Southwest Michigan

BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting
5250 Lovers Lane, Portage, MI 49002
Dial in: 1-844-655-0022
Access Code: 738 811 844
January 10, 2020
9:30 am to 11:30 am
Draft: 1/7/20

1. **Welcome Guests/Public Comment**

2. **Agenda Review and Adoption (d)**

3. **Financial Interest Disclosure Handling (M. Todd)**

4. **Consent Agenda**

    - December 13, 2019 SWMBH Board Meeting Minutes (d)

5. **Operations Committee**

    a. 11/20/19 Operations Committee Meeting Minutes (d) (D. Hess)
    b. Operations Committee Quarterly Report (d) (D. Hess)

6. **Ends Metrics Updates**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?

    a. Autism Spectrum Disorder Family Training (d) (R. Freitag)
    b. Tools Update (d) (M. Kean)
        i. *Intellectual Developmental Disabilities (Supports Intensity Scale)
        ii. *Substance Use Disorders (American Society of Addiction Medicine)
        iii. *Serious Mental Illness (Level Of Care Utilization System)
        iv. *Serious Emotional Disturbances (Child and Adolescent Functional Assessments Scale)

7. **Board Actions to be Considered**

    a. Fiscal Year 2020 Revised Budget (attachment) (T. Dawson)
    b. Credentialing of Behavioral Health Practitioners Policy (d) (M. Todd)
    c. Credentialing of Behavioral Health Organizational Providers Policy (d) (M. Todd)
    d. 2020 Quality Assurance and Performance Improvement Plan (d) (J. Gardner)
    e. Board Resolution (d)

8. **Board Policy Review**
Is the Board in Compliance? Does the Policy Need Revision?

   a. BG-001 Committee Structure (d)
   b. BG-004 Board Ends and Accomplishment (d)
   c. BG-007 Code of Conduct (d)

9. **Executive Limitations Review**
Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?

   - BEL-001 Budgeting (d) (M. McShane)

10. **Board Education**

    a. Fiscal Year 2020 Utilization Management Plan (d) (A. Wickham)
    b. Fiscal Year 2019 Customer Services Report (d) (S. Ameter)
    c. Michigan Health Endowment Fund Grant Update (M. Kean)
    d. Annual Board Compliance Education (d) (M. Todd)
    e. Fiscal Year 2019 Program Integrity Compliance Report (d) (M. Todd)

11. **Communication and Counsel to the Board**

    a. Fiscal Year 2020 Year to Date Financial Statements (d) (B. Casemore)
    b. Fiscal Year 2019 Medicaid Services Verification Report (d) (M. Todd)
    c. Board Member Attendance Roster (July-December 2019) (d)
    d. March 13, 2020 Draft Board Agenda (d)
    e. Public Policy Legislative Event (d)
    f. SWMBH Board Resignation (d)
    g. Death Audit Recoupment (d)
    h. May 2020 Board Retreat Draft Agenda (a)
    i. MDHHS System Reform Public Forums (d)
    j. MDHHS Letter on SWMBH Risk Management Strategy (d)
    k. 2020 Govern for Impact Forum (d)
    l. Healthcare Affordability State Policy Scorecard (d)
    m. Community Mental Health Association of Michigan Letter from DHHS (d)

12. **Public Comment**

13. **Adjournment**

Next SWMBH Board Meeting and Budget Hearing
March 13, 2020
9:30 am - 11:30 am
5250 Lovers Lane, Portage, MI 49002

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
December 13, 2019
9:30 am-11:30 am
5250 Lovers Lane, Suite 200, Portage, MI 49002
Draft: 12/19/19

Members Present: Tom Schmelzer, Edward Meny, Susan Barnes, Robert Nelson, Moses Walker, Patrick Garrett, Michael McShane

Guests: Bradley Casemore, Executive Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Joel Smith, Substance Use Treatment & Prevention Director, SWMBH; Jon Houtz, Pines Behavioral Health Alternate; Karen Lehmann, Woodlands Alternate; Deb Hess, Van Buren Community Mental Health; Susan Germann, Pines Behavioral Health; Ric Compton, Riverwood; Jane Konyndyk, Integrated Services of Kalamazoo; Brad Sysol, Summit Pointe; Janet Bermingham, St. Joseph County; Richard Thiemkey, Barry County Community Mental Health; Natalie Spivak, Chief Information Officer, SWMBH; Robert Schleichert, Interim Chief Information Officer, SWMBH; Michelle Jorgboyan, Senior Operations Specialist and Rights Advisor, SWMBH

Welcome Guests

Tom Schmelzer called the meeting to order at 9:30 am, introductions were made, and Tom welcomed the group.

Public Comment

None

Agenda Review and Adoption

Motion	Edward Meny moved to accept the agenda as presented.
Second	Patrick Garrett
Motion Carried	

Financial Interest Disclosure Handling

Mila Todd distributed a financial interest disclosure statement from Brad Casemore to each Board member. Board discussed and determined that no new Conflict of Interest Waiver needs to be granted regarding Brad Casemore's financial interest disclosure. Mila Todd will draft a consideration form for Tom Schmelzer to sign.

Consent Agenda

Motion	Patrick Garrett moved to approve the November 8, 2019 Board meeting minutes as presented.
Second	Susan Barnes
Motion Carried	

Operations Committee

Operations Committee Minutes October 30, 2019

Tom Schmelzer asked for comments or questions. Minutes accepted. Tom Schmelzer thanked the Operations Committee for their work and how it helps the Board to understand various issues.

Board Actions to be Considered

Financial Risk Management Plan

Tracy Dawson reported as documented.

Motion Robert Nelson moved to accept the Financial Risk Management Plan as presented.

Second Patrick Garrett

Motion Carried

Financial Management Plan

Tracy Dawson reported as documented.

Motion Edward Meny moved to accept the Financial Management Plan as presented.

Second Patrick Garrett

Motion Carried

Cost Allocation Plan

Tracy Dawson reported as documented and noted that SWMBH is the only PIHP that has a cost allocation plan.

Motion Patrick Garrett moved to accept the Cost Allocation Plan as presented.

Second Susan Barnes

Motion Carried

Policy and Events Calendar

Michelle Jorgboyan reported as documented.

Motion Robert Nelson moved to accept the Policy and Events calendar with a change to move his Policy review from April to June.

Second Susan Barnes

Motion Carried

Board Policy Review

BG-005 Chairperson's Role

Tom Schmelzer reviewed the policy as presented.

Motion Patrick Garrett moved that policy BG-005, the Board is in compliance and the policy does not need revision.

Second Edward Meny

Motion Carried

Executive Limitations Review

BEL-003 Asset Protection

Patrick Garrett reported as documented and noted the importance of this policy, commenting that SWMBH management does a good job.

Motion : Patrick Garrett moved that the Executive Officer is in compliance with BEL-003 Asset Protection and the policy does not need revision.

Second Robert Nelson

Motion Carried

Board Education

Fiscal Year 2020 Year to Date Financial Statements

Tracy Dawson reported as documented noting that she was still awaiting information from the Department regarding corrected revenue.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) Historical Data Report

Joel Smith reported as documented.

Year End Accomplishments Summary

Brad Casemore reported as documented. Tom Schmelzer commented on the tremendous work and many accomplishments of SWMBH during the last year. SWMBH staff were brought into the Board meeting so that the Board members could thank the staff personally. Robert Nelson requested a Board resolution formally acknowledge and thanking staff for their accomplishments. A resolution will be drafted for approval at the January's Board meeting.

Communication and Counsel to the Board

Fiscal Year 2020 Risk Management Letter

Tracy Dawson reported as documented. Robert Nelson suggested that the letter be re-sent to John Duvendeck' s replacement about one month after they take office.

Office of Recovery Oriented Systems of Care (OROSC) State Opioid Response Grant (SOR) Site Visit Review Results

Joel Smith reported as documented.

Board Membership Roster and Board Members' Attendance Roster

Brad reported as documented.

Aetna MI Health Link Claims Audit

Anne Wickham reported as documented, noting 100% compliance and thanked SWMBH staff, Gina Martuge who processes all claims for SWMBH.

MI Health Link: Review of Evaluation Findings

Brad Casemore noted the report in the packet for the Board's review, adding that he sent a response letter to MDHHS regarding flaws in the evaluation process.

St. Joseph CMHSAS Letter

Brad Casemore reported as documented.

MDHHS Director Gordon Opinion

Brad Casemore noted the article in the packet for the Board's review.

MDHHS Future of Behavioral Health Presentation

Brad Casemore noted the presentation in the packet for the Board's review. Moses Walker commented that these kinds of talks have been going on for a long time at the State.

MDHHS Future of Behavioral Health Fact Sheet

Brad Casemore noted the fact sheet in the packet for the Board's review.

Fiscal Year 2020 Supplemental Funding

Brad Casemore reported as documented and commented that nothing specifically benefits SWMBH in this supplemental bill.

February Board Meeting – RSVPs

Brad Casemore requested each Board member to determine their availability for a February 2020 Board meeting. Based on the number of Board members who will be unavailable a motion was made to cancel the February Board meeting.

Motion Susan Barnes moved to cancel the February 14, 2020 Board meeting.
Second Edward Meny
Motion Carried

Public Comment

None

Adjournment

Motion Edward Meny moved to adjourn at 10:45am.
Second Robert Nelson
Motion Carried

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: November 20, 2019
9:00am-2:00pm

Members Present – Debbie Hess, Jeannie Goodrich, Jeff Patton, Jane Konyndyk, Richard Thiemkey, Ric Compton and Bradley Casemore

Members Present via conference call – Kris Kirsch, Kathy Sheffield, Sue Germann

Guests – Tracy Dawson, Chief Financial Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Beth Guisinger, Manager of UM & Call Center, SWMBH; Michelle Jorgboyan, Senior Operations Specialist and Rights Advisor, SWMBH; Brad Sysol, Summit Pointe, Pat Davis, ISK

Call to Order – Debbie Hess began the meeting at 9:00 am.

New Chief Information Officer (CIO) Introduction – Brad Casemore introduced Natalie Spivak as SWMBH's new Chief Information Officer (CIO). Natalie Spivak introduced herself.

Review and approve agenda – Agenda approved with addition of yesterday's conference call with MDHHS.

Review and approve minutes from 10/30/19 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2019 YTD Financials – Tracy Dawson reported that financials in the packet are the same ones that were presented to the Board on 11/8/19.

Fiscal Year 2020 YTD Financials – Tracy Dawson stated that financials will be finished as email out on 11/21/19.

Fiscal Year 2020 Performance Bonus Incentive Program (PBIP) and Performance Improvement Plan – Brad Casemore reported as documented. Group discussed formulas and methodology and agreed to bring this topic back to next month's meeting. Brad Casemore pointed out that PBIP is state imposed, non-negotiable and began 10/1/19.

Public Policy Environment – Brad Casemore shared that he attended Gov. Whitmer's recent press announcement and made contact with Dr. Joneigh Khaldun, Chief Medical Executive and Chief Deputy Director for Health for the Michigan Department of Health and Human Services. Brad Casemore also shared that MDHHS is scheduling round robin calls with PIHPs and CMHSPs.

Opioid Health Homes (OHH) – Brad Casemore reviewed the history of OHH and noted that this is a conceptual model as opposed to a brick and mortar facility. OHH is scheduled to begin on 07/01/20. Jeannie Goodrich and Jane Konyndyk said that they are discussing and reviewing data and local providers. Meetings are ongoing.

Cass Woodlands Authority Status – Kathy Sheffield updated the group on recent Woodlands updates. Discussion followed.

Assessment of Behavioral Health Treatment Episode Data Set (BH TEDS) – Pat Davis shared that the State has formed two workgroups to review and develop rates, methodology, and rates around service codes, noting that four markers from BH TEDS are being used for rates; education level, labor force status, school attendance status and employment status. Brad Casemore stated that the Milliman Drive Tool License agreement was signed, and this should assist in research, insight and validation of historical experience data. Tracy Dawson is leading a review and reporting effort.

Electronic Uploading of Substance Use Disorder (SUD) Behavioral Health Treatment Episode Data Set (BH TEDS) – Anne Wickham stated that the project is on track for December and the schema is going to IT on Monday.

Michigan Health Link (MHL) Inpatient Psychiatric Diversion – Anne Wickham stated that Utilization Management is working with Dr. Ramesh on information that SWMBH needs from hospitals in order to admit or deny admissions for clients. Beth Guisinger stated that SWMBH is asking CMHSP crisis to see clients that are open and receiving services through their CMHSP to reduce unnecessary repeated inpatient admissions. SWMBH's goal is to provide better service for the individual and increase diversions of inpatient hospitalizations. SWMBH is working with Integrated Services of Kalamazoo and Summit Pointe to improve coordination of care regarding this issue. Anne Wickham will resend the written criteria for prescreens and diversions. Discussion followed

Fiscal Year 2019 Encounters and Medicaid Utilization Net Cost (MUNC) – Tracy Dawson reported as documented and noted that October's payment from the State was smaller than expected, the State admitted an error on their part and a payment adjustment is coming.

2020 Operations Committee Meetings – Debbie Hess reviewed the 2020 Operations Committee meeting date conflicts that arose in January and July. Group agreed to move January and July meetings to the fifth Wednesday of the month. Michelle Jorgboyan to revise send calendar and calendar invitations for those two months.

Psychiatric Residential Treatment Facilities (PRTF) – Brad Casemore reported as documented. Discussion followed. Moira Kean will continue to monitor and bring information and issues to the Regional Clinical Practices Committee. Moira Kean will also update the Operations Committee monthly on this topic.

Out of State Hospitals – Ric Compton discussed recent out of state hospital issue. Brad Casemore stated that SWMBH continues to balance best care and risk reduction. Discussion followed.

Tableau Year to Date Encounters Tracy Dawson reported as documented.

Fiscal Year 2020 PIHP-DHHS Contract Development – Brad Casemore stated that this Friday's meeting will cover the Michigan Department of Corrections, Global Assessment of Individual's Needs, and Office on Inspector General contract language finalization.

Michigan Health Endowment Fund (MHEF) Grant Update – Brad Casemore shared that SWMBH has hired three staff for MHEF grant positions, is finalizing an agreement with Western Michigan Education Department (WMED) and working with Integrated Services of Kalamazoo (ISK).

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) Historical Data Report – Brad Casemore reported as documented, noting that the State will likely attach dollars to test metrics of the PBIP next year.

December SWMBH Board Agenda – Brad Casemore noted that a draft Board agenda is included in the packet for review.

CMS News Releases – Brad Casemore reported as documented.

Dr. Khaldun – Brad Casemore reported as documented.

Adjourned – Meeting adjourned at 12:35pm

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Board Report
Quarterly Report for October, November and December 2019
Board Date 1/10/20

Action items:

- Endorsed Ends metrics for 2020 prior to going to the Board
- Agreed to pilot CMH staff providing crisis intervention at a hospital emergency room for MI Health Link enrollees who are requesting psychiatric hospitalization but whose history shows previous hospitalizations did not achieve hoped for outcomes. Goal is to provide better service and increase diversions from inpatient.

Discussion items:

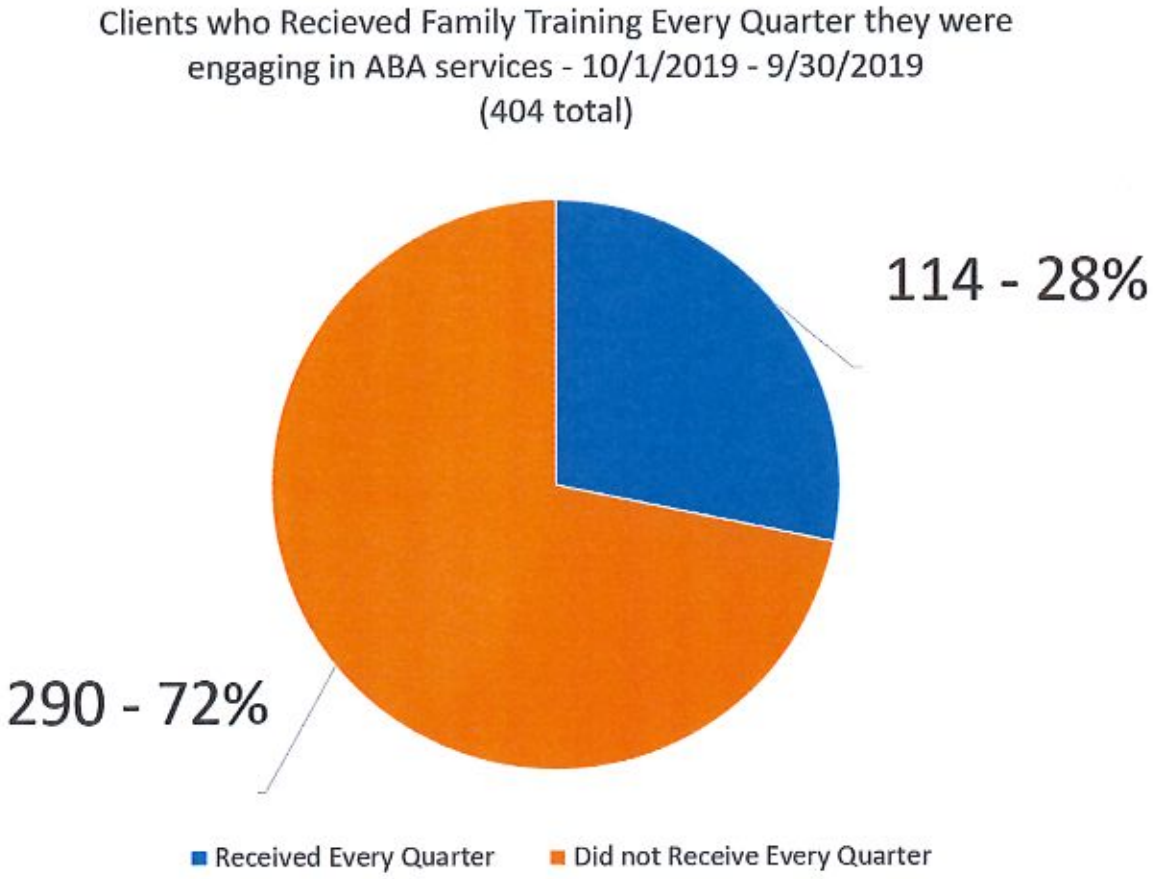
- Multiple topics for information, review and updates are discussed at each meeting as we move to making recommendations for actions. Some of the topics from this quarter included:
    - Ongoing review of year to date financial reports, successes and actions being taken to decrease expenditures
    - Reviewed of the smaller than expected revenue from the state; errors that were made and expected corrections to come in December
    - Reviewed Fiscal Year 2020 Contract Status/Updates
    - Reviewed Performance Bonus Incentive Program Fiscal Year 2019 and 2020
    - Reviewed Public Policy Committee Status/Updates
    - Reviewed Michigan Mission Based Performance Indicator System (MMBPIS) Results and New Standards
    - Ongoing review of Fiscal Year 2019 Encounters
    - Reviewed Individuals with Developmental Disabilities (I/DD) Level of Care (LOC) Guidelines work of subcommittee
    - Assessment Tools and Behavioral Health (BH) Treatment Episode Data Set (TEDS) status and review
    - Reviewed Autism Spectrum Disorder Services reports and recommended guidelines
    - Reviewed Grant Updates
    - Welcomed Natalie Spivak as SWMBH's new Chief Information Officer
    - Reviewed and discussed difficulties caused by state forbidding the use of Indiana psychiatric inpatient units, though no good solutions have been found
    - Reviewed and discussed various State and Milliman rate setting documents
    - Reviewed various SWMBH Policies
    - Reviewed Fiscal Year 2020 Utilization Management Plan
    - Reviewed Fiscal Year 2019 Customer Services Report
    - Reviewed Fiscal Year 2019 Medicaid Services Verification Report
    - Reviewed Managed Care Functional Review Provider Network Management Recommendations
    - Review of Director Gordon's proposed changes to Behavioral Health Services

ABA Family Behavior Treatment Guidance Rate Improvement
Board Update January 9th, 2020

8. At least 18% of parents and/or caregivers of youth and young adults who are receiving Applied Behavior Analysis (ABA) for Autism will receive Family Behavior Treatment Guidance at least once per quarter. This service supports families in implementing procedures to teach new skills and reduce challenging behaviors. Metric Measurement Period: (10/1/18 - 9/30/19) Board Report Date: January 9th, 2020 **Measurement:** # of youth/young adults whose parents and/or caregivers received behavior treatment guidance at least once per quarter # of youth/young adults receiving ABA services	Current Baseline: 12% Source Query Codes: Individual: 0370T/97156 Group: 0371T/97157

Family training is indicated to be one of the best ways to help clients receiving ABA services generalize the skills to the home environment. As such, improving the rate of provision for Family Training is a priority for the State, SWMBH, our CMHSP Partners, and our contracted ABA Providers.

According to the SWMBH Encounter Data, as of 12/17/2019, 28.2% of our clients with ABA service encounter data received Family Training at least once per quarter while they were receiving ABA services during fiscal year 2018/2019.



Functional Assessment Tools Board Metric

FY19 Year-End Update:

Metric Language: 95% of Functional Assessment tool detailed sub-element scores (LOCUS, ASAM, CAFAS, SIS) are received electronically by SWMBH from CMHSPs (By: 10/1/19)

- Intellectual Developmental Disabilities (Supports Intensity Scale - SIS)
- Substance Use Disorders (American Society of Addiction Medicine - ASAM)
- Serious Mental Illness (Level of Care Utilization System - LOCUS)
- Serious Emotional Disturbances (Child and Adolescent Functional Assessments Scale – CAFAS and Preschool and Early Childhood Functional Assessment Scale - PECFAS)

Status: We continue to receive monthly extracts of functional assessment tool data from each of the CMHs, which include detailed sub-element scores. Current regional totals are below. Every assessment tool, with the exception of ASAM, was completed at or above the 95% threshold. The overall rate of assessment tool completeness was 92.4% for the region for FY19, for all populations. A low ASAM completion rate of 77.1% brought the regional percentage below 95%. SWMBH has experienced challenges with accurate ASAM completeness measurement and will continue to work to ensure that ASAM completeness is being monitored and measured accurately.

FY 2019	ASAM	CAFAS/ PECFAS	LOCUS	SIS	All
Assessed	6057	4710	16,216	2,432	26,415
Eligible	7856	4795	16,654	2,540	31,845
Percent	77.1%	98.2%	97.4%	95.6%	92.4%

SWMBH Operating Policy 2.4

Subject: Clean Credentialing and Re-Credentialing Files	**Accountability:** Provider Network	**Effective Date:** 01/28/2015	Pages: 2
REQUIRED BY: **BBA Section** _____ **PIHP Contract Section** _____ **NCQA/URAC Standard:** CR 2_____ **Other** _____		Last Reviewed Date: 5/10/17	Past Reviewed Dates: 1/28/15 5/12/16
LINE OF BUSINESS: ☒ Specialty Waiver (B/C) ☒ 1115 Waiver ☒ Healthy Michigan ☒ SUD Medicaid ☒ SUD Block Grant ☒ MI Health Link ☒ OTHER:_____	**APPLICATION:** ☒ SWMBH Staff and Ops ☒ Participant CMHSPs ☐ SUD Providers ☐ MH / DD providers ☐ Other:_____	Last Revised Date:	Past Revised Dates: 1/28/15 5/12/16
Approved : _____ Date: _____		Required Reviewer: Director of Provider Network Management and Clinical Improvement	

I. Purpose

To establish a policy to streamline Southwest Michigan Behavioral Health's (SWMBH) review of credentialing and re-credentialing files of Practitioners and Organizational providers that are deemed clean and to determine which files require further review by the Credentialing Committee.

II. Policy

SWMBH defines clean files as credentialing and re-credentialing files that meet all established criteria set forth in policies 2.2 Credentialing and Re-credentialing Behavioral Health Practitioners and 2.3 Credentialing and Re-credentialing Organizational Providers.

III. Standards and Guidelines

A. Credentialing staff will verify that the credentialing application is completed accurately and fully.

B. Credentialing staff will complete primary source verifications set forth in policies 2.2 and 2.3 for all credentialing and re-credentialing files.

C. Files meeting all of the SWMBH established credentialing and re-credentialing criteria are noted as such and may be reviewed by the Prepaid Inpatient Health Plan (PIHP) or delegate's Medical Director. The Medical Director has the authority to determine that the file is "clean" and to sign off on it as complete, clean and approved. This will be signified by the Medical Director's signature on the face sheet of the credentialing file. The date of the signature will be the credentialing decision date. Clean files may also go through the Credentialing Committee for formal approval in lieu of the clean files approval process.

D. Files not meeting SWMBH's established clean file criteria will have the deficiencies/issues noted and will be reviewed by the Credentialing Committee for further discussion. To qualify as a "clean" file, the practitioner must meet all of the following criteria:

1. Current active license with no restrictions or limitations;
2. No sanctions (license, Medicare or Medicaid);
3. Practitioner has not opted out of Medicare, if applicable;

4. Current active DEA with no restrictions or limitations (if applicable);
5. Current malpractice coverage at the level required by contract;
6. No gaps in work history greater than 12 months over past five-year period;
7. Lack of present illegal drug use;
8. Ability to perform the essential functions of the position, with or without accommodation;
9. No professional liability settlements equal to or greater than $200,000 or more than two (2) cases settled with or without payment (past ten years for initial credentialing, two years for re-credentialing);
10. No adverse findings on National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB)*;
11. No restricted hospital privileges or other disciplinary activity*;
12. Minimum credentialing guidelines met for education, training, and board certification;
13. No miscellaneous credentialing red flags;
14. No reported complaints or potential quality concerns since the previous re-credentialing cycle;
15. No "Yes" response on any of the applicants attestation, disclosure, criminal history

*Historical for initial credentialing, or since previous re-credentialing cycle;

E. The Medical Director has the authority to forward a credentialing file to the Credentialing Committee at his or her discretion.

F. The Medical Director will never unilaterally deny a credentialing or re-credentialing request.

IV. Definitions

None

V. References

NCQA CR-2

VI. Attachments

None

Section: **Provider Network Management**	Policy Name: **Credentialing & Re-Credentialing: Organizational Providers**	Policy Number: **02.03**
Owner: **Chief Compliance & Privacy Officer**	Reviewed By: **Mila Todd**	Total Pages: **5**
Required By: ☐ **BBA** ☐ **MDHHS** ☐ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: **Approved by SWMBH Board 12/14/18**	Date Approved:
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **1/1/14**

Policy: Southwest Michigan Behavioral Health (SWMBH) and its participant Community Mental Health Service Providers (CMHSP) will credential and re-credential behavioral health organizational providers with whom they contract and that fall within their scope of authority and action.

Neither SWMBH nor its participant CMHSPs will discriminate against any provider solely on the basis of licensure, registration or certification. Neither SWMBH nor its participant CMHSPs will discriminate against health care professionals or organizations who serve high-risk populations or those that specialize in the treatment of conditions that require costly treatment.

Purpose: To ensure that all customers served receive care from licensed organizational providers who are properly credentialed, licensed and/or qualified.

Scope: SWMBH Provider Network Management
Participant CMHSPs
Network Providers

Responsibilities: SWMBH Provider Network Management, participant CMHSPs, and network providers will follow the requirements listed herein as it relates to credentialing.

Definitions: None

Standards and Guidelines:

A. Credentialing of Licensed Behavioral Health Facilities

1. Before executing an initial contract and at least every 2 years thereafter, SWMBH and its participant CMHSPs will require licensed behavioral health facilities (i.e., acute care psychiatric facilities, specialized residential homes, crisis residential providers, substance abuse residential and detoxification facilities, and substance abuse outpatient facilities) wishing to provide contracted services in the SWMBH network to submit a fully completed application, using the current approved SWMBH Organizational Credentialing Application. The application will contain:
   a. A signed and dated statement from an authorized representative.
   b. Documentation collected and verified for health care facilities will include (as applicable), but are not limited to, the following information:

Documentation Requirement	Clean File Criteria
Complete application with a signed and dated statement from an authorized representative of the facility attesting that the information submitted with the application is complete and accurate to the facilities' knowledge, and authorization SWMBH or CMHSP to collect any information necessary to verify the information in the credentialing application.	Complete application with no positively answered attestation questions.
State licensure information. License status and any license violations or special investigations incurred during the past five years or during the current credentialing cycle will be included in the credentialing packet for committee consideration.	No license violations and no special state investigations in time frame (in past five years for initial credentialing and past two years for re-credentialing).
Accreditation by a national accrediting body (if such accreditation has been obtained). Substance abuse treatment providers are required to be accredited. If an organization is not accredited, an on-site quality review will occur by SWMBH or CMHSP provider network staff prior to contracting.	Full accreditation status during the last accreditation review or no plan of correction for an on-site pre-credentialing site review. SWMBH recognizes the following accrediting bodies: CARF, Joint Commission, DNV Healthcare, NCQA, CHAPS, COA, and AOA.
Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query.	No malpractice lawsuits and/or judgments from within the last ten (10) years.
Verification that the providers has not been excluded from Medicare/Medicaid participation.	Is not on the OIG Sanctions list /SAM List
A copy of the facility's liability insurance policy declaration sheet.	Current insurance coverage meeting contractual expectations.

Any other information necessary to determine if the facility meets the network-based health benefits plan participation criteria that the network-based health benefits plan has established for that type of facility.	Information provided as requested by SWMBH or CMHSP.
Quality information will be considered at re-credentialing.	Grievance and appeals and recipient rights complaints are within the expected threshold given the provider size, MMBPIS and other performance indicators if applicable meet standard.

2. During initial credentialing and at re-credentialing, SWMBH or participant CMHSPs will submit credentialing packets along with primary source verifications and other supporting documentation to its Credentialing Committee for a decision regarding the inclusion on the SWMBH Provider Network. Packets will be reviewed for completeness prior to committee meeting. If files meet clean file criteria in every category listed, the medical director or designee may sign off to approve the provider, in lieu of taking to Credentialing Committee.
3. During initial credentialing and at re-credentialing, SWMBH and its participant CMHSPs will ensure that organizational providers are notified of the credentialing decision in writing within 10 business days following a decision. In the event of an adverse credentialing decision the organizational provider will be notified of the reason in writing and of their right to and process for appealing /disputing the decision in accordance with SWMBH policy 02.14.

B. Temporary/Provisional Credentialing Process

1. Temporary or provisional status can be granted one time to organizations until formal credentialing is completed.
2. Providers seeking temporary or provisional status must complete a signed application with attestation.
3. A decision regarding temporary/provisional credentialing shall be made within 31 days of receipt of application.
4. In order to render a temporary/provisional credentialing decision, verification will be conducted of:
   a. Primary-source verification of a current, valid license.
   b. Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query.
   c. Medicare/Medicaid sanctions
5. Each factor must be verified within 180 calendar days of the provisional credentialing decision. The organization shall follow the same process for presenting provisional credentialing files to the Credentialing Committee or medical director as it does for its regular credentialing process.
6. Temporary / Provisional credentialing status shall not exceed 60 days, after which time the credentialing process shall move forward according to this credentialing policy.

C. Assessment of Other Behavioral Health Organizations (other than acute care psychiatric facilities, specialized residential homes, crisis residential providers, substance abuse residential and detoxification facilities, and substance abuse outpatient facilities)

1. Before executing an initial contract, SWMBH and participant CMHSP will require other behavioral health organizations not listed in section A to provide:
   a. State and federal license, if applicable
   b. Current W-9
   c. Verification of liability insurance coverage
   d. Accreditation status, if applicable
2. If the provider is not accredited and will be providing services at their place of business (ambulatory clinics), an on-site quality review must occur prior to contracting. SWMBH recognizes the following accrediting bodies: CARF, Joint Commission, DNV Healthcare, CHAPS, NCQA, COA, and AOA.
3. SWMBH or the participant CMHSP will verify that the provider has not been excluded from Medicare participation (is not on the OIG Sanctions list/SAM List).
4. SWMBH or the participant CMH will verification that the provider has met all state and federal licensing and regulatory requirements, if applicable.

D. Organizational providers may be held responsible for credentialing and re-credentialing their direct employed and subcontracted professional service providers per SWMBH or SWMBH CMHSP contractual requirements. They shall maintain written policies and procedures consistent with SWMBH and MDHHS credentialing policies and any other applicable requirements. SWMBH or a participant CMHSP shall verify through on-site reviews and other means as necessary that the organizational provider's credentialing practices meet applicable policies and requirements.

