusion (DEI) committees or workgroups in the development of the MSHN Health Equity Advisory Committee Charter.	Chief Clinical Officer	03/31/22
				Develop outreach strategies to ensure that committee composition is inclusive of diverse representation and lived experience.	Chief Clinical Officer	06/30/22
				Identify scope of committee's responsibilities and develop processes for the committee to inform MSHN health equity initiatives.	Chief Clinical Officer	06/30/22
		MSHN will utilize population health data to identify and reduce health disparities that exist in the region.	Director of Utilization and Care Management	MSHN will ensure adequate data is collected about persons served, their health status and needs, social determinants of health (SDOH), and other impactful variables in order to better focus interventions.	Director of Utillization and Care Management	09/30/22
				MSHN will conduct a thorough assessment of existing data points that are already collected in order to reduce potential duplication and identify information that is missing.	Chief Information Officer	06/30/22
				Build capacity at PIHP for increased data sharing with CMHSP and SUDSP partners.	Chief Information Officer	09/30/22
				MSHN will use predictive modeling to identify at-risk groups and individuals in order to offer targeted prevention and intervention (including review of related software tools/products).	Director of Utillization and Care Management; Chief Information Officer	09/30/22

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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		MSHN will ensure there is strong regional infrastructure for diversity, equity, and inclusion in all aspects of organizational responsibility and operations.	Chief Clinical Officer	MSHN will engage in an organizational diversity, equity, inclusion (DEI) self-assessment and develop a workplan to address areas for improvement.	Chief Clinical Officer	06/30/22
				MSHN will conduct a review of organizational assessment tools and identify one or more that can be applied to behavioral health systems of care.	Chief Clinical Officer	06/30/22
				MSHN will assess the feasibility of applying standards related to DEI competency within its provider networks.	Chief Clinical Officer	09/30/22
				Assess the training needs of the provider networks related to increasing competency in the areas of diversity, equity and inclusion.	Chief Clinical Officer	09/30/22
				Once training needs have been identified develop a workplan to address gaps in knowledge/competency.	Chief Clinical Officer	03/31/23

Appendix 1 – Key Questions and Key Assumptions

Mid-State Health Network leadership developed what the team considered to be important or key assumptions and questions to address in the strategic planning process. These can certainly be expanded and debated but represent the best judgment and point of MSHN leadership.

KEY QUESTIONS	KEY ASSUMPTIONS
External System Reform/Redesign:	
Will the Specialty Integrated Plan (SIP) proposal made by MDHHS materialize?	MDHHS will not have the necessary staffing and other resources to drive major system reform/redesign.
Will MDHHS pursue management of the Medicaid unenrolled population through all or a single PIHP?	Carve in remains a material threat.
Should MSHN implement coordination and improvement efforts related to unenrolled population?	PIHP/Re-consolidation is favored (regionalism is not).
To what extent should MSHN partner with like-minded PIHPs/Regional Entities to address key "criticisms" upon which reform/redesign are largely based?	Autism benefit is placing a strain on the state budget despite continued increase in eligible cases.
To what extent should MSHN position itself to partner with Health Plans in anticipation of future redesign initiatives?	HCBS Final Rule requires that individuals receiving Medicaid services have full access to their community, including opportunities to seek employment and work in competitive, integrated settings.
What will be the future of CMHSPs?	
What key lessons were learned during the 298 and subsequent redesign discussions that we should be responding to as a regional PIHP collaborative?	
Internal Key Redesign Questions:	
Does MSHN Board and CMHSPs still support MSHN's effort to be the Premier PIHP? If so, what does that mean to them?	PIHP staff must be retained and MSHN must continue to fulfill (and exceed) expectations.
Is there value in other regional approaches to service delivery to demonstrate MSHN/PIHP as an efficient, coordinated, successful PIHP?	Regional finances will likely be pressured in future years (unlike prior years).
Will the CMHSPs in the MSHN region support MSHN pursuing:	Unless there are changes to MSHN bylaws, MSHN has no independent ability to pursue

KEY QUESTIONS	KEY ASSUMPTIONS
	multi-PIHP or public/private partnerships, multi-regional or statewide opportunities.
• a partnership with a physical health payer?	
• Partnerships with likeminded PIHPs to address key "criticisms" upon which reform/redesign are largely based?	
Does NCQA Managed Behavioral Healthcare Organization (MBHO) accreditation for MSHN bring value to PIHP and CMHSPs? And should NCQA accreditation be pursued anticipating that it will be required of the PIHP or by a future potential partner of the PIHP?	
What is the role for MSHN and how should MSHN be preparing for CCBHC, SIM, Opioid Health Homes, Behavioral Health Homes?	
If PIHPs are no longer contracted to MDHHS due to System Reform/Redesign, what role does the region envision for MSHN? What eventualities should MSHN be planning for?	
How does the region and the MSHN Board view MSHN engaging in partnerships that may expand its role, including geographic considerations?	
External Policy Issues:	
Will MDHHS continue delegating responsibilities for monitoring and oversight of key/new initiatives (i.e., 1915(i), HCBS Rule, etc.)?	HCBS Final Rule requires that individuals receiving Medicaid services have full access to their community, including opportunities to seek employment and work in competitive, integrated settings.
Will MDHHS alter autism budgeting/services due to continued benefit growth rate?	Autism benefit is placing a strain on the state budget despite continued increase in eligible cases.
Will MDHHS seek to strengthen a partnership between MRS and the PIHPs to increase efforts to improve beneficiary employment?	
Will MDHHS consider increasing attention and oversight on beneficiary rights and protections as person-driven initiatives and systems are implemented?	
How will MDHHS measure "success" for Healthcare Effectiveness Data and Information Set [HEDIS] and other quality measures when pandemic conditions impact performance?	

KEY QUESTIONS	KEY ASSUMPTIONS
Financing:	
How did the pandemic change our view on service delivery? And planning for service demand increases with expected reductions in rates (due to low utilization in FY20/FY21)?	Rates for FY21 and FY22 will be adjusted down due to low utilization during pandemic.
Other:	
What goals/objectives should be developed to promote diversity, equity and inclusion and where should that work be focused?	
How will the ongoing pandemic response affect internal and regional operations?	Pandemic response will continue at least through FY 21 and may carry over to FY 22
How will a PIHP/Re-attract replacement workers if staff move to other jobs (outside of the PIHP)?	
To what extent does the regional delegation model impact future options and current effectiveness/efficiency?	
Credit for our work and efforts. Concern that mental health on a whole needs an upgrade. Our workers are front-line workers that do not get appropriate appreciation outside of the mental health system. It is vital and needs to be a higher priority. The media coverage we do get seems to be negative. We could use getting more good stories covered.	
Performance Matters. Health systems are experts on looking and promoting the good things that they do based on universally accepted measures. We need to show the metrics that matter. That whole way of measuring performance for behavioral health is an area that the Health Plans are great at – marketing how they do well. MSHN is a leader of the PIHPs on virtually every metric the state and others say is important. We should promote this.	
Opioid engagement. We do need to see what is being done to honor our commitments to our clients addressing the opioid addiction epidemic.	
MSHN should lead reform, innovation and collaboration efforts in region and statewide efforts. Right now, it requires approval by the counties. Our bylaws require their approval, and	

KEY QUESTIONS	KEY ASSUMPTIONS
we need to do our best to get everyone on the same page.	
There is a significant stigma against the people we serve. For years, persons served were not considered important until there was substantial money poured into Behavioral Healthcare.	
The political leadership/environment that will be changing in our state. This can cause changes in how we are seen and how things are handled with future opportunities/threats.	

APPENDIX 2: Environmental Scan - Strengths, Weaknesses, Opportunities and Threats

Mid-State Health Network leadership developed what the team considered to be important environmental scan observations. These are arranged by strengths and weaknesses (internal-looking), threats and opportunities (external-looking). These can certainly be expanded and debated but represent the best judgment and point of view of MSHN leadership.

Priority	STRENGTHS	Priority	WEAKNESSES
A	High capacity, strong, dedicated and competent staff. Strong in independent work.	A	Too much duplication in region.
A	Consistently high performing PIHP: • Financial Stability • Quality/performance metrics • Compliance to state requirements • Data reporting	A	Value based purchasing is under-developed; lack of provider availability and understanding this move toward value-based purchasing; lack of acceptance to general outcomes (limited by funding streams-esp. SUD- that apply here/ lack of incentive $$) – Please see page 7 for additional details.
A	Highly collaborative in region and with external partners, a statewide leader in reciprocity. Listen to needs of region and incorporate network feedback.	A	MSHN lean staffing model.
A	Seen as a leader among PIHPs by many external stakeholders. Leader in new state waiver initiatives: HCBS, Autism. Influence, leading to systems change.	A	Governance model/operating agreement restricts our flexibility with financing our CMHSPs. Lack of ability to act independently.
A	Excellent reputation	A	Limited CMH data sharing/lack of access of integrated health data with PIHP.
A	Highly developed IT system and support infrastructure, including data analytics	A	Lack of well-defined outcome metrics.
A	MSHN provides strong fiscal oversight of provider network.	B	PIHP is not accredited.
A	Strong monitoring of provider network.	B	Inconsistent level of performance and depth of knowledge across provider network. Strains staff resources.
A	Innovation. We have the only Mobile Care Unit (MCU) providing	B	Lack of local PIHP funds.

Priority	STRENGTHS	Priority	WEAKNESSES
	Medication Assisted Treatment (MAT) in MI.		
A	Highly effective in remote work environment. Agile in our environment.	B	Much time and effort in getting things done related to change management (i.e., approval processes).
A	Developed strong communication with providers, especially during the COVID-19 pandemic. Envied among other regions. Including provider stabilization funds.	B	SUD Provider network does not feel adequately compensated for the indirect/admin requirements.
B	Established and efficient administration/processes	B	Inconsistency within MSHN departments related to how MSHN shares/monitors requirements to provider network (Site reviews, monitoring, etc.).
B	Network Adequacy	C	Tracking too many data points- ability to act on them/follow-through/monitoring
B	Transparency in operations, providing a lot of data and metrics; tracking a lot of data points	C	Not currently participating in state innovative projects, like opioid health homes.
C	Developing strength in regional change management processes, communications.	C	Challenges with attracting qualified staff to PIHP.
C	CCBHC participation in region.	C	Too many initiatives
	State keeps asking for more and more. We've tried to keep providing this information. If this were a private health plan, they would demand more money. We absorb too many responsibilities and new requirements without asking for more money. Unfunded mandates are a real issue.	C	Lack of CCBHC clarification, we don't know enough about the rules and regulations. Department hasn't provided guidance/model.
	CCBHC includes all populations and care needed. Mild/moderate services are opportunities – need to leverage the federal funds and new payment models of CCBHCs. PIHP needs to keep on top of this.		
	Opportunity to co-locate/co-operate integrated healthcare services. Supportive of health homes, PIHP initiatives that are already being promoted by the state. Supportive of expanding populations. But we need		

Priority	STRENGTHS	Priority	WEAKNESSES
	to truly "become" a medical home. Need to promote more physical health services. Get imaginative regarding how we can address individual's physical health care and develop a plan for caring for these individuals.		
	FQHCs and other funders may be able to help us understand how we can continue centering care around persons and family members served.		

PRIORITY	THREATS	PRIORITY	OPPORTUNITIES
A	Medicaid Health Plans continue to pursue carve in.	A	Expand value-based purchasing.
A	Some CMHSP (and some SAPTR) costs are high/above "market"; overhead costs have been considered high by some.	A	Statewide (and/or multi-regional) leadership opportunities for MSHN/PIHPs.
A	Effort to 'carve in' SUD benefit to health plans .	B	Further work to improve health integration at the point of service, especially in the SAPTR system but also in our CMHSP systems.
A	MHP mandatory "Rebid": 09/30/2023 – would likely start in FY 22.	C	Regional v. Statewide SIPs (or similar Public/Private arrangements).
A	If carve in, CMHSPs will not be able to continue status quo – what would change and …	B	…how can/should MSHN position itself to be of value to CMHSPs?
A	Milliman Fee Schedule project could be a threat to the system, their rate models and schedules are guides. They are not going to use this info and potential to drive how the PIHPs rates are set. (RE: Cost caps; Not recognizing full cost.) May be accelerated by budget shortfalls.	B	Standard cost allocation workgroup to reduce rate variance.
A	State budget shortfalls result in less available funding.	A	Example from above: (COMBINE INTO SINGLE REFORM/REDESIGN ITEM).
A	Reduction is rates due to COVID 19 service utilization decreases.	B	Health IT integration consent systems; can lead to expanded data sharing between physical/behavioral health payers.

PRIORITY	THREATS	PRIORITY	OPPORTUNITIES
C	ACA remains under threat- even under Biden administration as states challenge constitutionality (Medicaid Expansion, HMP, remains at risk). Track/monitor/react	B	Data sharing Social Determinants of Health (SDOH) with local health departments, MHPs other potential service providers.
A	Behavioral Health workforce shortage, attrition (institutional knowledge leaving org) due to COVID-19 pandemic. Retention strategies don't exist or can't be financially supported. • SUD labor force under compensation relative to CMHSP workforce.	B	MSHN can partner/collaborate demonstrate leadership to other PIHPs/regions and State regarding health equity and reducing health disparities.
B	IT-EMR-The physical health care systems are propriety and so much larger in nature/more robust versus the BH IT EMR are customized that makes data sharing difficult/impossible.	A	Lead development of legislature education strategy.
C	Parity isn't well understood and applied in the BH system even more impact on the person-centered planning, processes.	B	PIHPs should work toward a standardized benefit, access criteria across the region and among/between regions.
C	PIHPs fiscal health remains a concern statewide- MSHN is current exception.	C	EBPs introduce the opportunity for MSHN to be more data and outcomes driven. MSHN can partner/collaborate demonstrate leadership to other PIHPs/regions.
A	Lack of clarity regarding regional partners will support MSHN being or becoming. • Many of these threats described can lead to increase in compliance related activities (investigations, sanctions). Supervision of staff may be insufficient. Funding pressures lead to increase in sanctions/investigations.	A	MSHN can be more of a leader with physical health payers collaboration, including broadening/deepening population health initiatives.
B	State initiatives (such as MiCAL, etc.) may create more complex, less accessible public systems. State is making decisions and creating processes that are typically the responsibility of the PIHPs/CMHSPs		MSHN may get into a position to broaden services/supports provided to our regional partners.

PRIORITY	THREATS	PRIORITY	OPPORTUNITIES
	being assumed/orchestrated by the State. May create a more complex, less accessible public system.		
A	Legislature and their lack of understanding of public health and behavioral health systems.		
A	Reductions to SUD block grant may impair access for individuals and families to the SUD benefit.	B	Assess/evaluate delegated functions (esp. SUD system, but including CMHSP) to determine whether we can improve efficiency, effectiveness, value, equity.
C	Reduction/reticent to engage in activities that are not required in the MDHHS/PIHP contract that limit advances the region could be making in many areas.		
B	Continued issues with access of beneficiaries to psych inpatient care.		
B	SUD providers increasingly rely on MSHN for direction on how to perform, what to perform ("how to do their job"), lack of certified clinical supervisors, lack of access to best practices and published guidelines, technical assistance, required exceeds MSHN capacity.		
	Threats: Public system keeps trying to serve clients in a better more efficient way. If the health plans are the payers, they don't want to hear about problems or how to make things better. It will be all about the money.		

APPENDIX 3: Additional Stakeholder Input of Note

- Incorporating that we help consumers to be more self-reliant. Include this under better care.
- Helping the community. Need to reflect to how we help our communities. Connects very well to the population health activities to lift ALL the boats in the community up.
- Focus on consumer care, communities, and helping people. We are part of the community, and this will be lost in a privatized market.
- CMHSPs need to be able to continue to receive the money necessary to do their job. The primary focus of the PIHP should be to save the public system.
- Important to bring community care to people in a mental health crisis. Allows for people to have great access. We must remain accountable to the communities that we serve, especially the consumers and family members in the communities we serve.
- High percentage of minority kids do not like the public mental health system and how they are seen, talked to, and addressed. They dislike this system, and we have to fix that.
- Need to sit down at the table and have good, honest dialogs with people. Some of the best solutions have not been easy, but it comes out of being honest with each other and sharing your plans.
- PIHPs were created by the CMHSPs to hold off the last attack against the public system. Bottom line should be the continuation and protection of the public system. Every time we address the concerns, we give away the firm. Most CMHSPs will be challenged to continue the system.
- Need to protect capitation otherwise you won't be able to keep them in place. We need to convince the legislators that we're the best bang for the buck. We have to say we want a public system. It's the only thing that works for our consumers.
- Metrics –Are there programs in other regions that we could use to model our metrics? MSHN was actually tracking these initiatives and metrics before some other PIHPs and are seen as a model across the state. Metrics include how people access care, initiation and engagement, what care they are accessing, how long do they stay in care, health risks and how those are addressed, outcomes of care, and differences in outcomes based on race, age, etc.
- Standardized national measures – we are more and more tracking HEDIS measures and other national metrics so we can compare ourselves easily to other health plans.
- Is this data something that can be easily accessed? MSHN data is published on the MSHN website and you can see this in an aggregated manner in very accessible ways. Data is also available to the CMHSPs at a more granular level.
- Transportation is such a huge issue. Need to consider this as we look at "access to better health".
- Data collection – It's sometimes good to go back and look at what is already collected, so we are not always adding new things to measure.
- Dialog regarding how aggressively can we pursue an organization if something is not happening according to our standards or expectations. (i.e.: gaps in care, lack of follow up). MSHN noted we can and do assertive outreach based on alerts. At times it's the CMHSPs that really need to act on these things.
- The data metrics, tracking, identifying gaps in care, HEDIS measures, and clinical care pathways MSHN is discussing are all very consistent with the CCBHC model.

- Concerns about children – at risk youth – need to focus on prevention initiatives and kids who are underserved.
- Occasionally CMHSP will obtain/provide services to other CMHSPs and they note significant cost differences. Rate variation is certainly a threat to our system. Will be talking about that next session and where there may be "undesired cost variation". Big risks for the system related to rates that would be paid for under a health plan model.
- Concerns expressed regarding standardized benefits and costs – no one size fits all across all of these organizations. May even "punish" innovative programs and CMHSPs. May result in reducing everyone to the floor.
- The more we expand and innovate into the community -schools, police, and expand our reach, the more we demonstrate that we are different than a health plan.
- Need to be more visible and share what we're doing and the impacts we are having. Walk a Mile – positive stories of recovery, impacts, etc.
- Acknowledgement that this was a very complex and detailed area.
- Veteran's. It was raised that we need to center on Veteran's, many of whom are coming home at grave risk for mental illness.
- Accountability. These measurements and goals help identify and promote accountability of this public system. This is especially important in the times of privatization threats.
- Compliance Processes. Appreciation expressed for the goals of creating systems that detect and identify fraud and waste.
- Crisis Residential/Inpatient: Criteria is very similar. MSHN has led the state in providing access to psych inpatient, as the first region to quantify the number of denials. There were 19-21 per person per episode before admission. A statewide light was shown on the situation as the organization providing the initial energy to improve this problem across Michigan.
- Beds for Crisis/Inpatient: Has there been an increase or decrease? For children, it has decreased. Sometimes, it is about "who a hospital will take" – and were not about bed availability, but the level of acuity is too high for the unit. In some ways, this says "we don't want to take *your* referral". This is a significant civil rights issue for our system today. We would never do that for a stroke or cardiac issue.
- Education Regarding Services: Need more information and awareness for our citizens. Wonder if our strategic plan has an education and outreach component. Michigan is saying that it's important to have a crisis continuum within each community. MICAL is working on a statewide initiative to unify crisis efforts for PIHPs and CMHSPs.
- Integration of other services with crisis needs: What are we doing to address integration across served populations, include veteran's and those that would choose to commit 'death by cop'. Mobile crisis and other models are established. The relative degree of engagement has been negatively impacted by the pandemic.
- Measuring Consistency: How are we measuring consistency in the region? How are we comparing CMHSPs in MSHN? We have similar intakes across the counties. We also use standardized assessment tools (e.g., CAFAS, SIS, LOCUS, etc.) to aid in identifying need throughout the region. Depending on the area, there may be certain local features where service provision may be different based on the community.
- Our CMHSPs and portals of entry are operating under the same set of criteria for admission. A person admitted in one county is likely to be admitted by another CMHSP. Now it's important to consider how much services they get – amount, scope and duration – is individualized and could vary from place-to-place depending on a number of factors. Need to ensure care meets standards without losing its person-centeredness.