Procedures: None

Effectiveness Criteria: N/A

References: NCQA Credentialing and Credentialing CR8
MDHHS-PIHP Contract P.7.1.1
BBA § 438.214

Attachments: None

Southwest Michigan BEHAVIORAL HEALTH

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	5/18/15	N/A: before new template	N/A: before new template	N/A: before new template
2	12/1/16	N/A: before new template	N/A: before new template	N/A: before new template
3	12/1/17	N/A: before new template	N/A: before new template	N/A: before new template
4	12/14/18	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board

2020 Quality Assurance and Performance Improvement Plan Overview (QAPIP)

January 10, 2020

Southwest Michigan
BEHAVIORAL HEALTH

Introduction

Southwest Michigan Behavioral Health ("SWMBH") uses its Quality Assurance Performance Improvement Plan (QAPIP) to assure it is meeting all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities.

42 CFR section 438-210 indicates that;

The PIHP has a written Quality Management Plan, in which activities are identified.

42CFR section 438-230 indicates that;

The PIHP oversees and is accountable for any functions it delegates to any subcontractor.

The QAPI Program describes the organizational structure for SWMBH's administration of the QAPIP; the elements, components and activities of the QAPIP; the role of service recipients in the QAPIP; the mechanisms used for adopting and communicating process and outcome improvement, and to implement improvement strategies to meet and exceed best practice performance levels.

Authority and Structure

The SWMBH Board retains the ultimate responsibility for the quality of the business lines and services assigned to the regional entity.

General oversight of the QAPIP is given to the SWMBH's Quality Management (QM) Department, with a senior management officer being responsible for the oversight of QAPIP Implementation.

The SWMBH has established the Quality Management Committee (QMC) to provide oversight of the overall quality improvement processes.

The Community Mental Health Authorities (CMHAs) are responsible for maintaining a conforming performance improvement program within their respective organizations.

Purpose

The QAPIP delineates the features of the SWMBH Quality Management program. This QAPIP serves to promote quality customer service and outcomes through systematic monitoring of key performance elements integrated with system-wide approaches to continuous quality improvement.

Additional purposes of the QAPIP are to:

1. Continually evaluate and enhance the Regional Quality Improvement processes and outcomes.
2. Monitor, evaluate, and improve systems and processes for SWMBH.
3. Provide oversight and data integrity functions.
4. Develop and implement efficient and effective processes to monitor and evaluate service delivery, quality of care, and enrollee satisfaction.
5. Promote and support best practice operations and systems that promote optimal benefits for the consumers we serve.
6. Conduct and report the results of ongoing performance monitoring and structure accountabilities for meeting performance standards and requirements.
7. promote best practice evaluation design and methodology in performance monitoring and outcomes research and push process improvement techniques throughout the system
8. Promote timely identification and resolution of quality of care issues.
9. Conduct performance monitoring and improvement activities that will result in meeting or exceeding all internal and external performance requirements.

QUALITY CONTROL

Goals

1) Implementation of a Consumer Satisfaction Survey Performance Improvement Project, based on Consumer Feedback. (By: 6/30/20)

2) Formulate a series of instructional videos/tutorials, which live on the SWMBH SharePoint Portal for SWMBH and CMHSP access. (By: 12/30/2020)

Data Management

❖As part of a productive and active Quality Improvement system it is critical that data integrity and collection is systemically monitored and improved. As such it is important to review the system for errors and ensure that the data is correct, accurate, and timely.

1. System Reviews- the QM Department along with IT is responsible for ensuring that there are:

- ✓ *Data Reviews before information is submitted to the state*
- ✓ *Random checks of data for completeness, accuracy and that it meets the related standards.*
- ✓ *Source information reviews to make sure data is valid and reliable.*

2. The QMC and QM Department will address any issues identified in the system review.

3. Processes should be clearly defined and replicable with consistently applied methods of tracking to assure measurability in data collection. Re-measurements should happen as often as determined necessary for the identified project(s).

4. The Quality Department is also responsible for establishing/scheduling outside audits/monitoring reviews of SWMBH internal data systems, validations and accuracy.

This review is conducted by the Health Service Advisory Group (HSAG), on an annual basis.

Communication

SWMBH acknowledges the importance of disseminating quality-related information and improvement outcomes. Communication of findings will be made to the following groups:

- Stakeholders (when appropriate)
- SWMBH Board
- CMH staff and SWMBH staff
- Customers
- Others - State representatives

These groups and others may be provided information through a variety of methods including but not limited to:

- Newsletters
- SWMBH Website
- SWMBH SharePoint Site
- Tableau Analytics and Visual Dashboards
- SWMBH QM Reports
- Meetings
- External Reports

Evaluation

- The SWMBH QM department will complete an evaluation of the accomplishments and any potential gaps identified during the previous year's QM activities. When a gap is identified and addressed during that year it will be reported in the QAPI Effectiveness Review/Evaluation.

- A Performance Improvement/Corrective Action Plan may be required for any area where performance gaps are identified. This describes a project improvement plan of action (including methods, timelines, and interventions) to correct the performance deficiency. The QM department may approve, deny or increase level of scrutiny on Corrective Action Plans; contingent on the level of compliance demonstrated during the monitoring period.

QAPI 2020 Work Plan Key Performance Metrics

Activities/Programs Covered in 2018 Work Plan Include	
Annual Department and Regional Committee Goals and Objectives	Consumer Satisfaction Surveys and Analysis
Oversight of External Audits/Reviews (MDHHS, HSAG, NCQA)	External Monitoring Reviews (CMHSPs and SUD Providers)
Michigan Mission Based Performance Indicators (MMBPIS)	Customer Grievances and Appeals Tracking and Monitoring
Critical Incident, Sentinel Event and Risk Event Tracking/Reporting	Access to Care Tracking/Monitoring
Call Center Monitoring	Jail Diversion Data Analysis
Behavior Treatment Review Data	Performance Improvement Projects (PIPs)
Board Ends Metrics and Key Performance Metric Analysis and Reporting	Communication of Data and Outcomes to Internal and External Stakeholders

Questions?

Thank you!

Policy 3.1 Updated 12/20/2019 – 2020 Quality Assurance and Performance Improvement Plan

Southwest Michigan Behavioral Health
Quality Assurance and Performance Improvement Program
All SWMBH Business Lines

Year 2020 (October 1, 2019 - September 30, 2020)

Final Version Approved: 1/10/2020 (Board mtg. date)

Approved by SWMBH Board:
Submitted to MDHHS for Review:
Reviewed by SWMBH Quality Management Committee:
Reviewed by SWMBH MI Health Link Committee:

Table of Contents

I. *Introduction*

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) has a documented Quality Assessment and Performance Improvement Program (QAPIP) that meets required federal regulations: the specified Balanced Budget Act of 1997 as amended standards, 42 CFR § 438, requirements outlined in the PIHP contract(s), specifically AttachmentP.6.7.1.1.

Southwest Michigan Behavioral Health ("SWMBH") uses its QAPIP to assure it is meeting all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities. The QAPIP describes the organizational structure for the SWMBH's administration of the QAPIP; the elements, components, and activities of the QAPIP; the role of service recipients in the QAPIP; the mechanisms used for adopting and communicating process and outcome improvement, and to implement improvement strategies to meet and exceed best practice performance levels. SWMBH is a learning region where quality and cost are measured and improved.

SWMBH QAPIP is approved annually by the Southwest Michigan Behavioral Health (SWMBH) Board. The SWMBH EO and SWMBH Board grant the authority of the Quality Management (QM) department and the QM Committee. Additionally, more information related to the QAPIP standards can be found in SWMBH policies and procedures, SWMBH Strategic Guidance Document, QMC Committee Charter, and other departmental plans.

II. Purpose

The QAPIP delineates the features of the SWMBH QM program. This QAPIP serves to promote quality customer service and outcomes through systematic monitoring of key performance elements integrated with system-wide approaches to continuous quality improvement.

The SWMBH QAPIP spans across clinical service delivery within the network as well as benefit management processes within SWMBH. The program addresses access, quality, and cost for services delivered, inclusive of administrative aspects of the system, service delivery, and clinical care. Populations served by the SWMBH include persons who experience mental illness, developmental disabilities, and substance use disorders.

Additional purposes of the QAPIP are to:

- Continually evaluate and enhance regional Quality Improvement Processes and Outcomes.
- Monitor, evaluate, and improve systems and processes for SWMBH.
- Provide oversight and data integrity functions.
- Develop and implement efficient and effective processes to monitor and evaluate service delivery, quality, and integration of care and customer satisfaction.
- Improve the quality and safety of clinical care and services it provides to its customers.
- Promote and support best practice operations and systems that promote optimal benefits in service areas of service *accessibility, acceptability, value, impact,* and *risk-management* for all members.
- Conduct and report the results of ongoing performance monitoring and structure accountabilities for meeting performance standards and requirements.
- Promote best practice evaluation design and methodology in performance monitoring and outcomes research and push process improvement techniques throughout the system.
- Promote timely identification and resolution of quality of care issues.
- Conduct performance monitoring and improvement activities that will result in meeting or exceeding all external performance requirements.
- Meet the needs of external and internal stakeholders and provide performance improvement leadership to other departments.

III. Guiding Principles

During the November 8, 2019 Board Meeting, the SWMBH Board approved the 2020-2020 Board Ends Metrics and revised Mega Ends. The Mega Ends serve as the guiding principles for the development of annual Board Ends Metrics, Regional Committee Goals, SWMBH Department Goals, and Regional Strategic Objectives set forth by the SWMBH Board. Please see attachment (*Please see Attachment G - Strategic Alignment and Annual Goal Setting*)

Mega Ends

1. **Quality of Life.** Persons with Intellectual Developmental Disabilities (I/DD); Serious Mental Illness (SMI); Serious Emotional Disturbances (SED); Autism Spectrum Disorders (ASD) and Substance Use Disorders (SUD) in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery and family preservation.
2. **Improved Health.** Individual mental, physical health, and functionality are measured and improved.
3. **Exceptional Care.** Persons and families served are highly satisfied with the care they receive.
4. **Mission and Value-Driven.** CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.
5. **Quality and Efficiency.** The SWMBH region is a learning region where quality and cost are measured, improved, and reported.

IV. Strategic Imperatives

Strategic Imperatives: During the May 10, 2019 Board Retreat and Board Meeting, the Board voted on and established a new set of Strategic Imperatives. It is critical to the success of SWMBH and the Region that these Strategic Imperatives are tracked and monitored for success. The following are the approved 2019-2020 Strategic Imperatives:

1. Public Policy and Legislative initiatives
2. Uniformity of Benefit
3. Population Health Management
4. Revenue Maximization
5. Improved Analytics and Business Intelligence tools
6. Managed Care Functional Review
7. Use of Level of Care Guidelines
8. Cost reduction efforts for Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR)
9. Proof of Value and Improved Outcomes
10. Consistent use of Assessment tools and Authorization Process

V. Core Values of Quality Assurance and Improvement

1. **Quality healthcare will result from a benefit management system embracing input from all stakeholders**
    a. Educating all customers of SWMBH on continuous improvement methodologies, including providing support to other SWMBH departments and providers as requested. The inclusion of customers, families, stakeholders, and providers in the performance improvement design will promote optimal results.
    b. Promoting a person-centered philosophy will promote customer satisfaction as well as optimal treatment outcomes.
2. **Poor performance is costly**
    a. Performance improvement initiatives will be consistent with metrics as established by the SWMBH Board and prioritized in accordance with potential risk.
    b. Quality Improvement projects are best approached systemically; best practice improvement planning should promote elements of systematic monitoring, evaluation, feedback, and follow-up.

c. Valid, acceptable, accurate, complete, and timely data is vital to organizational decision-making.
    i. Making data accessible will impact value and reduce risk to SWMBH.

3. **Data Collection Values**
    a. Data that is consistently complete, accurate, and timely will lead to consistent measurement and over time ensure data integrity.
    b. Providers submitting data to SWMBH shall certify data integrity and have available for review the process used to collect the data.
    c. Performance that has demonstrated instability or significant variance to comparison performance on an ongoing basis will be monitored closely. Significant variation in results will indicate the need for a corrective action/performance improvement plan

VI. Authority and Structure

The SWMBH Board retains the ultimate responsibility for the quality of the business lines and services assigned to the regional entity. The SWMBH Board annually reviews and approves the QAPIP, receives periodic QAPIP reports, and the QAPI & UM Effectiveness Review/Evaluation throughout theyear.

In addition, review by the SWMBH Board and SWMBH EO, the QAPIP, and QAPI & UM Effectiveness Review/ Evaluation will be taken to the SWMBH Operations Committee to facilitate the development and management of quality assurance and improvement. The SWMBH Operations Committee consists of the EO, or their designee, of each participating CMHSP.

The general oversight of the QAPIP is given to the SWMBH's QAPI Department, with a senior management officer, the Director of QAPI, being responsible for the oversight of QAPIP Implementation. *(Please see attachment A – SWMBH organizational chart for more details)*

Internal Staffing and Resources of the QAPI Department
The SWMBH QAPI Department is charged with the purpose of developing and managing its program. This program plan outlines the current relationships and structures that exist to promote performance improvement goals and objectives. The QAPI Department is staffed with a Director of Quality Assurance and Performance Improvement, which oversees the QAPI Department, including the 2 Full-Time Quality Assurance Specialists. The QAPI Department also may utilize an outside contract consultant for special projects and preparation for accreditation reviews. The QAPI Director collaborates on many of the QAPI goals and objectives with the SWMBH Senior Leadership team and SWMBH Regional Committees, such as the; Quality Management Committee (QMC), Regional Information Technology Committee (RITC), Regional Utilization Management Committee (RUM), and the Regional Clinical Practices Committee (RCP).

As the primary data user, the QAPI Department works very closely with the IT Department to review and analyze data. In guiding the QAPI studies, the Business Data Analyst is tasked with performing complex analyses of data including statistical analyses of outcomes data to test for statistical significance of changes, mining large data sets and performs factor analyses to determine causes or contributing factors for outcomes or performance outliers; correlates analyses to determine relationships between variables. Based on the data, the Business Data Analyst will develop reports, summaries, recommendations and visual representations.

SWMBH staff will include a designated behavioral health care practitioner to support and advise the QAPI Department in meeting the QAPIP deliverables. This designated behavioral health care practitioner will provide supervisory and oversight of all SWMBH clinical functions to include; Utilization Management, Customer Services, Clinical Quality, Provider Network, Substance Abuse Prevention and Treatment, and other clinical initiatives. The designated behavioral health care practitioner will also provide clinical expertise and programmatic consultation and will collaborate with QAPI Director to ensure complete, accurate, and timely submission of clinical program data, including Jail Diversion and the Behavioral Treatment Committee. The designated behavioral health care practitioner is a member of the Quality Management

Committee (QMC).

Adequacy of Quality Management Resources

The QAPI Department works collaboratively with many different functional areas. Although each position identified below is not assigned to the QAPI Department, they maintain an active role in quality related activities. The following grid provides a representation of what percentage of total time is spent on quality related activities.

Title	Department	Percent of time per week devoted to QM
Director of Quality Assurance and Performance Improvement	QAPI	100%
(2) QAPI Specialist	QAPI	100%
Business Data Analyst I	QAPI	50%
Business Data Analyst II	QAPI	30%
Clinical Data Analyst	QAPI and PNM	20%
Manager of Utilization Management	UM	20%
Director of Clinical Quality	PNM	20%
Chief Information Officer	IT	30%
Senior Software Engineer	IT	20%
Member Engagement Specialist	UM	15%
Waiver and Clinical Quality Manager	PNM	10%
Applications and Systems Analyst	IT	20%
Designated Behavioral Health Care Practitioner	UM/PN	20%
Chief Compliance and Operations Officers	Com/Ops	15%

QAPI = Quality Assurance and Performance Improvement
PNM = Provider Network Management
UM = Utilization Management
IT = Information Technology

SWMBH will have appropriate staff to complete QAPI functions as defined in this plan. In addition to having adequate staff, the QAPI Department will have the relevant technology and access to complete the assigned tasks and legal obligations as a managed benefits administrator for a variety of business lines. These business lines include Medicaid, Healthy Michigan Plan, MiChild, Autism Waiver, MI Health Link (MHL) & Duals, SUD Block Grant, PA 2 funds, and other grant funding. Completion of these functions require resources that include but are not limited to:

- Access to regional data
- Software and tools to analyze data and determine statistical relationships

The QAPI Department is responsible for collecting measurements reported to the state and to improve and meet SWMBH's mission. In continuing the development of a systematic improvement system and culture, the goal of this program and plan is to identify any needs the organization may have in the future so that performance improvement is effective, efficient, and meaningful. The QAPI Department monitors and evaluates the overall effectiveness of the QAPIP,

assesses its outcomes, provides periodic reporting on the Program, including the reporting of Performance Improvement Projects (PIPs), and maintains and manages the Quality Management Committee (QMC) and MI Health Link QM Committees.

The QAPI Department collaborates with the Quality Management Committee (QMC) and the SWMBH Board in the development of an annual QAPI plan. QAPI Department also works with other functional areas and external organizations/venders like Streamline Solutions and the Health Service Advisory Group (HSAG) to review data collection procedures. These relationships are communicated with the EO and the SWMBH Board as needed. Other roles include:

- Reviewing and submitting data to the state
- Creating and maintaining QAPI policies, plans, evaluations, and reports
- Implementation of regional projects and monitoring of reporting requirements
- Assisting in the development of Strategic Plans and Tactical Objectives
- Assisting in the development of the Boards Ends Metrics and other Key Performance Indicators
- Communications and Reporting to our Integrated Care Organizations
- Analysis of reports and data; to determine trends and recommendations for process improvements

VII. Committees

Quality Management (QM) Committee

SWMBH has established the QMC to provide oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs, and outcomes. SWMBH values the input of all stakeholders in the improvement process, and QMC is one method of participant communication, alignment, and advice to SWMBH. QMC allows regional input to be gathered regarding the development and management of processes and policies related to quality. QMC is responsible for developing Committee goals, maintaining contact with other committees, identifying people, organizations, or departments that can further the aims of both the QAPI Department and the QMC. Cooperation with the QMC Program is required of all SWMBH staff, participants, customers and providers.

CMHSPs are responsible for the development and maintenance of a performance improvement program within their respective organizations. Coordination between the participant and provider performance improvement programs and SWMBH's program is achieved through standardization of indicator measurement and performance review through the QMC.

To assure a responsive system, the needs of those that use or oversee the resources, (e.g., active participation of customers, family members, providers, and other community and regulatory stakeholders) are promoted whenever possible. Training on performance improvement technology and methods, along with technical assistance, is provided as requested or as necessary.

Quality Management Committee (QMC) Membership

The QMC shall consist of an appointed representative from each participating CMHSP, representative(s) from the SWMBH Customer Advisory Committee (CAC), and SWMBH QAPI Departmental staff. All other ad hoc members shall be identified as needed, which may include; provider representatives, IT support staff, Coordinating Agency staff, and the SWMBH medical director and clinical representation. The QMC will make efforts to maintain consumer representation, assist with review of reports/data, and provide suggestions for Regional process improvement opportunities. All QMC members are required to participate; however, alternates will also be named in the charter and will have all the same responsibilities of members when participating in committee work.

QMC Committee Commitments include:

1. Everyone participates.
2. Be passionate about the purpose
3. All perspectives are professionally Expressed and Heard
4. Support Committee and Agency Decisions
5. Celebrate Success

Decision Making Process

Quality Management is one of the core functions of the PIHP. The QMC is charged with providing oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs, and outcomes. This committee allows regional input to be gathered regarding the development and management of processes and policies related to quality. Quarterly, QMC collaborates with the Regional Clinical Practices (RCP) and Regional Utilization Management (RUM) Committees on clinical and quality goals and contractual tasks.

The committee will strive to reach decisions based on a consensus model through discussion and deliberation. Further information on decision making can be found in the QMC charter. *(Please see Attachment B – QMC Charter for more details)*

QMC Roles and Responsibilities

- QMC will meet regularly (at a minimum quarterly) to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPIP, QAPI & UM Effectiveness Review/Evaluation, and Performance Improvement Projects (PIPs). Oversight is defined as reviewing data and approving projects.
- Members of the committee will act as conduits and liaisons to share information decided on in the committee. Members are representing the regional needs related to quality. It is expected that QMC members will share information and concerns with SWMBH QAPI staff. As conduits, it is expected that committee members attend all meetings by phone or in person. If members are not able to attend meetings, they should notify the QMC Chair Person as soon as possible. QMC members should be engaged in performance improvement issues, as well as bringing challenges from their site to the attention of the SWMBH committee for deliberation and discussion.
- Maintaining connectivity to other internal and external structures, including the Board, the Management team, other SWMBH committees, and MDHHS.
- Provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.
- Provide data review and recommendations related to efficiency, improvement, and effectiveness.
- Review and provide feedback related to policy and tool development.
- The primary task of the QMC is to review, monitor, and make recommendations related to the listed review activities with the QAPIP.
- The secondary task of the QMC is to assist the PIHP in its overall management of the regional QAPI functions by providing network input guidance and make suggestions for process improvement opportunities, with the goal of improving consumer outcomes.

2020 Quality Management Committee Goals (2020-2021)

1. **Implementation of a Consumer Satisfaction Survey Performance Improvement Project (By: 6/30/20)**
   - i. Review consumer feedback from MHSIP and YSS annual consumer satisfaction survey project
   - ii. Identify common denominators and classify into strategic categories
   - iii. Perform analysis on feedback and prioritize in order of importance (by number of comments identified for each category)
   - iv. Develop and target interventions to improve (3) identified problem areas
   - v. Determine tracking mechanisms and targets goals for each identified area
   - vi. Share results with Operations Committee and other relevant committees

2. **Formulate a series of instructional videos/tutorials, which live on the SWMBH SharePoint Portal for SWMBH and CMHSP access (By: 12/30/2020)**
    i. Perform a gap analysis to identify Regional Education needs, based on current contractual/oversight obligations
    ii. Identify Training resources and software/tools we will use to create educational resources.
    iii. Initial trainings will include: MMBPIS Indicator documentation, Jail Diversion documentation, Critical Incident tracking and documentation and SWMBH Poral navigation tutorial
    iv. Form sub-groups within QMC to review trainings and present trainings to their providers
    v. Test Access to the trainings/tutorials and ensure all CMHSP/SWMBH users have access to them
    vi. Present trainings to relevant Regional Committees or Internal SWMBH/CMHSP departments

3. **2020 Quality Management Committee Quarterly Review and Analysis Categories**
    I. Review of Regional Critical Incident Reporting Procedures and Requirements
    II. Review of Risk Event tracking, analysis and monitoring for consistency across all CMHSPs
    III. Review of Regional Jail Diversion processes, training and State reporting measures
    IV. Review of Regional Grievance and Appeals tracking, notices, letters against HSAG and Managed Care guidelines
    V. Review and analysis of Hospital Follow-up (FUH) Timeliness Metric
    VI. Review of HSAG and MDHHS selected Performance Improvement Measures

MI Health Link Committee

On March 1, 2015, SWMBH became part of the Center for Medicare and Medicaid Services project titled the "MI Health Link (MHL) demonstration project" for persons with both Medicare and Medicaid. SWMBH contracts and coordinates with two Integrated Care Organizations within the region. The two ICOs identified for Region 4 are Aetna Better Health of Michigan and Meridian Health Plan. As such, SWMBH will be held to standards that are incorporated into this QAPIP that are sourced from The Michigan Department of Health and Human Services (MDHHS), CMS Medicare rules, NCQA Health Plan standards, and ICO contract arrangements. In addition to the MHL demonstration contract, it is required that each specialty PIHP have a documented QAPIP that meets required federal regulations: the specified Balanced Budget Act of 1997 as amended standards, 42 CFR § 438, requirements outlined in the PIHP contract(s), specifically MDHHS Attachment P.7.9.1, Quality Assessment, and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans, and MI Health Link (MHL) demonstration project contracts, Medicaid Provider Manual and National Council on Quality Assurance (NCQA). SWMBH will maintain a QAPIP that aligns with the metrics identified in the MHL ICO contract. SWMBH will implement BH, SUD, and I/DD-oriented Health Care Effectiveness Data and Information Set (HEDIS) measures enumerated in the contract. This may include the implementation of surveys and quality measures, ongoing monitoring of metrics, monitoring of provider performance, and follow-up with providers as indicated.

The MHL Committee is charged with providing oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs, and outcomes. This committee allows regional input to be gathered regarding the development and management of processes and policies related to quality. The committee is one method of participant communication, alignment, and advice to SWMBH.

The committee tasks are determined by the SWMBH EO, committee chair and members, member needs, MI Health Link demonstration guidelines, including the Three-Way Contract, ICO-PIHP Contract, and NCQA requirements. The MHL QMC is accountable to the SWMBH EO and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the MHL demonstration, the ICO-PIHP contract, and across all business lines of SWMBH. The MHL QMC must provide evidence of review and thoughtful consideration of changes in its policies and procedures and work plan and make changes to its policies where they are needed. Analyzes and evaluates the results of QM activities to identify needed actions and make recommendations related to efficiency, improvement, and effectiveness. The MHL QMC will meet regularly (at a minimum quarterly) to inform quality activities and to demonstrate follow-up on all findings

and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined as reviewing data and approving projects.

MI Health Link Committee Membership

The MHL Committee shall consist of the QAPI Department staff, a designated behavioral health care practitioner and ICO representatives. This designated behavioral health care practitioner shall have oversight of any clinical metrics and participates in or advising the MHL Committee or a subcommittee that reports to the MHL Committee. The behavioral healthcare provider must have a doctorate and may be a medical director, clinical director or, participating practitioner from the organization or affiliate organization. All other ad-hoc members shall be identified as needed and could include provider representatives, IT support staff, Coordinating Agency staff, and medical director and clinical representation. Members of the committee are required to participate; however, alternates will also be named in the charter and will have all same responsibilities of members when participating in committee work.

Members of the committee will act as conduits and liaisons to share information decided on in the committee. Members are representing the regional needs related to quality. It is expected that members will share information and concerns with SWMBH QAPI staff. As conduits it is expected that committee members attend and are engaged in Performance Improvement issues, as well as bringing challenges from their site to the attention of the SWMBH committee for possible project creation.

Decision Making Process

The committee will strive to reach decisions based on a consensus model through discussion and deliberation. Further information on decision making can be found in the MHL QMC charter. *(Please see Attachment D – MHL Committee Charter for more details)*. The MHL Committee is responsible for maintaining contact with other committees as well as identifying people, organizations, or departments that can further the aims of both the QAPI Department and the Committee. The MHL QAPI section of the Committee coordinates with the UM and Provider Network MHL Committees. The QAPI Director is a member of both the UM and Provider Network MHL Committees. The QAPI Director may call on other QAPI team members or CMHSP partners to participate in MHL Committee meetings as necessary.

---See Attachment C, "MHL Charter – Decision Making." ---

Functional Area	Objectives	Lead Staff	Review Date
Committee	Approve last month's MHL Committee Meeting minutes.	All Committee Members	Monthly
UM	Grievances and Appeals	Member Engagement Specialist	Quarterly
Credentialing	Review and approval of MI Health Link policies and procedures.	Director of Provider Network	As needed
	Medical Director, Clean File Review Approvals Four clean file reviews since last meeting	Provider Network Specialist, or Director of Provider Network	Monthly
	Credentialing Applications for Committee Review	Provider Network Specialist, or Director of Provider Network	Monthly
	Practitioner Complaints	Provider Network Specialist, or Director of Provider Network	Quarterly
Quality	Policy and Procedure Review and Updates.	Director of QAPI or designated QAPI Specialist	As needed
	Annual Work plan Review (Quarterly).	Director of QAPI or designated QAPI Specialist	Quarterly, as indicated by QAPI work plan
	Annual Reviews/Audits (Recommendations for Improvement and review of results).	Director of QAPI or designated QAPI Specialist	As needed
	Practitioner Participation and Clinical Practice Guideline Review.	Director of QAPI or designated QAPI Specialist	Quarterly
	Performance Measures for Site Audit	Director of QAPI or designated QAPI Specialist	As needed
	Causal Analysis	Director of QAPI or designated QAPI Specialist	Quarterly
	Call Center Monitoring	Director of QAPI or designated QAPI Specialist	Monthly
	Timeliness Monitoring	Director of QAPI or designated QAPI Specialist	Monthly
	NCQA Reports	Director of QAPI or designated QAPI Specialist	Quarterly

UM/Clinical	Collaborative Initiatives Meridian ICT Update	Director of Utilization Management or Integrated Care Specialist	Monthly
	Complex Case Management	Director of Utilization Management or Integrated Care Specialist	Monthly
	NCQA Measures	Director of Provider Network or Director of Utilization Management	Monthly
	Policy and Procedure Review and Updates.	Director of Utilization Management or Manager of Utilization Management	As needed

MI Health Link Committee Roles and Responsibilities:

- Maintaining connectivity to other internal and external structures including the Board, the Management team, other SWMBH committees and MDHHS.
- Provide guidance in defining the scope, objectives, activities, and structure of the QAPIP.
- Provide data review and recommendations related to efficiency, improvement, and effectiveness.
- Review and provide feedback related to policy and tool development.
- The secondary task of the Committee is to assist the PIHP in its overall management of the regional QAPI functions by providing network input and guidance.
- The primary task of the Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program.
- Ensures follow-up as appropriate. Ensures practitioner participation in the QAPI program through planning, design, implementation or review. Ensures discussion (and minutes) reflects:
    - Appropriate reporting of activities, as described in the QM program description.
    - Reports by the QM director and discussion of progress on the QM work plan and, where there are issues in meeting work plan milestones and what is being done to respond to the issues.
- Ensures the organization describes the role, function and reporting relationships of the QM Committee and subcommittees.
- Ensures all MHL required reporting is conducted and reviewed, corrective actions coordinated where necessary, and opportunities for improvement are identified and followed-up.
- Ensures member and provider experience surveys are conducted and reviewed, and opportunities for improvement are identified and followed-up.
- Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. The appropriate body to approve the clinical practice guidelines may be the organization's QM Committee or another clinical committee.
- Ensures the organization approves and adopts preventive health guidelines and promotes them to practitioners to improve health care quality and reduce unnecessary variation in care. The appropriate body to approve the preventive health guidelines may be the organization's

QM Committee or another clinical committee.

- The organization annually:
- Documents and collects data about opportunities for collaboration.
- Documents and conducts activities to improve coordination between medical care and behavioral healthcare.
- Ensures the ICO and PIHP identify shared quality improvement measurement requirements and develop and implement related processes sharing results and undertaking correction and quality improvement activities.
- Ensures a care management quality control program is always maintained.

The MI Health Link Committee and QAPI Department is also responsible for reporting and achieving all quality withhold performance measures identified in the Integrated Care Organization (ICO) and Michigan Department of Health and Human Services (MDHHS) three – way contracts. The quality performance measure data will be collected by the QAPI Department and a report analysis will be performed in collaboration with the UM Department, Provider Network Management Department and with the Integrated Care Specialist. The identified quality withhold measures will be used to reconcile payments between the SWMBH and the ICO on an annual basis via a calendar year schedule identified in the contract.

Quality Performance Withhold Measures:

Each year, a set of Quality Performance Measures are reviewed and negotiated between the PIHP and the Integrated Care Organizations (ICO's). Pursuant to Section 3.4.3 of the Agreement, the quality-withhold measures and corresponding point values that will apply to PIHP in Demonstration Year 4 are as follows:

Domain	Measure	Source	Maximum Point Value	Benchmarks
Encounter Data	Encounter Data submitted timely, accurately, and completely in compliance with requirements in this Agreement	Encounter data file submissions	5-Timely 5-Complete 5-Accurate	-90% of paid claim encounters submitted by 15th of the month following payment -80% of paid claim encounters submitted within 180 days of the date of service -95% CMS initial acceptance rate of PIHP encounters
Assessments	Percentage of Enrollees with Level II assessments completed within 15 days of the Plan	Monthly assessment status reports	30	95%+ - 30 90-94% - 25 85-89% - 20 80-84% - 15 75-79% - 10

	referral for Level II assessment			
Care Transition Record Transmitted to Health Care Professional	Percentage of Enrollees with an inpatient psychiatric admission discharged to home or any other site of care for whom a transition record was transmitted within twenty-four (24) hours of discharge to the facility or behavioral health professional designated for follow-up care	Care transition audit	10	80%+ - 10
Documentation of Care Goals	Percentage of Enrollees with documented discussions of care goals	Documented care plans in ICBR	20	95%+ - 20 90-94% - 10
Follow-up after Inpatient Admission	Percentage of Enrollees with a follow-up visit with a behavioral health practitioner within 30 days of BH inpatient discharge	HEDIS 2019 data (FUH)	20	56%
Governance board	Participation of members appointed by PIHP on the ICO's advisory board	Advisory Board meeting minutes	5	2 participating advisory board appointments

VIII. Standards and Philosophy

The SWMBH's QAPIP functions according to a Continuous Quality Improvement (CQI) methodology to provide sound benefits management strategy that will yield higher satisfaction for all stakeholders. The regional quality management system combines traditional aspects of quality assurance with quality improvement using a variety of process and improvement strategies including:

✓ Develop measures that are reliable, and meet related standards

- ✓ Establish thresholds/benchmarks,
- ✓ Achieve target performance levels,
- ✓ Identify and analyze statistical outliers
- ✓ Implement Performance Improvement Projects
- ✓ Evaluate effectiveness (e.g. QAPI Effectiveness Review/Evaluation)
- ✓ Develop a system that is replicable and adaptable (appropriate scalability of program)
- ✓ Promote integration of QAPI into PIHP management and committee activity
- ✓ Promote coordination internally and externally throughout the region
- ✓ Incorporate relevant process and quality improvement methodologies
- ✓ Predefined quality standards
- ✓ Formal assessment of activities
- ✓ Measurement of outcomes and performance
- ✓ Strategies to improve performance

Other methodologies are used to control process include:

- ✓ ***Define*** the current process performance.
- ✓ ***Measure*** the current process performance.
- ✓ ***Analyze*** to determine and verify the root cause of the focused problem.
- ✓ ***Improve*** by implementing countermeasures that address the root causes.
- ✓ ***Control*** to maintain the gains

IX. Review Activities

The QAPI Department is responsible for a wide range of activities and monitoring contract requirements. The QAPI assessment consists of a variety of strategically planned activities that help to identify the actual practices, attitudes, performance, and conformance to standards. Reviews could be at a systematic, programmatic, or individual level. Some of the observed review activities include:

Review Activity	Activity Description
1. Annual QAPI Plan	The QAPI plan is a document that reflects the ongoing progress on QAPI activities throughout the year. The QAPI plan is developed by the QAPI Department with guidance from the QMC, RCP, and RUM. The Plan is reported annually to the EO, Operations Committee the SWMBH Board, and to customers and other stakeholders. The plan consists of the quality improvement, performance and outcome goals to be achieved throughout the year and addresses: • Yearly planned QI objectives/goals for improving: – Quality of clinical care. – Safety of clinical care. – Quality of service. – Members' experience. • Time frame for each objective/goal's completion. • Lead staff responsible for each objective/goal. • Monitoring of previously identified issues. • Evaluation of the QAPIP. ***--See Section XI, "2020 Quality Assurance Improvement Plan"***
2. Annual QAPI & UM Effectiveness Review & Evaluation	Monitoring, evaluation and reporting occurs on an on-going basis. Evaluation results will be shared annually with the EO, Operations Committee, the SWMBH Board, relevant Committees, customers and other stakeholders. The QM department will on an annual basis will do an effectiveness review/evaluation of the QAPIP that will include: • A description of completed and ongoing objectives/goals that address quality and safety of clinical care and quality of service. • Trending of measures to assess performance in the quality and safety of clinical care and quality of service. • Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing safe clinical practices throughout the organization. • Identification of any performance improvement needs or gaps in service. • Adequacy of QAPIP resources and staff including practitioner participation and leadership involvement in the QAPIP. • Remediation and corrective action plans. • Analysis of overall results for MDHHS quality & UM reporting metrics, such as: • MMBPIS Performance Indicators, Critical Incidents, Jail Diversion, Call Center Performance Metrics, Inter-Rater Reliability testing, Consumer Satisfaction Survey Results, RSA-r Survey Results, Program and Service Audit results and more.
3. Annual Goals and Objectives – Reports, Dashboards,	• Annual Goals and Objectives are discussed, monitored, and reported as defined by the objective scope. All Department and Regional Committee goals should align with SWMBH Board Ends Metrics and SWMBH Strategic Guidance

Outcome monitoring	• Document, which is the overarching tool to maintain strategy and tactical objectives, as defined by the Board. • Key Performance indicators will be compared and monitored with reports created. (Board Ends Metrics, Dept. Goals, Regional Committee Goals) • Training and monitoring of best practice standards will be completed as necessary. ***see attachment (G) – "2020-2021 Board Ends Metrics"***
4. Access Standards	• SWMBH will monitor that customers will have a face-to-face level 2 assessment completed within 15 days. • Contracts with providers will be monitored to assess customer access to services within Medicare and Medicaid standards on geography and type. • Assessments against standards related to regular and routine appointments, urgent/emergency care, after-hours care, and call center rates. • Behavioral Health will meet the following standards: **1.** Routine Non-Life-Threatening Emergency within 6 hours **2.** Urgent Care within 48 hours **3.** Routine Office Visits within 10 business days **4.** Call Center calls will be answered by a live voice within 30 seconds **5.** Telephone call abandonment rate is within 5%
5.Key Administrative Functions	In keeping with the need to provide performance oversight across a broad array of PIHP administrative functions, key areas of performance are reviewed by the identified functional committee(s): • *Provider Network* • *Compliance* • *Customer Services* • *Utilization Management* • *Administrative Support* Performance measures for respective functional areas are further described in functional documents, which provides description of associated plans, performance measures, and tracking processes
6. External Monitoring Reviews	The QAPI department will coordinate the reviews by external entities, including MDHHS, HSAG, NCQA review organization, and any accreditation organization as identified by the SWMBH Board. The QAPI department will also be available to assist affiliates in their external reviews.
7. Customer Provider Assessments	Surveys are collected throughout the year; and are reviewed by the QMC and MHL Committee and required by PIHP/MDHHS contract. Results are Reported to EO, the CAC, the Operations Committee, the SWMBH Board, customers, and other stakeholders annually. This data is used to identify trends and make improvements for the customer experience. The MHSIP survey is used for adult participants 17 years of age and over and the YSS survey is used for Youth under the age of 17.

8. Customer and Provider Assessments (MIHL)	Surveys are collected throughout the year; and are determined by the QMC and MHL Committee and required by PIHP contract. Reported to EO, the CAC, the Operations Committee, the SWMBH Board, customers, and other stakeholders annually. This data is used to identify trends and make improvements for the customer experience. When available; results are compared to State and National values, to provide performance benchmarks.
9. Michigan Mission Based Performance Indicators (MMBPIS)	A collection of state defined indicators that are aimed at measuring access, quality of service, and provide benchmarks for the state. Data is reported to Michigan Department of Health and Human Services (MDHHS), results are additionally communicated to the EO, the Operations Committee, the SWMBH Board, customers, and other stakeholders. The SWMBH maintains a dashboard to monitor the progress on each indicator throughout a year. The SWMBH QAPI Department reviews and approves plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate and documented interval time.
10. Critical Incidents/Sentinel Events/Risk Events	The state has provided definitions for three categories of events that the SWMBH monitors through the QAPIP. For further information see SWMBH Policy (3.5) Critical Incidents/Sentinel Events/Risk Events.
11. Customer Grievances and Appeals	Collected and monitored by the SWMBH and analyzed for trends and improvement opportunities. Categories will be used for reporting including: Quality of Care Complaints, Access, Attitude and Service, Bill/Financial, and Quality of Practitioner Office Site. These trends will be reviewed quarterly and annually.
12. Behavior Treatment Review Data	Collected by the SWMBH from the affiliates and available for review. For more information see SWMBH Policy Behavior Treatment Review Committee. The PIHP shall continually evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes.
13. Utilization Management	An annual Utilization Management (UM) Plan is developed and UM activities are conducted across the Affiliation to assure the appropriate delivery of services. Utilization mechanisms identify and correct under-utilization as well as over-utilization. UM data will be aggregated and reviewed by the Regional UM Committee as well as QMC for trends and service improvement recommendations. To ensure that the UM program remains current and appropriate, QM will do an annual evaluation of the UM program. The Utilization Management (UM) Plan Evaluation Components include: a) 2020 UM Program Description & Plan b) Policies and Procedures in compliance with contractual, state and regulatory and. accreditation requirement. c) Department Compliance with Established UM standards. d) Adequate Access a. Telephone Access to Services and Staff. e) Timeliness of UM Decisions a. Services b. Appeals f) UM Decision-Making a. Clinical Criteria

	g) Availability of Criteria h) Consistency of Applying Criteria i) Inter-rater reliability (IRR audit) j) Coordination of Care k) Quality of Care l) Outlier Management m) Over or under utilization n) Hospital Follow-Up o) Behavioral Healthcare Practitioner Involvement
14. Jail Diversion Data	Collected by the SWMBH from the participants and available for review. Collaborative program between participant CMHSPs and their County to provide mental health treatment and assistance, if permitted by law and considered appropriate, to people with serious mental illness who are considered at risk for 1 or more of the following; entering the criminal justice system; not receiving needed mental health services during incarceration in a county jail; not receiving needed mental health treatment services upon release or discharge from a county jail; and being committed to the jurisdiction of the Department of Corrections. SWMBH collects and reports the number of jail diversions (pre-booking, and post booking) of adults with mental illness (MI), adults with co-occurring mental health and substance abuse disorders (COD), adults with developmental disabilities (DD), and adults with developmental disabilities and co-occurring mental health and substance abuse disorders (DD & COD).
15. Call Center Monitoring Plan	The QM Department in collaboration with UM Department is responsible for ensuring a call center monitoring plan is in place. The monitoring plan includes National Quality Standards (NCQA) such as: providing routine quality assurance audits through random call monitoring and tracking call center service lines (crisis, emergent, immediate and routine) calls for timely responses. Call center performance measures may include: a) A call abandonment rate of 5% or less. b) Average call center answer time of 30 seconds or less. *c)* Service level standard of 75% or above. (*meaning 75% of calls are answered in 30 seconds or less and not abandoned)*
16. Collaborative Activities	In an effort to improve outcomes, the QM Department collaborates with multiple functional areas on a quarterly basis to provide quality updates and data reviews. Many of the QM Department functions overlap with Technology, Utilization Management and Clinical objectives/goals. The QM Department has an active present throughout all functional areas to enhance communication and feedback mechanisms between collaborative groups and Committee's. The QM Department also collaborates with other quality organizations, physical health organizations and venders to share information, to improve overall member outcomes.
17. Active Participation of providers and consumers in the QAPIP process	SWMBH QI Policy 3.2- III.D: Indicates that: "*Member feedback on QAPI activities will be sought and incorporated into the QAPI plan*". On a quarterly schedule, data is brought to Customer Service Committee by QAPI team members for presentation and feedback. Some of the reports that are shared with the Customer Service Committee and MI Health Link Committee's include: MMBPIS Performance Indicator reports; Customer Satisfaction survey planning and results; Grievance and Appeals reports; Critical Incident reports and the annual QAPI evaluation

	report. Lots of great feedback comes from these Regional Committees and it gives the QAPI department the opportunity to receive consumer feedback on opportunities for improvement. QAPI Key Performance Indicators are also reported to consumers through quarterly newsletters and on the SWMBH website. The QAPI department actively seeks out consumer involvement and feedback to proactively improve programs, services and ultimately improved outcomes for our customers.

X. 2020 Quality Assurance/Utilization Management Department Goals

QAPI Departmental Goals:

As indicated previously in the Plan, SWMBH is taking a different approach to Department and Committee goal setting in 2019. Each Department and Regional Committee will now work together to achieve the overarching Strategic Imperatives that were identified during the Board of Directors retreat on May 10, 2019. The following represent a list of those Strategic Imperatives: (***Please see attachment E for more details on completion of Strategic Imperatives***)

1. Public Policy and Legislative Initiatives
2. Uniformity of Benefit
3. Population Health Management
4. Revenue Maximization
5. Improved Analytics and Business Intelligence
6. Managed Care Functional Review
7. Use of Level of Care Tools and Guidelines
8. Cost Reduction Strategies (MLR and ALR)
9. Proof of Value and Outcomes

XI. Data Management

As part of a productive and active Quality Improvement system it is critical that data integrity and collection is systemically monitored and improved. As such it is important to review the system for errors and ensure that the data is correct, accurate, and timely.

a. System Reviews- the QM Department along with IT is responsible for ensuring that there are:
    i. Data Reviews before information is submitted to the state
    ii. Random checks of data for completeness, accuracy and that it meets the related standards.
    iii. Source information reviews to make sure data is valid and reliable.
b. The QMC and QM Department will address any issues identified in the system review.
c. Processes should be clearly defined and replicable with consistently applied methods of tracking to assure measurability in data collection. Re-measurements should happen as often as determined necessary for the identified project(s).
d. The Health Service Advisory Group (HSAG) and Michigan Department of Health and Human Services (MDHHS) complete annual audits on SWMBH data sources, to measure and validate the accuracy of all data transactions.
e. Maintaining and organization of the SWMBH portal and reports.
f. Maintaining and organization of reports in the Tableau Data Visualization system.

XII. Data Management Continued

In May of 2019, the Managed Information Business Intelligence (MIBI) Steering Committee was formed.
The purpose of the committee is to oversee Business Intelligence strategy, resources and priorities, including report development and maintenance, taxonomies, data dictionaries, data model development, and integrity of incoming data, to ensure organizational needs are met. The Directors of QAPI, IT and Clinical Quality meet on a monthly schedule to review prioritized and relevant data issues and policies. Since each department works cross functional with all available data sources, this meeting is a great way to minimize overlap and ensure identified tasks stay on track. The secondary purpose of the committee is to ensure all data sources are reports are in alignment with contractual requirements and exceeding metric benchmarks.

(Please see attachment J *"SWMBH Managed Information Business Intelligence Department Roles"*)

XIII. Communication

The QAPI Department interacts with all other departments within SWMBH as well as the participant Community Mental Health Services Programs (CMHSPs). The communication and relationship between SWMBH's other departments and CMHSPs is a critical component to the success of the QAPI Department. The QAPI Department works to provide guidance on project management, technical assistance and support data analysis to other departments and CMHSPs. The sharing of information with internal and external stakeholders through our Managed Information Business Intelligence system and through the SWMBH SharePoint site is key. The site offers a variety of interactive visualization dashboards that give real time status and analysis to the end user. At least annually, the QAPI department shares with relevant stakeholders and the SWMBH provider network in newsletter articles and on the SWMBH website its QAPI program information and results such as member survey and QAPI & UM evaluation results.

- SWMBH acknowledges the importance of disseminating quality-related information and improvement outcomes. Communication of findings will be made to the following groups:
- Stakeholders (Including providers inside the provider network), Customers and family members of customers (whenappropriate)
- SWMBH Board
- CMH staff and SWMBH staff
- Others – State representatives

These groups and others may be provided information through a variety of methods including but not limited to:

- ✓ Newsletters
- ✓ SWMBH Website
- ✓ SWMBH SharePoint Site
- ✓ Tableau Dashboards
- ✓ SWMBH QM Reports
- ✓ Meetings
- ✓ External Reports

XIV. 2020 Quality Assurance and Performance Improvement Plan

(October 1, 2019- September 30,2020)

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
1. Michigan Mission Based Performance Improvement System (MMBPIS)	➢ MMBPIS Performance Standards will meet or exceed the State indicated benchmark, for each of the (17) Performance Measures reported to State.	➢ Maintain a dashboard tracking system to monitor progress on each indicator throughout the year (located on SWMBH Portal). ➢ Report indicator results to MDHHS on a Quarterly basis. ➢ Status updates to relevant Committees such as: QMC; RUM; RCP and Operations Committee. ➢ Ensure CMHSPs are submitting the approved template to the SWMBH FTP site on the 25th of each month. ➢ Ensure each CMHSP receives a Corrective Action Plan for any indicators that missed the State indicated bench mark. ➢ Ensure CMSHP Corrective Action Plans are achieved and improvements are recognized. ➢ Participate in MDHHS Performance indicator workgroup and communicate any changes with indicator measurement or reporting to internal and external stakeholders.	January 2020 – December 2020	QAPI Director QAPI Specialist Clinical Quality Director SUD Manager	Quarterly Submissions to MDHHS: *Q1 - 3/31/20 *Q2 - 6/30/20 *Q3 - 9/30/20 *Q4 - 12/30/20 CMHSPs submit monthly reports on the 25th of each month Via the FTP site. Annual on-site reviews for all (8) CMHSPs beginning in June 2020.

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
2.Event Reporting (Critical Incidents, Sentinel Events and Risk Events)	➢ Event Reporting-trending report Adhere to MDHHS and ICO reporting mechanisms and requirements for qualified events as defined in the contract language. ➢ Ensure CMHSPs are submitting monthly reports. ➢ Development of educational materials and guidance on Sentinel and Immediate Event reporting.	➢ Event Reporting Quarterly reports to QMC; RUM, RCP and MHL committees as part of process. ➢ Quarterly Reports of any qualified events to MDDHS including: o Suicide o Non-Suicide Death o Emergency Medical Treatment Due to medication error o Hospitalization due to injury or medication error o Arrest of a consumer that meets population standards	October 2019 – September 2020	QAPI Director QAPI Specialist	Monthly Report Submission to QAPI Specialist with Sentinel and Immediate Events being reported within 48 hours to the event reporting email address: eventreporting@swmbh.org Annual on-site reviews for all (8) CMHSPs occur in June. Select Critical Incidents are selected for review.
3.Uniformity of Benefits Cross functional Goal	➢ Perform analysis on the consistency of Inter-rater Reliability Testing to ensure uniformity of benefit. ➢ Complete analysis on Level of Care Guidelines and examine outliers/trends.	➢ Perform analysis on tool scores relative to medically necessary level of care (LOC). ➢ Identify and schedule reports on functional assessment tool scores. ➢ Ensure functional assessment data related to the LOCUS, SIS, CAFAS and ASAM are being received in the SWMBH data warehouse.	October 2019 – September 2020	Utilization Management Director Clinical Quality Manager Data Analyst Director of QAPI QAPI Specialist	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
4.Behavioral Treatment Review Committee Data Cross Functional Goal	➢ Information is collected by SWMBH from CMHs and available for review. ➢ The PIHP will continually evaluate its oversight of "vulnerable" consumers to identify ➢ opportunities for improving care.	➢ The QMC Committee will review the data collected from CMHs for trends and outliers on a quarterly basis. ➢ If trends are identified the QMC will collaborate with the Operations Committee and Regional Clinical Practices Committee to identify improvement strategies. ➢ The QMC Committee will formulate methods for improving care of "vulnerable" people.	October 2019 – September 2020	QAPI Specialist QAPI Director Data Analyst Director of Clinical Practices Regional Operations Committee	Quarterly
5.Jail Diversion Data Collection	➢ SWMBH collects and reports the number of jail diversions (pre- booking, and post booking) of adults with mental illness (MI), adults with co-occurring mental health and substance abuse disorders (COD), adults with development al disabilities (DD), and adults with development al disabilities	➢ The QMC will evaluate data trends and specific CMHSP results. ➢ Jail Diversion data is shared at QMC, RUM, and RCP regional committees. ➢ Identified Trends and suggestions for policy change are share with Regional Entities through the Operations Committee and Utilization Management Committee as needed.	October 2019 – September 2020	QAPI Specialist QAPI Director Director of Clinical Practices Director of Utilization Managemen t	Annually or as needed

	and co-occurring mental health and substance abuse disorders (DD & COD).				

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
6.External Monitoring Reviews	➢ Ensure that the participant has achieved each Quality element, as identified in the 2020 site review tool with satisfactory results. ➢ Help to formulate Corrective Action Plans for any Quality Review Elements scored out of compliance.	➢ Participant written Quality Improvement Plan for the fiscal year. ➢ Review participants Sentinel event and Critical Incident policy. ➢ Ensure participant has a BTRC that meets MDHHS requirements. ➢ The participants Jail Diversion Policy is compliant. ➢ Review of MMBPIS Performance Indicators, primary source verification documentation and protocols. ➢ Call Data Reports are submitted on a quarterly schedule (*i.e., call abandonment rate, average answer time in seconds and total incoming call volume*)	October 2019 – September 2020	QAPI Specialist QAPI Director	Annually or as needed

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
7.Review of Provider Network Audits, Guidelines, and Medicaid Verification Cross functional Goal	➢ Review audits and reports from other SWMBH departments for continuous improvement opportunities.	➢ Annual report to QMC Committee on any findings or opportunities for improvement. ➢ Corrective Action Plans (CAP) developed, issued and tracked as needed. ➢ QAPI dept. will monitor its provider network on an annual basis to ensure systematic approaches to monitoring are occurring. Results are included in the QAPI annual Evaluation report. ➢ NCQA Clinical Practice Guidelines measure performance against at least (2) aspects of the (3) guidelines. (3) Clinical practice guidelines.	October 2019 September 2020	QAPI Specialist QAPI Director Chief Compliance Officer Director of Clinical Quality	Annually

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
8.Monitor the Complaint Tracking System for Providers and Customers	➢ Monitor Grievance, Appeals and Fair Hearing Data ➢ Monitor denials and UM decisions for trends related to provider complaints for all business lines ➢ Work through Regional Committees if trends are identified to improve outcomes	➢ At a minimum, quarterly reports on customer complaints to the QMC Committee; MHL Committee; RUM Committee and RCP Committee are reviewed. ➢ Ensure proper reporting, monitoring and follow-up resolution of Grievance and Appeals data including: ➢ Billing or Financial Issues ➢ Access to Care ➢ Quality of Practitioner Site ➢ Quality of Care ➢ Attitude & Service	October 2019 – September 2020	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Director of Clinical Quality	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
9.External Monitoring, Audits and Reviews	➢ The Quality Management Department will coordinate the reviews by external entities, including MDHHS, HSAG, ➢ ICO's, NCQA and other organizations as identified by the SWMBH board. ➢ The Quality Department will ensure that SWMBH achieves the goal/score established by the Board Ends Metrics or meets the reviewing organizations expectations. ➢ The Quality Department will collect changes to contracts, managed care regulations and other contractual standards and provide education and resources to SWMBH and CMHSPs.	➢ The Quality Department will ensure all documentation is returned to the external monitoring agency in a timely manner. ➢ The Quality Department will notify other functional areas of reviews and ensure all arrangements and materials/documents are ready for review. ➢ The SWMBH QAPI Department reviews and approves plans of correction (CAPs) that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate and documented interval time. The QAPI Department may increase level of monitoring/oversight for Regional performance indicators that are consistently out of compliance.	October 2019 – September 2020	All Functional Area Senior Leaders QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Director of Clinical Quality	Annually or audits as scheduled

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
10. Utilization Management Cross functional Goal	➢ UM data will be aggregated and reviewed by the Regional UM Committee and Quality Management Committee for trends and service improvement recommendations. ➢ Identify Best Practice Standards and Thresholds to ensure valid and consistent UM data collection techniques.	➢ Report development and production. Identify software needs to track outlier management. ➢ MDHHS required initiatives. Identify reports necessary to review current utilization patterns. ➢ Work with committees to analyze data by population and level of care. ❖ **Annual UM Evaluation (FY 2020):** o Department Compliance with Established UM standards o Adequate Access/Telephone Access to Services & Staff o Timeliness of UM Decisions: Service & Appeal o UM Decision-Making: Clinical Criteria; Availability of Criteria; Consistency of Applying Criteria; Inter-rater reliability (IRR audit) o Coordination of Care o Quality of Care o Outlier Management o Over or under utilization o Hospital Follow-Up o Level II Assessments o Customer Satisfaction on service experienced with UM Department	October 2019 – September 2020	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality	Some components are monitored Monthly. All results are included in the QAPI annual Evaluation.

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
11. Emergent and Non – Emergent Access Cross functional Goal	➢ Emergent and non-emergent cases are periodically monitored to ensure compliance with standards.	➢ All crisis/emergent Calls are immediately transferred to a qualified practitioner. ➢ Non-emergent time on-hold must not exceed three minutes. ➢ All non-emergent call backs should occur within one business day. ➢ Individuals with emergent needs, shall be provided an immediate intervention.	October 2019 – September 2020	QAPI Specialist QAPI Director Director of Clinical Quality Chief Operations Officer Utilization Manager	Monthly
12. Call Center Monitoring (SWMBH reporting) for MI Health Link Business Line	➢ Ensure that a call center monitoring plan is in place. ➢ Provide routine quality assurance audits. ➢ Random (live) Monitoring of calls for quality Assurance. ➢ Tracking and monitoring of all internal service lines (crisis, emergent, immediate and routine) ➢ Collect and analyze quarterly call reports submitted by CMHSPs	➢ A review of calls and agent performance to meet a scoring criteria of 96.25% performance rate is completed and evaluated. (*not required)* ➢ Achieve a call abandonment rate of 5% or less. ➢ Monitor number of calls received for each service line. ➢ Average answer time is confirmed as; 30 seconds or less. ➢ Service level standard of 75% or above. ➢ A minimum of 12 internal (UM) calls will be evaluated per month *(calls selected randomly across all available agents)*	October 2019 – September 2020	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Monthly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
13. Management of Information Systems and Data Reporting Cross functional goal	➢ Quality Department; QMC and MHL Committee to review quality and timeliness of data reporting. ➢ Ensure Reports are timely and accurate for internal/external stakeholders.	➢ Claims Payment and tracking systems accuracy. ➢ Ensure timeliness and accuracy of Quality Indicator submissions to MDHHS. ➢ Grievance and Complaint tracking analysis. ➢ Data Security tracking. Reporting any breaches to ICO's and contract agencies. ➢ Tracking and analyzing services, cost by population groups and special needs categories. ➢ Access to care tracking (Level II Timeliness report). ➢ Monitor Data Quality, Timeliness and Completeness: ➢ Volume: Encounters submitted at 85% of monthly rolling average. ➢ Completeness: 99.8% of encounters are submitted and accepted by MDHHS (CMHSP to supply the num/denom. ➢ Timeliness: 95% of encounters adjudicated through submission cycle within 30 days or less. ➢ Assessments: 90% of consumers received the appropriate	October 2019 – December 2020	QAPI Director Chief Information Officer Chief Operations Officer Senior Systems Architect Applications and systems Analyst	Monthly

		assessment ➢ 98% of Encounters have a BH TEDs match or close match			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
14. Coordination of Care	➢ Monitors for continuity and coordination of care members receive across the network and actions improve. ➢ Demonstrate re-measurement for selected interventions. ➢ Quantitative and causal analysis of data to identify improvement opportunities. ➢ Monitors and tracks analysis of communication with health plans to coordinate BH treatment for members.	➢ Use of Care Management Technology (CMT) and CC360 to measure: Exchange of information across the continuum of BH Services. ➢ Administration and analysis of Provider Survey on collaboration and coordination of care between behavioral healthcare and medical care. ➢ Measure and analysis of appropriate use of psychotropic medications. ➢ Measure and analysis of services/programs for consumers with severe and persistent mental illness. ➢ Develop and implement a procedure for Complex Care Management community Outreach to improve member engagement and coordination. ➢ Increase outreach and care coordination with regional ED to improve BH	October 2019 – September 2020	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant Chief Compliance Officer	Quarterly

		prescreening process and reduce IP admissions. ➢ Increase outreach to Veteran and Military Families that are not currently receiving services.			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
15. Quality of Clinical Care Cross functional goal	➢ Provide Qualitative analysis for the identified opportunities . ➢ Re-measure identified opportunities and determine if interventions were effective.	➢ Create a procedure describing ➢ Create a procedure describing how the organization assists pediatric members with transition to adult practitioner. ➢ Implementation and analysis of electronic based technologies, such as: o E-visits o E-Appointment scheduling o E-prescribing o E-referrals o E-enrollment in case management or wellness programs o Online record access o My Strength Program ➢ Assist with Clinical Quality Site Reviews with monitoring the following categories: o Physician Coordination o Assessment Case files and Scoring o Progress Notes/Goals/Object	October 2019 - September 2020	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Quarterly

		ive s o Care Transitions Analysis/Reports o TEDS and Customer Discharge/Transfer			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
16. Safety of Clinical Care Cross functional goal	➢ Track patient safety/risk events and make recommendation for regional improvement. ➢ Provide a comparative report using current year and previous year's data to identify safety/risk concerns and trends. ➢ Analysis of reported risk events to identify trends.	➢ Complete an annual analysis of patient safety activities. ➢ Track and provide analysis on patient safety concerns, risk incidents including Adverse incidents, Critical Incidents or Sentinel Event that are reported by CMHSPs on a monthly basis. ➢ Monitoring/Discussi on s and collect minutes during the BRTC meetings. ➢ Cover and identified network-wide safety issues during Regional Clinical and Quality meetings. ➢ ICO Case Management ➢ Review of I & A's ➢ Background checks for Providers during Credentialing/Re-credentialing process ➢ Case Management Review Sessions	October 2019 - September 2020	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Quarterly or as needed

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
17. Member Experience	➢ Develop and evaluate the effectiveness of programs and initiatives, the QM department and QMC and MHL Committee analyzes data and customer input from various sources including customer surveys, audits, reported incidents and member or provider complaints. ➢ Data is used to identify trends and make improvements for the customer experience and improved outcomes.	➢ Distribution and analysis of an annual customer satisfaction survey for members who have received multiple services during the survey time period. ➢ Distribution, collection and analysis of annual Person in Recovery Survey (RSA-r). ➢ Medicaid Member Service Satisfaction Surveys. ➢ Medicare Member Service Satisfaction Surveys. ➢ MI Health Link – Dual Eligible Member Satisfaction Surveys. ➢ Complex Case Management Member Experience Survey. ➢ Distribution and analysis of MH and Physical Health provider communication satisfaction surveys. ➢ Causal analysis of grievance and appeal data broken into categories including: Quality of care, access, attitude and service, billing and financial issues and quality of practitioner office site.	October 2019 - December 2020	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership	Annually

		➢ Member Grievance and Appeals data ➢ Complex Case Management. ➢ Grievance and Appeals data o Results are presented to the EO, Customer Advisory Committee, Operations Committee, QMC, MHL Committee, RCP, RUM, SWMBH Board and other stakeholders annually.			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
18. Sharing and Communication of Information	➢ The Quality Department will demonstrate Sharing of information and communicati on through various internal and external resources to its membership and providers.	➢ Ensure availability of information about QI program and results through newsletter, mailings, website, and member handbook and practitioner agreements. ➢ Provide newsletter articles communicating QI performance results and satisfaction results for members and practitioners. ➢ Provide access to QMC and MHL meeting minutes and materials to internal customers. ➢ Access to the SWMBH website for various publications and Provider Directory. ➢ Access to the SWMBH SharePoint Portal	January 2019 - December 2020	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager News Letter Editor Chief Information Technology Officer	Quarterly

		for internal and external stakeholders, as a collaborative information sharing resource and report delivery system.			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
19. Serving Culturally and Linguistically Diverse Members Cross functional goal	➢ The Quality Department will work with other SWMBH Departments to address the Cultural and Linguistic needs of its membership. ➢ Review the annual Network Adequacy Plan and provide feedback for improvement projects/interventions.	➢ Ensure that Cultural Competency policies are being followed. ➢ Review Cultural Competency Plan on an annual basis to address any identified barriers to care. ➢ Work with Provider Network to improve network adequacy to meet the needs of underserved groups. ➢ Work with Provider Network to perform analysis on the network adequacy report and support identification of culturally diverse provider resources. ➢ Review Annual Cultural Competency Policies and Plan. ➢ Annually review and update Cultural Competency Goals and work plan. ➢ Annually review CMHSP partner Cultural Competency Plans.	October 2019 - September 2020	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership Director of Provider Network SWMBH Cultural Committee Chair Person	Annually

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
20. Serving Members with Complex Health Needs **Cross functional goal**	➢ The Quality Management Department will work with the Utilization Management and Clinical Departments to use process and outcome measures to improve quality and performance.	➢ Measure program effectiveness, process, member satisfaction data and outcomes to help improve the Complex Care Management Program. ➢ Population Assessment ➢ Complex Case Management Member Satisfaction Survey ➢ Causal Analysis of Complex Case Management Grievance and Appeal Data ➢ Monitor and Evaluate Access to care standards to ensure members are receiving timely services. ➢ Help to identify population health trends and plan programs and services accordingly. ➢ Qualitative and Quantitative Analysis ➢ Evaluate and monitor efforts to identify eligible CCM members.	October 2019 – September 2020	Integrated Care Nurse QAPI Director Medical Director or Consultant Director of Clinical Quality Director of Utilization Management	Quarterly

XV. QAPI – UM Evaluation

On at least an annual basis, the QAPIP is evaluated. The QAPI & UM Effectiveness Review/Evaluation document is a companion document to the annual QAPIP and will be completed at the end of the fiscal year, or shortly thereafter. The QAPI & UM Effectiveness Review/Evaluation assesses the overall effectiveness of the QAPI and UM Programs including the effectiveness of the committee structure, the adequacy of the resources devoted to it, practitioner and leadership involvement, the strengths and accomplishments of the program with special focus on patient safety and risk assessment and performance related to clinical care and service. Progress toward the previous year's project plan goals are also evaluated. The SWMBH QM department completes the evaluation and identifies the accomplishments and any potential gaps during the previous year's QM activities. When a gap is identified and addressed during that year it will be reported in the QAPI Effectiveness Review/Evaluation, other gaps may be incorporated into the next year's QAPI plan. The findings within the QAPI Effectiveness Review/Evaluation will be reported to the QM Committee, Operations Committee, SWMBH EO, and SWMBH Board.