- Support for compliance areas – Confidence in the monitoring and oversight that is in place.
- How does MSHN define Better Value ---answer – value proposition = Quality /Cost and Outcomes. This is a weakness overall in public mental health system. We don't always look at our financial performance.
- Unpredictable costs ----cost of "habilitation", cost of "recovery" is difficult to quantify.
- Concerns about how we define this in an area without competition. Concerns regarding having to compete on costs.
- How do we help prepare the CMHSPs and/or the Providers for a potential future with a private payer? This should not be an area of focus. We should focus on implementing the advocacy plan, fight and see what happens.
- General Support for goals/objectives as presented.
- Keep doing what we're doing… be a shining star… show the state that it really does work. We have numbers to show that we're performing.
- Concerns about spending too much time focusing on the threat and potential things that might happen. If anything, we need to talk about putting up a fight, and in the meantime do the job we do.
- Value Based pricing – not clear how that could be helpful at this time given the current payment models. For SUD, there is more opportunity for this.
- Clarification that at times the PIHP has and will address spending concerns if a CMHSP is out of budget.
- Support for what MSHN is doing ---keep it up.
- Need to consider both the politics plus the marketing to support a public system
- How are we affirming/confirming how we're doing at the individual provider/health home level? There are a TON of direct care/support workers in this region. With the exception of the SUD providers, it is all delegated to the CMHSP, and there is no state reporting on this. This is especially challenging for direct care workers.
- How is this different than the rest of Michigan's workforce? Is the culture of the workforce part of the problem? It is challenging… What do we do to prevent burnout? How do we continue to support? What can we do to address the issues (i.e., funding, Fee For Service (FFS), staffing shortages, etc.)? We can listen well, assist with administrative functions where we can, create career pathways and ladders, help them to compete, etc.
- As we look at equity issues, it's important to carefully consider - Why does this matter and what can we do about it? Need to look carefully at what's happening within the service delivery within MSHN. What are the actual impacts of the system we have created? (i.e.: lack of follow up care? Discrepancies in prescribing patterns?)
- Need to better understand the causes for the inequities. Why isn't follow up after DC happening consistently for all? Need to get to the bottom of this and understand the root causes.
- Very supportive of this initiative. Difficult to know where to start.
- Taking some good first steps in being honest with each other and really looking at the data.
- Starts with understanding and creating safe spaces.
- Goals may need to be modified based on input from people in the community and insights of the advisory panel. Focus on the population data and what we can learn about the inequities.
- Seek first to understand. Then take actions within the scope of our responsibilities.
- Consider fewer goals/objectives and focus on the things that are within MSHN scope/ability to impact.

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CREATION OF AT LARGE MEMBER(S) OF THE

MID-STATE HEALTH NETWORK BOARD OF DIRECTORS EXECUTIVE COMMITTEE

Background

In considering nominees for elected office on the Mid-State Health Network Board, Nominating Committee (2021) identified that creating at large member(s) of the Board Executive Committee may improve future board leader development and increase the participation of non-officer board members in the activities of the Executive Committee.

The Nominating Committee notes that the Board Executive Committee is not described in the bylaws or other policies of the Board of Directors, but also recognizes that board action to appoint non-officer member(s) to the Executive Committee may be needed.

Accordingly, the MSHN Nominating Committee (2021) recommends the adoption of the following motion.

Recommended Motion:

Motion to create up to two At Large members of the MSHN Board Executive Committee and to elect at large members of the Executive Committee during the regular board officer election timeline and process.

September 14, 2021

MSHN
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Community Mental Health Member Authorities

Bay Arenac Behavioral Health

CMH of Clinton.Eaton.Ingham Counties

CMH for Central Michigan

Gratiot Integrated Health Network

Huron Behavioral Health

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

LifeWays CMH

Montcalm Care Center

Newaygo County Mental Health Center

Saginaw County CMH

Shiawassee Health & Wellness

Tuscola Behavioral Health Systems

MEMO

To: MSHN Board Members

From: Kerin Scanlon, Nominating Committee Chairperson

Date: September 14, 2021

Subject: Slate of Officers

The Nominating Committee presents the following candidates for elected office for board consideration during the election to be held September 14, 2021.

Office	Candidate
Chairperson	Ed Woods
Vice-Chairperson	Irene O'Boyle Kurt Peasley
Secretary	Kurt Peasley
At Large Executive Committee Member	David Griesing

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REPORT OF THE MSHN CHIEF EXECUTIVE OFFICER
TO THE MSHN BOARD OF DIRECTORS
July/August 2021

PIHP/REGIONAL MATTERS

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

- MSHNs suite of three offices within the Michigan Optometric Association (MOA) building have been closed since March 16, 2020.
    - **UPDATE:** Note that due to recent storms in the Lansing area, water infiltrated the building causing some puddling and damage to walls and flooring. MOA is effectively addressing the issue, including drying of carpeting, removal and replacement of damaged walls, repainting, etc. Work is expected to be completed by mid-late September.
- 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 two employees, Sherry Kletke (Executive Assistant), who is office-based and Linda Manser (SIS Assessor) who is field based.
- Mid-State Health Network internal operations will continue to be performed and conducted via away from office (remote) work arrangements for an indeterminate period, for all employee classifications unless specific operational or business requirements mandate that a specific employee or group of employees be deployed for in-person work at either the MSHN office location(s) or at provider or community-based site(s). We remain in regular communication directly with MSHN staff and through leadership team members.
- MSHN is engaged in the process of evaluating the conditions for a return to office-based work, continuation of remote-based work, or a hybrid arrangement, including gathering information on employee preferences and individual position requirements.
    - **UPDATE:** MSHN leadership conducted an extensive employee survey focused on feedback of remote-based pandemic operations and requesting recommendations for consideration in future operations. The employee survey is rich with input and feedback, almost all of which was positive and constructive. The overwhelming majority of employees expressed a desire to continue remote-work or hybrid arrangements in the future. This is just one source of input Leadership is considering. Additional sources of input and next steps will be provider survey feedback, and a position-by-position analysis of tasks to determine which tasks are most suitable/most effective for in-person performance, remote performance or hybrid operations.

2. **MSHN Regional Operations Status:**

- CMHSPs: All CMHSPs in the region remain functional and capable of delivering all essential services and supports to beneficiaries, families, and communities. CMHSPs in the region are at various tiers and in various stages of office-based services re-engagement. Most are continuing with a blend of telehealth and in-person services.
- SUD Prevention, Treatment and Recovery Providers: All SUD providers remain functional and capable of delivering all essential services and supports to beneficiaries, families and

communities. In all cases, services and supports that can be delivered telephonically or by means of video or other alternatives to in-person/face-to-face have been developed and deployed (as authorized under State guidance).

3. **Provider Stabilization Update:**

- **UPDATE:** Previous board reports have provided background on regional provider stabilization activities. As of July 31, 2021, and reported to MDHHS in late August, MSHN CMHSP networks have been supported with a cumulative $11.8M in stabilization support. MSHN has also provided a cumulative total of $3.1M in support to its substance abuse treatment network.
- 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.
    - **UPDATE:** MSHN has recommended to BHDDA that the provider stabilization/support initiative continue through FY 22.

4. **MDHHS/MSHN Contract Amendment #3:**

MDHHS issued a third change order (Amendment #3) to the FY 21 Contract. The amendment made corrections to content in Amendment #2 (which was approved by the MSHN Board at its July meeting). The corrections updated language that had been agreed to in Amendment #2 but that were missing from the final released version. MSHN policy requires that I inform the Board when I sign an agreement with MDHHS. I informed the MSHN Executive Committee (as noted in the 08/20/21 minutes) that I signed the agreement because it was merely a correction to the board approved amendment. There were no financial components to the amendment.

5. **FY 22 Budget Process Update:**

As of the date of this report below, the Michigan legislature has not yet passed the budget for many state departments, including MDHHS. Also as of the date of this report, MDHHS has not released a final PIHP rate certification letter for FY 22. These variables are outside of the control of MSHN, which has used best available information to project FY 22 revenues. We remain hopeful that we can present an updated FY 22 budget for board consideration at the September 2021 meeting. MSHN must have an approved budget to start the year on 10/01/2021.

6. **Region (and Statewide) Workforce Issues Continue:**

Providers across the region continue to experience extreme workforce issues impacting services and supports. While filled with acronyms, I have attached a memorandum which MSHN sent to BHDDA Director Allen Jansen which summarizes the issues in our region as compiled by Dr. Todd Lewicki, Chief Behavioral Health Officer, with contributions from across MSHN leadership team members. BHDDA is convening two workgroups to focus on short- medium- and long-term strategies to impact/reduce the workforce issues. As noted in #5 above, the Michigan legislature has not yet passed the MDHHS budget, which does include a continuation of the direct care worker premium pay initiative. While these workforce issues extend well beyond just the Direct Care Workers in our region and across the state, MSHN and the Regional Operations Council are recommending a continuation of the regional premium pay initiative if it is not included in the approved MDHHS budget. We have prepared a separate document to assist you with evaluating that motion.

STATE OF MICHIGAN/STATEWIDE ACTIVITIES

7. **MSHN State Opioid Response (SOR) Site Visit:**

The MDHHS Office of Recovery Oriented Systems of Care (OROSC) performed a site visit of MSHN compliance with Federal and State SOR Grant requirements on July 21. Following is an excerpt from the site visit findings letter provided by MDHHS/OROSC to MSHN:

> After careful consideration and review of the requirements and documentation submitted, we have determined that *Mid-State Health Network* is in compliance with the *Substance Abuse and Mental Health Services Administration's Funding Opportunity Announcements and the Michigan Department of Health and Human Services* Contract.
>
> Currently, *Mid-State Health Network* has all the necessary tools in place to manage, maintain and report on the *SOR* activities and data from their provider network. Their providers will screen individuals to assess their needs and provide or make referrals for interventions as needed for individuals with an Opioid Use Disorder (OUD).
>
> We greatly appreciate *Mid-State Health Network's* preparation for the site visit and their commitment to provide our staff with the necessary documentation.

While this is an all-agency effort, we recognize the contributions of MSHN staff led by Dani Meier, Heather English, Trisha Thrush, Rebecca Emmenecker, Kari Gulvas, Sarah Andreotti and Amy Keinath, to this outcome.

8. **CCBHC Demonstration Operations:**

Amanda Ittner, MSHN Deputy Director, is the regional lead for CCBHCs and her report contains recent updates. BHDDA has not yet issued draft contract language for PIHP/MSHN contracts. A draft implementation guide has been published, along with draft concept papers and other documents that attempt to spell out the roles and responsibilities of PIHPs and CCBHCs (all are CMHSPs in the MSHN region) and financing arrangements. MSHN and our in-region CCBHC partners: CEI-CMH, Saginaw CMH, and the Right Door, are not yet satisfied with the status and implementation plan and are working with our State partners to ensure successful implementation beginning October 1, 2021.

9. **House and Senate Behavioral Health System Redesign Proposals:**

The summer has been very quiet from the standpoint of official actions on the House and Senate public behavioral health system redesign proposals. Based on reports, Rep. Mary Whiteford has been traveling the state and meeting with stakeholders on the proposal that she (and others) have introduced. The CMH Association is reporting that a hearing will be held on the Senate proposal in mid-September. MSHN has also learned from an in-region leader that a public meeting was attended where Rep. Green indicated, without proof or citing his sources, that (among other things) MSHN is wasteful and being mismanaged (as are the rest of the PIHPs). MSHN will be seeking a meeting with Rep. Green to provide factual information and to understand his position. MSHN has also continued to circulate the MSHN Board Statement on System redesign approved at the July board meeting.

We have also been informed by MDHHS that a third proposal by the House Democratic Caucus may evolve, but MSHN has not seen solid information. MSHN will distribute factual information when we have it (if it develops).

10. **National Medicaid Managed Care Financial Results - 2020:**

Milliman, a national actuarial firm and consulting actuaries to MDHHS, has released its annual "Medicaid Managed Care Financial Results for 2020" report, which is available at this link.

There are several items to bring to the attention of the Mid-State Health Network Board:

Appendix 4 (Financial Results by State) shows that the Medicaid Managed Care Plans in Michigan have the following metrics results:

MLR (Medical Loss Ratio) [the proportion of revenue that was used to fund claim expenses, or in layman's terms, the amount of revenue spent on services] – 79%

- A MLR of 85% or higher is required of MHPs in Michigan under their MDHHS contract

ALR (Administrative Loss Ratio) [percentage of revenue used to fund administrative expense] – 18%

UW Ratio (Underwriting Ratio) [positive = financial gain; negative = financial loss; the "left over" revenue after medical and administrative expenses considered available to fund surplus or profit] – 3%

RBC Ratio (Risk Based Capital Ratio) [proportion of required minimum capital held by the MCO] – 481%

In short, the MHPs in Michigan are spending 21% on non-service costs, contributing about 3% to profit, and have almost 500% more capital in reserves than the minimum required.

By comparison, PIHPs in Michigan have an MLR of about 94% (about a 6% ALR) and are contractually limited to 7.5% of revenue in reserve.

11. **Michigan Psychiatric Care Improvement Project:**

I have been reporting on the Michigan Psychiatric Care Improvement Project and many other BHDDA initiatives. Please see the attached August 2021 Update provided by BHDDA on the status of these many initiatives directly related to Psychiatric Care Improvement. Also note that MSHN is directly involved in these initiatives.

FEDERAL/NATIONAL ACTIVITIES

12. **SAMHSA Grants to Prevent Prescription/Opioid Overdose Deaths**

SAMHSA has "announced the distribution of 13 grants totaling $11 million to reduce the number of prescription drug/opioid overdose-related deaths and adverse events by training first responders and other key community groups. The *Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths* will fund training to prevent prescription drug/opioid overdose-related deaths, as well as secondary prevention strategies,

including the purchase and distribution of naloxone, a medication to prevent overdose by opioids, to first responders." The Michigan State Department of HHS received $850,000 for that purpose.

Additional information is available at this link.

13. **Dying from Drugs: A New Look at Overdose Deaths in the US:**

The National Institute for Health Care Management (NIHCM) Foundation has published an infographic entitled *Dying from Drugs: A New Look at Overdose Deaths in the U.S*. It notes that "the COVID-19 pandemic has had a devastating impact on people living with substance use disorder. Not only are they at higher risk for contracting the virus and having worse outcomes, but more people also have been dying from overdoses during the pandemic. NIHCM's analysis of the latest data highlights several troubling, ongoing trends about overdose deaths:

- It's more than opioids: Most overdose deaths (86%) are due to opioids and stimulants, but other substances are also playing a role. When these other types of drugs are involved, the deaths are more often ruled to be suicides.
- A deadly combination: The frequent combination of unpredictable and highly lethal synthetic opioids with stimulants and other types of opioids is driving the rapid increases in fatalities for these drugs. Most of these deaths are accidental.

Solving the crisis will rely on the use of evidence-based strategies, systemic reforms, broad-ranging partnerships and attention to equity and cultural and geographic differences."

The infographic and additional information are available at this link. The Michigan Opioid Response Task Force Report (and other information specific to Michigan) is available at this link.

14. **CMS Post Covid Planning Guidance**

CMS has "released a State Health Official (SHO) letter that is intended to assist states in their planning efforts to resume routine Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) operations for the eventual end of the COVID-19 public health emergency (PHE). The SHO letter (available at this link) updates specific eligibility and enrollment guidance initially provided to states in the December 2020 SHO #20-004, "*Planning for the Resumption of Normal State Medicaid, CHIP, and BHP Operations Upon Conclusion of the COVID-19 Public Health Emergency*." Specifically, this SHO letter provides updated guidance that:

- Extends the timeframe for states to complete pending eligibility and enrollment work to up to 12 months after the PHE ends.
- Requires states to complete a redetermination of eligibility after the PHE for all beneficiaries prior to taking any adverse action."

15. **Substance Abuse Issues Worsening in the US:**

The Kaiser Family Foundation has released an issue brief entitled *Substance Use Issues Are Worsening Alongside Access to Care (available at this link)*. "Amid the crisis of the COVID-19 pandemic, the United States is also facing a worsening substance use crisis. More than one in ten adults have reported starting or increasing the use of alcohol or drugs to cope with the pandemic. Additionally, deaths due to drug overdose spiked during the pandemic, primarily driven by opioids. Recently released data shows that over 93,000 drug overdose deaths were reported in 2020 – the highest on record and nearly a 30% increase from 2019." The brief makes the following points:

- "The recent uptick in substance use issues is disproportionately affecting many people of color.
- White people continue to account for the largest share of deaths due to drug overdose, but people of color are accounting for a growing share of drug overdose deaths over time.
- These recent trends are contributing to emerging disparities in drug overdose deaths among Black and American Indian and Alaska Native (AIAN) people, which may worsen if they continue.
- Substance use issues were a concern even before the pandemic, yet many of those in need of care, particularly people of color, were not receiving treatment.
- There is some reporting and evidence indicating that access and utilization of substance use services has further worsened during the pandemic.
- There have been some recent policy actions to address the worsening substance use crisis."

Submitted by:

Joseph P. Sedlock, MSA
Chief Executive Officer
Mid-State Health Network
Finalized: 08/30/2021

Attachments:

- MSHN Regional Staffing Crisis Summary
- BHDDA Report on Michigan Psychiatric Care Improvement Project

MSHN
Mid-State Health Network

August 12, 2021

TO: Allen Jansen, Senior Deputy Director, Behavioral Health and Developmental Disabilities Administration, Michigan Department of Health and Human Services

FROM: Joseph P. Sedlock, Chief Executive Officer, Mid-State Health Network

RE: WORKFORCE AVAILABILITY/STAFFING CRISIS

Thank you for your persistent attention to this worsening crisis in our industry (and frankly across many industries). The purpose of this memo is to provide you with specific information not suitable for sharing in the more public forums where there have been opportunities to provide input. The following information is a compilation developed by Dr. Todd Lewicki, our Chief Behavioral Health Officer, and contributed to by many leaders in our region.

In the dialog so far, much less attention has been given to the substance abuse prevention, treatment and recovery workforce than the CMH workforce. Please know that, at least from our perspective, the issues are just as profound if not worse.

Apologies in advance for the informality of presentation of the information that follows. We wanted to get this to you quickly. You have seen or heard most of this before, but we wanted to provide a written summary of the experience of this region for your use with internal (or other) colleagues.

Impact to Providers and Beneficiary Services

- Specific provider impacts:
  - Lighthouse-Traverse City and Caro not accepting new referrals
  - Umbrellex-not accepting new referrals
  - Beacon Specialized Living- not accepting new referrals
  - Flatrock- not accepting new referrals
  - Autism program at Stonecrest has closed
  - Central State Community Services- noted that one site was closed, has a high acuity home with two staff per shift; they are having great difficulty recruiting staff
  - McBride declined to submit an RFP to establish a crisis residential unit due to current staffing shortages in their existing homes
  - LifeWays was set to end a contract with Hope Network for crisis residential services and it was ended two months early due to a staffing shortage in the home
  - Hawthorn is having staffing trouble as well and has no resources to assist in community placement alternatives.
  - The State Hospital Administration's (SHA) Direct Community Placement Program (DCPP) has two providers, Hope Network and Beacon Residential, that are now having difficulty accepting placements in the DCPP due to not having enough staff
  - Holy Cross Services (SUD Provider) has closed 3 residential site locations in the last 12 months, citing staffing shortages as a primary contributor
  - Multiple SUD providers have struggled with retaining staff and have had high turnover. This includes OTPs like the former Red Cedar (now Lansing CTC) and others; this includes both bachelors and masters level clinicians.

  - The Recovery Center, a withdrawal management provider in Lansing has struggled with chronically low utilization rates for years in part because they could never get all the staffing in place for a fully operational 3.7 ASAM withdrawal management program. This includes enough medical supportive staff (ie. Nursing level) to maintain the ASAM staffing requirements. Shortage of CCS's in State to supervise SUD treatment programs as required by LARA. An example in region 5 is Cristo Rey SUD Services in Lansing They have been advertising and looking for a CCS for over a year.
  - Providers report qualified/credentialed staff are choosing to leave SUD field due to too many credentialing requirements (i.e., MCBAP) and low pay compared to mental health positions.
  - Some providers have had to discontinue programs due to staff shortages. MSHN has lost at least one women's specialty provider program due to this.
  - Wait lists have been implemented in withdrawal management and residential programs due to not having staff to handle more clients.
- Providers who used to accept high acuity individuals cannot do so now due to lack of adequate staffing to maintain safety
- Some residential providers are having to close locations and consolidate residents into remaining locations due to staffing shortage. (Reported by CMHSPs and by MSHN HCBS staff)
- Some residential providers have open bed capacity but are unable to accept new referrals due to not having adequate staffing. Additionally, residential providers are less likely to accept referrals of individuals with complex needs/behaviors due to staffing shortages.
- Inpatient psychiatric units frequently denying admissions due to lack of adequate staffing (increased instances of denials due to "high acuity" even though there might be an available bed)
- Some providers report experiencing financial hardship associated with increased overtime due to the increased need to fill hours
- Providers report that increased paperwork and documentation requirements from MDHHS takes away from time to serve individuals, magnified more so by staffing shortages.