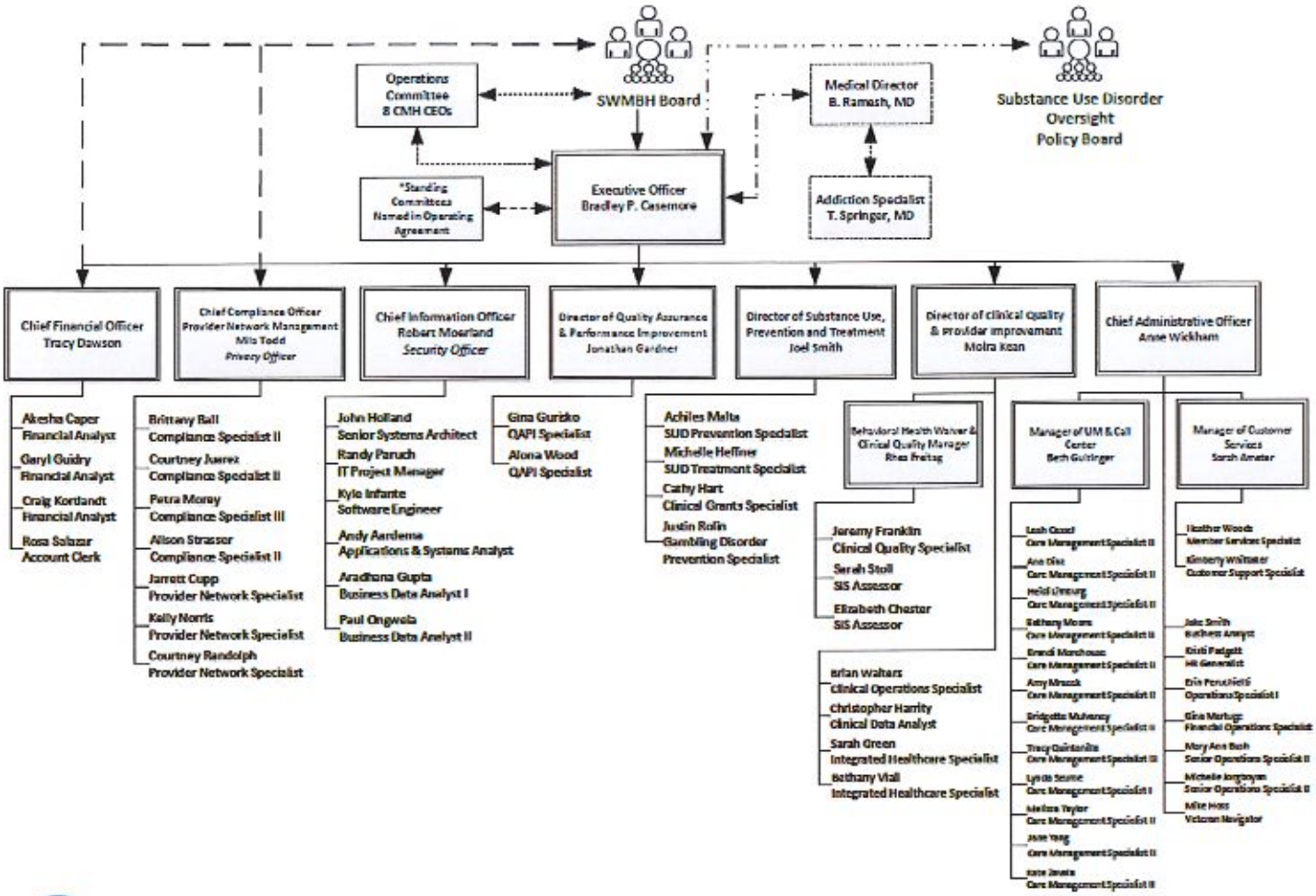
A Performance Improvement/Corrective Action Plan may be required for any area where performance gaps are identified. This describes a project improvement plan of action (including methods, timelines, and interventions) to correct the performance deficiency. A corrective action/performance improvement plan could be requested of a SWMBH department, CMHSP, or Provider Organization. When a provider within the network is required to complete such a plan, the Provider Network department will be involved and a notification of the needed action and required response will be given to the provider. A sanction may be initiated based on the level of deficiency and/or failure to respond to a Performance Improvement/Corrective Action Plan request.

XVI. References:

BBA Regulations, 42 CFR 438.240
MDHHS –PIHP Contract Attachment P 6.7.1.1 et al SWMBH Quality Management Policies 3.1 and 3.2 NCQA – 2019 MBHO Accreditation Standards – QI 11B Quality Management Committee Charter

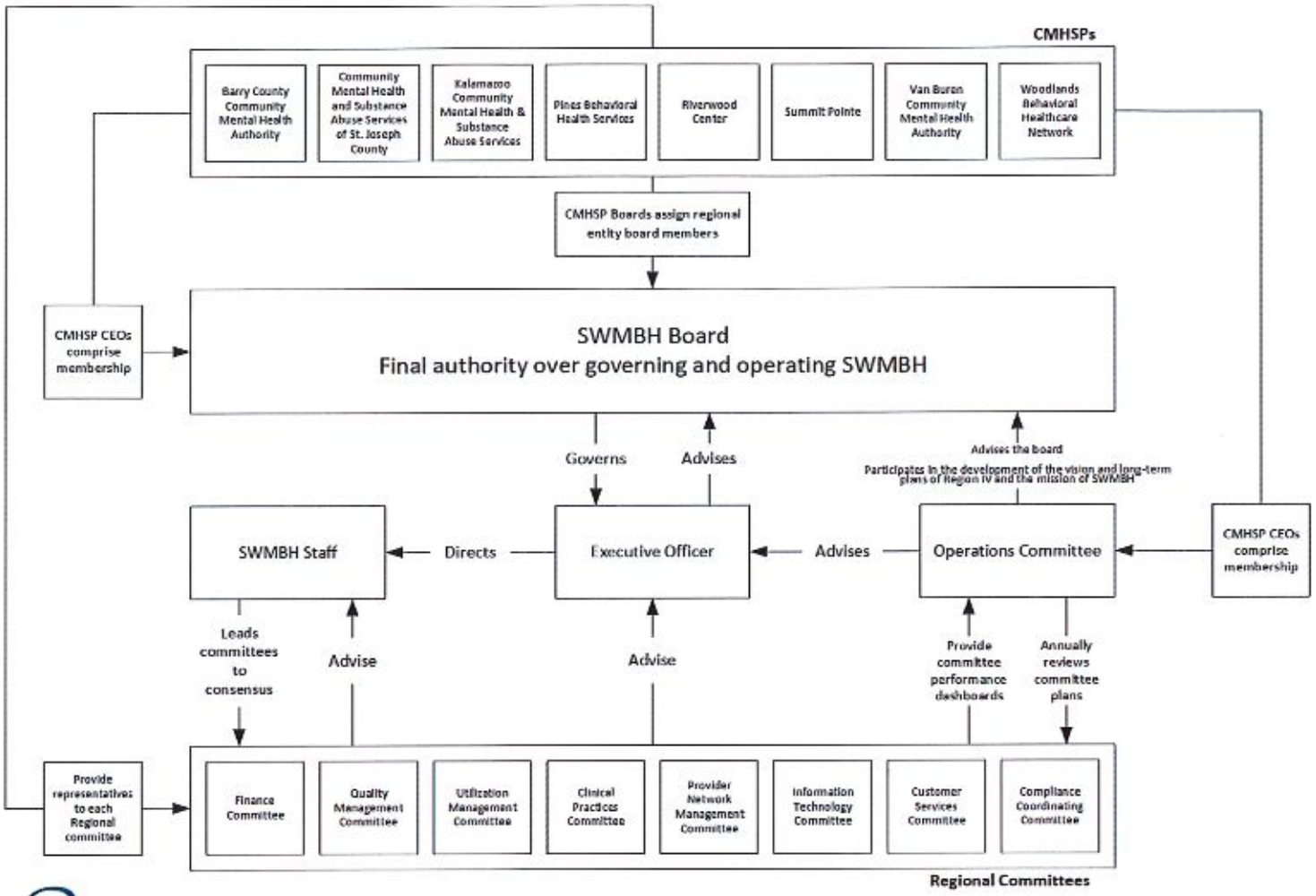
XVII. Attachments

Attachment A: Southwest Michigan Behavioral Health Organizational Chart



Attachment B: SWMBH Regional Committee Structure

SWMBH Organizational and Committee Structure



SWMB Organizational and Committee Structure
Updated 3/19/19

Attachment C: MI Health Link Quality Management Committee Charter

☒ MI Health Link
☒ SWMBH Committees: Quality Management (QMC); ☒ Provider Network Credentialing (PNCC); ☒ Clinical and Utilization Management (CUMC); ☒ Cultural Competency Management
Duration: ☒ On-Going ☐ Deliverable Specific

Charter Effective Date: 6/1/15
Charter last Review Date: 12/17/19

Approved By:

_____

Signature:

_____

Date:

_____

Purpose:	SWMBH MI Health Link Committees are formed to assist SWMBH in executing the MI Health Link demonstration goals and requirements, NCQA requirements, and contractual obligations and tasks. MI Health Link Committees ensure a care management quality control program is maintained at all times and that the PIHP shall render an authorization and communicate the authorized length of stay to the Enrollee, facility, and attending physician for all behavioral health emergency inpatient admissions in authorized timeframes. The committee ensures the PIHP and ICO conduct regular and ongoing collaborative initiatives that address methods of improved clinical management of chronic medical conditions and methods for achieving improved health outcomes. The organization approves and adopts preventive health guidelines and promotes them to practitioners in an effort to improve health care quality and reduce unnecessary variation in care. The appropriate body to approve the preventive health guidelines may be the organization's QI Committee or another clinical committee.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the committee chair and members, member needs, MI Health Link demonstration guidelines including the Three-Way Contract, the ICO-PIHP Contract and NCQA requirements. Each committee is accountable to the SWMBH Executive Officer and is responsible for assisting SWMBH Leadership to meet the Managed Care Benefit requirements within the MI Health Link demonstration, the ICO-PIHP contract, and across business lines of SWMBH. The committee is to provide their expertise as subject matter experts.
Committees Purposes:	**Quality Management Committee:** • The QI Committee must provide evidence of review and thoughtful consideration of changes in its QI policies and procedures and work plan and make changes to its policies where they are needed. *NCQA, MBHO, QI 1: Program Structure: Quality Improvement Program Structure, Element A; QI 2: Program Operations: QI Committee Responsibilities, Element A.* • Analyzes and evaluates the results of QI activities to identify needed actions and make recommendations related to efficiency, improvement, and effectiveness. Ensures follow-up as appropriate.

	NCQA, MBHO, QI 2: Program Operations, QI Committee Responsibilities Element A (Factor 1, 2 & 5) • Ensures practitioner participation in the QI program through planning, design, implementation or review. *NCQA, MBHO, QI 2: Program Operations, Element A QI Committee Responsibilities, Element A (Factor 3).* • Ensures discussion (and minutes) reflects appropriate reporting of activities, as described in the QI program description. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1).* • Reports by the QI director and discussion of progress on the QI work plan and, where there are issues in meeting work plan milestones and what is being done to respond to the issues. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 7). QI 1: Annual Evaluation, Element B (Factor 3).* • Ensures the organization describes the role, function and reporting relationships of the QI Committee and subcommittees. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1 & 4).* • Ensures all MI Health Link required reporting is conducted and reviewed, corrective actions coordinated where necessary, and opportunities for improvement are identified and followed-up. *NCQA, MBHO, QI 1: Program Structure; QI 2: Program Operations, QI Committee Responsibilities, Element A.* • Ensures member and provider experience surveys are conducted and reviewed, and opportunities for improvement are identified and followed-up. *NCQA, MBHO, QI 6: Member Experience; 9: Complex Case Management, Member Experience with Case Management, Element I (Factor 1); UM 10 Experience with the UM Process.* • Review of current status and upcoming MHL audits • Review of demonstration year quality withhold measures **Credentialing Committee:** • Uses a peer review process to make credentialing and recredentialing decisions and which includes representation from a range of participating practitioners. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 1). Aetna Contract-Attach C4; Meridian Contract.* • Reviews the credentials of all practitioners who do not meet established criteria and offer advice which the organization considers. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 2). Aetna Contract; Meridian Contract.* • Implements and conducts a process for the Medical Director review and approval of clean files. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A (Factor 10); CR 2: Credentialing Committee, Element A (Factor 3). Aetna Contract; Meridian Contract.* • Reviews and authorizes policies and procedures.

NCQA, MBHO, CR 1: Credentialing Policies; CR 2: Credentialing Committee. QI 2: Program Responsibilities, QI Committee Responsibilities, Element A. Aetna Contract-Attach C4; Meridian Contract

- Ensures that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision.
  NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 9). Aetna Contract & Meridian Contract
- Ensures reporting of practitioner suspension or termination to the appropriate authorities.
  NCQA, MBHO, CR 6: Notification to Authorities and Practitioner Appeal Rights, Actions Against Practitioners, Element A (Factor 2); NCQA, MBHO, CR 6: Notification to Authorities and Practitioner Appeal Rights, Reporting to the Appropriate Authorities, Element B. Aetna & Meridian Contracts.
- Ensures practitioners are informed of the appeal process when the organization alters the conditions of practitioner participation based on issues of quality or service.
  NCQA, MBHO, CR 6: Notification to Authorities and Practitioner Appeal Rights, Element A (Factor 4); CR 6: Notification to Authorities and Practitioner Appeal Rights, Practitioner Appeal Process: Element C (Factor 1). Meridian Contract.
- Ensures the organization's procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to, the following:
  - Maintaining a heterogeneous credentialing committee membership and the requirement for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate when they make decisions.

  NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7) Aetna Contract & Meridian Contract
  - Periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selections of practitioners.

  NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7). Aetna Contract& Meridian Contract
- Ensures annual audits of practitioner complaints to determine if there are complaints alleging discrimination.
  NCQA, MBHO, CR 5: Ongoing Monitoring, Ongoing Monitoring and Intervention: Element A (Factor 3). Aetna Contract; Meridian Contract.

Utilization Management Committee:

- Reviews and authorizes policies and procedures.
  NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A.
- Is involved in implementation, supervision, oversight and evaluation of the UM program.
  NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A. UM 1: Utilization Management Structure, Behavioral Healthcare Practitioner Involvement, Element B.
- Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring.
  NCQA, MBHO, QI 5: Accessibility of Services, Assessment against Telephone Standards, Element B. Aetna Contract; Meridian Contract.

- Ensures review of tools/instruments to monitor quality of care are in meeting minutes.
  NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria, Element A. Aetna Contract-Attachment C.; Meridian Contract.
- Ensures annual written description of the preservice, concurrent urgent and non-urgent and postservice review processes and decision turnaround time for each.
  NCQA, MBHO, UM 5: Timeliness of UM Decisions, Timeliness of UM Decision Making, Element A & Notification of Decisions, Element B. Aetna Contract; Meridian Contract-Attach C.
- Ensures at least annually the PIHP review and update BH clinical criteria and other clinical protocols that ICO may develop and use in its clinical case reviews and care management activities; and that any modifications to such BH clinical criteria and clinical protocols are submitted to MDCH annually for review and approval.
  NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 5). Aetna Contract, p. 33-34 (9.27); Meridian Contract
- Ensures the organization:
  - Has written UM decision-making criteria that are objective and based on medical evidence.
    NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 1). Aetna Contract; Meridian Contract-Attachment C.
  - Has written policies for applying the criteria based on individual needs.
    NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 2). Aetna Contract; Meridian Contract.
  - Has written policies for applying the criteria based on an assessment of the local delivery system.
    NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 3). Aetna Contract; Meridian Contract.
  - Involves appropriate practitioners in developing, adopting and reviewing criteria.
    NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 4). Aetna Contract; Meridian Contract-Attachment C.
  - Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring.
    NCQA, MBHO, QI 5: Accessibility of Services, Assessment against Telephone Standards, Element B; Aetna Contract; Meridian Contract

Cultural Competency Management Committee:

- Has written policies, procedures and plan for promoting and ensuring a culturally competent, sensitive and inclusive environment.
- Conducts an annual review of the Network Adequacy Report to ensure that the data covers all members' language, race and ethic needs as well as ensure that there is data available for practitioner race, ethnic background and language skills. There will be a comparison of the two data sets to determine if the provider network is enough to meet its members' needs, identify areas of improvement and set interventions if needed. Will review internal and provider organizational systems to determine level of compliance with the Culturally & Linguistic Appropriate Services (CLAS) standards and other pertinent requirements for MI Health Link.
  NCQA, MBHO, QI 4: Availability of Practitioners and Providers.

	Integrated Care/Clinical Quality Committee: • Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. *NCQA, MBHO, QI 10: Clinical Practice Guidelines-Element A; 2: Program Responsibilities, QI Committee Responsibilities, Element A.* • Monitors the continuity and coordination of care that members receive across the behavioral healthcare network and takes action, as necessary, to improve and measure the effectiveness of these actions. • The organization collaborates with relevant medical delivery systems to monitor, improve and measure the effectiveness of actions related to coordination between behavioral and medical care. *NCQA, MBHO, CC 1 & 2: Collaboration between Behavioral Healthcare and Medical Care Aetna Contract-Attachment C.2; Meridian Contract* • Ensures assessment of population health needs, including social determinants and other characteristics of member population, is completed annually, and the CCM program is adjusted accordingly. *NCQA, MBHA, QI 9A: Complex Case Management, Population Assessment* • Ensures member survey results feedback is reviewed and follow-up occurs as appropriate. *NCQA, MBHO, QI 9J: Complex Case Management, Experience with Case Management* • The organization demonstrates improvements in the clinical care and service it renders to members. *QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Monitors performance for all HEDIS/NQF measurements minimally annually. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Selects 3 or more clinical issues for clinical quality improvements annually. Ensures that appropriate follow up interventions are implemented to improve performance in selected areas. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Approves developed logic for calculating HEDIS measure and ensure it follows HEDIS specifications. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program*
Relationship to Other Committees:	These three committees will sometimes plan and likely often coordinate together. The committees may from time-to-time plan and coordinate with the other SWMBH Operating Committees.
Membership:	The SWMBH Executive Officers and Chief Officers appoint the committee Chair and Members. Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. Members are representing the regional needs related to Provider Network Credentialing; Quality Management and Clinical/Utilization Management as it relates to MI Health Link. It is expected that members will share information and concerns with the committee. As conduits it is expected that committee members attend and are engaged in issues, as well as bringing challenges to the attention of the SWMBH committee for possible project creation and/or assistance.

Decision Making Process:	The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal committee members a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a representative either by phone or in person, they also lose the right to participate in the voting structure on that day.

Attachment D: Quality Management Committee Charter

Quality Management Committee Charter

☒ SWMBH Committee Quality Management Committee (QMC) ☐ SWMBH Workgroup: _____Duration:
☒On-Going ☐ Deliverable Specific

Date Approved: 5/1/14

Last Date Reviewed: 12/19/19

Next Scheduled Review Date: 12/20/20

Purpose:	Operating Committees can be formed to assist SWMBH in executing the Board Directed goals as well as its contractual tasks. Operating Committees may be sustaining or may be for specific deliverables.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the SWMBH EO with input from the Operations Committee. Each committee is accountable to the SWMBH EO and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the Balanced Budget Act, the PIHP contract, and across all business lines of SWMBH. The committee is to provide their expertise as subject matter experts.

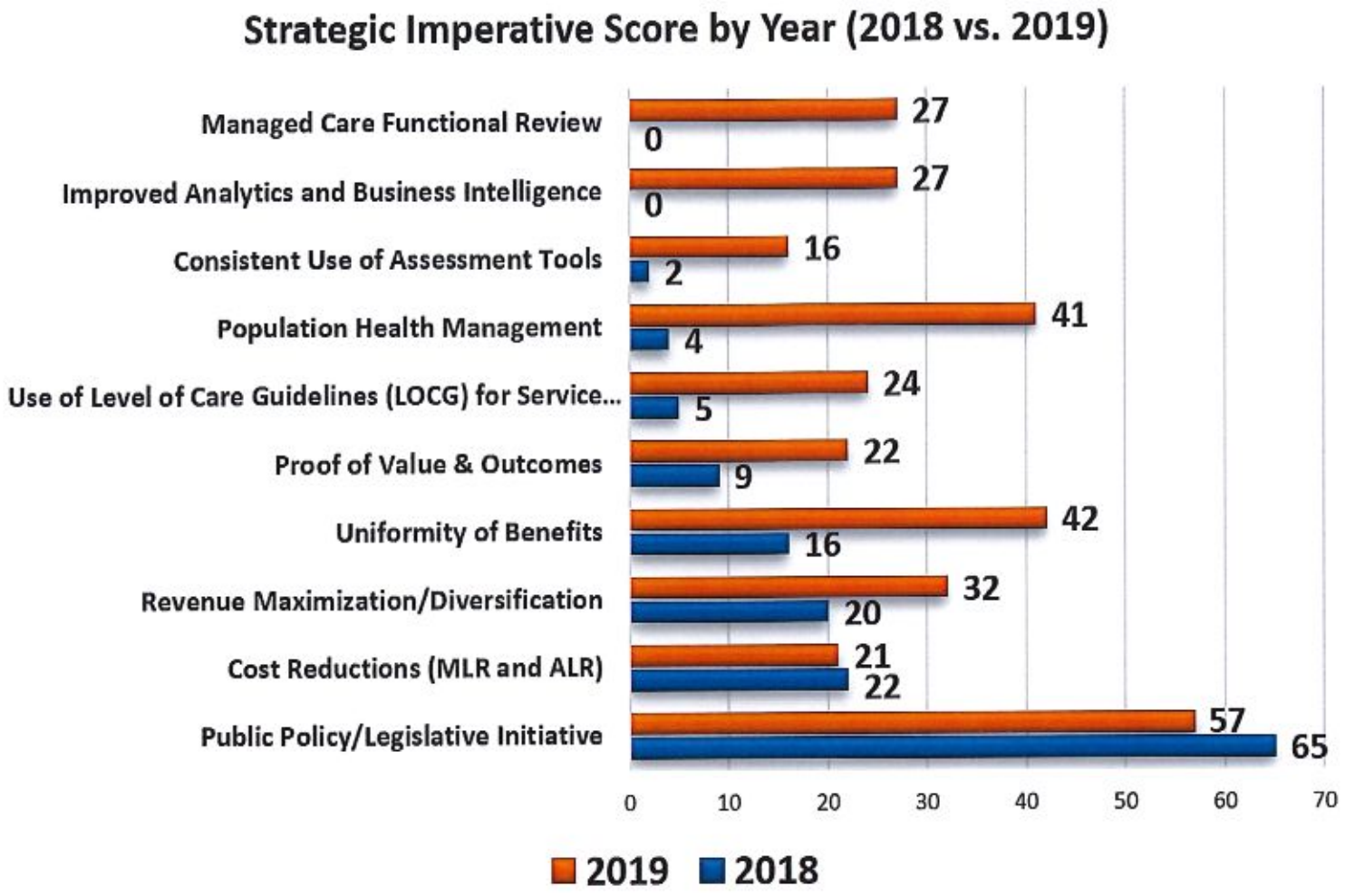
Committee Purpose:	• *The QMC will meet at a minimum on a quarterly basis to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined as reviewing data and approving projects.* • *The QMC will implement the QAPI Program developed for the fiscal year.* • *The QMC will provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.* • *The QMC will provide data review and recommendations related to efficiency, improvement, and effectiveness.* • *The QMC will review and provide feedback related to policy and tool development.*

	• *The primary task of the QM Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program/Plan* • *The secondary task of the QM Committee is to assist the PIHP in its overall management of the regional QM function by providing network input and guidance.* • *Assist the RITC Committee with management and oversight of the Data Exchange sub-workgroup related to regional strategic imperatives and CMH data submission quality and completeness.* • *Work with the RITC Committee to create sub-workgroups, as needed, to facilitate regional initiatives or address issues/problems as they occur.*

Relationship to Other Committees:	At least annually there will be planning and coordination with the other Operating Committees including: • Finance Committee • Utilization Management Committee • Clinical Practices Committee • Provider Network Management Committee • Health Information Services Committee • Customer Services Committee • Regional Compliance Coordinating Committee
Membership:	The Operating Committee appoints their CMH participant membership to each Operating Committee. The SWMBH EO appoints the committee Chair. • Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. • Members are representing the regional needs related to Quality. It is expected that members will share information and concerns with SWMBH staff. As conduits, it is expected that committee members attend and are engaged in issues and discussions. Members should also bring relevant quality related challenges from their site to the attention of the SWMBH committee for possible project creation and/or assistance. Membership shall include: 1. Appointed participant CMH representation 2. Member of the SWMBH Customer Advisory Committee with lived experience 3. SWMBH staff as appropriate 4. Provider participation and feedback

Decision Making Process:	The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal committee members and a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a representative either by phone or in person, they will lose the right to participate in the voting structure for that meeting.
Deliverables:	The Committee will support SWMBH Staff in the: • Annual Quality Work Plan development and review • QAPI Evaluation development and review • Michigan Mission-Based Performance Indicator System (MMBPIS) regional report • Event Reporting Dash Board • Regional Survey Development and Analysis • Completion of Regional Strategic Imperatives or goals, assigned to the committee • Completion, feedback and analysis on any Performance Improvement Projects assigned to, or relevant to the committee

Attachment E: Strategic Imperative Score by Year



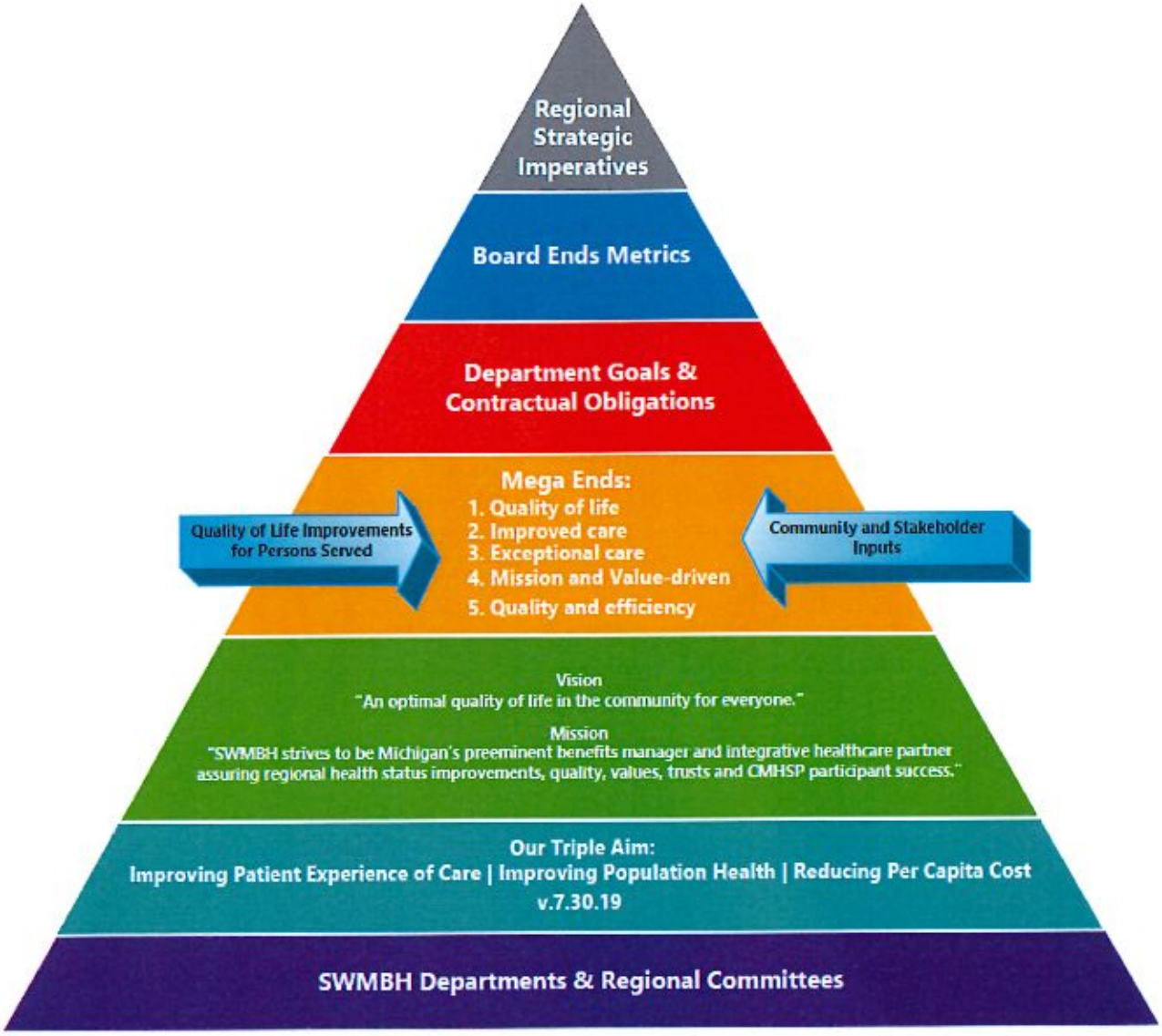
2018 Results:

1. Public Policy/Legislative Initiative	65
2. Cost Reductions (MLR and ALR)	44
3. Revenue Maximization/Diversification	43
4. Uniformity of Benefits	24
5. Proof of Value & Outcomes	18
6. Use of Level of Care Guidelines (LOCG) for Service Authorization Consistency	14
7. Population Health Management	8
8. Consistent Use of Assessment Tools	3
9. Improved Analytics and Business Intelligence	1
10. Managed Care Functional Review	0