Impact to Persons Served

- Many individuals in need are high care waiver consumers and providers are increasingly unable to meet their needs
- There is an increase in individuals sitting in acute care settings due to difficulty with discharge plan options
- Individuals languishing in emergency departments due to lack of inpatient psychiatric beds and/or refusal to accept referrals due to "high acuity"
- Disruption for individuals who are required to move homes due to provider site closings. This also relates to the individual's loss of choice of home as well as the loss of their home, not just housing
- Available staff are often working long shifts (20+ hours) and many overtime hours which increases chances and occurrences of errors in work, resulting in many CMHSPs reporting an increase in incident reports, substantiated abuse/neglect complaints, falls, and med errors.
- Lack of qualified psychologists to provide support and training for staff that need to understand and implement behavioral plans leading to lack of skills and confidence for working with individuals who have high behavioral needs

- CMH continues to get refusals for ambulance companies to transport individuals out of county due to being short staffed. More recently, ambulance companies have been passing off many mental health placement and med clearance transports to the Lansing Fire Dept.
- Wait lists cause individuals not to be able to access services when they need them and are in the contemplation/preparation stage of change.
- Programs that close narrow the options for care that is available to the persons in need.
- Staff can't be maintained and paid when not providing services, such as jail-based or hospital based services where they are not allowing services inside.
-

Identified Barriers to Recruitment & Retention of Qualified Staff

- Staff morale affected deeply by the pandemic; increasingly difficult for employers and supervisors to lift morale.
- At smaller provider organizations many positions require on-call from departments with few staff, leading to existing resources being spread extremely thin; staff burnout and fatigue are at a new high
- The Intensive Crisis Stabilization Services (ICSS) expectation of deploying staff into the community potentially with no relationship with the child/family has CMHSP staff concerned for their safety and how they can protect themselves
- There are more employment options offering sign-on bonuses and higher hourly rates, i.e entry level jobs in other sectors are offering higher wages. SUD providers often lose staff to higher-paying CMHSPs and CMHSPs lose staff to higher paying providers/organizations as well as clinicians leaving for private practice to have higher income and more control over caseloads.
- Telehealth organizations and for-profit provider systems are recruiting aggressively and attracting workers away from the public system for higher pay.
- Constant public discourse in legislature about perceived CMH and SUD system inadequacies creates anxiety and uncertainty for workforce. Due to CMHSP/SUD provider staffing shortages, the legislation may see their system change initiatives as necessary and justifiable, i.e., CMHSP and SUD provider system shortages become a self-fulfilling prophecy for why the legislature is pushing for system redesign.
- Recruiting is low due to staff word-of-mouth and sharing stories of difficulties; each time a person resigns, it reignites discussion and speculation among remaining staff.
- Visible lack of support from MDHHS in recent public addresses which leave out the good things CMHSPs and PIHPs are doing amidst these challenges
- There is the feeling that the clinical role has gotten too big, leading to staff being overwhelmed and burned out (at all levels in the service hierarchy)
- 31N funding is enticing CMH children's services staff to leave and work in the educational system.
- Providers report qualified/credentialed staff are choosing to leave SUD field due to too many credentialing requirement (i.e., MCBAP) and low pay compared to mental health positions.
- Unemployment is a higher wage than working wages for some, and they don't have to deal with possible health risks when on unemployment.
- A person can earn a higher wage at a workplace such as McDonalds and not have the risks and responsibilities of working in the SUD field.
- SUD requirements for clinicians have continued to grow, while wages stay the same.
- Peer coaches are paid a low wage, and the expectations and costs to be a coach continue to mount.

- An individual that starts in the field of SUD services that has master's level qualifications can (and usually does) leave and have several other options and earn double or more the income with better benefits in the mental health side of services.
- Many of the SUD providers are unable to offer any benefits to employees due to reimbursement rates being so low.
- Many of the SUD providers do not pay the individual wages if they must take a day off to attend a training.
- Most SUD providers are unable to pay for training costs for employees, although they expect the employees to attend, leaving the employee to cover not only their lost wages, the cost of the training and sometimes a hotel stay as well as mileage costs.
- Licensure or certification costs are usually not covered for employees by the provider.

PIHP/CMHSP Efforts to Address Identified Issues

- CMHSPs and providers are offering enhanced employee compensation rates and this has had little effect on recruitment/retention
- Some CMHSPs have offered higher rates for specialized residential for individuals with complex needs and are still having difficulty finding appropriate placement options
- Directors and supervisors are exhaustively reviewing where certain duties of workers can be reduced to help manage the load
- Some CMHSPs utilizing supports coordinator assistants to help alleviate workload on case managers and supports coordinators.
- Some CMHSPs redeploying CMHSP staff to provide services (e.g., community living supports) that contracted providers are unable to provide due to staffing shortages.

PIHP/CMHSP Solutions Brainstorming

- Continued advocacy with MDHHS to evaluate feasibility of reducing/suspending some requirements or new initiatives until provider system has stabilized. The effect of continued addition of requirements and specializations (i.e., documentation, training, fidelity reviews, tracking, EMR system enhancements, SCA, EQI, CCBHC, MiCAL, BHDDA CRM, and so many more) have created challenges and additional time and burdens to meet, directly influencing burnout, morale, and staffing
- Are there opportunities for additional state initiatives around student loan repayment programs and other supports to incentivize qualified individuals to work in public behavioral health sector? This was briefly offered as an incentive for clinicians to become Suboxone-waivered under the STR grant but that was retracted after SAMHSA rejected that application of the funds. We may not be able to secure federal grant funding to address workforce issues through student loan forgiveness but could look at alternative ways to implement this incentive.
- Create a clear career track to be able to identify opportunities to move up through the organization. ABA benefit is a good example: person is hired as a tech and provider helps support paying for the staff to receive education, supervision, and support to move through the track.
- Offer direct care staff affordable healthcare (Form a direct care worker association to help purchase group insurance to control costs).
- Promote the value of work in the field.

- Ensure there is activity money for individuals, direct care workers use their own money at times and are not reimbursed.
- Consider incentives if stay with employer for a minimum of a year, or bonus for referring a new worker.
- Use different strategies in attracting workers to urban and rural work settings. If the town where the work is located is also a tourist destination, workers cannot afford to live where they work, making transportation more difficult.
- PIHP offer reimbursement rates to SUD providers for services that would cover the costs of employees having the following available to them:
    - Reimbursement for staff wages, accommodations, and mileage when attending trainings.
    - Cover costs of the trainings.
    - Offer regular opportunities for raises in rate of pay.
    - Offer benefits, such as dental and health insurance (that is affordable) to all staff.
    - Offer paid time off to all employees.
    - Availability of paid mental health days

Michigan Psychiatric Care Improvement Project (MPCIP)

August 2021 Update

Overview

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

Two Part Crisis System

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

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

Opportunities for improvement

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

MI-SMART (MEDICAL CLEARANCE PROTOCOL)

Overview

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

Current Activities:

- Education of key stakeholders statewide; supporting early implementation sites; performance metric development.
- Two free MiSMART trainings with CMEs were held in July. Both were well attended.
- As of 4/15/21: Adopted/Accepted by: 29 Emergency Departments, 13 Psychiatric Hospitals, 13 CMHSPs.
- Targeted outreach to specific psychiatric hospitals and CMHSPs in geographic areas of ED adoption
- Exploration of use of Mi-SMART form and the role of Medical Clearance as part of CSU certification.

MICHIGAN CRISIS AND ACCESS LINE (MICAL)

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

CALL SIDE

Overview

- Crisis triage, support, and information and referral services 24/7 via phone, text, and chat
- Predicated on Recovery & Resiliency Principles: Caller-defined crisis, holistic, person-centered approach to crisis and crisis resolution, no call limits or time limits, trauma informed, non-judgmental, orienting people in

1. SAMHSA National Guidelines for Behavioral Health Crisis Care https://www.samhsa.gov/find-help/implementing-behavioral-health-crisis-care
*MDHHS intends to explore partnerships with key stakeholders to fund these services for everyone.

or out of the call to identify and address needs (instead of screening for services).

- Supports all Michiganders with behavioral health and substance use disorder needs to locate care regardless of severity level or payer type. Integrated with BHDDA Peer/ Recovery Coach Warm line, warm hand-offs and follow-ups, crisis resolution and/or referral, 24/7 warm line, and information and referral offered.
- MiCAL will not prescreen individuals. MiCAL will not directly refer people to psychiatric hospitals or other residential treatment. This will be done through PIHPs, CMHSPs, Emergency Departments, and Crisis Stabilization Units.
- Individual level performance measures.
- Opportunity for systems level change: data source for systems level needs i.e. to be addressed in collaboration with other systems including other crisis lines.
- Common Ground is the MiCAL staffing vendor.
- Target Dates: Pilot start date: Upper Peninsula and Oakland April 2021; **Operational Statewide October 2022.**
- Planned Design Activities:
    - Targeted Engagement Discussions to ensure MiCAL meets all Michiganders' needs. This process will pull together providers and people with lived experience for a specific population groups to ensure that MiCAL is effectively outreaching and serving them.
    - Resources: Developing partnerships and technological integration with 211 and OpenBeds to ensure MiCAL has up to date resource information.

Current Activities

- MiCAL Pilot is active in Upper Peninsula and Oakland County on April 19th.
- MiCAL and the Michigan Warmline have received over 19,000 calls, texts, and chats since April 19th (MiCAL go live); mostly calls.
- Pilot is focused on streamlining and routinizing care coordination processes with CMHSPs and ensuring that CRM technology supports these processes.
- MiCAL will be working smoothly before it is rolled out to any additional areas.
- First Responder Crisis support project called Frontline Strong in partnership with Wayne State is in development.
- Conducting meetings with each PIHP Director to talk about the timing and implementation process of MiCAL in their area. We are prioritizing areas without NSPL coverage.
- Development of MiCAL Handbook for PIHPs and CMHSPs
- Integration with 211 and MiCARE (OpenBeds) for up to date resources

BHDDA Customer Relationship Management (CRM) – Internal Business Processes

Overview

- BHDDA will be transitioning all its internal business processes to a customer relationship management (CRM) system. The BHDDA CRM is a customized technological platform designed to automate and simplify procedures related to the regulatory relationship between BHDDA and its customers: PIHPs, CMHSPs, CCBHCs, SUD entities, Michiganders, etc.
- Three internal business processes are included in the pilot phase: CMHSP Certification, Customer Services, and MDHHS/ PIHP/ CMHSP Contract Management.
- Pilot PIHPs and CMHSPs, a few other CMHSPs, and SUD treatment entities are participating in the design and user testing process.

Current Activities

- Official renaming of the MiCAL CRM to the BHDDA CRM

- BHDDA CRM Orientation sessions for PIHP and CMHSP leadership were held July 29th and Aug. 3rd (two options of the same orientation)
- BHDDA CRM Orientation for IT System Administrators are being held week of August 2nd (two options of the same orientation)
- Customer Service and Contract Management Training for CMHSP/ PIHP staff is occurring during the last two weeks in August.
- An additional benefit that is occurring through the CRM design is that there will be written documentation on each of the business processes describing the process, highlighting requirements as part of the training around each of these processes.
- Design work is being done on: CCBHCs, CMHSP Certification, and ASAM Level of Care.

988 COALITION

Overview

- MDHHS received a grant from Vibrant Emotional Health (Vibrant) to plan for the implementation of a new, national, three-digit number for mental health crisis and suicide response (9-8-8), which will launch on or before July 16, 2022.
- The 9-8-8 Planning Coalition will gather input from stakeholders to aide in the development of Michigan's implementation plan. Coalition members will examine the state's current system and capacity for mental health crisis calls, review model legislation for establishing a consistent statewide system for 9-8-8 calls, and offer input on potential funding models and sources, among other things.
- The group meets once a month virtually between March and September 2021.

Current Activities

- Workgroup meetings have focused on topics such as vision, follow up care, and resources. Upcoming topics are metrics, communications, and funding.
- Individual meetings are being held with existing NSPL centers to talk about their roles and MiCAL's role in the 988 system. MiCAL's legislative mandate, funding, staff considerations, statewide consistency, and knowledge of local resources are being taken into account as part of this development.
- 911 at state and local levels are creating draft best guidance document for local partnerships between PSAPs and MiCAL.
- Planning process has been extended to the end of January. The primary focus of the plan is on ensuring Michigan has capacity to handle 988 calls when it goes live in July 2022.
- The 988 coverage plans mirrors the current NSPL system, which is 6 NSPL centers will provide primary coverage for regions of Michigan as they are able. MiCAL will provide primary coverage for all other parts of Michigan and secondary coverage in the areas where there is already a NSPL center providing primary coverage.
- Vibrant is currently developing 988 Call center requirements around training, metrics, follow up, and publicity. We will adopt their requirements as a baseline. All the NSPL centers will meet regularly to support each other to implement these requirements and work towards consistency across the state.

PSYCHIATRIC BED TREATMENT REGISTRY

Overview

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

- Electronic service registry housing psychiatric beds, crisis residential services, and substance use disorder residential services.
- **Target audience:** Psychiatric Hospitals, Emergency Departments, CMHSP staff, PIHP staff.
    - Public and broader stakeholder access through MiCAL.
    - Broad cross-sector Advisory Workgroup.
- **Target Implementation Date:** Implemented statewide by January 2022.

Current Activities

- Integration of Registry with MiCAL per legislation and funding requirements.
- Psychiatric Beds will be included in the OpenBeds – MiCARE registry. This change was made due to stakeholder feedback that it was unrealistic to expect providers to enter information into two different registries and to use two different registries to find referral resources for people in need.
- LARA is incorporating Psychiatric Beds into their current statewide rollout.
- Advisory Workgroup meeting will be scheduled shortly to explore the use of OpenBeds technology as part of a streamlined psych bed referral process.

CRISIS STABILIZATION UNITS

Overview

- PA 402 of 2020 codifies Crisis Stabilization Units (CSUs) in the Mental Health Code. This new statute requires MDHHS to develop, implement, and oversee a certification process for CSUs. The legislation did not appropriate funding.
- MDHHS is contracting with Public Sector Consultants to help develop with the develop of a Michigan Model and certification criteria.
- MDHHS is convening a cross sector stakeholder group to develop a Michigan model. As a group Stakeholders will review models from other states and from Michigan to make recommendations around a model that will best fit the behavioral health needs of all Michiganders.
- Timing: Current to December 2021

Current Activities

- MDHHS is contracting with PSC/HMA to help develop a Michigan model and certification process.
- PSC is facilitating twice monthly stakeholder groups with the initial focus will be on setting high level standards, determining capacity needs, and a thorough assessment of existing CSU like facilities in Michigan. The recent meetings have hosted National SMEs to present on successful models such as the Arizona model and the EmPATH model.
- PSC is also doing extensive research on best practices in other states as well as in Michigan.
- Stakeholder Workgroup has over 50 members and is inclusive of people with lived experience, Peers, and representatives from diverse disciplines and geographic regions.
- MDHHS is exploring funding opportunities for CSU pilots. Rural areas will be a special focus.
- Listening sessions on rural crisis are scheduled.

SMI/SED 1115 WAIVER APPLICATION

Overview

- This project may be impacted in scope and timeline by COVID-19.

- MDHHS will apply for the CMS Medicaid funding waiver.
- Identifying innovations, gaps, barriers, and priorities:
    - Environmental Scan: discussions with other states, literature review.
    - CMHSP survey: informative only, identify innovations and gaps – i.e. licensing issues around crisis services.
- Possible directions of this initiative:
    - Increase and standardize community-based crisis service capacity to meet recovery, resiliency focused definitions.
    - Exploration of Mobile Crisis Expansion.
    - IMD Exclusion Exception.
    - PRTF Look-a-likes for Adults.
    - Exploration of Crisis Receiving & Stabilization Models such as Psychiatric Emergency Centers, Living Room Model, EmPATH.
    - Children's Therapeutic Foster Care.
- Target Date: beginning stages – Application fall 2021.

Current Activities

- MDHHS has contracted with PSC/HMA to help develop the 1115 Waiver.

OTHER INFORMATION:

- MDHHS has also contracted with PSC/HMA to develop recommendations to expand mobile crisis for adults in Michigan.
- Diversion Council and Wayne State Center for Behavioral Health Justice (CBHJ) is also focused on looking at adult mobile crisis models. With permission of individual CMHSPs, they are using the CMHSP Crisis Survey data as baseline data to help determine who to contact to learn about successful existing mobile crisis models and any challenges implementing mobile crisis.

QUESTIONS OR COMMENTS?

- Krista Hausermann (hausermannk@michigan.gov)
- Jon Villasurda (villasurdaj@michigan.gov)

REPORT OF THE MSHN DEPUTY DIRECTOR
to the Board of Directors
July/August 2021

OPERATIONAL UPDATES

Certified Community Behavioral Health Clinic (CCBHC) Update

MDHHS, CCBHCs, PIHPs and MSHN's regional CCBHC partners have been meeting frequently to support CCBHC implementation for October 1, 2021. Multiple meetings have occurred throughout August to enroll and train staff on the Customer Relationship Management Software (CRM). The CRM will be utilized to submit CCBHC application certifications and is expected to go live on September 8, 2021. On August 8, 2021, MDHHS released the first draft of the CCBHC Handbook for review and discussion as well as a draft list of enrollees expected to qualify for CCBHC services. MSHN is working with our partners to define internal processes for distribution of CCBHC revenue, accurately accounting for CCBHC cost outside of the sub capitated Medicaid revenue and preparing for the future training on the PIHPs role in reviewing/authorizing enrollments, receipt, and processing of grievances, as well as reporting and monitoring of quality metrics. To ensure MSHN can provide the additional revenue to the CCBHCs in our region on October 1, 2021, MSHN has included an amendment to the CMHSP contract that includes the following:

- Adherence to all requirements listed in the MDHHS CCBHC Demonstration Handbook
- Coordination with PIHP regarding Designated Collaborating Organizations
- Appropriate accounting for CCBHC activities (cost allocation/settlement) for both Medicaid and Non-Medicaid
- Appropriate billing and reporting of claims/encounters, including third party

On September 2, 2021 MSHN received an updated handbook, Medical Services Administration (MSA) policy and draft contract language. MSHN and our CCBHC partners are in the process of reviewing the newly released documents and will revise the Medicaid subcontract language as appropriate.

The MSA Policy along with the MDHHS CCBHC website can be located here.

MSHN Staffing Update

Michael Scott, MSHN's Veterans Navigator submitted his resignation as of August 27, 2021. MSHN would like to extend our warm wishes to his future pursuits.

MSHN has posted a *New* Financial Specialist position due to the anticipated increased responsibilities with CCBHC. The job description is located on our website under careers for viewing/application. With this addition, MSHN has decided not the fill the claims processor position as this function will be absorbed within the current structure.

MSHN has posted our vacancies on the MSHN website at: https://midstatehealthnetwork.org/stakeholders-resources/about-us/Careers.

Balanced Scorecard – FY21, as of June 30, 2021

The Balanced Scorecard (BSC) for June 30, 2021 has been attached for the Board of Directors review and update related to key performance indicators on MSHN's progress with our strategic initiatives and compliance with MDHHS contractual requirements. Metrics with a performance level of red/yellow are being identified for targeted initiatives to improve regional performance. MSHN councils and committees review their applicable BSC to ensure targets are achieved by year end. To view the full report, **see the link below *FY21 Q3 Balanced Scorecard Report*.**

Michigan Crisis and Access Line (MiCAL)

Michigan Crisis and Access Line (MiCAL) was established by MDHHS to support Michiganders with behavioral health and substance use disorder needs. MiCAL is a 24/7 centralized statewide crisis line available to all Michiganders via phone, text, or chat – regardless of insurance coverage. MiCAL is supported by a Customer Relationship Management (CRM) system that monitors, tracks, and reports on MiCAL operations and also has a Partner Portal system that provides CMHSP/PIHP staff visibility into Michigander interactions with MiCAL. MDHHS intends to use the Partner Portal to manage a number of different functions including:

- Sharing of information with PIHPs/CMHSPs about consumer contacts with the MiCAL hotline
- Communication about customer service inquiries that are received through MDHHS
- Notification of potential contractual compliance issues
- CCBHC Certification
- American Society of Addiction Medicine (ASAM) Level of Care Certification

MSHN staff have participated in trainings and webinars to support statewide implementation for Customer Inquiries and Contractual Compliance business processes, effective October 1, 2021. PIHPs will be responsible to coordinate and follow up on Corrective Action Plans (CAP) within the CRM, noncompliance issues and respond to BHDDA with information required to assist Michiganders.

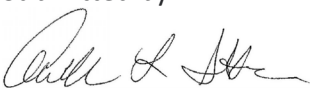
Information Technology – Michigan Health Information Network

MSHN and our regional CMHSPs have agreements in place and are actively participating in exchanging information with Michigan Health Information Network (MiHIN). Admission, Discharge and Transfer records are being received and processed using the identity process of Active Care Relationships (ACRS). MSHN is actively working with MiHIN to expand the use of data that MiHIN has available. MSHN is participating in the pilot project for electronic consent management (eCMS) and will have a single SUD provider organization participate with testing the eCMS workflow process. MSHN will be sending Admission and Discharge records to MiHIN on behalf of the SUD provider organization prior to September 30, 2021, if MiHIN has the eCMS module ready for use in MI Gateway. Pilot testing with MSHN is expected to continue through September. For more information technology updates, **see the link below *FY21 Q3 Information Technology Department Report.***

Population Health Activities: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

MSHN has been working with Zenith Technology Solutions (MSHN's data analytics platform) to develop reports for monitoring treatment initiation and engagement of individuals served for alcohol and other drug dependence. The reports are also stratified by race/ethnicity in order to identify any existing health disparities. Initial data review indicates there is a disparity in the rates of substance use treatment initiation and engagement for African American individuals compared to White individuals. During Q4 MSHN will perform additional data analysis at the county level. MSHN intends to share data for this measure with SUD provider organizations in order to develop strategies for increasing engagement. For more information on population health activities, **see the link below *FY21 Q3 Population Health & Integrated Care Report.***

Submitted by:



Amanda L. Ittner
Finalized: 9.2.21

Links to Reports:
FY21 Q3 Balanced Scorecard Report
FY21 Q3 Information Technology Department Report
FY21 Q3 Population Health & Integrated Care Report

MSHN FY21 - Board of Directors and Operations Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2021	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth	MSHN Strategic Plan FY19-FY20	+6%	0% Decrease over FY20		1-10% Decrease	11-19% Decrease	20% or more Decrease
	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular screening during the measurement year.	Aligns with strategic plan goal to establish clear criteria and practices that demonstrate improved primary care coordination and with Performance Measure Portfolio	78%	78.5% (2017 National data)		>=78.5%	54.4%-78.4%	<54.4%
	Expand SUD stigma reduction community activities.	MSHN WILL SUPPORT AND EXPAND SUD-RELATED STIGMA REDUCTION EFFORTS THROUGH COMMUNITY EDUCATION	106	144		>=144	<144 and >72	<=72
	Increase health information exchange/record sets	MSHN will improve and standardize processes for exchange of data between MSHN and MHPs; CMHSPs and MSHN. Using REMI, ICDP and CC360 as well as PCP, Hospitals, MHPs.	3	2		3	2	1
	Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use. (NEW)	MDHHS/PIHP Contracted, Integrated Health Performance Bonus Requirements	1	0		0	1	2
BETTER CARE	The percentage of discharges for adults who were hospitalized for treatment of selected mental illness or intentional self harm diagnosis and who had a follow up visit with a mental health provider within 30 days of discharge.(FUH)	Measurement Portfolio NQF 0576; PIHP/MDHHS Contract, 2021 Performance Bonus	70%	58%		>=58%	0	<58%
	Behavior Treatment Plan standards met vs. standards assessed from the delegated managed care reviews.	MDHHS Technical Requirement for Behavior Treatment Plans.	67%	95% or greater		95-100%	90-94%	<90%
	Engagement of AOD Treatment-Percentage who initiated treatment and who had 2 or more additional AOD services or medication treatment within 34 days of the initiation visit.	Aligns with best practices for assisting indiviudals to initiate services and engage in continuation of care.	Engagement: 43.07%	Above Michigan 2020 levels; E: 12.5% (2016)		Increase over National levels	No change from National levels	Drop below National levels
	Integrate standardized assessment tools into REMI	MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region	2	2		3	2	1
	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth	MSHN Strategic Plan FY19-FY20	+6%	0% Decrease over FY20		1-10% Decrease	11-19% Decrease	20% or more Decrease
	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person centered plan	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan; MDHHS Site Review Findings 2019-2020	85%	100%		100%	90%-99%	<90%

MSHN FY21 - Board of Directors and Operations Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of June 2021	Target Value	Performance Level	Target Ranges		
BETTER VALUE	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	84%	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
	MSHN reserves (ISF)	MSHN WILL WORK WITH ITS CMHSPS AND BOARD OF DIRECTORS TO ESTABLISH A RESERVE'S TARGET SUFFICIENT TO MEET FISCAL RISK RELATED TO DELIVERY OF MEDICALLY NECESSARY SERVICES AND TO COVER ITS MDHHS	7.5%	7.5%		> 6%	≥ 5% and 6%	< 5%
	Develop and implement Provider Incentives (VBP, ER FU, Integration)	MSHN will develop methodologies, within established rules, to incentivize providers to cooperate with the PIHP to improve health or other mutually agreeable outcomes.	1	2		2	1	0
	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization.	The MDHHS requirement of 95% slot utilization or greater.	94.70%	95% or greater		95-100%	90-94%	<90%
	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages	MSHN Strategic Plan FY19-FY20, Federal Parity Requirements	2%	<= 5%		<=5%	6%-10%	>=11%
Better Provider Systems	Providers demonstrate increased compliance with the MDHHS/MSHN Credentailing and Staff Qualification requirements. (SUD Network and CMHSP Network)	QAPIP Goal; HSAG and MDHHS reviews	Awaiting HSAG 2021 review	80%		>80%	70-79%	<70%
	Managed Care Information Systems (REMI) Enhancements	Provider portal, Patient Portal, ASAM Continuum, Authorization Data, Site Review Module, WSA, Critical Incidents/Grievance and Appeals Module	3	4		3	2	1
	MSHN and its CMHSP participants develop and implement a regional provider application	Reciprocity & Efficiency Standards	75%	100%		100%	70-99%	<70%
	Improve data availability	MSHN FY20-21 Strategic Plan - Staff, Consumers, Providers, and Stakeholders	60%	100%		75%	50%	25%
	CMHSP Participants fully implement Electronic Visit Verifcation in accordance with MDHHS requirements (CMHSP Network)	Committee Goals; Cures Act, CMS	awaiting MDHHS	12		12	8-11	<8

MSHN
Mid-State Health Network

Background:

In accordance with the MSHN Board of Directors to review financials, at a minimum quarterly, the Statement of Net Position and Statement of Activities for the Period Ending July 31, 2021, have been provided and presented for review and discussion.

Recommended Motion:

The MSHN Board of Directors receives and files the Statement of Net Position and Statement of Activities for the Period Ending July 31, 2021, as presented.

Mid-State Health Network
Statement of Activities
As of July 31, 2021

	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	163,551	375,641	(212,090)	(56.46) %	1a
Medicaid Use of Carry Forward	$ 23,175,056	33,254,471	19,312,546	13,941,925	72.19 %	1b
Medicaid Capitation	634,480,358	599,958,137	528,733,633	71,224,504	13.47 %	1c
Local Contribution	3,140,208	2,355,156	2,616,840	(261,684)	(10.00) %	1d
Interest Income	218,000	27,543	181,667	(154,124)	(84.84) %	1e
Change in Market Value	0	0	0	0	0.00 %	
Non Capitated Revenue	21,249,929	10,690,609	17,708,274	(7,017,665)	(39.63) %	1f
Total Revenue	682,714,320	646,449,467	568,928,601	77,520,866	13.63 %	
Expenses:						
PIHP Administration Expense:						
Compensation and Benefits	6,575,012	4,603,245	5,479,178	(875,933)	(15.99) %	
Consulting Services	130,000	73,958	108,334	(34,376)	(31.73) %	
Contracted Services	96,040	70,810	80,033	(9,223)	(11.52) %	
Other Contractual Agreements	630,615	274,733	525,513	(250,780)	(47.72) %	
Board Member Per Diems	18,060	7,980	15,050	(7,070)	(46.98) %	
Meeting and Conference Expense	117,815	18,191	98,179	(79,988)	(81.47) %	
Liability Insurance	37,433	36,783	31,194	5,589	17.92 %	
Facility Costs	158,791	138,076	132,326	5,750	4.35 %	
Supplies	325,350	232,524	271,125	(38,601)	(14.24) %	
Depreciation	81,927	68,272	68,272	0	0.00 %	
Other Expenses	972,400	788,120	810,334	(22,214)	(2.74) %	
Subtotal PIHP Administration Expenses	9,143,443	6,312,692	7,619,538	(1,306,846)	(17.15) %	2a
CMHSP and Tax Expense:						
CMHSP Participant Agreements	554,299,329	547,875,677	461,916,107	85,959,570	18.61 %	1b,1c
SUD Provider Agreements	53,626,941	37,562,018	44,689,117	(7,127,099)	(15.95) %	1c,1f
Benefits Stabilization	2,498,500	2,082,084	2,082,084	0	0.00 %	1b
Tax - Local Section 928	3,140,208	2,355,156	2,616,840	(261,684)	(10.00) %	1d
Taxes- IPA/HRA	21,833,596	17,887,209	18,194,664	(307,455)	(1.69) %	2b
Subtotal CMHSP and Tax Expenses	635,398,574	607,762,144	529,498,812	78,263,332	14.78 %	
Total Expenses	644,542,017	614,074,836	537,118,350	76,956,486	14.33 %	
Excess of Revenues over Expenditures	$ 38,172,303	$ 32,374,631	$ 31,810,251			

Mid-State Health Network
Statement of Net Position by Fund
As of July 31, 2021

	Behavioral Health Operating	Medicaid Risk Reserve	Total Proprietary Funds	
Assets				
Cash and Short-term Investments				
Chase Checking Account	41,411,817	0	41,411,817	1a
Chase MM Savings	16,813,452	0	16,813,452	
Savings ISF Account	0	45,954,870	45,954,870	1b
Savings PA2 Account	8,910,299	0	8,910,299	1c
Total Cash and Short-term Investments	$ 67,135,568	$ 45,954,870	$ 113,090,438	
Accounts Receivable				
Due from MDHHS	6,164,591	0	6,164,591	2a
Due from CMHSP Participants	1,249,580	0	1,249,580	2b
Due from CMHSP - Non-Service Related	10,150	0	10,150	2c
Due from Other Governments	343,677	0	343,677	2d
Due from Miscellaneous	237,209	0	237,209	2e
Total Accounts Receivable	8,005,207	0	8,005,207	
Prepaid Expenses				
Prepaid Expense Rent	4,529	0	4,529	2f
Prepaid Expense Other	8,850	0	8,850	2g
Total Prepaid Expenses	13,379	0	13,379	
Fixed Assets				
Fixed Assets - Computers	189,180	0	189,180	2h
Accumulated Depreciation - Information Tech	(183,925)	0	(183,925)	
Fixed Assets - Vehicles	251,983		251,983	2i
Accumulated Depreciation - Vehicles	(67,196)		(67,196)	
Total Fixed Assets	190,042	0	190,042	
Total Assets	**$ 75,344,196**	**$ 45,954,870**	**$ 121,299,066**	
Liabilities and Net Position				
Liabilities				
Accounts Payable	$ 13,690,298	$ 0	$ 13,690,298	1a
Current Obligations (Due To Partners)				
Due to State	2,560,754	0	2,560,754	3a
Other Payable	4,535,404	0	4,535,404	3b
Due to State HRA Accrual	5,263,815	0	5,263,815	1a, 3c
Due to State-IPA Tax	1,023,285	0	1,023,285	3d
Accrued PR Expense Wages	153,821	0	153,821	3e
Accrued Benefits PTO Payable	345,569	0	345,569	3f
Accrued Benefits Other	45,231	0	45,231	3g
Total Current Obligations (Due To Partners)	13,927,879	0	13,927,879	
Deferred Revenue	8,160,163	0	8,160,163	1b 1c 2b 3b
Total Liabilities	35,778,340	0	35,778,340	
Net Position				
Unrestricted	39,565,856	0	39,565,856	3h
Restricted for Risk Management	0	45,954,870	45,954,870	1b
Total Net Position	39,565,856	45,954,870	85,520,726	
Total Liabilities and Net Position	**$ 75,344,196**	**$ 45,954,870**	**$ 121,299,066**	

Mid-State Health Network
Notes to Financial Statements
For the Ten-Month Period Ended,
July 31, 2021

Please note: The 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 Financial Status Reports (FSR)submitted to MDHHS March 2021. In addition, MSHN's Financial Audit and Compliance Examination are complete.

Statement of Net Position:

1. Cash and Short-Term Investments
   a) The Cash Chase Checking and Chase Money Market Savings accounts is the cash available for operations. A portion of cash available for operations will be used to cover accounts payable and taxes.
   b) The Savings Internal Service Fund (ISF) and Investment ISF reflect designated accounts to hold the Medicaid ISF funds separate from all other funding per the MDHHS contract.
   c) The Savings PA2 account holds PA2 funds and is also offset by the Deferred Revenue liability account.
2. Accounts Receivable
   a) Approximately 86% of the balance in Due from MDHHS represents amounts owed to MSHN for HRA payments for April and July 2021. The remaining balance in this account stems from Block Grant and other various grants funds owed to MSHN.
   b) Due from CMHSP Participants reflects FY 20 cost settlement activity as well as cost settlement for other fiscal years.

CMHSP	Other	Cost Settlement	Payments/Offsets	Total
Bay	-	1,507,216.69	900,202.00	607,014.69
CEI	102,173.00	7,987,426.60	8,925,000.00	(835,400.40)
Central	-	4,258,455.75	4,026,819.00	231,636.75
Gratiot	-	502,080.07	383,312.00	118,768.07
Huron	-	-	-	-
The Right Door	-	1,505,249.03	1,306,783.00	198,466.03
Lifeways	-	-	-	-
Montcalm	-	2,174,569.26	2,174,569.26	-
Newaygo	-	1,633,235.19	985,813.00	647,422.19
Saginaw	-	5,544,148.31	5,544,148.31	-
Shiawassee	-	216,185.16	216,185.16	-
Tuscola	-	1,617,172.00	1,335,500.00	281,672.00
Total	**102,173.00**	**26,945,738.06**	**25,798,331.73**	**1,249,579.33**

   c) Due from CMHSP – Non-Service Related reflects the balance for 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 balance reflects FY 21 quarter 2 outstanding collections due from two counties.
e) Approximately 52% 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) Prepaid Expense Rent balance consists of security deposits for three MSHN office suites.
g) Nearly 74% of 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. The remaining portion in this account includes prepaid training for MSHN staff.
h) This is an account used to track Managed Care Information System (MCIS) costs associated with PCE. Amounts in this account are being depreciated.
i) 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 FY 20 lapse amount which is $2.6 M based on the Compliance Examination. 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) Accrued payroll expense wages represent expense incurred in July and paid in August.
f) Accrued Benefits PTO (Paid Time Off) payable is the required liability account set up to reflect paid time off balances for employees.
g) Accrued Benefits Other represents retirement benefits expense incurred in July and paid in August.
h) The Unrestricted Net Position represents the difference between total assets, total liabilities, and the restricted for risk management figure.

Statement of Activities:

1. Revenue
    a) This account tracks SIS revenue earned from CMHSPs, Veterans Navigator activity and other small grants. Actual revenue is lower than expected due to ongoing pandemic concerns.
    b) Medicaid Use of Carry Forward represents FY 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 FY 21 premium payments through July 2021. MDHHS has committed to funding this activity throughout the remainder of the fiscal year with monthly payment disbursements to PIHPs. In addition, Medicaid Eligibles are increasing as there is a moratorium on disenrollments. Medicaid Capitation dollars are disbursed to CMHSPs based on per eligible per month (PEPM) payment files and paid to SUD providers based on service delivery.
    d) Local Contribution is flow-through dollars from CMHSPs to MDHHS. Typically, revenue equals the expense side of this activity under Tax Local Section 928. Local Contributions were scheduled to reduce over the next few fiscal years until completely phased out. 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 is earned from investments and changes in principle for investments purchased at discounts or premiums. The "change in market value" account records activity related to market fluctuations. Actual interest income is less than anticipated due to ongoing low interest rates and fewer investment opportunities to generate this revenue. In addition, the other portion of interest income is amounts earned from the PA2 and General Savings accounts.
    f) This account tracks non-capitated revenue for SUD services which include Community Grant and PA2 funds. 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 item with the largest dollar amount variance is compensation. MSHN's compensation includes vacant Home and Community Based Waiver positions expected to be filled in the future pending MDHHS's transfer of responsibilities to the PIHP.
    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 July 31, 2021

DESCRIPTION	CUSIP	TRADE DATE	SETTLEMENT DATE	MATURITY DATE	CALLABLE	AMOUNT DISBURSED	PRINCIPAL	AVERAGE ANNUAL YIELD TO MATURITY
UNITED STATES TREASURY BILL	912796SP5	4.23.19	4.25.19	10.24.19	no	988,182.64	1,000,000.00	2.365%
UNITED STATES TREASURY BILL	912796SP5	4.23.19	4.25.19	10.24.19			(1,000,000.00)	
FEDERAL HOME LOAN MTG CORP	3137EAEF2	5.2.19	5.3.19	4.20.20	no	624,605.01	630,000.00	2.331%
FEDERAL HOME LOAN MTG CORP	3137EAEF2						(630,000.00)	
UNITED STATES TREASURY BILL	912796RN1	6.7.19	6.10.19	12.5.19	no	1,979,752.50	2,000,000.00	2.068%
UNITED STATES TREASURY BILL	912796RN1						(2,000,000.00)	
UNITED STATES TREASURY BILL	912796TF6	8.14.19	8.15.19	2.13.20	no	2,972,607.48	3,000,000.00	1.823%
UNITED STATES TREASURY BILL	912796TF6						(3,000,000.00)	
UNITED STATES TREASURY BILL	912796TK5	9.12.19	9.12.19	3.12.20	no	991,043.07	1,000,000.00	1.788%
UNITED STATES TREASURY BILL	912796TK5						(1,000,000.00)	
FEDERAL FARM CREDIT BANK	3133ELCD4	12.2.19	12.3.19	6.2.21	yes	2,000,092.22	2,000,000.00	1.660%
FEDERAL FARM CREDIT BANK	3133ELCD4						(2,000,000.00)	
UNITED STATES TREASURY BILL	912796UC1	2.12.20	2.13.20	1.28.21	no	2,959,268.75	3,000,000.00	
UNITED STATES TREASURY BILL	912796UC1						(3,000,000.00)	
UNITED STATES TREASURY BILL	912796C56	1.28.21	1.28.21	7.29.21	no	2,999,590.50	3,000,000.00	0.027%
UNITED STATES TREASURY BILL	912796C56	1.28.21	1.28.21	7.29.21			(3,000,000.00)	
JP MORGAN INVESTMENTS							-	
JP MORGAN CHASE SAVINGS							45,438,359.97	0.050%
							$ 45,438,359.97	

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**

Block Grant Update

Federal Substance Abuse Prevention & Treatment Block Grant (SAPTBG) Funds are available to pay the cost of services for individuals who have no insurance or are underinsured. These dollars may also be used to fund discretionary services that are not funded by Medicaid or HMP (examples: transportation assistance, recovery housing). Beginning January 1, 2021, MSHN implemented numerous Block Grant Spending Reductions strategies to align actual expenses with a nearly 37% decrease in MDHHS funding. The summary of changes includes benefit plan modifications such asauthorization adjustments and reduced service episodes. In addition, some services were impacted by implementing lower reimbursement rates and applying higher consumer copays.

Please Note: MSHN committed that individuals already in treatment prior to January 1,2021, would not be subject to the new Block Grant benefit limits. As such, the UtilizationManagement team continued to authorize accordingly at previous levels. As we move throughout the remainder of Fiscal Year 2021, we anticipate a more noticeable reduction in costs as those individuals phase out of treatment. Persons who entered treatment on or after January 1, 2021, are subject to benefit limits.

The strategies implemented are helping MSHN see lower overall trends in paid amounts, cases, and units since January 2021. The attached document displays spending from July 2020 through June 2021. The Analytical Summary box on page two examines the average for July - December 2020 as compared to January and then the next month February is compared to the prior one and so on. The analysis highlights that we are moving in the right direction to achieve the goal of bringing actualexpenses closer to available Block Grant Revenue. A few items to note regarding the analysis:

- June 2021 data is not included in the **summary box information** as claims for this month are incomplete (claimslag). In addition, report totals for months included in the attached analysis may vary as more claims trickle in, but significant changes are not anticipated.
- Case count decreases should be primarily related to Block Grant changes.
- Unit decreases result from Block Grant changes and shifting multiple servicesinto one bundled reimbursement.

JUNE 2021 UPDATE: Through June 2021, MSHN used approximately $6.24 M in Block Grant Funds. The updated allocation amount is $9.46 M which leaves a balance of $3.22 M for the remainder of Fiscal Year 2021. The March through May spending average is approximately $300 k and totals approximately $900 k in disbursements for July through September. At this point we are not expecting cost overruns and therefore are not anticipating a request for use of PA2 funds to offset regional Block Grant spending.

This report format will be used to keep you updated for the remainder of this fiscal year-end (9.30.2021).