2019 Results:

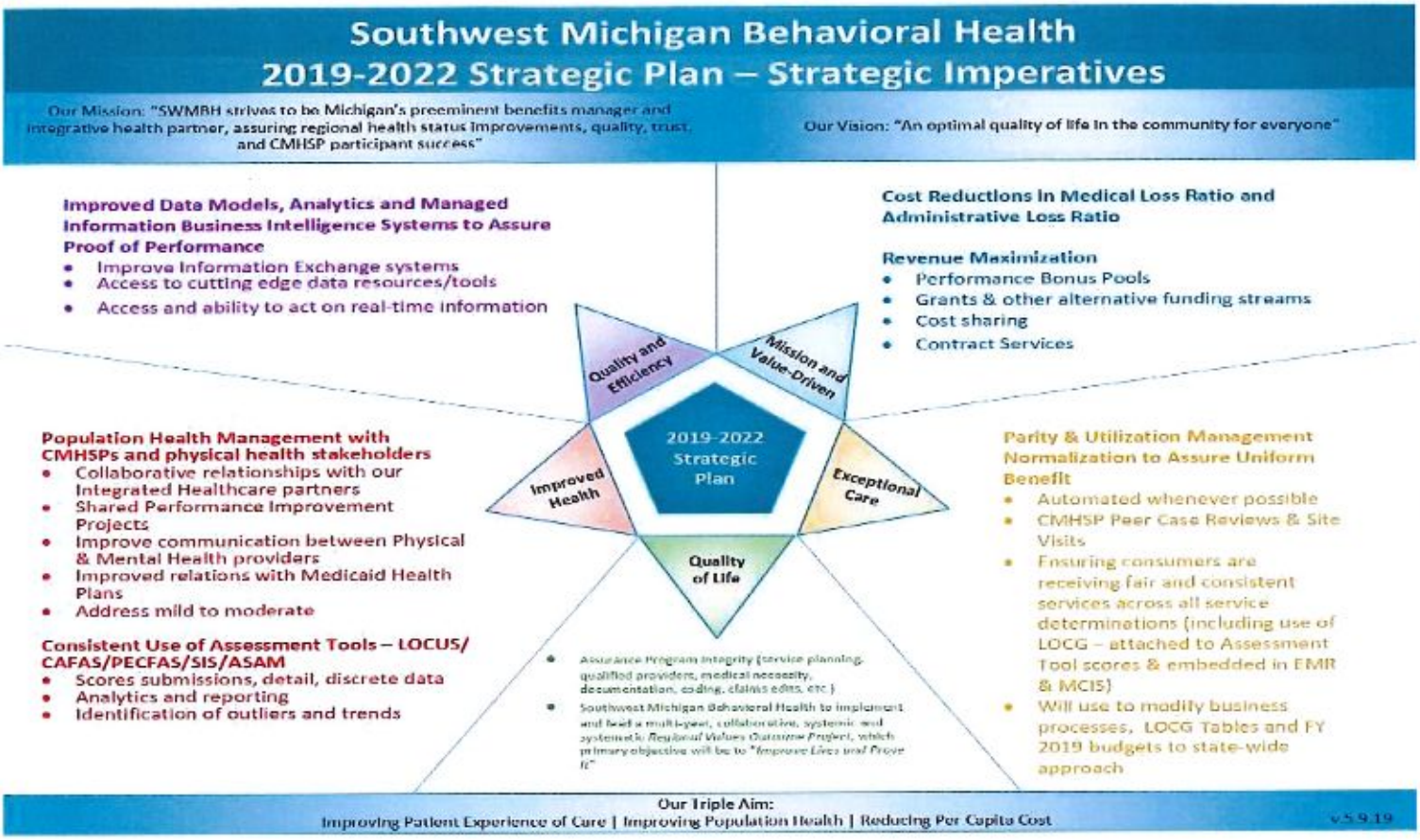
1. Public Policy/Legislative Initiative	57
2. Uniformity of Benefit	42
3. Population Health Management	41
4. Revenue Maximization	32
5. Improved Analytics and Business Intelligence	27
6. Managed Care Functional Review	27
7. Use of Level of Care Guidelines (LOCG) for Service Authorization Consistency	24
8. Cost Reductions (MLR and ALR)	21
9. Proof of Value & Outcomes	22
10. Consistent Use of Assessment Tools	17

Attachment F: Regional Strategic Imperatives



Strategic Alignment – Annual Goal Planning
Revised 7/30/19

Attachment G: 2018-2021 Strategic Plan – Board Ends Metrics



Attachment H: 2019 Board Member Roster

Southwest Michigan
BEHAVIORAL HEALTH

2020 Board Member Roster

Barry County
- Robert Nelson
- Robert Becker (Alternate)

Berrien County
- Edward Meny - Vice-Chair
- Nancy Johnson (Alternate)

Branch County
- Tom Schmelzer - Chair
- Jon Houtz (Alternate)

Calhoun County
- Patrick Garrett
- Kathy-Sue Vette (Alternate)

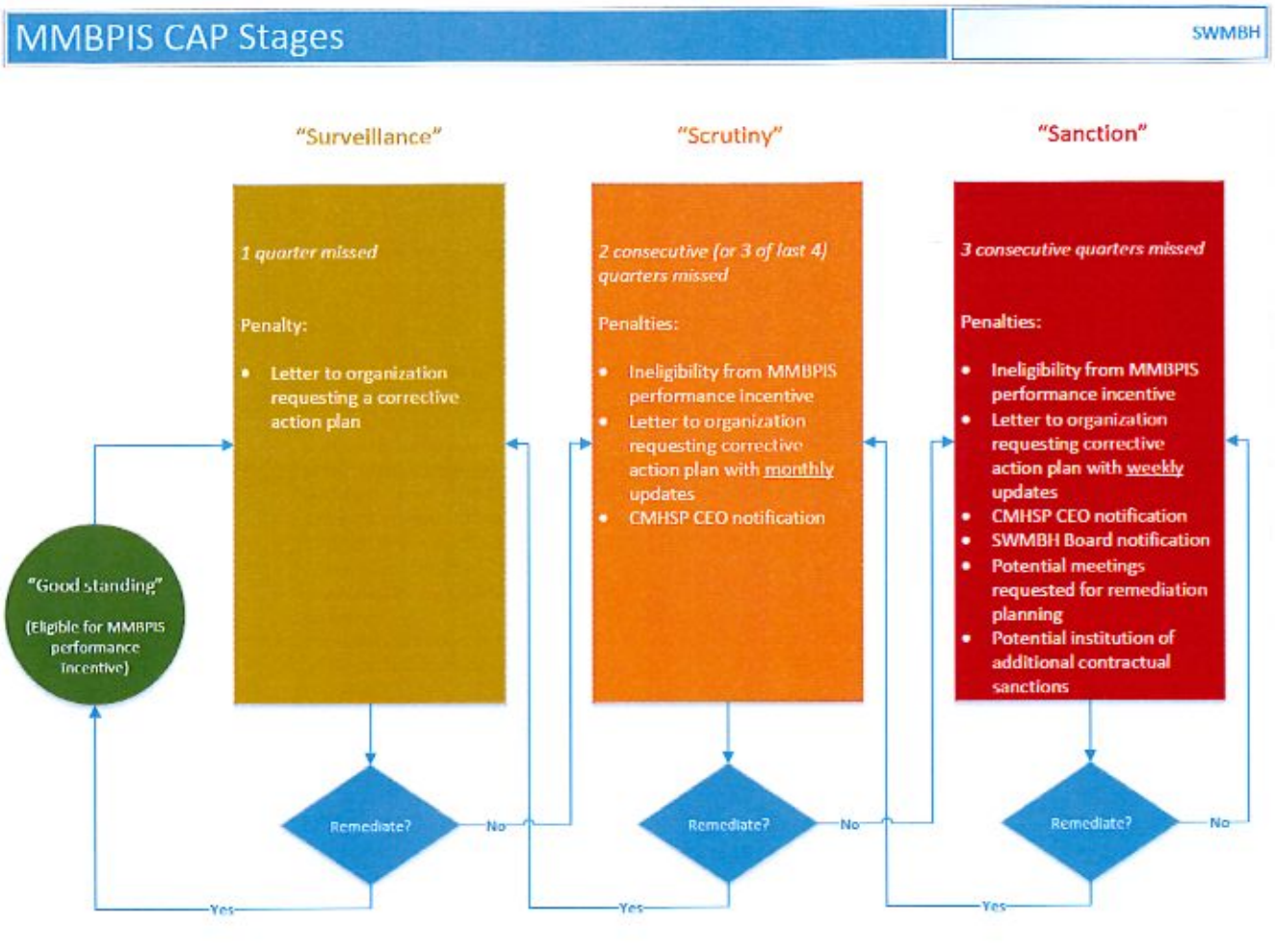
Cass County
- Michael McShane
- Karen Lehman (Alternate)

Kalamazoo County
- Moses Walker
- Patricia Guenther (Alternate)

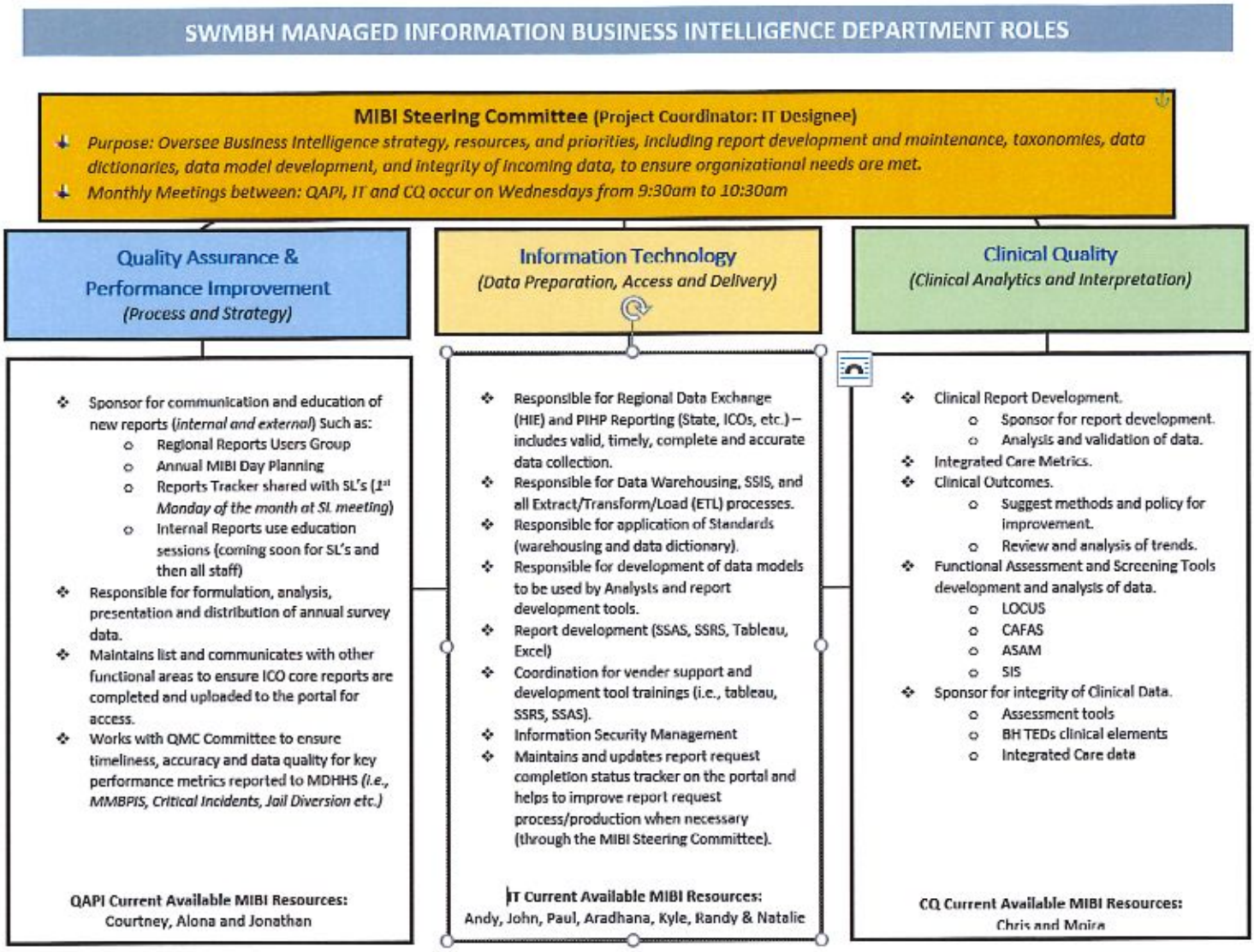
St. Joseph County
- Angie Price
- Cathi Abbs (Alternate)

Van Buren County
- Susan Barnes - Secretary
- Angie Dickerson (Alternate)

Attachment I: MMBPIS CAP Stages



Attachment J: Managed Information Business Intelligence Department Roles



Attachment K: SWMBH Value Framework

Value Framework

Our Mission

"SWMBH strives to be Michigan's preeminent benefits manager and integrative healthcare partner, assuring regional health status improvements, quality, value, trust, and CMHSP participant success".

Mega Ends

Quality of Life	Improved Health	Exceptional Care	Mission and Value-Driven	Quality and Efficiency
Persons with Intellectual Developmental Disabilities, Serious Mental Illness, Autism Spectrum Disorder, Serious Emotional Disturbances and Substance Use Disorders in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery and family preservation.	Individual mental health, physical health and functionality are measured and improved.	Persons and families served are highly satisfied with the care they receive.	CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.	The SWMBH region is a learning region where quality and cost are measured, improved and reported.

Triple Aim

Improving Patient Experience of Care | Improving Population Health | Reducing Per Capita Cost

Our Vision

"An optimal quality of life in the community for everyone".

Attachment L: Board Ends Metrics

2020 – 2021 SWMBH Board Ends
Fiscal and Calendar Year Metrics
Board Approved on November 8, 2019

2020-2021 Board Ends Metrics Review and Approval Schedule:

- *2019-2020 Strategic Imperatives discussion by SWMBH Board on: 5/10/19*
- *Operations Committee Review and Endorsement on: 10/30/19*
- *Utilization Management and Clinical Practices Committee Review and Endorsement on: 10/14/19*
- *Quality Management Committee Review and Endorsement on: 9/26/19*

Mega Ends:

1. **Quality of Life**: Persons with Intellectual Developmental Disabilities (I/DD); Serious Mental Illness (SMI); Serious Emotional Disturbances (SED); Autism Spectrum Disorders (ASD) and Substance Use Disorders (SUD) in the SWMBH region see improvements in their quality of life and maximize self- sufficiency, recovery and family preservation.
2. **Improved Health**: Individual mental health, physical health and functionality are measured and improved.
3. **Exceptional Care**: Persons and families served are highly satisfied with the care they receive.
4. **Mission and Value-Driven**: CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.
5. **Quality and Efficiency**: The SWMBH region is a learning region, where quality and cost are measured, improved and reported.

Our Mission:

"SWMBH strives to be Michigan's preeminent benefits manager and integrative healthcare partner, assuring regional health status improvements, quality, value, trust, and CMHSP participant success".

Our Vision:

"An optimal quality of life in the community for everyone."

Our Triple Aim:

Improving Patient Experience of Care | Improving Population Health | Reducing Per Capita Cost

Quality of Life

Persons with Intellectual Developmental Disabilities (I/DD); Serious Mental Illness (SMI); Serious Emotional Disturbances (SED); Autism Spectrum Disorders (ASD) and Substance Use Disorders (SUD) in the SWMBH region see improvements in their quality of life and maximize self- sufficiency, recovery and family preservation.

Improved Health

Individual mental health, physical health and functionality are measured and improved.

PROOFS	STATUS	PROOFS	STATUS
1. Achieve 95% of Performance Based Incentive Program monetary award based on MDHHS specifications. Metric Measurement Period: (10/1/19 - 11/15/20) Metric Report Date: March 12, 2021 (or when DHHS replies) A. **Identification of Veteran's eligible for services**: Timely submission of the Veteran Services Navigator (VSN) Data Collection form through DCH File transfer. Improve and maintain data quality on BH-TEDS military and veteran fields. Measurement period: 10/1/19 – 3/31/20 B. **Increased Data sharing**: Send ADT messages for purposes of care coordination through health information exchange. Submit report addressing IT systems barriers and remediation efforts by: 7/31/20 C. **Initiation and Engagement**: The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: Initiation of AOD Treatment: The percentage of enrollees who initiate treatment within 14 calendar days of the diagnosis. D. SWMBH will submit a qualitative narrative Summary report to MDHHS, related to efforts, activities and achievements with the following metrics: (By: November 15, 2020) 1. Comprehensive Care 2. Patient – Centered Medical Homes 3. Coordination of Care 4. Accessibility to Services 5. Quality and Safety	This metric has been modified to align with 2020 MDHHS approved PBIP Narrative Language	**2. Achieve the following Joint expectations for the MHP's and SWMBH. There are 100 points possible for this bonus metric in FY2019:** Metric Measurement Period: (1/1/20 - 12/30/20) Metric Report Date: October 9, 2020 (or when DHHS replies) 1. ***Joint Care Management***: 90% of care plans evaluated must achieve full compliance. 2. ***Follow-up after Hospitalization for Mental Illness (30 days):*** The adult minimum standard is 58% and the child minimum standard is 70%. 3. **Plan All-Cause Readmission (30 days):** Review and validate data, noting discrepancies found that impact the measure results, as well as actions taken to address data issues. Submit report (By: June 30, 2020) 4. **Follow-up after Emergency Department Visit for Alcohol and Drug Dependence:** Members 13 years and older with an (ED) visit for alcohol and other drug dependence, that had a 30-day follow-up visit. Submit a narrative report (4 pages) on findings of efforts to review data. Analysis should include disparities among racial and ethnic minorities. Submit report. Informational only in 2020. (By: June 30, 2020). *Possible bonus credit for #2 Follow-up after Hospitalization: +1 point – Youth over 90% +1point – Adults over 85%	This metric has been modified to align with 2020 MDHHS approved Metrics Language

Exceptional Care: Persons and families served are highly satisfied with services they receive.		Mission and Value Driven: CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.	
PROOFS	**STATUS**	**PROOFS**	**STATUS**
3. 2020 Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH 2019 results for the following categories: Metric Measurement Period: (1/1/20 - 9/30/20) Board Report Date: January 10, 2021 A. Mental Health Statistic Improvement Project Survey (MHSIP) tool. *(Improved Functioning – baseline: 85.1%)* B. Youth Satisfaction Survey (YSS) tools. *(Improved Outcomes – baseline 81.3%)* C. Initiate Performance Improvement Project (PIP), targeting consumer feedback category with the highest volume of responses and potential improvement. (By: July 31, 2020)	Modified Metric	**4. 48/56 or 85% of State Measured MMBPIS Indicators will be at or above the State benchmark for 4 quarters for FY 20.** Metric Measurement Period: (1/1/20 - 12/31/20) Board Report Date: March 12, 2021 **Measurement:** Total number of indicators that met State Benchmark Total number of indicators measured	New Indicator may be informational only for 2020, until a new benchmark is established (2a, 2b and 3) No exceptions or exclusions indicators: (2a 2b and 3)
5. Implementation of the GAIN Assessment Tool for FY20 by 10/1/20 Per MDHHS Contract. Metric Measurement Period: (10/1/19 - 10/1/20) Board Report Date: December 11, 2020 a. Full system Implementation and integration by CMHSP's and Provider sites (By: 10/1/20) b. Training and certifying all relevant clinicians to administer the GAIN (By: 8/1/20) c. Establish baseline in FY20 for FY21.	New	**6. Regional Habilitation Supports Waiver slots are full at 98% throughout FY20.** Metric Measurement Period: (10/1/19 - 9/30/20) Board Report Date: October 9, 2020 **Measurement:** (%) of waiver slot (months) filled x 12 (#) of waiver slot (months) available *+1-point bonus credit will be awarded for (5) or more new HSW Slots SWMBH receives from MDHHS during FY20.	Existing Metric 2019 Slots: 690 2020 Slots: 710

7. Each quarter, at least 53% of parents and/or caregivers of youth and young adults who are receiving Applied Behavior Analysis (ABA) for Autism will receive Family Behavior Treatment Guidance. This service supports families in implementing procedures to teach new skills and reduce challenging behaviors. Metric Measurement Period: (10/1/19 - 9/30/20) Board Report Date: December 11, 2020 **Measurement:** # of youth/young adults whose parents and/or caregivers received behavior treatment guidance at least once per quarter # of youth/young adults receiving ABA services	Measure is in alignment with DHHS language and logic.
8. Achieve a (4 percentage point) improvement in the rate of Diabetes screenings for consumers with schizophrenia or Bipolar Disorder who are using Antipsychotic Medications. Metric Measurement Period: (1/1/20 - 12/31/20) Board Report Date: June 11, 2021 **Measurement:** Percent of members 18-64 years old with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year. **Target Goal:** 80% Current Status: 76%	+4% points improvement would be considered a statistically significant improvement This measure is reviewed and validated by HSAG

The following Board End Metrics fall into multiple Mega End categories.

Quality and Efficiency:	**Mission and Value Driven:**
The SWMBH region is a learning region, where quality and cost are measured, improved and reported.	CMHSPs and SWMBH fulfill their agencies' missions and supportthe values of the public mental health system.

9. 2020 Health Service Advisory Group (HSAG) External Quality Compliance Review. All standards and corrective action plans evaluated, will receive a minimum compliance score of 90% or designation that the standard has been "Met". Metric Measurement Period: (1/1/20 - 12/30/20) Board Report Date: February 12, 2021 **Measurement:** Number of Standards Identified "Met" at 90% Total Elements Evaluated (8)	**Scheduled for September 2020** 2018 Results: 167/187 or 89% of Total Elements Evaluated achieved compliance. Standards evaluated at (Below 90%): 1. Customer Service (2018 score – 86%) 2. Grievance Process (2018 score – 81%) 3. Appeals (2018 score – 87%) SWMBH ranked 2nd highest among 10 PIHP's. The Board Metric of 90% was "Not Met".
10. 2020 HSAG Performance Measure Validation Audit Passed with (95% of Measures evaluated receiving a score of "Met") Metric Measurement Period: (1/1/20 - 6/30/20) Board Report Date: September 11, 2020 **Measurement:** Number of Critical Measures that achieved "Met" Total number of Critical Measures Evaluated	**Scheduled for July 2020** **2019 Results** 37/37 or 100% of Total Elements Evaluated received a designation score of "Met", "Reportable" or "Accepted". The Board Ends Metric was successfully "Met".
11. A. 97% of applicable MH served clients (with an accepted encounter) **will have a matching and accepted BH TEDS record as confirmed by the MDHHS quarterly status report.** B. **97% of applicable SUD** served clients (with an accepted encounter) **will have a matching and accepted BH TEDS record as confirmed by the MDHHS quarterly status report.** Metric Measurement Period: (1/1/20 - 7/1/20) Board Report Date: September 11, 2020 **Measurement:** (#) of reportable MH/SUD encounters (#) of MH/SUD encounters with BH TEDS matching record	Data Source: MDHHS Monthly Status Reports Current Baseline: 2/16/19 • MH = 87.12% • SUD = 85.63% Current Status: 8/5/19 • MH = 94.11% • SUD = 94.43% 95% puts SWMBH in the green (compliance) on the MDHHS report. Matching rules as defined by MDHHS. Must have a matching and accepted BH TEDS record completed within one year of the encounter. For MH, this means that SWMBH minimally need an annual update record completed by the provider/CMHSP.

12. Completion of LOC guidelines to ensure consistent Medicaid benefit across the Region. (By: 4/15/20)

Metric Measurement Period: (10/1/19 - 4/1/20)
Board Report Date: April 10, 2020

A. Significant Improvement of Functional Assessment tool detailed sub- element scores (LOCUS, ASAM, CAFAS, SIS) are received electronically by SWMBH from CMHSPs. (By: 4/1/20)
B. Complete detailed specification sheets for each Assessment tool, including; what elements are required in transactions and validity and quality of data standards. (By: 3/6/20)

Tool	Current Status	Goal
LOCUS:	98.6%	99.6%
ASAM:	85.1%	88.3%
CAFAS:	95.6%	97.2%
SIS:	88.8%	91.8%

Replacement
Metric

Goal for each Assessment was based on a significant variation (%) improvement calculation.

(subtract benchmark number from target result and divide the result by the benchmark number, equals final (%) improvement variance result)

(ex. 85.1 – 89.3/89.3x = 88.3)

Each completed Goal is ¼ point. (1/4 x 4 = 1 point)
If all Goals are completed successfully +1 bonus point awarded.

13. SWMBH will achieve 90% of available monetary bonus award for achievement of quality withhold performance measures identified in the (2019-2020) MHL Integrated Care Organization (ICO) contracts including:

Metric Measurement Period: (1/1/20 - 12/30/20)
Board Report Date: March 10, 2021

a. 90% of paid claim encounters are submitted by the 15th of the month following payment.
b. 95% CMS initial acceptance rate of PIHP encounters are received monthly.
c. 95% of enrollees have a level II assessment completed within 15 days of their level I assessment.
d. 80% of enrollees with an inpatient psychiatric admission discharged to home or any other site of care for whom a transition record was transmitted within (24 hours) of discharge to the facility or BH professional designated for follow-up care.
e. 95% of enrollees have documented discussions regarding care goals.

Modified
Contingent on Demonstration
Year 4-5 approved Quality
Withhold Metrics

f. The PIHP will designate (2) members to serve on the MHL advisory board. *SWMBH achieves 1-point credit for achievement of (*90% of total possible points - each contract*) +1pt. Aetna Quality Withhold Measures +1pt. Meridian Quality Withhold Measures	

Each Board End Metric proof's current status will be placed into one of (3) categories.

LEGEND: COMPLETED GOAL/ON TARGET: GREEN GOAL NOT MET/BEHIND SCHEDULE: RED PENDING: BLUE

Pending: proof could mean that;

- More Information is needed.
- The event/program/intervention has been scheduled, but not taken place (i.e., audits or final data submissions).
- Data has not been completed yet (i.e., due on a quarterly basis or different time table/schedule).
- Metric is on hold, until further information is received.

Goal Not Met: proof could mean that;

- The proof is behind its established timeline in being completed.
- Reports or evidence for that proof have not been identified.
- The identified metric proof has passed its established timeline target.

Completed Goal:

- Evidence/proof exists that the metric has been successfully completed.

All Board Ends Metrics will be in alignment with 2020-2021 Board Approved Strategic Imperatives

1. Public Policy and Legislative Initiatives.

2. Parity and Utilization Management Normalization to Assure Uniformity of Benefit.
3. Cost Reductions in Medical Loss and Administrative Loss Ratio.
4. Improved Data Models, Analytics and Managed Information Business Intelligence Systems.
5. Development of Performance Based Care and Outcomes Metrics.
6. Integrated Care Management with CMHSP and Physical Health Stakeholders.
7. Revenue Maximization - Capture all possible and available revenue opportunities.

Southwest Michigan
BEHAVIORAL HEALTH

Principal Office: 5250 Lovers Lane, Suite 200, Portage, MI 49002
P: 800-676-0423
F: 269-883-6670

RESOLUTION OF THE SWMBH BOARD

WHEREAS, Southwest Michigan Behavioral Health Regional Entity (SWMBH)was created under MCL 330.1204b of the Mental Health Code with the adoption and filing of SWMBH Bylaws by the eight Participant community mental health services programs named in Section 1.1 of the Bylaws; and

WHEREAS, during the December 13, 2019 SWMBH Board meeting the 2019 SWMBH accomplishments were reviewed, so therefore

BE IT RESOLVED that the SWMBH Board recognizes and congratulates the SWMBH staff for their dedication, commitment and hard work evidenced in the 2019 Successes and Accomplishments document. Further, the Board recognizes the SWMBH staff for their dedication to the success of Southwest Michigan Behavioral Health and more importantly to the consumers that are served throughout the region.

RESOLUTION DECLARED ADOPTED

By

_____
SWMBH Board Secretary

_____
Date

Southwest Michigan
BEHAVIORAL HEALTH

Section:	Policy Number:	Pages:
Board Policy - Governance	BG-001	1
Subject:	**Required By:**	**Accountability:**
Committee Structure	Policy Governance	SWMBH Board
Application: ☒ SWMBH Governance Board ☐ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date:	**Last Review Date:**	**Past Review Dates:**
03.14.2014	1/11/19	3.13.15, 3/11/16, 3/10/17, 3/9/18

I. **PURPOSE:**
To define a SWMBH Board Committee.

II. **POLICY:**
A committee is a Board Committee only if its existence and charge come from the Board, regardless whether Board Members sit on the committee. Unless otherwise stated, a committee ceases to exist as soon as its work is complete.

III. **STANDARDS:**
1. The Board will charge the committee formed.

Southwest Michigan
BEHAVIORAL HEALTH

Section:	Policy Number:	Pages:
Board Policy – Accomplishment	BG-004	1
Subject:	**Required By:**	**Accountability:**
Board Ends and Accomplishment	Policy Governance	SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date:	**Last Review Date:**	**Past Review Dates:**
04.11.2014	1/11/19	12.12.14, 1/8/16, 1/13/17, 1/12/18

I. **PURPOSE:**
To clearly identify the role of Ends monitoring and define accomplishment for SWMBH

II. **POLICY:**
The SWMBH Board will provide clear direction by determining Ends, approving Interpretations and adopting Ends Metrics.

III. **STANDARDS:**
Accordingly, the SWMBH Board shall:

1. Identify areas of focus (Ends) for strategic monitoring.

2. Approve Interpretations of Ends. EO shall propose Interpretations.

3. Adopt Ends Metrics which are clear, succinct, results-oriented, achievable, realistic and objective. EO shall propose Ends Metrics.

4. Regularly review data related to focus (Ends) Metrics as planned in the Board-approved calendar, upon request of the Board, or at the initiation of the EO.

5. Revisit Ends, Interpretations and Metrics as it sees fit. The EO may propose to the Board additions or revisions to Ends, Interpretations and Metrics as the EO sees fit. No changes to these are permitted absent Board approval.

Southwest Michigan
BEHAVIORAL HEALTH

Section:	Policy Number:	Pages:
Board Management/Governance	BG-007	2
Subject:	**Required By:**	**Accountability:**
Code of Conduct	Policy Governance	SWMBH Board
Application: ☒ SWMBH Governance Board ☐ SWMBH Executive Officer (EO)		**Required Reviewer:** SWMBH Board
Effective Date:	**Last Review Date:**	**Past Review Dates:**
01.10.2014	1/11/19	1.09.15, 1/8/16, 1/13/17, 2/9/18

I. **PURPOSE:**
The Board commits itself to ethical, lawful, and businesslike conduct including proper use of authority and appropriate decorum when acting as Board Members.

II. **POLICY:**
It shall be the policy of SWMBH Board that SWMBH Board Members represent the interests of Southwest Michigan Behavioral Health. This accountability supersedes any potential conflicts of loyalty to other interests including advocacy or interest groups, membership on other Boards, relationships with others or personal interests of any Board Member.

III. **STANDARDS:**

1. Members will follow the SWMBH Conflict of Interest Policy

2. Board Members may not attempt to exercise individual authority over the organization except as explicitly set forth in Board policies.
   a. Members' interaction with the Executive Officer or with staff must recognize the lack of authority vested in individuals except when explicitly Board-authorized.
   b. Members' interaction with public, press or other entities must recognize the same limitation and the inability of any Board Member to speak for the Board unless provided in policy.
   c. Members' commenting on the agency and Executive Officer performance must be done collectively and as regards to explicit Board policies.

3. Members will respect the confidentiality appropriate to issues of a sensitive nature including, but not limited, to those related to business or strategy.

4. Confidentiality: Board Members shall comply with the Michigan Mental Health Code, Section, 330.1748, & 42 CFR Part 2 relative to substance abuse services, and any other applicable privacy laws (Materials can be found by contacting the SWMBH Compliance Department)

5. Members will be properly prepared for Board deliberation.

6. Member will support the legitimacy and authority of the final determination of the Board on any matter, without regard to the Member's personal position on the issue.

7. Delegation of Authority: SWMBH Board will use due care not to delegate substantial discretionary authority to individuals whom they know, or should have known through due diligence, have a propensity to engage in illegal activities.

8. Excluded Individuals: Persons who have been excluded from participation in Federal Health Care Programs may not serve as Board Members. The Board Member becomes responsible for notifying the SWMBH Compliance Department if they believe they will become an excluded individual. The Board Member is responsible for providing information necessary to monitor possible exclusions. SWMBH shall periodically review Board Member names against the excluded list per regulatory and contractual obligations.

9. Members will read and seek to understand the SWMBH Compliance Plan and Code of Conduct.

    A. Members have a duty to report to the SWMBH Chief Compliance Officer any alleged or suspected violation of the Board Code of Conduct or related laws and regulations by themselves or another Board Member.
    B. Members may seek advice from the Board Chairman or the SWMBH Chief Compliance Officer concerning appropriate actions that may need to be taken in order to comply with the Code of Conduct or Compliance Plan.
    C. Reporting Suspected Fraud: SWMBH Board must report any suspected "fraud, abuse or waste" (consistent with the definitions as set forth in the Compliance Program Plan) of any SWMBH funding streams.
    D. Failure to comply with the Compliance Plan and Board Code of Conduct may result in the recommendation to a Participant CMH Board for the member's removal from the SWMBH Board.
    E. Members will participate in Board compliance trainings and educational programs as required.
    F. SWMBH Board will establish at SWMBH, and encourage throughout its region, cultures that promote prevention, detection, and resolution of instances of misconduct in order to conform to applicable laws and regulations.
    G. SWMBH Board Members shall cooperate fully in any internal or external Medicaid or other SWMBH funding stream compliance investigation.

"Conflict of Interest" (Definition): means any actual or proposed direct or indirect financial relationship or ownership interest between the Board Member and any entity with which SWMBH has or proposes to have a contract, affiliation, arrangement or other transaction.