Mid-State Health Network
Summary of Block Grant Funded Claims for Dates of Service July 1, 2020 through June 30, 2021

	2020						2021						Reduction
Row Labels	July	August	September	October	November	December	January	February	March	April	May	June	Strategy
90791 - Psychiatric Evaluation													Benefit Plan Change
Sum of PAID AMOUNT	225.00				112.50			112.50				337.50	
Sum of ALLOWED UNITS	2				1			1				3	
Distinct Count of CASE #	2				1			1				3	
90832 - Individual Therapy													Benefit Plan Change
Sum of PAID AMOUNT	16,044.40	10,152.84	9,259.86	8,435.49	5,494.28	4,301.55	4,893.73	5,858.73	4,736.00	3,074.00	2,211.91	2,416.00	
Sum of ALLOWED UNITS	308	198	182	168	113	92	95	112	89	57	42	44	
Distinct Count of CASE #	154	131	120	114	82	67	73	75	64	39	32	27	
90834 - Individual Therapy													Benefit Plan Change
Sum of PAID AMOUNT	9,268.00	17,364.39	18,484.19	16,405.13	9,904.54	9,799.50	10,984.66	11,684.64	5,312.73	4,724.24	5,785.69	5,679.00	
Sum of ALLOWED UNITS	130	222	234	211	136	138	140	148	70	66	74	67	
Distinct Count of CASE #	86	150	144	126	99	94	97	104	55	49	56	49	
90837 - Individual Therapy													Benefit Plan Change
Sum of PAID AMOUNT	22,627.92	23,195.80	26,252.38	24,187.22	14,396.65	13,782.73	10,936.17	12,598.53	19,057.13	15,799.86	14,169.93	10,677.50	
Sum of ALLOWED UNITS	233	232	268	246	151	148	113	130	189	148	133	99	
Distinct Count of CASE #	109	133	137	119	89	73	68	75	85	70	64	59	
90853 - Group Therapy													Benefit Plan Change
Sum of PAID AMOUNT	3,973.50	5,418.40	6,623.52	17,583.52	7,737.04	5,785.50	3,306.63	2,672.00	9,726.27	3,137.18	8,131.13	7,353.00	
Sum of ALLOWED UNITS	57	74	89	207	105	84	49	40	116	42	95	82	
Distinct Count of CASE #	22	32	39	78	52	35	25	19	40	22	33	32	
96372 - Medication Administration													Benefit Plan Change
Sum of PAID AMOUNT										58.00	29.00	29.00	
Sum of ALLOWED UNITS										2	1	1	
Distinct Count of CASE #										2	1	1	
99202 - E&M - New Consumer													Benefit Plan and Copay Changes
Sum of PAID AMOUNT	552.00	472.54	837.42	920.00	368.00	276.00	261.00	348.00	92.00	92.00	363.00		
Sum of ALLOWED UNITS	6	6	11	10	4	3	3	4	1	1	4		
Distinct Count of CASE #	6	6	11	10	4	3	3	4	1	1	4		
99203 - E&M - New Consumer													Benefit Plan and Copay Changes
Sum of PAID AMOUNT									271.00	77.25	414.00		
Sum of ALLOWED UNITS									2	1	3		
Distinct Count of CASE #									2	1	3		
99212 - E&M - Existing Consumer													Benefit Plan and Copay Changes
Sum of PAID AMOUNT							36.41						
Sum of ALLOWED UNITS							1						
Distinct Count of CASE #							1						
99213 - E&M - Existing Consumer													Benefit Plan and Copay Changes
Sum of PAID AMOUNT	4,514.18	4,888.11	5,303.73	4,751.11	4,697.31	3,865.35	2,928.81	2,626.55	1,777.05	1,271.24	1,721.24	1,086.00	
Sum of ALLOWED UNITS	55	60	67	62	60	51	38	34	22	17	22	13	
Distinct Count of CASE #	48	55	60	52	55	42	37	32	21	17	21	12	
99214 - E&M - Existing Consumer													Benefit Plan and Copay Changes
Sum of PAID AMOUNT										92.84			
Sum of ALLOWED UNITS										1			
Distinct Count of CASE #										1			
99215 - E&M - Existing Consumer													Benefit Plan and Copay Changes
Sum of PAID AMOUNT										41.06		227.00	
Sum of ALLOWED UNITS										1		1	
Distinct Count of CASE #										1		1	
A0110 - Transportation - Bus Token													Benefit Plan Change
Sum of PAID AMOUNT	481.96	414.00	645.98	549.96	576.99	601.99	12.50	56.97	151.96	46.99	61.99	331.45	
Sum of ALLOWED UNITS	23	23	36	31	32	27	2	3	7	4	3	8	
Distinct Count of CASE #	21	23	34	29	32	27	2	3	7	4	3	8	
G2067 - Methadone Weekly Bundle													Benefit Plan Change
Sum of PAID AMOUNT	400.00	300.00	180.00	80.00	100.00		521.74			24.00			
Sum of ALLOWED UNITS	10	15	10	4	5		5			2			
Distinct Count of CASE #	4	5	4	1	1		3			1			
G2078 - Methadone Take Home Supply													Benefit Plan Change
Sum of PAID AMOUNT	14.12	21.18	14.12				3.26						
Sum of ALLOWED UNITS	2	3	2				2						
Distinct Count of CASE #	1	1	2				2						
H0001 - Assessment													Benefit Plan Change
Sum of PAID AMOUNT	9,960.23	10,487.56	11,415.27	10,048.12	7,048.08	5,482.50	7,129.54	6,885.00	5,790.31	4,228.05	5,992.50	5,482.50	
Sum of ALLOWED UNITS	79	84	87	74	59	43	59	54	46	34	47	43	
Distinct Count of CASE #	79	84	87	74	59	43	58	54	46	34	47	43	
H0003 - Drug Screen													Benefit Plan Change
Sum of PAID AMOUNT	255.00	127.50	51.00	76.50	127.50	76.50	51.00	51.00					
Sum of ALLOWED UNITS	10	5	2	3	5	3	2	2					
Distinct Count of CASE #	7	4	2	2	4	2	2	2					
H0004 - Individual Counseling													Benefit Plan Change
Sum of PAID AMOUNT	7,987.50	7,226.00	6,795.50	7,189.00	6,729.50	7,487.50	6,667.00	4,602.00	3,948.00	1,754.50	941.50	743.00	
Sum of ALLOWED UNITS	367	345	324	346	313	361	311	224	185	84	45	36	
Distinct Count of CASE #	60	64	64	68	67	61	66	46	39	15	13	8	
H0005 - Group Counseling													Benefit Plan Change
Sum of PAID AMOUNT	748.00	1,767.00	1,260.00	2,178.00	1,476.00	2,019.00	1,563.00	738.00	492.00	820.00	656.00	492.00	
Sum of ALLOWED UNITS	18	42	30	53	36	49	38	18	12	20	16	12	
Distinct Count of CASE #	11	13	12	16	17	18	15	7	5	6	5	3	
H0006 - Case Management													Benefit Plan Change
Sum of PAID AMOUNT	14,459.00	14,891.00	15,163.00	17,377.00	13,628.50	15,981.00	14,270.50	10,561.00	12,333.00	10,004.50	8,203.00	6,024.50	
Sum of ALLOWED UNITS	350	359	367	412	329	385	344	255	298	243	196	144	
Distinct Count of CASE #	231	246	240	268	229	237	233	182	183	164	139	113	
H0010 - Withdrawal Management													Benefit Plan Change
Sum of PAID AMOUNT	8,970.00	3,450.00	4,485.00	7,590.00	3,450.00	4,830.00	3,105.00	6,900.00	4,830.00	5,175.00	2,415.00	2,070.00	
Sum of ALLOWED UNITS	26	10	13	24	10	14	12	20	14	15	7	6	
Distinct Count of CASE #	9	3	6	7	3	5	4	6	4	4	3	3	
H0012 - Withdrawal Management													Benefit Plan Change
Sum of PAID AMOUNT	1,875.00	937.50	1,290.00	1,562.50	937.50			625.00	3,125.00	1,250.00			
Sum of ALLOWED UNITS	6	3	4	5	3			2	10	4			
Distinct Count of CASE #	2	1	2	2	1			1	3	1			
H0018 - Residential Treatment													Benefit Plan and Copay Changes
Sum of PAID AMOUNT	2,123.50	890.50		68.50				598.50	399.00	66.50	1,944.00		
Sum of ALLOWED UNITS	31	13		1				9	6	1	28		
Distinct Count of CASE #	1	1		1				1	2	1	2		
H0019 - Residential Treatment													Benefit Plan and Copay Changes
Sum of PAID AMOUNT	29,109.50	29,032.00	28,519.00	29,257.50	27,401.00	28,633.50	36,053.50	26,424.00	19,250.00	17,844.50	9,463.00	19,448.00	
Sum of ALLOWED UNITS	190	191	187	191	180	189	246	186	134	116	62	131	
Distinct Count of CASE #	16	14	16	14	16	15	15	18	10	10	7	10	
H0020 - Methadone Dosing													Benefit Plan Change
Sum of PAID AMOUNT	29,960.00	28,448.00	26,688.00	26,272.00	23,152.00	21,976.00	19,296.00	14,080.00	11,928.00	7,648.00	6,832.00	4,216.00	
Sum of ALLOWED UNITS	3,745	3,582	3,338	3,284	2,894	2,747	2,412	1,760	1,491	956	854	527	
Distinct Count of CASE #	131	122	125	118	102	94	87	73	59	39	34	25	
H0038 - Peer Recovery Supports													Benefit Plan and Copay Changes
Sum of PAID AMOUNT	37,553.30	50,334.00	47,739.00	54,802.74	51,611.00	43,536.00	31,057.50	25,231.75	20,955.00	5,810.00	5,307.00	8,079.00	
Sum of ALLOWED UNITS	2,711	3,682	3,555	4,042	3,979	3,414	2,827	2,097	2,031	612	562	878	
Distinct Count of CASE #	127	119	144	170	165	172	160	147	140	71	71	54	

Mid-State Health Network
Summary of Block Grant Funded Claims for Dates of Service July 1, 2020 through June 30, 2021

Row Labels	2020 July	August	September	October	November	December	2021 January	February	March	April	May	June	Reduction Strategy
H0048 - Drug Screen													Benefit Plan Change
Sum of PAID AMOUNT	1,756.00	2,144.70	2,198.80	2,351.10	1,927.10	2,051.10	2,154.89	2,415.50	2,105.00	1,959.00	1,819.00	2,196.50	
Sum of ALLOWED UNITS	143	177	181	193	159	169	175	196	170	158	147	178	
Distinct Count of CASE #	107	116	116	126	122	112	128	140	127	125	109	120	
H0050 - Brief Intervention													Benefit Plan Change
Sum of PAID AMOUNT					15.50								
Sum of ALLOWED UNITS					1								
Distinct Count of CASE #					1								
H2027 - Didactic Services													Benefit Plan Change
Sum of PAID AMOUNT	418.00	1,040.00	622.50	1,391.00	489.00	456.00	198.00			341.00	165.00		
Sum of ALLOWED UNITS	74	188	107	248	90	90	36			62	30		
Distinct Count of CASE #	7	6	7	9	6	4	2			2	2		
H2034 - Recovery Housing													Benefit Plan Change and Rate Reduction
Sum of PAID AMOUNT	116,409.36	120,358.85	118,926.22	121,582.66	132,299.91	148,104.97	103,245.90	82,205.25	75,469.50	60,134.00	44,022.50	32,928.00	
Sum of ALLOWED UNITS	5,033	5,178	5,150	5,264	5,746	6,040	5,574	4,443	4,240	3,069	2,374	1,874	
Distinct Count of CASE #	233	238	229	243	248	253	240	211	184	161	119	102	
S0215 - Transportation - Per Mile													Benefit Plan Change
Sum of PAID AMOUNT	1,371.26	1,835.04	1,258.38	2,084.16	1,394.61	459.76	534.80	563.92	596.40	677.60	870.80	30.80	
Sum of ALLOWED UNITS	2,447	3,246	2,193	3,636	2,427	793	955	1,007	1,065	1,210	1,555	55	
Distinct Count of CASE #	29	37	28	34	30	9	10	11	12	13	16	1	
S9976 - Residential Room and Board													Benefit Plan Change and Rate Reduction
Sum of PAID AMOUNT	174,316.75	177,454.50	195,182.25	205,885.00	183,094.00	184,115.00	137,897.00	136,038.00	147,840.00	131,964.00	128,778.00	106,470.00	
Sum of ALLOWED UNITS	6,240	6,353	6,984	7,363	6,552	6,593	6,582	6,479	7,057	6,288	6,135	5,070	
Distinct Count of CASE #	413	436	445	461	417	397	425	451	444	398	416	342	
T1009 - Childcare Services													Benefit Plan Change
Sum of PAID AMOUNT	5,247.00	7,587.00	6,854.00	5,904.00	3,707.00	5,723.00	6,402.00	6,477.00	5,952.00	5,660.00	2,856.00		
Sum of ALLOWED UNITS	82	109	114	91	58	70	88	70	85	72	30		
Distinct Count of CASE #	6	7	10	7	7	7	8	4	8	5	5		
T1012 - Peer Recovery Supports													Benefit Plan and Copay Changes
Sum of PAID AMOUNT	9,334.00	8,567.00	11,619.00	13,578.00	20,768.00	21,658.00	9,412.00	7,813.00	5,824.00	312.00	525.00	180.00	
Sum of ALLOWED UNITS	326	314	430	438	609	651	295	231	175	9	21	6	
Distinct Count of CASE #	63	60	74	81	79	82	62	45	36	5	6	3	
Total Sum of PAID AMOUNT	**509,954.48**	**528,805.41**	**547,668.12**	**582,110.21**	**522,643.51**	**531,002.45**	**412,922.54**	**368,166.84**	**361,961.35**	**284,087.31**	**253,678.19**	**216,496.75**	
Total Sum of ALLOWED UNITS	**22,704**	**24,714**	**23,965**	**26,607**	**24,057**	**22,154**	**20,404**	**17,525**	**17,515**	**13,295**	**12,486**	**9,278**	
Total Distinct Count of CASE #	**1,368**	**1,405**	**1,406**	**1,434**	**1,324**	**1,242**	**1,259**	**1,234**	**1,131**	**974**	**908**	**785**	

SUMMARY

	July - December Monthly Average	January	February	March	April	May	
Total Sum of PAID AMOUNT	**537,030.70**	**412,922.54**	**368,166.84**	**361,961.35**	**284,087.31**	**253,678.19**	
Total Sum of ALLOWED UNITS	**24,034**	**20,404**	**17,525**	**17,515**	**13,295**	**12,486**	
Total Distinct Count of CASE #	**1,363**	**1,259**	**1,234**	**1,131**	**974**	**908**	
Change in PAID AMOUNT		(124,108.16)	(44,755.70)	(6,205.49)	(77,874.04)	(30,409.12)	(283,352.51)
% Change in PAID AMOUNT		-23.11%	-10.84%	-1.69%	-21.51%	-10.70%	
Change in ALLOWED UNITS		(3,630)	(2,879)	(10)	(4,220)	(809)	
% Change in ALLOWED UNITS		-15.10%	-14.11%	-0.06%	-24.09%	-6.08%	
Change in CASES		(104.00)	(25.00)	(103.00)	(157.00)	(66.00)	
% Change in CASES		-7.63%	-1.99%	-8.35%	-13.88%	-6.78%	

MSHN
Mid-State Health Network

Background

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

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

Therefore, MSHN presents the attached FY22 Contract Listing for Board approval and authorization of the Chief Executive Officer to sign.

Recommended Motion:

The MSHN Board authorizes its Chief Executive Officer to sign and fully execute the contracts as presented and listed on the FY22 contract listing.

MID-STATE HEALTH NETWORK
FISCAL YEAR 2022 NEW AND RENEWING CONTRACTS
September 2021

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	FY2022 CONTRACT AMOUNT	FY2021 CONTRACT AMOUNT	INCREASE/ (DECREASE)
PIHP RETAINED FUNCTION CONTRACTS					
CEI Community Mental Health Authority	File Management, Historical data Repository & Data	10.1.21 - 9.30.22	**$ 175,000**	$ 175,000	-
CMH for Central Michigan	SIS Quality Lead	10.1.21 - 9.30.22	**$ 27,500**	$ 27,000	**500**
Dr. Bruce Springer	SUD Medicial Director Services	10.1.21 - 9.30.22	**$ 30,000**	$ 30,000	-
Dr. Zakia Alavi, MD	Chief Medical Officer (Rate of $145/Hr.)	10.1.21 - 9.30.22	$ -	$ -	-
			$ 232,500	$ 232,000	**$ 500**

CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION	CONTRACT TERM	FY2022 CONTRACT AMOUNT	FY2021 CONTRACT AMOUNT	INCREASE/ (DECREASE)
PIHP ADMINISTRATIVE FUNCTION CONTRACTS					
Addis Enterprises (AE Design)	Website Design and Development	10.1.21 - 9.30.22	**$ 16,000**	**$ 16,000**	-
Amanda Slack	Population Health & Integrated Care Spec. ($35/Hr.	10.1.21 - 9.30.22	**$ 10,800**	**$ 10,800**	-
ASAM	ASAM Continuum License Agreement & BAA	6.24.21 - 1.23.24			
BOX		10.1.21 - 9.30.22	**$ 20,600**	**$ 19,800**	**800**
CoStaff	PEO Services	10.1.21 - 9.30.22	**$ 60,040**	**$ 60,040**	-
EAP Amendment (New Directions)	Employee Assistance Program	3.3.20 - 3.3.22	**$ 3,350**	**$ 3,350**	-
Jannifer Maino	Strategic Initiatves Consultant ($65.00 hourly rate)	10.1.21 - 9.30.22	**$ -**	**$ -**	-
Linda Fletcher, MS, CPNP	PDN Services	10.1.21 - 9.30.22	**$ 2,640**	**$ 2,640**	-
Maner Costerisan, East Lansing, Michigan	Accounting and Financial Management System	10.1.20 - 9.30.23	**$ 54,650**	**$ 54,650**	-
Michigan Consortium of Healthcare Excellence (MCHE)	MCG Parity Software	10.1.21 - 9.30.22	**$ 75,000**	**$ 90,500**	**(15,500)**
Michigan Optometric Association	Facilities Rental (Yr. 3 of 3)	10.1.21 - 9.30.22	**$ 73,879**	**$ 73,136**	**743**
Microsoft AZURE	Subcription Service	10.1.21 - 9.30.22	**$ 72,000**	**$ 72,000**	-
MiHIN	Use Case & SOW and MIDIGATE	10.1.21 - 9.30.22	**$ 104,000**	**$ 104,000**	-
Milliman	DRIVE License Agreement; 1k per user	10.1.21 - 10.31.22	**$ 2,000**	**$ 2,000**	-
MORC	SIS Assessment Services ($647/Assessment)	9.30.19 - Open	**$ -**	**$ -**	-
PCE Systems	MCIS System	10.1.21 - 9.30.22	**$ 345,200**	**$ 345,200**	-
PEC Technologies	Web Development/Random Sampling	10.1.21 - 9.30.22	**$ 5,000**	**$ 5,000**	-
Providence Consulting Company, Lansing, Michigan	Computer Help Desk Support and Security	10.1.21 - 9.30.22	**$ 85,000**	**$ 85,000**	-
GreatAmerica Financial Services Corp.	Subscription Service Re Laptops (3 yr. Term)	3.3.20 - 3.3.23	**$ -**	**$ -**	-
Recovery Pathways, LLC	MCU Vehicle Lease	10.1.21 - 9.30.22	**$ 1**	**$ 1**	
Relias Learning, LLC	On-Line Training Services Package (Amount will be pro-rated on an annual basis)	10.1.19 - 9.30.22	**$ 410,709**	**$ 410,709**	-
Roslund Prestage & Company, Alma, Michigan	Single, Financial and Compliance Audits	10.1.21 - 9.30.22	**$ 25,300**	**$ 25,300**	-
TBD Solutions, LLC, Ada Michigan	Business/Information Technology Consulting	10.1.21 - 9.30.22	**$ -**	**$ -**	-
TBD Solutions, LLC, Ada Michigan	Data Analysis and Knowledge Services	10.1.21 - 9.30.22	**$ 90,000**	**$ 55,000**	**35,000**
TBD Solutions, LLC, Ada Michigan	Crisis Residential Consultation	10.1.21 - 6.30.22	**$ 16,830**	**$ 16,830**	-
Zenith Technology Solutions (ZTS)	Metrics, Data Analysis, Outcome Measures, Monitoring	10.1.21 - 9.30.22	**$ 248,000**	**$ 248,000**	-
			$ 1,720,999	**$ 1,699,956**	**21,043**

CONTRACTING ENTITY	SUD PROVIDERS PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	FY2022 CONTRACT AMOUNT	FY2021 CONTRACT AMOUNT	INCREASE/ (DECREASE)
SUD SERVICE PROVIDER CONTRACTS (Cost Reimbursement/Fee For Services) NOTE: Fee for Service contracts show "-" amount (PA2 Funds to be approved by OPB at October 2021 Meeting)**					
Addiction Solutions Counseling Center **	Treatment and Prevention	10.1.21 - 9.30.22	**$ 29,320**	14,320	**15,000**
Addiction Treatment Services	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Arbor Circle **	Treatment and Prevention	10.1.21 - 9.30.22	**$ 404,359**	543,520	**(139,161)**
Barry Eaton District Health Dept.**	Prevention	10.1.21 - 9.30.22	**$ 9,772**	7,062	**2,710**
Bear River Health	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Big Brothers/Big Sisters of Jackson **	Prevention	10.1.21 - 9.30.22	**$ 49,485**	49,485	-
Boys and Girls Club of Bay County, Inc. **	Prevention	10.1.21 - 9.30.22	**$ 114,823**	117,073	**(2,250)**
Boysville of Michigan, Inc. DBA Holy Cross Services	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Catholic Charities of Jackson, Lenawee & Hillsdale Counties	Treatment	10.1.21 - 9.30.22	**$ -**	31,790	**(31,790)**
Catholic Charities of Shiawassee & Genesee Counties **	Treatment and Prevention	10.1.21 - 9.30.22	**$ 134,384**	183,806	**(49,422)**
Catholic Charities of West Michigan	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Catholic Human Services	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Cherry Street (Health) Services	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Child & Family Charities **	Treatment and Prevention	10.1.21 - 9.30.22	**$ 192,125**	250,346	**(58,221)**
City of Saginaw (Police Dept.)**	Prevention	10.1.21 - 9.30.22	**$ 55,705**	65,029	**(9,324)**
CMH for CEI - CMHSP	Treatment	10.1.21 - 9.30.22	**$ 1,131,805**	1,446,691	**(314,886)**
Community Program, Inc. (dba Meridian Health Services)	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Cristo Rey Community Center **	Treatment and Prevention	10.1.21 - 9.30.22	**$ 262,228**	503,125	**(240,897)**
DOT Caring Centers, Inc./ Saginaw Valley Centers, Inc.	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Eaton Regional Education Service Agency (RESA) **	Prevention	10.1.21 - 9.30.22	**$ 589,596**	713,656	**(124,060)**
Family & Children's Services of Midland	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Family Services & Children's Aid **	Treatment and Prevention	10.1.21 - 9.30.22	**$ 502,988**	494,883	**8,105**
First Ward Community Center **	Prevention	10.1.21 - 9.30.22	**$ 268,377**	268,337	**40**
Flint Odyssey House, Inc.	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Gratiot County Child Advocacy Association**	Prevention	10.1.21 - 9.30.22	**$ 171,165**	169,907	**1,258**
Great Lakes Bay Health Centers Hearth Home (f.k.a HDI Hearth	Prevention	10.1.21 - 9.30.22	**$ 93,000**	93,000	-
Great Lakes Recovery Center	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Harbor Hall Treatment Services	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
HealthSource Saginaw, Pathways Chemical Dependency Center	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
Home of New Vision (HNV)**	Treatment & Prevention	10.1.21 - 9.30.22	**$ 264,000**	597,357	**(333,357)**
Huron County Health Department **	Prevention	10.1.21 - 9.30.22	**$ 163,619**	166,619	**(3,000)**
Ingham County Health Department **	Prevention	10.1.21 - 9.30.22	**$ 96,656**	96,656	-
Ionia County Health Department **	Prevention	10.1.21 - 9.30.22	**$ 143,000**	145,980	**(2,980)**
Kalamazoo Probation Enahncement Program (KPEP)	Treatment (MDOC)	10.1.21 - 9.30.22	**$ -**	-	-
Lansing Comprehensive Treatment Center (fka Red Cedar	Treatment	10.1.21 - 9.30.22	**$ -**	-	-
LifeWays Community Mental Health Authority **	Treatment and Prevention	10.1.21 - 9.30.22	**$ 124,336**	9,400	**114,936**
List Psychological Services, Inc. **	Treatment and Prevention	10.1.21 - 9.30.22	**$ 67,751**	71,751	**(4,000)**
McCullough, Vargas & Assoc.	Treatment and Prevention	10.1.21 - 9.30.22	**$ 75,000**	92,343	**(17,343)**
McLaren Bay Region Neighborhood Resource Center **	Prevention	10.1.21 - 9.30.22	**$ 122,095**	128,595	**(6,500)**
Michigan Therapeutic Consultants. PC**	Treatment	10.1.21 - 9.30.22	**$ 7,000**	-	**7,000**
Mid-Michigan District Health Department**	Prevention	10.1.21 - 9.30.22	**$ 262,371**	268,621	**(6,250)**
Mid-Michigan Recovery Services (f.k.a. NCALRA)	Treatment	10.1.21 - 9.30.22	**$ 132,734**	135,385	**(2,651)**

CONTRACTING ENTITY	SUD PROVIDERS PROJECTS/PROGRAM DESCRIPTION	CONTRACT TERM	FY2022 CONTRACT AMOUNT	FY2021 CONTRACT AMOUNT	INCREASE/ (DECREASE)
SUD SERVICE PROVIDER CONTRACTS (Cost Reimbursement/Fee For Services) NOTE: Fee for Service contracts show "-" amount (PA2 Funds to be approved by OPB at October 2021 Meeting)**					
Mindful Therapy, LLC	Treatment	10.1.21 - 9.30.22	$ -	-	-
New Paths	Treatment (MDOC)	10.1.21 - 9.30.22	$ -	-	-
Newaygo County R.E.S.A. **	Prevention	10.1.21 - 9.30.22	$ **93,500**	97,250	**(3,750)**
North Kent Guidance Services, LLC	Treatment	10.1.21 - 9.30.22	$ -	-	-
Our Hope Association (Women Only)	Treatment	10.1.21 - 9.30.22	$ -	-	-
Peer 360 **	Prevention	10.1.21 - 9.30.22	$ **913,950**	861,950	**52,000**
Pinnacle Recovery Services	Treatment	10.1.21 - 9.30.22	$ **9,525**	11,250	**(1,725)**
Prevention Network **	Prevention	10.1.21 - 9.30.22	$ **80,000**	80,000	-
Professional Psychological & Psychiatric Services (PPPS)	Treatment	10.1.21 - 9.30.22	$ -	-	-
Randy's House	Recovery	10.1.21 - 9.30.22	$ **23,870**	25,714	**(1,844)**
Recovery Pathways, LLC	Treatment	10.1.21 - 9.30.22	$ **272,684**	478,516	**(205,832)**
Sacred Heart Rehabilitation Center **	Treatment and Prevention	10.1.21 - 9.30.22	$ **118,530**	111,222	**7,308**
Saginaw Odyssey House	Treatment	10.1.21 - 9.30.22	$ -	7,440	**(7,440)**
Saginaw Psychological Services	Treatment	10.1.21 - 9.30.22	$ -	47,349	**(47,349)**
Saginaw Youth Protection Council **	Prevention	10.1.21 - 9.30.22	$ **301,922**	301,922	-
Salvation Army Turning Point	Treatment	10.1.21 - 9.30.22	$ -	-	-
Samaritas - Charlotte	Treatment	10.1.21 - 9.30.22	$ -	79,643	**(79,643)**
Shiawassee County Circuit Court - Family Division **	Prevention	10.1.21 - 9.30.22	$ **16,620**	16,602	**18**
St. John's Police Department **	Prevention	10.1.21 - 9.30.22	$ **6,671**	8,556	**(1,885)**
State of Michigan - Michigan Rehabilitation Services**	Vocational Rehabilitation Services (Interagency	10.1.21 - 9.30.22	$ **30,000**	30,000	-
Sterling Area Health Center **	Treatment and Prevention	10.1.21 - 9.30.22	$ **139,011**	142,011	**(3,000)**
Sunrise Centre	Treatment	10.1.21 - 9.30.22	$ -	-	-
Ten Sixteen Recovery Network **	Treatment and Prevention	10.1.21 - 9.30.22	$ **1,369,433**	1,299,707	**69,726**
The Legacy Center - Midland Area Partnership **	Prevention	10.1.21 - 9.30.22	$ **150,811**	156,811	**(6,000)**
Victory Clinical Services **	Treatment	10.1.21 - 9.30.22	$ -	-	-
VCS Battle Creek		10.1.21 - 9.30.22	$ -	-	-
VCS III - Jackson		10.1.21 - 9.30.22	$ -	-	-
VCS IV - Saginaw		10.1.21 - 9.30.22	$ -	-	-
VCS Lansing		10.1.21 - 9.30.22	$ **7,000**	-	**7,000**
W.A. Foote Memorial Hospital (dba Henry Ford Allegiance	Treatment and Prevention	10.1.21 - 9.30.22	$ **113,524**	119,024	**(5,500)**
WAI-IAM (Rise Transitional Housing)	Recovery	10.1.21 - 9.30.22	$ **17,500**	24,429	**(6,929)**
Wedgwood Christian Services **	Treatment	10.1.21 - 9.30.22	$ **73,680**	74,821	**(1,141)**
Wellness, Inx **	Treatment and Prevention	10.1.21 - 9.30.22	$ **557,775**	557,775	-
Women of Colors **	Prevention	10.1.21 - 9.30.22	$ **227,840**	222,840	**5,000**
			$ **9,991,540**	$ 11,419,569	$ **(1,428,029)**

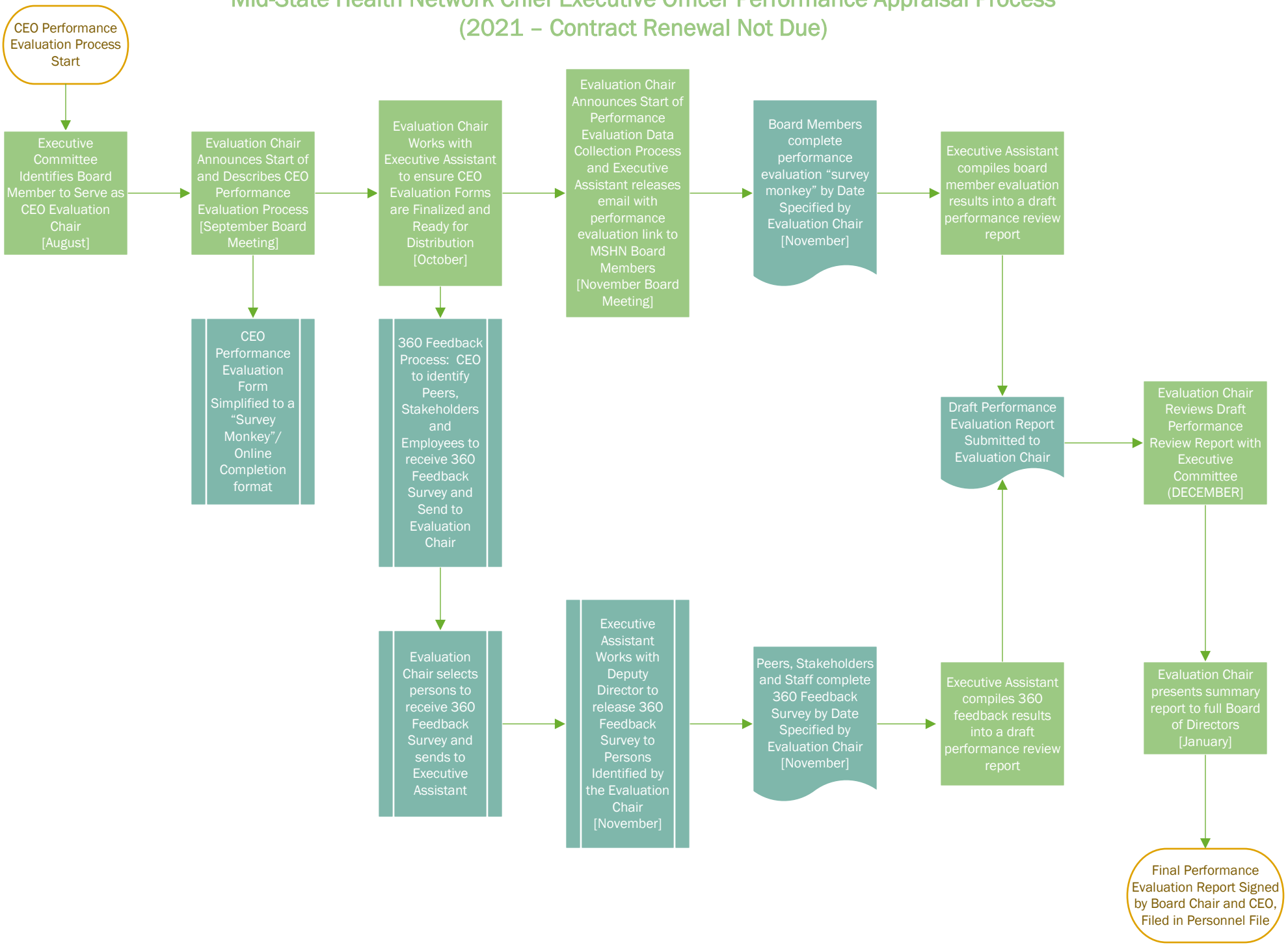
CONTRACTING ENTITY	CONTRACT SERVICE DESCRIPTION (Revenue Contract)	CONTRACT TERM	FY2022 CONTRACT AMOUNT	FY2021 CONTRACT AMOUNT	INCREASE/ (DECREASE)
PIHP REVENUE CONTRACTS					
Saginaw CMH	SIS LOA ($350/Completed Assessment)		$ -	-	-
Shiawassee CMH	SIS LOA ($350/Completed Assessment)		$ -	-	-
Michigan Department of Health & Human Services (EGrAMS)	Clubhouse Engagement **	10.1.21 - 9.30.22	$ **135,000**	174,500	**(39,500)**
	Community Grant **	10.1.21 - 9.30.22	$ **5,154,076**	5,154,076	-
	Gambling Disorder Prevention Project **	10.1.21 - 9.30.22	$ **189,074**	189,074	-
	Prevention **	10.1.21 - 9.30.22	$ **2,292,055**	2,292,055	-
	Prevention II - Covid	10.1.21 - 9.30.22	$ **848,250**	614,981	**233,269**
	State Disability Assistance **	10.1.21 - 9.30.22	$ **302,084**	302,084	-
	State Opioid Response II **	10.1.21 - 9.30.22	$ **1,181,979**	1,494,004	**(312,025)**
	SUD - Administration	10.1.21 - 9.30.22	$ **518,000**	518,000	-
	SUD Administration - COVID	10.1.21 - 9.30.22	$ **50,000**	50,000	-
	SUD Services - Tobacco II	10.1.21 - 9.30.22	$ **4,000**	4,000	-
	SUD Services - Women's Specialty Services	10.1.21 - 9.30.22	$ **1,204,088**	1,204,088	-
	Treatment - COVID	10.1.21 - 9.30.22	$ **2,887,590**	1,320,111	**1,567,479**
	Veteran's Systems Navigator **	10.1.21 - 9.30.22	$ **100,000**	113,344	**(13,344)**
	Women's Specialty Services - COVID	10.1.21 - 9.30.22	$ **522,261**	474,832	**47,429**
Michigan Department of Health & Human Services	Medicaid Managed Specialty Supports and Services Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs	10.1.21 - 9.30.22	$ -	-	-
			$ **15,388,457**	$ 13,905,149	$ **1,483,308**

MID-STATE HEALTH NETWORK
FISCAL YEAR 2022 CMHSP CONTRACTS
September 2021

CONTRACTING ENTITY	CMHSP SERVICE AREA	CONTRACT TERM	FY2022 CONTRACT AMOUNT*	FY 2021 TOTAL CONTRACT AMOUNT*	INCREASE/ (DECREASE)	FY 2022 REVENUE PROJECTION	REVENUE OVER/(UNDER) EXPENSE	Direct Care Workers (DCW)
PIHP/CMHSP MEDICAID SUBCONTRACTS								
Bay-Arenac Behavioral Health	Bay & Arenac	10.1.21 - 9.30.22	**53,242,056**	50,003,906	3,238,150	51,142,056	(2,100,000)	2,100,000
CEI Community Mental Health Authority	Clinton, Eaton & Ingham	10.1.21 - 9.30.22	**139,226,737**	122,012,470	17,214,267	139,226,737	0	$-
Community Mental Health of Central Michigan	Clare, Gladwin, Isabella, Mecosta, Midland, Osceola	10.1.21 - 9.30.22	**119,176,833**	102,589,575	16,587,258	108,272,563	(10,904,270)	7,750,000
Community Mental Health Authority Gratiot County	Gratiot	10.1.21 - 9.30.22	**15,980,552**	15,536,613	443,939	17,152,317	1,171,765	$-
Huron County Community Mental Health Authority	Huron	10.1.21 - 9.30.22	**13,042,479**	11,750,414	1,292,065	10,255,300	(2,787,179)	298,000
The Right Door for Hope, Recovery & Wellness	Ionia	10.1.21 - 9.30.22	**17,663,940**	17,232,432	431,508	17,663,940	(0)	232,750
LifeWays Community Mental Health Authority	Jackson & Hillsdale	10.1.21 - 9.30.22	**84,346,452**	75,648,444	8,698,008	79,295,874	(5,050,578)	5,050,000
Montcalm Care Network	Montcalm	10.1.21 - 9.30.22	**22,173,800**	20,363,500	1,810,300	22,606,720	432,920	500,000
Newaygo County Community Mental Health Authority	Newaygo	10.1.21 - 9.30.22	**16,185,650**	15,455,924	729,726	16,570,153	384,503	150,000
Saginaw County Community Mental Health Authority	Saginaw	10.1.21 - 9.30.22	**84,584,284**	79,715,558	4,868,726	84,584,284	(0)	3,250,000
Shiawassee County Community Mental Health Authority	Shiawassee	10.1.21 - 9.30.22	**22,824,164**	20,593,151	2,231,013	22,824,164	(0)	640,000
Community Mental Health Authority Tuscola County	Tuscola	10.1.21 - 9.30.22	**21,520,381**	21,176,969	343,412	21,520,381	(0)	$-
			609,967,328	552,078,956	57,888,372	591,114,489	(18,852,839)	19,970,750

CONTRACTING ENTITY	CMHSP SERVICE AREA	CONTRACT TERM	FY2022 CONTRACT AMOUNT	FY2021 CONTRACT AMOUNT	INCREASE/ (DECREASE)
PIHP/CMHSP CLUBHOUSE SPENDDOWN CONTRACTS					
Bay-Arenac Behavioral Health	Bay & Arenac	10.1.21 - 9.30.22	**$ 5,000**	7,450	**(2,450)**
CEI Community Mental Health Authority	Clinton, Eaton & Ingham	10.1.21 - 9.30.22	**$ 60,000**	60,000	-
Community Mental Health of Central Michigan	Clare, Gladwin, Isabella, Mecosta, Midland, Osceola	10.1.21 - 9.30.22	**$ 40,000**	53,800	**(13,800)**
LifeWays Community Mental Health Authority	Jackson & Hillsdale	10.1.21 - 9.30.22	**$ 18,000**	33,250	**(15,250)**
Montcalm Care Network	Montcalm	10.1.21 - 9.30.22	**$ 12,000**	20,000	**(8,000)**
			$ 135,000	$ 174,500	**$ (39,500)**

Mid-State Health Network Chief Executive Officer Performance Appraisal Process
(2021 – Contract Renewal Not Due)



MSHN
Mid-State Health Network

FY2022 MSHN BOARD OF DIRECTORS MEETING CALENDAR

Background

The Mid-State Health Network Board of Directors considers the next fiscal year meeting calendar during the Annual Meeting.

Recommended Motion:

Motion to adopt the FY2022 MSHN Board of Directors meeting calendar as presented.

September 14, 2021

MSHN
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TENTATIVE

FY2022 MID-STATE HEALTH NETWORK

REGIONAL BOARD OF DIRECTORS MEETING CALENDAR

(All meetings are scheduled to convene at 5:00 p.m. unless otherwise noted)

Meeting Date	Meeting Location
November 2, 2021	Best Western Okemos/East Lansing Stadium Room 2209 University Park Dr, Okemos, MI 48864
January 11, 2022 (Moved due to New Year's)	Best Western Okemos/East Lansing Stadium Room 2209 University Park Dr, Okemos, MI 48864
March 1, 2022	Best Western Okemos/East Lansing Stadium Room 2209 University Park Dr, Okemos, MI 48864
May 3, 2022	To Be Determined based upon COVID-19 impacts
July 5, 2022	To Be Determined based upon COVID-19 impacts
PUBLIC HEARING: September 13, 2022 (Moved due to Labor Day)	To Be Determined based upon COVID-19 impacts
September 13, 2022 (Moved due to Labor Day)	To Be Determined based upon COVID-19 impacts

Calendar is tentative until Board approved

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

Tuesday, July 6, 2021

Mt. Pleasant Comfort Inn and Suites

Meeting Minutes

1. Call to Order

Vice-Chairperson Irene O'Boyle called this meeting of the Mid-State Health Network Board of Directors to order at 5:01 pm.

2. Roll Call

Acting Secretary Jim Anderson conducted the Roll Call for Board Members in attendance.

Board Member(s) Present: Jim Anderson (Bay-Arenac), Brad Bohner (LifeWays), Joe Brehler (CEI)–joined at 5:15 p.m., Bruce Cadwallender (Shiawassee), Craig Colton (Huron), Ken DeLaat (Newaygo), David Griesing (Tuscola), Dan Grimshaw (Tuscola)-joined at 5:34 p.m., Dianne Holman (CEI), John Johansen (Montcalm), Steve Johnson (Newaygo), Jeanne Ladd (Shiawassee)-joined at 5:15 p.m., Rhonda Matelski (Huron), Pat McFarland (Bay-Arenac), Deb McPeek-McFadden (Ionia), Gretchen Nyland (Ionia), Irene O'Boyle (Gratiot), Kurt Peasley (Montcalm), Joe Phillips (CMH for Central Michigan), Tracey Raquepaw (Saginaw), Kerin Scanlon (CMH for Central Michigan), and Ed Woods (LifeWays)

Board Member(s) Absent: Tina Hicks (Gratiot)

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

3. Approval of Agenda for July 6, 2021

Board approval was requested for the Agenda of the July 6, 2021, Regular Business Meeting.

MOTION BY DEB MCPEEK-MCFADDEN SUPPORTED BY KURT PEASLEY FOR APPROVAL OF THE AGENDA OF THE JULY 6, 2021, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 19-0.

4. Public Comment

There was no public comment.

5. Board Development: Gambling: Prevention and Treatment

Ms. Kari Gulvas and Ms. Sarah Andreotti presented on The MSHN Gambling Disorder Prevalence Study included in the packet. Study results can be found on the MSHN website at this link and will be updated later this summer. Board members discussed and had their questions answered.

Dr. Dani Meier commented that there is a high co-occurrence of substance use disorders and gambling disorders so the region's providers will continue to screen for gambling disorders during the substance use disorder assessment and screening. If the screening determines anything that suggests a gambling disorder, the gambling disorder hotline or therapy options will be recommended.

Vice-Chairperson Irene O'Boyle thanked Ms. Kari Gulvas and Ms. Sarah Andreotti for their work on putting the presentation together.

6. CEO Report

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

- MSHN COVID-19 Internal Operations Status
- MSHN Regional Operations Status
- Provider Stabilization Update
- Substance Abuse Prevention and Treatment Block Grants (SAPTBG)
- MSHN Board Strategic Planning
- MSHN Board Survey/Board Packet Availability

  The Executive Committee would like to ask the preference of the Board regarding the packet distribution timeline. Packets could be distributed 10 days prior to the meeting; however, packets may not be complete because financials are not available that early so those would then need to be sent separately, or to send the complete packet as currently scheduled one week prior (7 calendar days) to the meeting date. The majority preference was to receive a complete packet after the financials were available, which sets the distribution as currently scheduled at least seven (7) calendar days prior to the meeting and if available sooner, the packet will be sent sooner.