Southwest Michigan
BEHAVIORAL HEALTH

Section:	Policy Number:	Pages:
Board Policy - Executive Limitations	BEL-001	1
Subject:	**Required By:**	**Accountability:**
Budgeting	Policy Governance	SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
02.14.2014	1/11/19	8.8.14, 11/13/15, 1/13/17, 1/12/18

I. **PURPOSE:**

II. **POLICY:**
Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate from Board Accomplishments/Results/Ends priorities, risk fiscal jeopardy, or fail to be derived from multi-year plan.

III. **STANDARDS:**
Accordingly the Executive Officer may not allow budgeting which;

1. Contains too little information or omits information to enable credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.

2. Plans the expenditures in any fiscal year of more funds than are conservatively projected to be available for that period.

3. Provide less than is sufficient for board prerogatives, such as costs of fiscal audit, Board development, Board and Committee meetings, and Board legal fees.

4. Endangers the fiscal soundness of future years or ignore the building of organizational capability sufficient to achieve future ends.

5. Cannot be shared with the Board on a monthly basis.

Southwest Michigan Behavioral Health
Executive Limitations
Monitoring to Assure Executive Performance

January 10, 2020

Policy Number: BEL-001
Policy Name: Budgeting
Board Date: January 10, 2020
Assigned Reviewer: Michael McShane

Policy:

Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate from Board Accomplishments/Results/Ends priorities, risk fiscal jeopardy, or fail to be derived from a multi-year plan.

CEO Response: This report addresses fiscal year 2019 (October 1, 2018 to September 30, 2019) and budget process for fiscal year 2020 (October 1, 2019 to September 30, 2020). Budgeting and financial reporting have been driven by adopted Board Ends Metrics, Board-reviewed Assumptions and fiscal parameters as well as Board directives from Board Planning Sessions.

Accordingly, the CEO may not allow budgeting which:

1. *Contains too little information or omits information to enable credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.*

CEO Response: Fiscal year 2019 and fiscal year 2020 budgeting and financial reporting each included as much information from the state as they would provide to enable credible projection and tracking of revenues. Expense projections include appropriate categories with specificity on the multiple SWMBH contracts and business lines and across eight Participant CMHs. Capital and operational items were budgeted and reported as were cash flows.

SWMBH provided technical assistance and expectations guidance to CMHSP's throughout the FY2020 budget development process, and

Medicaid and Healthy Michigan eligibles trending and projections (which drive projected Medicaid and Healthy Michigan revenues) were made for fiscal year 2019 and fiscal year 2020. Fiscal year 2019 Medicaid revenue actual receipts to budget projections were up $93,487 (less than a percent point.0%) and up

$6,452,339 (3.0%) from fiscal year 2018. The increase was due to a change in the rate setting process.

Healthy Michigan Plan fiscal year 2019 revenue receipts were up $1,481,649(5.1%) from budget, and up $4,246,364 (4%) from fiscal year 2018.

Capital and operational items are detailed consistent with GAAP. Cash flows are projected and monitored. Budget documents, financial reports and accompanying materials disclose related planning assumptions which were reviewed with the Board in June 2018 for fiscal year 2019, and in June 2019 for fiscal year 2020.

Monthly fiscal year 2019 year to date financial reports have been provided to the Board monthly. All files are maintained at SWMBH Finance Department. Participant CMH CFOs and CEOs routinely review financial projections and results, as well as budget development materials.

Significant efforts by all have occurred to assure common cost allocation per federal regulations the SWMBH Board-approved Financial Risk Management and Cost Allocation Plans and MDHHS guidance.

2. *Plans the expenditures in any fiscal year of more funds than are conservatively projected to be received in that period.*

CEO Response: SWMBH Board approved budget for fiscal years 2019 and 2020 did plan for the expenditures to be more than funds projected to be received, and cost throughout the entire region related to Medicaid beneficiaries went well over budget.

3. *Provide less than is sufficient for board prerogatives, such as costs of fiscal audit, board development, board and committee meetings, and board legal fees.*

CEO Response: The fiscal year 2019 and 2020 budget included line items and sufficient amounts for Board prerogatives including costs of financial and compliance audit, board development, board and committee meetings and board legal fees.

4. *Endangers the fiscal soundness of future years or ignores the building of organizational capability sufficient to achieve future ends.*

CEO Response: The fiscal year 2019 actual performance and the fiscal year 2020 budget and performance year to date require the EO to re-examine central and CMH expenses to the depth and breadth he finds necessary to effect necessary change, without violating contract terms or Board directives.

SWMBH did not ignore the building of organizational capability sufficient to achieve Ends in future years but management is concerned about the possibility of ending fiscal year 2020 without out any Medicaid Savings and a largely depleted Internal Service Fund.

SWMBH has been active in a number of expense reductions, revenue maximization and funding advocacy efforts with some successes.

5. *Cannot be shared with the board on a monthly basis.*

CEO Response: The fiscal year 2019 and 2020 financial reports have been shared with the Board congruous with the Board's governing documents, and in format(s) approved or accepted by the Board. Throughout fiscal year 2019 and into 2020 monthly financial reports, critical assumptions, and threats to fiscal health were regularly shared with the Board.

The CEO provided this report and supporting materials to assigned Reviewer. CEO and CFO offered to meet with assigned Reviewer.

Supporting Documents

- Board Ends Metrics, 2018-2019
- Fiscal Year 2020 Budget Assumptions and Parameters
- Fiscal Year 2019 Board approved Budget
- Fiscal year 2020 Board-approved Budget
- Fiscal Year 2019 Board Retreat Summary
- Fiscal Year 2019 Financial Statements

END

Southwest Michigan Behavioral Health

Utilization Management Program for Members Enrolled in Medicaid, Healthy Michigan Plan, SUD Community Grant, Flint 1115 Waiver, Autism Benefit, SED, Child or Habilitation Supports Waivers

FY 2020 (October 1,2019 – September 30, 2020)

Table of Contents

Introduction

Southwest Michigan Behavioral Health is the Regional Entity designated to function as the Prepaid Inpatient Health Plan performing the benefits management function for members receiving services under the Medicaid Managed Specialty Supports and Services Demonstration 1115 Waiver, 1915 (c) (i) Program(s), the Healthy Michigan Program, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs for behavioral health specialty and substance use disorder services for the eight county region of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St Joseph and Van Buren counties. The specialty mental health services are provided by eight Community Mental Health Services Programs (CMHSP's: Barry County Community Mental Health and Substance Abuse Services, Community Mental Health and Substance Abuse Services of St. Joseph County, Kalamazoo Community Mental Health and Substance Abuse Services, Pines Behavioral Health, Riverwood Center, Summit Pointe, Van Buren Community Mental Health, Woodlands Behavioral Health Network) and their provider networks. The substance use disorder services are managed and/or provided by a combination of various CMHSP's and the SWMBH provider network. SWMBH is also designated as a duals demonstration pilot region for persons enrolled in the MI Health Link plan (MHL).

These various funding source/programs managed by SWMBH possess different definitions, criteria and benefits. The Medicaid Managed Specialty Supports and Services program is available to both children and adults and is funded under Medicaid which is a Federal and state entitlement program that provides physical and behavioral health benefits to low income individuals who have no insurance. Criteria for Medicaid varies based among other indicators including on disability type, physical health status, age and income. Healthy Michigan Plan provides comprehensive health care coverage for a category of eligibility for individuals who are 19-64 years of age; have income at or below 133% of the federal poverty level; do not qualify for or are not enrolled in Medicare; do not qualify for or are not enrolled in other Medicaid programs; are not pregnant at the time of application; and are residents of the State of Michigan. The Flint 1115 Waiver a program available under Medicaid. Eligibility for coverage includes children up to the age of 21 who are or were being served by Flint's water system between April 2014 and a future date when the water system is deemed safe. Pregnant women and their children also will be made eligible. Substance Use Disorder Community Block Grant is a Federal program that provides substance use disorder benefits to low income individuals who have no insurance.

Purpose

The purpose of the Utilization Management (UM) Program is to maximize the quality of care provided to customers while effectively managing the Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waivers and SUD Community Grant resources of the Plan while ensuring uniformity of benefit. SWMBH is responsible for monitoring the provision of delegated UM managed care administrative functions related to the delivery of behavioral health and substance use disorder services to members enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waiver and SUD Community Grant. SWMBH is responsible to ensure adherence to Utilization Management related statutory, regulatory, and contractual obligations associated with the Department of Health and Human Services (DHHHS) Medicaid Specialty Services and SUD contracts, Medicaid Provider Manual, mental health and public health codes/rules and applicable provisions of the Medicaid Managed Care Regulations, the Affordable Care Act and 42 CFR.

The utilization management program consists of functions that exist solely to ensure that the right person receives the right service at the right time for the right cost with the right outcome while promoting recovery, resiliency, integrated and self-directed care. The most important aspects of the utilization management plan are to effectively monitor population health and manage scarce resources

for those persons who are deemed eligible while supporting the concepts of financial alignment and uniformity of benefit. Ensuring that these identified tasks occur is contingent upon uniformity of benefit, commonality and standardized application of Intensity of Service/Severity of Illness criteria and functional assessment tools across the Region, authorization and linkage, utilization review, sound level of care and care management practices, implementation of evidenced based clinical practices, promotion of recovery, self-determination, involvement of peers, cross collaboration, outcome monitoring and discharge/transition/referral follow-up.

Values

SWMBH intends to operate a high quality utilization management system for public behavioral health and substance abuse services which is responsive to community, family and individual needs. The entry process must be clear, readily available and well known to all constituents. To be effective, information, assessment, referral and linkage capacity must be readily and seamlessly available. Level of care and care management decisions must be based on medical necessity and on evidenced based, wellness, recovery and best practice. SWMBH is committed to ensuring use of evidence-based services with member matching that drive outcomes/results/value for taxpayer dollar and maximization of equity across beneficiaries. As a steward of managing taxpayer dollars, SWMBH is committed to the identification, development and use of innovative and less costly supportive services (e.g., Assistive Technology, Certified Peer Supports and Recovery Coaches, etc.) while meeting the service needs of members in the region. SWMBH recognizes that access to physical and behavioral health services is critical to successful recovery and outcomes at both the individual and service management levels. Maximizing access to integrated service depends upon appropriate utilization throughout all aspects of the screening, assessment, level of care and care management decision making processes and care coordination and through oversight, fidelity and outcomes monitoring.

Authority and Structure

Program Oversight

The SWMBH Utilization Management Program shall operate under the oversight of the SWMBH Medical Director. Additionally, the Regional Utilization Management Committee shall serve in a critical role involving deliberation, consultation and proof of performance realms. The SWMBH Medical Officer is accountable for management of the PIHP's Utilization Management Program. Jointly with the board-certified Medical Officer, the Chief Administrative Officer and Manager of UM and Call Center provides clinical and operational oversight and direction to the UM program and staff and ensures that SWMBH has qualified staff accountable to the organization for decisions affecting customers.

Committee

SWMBH has established the Regional Utilization Management Committee (RUM) to review and provide input on monitoring and ensuring the uniformity and consistent application of standardized screening and assessment tools and level of care, service determination and eligibility criteria at a local care management level. Using level of care and utilization data to track service provision to customers and to the implementation of level of care and care management practices. Further, the committee is responsible for identifying service gaps and training needs for regional utilization management activities.

Staffing

The RUM is a PIHP Committee consisting of cross collaborative leadership representation from SWMBH including the Chief Administrative Officer and the Director of Clinical Quality andeach of the eight Community Mental Health Service Programs. At a minimum collaboration occurs with the Quality Management Committee (QMC) on an annual basis. Ongoing consultation and ad hoc representation from the SWMBH Medical Director, Customer Services, QMC, Finance, IT, Provider Network and Outcomes is available to the committee. RUM clinical representatives are experienced clinical

professionals with specialty representation for Child and Adolescent Serious Emotional Disturbance, Adults and Children with Intellectual/Developmental Disabilities, Adults with Serious and Persistent Mental Illness, and Adults and Children with Substance Use Disorders. The committee members are designated by the CEOs and empowered to make policy decisions for their CMHSP's as required by the scope of the committee in the area of Utilization Management. Furthermore, members ensure that pertinent information from the committee is shared with their respective CMHSP. The RUM committee meets at a minimum 10 times per year.

Roles of the Committee

The RUM is charged with the following

1. Ensure adherence to consistent and application of assessment tools, level of care guidelines and medical necessity criteria at the Local Care Management Level and development of recommendations for UM level of care guidelines.
2. Review and provide input on the UM Program on an annual basis assuring adherence to and synchronization with Operating Agreement sections and RUM Charter, with final approval by the PIHP Chief Administrative Officer, the Director of Clinical Quality and the Medical Director.
3. Provide input regarding the outlier management program including level of care and service utilization guidelines that may be provided without authorization, level of care and typical service utilization guidelines reviewed at the local care management level and outlier levels of care and typical service utilization data reviewed by the PIHP. This information is reviewed by the Operating Committee.
4. Ensure that services rendered are delivered by qualified staff or contracted practitioner providers. Ensure that timely and focused utilization review (UR) is provided for delegated Utilization Management functions.
5. Develop, review and act upon service utilization and outcomes data and/or reports for purposes of demonstrating consistent Uniform Benefit (including reports of under and over utilization).
6. Review service use and population health data that may affect policy and procedure including, but not limited to Appeal/Fair Hearing determinations, Recipient Right decisions, clinical best practices and service utilization and cost data.
7. Assures adherence to related data and report specification's through cross collaboration with other applicable regional committees including the Regional Quality Management, Regional Clinical Practices and Regional Customer Services Committees.

Standards and Philosophy

SWMBH is responsible for monitoring the provision of services to members enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waiver and SUD Community Grant. SWMBH ensures adherence to statutory, regulatory, and contractual obligations. Furthermore, the utilization management program is designed to be consistent with and supportive of assuring achievement of SWMBH's Board focus and guiding principles

The UM program document and subsequent policies provide a description of processes, procedures and criteria necessary to ensure cost-effectiveness, achieving the best customer outcome for the resources spent. As a Regional Entity, SWMBH's duty is to assure region-wide **uniformity** of:

1. Benefit
2. Adequate timely access
3. Application of functional assessment tools, evidenced based practices and medical necessity criteria
4. UM decision-making including application of eligibility criteria and level of care guidelines

Management information system(s) adequate to support the UM Program is central, as SWMBH, the participant CMHSP's and the SWMBH provider network rely on SWMBH IT IS, QAPI and PNM for reports. The functionalities and maintenance of such systems include, but are not limited to:

1. Utilization of electronic health information systems and incorporation/integration of behavioral health and physical health data
2. Real-time access to aggregate and case level information which is complete, accurate, timely
3. Reporting services which are automated and routine, inclusive of rule-based alerts
4. Reporting formats which are readily available, graphically presented, easy to understand and present actionable information aligned to SWMBH Ends and goals
5. Utilization of a managed care information system that meets meaningful use standards
6. Collection of uniform behavioral health and physical health data elements and utilization of functional assessment tools that provide input into severity of illness and a means to provide the data to SWMBH to manage over/under utilization and employ risk stratification models both in an effort to manage and impact population health.

Access to SWMBH Behavioral Health Services

A beneficiary may access the system through any of the following avenues:

1. Requesting services directly from SWMBH during business and after hours toll-free access/crisis line.
2. Telephonic screening or face-to-face assessment by the local CMHSP
3. Crisis behavioral health services through the local CMHSP, inpatient hospitals, mobile crisis teams, and urgent care centers
4. Requesting services from a local substance use disorder provider or CMHSP who, depending on the level of medically necessary care, subsequently collaborates with SWMBH UM for screening and authorization.

Access Standards

1. The percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (Standard = 95%)
2. The percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for services. F
3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (Standard = 95%)

4a. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (Standard = 95%)
4b. The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days. (Standard = 95%)
5. Achieve a call abandonment rate of 5% or less.
6. Average call answer time 30 seconds or less.

Level of Intensity of Service Determination

Level of Intensity	Definition	Expected Decision/Response Time
Emergent - Psychiatric	The presence of danger to self/others; or an event(s) that changes the ability to meet support/personal care needs including a recent and rapid deterioration in judgment	Within 3 hours; Prior authorization not necessary for the screening event. Authorization required for an inpatient admission within 3 hours of request
Urgent – Psychiatric	At risk of experiencing an emergent situation if support/service is not given	Within 72 hours of request; prior authorization required; if services is denied/ appealed and deemed urgent, Expedited Appeal required within 72 hours of denial
Routine	At risk of experiencing an urgent or emergent situation if support/service is not given	Within 14 days; Prior authorization required
Retrospective	Accessing appropriateness of medical necessity on a case-by- case or aggregate basis after services were provided	Within 30 calendar days of request
Post-stabilization	Covered specialty services that are related to an emergency medical condition and that are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the beneficiary's condition	Within 1 hour of request

Coordination and Continuity of Care

SWMBH is committed to ensuring each customer receives services designed to meet each individual special health need as identified through a functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and substance abuse treatment services as well as integrated physical health needs and needs that may be accessed in the community including, but not limited to, employment, housing, financial assistance, etc. The assessment is completed or housed in a uniform managed care information system with collection of common data elements which also contains a functional assessment tool that generates population-

specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, CAFAS (Child and Adolescent Functional Assessment Scale) for Youth with Serious Emotional Disturbance, SIS (Supports Intensity Scale) for Customers with Intellectual/Developmental Disabilities, ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a Substance Use Disorder. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriate clinical professionals. Treatment plans are developed through a person-centered planning process with the customer's participation and with consultation from any specialists providing care to the customer.

SWMBH ensures adherence to statutory, regulatory, and contractual obligations through four primary Utilization Management Functions.

1. Access and Eligibility: To ensure timely access to services, SWMBH provides oversight and monitoring of local access, triage, screening, and referral (see Policy Access Management). SWMBH ensures that the Access Standards are met including MMBPIS.
2. Clinical Protocols: To ensure Uniform Benefit for Customers, consistent functional assessment tools, medical necessity, level of care and regional clinical protocols have been or will be identified and implemented for service determination and service provision (see Policy Clinical Protocols and Practice Guidelines).
3. Service Authorization: Service Authorization procedures will be efficient and responsive to customers while ensuring sound benefits management principles consistent with health plan business industry standards. The service determination/authorization process is intended to maximize access and efficiency on the service delivery level, while ensuring consistency in meeting federal and state contractual requirements. Service authorization utilizes level of care principles in which intensity of service is consistent with severity of illness
4. Utilization Management: Through the outlier management and level of care service utilization guidelines for behavioral health and outlier management, level of care service utilization guidelines and central care management processes for substance use disorders, an oversight and monitoring process will be utilized to ensure utilization management standards are met, such as appropriate level of care determination and medically necessary service provision and standard application of Uniformity of Benefit (see Policy Utilization Management).

The SWMBH Utilization Management plan is designed to maximize timely local access to services for Customers while providing an outlier management process to reduce over and underutilization (financial risk) for each partner CMHSP and the substance use disorder provider network. The Regional Utilization Management Plan endorses two core functions.

1. Outlier Management of identified high cost, high risk service outliers or those with need under-utilizing services.
2. The Outlier Management process provides real-time service authorization determination and applicable appeal determination for identified service outliers. The policies and procedures meet accreditation standards for the SWMBH Health Plan for Behavioral Health services (Specialty Behavioral Health Medicaid and SUD Medicaid and Community Grant). Service authorization determinations are delivered real-time via a managed care information system or a telephonic review process (prospective, concurrent, and retrospective reviews). Outlier Management and level of care guideline methodology is based upon service utilization across the region. The

model is flexible and consistent based upon utilization and funding methodology. Oversight and monitoring of delegated specialty behavioral health UM functions. The Utilization Review process uses monthly review of outlier management reports and annual review with specialized audit tools that monitor contractual, statutory, and regulatory requirements. The reports and UR tool speak to ensuring intensity of service matching level of care with services and typical service utilization as well as any additional external audit findings (MDHHS, EQRO, etc.). Should any performance area be below the established benchmark standard, the Utilization Review process requires that a Corrective Action Plan be submitted to address any performance deficits. SWMBH clinical staff monitor the implementation of the Corrective Action Plans.

The outlier management process and subsequent reports to manage it, including Over and under utilization and uniformity of benefit, are based on accurate and timely assessment data and scores of agreed tools and service determination transactions being submitted to the SWMBH warehouse, implementation of level of care guidelines and development of necessary reports for review.

Review Activities

Utilization Management

Based on an annual review by SWMBH cross collaborative departments utilizing clinical and data model audits, an annual Utilization Management Program is developed and UM oversight and monitoring activities are conducted across the region and provider network to assure the appropriate delivery of services. Participant CMHSP's are delegated most utilization management functions for mental health under their Memorandum of Understanding and most CMHSP's are delegated UM functions for a limited scope of SUD services. SWMBH provides, through a central care management process, UM functions for all services delivered by SUD providers and all acute/high intensity SUD services inclusive of Detox, Residential and MAT/Methadone. Based upon the UM Program review, annual audits and report findings, modifications are made systemically through the UM annual work plan/goals and policy/procedure. Specific changes may be addressed through corrective action plans with the applicable CMHSP's, providers or SWMBH departments.

Provider Network practitioners and participant CMHSP clinical staff review and provide input regarding policy, procedure, clinical protocols, evidence-based practices, regional service delivery needs and workforce training. Each CMHSP is required to have their own utilization management/review process. The Medical Director and a Physician specializing in Addictionology meets weekly with SWMBH UM staff to review challenging cases, monitor for trends in service, and provide oversight of application of medical necessity criteria. Case consultation with the Medical Director who holds an unrestricted license is available 24 hours a day. SWMBH provides review of over and underutilization of services and all delegated UM functions. Inter-rater reliability testing is conducted annually for any SWMBH clinical staff making medical necessity determinations through the centralized care management or outlier management processes.

Determination of Medical Necessity

Treatment under the customer's behavioral health care benefit plan is based upon a person-centered process and meets medical necessity criteria/standards before being authorized and/or provided. Medical necessity criteria for Healthy Michigan Plan and Medicaid for mental health, intellectual/developmental disabilities, and substance abuse supports and services and provider qualifications are found in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. Levels of Care, service utilization expectations, changes (if any) in MDHHS Medicaid

criteria or professional qualifications requirements, and utilization management standards are reviewed annually by the RUM Committee with final approval by the SWMBH Medical Director.

Services selected based upon medical necessity criteria are:

1. Delivered in a timely manner, with an immediate response in emergencies in a location that is accessible to the customer;
2. Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
3. Provided in the least restrictive appropriate setting; (inpatient and residential treatment shall be used only when less restrictive levels of treatment have been unsuccessful or cannot be safely provided);
4. Delivered consistent with national standards of practice, including standards of practice in community psychiatry, psychiatric rehabilitation and in substance abuse, as defined by standard clinical references, generally accepted practitioner practice or empirical practitioner experience;
5. Provided in a sufficient amount, duration and scope to reasonably achieve their purpose – in other words, are adequate and essential; and
6. Provided with consideration for and attention to integration of physical and behavioral health needs.

Process Used to Review and Approve the Provision of Medical Services

1. Review decisions are made by qualified medical professionals. Appropriately trained behavioral health practitioners with sufficient clinical experience and authorized by the PIHP or its delegates shall make all approval and denial determinations for requested services based on medical necessity criteria in a timely fashion.
2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consulting with treating physician as appropriate
3. The reasons for decisions and the criteria on which decisions are made are clearly documented and available to the customer and provider.
4. Well-publicized and readily available appeals mechanisms for both providers and members exist. Notification of a denial includes a description of how to file an appeal and on which criteria the denial is based.
5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
6. There are mechanisms to evaluate the effects of the program using data on customer satisfaction, provider satisfaction or other appropriate measures.
7. Utilization management functions that are delegated to a CMHSP may not be sub-delegated without prior approval and pre-delegation assessment by SWMBH.

Use of Incentives

The use of incentives related to service determination approvals, denials or promotion of underutilization is prohibited. Service determinations are based only on medical necessity criteria and benefits coverage information. This information is provided to members, staff and providers via policy and other informational documentation such as the member handbook and the SWMBH website.

Intensity of Service and Severity of Illness (Levels of Care)

The expectation for service provision is that intensity of service will be aligned with severity of illness. For each population served (adults with mental illness, youth with emotional disturbances, persons with intellectual and developmental disabilities, and persons with substance use disorders), SWMBH utilizes a standardized functional assessment to identify level of need at initiation of services and at established intervals throughout service provision. SWMBH and its participant CMHs have established regional Levels of Care that correspond to needs identified through the functional assessment process, which are based on severity of illness and intensity of need. The Levels of Care and Core Service Menus for adults with mental illness were updated in 2018, with implementation on January 1, 2019. The Levels of Care and Core Service menus for youth with emotional disturbances, persons with intellectual and developmental disabilities, and persons with substance use disorders are in the process of being updated for 2019 implementation. The levels and service menus that were developed in 2016 are being used for those population areas until the updates are complete.

Each Level of Care contains a Core Service Menu with suggested service types as well as expected annual amounts of services, corresponding to needs commonly presenting at each level. Services that fall within the Core Service Menu for a given Level of Care are services for which medical necessity has been established via the functional assessment, and do not require additional UM review. Services requested that fall outside of the Core Service Menu for an individual's Level of Care may be authorized if medical necessity is established through a utilization review. These requests are referred to as Exceptions.

Most services designated as Exceptions are authorized through Local Care Management via a delegation to the CMHSPs. CMHSPs are delegated Healthy Michigan Plan and Medicaid authorization/UM functions for behavioral health community-based supports and services. For those CMHSPs which are delegated authorization/UM functions for substance use services, CMHSPs authorize and provide medically necessary services according to the SWMBH Levels of Care for SUD. For authorization of any Exception, a utilization management professional will review the request to determine if medical necessity has been established for the service, including the amount, scope, and duration of the service being requested. Exception approvals always clearly document medical necessity, and how the intensity of the service is indicated by the individual's level of need.

Levels of Care for Mental Health Specialty Services

Levels of Care for each of the SWMBH population areas are described below. Core Service Menus with recommended authorization thresholds for all levels of care (except for children with intellectual and developmental disabilities) have been developed, and are attached to SWMBH Regional Policy 4.10 Levels of Care.

PIHP Service Eligibility

Not all Medicaid-eligible persons with mental illness or emotional disturbances are eligible for PIHP services. For adults with mental illness and youth with emotional disturbance, thresholds for meeting eligibility for PIHP services are denoted below Level of Care descriptions that follow. Behavioral health services for persons with mild to moderate mental illness or emotional disturbances are provided through Medicaid health plans. All Medicaid behavioral health services for persons with substance use disorders and intellectual and developmental disabilities are provided through the PIHP.

Crisis Services

Crisis services are considered a benefit for any SWMBH customer or anyone who is physically in a county of the SWMBH region who is in need of urgent intervention. Crisis services are not considered a Level of Care and do not require prior authorization. Appropriately trained and qualified CMHSP behavioral

health practitioners with sufficient clinical experience who meet the qualifications for a preadmission unit pursuant to Michigan Mental Health Code 330.1409 Sec 409 provide prescreening services and authorization of 1-3 days of psychiatric inpatient or crisis residential, and any appropriate diversion and/or second opinion services.

Levels of Care for Adults (18 years or older) with Serious Mental Illness or Co-occurring MI and Substance Use Disorders. Level of Care Utilization System (LOCUS) The LOCUS is utilized to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level VI- Intensive High Need/Acute (Medically Managed Residential)
Customers receiving services at this level of care are adults with a LOCUS score typically of 28 or higher including a score of 4 on dimension I and who present as a persistent danger to self or others. Treatment is typically provided in an inpatient setting and is aimed at ensuring safety and minimizing danger to self and others and alleviating the acute psychiatric crisis.

Level V – Intense Need/Acute (Medically Monitored Residential)
Customers receiving services at this level of care are adults with a LOCUS score typically of 23-27 including a score of 4 on dimension II or III and who present as danger to self or others. Treatment is typically provided in a community based free standing residential setting such as Crisis Residential and is aimed at providing reasonable protection of personal safety and property and minimizing danger to self and others.

Level IV – High Need (Medically Monitored Non- Residential Services)
Customers receiving services at this level of care are adults with a LOCUS score typically of 20-22 including a score of 4 on dimension IV or V and who present with a significant impairment of functioning in most areas, moderate to significant risk of harm to self or others, with significant supported needed to function independently in the community. May be engaging in high risk behaviors and be involved in the criminal justice system. Treatment typically is provided in the community and include services such as Assertive Community Treatment and Partial Hospitalization

Level III – Moderate Need (High Intensity Community Based Services)
Customers receiving services at this level of care are adults with a LOCUS score typically of 17-19 including a sum score of 5 or less on dimension IV A & B and who present with intensive support and treatment needs however demonstrate low to moderate risk of harm to self or others, require minimal support to reside independently in the community. Occasional risk activities. Needs regular assistance with linking/coordinating and developing skills and self-advocacy. Treatment is typically provided in the community and include such services as targeted case management and supports coordination

Level II – Low Need (Low Intensity Community Based Need)
Customers receiving services at this level of care are adults with a LOCUS score typically of 14-16 who present with ongoing treatment needs however have a low impairment of functioning in most areas, low to minimal risk of harm to self or others, able to reside independently in the community. Minimal assistance with linking/coordinating actively utilizing self-improvement and treatment skills acquired. Treatment is provided in the community and is typically clinic based.

Level I – Minimal Need (Recovery Maintenance and health Management)
Customers receiving services at this level of care are adults with a LOCUS score typically of 10-13 with minimal impairment of functioning, minimal to no risk of harm to self or others, reside independently in the community. Minimal encouragement with linking/coordinating actively utilizing self-improvement and treatment skills acquired. May use PSR assistance with maintaining recovery. Treatment is provided in the community and is typically clinic based.

Level 0 -- Basic Services

Basic services are those services that should be available to all members of a community. They are services designed to prevent illness or to limit morbidity. They often have a special focus on children, and are provided primarily in community settings but also in primary care settings. There is clinical capability for emergency care, evaluations, brief interventions, and outreach to various portions of the population. This would include outreach to special populations, victim debriefing, high-risk screening, educational programs, mutual support networks, and day care programs. There are a variety of services available to provide support, address crisis situations and offer prevention services.

Thresholds for PIHP Service Eligibility for Adults with Mental Illness (subject to confirmation from biopsychosocial assessment):

Eligible for PIHP Medicaid Services (Severe need):

- LOCUS Recommended Disposition Level of 3, 4, 5, or 6, or
- LOCUS Recommended Disposition Level of 2 with need for specialty behavioral supports and services as evidenced by meeting Michigan Mental Health code definition for SMI

Not Eligible for PIHP Medicaid Services (Mild/Moderate need):

- LOCUS Recommended Disposition Level 0 or 1, or
- LOCUS Recommended Disposition Level of 2 but does not meet Michigan Mental Health code definition for SMI.

Levels of Care for Children (ages 4 – 18) with Serious Emotional Disturbance (SED) or Co-occurring SED and Substance Use Disorders. The Child and Adolescent Functional Assessment Scale (CAFAS) is utilized for ages 7-18, and the Pre-school and Early Childhood Functional Assessment Scale (CAFAS) is utilized for ages 4-6, to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level IV -- Intense Need

Customers in this level of care are children with a CAFAS or PECFAS score of 160 or higher who require total assistance and present with inability to function in most areas, persistent danger to self and others, at significant risk of institutionalization or placement out of the home, involved in numerous provider systems (criminal justice, mental health, department of human services, school). High risk difficulties in school/day care setting or substance use dominates life or is out of control.

Level III – High Need

Customers in this level of care are children with a CAFAS or PECFAS score of 120-150 with inability to function in most areas, persistent danger to self and others, at moderate to significant risk of institutionalization or placement out of the home, likely involved in numerous provider systems (criminal justice, mental health, department of human services, school). Significant difficulties in school/day care setting. Treatment needs likely beyond home based services.

Level II – Moderate Need

Customers in this level of care are children with a CAFAS or PECFAS score of 80-110 with moderate to significant inability to function in many areas, instability in living environment, multiple service needs, family requires regular support, crisis intervention services needed. Likely at risk for out of home placement, displays disruptive behavior.

Level I – Low Need

Customers in this level of care are children with a CAFAS or PECFAS score of 50-70 with minimal inability to function in some areas, overall stable living environment, service needs focus on building resiliency and other protective factors in child/family, crisis intervention not needed or infrequently need.