- State of Michigan/Statewide Activities

  House Behavioral Health System Redesign Proposal

Senator Shirkey's proposal looks likely to be introduced in mid-July. The House proposal is still a threat, but advocacy efforts continue. One key issue to note is that the Substance Use Disorder (SUD) delivery system is not even being considered in this new proposal. This region has demonstrated that we are performing and carrying out our responsibilities successfully and at an exemplary level of performance. A board member asked legislators what problem they are hoping to address? Their answers are they are looking to have service accessibility for the individuals living with mild to moderate forms of mental illnesses and their concern over the lack of psychiatric inpatient beds, neither of which are the direct responsibility of CMHSPs or PIHPs. Legislators indicated that they also want consumers involved in governance and oversight committees; the board member pointed out that consumers are on the CMHSP and PIHP Boards. The board member feels there needs to be a greater education to the legislators of what CMHSP's are responsible for. The CCBHC model would provide services for individuals living with mild to moderate forms of mental illness.

Michigan Crisis and Access Line (MiCAL)

- Federal/National Activities

  A New Look at Overdose Deaths in the U.S.

7. Deputy Director Report

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

- CCBHC Update
- MSHN Staffing Updates
- Medicaid Event Verification (MEV) Compliance and Oversight
- Performance Bonus Incentives

8. Chief Financial Officer's Report

Ms. Leslie Thomas provided an overview of the financial reports included within board meeting packets for the period ended May 31, 2021.

MOTION BY TRACEY RAQUEPAW, SUPPORTED BY DAVID GRIESING TO RECEIVE AND FILE THE STATEMENT OF NET POSITION AND STATEMENT OF ACTIVITIES FOR THE PERIOD ENDING MAY 31, 2021, AS PRESENTED. MOTION CARRIED: 22-0.

Ms. Leslie Thomas provided an overview of the Federal Substance Abuse Prevention & Treatment Block Grant (SAPTBG) Funds included within board meeting packets.

New Block Grant money may be made available yet this fiscal year and, depending on the rules when released, could be used to offset some or many of the reductions MSHN was forced to absorb earlier in this fiscal year. Ms. Thomas reviewed a detailed report

that shows that block grant reductions implemented by MSHN are trending in the intended direction and that more information will be available at year end. Ms. Thomas pointed out that, even though the region is in a surplus revenue position, those Medicaid and Healthy Michigan funds cannot be used to offset block grant reductions.

Mr. Sedlock introduced discussion of the revenue position of the MSHN region. Mr. Sedlock and Ms. Thomas summarized several initiatives that were under study, some of which do not have auditor support and, if implemented, could result in an adverse finding for MSHN and/or regional partners. There is a sizeable projected year end surplus of revenue, caused by higher-than-expected revenue and lower than expected/budgeted expenses. Most of these fiscal dynamics are COVID related. From a risk management perspective, MSHN cannot proceed with initiatives that could put the region in jeopardy of an adverse audit finding and will only support initiatives where such risk does not exist. CMHSPs in the region are currently contractually authorized to spend up to the PEPM funding and may spend up to that level if it will not put the region at risk. MSHN is first prioritizing expenditures to strengthen consumer supports and services. Ms. Ittner gave the example of the crisis residential service that MSHN is attempting to establish for benefit of the region's consumers. MSHN will continue to work with our regional partners to make allowable investments.

9. Contracts for Consideration/Approval

Ms. Amanda Ittner provided an overview of the FY21 contract listing provided in the meeting packet and requested the board authorize MSHN's CEO to sign and fully execute the contracts listed on the FY21 contract listing.

MOTION BY JIM ANDERSON, SUPPORTED BY PAT McFARLAND TO AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO SIGN AND FULLY EXECUTE THE CONTRACTS LISTED ON THE FY21 CONTRACT LISTING, AS PRESENTED. MOTION CARRIED: 22-0.

10. Executive Committee Report

Vice-Chairperson Irene O'Boyle reported the executive committee met on several items included in the meeting minutes under the consent agenda, most importantly to work on the letter to Legislators regarding the System Redesign Proposals.

Next Board Executive Committee Meeting is scheduled for July 16, 2021. Vice-Chairperson O'Boyle reminded board members that all are welcome.

11. Nominating Committee Report

Ms. Kerin Scanlon, Chairperson of the Nominating Committee, gave a report from the Nominating Committee meeting on June 29, 2021. In April, the nominating committee reviewed the nominations and elections process and in June the committee reviewed the results of a board survey on interest in candidacy for an officer position. Elections will be held at the September Board meeting, which will include nominations from the floor. The elections will likely start with election for the Chairperson, then the Vice-Chairperson and

then the Secretary. Ballot counting will take place in the same room under the presence of the Board members by Ms. Kerin Scanlon and Ms. Sherry Kletke counting the ballots.

Vice-Chairperson O'Boyle thanked Ms. Kerin Scanlon for her time and efforts she has put forth so far on the Nominating Committee.

12. Chairperson's Report

Vice-Chairperson Irene O'Boyle provided remarks as follows:

Board Member Ms. Leola Wilson has submitted her resignation from the Board. Mr. Joe Sedlock has been in touch with Saginaw County CMH for a replacement. Vice Chair O'Boyle suggested sending a recognition to Leola from the Board. MSHN staff will do so on behalf of the Board and staff.

Vice-Chairperson O'Boyle asked for a Board Member to act as a voting delegate for a special meeting of the Member Assembly taking place on July 20, 2021, from 10:00 a.m. to 11:00 a.m. Mr. Pat McFarland has volunteered. MSHN staff will send the meeting information and will submit his name to Community Mental Health Association of Michigan to add his name to the material distribution list.

13. Approval of Consent Agenda

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

MOTION BY JOHN JOHANSEN, SUPPORTED BY DEB MCPEEK-MCFADDEN, TO APPROVE THE FOLLOWING DOCUMENTS ON THE CONSENT AGENDA: APPROVE MINUTES OF THE MAY 4, 2021 BOARD OF DIRECTORS MEETING; RECEIVE SUD OVERSIGHT POLICY ADVISORY BOARD MEETING MINUTES OF JUNE 16, 2021; RECEIVE BOARD EXECUTIVE COMMITTEE MEETING MINUTES OF MAY 21, 2021, MAY 25, 2021 AND JUNE 18, 2021; APPROVE EXECUTIVE COMMITTEE ACTION MAY 25, 2021 AND TO APPROVE BOARD STATEMENT AND SEND TO POLICY MAKERS RELATING TO SYSTEM REDESIGN PROPOSALS; RECEIVE POLICY COMMITTEE MINUTES OF JUNE 1, 2021; RECEIVE OPERATIONS COUNCIL KEY DECISIONS OF MAY 17, 2021 AND JUNE 7, 2021; RECEIVE NOMINATING COMMITTEE MEETING MINUTES OF APRIL 14, 2021; AND TO APPROVE ALL OF THE FOLLOWING POLICIES: EMPLOYEE COMPENSATION, PERFORMANCE EVALUATION, PERSONNEL MANUAL, POSITION MANAGEMENT, PUBLIC HEALTH EMERGENCY NOTICE, REIMBURSEMENT FOR CREDENTIALS, LICENSURES AND MEMBERSHIPS, SEPARATION POLICY AND SUCCESSION PLANNING POLICY. MOTION CARRIED: 22-0.

14. Other Business

Vice-Chairperson Irene O'Boyle expressed her thanks from the Board to Mr. Joe Sedlock and MSHN staff for arranging today's in-person Board meeting that allowed for social distancing.

15. Public Comment

There was no public comment.

16. Adjournment

The MSHN Board of Directors Regular Business Meeting adjourned at 6:49 pm. Motion by Mr. Jim Anderson, Supported by Mr. David Griesing. Motion carried: 22-0

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Mid-State Health Network Board of Directors
Executive Committee Meeting Minutes
Friday, August 20, 2021, 8:00 a.m.

Members Present: Ed Woods, Chairperson; Irene O'Boyle, Vice-Chairperson; James Anderson, Acting Secretary; Kurt Peasley, Ex-Officio

Guests Present: None

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

1. **Call to order:** Chairperson Ed Woods called this meeting of the MSHN Board Executive Committee to order at 8:01 a.m.

2. **Approval of Agenda:** Motion by Kurt Peasley supported by Irene O'Boyle to approve this meeting's agenda as presented. Motion carried.

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

4. **Board Matters:**
   4.1 September 2021 Draft Board Meeting Agenda: The Executive Committee reviewed the draft agenda for the September 14, 2021 board meeting. Executive Committee requests that the public hearing occur first (at 5:00 pm), followed by the regular board meeting. The committee reviewed the remainder of the agenda, which includes FY 21 regional budget amendment, FY 22 regional budget, request to continue direct care worker premium pay (if the legislature doesn't enact it in the budget process), strategic plan for the next two years, election of officers, and other items.

   4.2 September Executive Committee Meeting (09/17): Because the next scheduled Executive Committee is just a few days after the September board meeting, administration recommends cancellation. The Executive committee concurs, and the meeting is cancelled.

   4.3 MDHHS/MSHN Contract Amendment #3: J. Sedlock reported that he has signed a MSHN/MDHHS contract amendment that was a straightforward technical correction to amendment #2. There were no financial components to the amendment.

   4.4 MSHN CEO Performance Review Process: The Committee reviewed the flow chart showing the CEO performance evaluation process for 2021. Administration has made improvements in the forms completed by board members to make it easier and faster to complete the process. Irene O'Boyle was appointed as the Evaluation Chairperson and agreed to serve. Ms. O'Boyle will work with Executive Assistant Sherry Kletke and Deputy Director Amanda Ittner to conduct the performance review. A Ittner summarized the 360-feedback process and components.

5. **Administrative Matters:**
   5.1 Provider-Related Update: J. Sedlock provided an overview of the decision to not renew a provider contract and answered Committee member questions.

   5.2 FY 22 Budget Process Update: J. Sedlock noted that the legislature has not yet passed the budget for many state departments, including MDHHS. He also noted that MDHHS has not released a final PIHP rate certification letter. These variables are outside of the control of MSHN, which is using available data to

project revenue for FY 22. Once final figures are available, hopefully prior to the board meeting, revenue projections will be updated.

5.3 MSHN Employee Survey (Pandemic Response Period Feedback and Post-COVID Operations): J. Sedlock and A. Ittner summarized employee feedback on leadership handling of the COVID-19 pandemic response and considerations for future operations. The Executive Committee expressed support for administration's focus on what is best for the organization in carrying out its responsibilities and for not taking a "one size fits all" approach. Leadership next steps are to conduct a position-by-position analysis for whether continuation of remote work arrangements or implementation of a hybrid arrangement are in the organization's interests.

5.4 Other: None

6. **Other:**
   6.1. Any other business to come before the Executive Committee: None

   6.2. The next Executive Committee Meeting is scheduled for Friday, October 15, 2021

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

8. **Adjourn:** Meeting adjourned at 8:48 a.m.

MID-STATE HEALTH NETWORK

BOARD POLICY COMMITTEE MEETING MINUTES
TUESDAY, AUGUST 3, 2021 (VIDEO CONFERENCE)

Members Present: Irene O'Boyle, Kurt Peasley, Jim Anderson, Jeanne Ladd

Members Absent: John Johansen

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

1. CALL TO ORDER

   Under Chairperson Johansen's absence, Ms. Irene O'Boyle agreed to chair the Board Policy Committee meeting today. Ms. O'Boyle called the Board Policy Committee meeting to order at 10:02 a.m.

2. APPROVAL OF THE AGENDA

   MOTION by Kurt Peasley, supported by Jim Anderson, to approve the August 3, 2021, Board Policy Committee Meeting Agenda, as presented. Motion Carried: 4-0.

3. POLICIES UNDER DISCUSSION:

   No policies were presented for further discussion.

4. POLICIES UNDER BIENNIAL REVIEW

   Ms. O'Boyle invited Ms. Ittner to inform members on the revisions made to the policies being presented under biennial review. Ms. Ittner provided an overview of the substantive changes within the policies. The Information Technology chapter has been reviewed by the MSHN Chief Information Officer and the Regional Information Technology Council. The Provider Network Management Policy has been reviewed by MSHN Leadership Team as it relates to SUD Provider Risk Assessment.

   CHAPTER: INFORMATION TECHNOLOGY
   1. BREACH NOTIFICATION
   2. DISASTER RECOVERY
   3. INFORMATION MANAGEMENT
   4. RECORD RETENTION

   CHAPTER: PROVIDER NETWORK MANAGEMENT
   1. PROVIDER NETWORK MANAGEMENT

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

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

5. New Business - FY2022 Policy Committee Calendar

   MOTION by Kurt Peasley, supported by Jeanne Ladd, to approve the FY2022 Policy Committee Calendar as presented. Motion carried: 4-0.

6. Adjourn

   Ms. O'Boyle adjourned the Board Policy Committee Meeting at 10:12 a.m.

Meeting Minutes respectfully submitted by:
MSHN Executive Assistant

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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: July 19, 2021

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

Agenda Item	Action Required				
CONSENT AGENDA	• Item C – data seems off for CMHCM – Penetration Report • Item D – data for enrolled CMHCM seems off – Penetration Report by Race • Item H – Deputy Director report indicates some variances in performance bonus incentives – racial disparities; MSHN will share further details on this as it goes to Quality and Clinical review. • Item K – HEP C and does MSHN want CMHs to become a HEP C provider; at this point it is just an awareness.				
	Information reports – MSHN will follow up on above bullets	By Who	A. Ittner	By When	N/A
FY 21 Savings Estimates thru May 2021	Leslie reviewed the savings estimates through May 2021 and reminded Ops Council that MSHN will produce these reports every other month until end of year.				
	Discussion ONLY	By Who	N/A	By When	N/A
Projected Lapse Discussion (Continuation from 07/02/2021)	Joe reviewed the board discussion, legal opinions, etc. regarding the use of funds for provider/staff recognition. Discussed regional approach to utilization of projected lapse of 46.9million The regional provider stabilization guidance has the flexibility to allow CMHSP the ability to provide funding for providers struggling with retention, recruitment, etc. MSHN will not approve proposals that would put the region at risk				
	CMHs will submit request to MSHN for additional funds above the PEPM for provider stabilization, staff recognition and retention. MSHN will bring to August Operations Council for review and discussion. Only requests that exceed current contracts (Operating Agreement and Medicaid Sub-Contracting Agreement) would require board consideration/action in September.	By Who	CEO's	By When	8.16.21
RELIAS Contract	Amanda reviewed the proposed increases in the RELIAS contract and options to reduce the increase by extending the term.				
	CMHs authorized MSHN to negotiate the contract and determine best option for the region.	By Who	A. Ittner	By When	9.1.21

Agenda Item	Action Required				
Operations Council Meeting Calendar (Proposed)	Joe reviewed the draft calendar and the continuation of virtual meetings.				
	CMHs supported the continuation of virtual and the meeting schedule. Calendar invites will be sent out.	By Who	J. Sedlock	By When	10.1.21
MiCAL Expansion into MSHN Region (prep for meeting with MDHHS 07/21/2021)	Information has been included in the packet regarding the rollout of MiCAL. Joe, Todd an Amanda will be meeting with MDHHS/MiCAL on 7.21.21. What feedback/concerns can MSHN support the CMHs in the meeting. • Crisis/text line connections vs. CRM • Communication including documentation/meeting minutes/even if draft. • Sanctions included				
	Informational Only	By Who	N/A	By When	N/A
System Redesign – House (and all other)	Robust discussion. Joe discussed MSHN meeting with Al Jansen next week to showcase how successful our region has been and any support or model for the PIHPs. Amanda and Joe will continue to meet with interested parties and potential future partners. If certain outcomes are desired, please identify and MSHN will/can and support those efforts. Solid support from Operations Council for continuing exploration of these current and future relationships and continuing efforts to counter House and Senate Proposals with MSHN performance information.				
	Joe will send on his notes from his testimony regarding the House hearing.	By Who	J. Sedlock	By When	7.31.21
		By Who		By When	
		By Who		By When	
		By Who		By When	
		By Who		By When	

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REGIONAL OPERATIONS COUNCIL/CEO MEETING
Key Decisions and Required Action
Date: August 16, 2021

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

Agenda Item	Action Required				
CONSENT AGENDA	No questions or removals.				
	Approved as presented.	By Who	N/A	By When	N/A
FY22 MSHN Regional Budget	L. Thomas presented the FY22 Budget as reviewed by Finance Council. The rate certification letter has not been received which makes our revenue projections soft. Discussion regarding the DCW and if it will be extended and funded by legislation. If the rate certification is received prior to board meeting; MSHN will revise and sent out to Ops for review. CCBHC cost/revenue is not included in the budget proposal. Discussed approach of presenting a budget proposal to the board regarding DCW regional continuation				
	Endorsed and recommended for MSHN Board approval as presented with the inclusion of MSHN Board motion on DCW regional continuation (if/then/else); Next step for September Board	By Who	J. Sedlock	By When	9.1.21
FY22 Medicaid Subcontracting Agreement Review	A. Ittner reviewed the change log and related changes presented for approval on the FY22 Medicaid Subcontracting Agreement • Pg. 139 (reading level) says 6.9 should be 6.				
	Ops to review and provide any feedback by end of week; after 8/20, will be considered final. FY22 contracts will be sent out by end of August to CMHs.	By Who	A. Ittner	By When	8.21.21
FY22 Training Grid Review	Training Grid Options for IF's: training coordinators and possibly PNC will bring back any recommendations for inclusion.				
	Ops to review and provide any feedback by end of week. After 8/20, will be considered final.	By Who	A. Ittner	By When	8.21.21
FY22-23 MSHN Strategic Plan – Final Draft Review	J. Sedlock reviewed the draft strategic planning document and added task/activity to support the priorities/goals.				
	Operations Council endorsed the strategic plan for MSHN; approval by MSHN Board	By Who	J. Sedlock	By When	9.14.21

Agenda Item	Action Required				
System Redesign-Ongoing Dialog/Discussion/Regional Strategies	C. Pinter discussed the survey link that Shirkey sent out on the proposal. CMHs weighed in on the proposals by Shirkey. CMHAM has come out in favor of responding.				
	Discussion Only	By Who	N/A	By When	N/A
Regional COVID related updates/planning	Question on booster vaccine;				
	MSHN will check and send out communication	By Who	A. Ittner	By When	8.21.21

MSHN
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2021 Board Nominating Committee Meeting
June 29th, 2021 – 11:00 AM

Board Committee Members Present: Kerin Scanlon; Chairperson, Steve Johnson, Deb McPeek-McFadden

MSHN Staff Present: Sherry Kletke, Executive Assistant; Joseph Sedlock, Chief Executive Officer

1. **Call to Order:**
   Chairperson Kerin Scanlon called the meeting to order at 11:02 a.m.

2. **Review of MSHN Board Survey**:
   Chairperson Kerin Scanlon shared the Board Survey results showing a total response rate of 67% (16 responses).

3. **Considerations for Putting Forward a Slate of Officer Candidates:**
   The Nominating Committee discussed the slate of officer Candidates. Ms. Kerin Scanlon will reach out to those candidates. 14 of the 16 respondents indicated they were not interested in a board leadership position. Many respondents nominated existing officers or other board members for seats as officers. Several individuals nominated had responded to the survey that they were not interested in an officer position. The committee determined to honor these statements and will not bring those nominees forward for election. The committee also discussed possible options for filling the "Past President or Officer" position, if necessary, based on the election results.

4. **Board Officer Candidate Nominee Information/Survey :**
   The Nominating Committee reviewed the Nominee Information Form that will be used for the September 2021 elections, which is based on bylaws conditions for office holders and other information requested of candidates in the past. Only the candidates will be asked to complete the Nominee Information Form. MSHN staff will send the form to each of the candidates to be completed and completed forms will be included in the September Board packet. The committee agreed to accept the Nominee Information Form as presented.

5. **Board Officer Elections Ballots:**
   The Nominating Committee reviewed the Ballot Form that will be used for the September 2021 elections. The committee agreed to accept the Ballot Form as presented.

6. **Board Officer Elections Procedures for September Elections:**
   The Nominating Committee agreed that elections will begin with the Chair, then the Vice-Chair and then the Secretary, unless there are multiple candidates for a certain office (which would be done first). The Chairperson of the Nominating Committee and the Executive Assistant will count the ballots in a location visible to the Board Members. Mr. Sedlock will

discuss the voting process with Board chair, Mr. Ed Woods, to allow Nominating Committee Chairperson, Ms. Kerin Scanlon, to run the election in September, since he will be standing for election.

7. **Other Business:**
Ms. Deb McPeek-McFadden wished to acknowledge Ms. Kerin Scanlon's work at being Nominating Committee Chair and Mr. Steve Johnson joined her in expressing appreciation and thanks her for her leadership.

8. **Adjournment:**
Chairperson Kerin Scanlon adjourned the meeting at 11:19 a.m.