Level 0 – Minimal Need

Customers in this level of care are children with a CAFAS or PECFAS score of 40 and below with minimal inability to function in some areas, overall stable living environment, service needs focus on building resiliency and other protective factors in child/family, crisis intervention services not needed or needed infrequently. Children ages Infant-7 are typically placed in the Level I category for utilization management purposes with needed services authorized based upon medical necessity.

Thresholds for PIHP Service Eligibility for Youth with Emotional Disturbance, ages 7-17 (subject to confirmation from biopsychosocial assessment):

Eligible for PIHP Medicaid Services (Severe need):

- CAFAS total score of 50 or greater (using the eight subscale scores), or
- Two 20s on any of the first eight subscales of the CAFAS, or
- One 30 on any subscale of the CAFAS, except for substance abuse only.

Not Eligible for PIHP Medicaid Services (Mild/Moderate need):

- CAFAS total score of less than 50 (using the eight subscale scores), and
- No more than one 20 on any of the first eight subscales of the CAFAS, and
- No 30 on any subscale of the CAFAS, except for substance abuse only.

Levels of Care for Adults (ages 18 and older) Intellectual and Developmental Disabilities. The Supports Intensity Scale (SIS) is utilized to identify level of support needs for adults with intellectual and developmental disabilities. The SIS ABE score (the composite score of SIS Part A: Home Living Activities; Part B: Community Living Activities; and Part E: Health and Safety Activities), and the Medical and Behavioral Needs scales, are used to determine recommended level of care.

Level VI- Acute (Any functional support needs, extraordinary medical and/or behavioral support needs). ABE - Any Score. Medical 10+ OR Behavior 10+

Customers receiving services at this level of care are adults (18 years or older) and demonstrate extraordinary behavioral and/or medical needs typically provided in an acute care setting or a nursing home. May have potentially harmful, injurious or dangerous behaviors requiring frequent and consistent proactive interventions, and a formal behavior treatment plan. May have extensive medical/health needs, requiring monitoring and/or oversight multiple times during the day. Nursing services typically required to develop and train on health care protocols, if applicable.

Level V – Intense Need (Any functional support needs, high medical and/or behavioral support needs). ABE - Any Score. Medical 7-9 OR Behavior 7-9

Customers receiving services at this level of care are adults (18 years or older) and typically demonstrate significant medical needs and/or extensive behavioral needs and require total assistance on a daily basis with 1:1 or higher level of staffing. May have potentially harmful, injurious or dangerous behaviors requiring frequent and consistent proactive interventions, and a formal behavior treatment plan. May have extensive medical/health needs, requiring daily (or more) monitoring and/or oversight and hands on assistance. Nursing services may be required to develop and train on health care protocols, if applicable.

Level IV – High Need (Any functional support needs, moderate medical and/or behavioral support needs). ABE - Any Score. Medical 4-6 OR Behavior 4-6

Customers receiving services at this level of care are adults (18 years or older) and typically demonstrate substantial behavioral needs and/moderate physical healthcare needs due to medical conditions. Safety risks exist to self or others, potentially with need for environmental accommodations. May have harmful, injurious or dangerous behaviors requiring frequent and consistent proactive interventions, and a formal behavior treatment plan. May have medical/health needs requiring weekly (or more) monitoring and/or oversight and assistance.

Level III – Moderate Need (High functional support needs, low medical and behavioral support needs). ABE Score 28+, and Medical Score 0-3, and Behavior 0-3

Customers receiving services at this level of care are adults (18 years or older) and typically require frequent prompts/reminders, coaching, and/or training to engage or complete activities (less than daily/more than weekly) or physical support, or some hands-on physical support/guidance. Moderate behavioral issues may be present with or without the need for a Behavior Plan. May experience physical health issues that require increased supports.

Safety risks may be present that need to be addressed or monitored; includes safety to self and safety in the community.

Level II – Low Need (Moderate functional support needs, low medical and behavioral support needs. ABE Score 23-27, and Medical Score 0-3, and Behavior 0-3

Customers receiving services at this level of care are adults (18 years or older) and typically require occasional verbal prompts/reminders, coaching, and/or training to engage or complete activities (weekly or less) and monitoring of support needs with changes as situation dictates. May require a behavior support plan to ensure consistency and proactive approaches.

Level I – Minimal Need (Low functional support needs, low medical and behavioral support needs). ABE Score 0-23, and Medical Score 0-3, and Behavior Score 0-3

Customers receiving services at this level of care are adults (18 years or older) and typically require minimal prompts to engage or complete activities, monitoring of support needs with changes as situation dictates. Support may be needed for community inclusion. May require a behavior support plan to ensure consistency and proactive approaches.

Levels of Care for Children Developmental Disabilities (infants through age 17) (Functional Assessment Tool TBD)

Level V – Intense Need

Customers receiving services at this level of care are children and typically require total assistance on a daily basis including enriched staffing (24 hours per day, 2:1, or 1:1 staffing during awake hours).

Level IV – High Need

Customers receiving services at this level of care are children who typically require daily reminders to engage or complete activities and personal support which may include enhanced staffing (24 hours per day, 1:2 or 1:1 staffing while awake) has an active Behavior Management Plan and or specialty professional staff (OT, PT, etc.).

Level III – Moderate Need

Customers receiving services at this level of care are children who typically require frequent prompts/reminders to engage or complete activities (less than daily/more than weekly) or physical support. Moderate behavioral issues may be present with or without the need for a Behavior Plan.

Level II – Low Need

Customers receiving services at this level of care are children who typically require occasional prompts/reminders to engage or complete activities (weekly or less) to insure maintenance of

skills or physical support. Mild/moderate behavioral issues without the need for a Behavior Management Plan.

Level I – Minimal Need

Customers receiving services at this level of care are children who typically require minimal prompts to engage or complete activities, monitoring of support needs with changes as situation dictates. Support may be needed for community inclusion.

Levels of Care for Substance Use Treatment Services for Adults and Adolescents. The American Society of Addiction Medicine - Patient Placement Criteria (ASAM) are utilized to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level 0.5 – Early Intervention

Services include assessment and education for those who are at risk, but do not currently meet the diagnostic criteria for a substance-related disorder. Customers who are determined to have this level of need are typically referred to available community resources including support groups and prevention activities. Customer is screened for co-occurring mental health issues and referred to appropriate levels of care to meet identified needs. Per definition, early intervention as a specifically focused treatment program, including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process, and individuals who may not meet the threshold of abuse or dependence.

Level 1.0 – Outpatient Services

Community-based substance use outpatient treatment of less than 9 hours per week for adults and less than 6 hours per week for youth. Treatment is directed at recovery, motivational enhancement therapy and strategies to reduce or eliminate substance use and improve ability to cope with situations without substance use.

Level 2.1 – Intensive Outpatient

Community-based substance use outpatient treatment of greater than 9 hours per week for adults and greater than 6 hours per week for youth. Treatment is directed to treat multidimensional instability. This level of care may be authorized as a step-down from a higher level of care or in situations in which a higher level of care would otherwise be warranted, but is not an appropriate option (either due to inability to participate in a residential treatment program or motivational issues).

Level 2.5 – Partial Hospitalization

Partial Hospitalization treatment is a structured treatment similar to the treatment available in a residential setting, however is directed toward customers who require greater than 20 hours per week of treatment for multidimensional stability, but not requiring 24 hour care.

Level 3.1 – Clinically-Managed Low-Intensity Residential

Clinically-managed low-intensity residential treatment includes a 24-hour setting with available trained staff and at minimum 5 hours of clinical treatment services per week.

Level 3.3 – Clinically-Managed Medium-Intensity Residential

Clinically-managed medium-intensity residential treatment includes a 24-hour setting with staff who are trained to treat multidimensional needs and address risk/imminent danger.

Level 3.5 – Clinically Managed High Intensity Residential

Clinically-managed high-intensity residential treatment includes a 24-hour setting with staff who are trained to treat multidimensional needs and address risk/imminent danger and prepare for outpatient step-down. Member must be able to tolerate and use full active milieu available.

Level 3.7 – Medically-Monitored Intensive Inpatient

Medically-Monitored Intensive Inpatient – Nursing care with physician availability 24-hours per day for significant problems that arise in Dimensions 1, 2, or 3. Counselor is available 16 hours per day.

Level 4 – Medically-Managed Intensive Inpatient

Medically-Managed Intensive Inpatient – Nursing care and daily physician care 24-hours per day for severe, unstable problems that arise in Dimensions 1, 2, or 3. Counselor is available to engage the member in treatment.

Level I-D – Detoxification

Detoxification – Nursing care with services provided by a licensed hospital 24-hours per day only to address medical or psychiatric needs.

Level OMT – Opioid Maintenance Therapy

Opioid medication and counseling available daily or several times per week to maintain multidimensional stability for those with opioid dependence. Opioid maintenance therapy is considered to be an appropriate and effective treatment for opiate addiction for some customers, particularly customers who have completed other treatment modalities without success, and are motivated to actively engage in the treatment necessary in OMT.

Review Process

A Prospective Review involves evaluating the appropriateness of a service prior to the onset of the service. A Concurrent Review involves evaluating the appropriateness of a service throughout the course of service delivery. Retrospective Review involves evaluating the appropriateness of a service after the services have already been provided. Determinations are made within the previously identified timeframes.

UM staff obtain review information from any reasonably reliable source. The purpose of review is to obtain the most current, accurate, and complete clinical presentation of the customer's needs and whether the services requested are appropriate, sufficient, and cost-effective to achieve positive clinical outcomes. Only information necessary to make the authorization admission, services, length of stay, frequency and duration is requested.

Outlier Management

An integral part of SWMBH's Performance Improvement Based Utilization Management Program is continued development and implementation of its outlier management methodology. This process is a key strategy for identifying and correcting over and underutilization of services. This strategy provides the foundation for systemic performance improvement focus by the PIHP versus intensive centralized utilization controls. The design encompasses review of resource utilization of all plan customers covered by the PIHP. The intent of the outlier management approach is to identify issues of material under-utilization or over-utilization and explore and resolve it collaboratively with involved CMHSP(s).

1. Outlier Definition
   "Outlier" is generally defined as significantly different from the norm. SWMBH defines "outlier" in relation to UM as follows:
   - A pattern or trend of under- or over-utilization of services (as delivered or as authorized), compared to the typical pattern of service utilization. Over or under-utilization trends can be identified at a variety of comparative levels, including but not limited to the population, CMH, state, service type, or provider levels.
2. Outlier Identification

Multiple tools are available to SWMBH for monitoring, analyzing and addressing outliers. SWMBH's Performance Indicator Reports (MDHHS required performance standards), service utilization data, and cost analysis reports are available to staff and committees for review and comparison of overall performance. The service use analysis reports are developed to allow detailed analysis of resource utilization at macro and micro levels. Outlier reviews are organized to focus extreme outliers in contrast to regionally normative patterns. Specific outlier reports are available and generated in the MCIS and reviewed by SWMBH Utilization Management to provide adequate oversight of service utilization and potential issues of uniformity of benefit.

3. Outlier Management Procedures

A. As outliers are identified, protocol driven analysis will occur at SWMBH and the regional committee level to determine whether the utilization is problematic and in need of intervention. Data identified for initial review will be at aggregate levels for identification of statistical outliers. Additional information will be accessed as needed to understand the utilization patterns and detail.

B. Identified outliers are evaluated to determine whether further review is needed to understand the utilization trend pattern. If further review is warranted, active communication between the SWMBH staff and the regional committee or the CMHSP will ensue to ensure understanding of the utilization trends or patterns.

C. If the utilization trends or patterns are determined to require intervention at the CMHSP or the individual level, collaborative corrective action plans are jointly discussed with the CMHSP by SWMBH staff with defined timelines for completion. Corrective action plans might include:

1. Brief description of the finding(s) and supporting information;
2. Specific steps to be taken to correct the situation and a timetable for performance of specified corrective action steps;
3. A description of the monitoring to be performed to ensure that the steps are taken;
4. A description of the monitoring to be performed that will reflect the resolution of the situation.
5. Following initial review and efforts for resolution at a desk audit level, the disposition can include either positive resolution or advance to next level of review with consultation with the provider conducted by assigned PIHP staff;
6. Following consultation, recommendations are reviewed by the Director of Clinical Quality and/or the Medical Director for disposition determination. The MD and/or Director of Clinical Quality will review the recommendations, corrective action plans and processes undertaken to resolve the outlier event(s) and render final disposition.

D. The MD and Director of Clinical Quality will take into consideration the outlier severity in determining recommended remedies. The following options available at this level include:

1. Acceptance of PIHP recommendations.
2. Direction for additional PIHP staff and provider action(s),
3. Clinical Peer Review -The Peer Review consists of review, consultation, and recommendations for resolution.
4. Render final disposition.
5. Provide recommendations for action for remediation to the SWMBH CEO

E. If the utilization trends or patterns are determined to be systemic or regional in nature, collaborative corrective action is jointly discussed at the regional committee level with defined timelines for completion. Corrective action includes:
   1. Brief description of the finding(s) and supporting information;
   2. Specific steps to be taken to correct the situation and a timetable for performance of specified corrective action steps at the PIHP and CMHSP/Provider level;
   3. A description of the monitoring to be performed to ensure that the steps are taken;
   4. A description of the monitoring to be performed that will reflect the resolution of the situation.
   5. Following initial review and efforts for resolution, the review findings can include either positive resolution or advance to next level of review with consultation with the provider conducted by assigned PIHP staff;

F. The spectrum of remedies available to the PIHP in relation to its provider panels stems from the authority of the PIHP Board. Subject to PIHP CEO's approval, possible remedies can include but are not limited to:
   1. Non-payment for case.
   2. Plan member switch to new provider.
   3. Provider loss of "Delegated Benefit Management" status.
   4. Loss of credential for specified service(s).
   5. Pro-rata payback on class of cases.
   6. Contract Amendment (modification of performance expectations, compensation, or range of services purchased).
   7. Removal from provider panel.

Data Management

Data management and standardized functional assessment tools and subsequent reporting tools are an integral piece to utilization management and application of uniform benefit. Utilization mechanisms identify and correct under-utilization as well as over-utilization.

Management/monitoring of common data elements are critical to identify and correct overutilization and underutilization as well as identify opportunities for improvement, patient safety, call rates, Access standards and customer quality outcomes. A common Managed Care Information System with Functionality Assessment and Level of Care Tool scores drives Clinician/Local Care Manager/Central Care Manager review and action of type, amount, scope, duration of services. As such there is a need for constant capture and analyses of customer level and community level health measures and maximization of automated, data-driven approaches to UM and to address population health management.

The purpose of data management is to evaluate the data that is collected for completeness, accuracy, and timeliness and use that data to direct individual and community level care. As part of data management, Levels of Care for customers can be assigned. This work allows for people to be assigned categories of expected services and addresses a uniform benefit throughout the region. It's a goal of UM to identify the levels of care and subsequent reports to manage utilization and uniform benefit.

Communication

UM Program Plan

The UM Program Plan is developed as part of the Quality Assurance Improvement Plan and formally approved and distributed as part of it. The UM plan is reviewed by and input sought from various committees including RUM, Quality Improvement and the Customer Advisory Council. The UM plan is distributed to providers according to the SWMBH distribution policy. Providers, customers and general stakeholders can access the UM plan through the SWMBH website. The SWMBH Board receives UM education annually.

Availability of Utilization Management Staff

SWMBH UM staff are available by telephone (toll free) from 8:00 a.m. to 8:00 p.m. Monday through Friday of each normal business day. Utilization Review staff respond to email and telephonic communications within one business day during provider's normal business hours. UM staff identify themselves by name, ~~titile~~ and organization during correspondence. UM requirements and procedures are made available upon request as well as contained in the provider manual and in the customer handbook. When a denial determination occurs, SWMBH provides the opportunity for the requesting customer or provider to discuss the determination with either the reviewer making the determination or, if not available within one business day, a different clinical peer reviewer.

After-hours emergency services are available to customers and providers through a phone service which provides emergency referral and information outside of normal business hours by licensed professional staff. Additionally, UM staff are available to providers after hours, weekends and holidays to make determinations for a limited set of acute services. Customers and providers have the ability to leave a message for UM staff through this service and also may fax information to SWMBH after hours. Each CMHSP with UM Medicaid/HMP delegated functions manages the UM process based on local policy and procedure that adheres to regional contractual and statutory requirements.

Peer Clinical Review

Utilization Management staff are available to discuss authorization decisions with the requesting customer, provider and attending physician (if applicable). The Utilization Management staff assist with physician to physician communication with the Medical Director and assist in obtaining relevant clinical information and documentation for review. When a decision is made to deny an authorization request, UM staff provides within one business day, upon request, the opportunity to discuss the determination with the UM Peer Reviewer who made the determination, or another Peer Clinical Reviewer if the original reviewer cannot be available within one business day. If this Peer communication does not result in an authorization, the provider is given information regarding how to appeal the determination and any applicable timelines. Upon request, UM will provide specific clinical rationale on which the decision to deny the authorization was made.

Evaluation

The UM program is reviewed at least annually to determine if the Fiscal Year goals have been achieved and identify trends and areas for improvement. While the Regional Quality Management Committee manages the evaluation, the RUM is involved with this review and responsible for implementing any improvement activities at the CMHSP and throughout their provider network. The purpose of the annual evaluation is to identify any best practices that could be incorporated into the UM plan as well as continue to improve on the care provided to SWMBH customers. Additionally, Inter-rater reliability of application of medical necessity will be evaluated annually. Oversight and monitoring of medical necessity determinations and utilization management decisions will be conducted annually to validate

consistent application and understanding of uniform benefit, clinical protocols and medical necessity criteria.

Definitions

Authorization: An authorization is an approval of service(s) by an insurance company.

Core Service Menu: The services which are available with defined Recommended Thresholds for an identified population at a given Level of Care.

Exception: Service(s) that fall above the Recommended Threshold or outside of the Core Service Menu for a given Level of Care.

Level of Care: Refers to the intensity of services (setting, frequency and mode) an individual will receive during a specific stage of treatment.

Medical Necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. (Medicaid Provider Manual)

Medical Necessity Criteria: Guidelines that direct the most appropriate service or level of care which can reasonably be expected to improve symptoms associated with the customer's diagnosis and is consistent with generally accepted standards of practice.

Outlier: A pattern or trend of under- or over-utilization of services (as delivered or as authorized), compared to the typical pattern of service utilization. Over or under-utilization trends can be identified at a variety of comparative levels, including but not limited to the population, CMH, state, service type, or provider levels.

Person-Centered Planning: *Person-centered planning means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities.* MCL 330.1700(g)

Serious Emotional Disturbance: As described in Section 330.1100c of the Michigan Mental Health Code, a serious emotional disturbance is a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:

1) A substance use disorder
2) A developmental disorder
3) A "V" code in the diagnostic and statistical manual of mental disorders

Serious Mental Illness: As described in Section 330.1100c of the Michigan Mental Health Code, a serious mental illness is a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness.

Uniform Benefit/Uniformity of Benefit: Consistent application of and criteria for benefit eligibility, level of care determination and service provision regardless of various demographics including geographic location, **based upon the clinical and functional presentation of the person served, over time.**

Utilization Review: The process of monitoring, evaluating medical necessity, use, delivery, cost effectiveness, appropriateness, and the efficient use of health care services provided by health care professionals on a prospective, concurrent or retrospective basis. Utilization review activities include monitoring of individual consumer records, specific provider practices and system trends. to determine appropriate application of Guidelines and Criteria in the following areas: level of care determination, Application of Service Selection Criteria, Application of Best Practice Guidelines, Consumer outcomes, Over-Utilization/under Utilization, and Review of clinical or resource utilization Outliers.

Utilization Management: A set of administrative functions that pertain to the assurance of appropriate clinical service delivery. Through the applicat of written policies and procedures, Utilization Management is designed to ensure that only eligible beneficiaries receive speciality plan benefits; that all eligible beneficiaries receive all medically necessary specialty plan benefits required to meet their needs and desires; and that beneficiaries are linked to other Medicaid Health Plan or other services when necessary. Utilization Management functions include: Access and eligibility determination, level of care assessment and service selection, Authorization processes, utilization review, and care management activities.

Roles

CMH Role: Adhere to prescribed Assessment Tools use, frequency and reporting to SWMBH. Adhere to Level Of Care Guidelines. Report and Perform Local Care Management per UM Plan, Delegation

Agreement and Policy. Report Authorizations, Assessment and Encounter data to SWMBH as prescribed.

SWMBH Role: Perform Central Care Management per UM Plan and Policy. Oversee and monitor delegated Local Care Management per UM Plan and Policy. Provide regular UM analytic management reports for SWMBH and CMHs. Regularly identify trends and material variations.

Shared Role (Director of Clinical Quality, Local Care Manager designees and RUM Committee): Regularly review UM analytic management reports. Identify trends and variations, including gaps in completeness, timeliness and accuracy of applicable Data. Annual statistical analysis of LOC Guidelines with modifications as necessary. Adjust business process and/or decision trees as necessary. Sample and discuss aggregate service type anomalies. Sample and discuss case outliers.

References/Additional Guiding Document

SWMBH UM Policy Manual Section 4 and Attachments
SWMBH Level of Care Guidelines

Plan Review and Approval

Medical Director: _____
Signature/date of review

Chief Administrative Officer: _____
Signature/date of review

Director of Clinical Quality: _____
Signature/date of review

Southwest Michigan
BEHAVIORAL HEALTH

FY 19 Customer Service Annual Report

January 10, 2020

SWMBH Customer Services Office Responsibilities

- Welcome and orient individuals to services and benefits available and to the provider network.
- Develop and provide information to members about how to access mental health, primary health, and other community services.
- Provide information to members about how to access the various Rights processes.
- Help individuals with problems and inquiries regarding benefits.
- Assist people with and oversee local complaint and grievance processes.
- Track and report patterns of problem areas for the organization.

SWMBH Customer Services Office Responsibilities

- Maintain Policies and Procedures that meet and exceed all expectations set.
- Manage Regional Customer Services Committee Charter and membership to represent all of SWMBH member counties.
- Manage and Distribute the SWMBH Medicaid and MI Health Link Customer Handbooks.
- Update regional documents to communicate with customers regarding SWMBH-level service decisions.
- Maintain marketing and member related communications and brochures

SWMBH Customer Services Office Responsibilities

- Create and Maintain a Welcoming atmosphere for customers of SWMBH network.
- Promote Customer Voice to be heard throughout SWMBH business activities.
- Provide assistance with all complaints, grievances, or appeals filed with CS office.
- Collect and review aggregate data regarding customer grievances and appeals.

SWMBH Customer Services Activities

Updated and/or distributed SWMBH network customer/stakeholder educational materials.

- 3 Members Newsletters
- 2 Handbooks
  - Both Medicaid and MHL handbooks were updated
- Informational materials- SWMBH general, Substance Use Disorder, Recovery Oriented Systems of Care, MI Health Link, VA Navigator, Complex Case Management, and Autism Services Brochures
- SWMBH and Recovery Oriented Systems of Care Marketing Materials
- MI Health Link Welcome Packet and orientation materials

SWMBH Customer Services Activities

HSAG external review

- Implemented CAP from FY 18 regarding customer service, grievance and appeals.
  - This included implementation and training of state mandated templates as well as a training on use of plain language, striving for 4th grade reading level.
  - On-going monitoring of standards to ensure compliance
- Member Rights and Protections reviewed FY 19
  - Praised for being well organized
  - Preliminary report was full compliance
- Utilization Management reviewed FY 19
  - Clinical file review including denial letters (look back period 10/1/18- 4/30/19)
  - Constructive feedback to CMHs regarding plain language and accurate information being provided

SWMBH Customer Services Activities

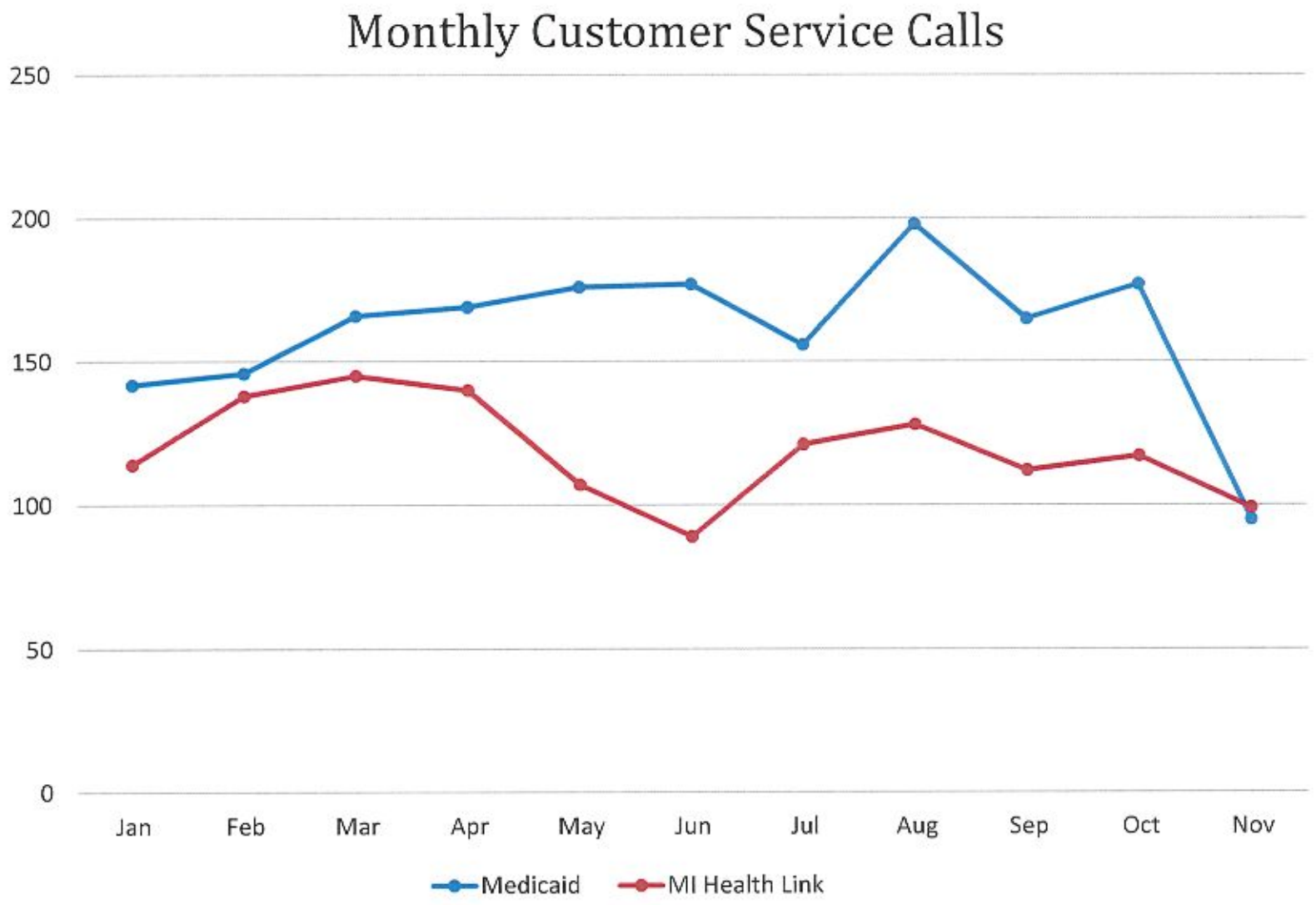
- Customer Advisory Committee (CAC) convened 11 times in FY 19
- CAC reviewed and provided input on
  - QAPIP
  - Policy updates
  - Member handbooks
  - Grievance and appeals data
  - Member newsletters
  - Participation in regional and state community marketing and educational events
- Reviewed membership and criteria to ensure appropriate representation of populations served
- Successfully seated new members from 4 counties
  - Still need representation from Barry, Berrien and Branch Counties
- Started seating county representatives on operating committees again

SWMBH Customer Services Activities

- *January, 2019- November, 2019* Customer/Member Services fielded 3071 phone calls on the designated lines*
  - MA Customer Service line received 1761 calls
  - MHL Member Service line received 1310 calls
- Completed 800 follow up calls
  - Members discharged from Substance Use Disorder residential settings = 692
  - Members discharged from Inpatient Psychiatric setting = 108**

*new system put in place in January so we do not have access to data from 1st quarter
** will be completed by Integrated Health team next fiscal year

SWMBH Customer Services Activities



SWMBH Customer Services Activities

SWMBH and 8 affiliate CMH providers managed and/or provided oversite of 360 Medicaid and MI Health Link Grievances, Appeals and 2nd Opinions

- MA/HMP/BG Local Appeals reported: 103
- MA/HMP/BG Grievances reported: 217
- MA/HMP/BG Second Opinions reported: 16
- MA/MHL Fair Hearings reported: 15
- MI Health Link Grievances reported: 4
- MI Health Link Appeals reported: 5

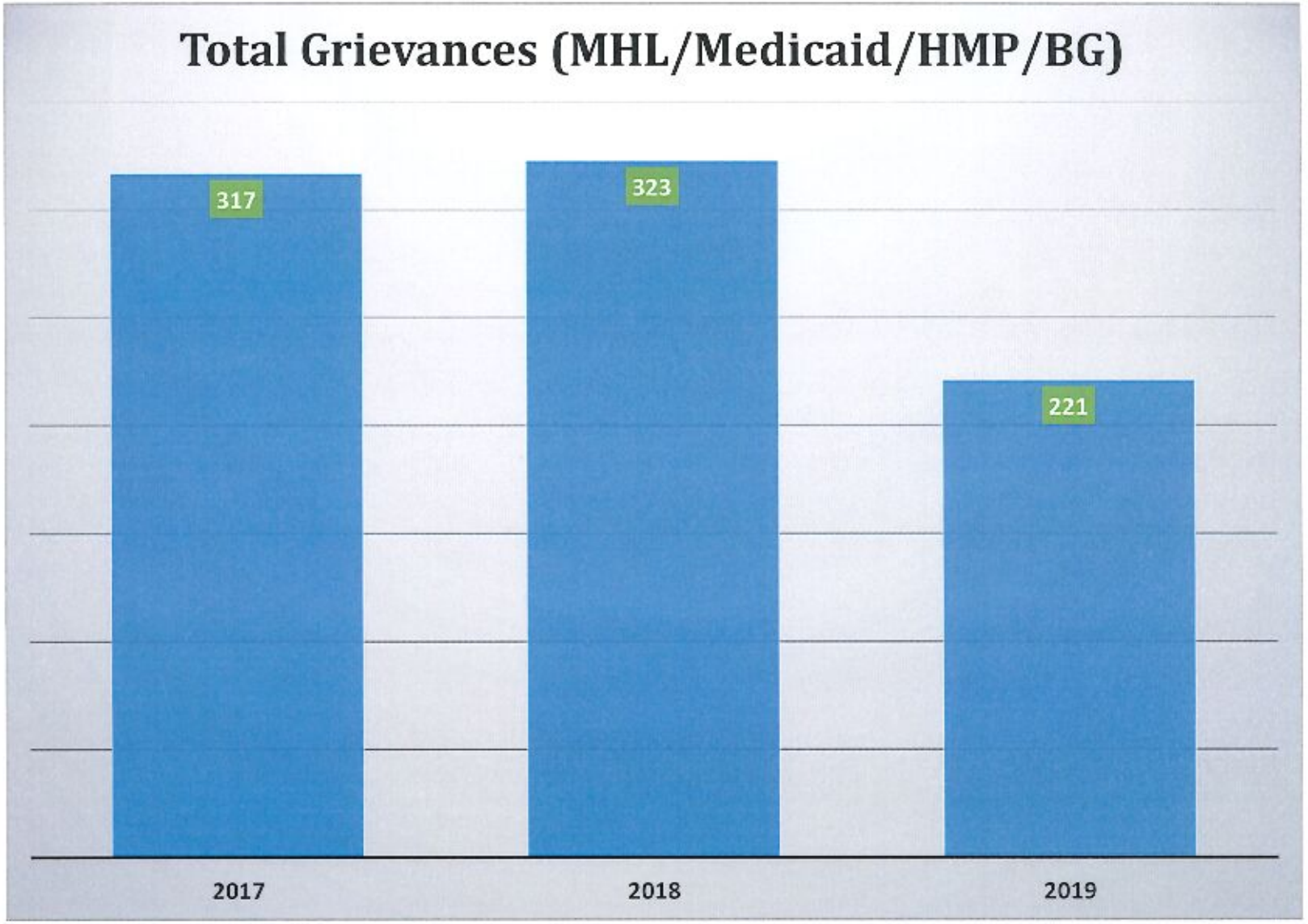
SWMBH Customer Services Activities

Southwest Michigan Behavioral Health						
Customer Grievance and Appeal Data						
FY 2018 - 2019						
SWMBH REGIONAL TOTAL (MA/HMP/BG)						
Activity	Outcome	Q1	Q2	Q3	Q4	**Total Events:**
Local Appeals Including: Termination Reduction Suspension of current services and Denial of additional services	Withdrawn	1				**1**
	Resolved with Customer Services	2		2	2	**6**
	Decision Affirmed	18	22	22	6	**68**
	Decision Reversed	5	7	9	7	**28**
Access 2nd Opinions	Withdrawn		4			**4**
	Resolved with Customer Services					**0**
	Decision Affirmed	2	2	1	2	**7**
	Decision Reversed		1	1	1	**3**
Hospital 2nd Opinions	Withdrawn					**0**
	Resolved with Customer Services					**0**
	Decision Affirmed			1	1	**2**
	Decision Reversed					**0**
Administrative Medicaid (Fair) Hearings	Decision Affirmed	2			2	**4**
	Decision Reversed			1		**1**
	Dismissed or Withdrawn	3	1	3	1	**8**
Grievances	Settled/Resolved	57	61	55	44	**217**
	TOTAL events:	**90**	**98**	**95**	**66**	**349**