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2021 Board Nominating Committee Meeting Minutes
August 20, 2021 – 10:00 AM

Board Committee Members: Kerin Scanlan, Chairperson, Steve Johnson, Deb McPeek-McFadden
MSHN Staff: Joseph Sedlock, Chief Executive Officer

AGENDA

1. **Call to Order:** Chairperson Scanlon called this meeting of the MSHN Board Nominating Committee to order at 10:13 AM

2. **Committee Chair Update:** Chairperson Scanlon has been in touch with several board members who were nominated for officer positions but that indicated in their interest survey that they were not interest in an officer position. These potential candidates are willing to serve in an Executive Committee At-Large capacity, but do not wish to be considered for officers at this time. The current Ex-Officio member would rotate off of the Executive Committee. The current acting secretary, who would become an ex-officio member of the Executive Committee is willing to serve, but is recommending new members of the Executive Committee for potential future officer roles. Mr. Sedlock indicated there is no provision or rule for At-Large members, nor is there a rule about having more than one at large member.

   Chairperson Scanlon will finish calls to potential at-large candidates and will send an email to the committee with results. Administration will distribute board officer candidate surveys to identified At-Large candidates and request return.

   The Committee noted that board action will be needed to create Executive Committee At-Large positions. Administration will assist Chairperson Scanlon by preparing a motion summary with background on the creation of At-Large members of the Executive Committee for inclusion in the board meeting packet.

   Administration will include all board officer/election candidate survey forms in the board meeting packet.

3. **Elections Process Finalization:** J. Sedlock confirmed with Board Chairperson Woods that since he is standing for election to office, the board elections process will be operated by Nominating Committee Chairperson Scanlon. The committee discussed acquiring the vote of board members present by phone (assuming a quorum present at the meeting location). Administration will establish a process for Board members present by phone to submit their vote by email to MSHN Executive Assistant Sheryl Kletke, who will show the vote to Nominating Committee Chairperson Scanlon to confirm and include in vote totals. The Committee recognized that this may briefly delay reporting result.

4. Adjourned 10:30 a.m.

MSHN
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POLICIES AND PROCEDURE MANUAL

Chapter:	**Information Technology**		
Title:	**Breach Notification Policy**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** ~~Annually~~Biennial **Author:** Chief Information Officer	**Adopted Date: 01.09.2018** **Review Date:** ~~09.10.2019~~06.28.2021 **Revision Eff. Date:**	**Related Policies:** Information Management Policy

Purpose

To ensure that Mid-State Health Network (MSHN) maintains HIPAA security breach notification policies and procedure that meet legal and regulatory standards under the Medicaid Specialty Supports and Services contract and federal and state privacy guidelines and to ensure compliance with notification requirements.

Policy

Mid-State Health Network, a HIPAA Covered Entity (CE), and its Business Associates (BA) must provide notification following the discovery of a breach of unsecured protected health information in accordance with 45 CFR §§ 164.400-414 (notification in the case of breach of unsecured protected health information).

Notification by a Business Associate to Mid-State Health Network as the Covered Entity:
A Business Associate shall notify Mid-State Health Network immediately following the discovery of a breach of unsecured protected health information as outlined in the Breach Notification Procedure. Mid-State Health Network, as the Covered Entity, is responsible for breach notification to the individual, Secretary of Health and Human Services, and the media, as required, unless delegated to the Business Associate and stated in the Business Associate Agreement.

Notifications are required if the breach involved unsecured protected health information. Encryption and destruction are technologies and methodologies for rendering PHI unusable, unreadable, or indecipherable to unauthorized individuals. Covered entities and Business Associates that secure information as specified by this guidance are not required to provide notifications following the breach of such information.

Policies and Procedures:
MSHN and its Provider Network must have in place written policies and procedures regarding privacy of PHI and breach notification in compliance with applicable laws and regulations.

Training:
MSHN and its Provider Network must be trained on the policies and procedures with respect to protected health information, privacy and security practices, and breach notification as necessary and appropriate for personnel to carry out their duties.

Refraining from Intimidating or Retaliatory Acts:
MSHN and its Provider Network may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual for the exercise by the individual of any right established, or for participation in any process provided for, by this procedure or any Privacy Practices, including the filing of a complaint under this section;

Waiver of Rights:
Mid-State Health Network will not require individuals to waive their rights under federal privacy laws as a condition of the provision of treatment, payment, enrollment or eligibility for benefits.

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 Provider

Definitions

Business Associate: A HIPAA business associate is any organization or person working in association with or providing services to a covered entity who handles or discloses Personal Health Information (PHI) or Personal Health Records (PHR).
Covered Entity: A HIPAA covered entity is any organization or corporation that directly handles Personal Health Information (PHI) or Personal Health Records (PHR). The most common examples of covered entities include hospitals, doctors' offices and health insurance providers.
Breach: An impermissible use or disclosure under the HIPAA Privacy Rule that compromises the security or privacy of the protected health information.
Unsecured Protected Health Information: protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section13402(h)(2) of Public Law 111–5 (HITECH Act) on the HHS Web site.
Workforce: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for Mid-State Health Network or a business associate, is under the direct control of Mid-State Health Network or a business associate, whether or not they are paid by Mid-State Health Network or a business associate.
Intimidating or Retaliatory Act: To demote, terminate, withhold pay, or suspend a person for filing a complaint, participating in an investigation, or opposing an unlawful act, related to HIPAA privacy and security breach notification.

Other Related Materials

MSHN Compliance Plan

References/Legal Authority

45 CFR § 164 Privacy of Individually Identifiable Health Information
45 CFR § 164.400-414 Breach Notification Rule
Public Law 111-5 Health Information Technology for Economic and Clinical Health Act (HITECH Act)

Change Log:

Date of Change	Description of Change	Responsible Party
06.21.2017	New Policy	Chief Information Officer
06.2018	Annual Review	Chief Information Officer
06.2019	Annual Review	Chief Information Officer
06.2021	Biennial Review	Chief Information Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Information Technology		
Title:	Disaster Recovery		
Policy: ☒ Procedure: ☐ Page: 1 of 1	Review Cycle: ~~Annually~~Biennial Author: Chief Information Officer	Adopted Date: 07.07.2020 Review Date: 06.28.2021 Revision Eff. Date:	Related Policies: Information Management Policy

Purpose

To ensure that Mid-State Health Network (MSHN) maintains a disaster recovery plan to provide information for management and workforce members to ensure recovery from a loss of data due to an emergency or disaster such as fire, vandalism, terrorism, system failure, or natural disaster affecting systems and processes that contain protected health information.

Policy

Mid-State Health Network will maintain a disaster recovery plan. The disaster recovery plan will be reviewed ~~annually~~ biennially and communicated to all staff.

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 Provider

Definitions

Protected Health Information: health information that can be used to individually identify persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section13402(h)(2) of Public Law 111–5 (HITECH Act) on the HHS Web site.

Workforce: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for Mid-State Health Network or a business associate, is under the direct control of Mid-State Health Network or a business associate, whether or not they are paid by Mid-State Health Network or a business associate.

Other Related Materials

MSHN Disaster Recovery Plan

References/Legal Authority

Administrative Safeguards - HIPAA Section 164.308(a)(7)
Public Law 111-5 Health Information Technology for Economic and Clinical Health Act (HITECH Act)

Change Log:

Date of Change	Description of Change	Responsible Party
02.03.2020	New Policy	Chief Information Officer
06.2021	Biennial Review	Chief Information Officer

Chapter:	Information Technology		
Section:	Medicaid Information Management Policy		
Policy ☒ Procedure ☐ Page: 1 of 2	Review Cycle: ~~Annually~~Biennial Author: Chief Information Officer	Adopted Date: 11.22.2013 Review Date: ~~09.10.2019~~06.28.2021 Revision Eff. Date:	Related Policies: N/A

Purpose

To ensure that all CMHSP participants in Mid-State Health Network (MSHN) maintain Information Services practices that are adequate to fulfill their obligations under the Medicaid Specialty Supports and Services contract. This policy and all related procedures shall apply only to those Information Management activities involving the use of Medicaid funding.

Policy

MSHN shall ensure that each CMHSP participant has an effective information system that complies with requirements established by federal and state statutes and the MDHHS contract for Medicaid Specialty Supports and Services. Each CMHSP participant Information System must have mechanisms for collecting, managing, and submitting required data.

A. MSHN Information Services Responsibilities

1. MSHN shall distribute Medicaid enrollment files to each CMHSP participant.
2. MSHN shall maintain mechanisms to collect MDHHS required information from CMHSPs, aggregate it as necessary, submit it to MDHHS and provide appropriate feedback to CMHSPs.
3. MSHN shall ensure compliance by review and monitoring of data submission and reports as well as conducting CMHSP site visits as necessary.

B. CMHSP Information Services Responsibilities

1. Each CMHSP participant shall maintain current knowledge of all MDHHS technical advisories and expectations related to Information Technology standards, reporting requirements and data submissions.
2. Each CMHSP participant shall timely and accurately report required data in accordance with MSHN and MDHHS requirements.
3. Each CMHSP participant shall meet HIPAA Privacy, Security, HITECH Act and BBA standards for information system functions as delegated by MSHN and shall provide evidence of compliance upon request.

C. Monitoring and Oversight

1. The MSHN Chief Information Officer (CIO) will monitor performance of the information systems functions and shall review MSHN policy ~~annually~~ biennially with CMHSP participant CIOs.
2. External review will be conducted annually and will include MDHHS and External Quality Review on-site visits and reporting.

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:
BBA: The Balanced Budget Act of 1997
CMHSP: Community Mental Health Service Provider
HIPAA: Health Insurance Portability and Accountability Act
HITECH: Health Information Technology for Economic and Clinical Health
IT: Information Technology
MDHHS: Michigan Department of Health and Human Services
PIHP: Prepaid Inpatient Health Plan

Other Related Materials
Data Validation Procedure
Information Management Procedure
MSHN Compliance Plan

Monitoring and Review Completed By
The MSHN Chief Information Officer (CIO) shall monitor performance of the information systems functions and shall review MSHN policy annually with CMHSP participant CIOs.

References/Legal Authority
Medicaid Managed Care provisions of the Balanced Budget Act (BBA) of 1997
Health Insurance Portability and Accountability Act (HIPAA) of 1996
Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009
MDHHS Medicaid Specialty Supports and Services Contract

Change Log:

Date of Change	Description of Change	Responsible Party
11.22.2013	New Policy	IT Council
09.2014	Annual Review with new policy format	Chief Executive Officer
10.2015	Annual Review	Chief Information Officer
06.2017	Annual Review	Chief Information Officer
06.2018	Annual Review	Chief Information Officer
06.2019	Annual Review	Chief Information Officer
06.2021	Biennial Review	Chief Information Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	Information Technology		
Title:	Record Retention Policy		
Policy: ☒ Procedure: ☐ Page: 1 of 2	Review Cycle: ~~Annually~~Biennial Author: Chief Information Officer	Adopted Date: 09.02.2014 Review Date: ~~09.10.2019~~06.28.2021 Revision Eff. Date:	Related Policies: HIPAA Information Management Disaster Recovery

Purpose

To ensure that Mid-State Health Network (MSHN) maintains Record Retention practices that meet legal and regulatory standards under the Medicaid Specialty Supports and Services contract, the State of Michigan Records Retention and Disposal Schedule, and federal and state financial guidelines, including Health Insurance Portability & Accountability Act (HIPAA).

Policy

MSHN shall have effective record retention policies and procedures that comply with requirements established by the Michigan Department of Health and Human Services (MDHHS) contract for Medicaid Specialty Supports and Services and the State of Michigan Records Retention and Disposal Schedule, and federal and state statutes, including HIPAA. This policy is also intended to eliminate accidental or innocent destruction of records, as well as promote efficiency and reducing unnecessary storage of documents.

MSHN record retention policies and procedures must have mechanisms for securely storing and retaining/destroying data as required and recommended.

- MSHN shall annually review their administrative files.
- Records shall be retained/disposed according to State of Michigan Records Retention and Disposal Schedule and federal and state legal and regulatory standards.
- All records disposal will be done in a manner ensuring confidentiality of protected data.

MSHN shall ensure compliance by reviewing and monitoring record retention policies and procedures as well as conducting site visits as necessary.

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

MSHN: Mid-State Health Network
CMHSP: Community Mental Health Services Program
IS: Information Services or Information Systems
IT: Information Technology
MDHHS: Michigan Department of Health and Human Services
PIHP: Prepaid Inpatient Health Plan
BBA: The Balanced Budget Act of 1997
HIPAA: Health Insurance Portability & Accountability Act

Other Related Materials
Data Validation Procedure
Information Management Procedure
MSHN Compliance Plan

References/Legal Authority
Medicaid Managed Care provisions of the Balanced Budget Act (BBA) of 1997
Health Insurance Portability and Accountability Act (HIPAA) of 1996
MDHHS Medicaid Specialty Supports and Services
Contract
MDHHS Medicaid Provider Manual
Michigan DTMB Community Mental Health Record Retention Schedule
https://www.michigan.gov/dtmb/0,5552,7-358-82548_21738_31548-56101--,00.html (refer to GS20)

Change Log:

Date of Change	Description of Change	Responsible Party
03.13.2014	New Policy	K. Tilley
05.18.2016	Annual Review	F. Goodrich
06.21.2017	Annual Review	Chief Information Officer
06.2018	Annual Review	Chief Information Officer
06.2019	Annual Review	Chief Information Officer
06.2021	Biennial Review	Chief Information Officer

MSHN
Mid-State Health Network

POLICIES AND PROCEDURES MANUAL

Chapter:	**Provider Network Management**		
Section:	**Provider Network Management**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 4	**Review Cycle:** Annually **Author:** Provider Network Management Committee	**Adopted Date: 12.03.2013** **Review Date:** 03.03.2020 **Revision Eff. Date:**	**Related Policies:** SUD Direct Service Provider Procurement MSHN Procurement Policy

Purpose

To establish guidelines for the development and management of the Mid-State Health Network (MSHN) provider network and CMHSP Service Delivery System; to establish standardized systems and processes for the provider network and contract management administration and oversight across MSHN.

Policy

A. Network Monitoring and Oversight

1. MSHN shall execute a standard written agreement with each CMHSP Participant/Substance Use Disorder Service Provider (SUDSP) to establish CMHSP Participant/SUDSP responsibilities and ensure compliance with all applicable federal and state standards and requirements including those of the Balanced Budget Act, Medicaid Provider Manual and the Medicaid Specialty Services and Supports Contract.

2. MSHN will monitor CMHSP Participants/SUDSPs at least annually in order to assure the safety, protection, and welfare of consumers/service recipients and to assure compliance with MSHN Policies and all applicable laws and contractual obligations. Such monitoring shall include, but not be limited to, Medicaid claims verification, provider training and credentialing, clinical documentation review, utilization management, and the review of customer services, person-centered planning, and quality assurance activities. Annually, MSHN will additionally conduct formal Risk Assessment for each SUDSP provider, which summarizes risk information not fully captured in the site review process. Risk level will be considered during the following times:

   A. Organizational provider recredentialing (biennially) and will be used to determine ongoing participation in the network.
   B. When SUDSP seeks contract expansion (i.e. new site or new services).
   C. When SUDSP requests additional cost reimbursement funding (lesser of 50% increase in annual allocation or total cost reimbursement over $100,000 at the discretion of the MSHN Chief Financial Officer).

23. CMHSP Participants/SUDSPs unable to demonstrate acceptable performance shall be required to provide corrective action including but not limited to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN.

B. Network Adequacy/Sufficiency

1. MSHN shall ensure an adequate and sufficient network of providers through a variety of mechanisms including, but not limited to, the development of a comprehensive list of all providers in the region, regular reviews of access and availability data, review of annual CMHSP Community Needs Assessments and Demand for Services data, review of utilization reports, and solicitation of stakeholder input.

2. Each CMHSP Participant shall conduct a local assessment of community need consistent with the MDHHS Guidelines for Community Needs Assessment. This assessment shall aid in informing decisions related to the sufficiency and adequacy of the provider network to address local needs and priorities. The assessment shall also determine whether services are available in accordance with MDHHS and Medicaid Provider Manual requirements.

3. Annually MSHN shall evaluate the needed and actual capacity of its provider network via a review of available data sources. MSHN shall consider, at a minimum, anticipated Medicaid enrollment, expected utilization, and required numbers and types of providers, number of network providers not accepting new beneficiaries, geographic location of providers and beneficiaries, the distance, travel time, and the availability of transportation including physical access for beneficiaries with disabilities. MSHN shall also consider the availability of local inpatient beds, crisis capacity, local alternatives to residential care, and regional alternatives to segregated day service in its decisions about network capacity and sufficiency. Consumer satisfaction with the existing service array shall also be reviewed and considered in this annual assessment.

4. Based on this analysis MSHN may redistribute resources per the Operating Agreement where necessary to ensure timely access and necessary service array to address consumer demands. MSHN will explore economies of scale in purchasing, rate setting, regional capacity development and other efficiencies. MSHN shall also annually produce a plan from its evaluation findings and shall develop recommendations for network development.

C. MSHN shall monitor and maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract for all eligible persons including those with limited English proficiency or physical or mental disabilities. MSHN will ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

D. CMHSP Service Delivery System

1. Development and management of the CMHSP Service Delivery System are functions delegated by the PIHP to the CMHSP Participants. Contracts executed between CMHSPs and subcontractors shall be consistent in terms of provider expectations, though documents may differ among CMHSPs. CMHSP Participants shall develop mechanisms for sharing application materials, provider monitoring/auditing reports, and provider training and credentialing when contracting with common providers in the region.

2. MSHN shall require each CMHSP Participant to have written policies and procedures and to maintain evidence of compliance with network development standards that meet state and federal requirements. This includes:
   i. Public, fair, and open processes for provider selection, provider qualification programs or other similar valid processes taking place on a regular or reoccurring basis.
   ii. Consumer input in CMHSP provider selection processes where feasible, that includes new program development or service array expansion to meet local needs where indicated.
   iii. Provider orientation and training for specific service delivery needs that meet requirements and conforms with applicable best practices, and methods to identify new workforce training needs.
   iv. Verification of provider qualifications and credentials required for service delivery responsibilities.
   v. An assigned individual at each CMHSP who is responsible to maintain compliance and consistency with standards and requirements in this area.
   vi. Compliance with State and Federal Procurement Guidelines.

3. Each CMHSP Participant shall assign staff to carry out the network development and management functions delegated by the PIHP in a manner consistent with the standards and requirements established by MDHHS, the BBA and MSHN.

E. SUDSP Service Delivery System

1. Development and management of the SUDSP service delivery system is a retained function of the PIHP. MSHN impanels SUDSPs in accordance with the MSHN SUD Direct Service Provider Procurement Policy. Contracts executed between MSHN and SUDSPs shall be consistent in terms of provider expectations, though documents may differ among SUDSPs.

2. MSHN shall require each SUDSP to have written policies and procedures and to maintain evidence of compliance with network development standards that meet state and federal requirement. This includes:

   i. Provider orientation and training for specific service delivery needs that meet requirements and conform with applicable best practices, and methods to identify new workforce training needs.
   ii. Verification of provider qualifications and credentials required for service delivery responsibilities.
   iii. An assigned individual who is responsible to maintain compliance and consistency with standards and requirements in this area.
   iv. Compliance with State and Federal Procurement Guidelines.

F. Provider Qualifications and Credentialing

1. MSHN shall ensure that CMHSP Participants/SUDSP comply with all MDHHS guidelines and federal regulations related to credentialing, re-credentialing, and primary source verification of professional staff, as well as the qualifying of non-credentialed staff, and in accordance with MSHN policies and procedures. MSHN will monitor CMHSP/SUDSP credentialing and qualifying activities at least annually to ensure compliance with these standards.

G. Conflict of Interest

1. All CMHSP Participants/SUDSPs will consistently function with integrity, in compliance with requirements of all applicable laws, utilizing sound business practices, and with the highest standards of excellence.

H. Payment Liability

1. MSHN shall ensure that CMHSP Participants/SUDSPs comply with enrollee rights related to payment liability. Written agreements shall ensure that beneficiaries are not held liable when the PIHP does not pay the health care provider furnishing services under the contract.

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

Definitions/Acronyms:
CMHSP: Community Mental Health Service Programs
MDHHS: Michigan Department Health and Human Services
MSHN: Mid-State Health Network, the Prepaid Inpatient Health Plan
SUDSP: Substance Use Disorder Service Provider

Related Procedures
N/A

Monitoring and Review Completed By:

This policy shall be reviewed annually by the MSHN Director of Provider Network Management in collaboration with CMHSP Participants. Compliance with this policy shall be ensured through any of the following: Annual monitoring of CMHSP Participants (i.e. delegated managed care), review of data and submitted reports, and/or on-site visits. External monitoring by MDHHS and/or accreditation bodies may also occur.

References/Legal Authority

- BBA 438.214(b)(2) Provider Selection
- Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program (which includes attachment P.7.1.1)
- Medicaid Provider Manual
- Federal Procurement Guidelines (The Office of Federal Procurement Policy (OFPP) - Office of Management and Budget)
- MSHN Procurement Policy
- MSHN SUD Direct Service Provider Procurement Policy
- Provider Risk Assessment Profile

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New Policy	Provider Network Mgmt Committee
12.2014	Annual Review	Provider Network Mgmt Committee
03.2016	Annual Review and Revisions	Provider Network Mgmt Committee
08.24.2017	Annual Review and Revisions	Provider Network Mgmt Committee
09.2018	Annual Review, No Revisions	Provider Network Mgmt Committee
09.2019	Annual Review	Director of Provider Network Mangement
2020	Risk Assessment for SUDSPs	Director of Provider Network Management