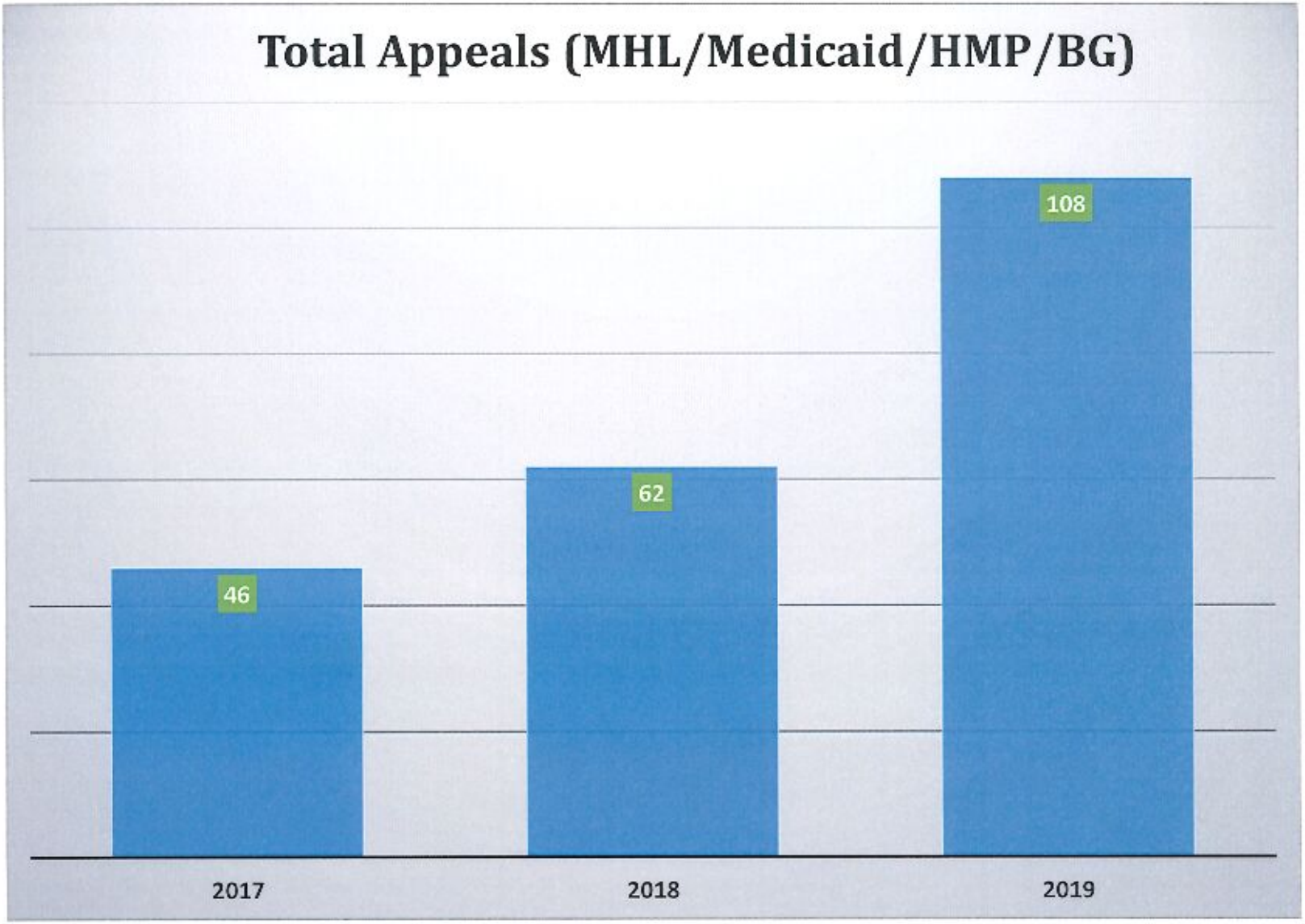
SWMBH Customer Services Activities

Southwest Michigan Behavioral Health Customer Grievance and Appeal Data January – November 2019 SWMBH REGIONAL TOTAL (MHL)						
Activity	Outcome	Q1	Q2	Q3	Q4	**Total Events:**
Local Appeals Including: Termination Reduction Suspension of current services and Denial of additional services	Withdrawn					**0**
	Resolved with Customer Services					**0**
	Decision Affirmed	2	1			**3**
	Decision Reversed	1	1			**2**
Access 2nd Opinions	Withdrawn					**0**
	Resolved with Customer Services					**0**
	Decision Affirmed					**0**
	Decision Reversed					**0**
Hospital 2nd Opinions	Withdrawn					**0**
	Resolved with Customer Services					**0**
	Decision Affirmed					**0**
	Decision Reversed					**0**
Administrative Medicaid (Fair) Hearing	Decision Affirmed		1			**1**
	Decision Reversed					**0**
	Dismissed or Withdrawn			1		**1**
Grievances	Total Resolved		1	3		**4**
	TOTAL events:	**3**	**4**	**4**		**11**

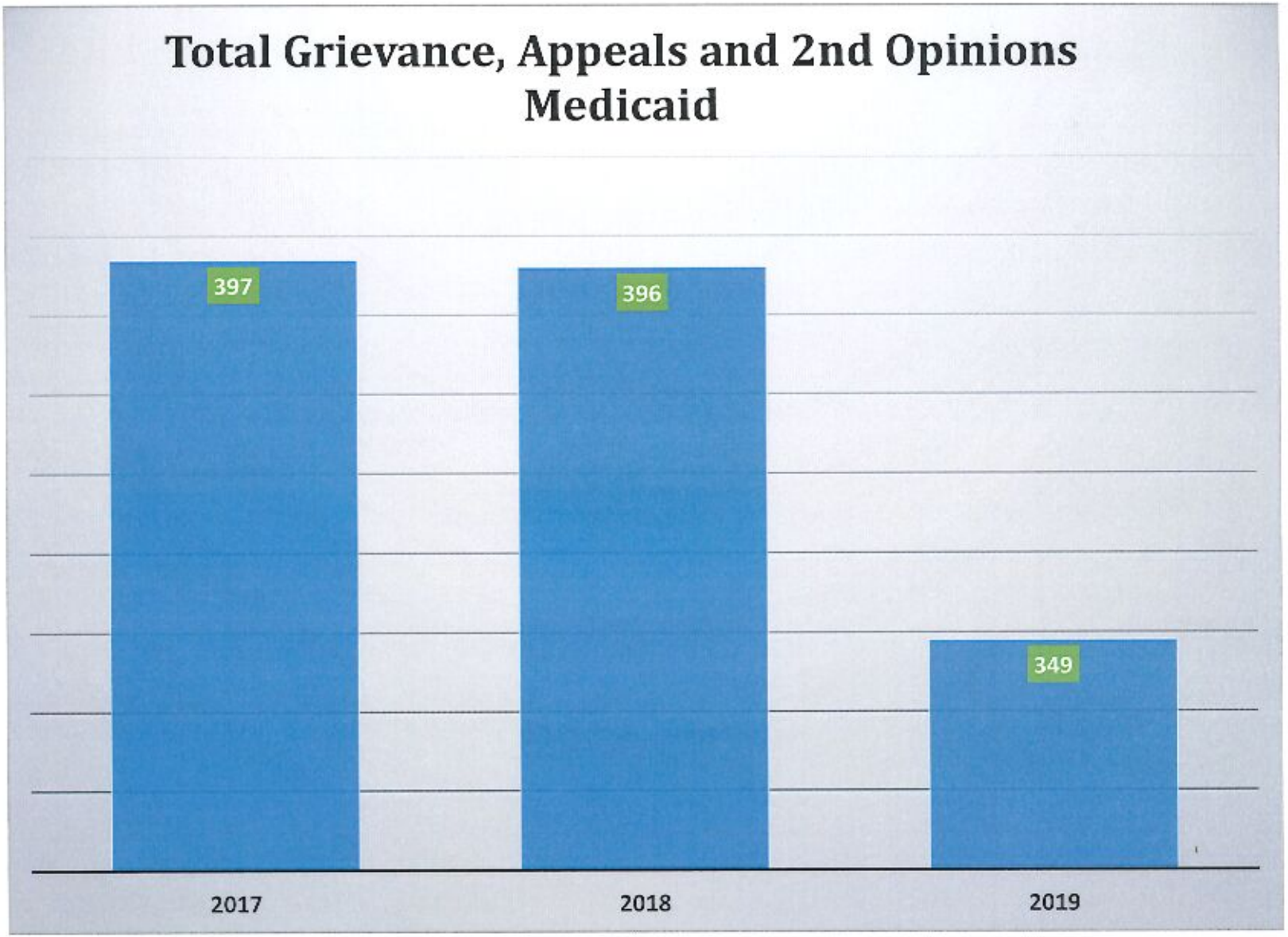
SWMBH Customer Services Activities



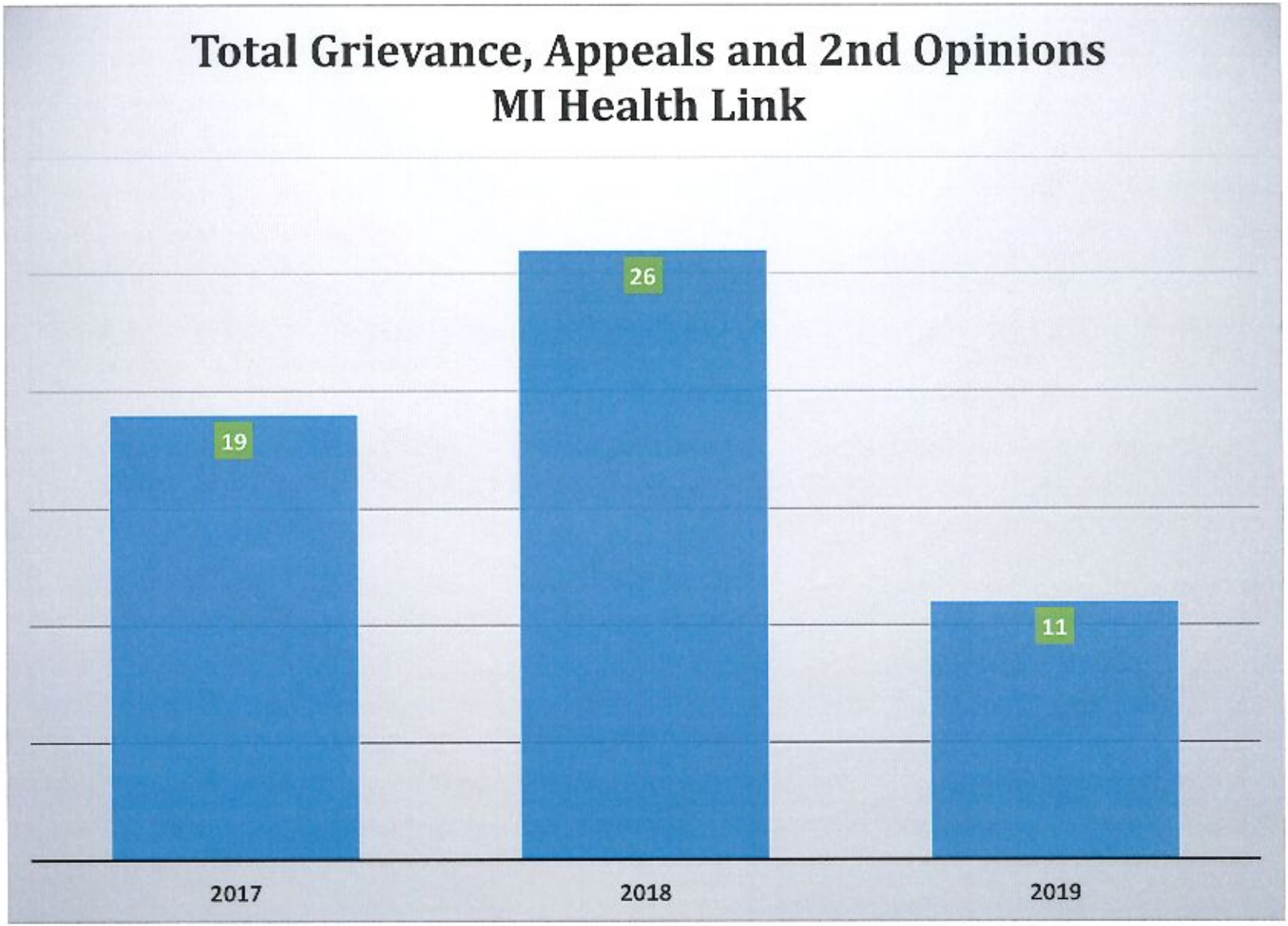
SWMBH Customer Services Activities



SWMBH Customer Services Activities



SWMBH Customer Services Activities



Community and Advocacy Events

- SWMBH participated in 28 community events region-wide, including:
  - Borgess Health Fair
  - Branch County Fair
  - Van Buren Back to School Bonanza
  - Walk a Mile
  - KPH Summer Fest
  - Project Connect and VA Stand Downs
  - Kalamazoo WRAPS Kids Event
  - Cass County Community Mental Health Awareness Celebration
  - Recovery Coach Conference

Looking to FY 20

- Complete the Health Services Advisory Group 2020 audit with 90% or higher compliance for Customer Services, Grievances, and Appeals.
- Review and update regional processes for MHL and SUD Adverse Benefit Determinations
  - To ensure effective and efficient communication and notification of rights to members
  - Define what is being sent by whom, why and when
- Define and implement a regional process to notify members of denials of payment
  - This is in response to 2019 HSAG audit
  - Templates and process will be developed for both MI Health Link and Medicaid
- Continue to define and refine how data is reported and reviewed
  - Create crosswalk definitions (between EMRs)
  - Create new reporting mechanism for quarterly G&A data collection
- Outreach to counties
  - Continued CAC membership recruitment
  - Customers seated on Operations Committees

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Questions

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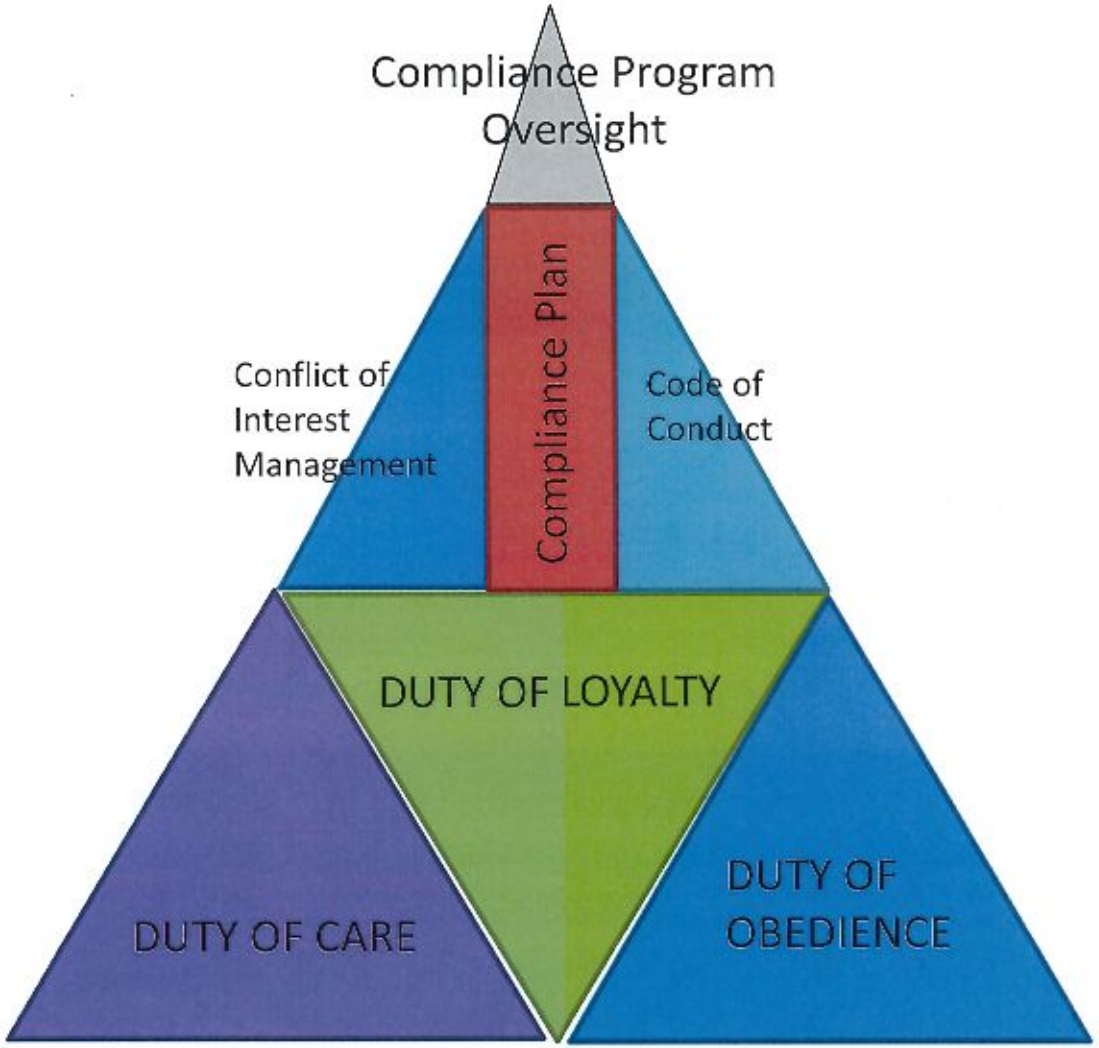
Corporate Compliance Role and Function

01/10/2020

Board of Directors: Role & Function



Board of Directors: Role & Function

FIDUCIARY DUTIES OWED TO SWMBH:

- Duty of Care – requires a Board Member to exercise reasonable care that an ordinarily prudent person would use in similar circumstances.
- Duty of Loyalty – requires a Board Member to act faithfully in the best interest of the organization and never for self-benefit financially or any other personal gain.
- Duty of Obedience – requires a Board Member to serve in a manner that is faithful to and consistent with the organization's mission.

SWMBH Board Members' Compliance role flows from and compliments these fiduciary duties.

Board of Directors: Role & Function

Recognize and Avoid Conflicts of Interest

- Can I act in the best interests of the Region as a whole?
- Do I have a relationship/position that may effect my decision-making when sitting as a SWMBH Board Member?
    - Examples – spouse is employed by a provider within SWMBH's provider network; you serve as a Board member for a contracted entity; child works for a SWMBH vendor.

- Complete Financial Interest Disclosure Statements (FIDs) annually and whenever a new actual or perceived COI exists.
    - Chief Compliance Officer reviews and Board determines of a real or perceived COI exists.
    - If no, no further action.
    - If yes, Board evaluates what restrictions can be implemented so Board Member can continue service AND continue with actual/perceived COI, OR if the two positions are mutually exclusive (very rare).

- Duty to disclose AND duty to inquire of other Board Members
- Protects the integrity of Board action and ensures that you are fulfilling your fiduciary duties owed to SWMBH.

Board of Directors: Role & Function

Comply with Corporate Compliance Plan & Code of Conduct

- Comply with SWMBH's Corporate Compliance Plan;

- Comply with SWMBH's Code of Conduct including:
  - Understanding and abiding by reporting obligations – duty to report actual/suspected fraud, waste, or abuse to the Chief Compliance Officer;
  - Cooperating fully with any Compliance investigation;
  - Remaining free of the influence of alcohol and illegal drugs while performing Board service;
  - Abstaining from harassment and discrimination in any form;
  - Remaining free from conflicts of interest;
  - Maintaining confidentiality, when appropriate (subject to OMA);
  - Not accepting or soliciting business courtesies or gifts meant to effect business decisions, nor any single gift of more than a $25 value or $300 value per year.

Board of Directors: Role & Function

Ensure Compliance Program Oversight

Compliance Program Oversight – the exercise of reasonable care to assure that SWMBH staff carry out their management responsibilities and comply with the law, and that the Compliance Program is effective.

How should Board oversight of Compliance Program functions be accomplished?

Board Oversight Responsibilities

Making inquiries to ensure:

- (1) a corporate information and reporting system exists, and
- (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course. *(In re Caremark Int'l, Inc. Derivative Litig. 698 A.2d 959 (Del. Ch. 1996)).*

Practical Guidance for Health Care Governing Boards on Compliance Oversight (Published April 20, 2015):

- "The existence of a corporate reporting system is a key compliance program element, which not only keeps the Board informed of the activities of the organization, but also enables an organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity."

Board Oversight Responsibilities

(1) a corporate information and reporting system exists…

- Designation of Chief Compliance Officer
  - Delegated day-to-day operational responsibility for the development and implementation of the compliance program
  - Direct access and accountability to the Board
  - Schedule for reporting included on the Board Calendar
- Reporting obligations, including Whistleblower protections, are well-publicized and communicated to Board members, staff, and network providers
  - Corporate Compliance Plan
  - SWMBH Code of Conduct
  - SWMBH Policy for reporting FWA

Board Oversight Responsibilities

(2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.

- Annually the Board reviews and prospectively approves the PI/C Corporate Compliance Plan.
  - Includes Audit & Monitoring Plan
- Bi-annual reports to the Board regarding PI/C investigations, breaches, and audits. Includes any reporting to outside entities.
- Annual PI/C Program Evaluation submitted to the Board to review program initiatives, changes, and improvements.
- Periodic updates as necessary.

Are you satisfied with the information you receive? If not, it is your responsibility to instruct management that you want more.

SWMBH Compliance Team

- SWMBH Program Integrity & Compliance Department
  - Four Compliance Specialists – Brittany Ball, Alison Strasser, and two vacant positions
  - Responsible for day-to-day operations of the Compliance Program
- SWMBH Compliance Committee
  - Comprised of SWMBH Senior leadership from varying departments, as well as a CMH CEO (presently Van Buren's Debbie Hess)
  - Responsible for oversight of Compliance Program activities
  - Meets monthly
- Regional Compliance Coordinating Committee
  - Compliance Officer from each CMHSP and SWMBH Compliance Dept.
  - Meets monthly to coordinate compliance activities across the Region
- Corporate Counsel
- PIHP Compliance Officers
  - Meet every other month to discuss compliance related issues

SWMBH Compliance Risks

- Fraud, Waste, and Abuse
- Appropriate and accurate coding of services
- Appropriate use of modifiers
- Proper credentials for clinicians providing service(s)
- Third Party Liability/Coordination of Benefits
- Excluded providers
- Privacy of Protected Health Information (PHI)

SWMBH Compliance Risks

- How does SWMBH manage Compliance Risks?
  - Routine audit & monitoring
    - Quarterly Medicaid claims review
    - Quarterly MHL claims review
    - SUD Reviews – Block Grant ATP and COB
  - Focused audits
    - As part of investigations
    - Necessitated by concerning findings and/or poor performance on a routine audit(s)
  - Well publicized reporting system
    - SWMBH internal, CMHSPs, entire provider network
  - Excluded provider monitoring
    - Prior to hire/contracting, monthly for all staff, "Screened Persons", provider entities, and contractors that meet statutory threshold

SWMBH Compliance Risks

- How do we manage them? (continued)
  - Data Mining
    - Developed business processes as part of department goals this year, now ready for implementation to address:
      - Overlapping billing
      - Appropriate use of specific modifiers (in response to investigation findings)
      - Third party billing reviews
  - Training/Education & Effective lines of Communication
    - At hire, electronically annually, in-person annually during Compliance Week
    - Open-door policy for entire Compliance team
  - Organizational Risk Assessment Work Plan
    - Implemented organization-wide

Board Compliance Reports

- Current schedule:
  - Bi-annual reports
    - Number, type, and outcome of investigations and breaches
    - Update on on-going compliance audits
  - Annual Corporate Compliance education
    - Refresher on Board's role
    - Highlight risks and how SWMBH addresses
  - Updates as needed
    - Anytime an external agency is involved, or when disclosure is required to an authoritative body
    - Any situations that would implicate the entity's Executive Officer
  - Board prospectively reviews and approves the Corporate Compliance Plan for the coming Fiscal Year
- Do you feel this meets your needs?
- Is there additional information you feel is necessary?

Southwest Michigan
BEHAVIORAL HEALTH

Code of Conduct

Important Phone Numbers

Compliance Hotline: (800) 783-0914

Mila C. Todd, Chief Compliance & Privacy Officer: (269) 488-6794

Southwest Michigan Behavioral Health Vision, Mission, Values and Behavioral Standards

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH VISION

To ensure persons with specialty care needs reside in their own community, have a quality and healthy lifestyle and are fully accepted.

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH MISSION

To provide a community-based, integrated specialty care system for individuals and families with mental health, developmental disabilities and substance abuse needs that empowers people to succeed. To ensure all persons receiving our services have access to the highest quality care available.

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH VALUES

Customer Driven
Person-Centered
Recovery Oriented
Evidenced-Based
Integrated Care
Trust
Integrity

Transparency
Inclusive
Accessibility
Acceptability
Impact
Value
Culturally Competent & Diverse Workforce
High Quality Services
Regulatory Compliance

The Code of Conduct serves to function as a foundational document that details the fundamental principles, values and framework for action within Southwest Michigan Behavioral Health's (SWMBH) compliance program. The Code of Conduct articulates SWMBH's commitment to comply with all applicable Federal and State standards. The standards not only address compliance with statutes and regulations, but also set forth broad principles that guide employees in conducting business professionally and properly. The standards included in the Code of Conduct will promote integrity, support objectivity, and foster trust. Furthermore, the SWMBH standards of conduct will reflect a commitment to high quality health care delivery as evidenced by its conduct, of on-going performance assessment, improved outcomes of care, and respect for the rights of SWMBH's consumers.

SWMBH is committed to conducting its business in a manner that facilitates quality, efficiency, honesty, integrity, confidentiality, respect and full compliance with applicable laws and regulations. In order to achieve this goal, SWMBH recognizes that it must require its staff to maintain a standard of behavior that is both lawful and ethical. Accordingly,

- SWMBH will advise and train its staff about the applicable laws and requirements.
- SWMBH board members, administration, staff, participating CMHSP's and providers are expected to assume personal responsibility and accountability for understanding relevant laws, regulations and contract and grant requirements and for ensuring compliance.
- SWMBH management is committed to informing those under their supervision that they should comply with the applicable standards and, if they do not comply, appropriate disciplinary action will be taken.

Definitions

- Abuse: means provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

- Fraud (per CMS): means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act.

- Fraud (per Michigan Medicaid): Michigan law permits a finding of Medicaid fraud based upon "constructive knowledge." This means that if the course of conduct "reflects a systematic or persistent tendency to cause inaccuracies" then it may be fraud, rather than simply a good faith error or mistake.

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

Reporting Violations

All staff or agents of the organization have the responsibility not only to comply with the laws and regulations but to ensure that others do as well. Any staff or agent who has firsthand knowledge of activities or omissions that may violate applicable laws and regulations is required to report such wrongdoing. Reporting suspected violations is mandatory, not optional. Staff will be informed that in some instances, failure to report a suspected violation may be the basis for disciplinary action against the staff. Corporate Compliance violations may be reported to the Chief Compliance Officer through either the hotline **(800) 783-0914**, e-mail, in person or in writing. All reports of wrongdoing shall be investigated to the extent necessary to determine their validity. No staff, provider or agent making such a report in good faith shall be retaliated against by SWMBH, staff, or agents and will be protected by the Michigan Whistleblower's Protection Act. Discipline for engaging in acts that violate applicable laws and regulations, making knowingly false reports, or discipline for any other performance-related reason unconnected to reporting potential violations is not retaliation.

Resources for Guidance

Staff or agents may seek clarification from the Compliance Program, organizational policies, or may direct questions to the Chief Compliance Officer through either the hotline, e-mail, in person or in writing.

Confidentiality

All staff or agents making reports are encouraged to disclose their identity, recognizing that anonymity may hamper complete and timely investigation. Nonetheless, anonymous reports are better than no report at all, and no report shall be refused or treated less seriously because the

reporter wishes to remain anonymous. Confidentiality and anonymity of the reporter/complainant and the content of the report will be preserved to the extent permitted by law and by the circumstances. Information about reports, investigations, or follow-up actions shall not be disclosed to anyone other than those individuals charged with responsibility in investigation and remedial action as well as legal counsel.

Examples of Fraud, Waste and Abuse That Should Be Reported

Examples of fraud, waste and abuse activities that should be reported include, but are not limited to, the following;

- Financial
  - Forgery or alteration of documents related to SWMBH services and/or expenditures (checks, contracts, purchase orders, invoices, etc.);
  - Misrepresentation of information on documents (financial records and medical records);
  - Theft, unauthorized removal, or willful destruction of SWMBH records or property;
  - Misappropriation of SWMBH funds or equipment, supplies or other assets purchased with Medicaid or Medicare funds; and
  - Embezzlement or theft

- Beneficiaries/Consumers:
  - Changing, forging or altering medical records;
  - Changing referral forms;
  - Letting someone else use their Medicaid or Medicare card to obtain SWMBH covered services;
  - Misrepresentation of eligibility status;
  - Identity theft;
  - Prescription diversion and inappropriate use;
  - Resale of medications on the black market;
  - Prescription stockpiling;

- Provider
  - Lying about credentials such as a college degree;
  - Billing for services that were not provided;
  - Billing a balance that is not allowed;
  - Double billing or upcoding;
  - Underutilization – not ordering or providing services that are medically necessary;
  - Overutilization – ordering or providing services in excess of what is medically necessary;

- Falsifying information (not consistent with the consumer's condition or medical record) submitted through a prior authorization or other service utilization oversight mechanism in order to justify coverage;
- Forging a signature on a contract or other document;
- Pre- or post-dating a contract or other document;
- Intentionally submitting a false claim;
- Changing, forging or altering medical records;
- Kickbacks, inducements and/or other illegal remunerations; and
- Illegal use of drug samples

Internal Investigation

All reports of wrongdoing, however received, shall be investigated and documented according to the Corporate Compliance Investigation Procedure. No one involved in the process of receiving and investigating reports shall communicate any information about a report or investigation, including the fact that a report has been received or an investigation is ongoing, to anyone within SWMBH who is not involved in the investigatory process or to anyone outside SWMBH without the prior approval of the Chief Compliance Officer. All staff and agents are expected to cooperate fully with investigation efforts.

Disciplinary Accountability and Consequences

SWMBH has formulated guidelines regarding the consequences and disciplinary action for staff who have failed to comply with SWMBH policies and procedures, Federal and State laws or the Corporate Compliance Plan. The disciplinary measures will vary depending upon the severity of the transgression. Sanctions could range from an oral warning to suspension, termination or financial penalties as appropriate.

Disciplinary actions will be taken in a fair, equitable, appropriate and consistent manner. All staff will be subject to the same disciplinary action for the commission of similar offenses.

Conflicts of Interest

In order to safeguard SWMBH's commitment to ethical and legal standards of conduct, Board Members, all officers, all senior management members, medical staff, and individuals with Board-designated powers and/or authority shall avoid any action that conflicts with the interests of the organization and refrain from being influenced by personal considerations in the performance of their duties. Unless properly disclosed and approved by SWMBH, it could be a conflict of interest to, but is not limited to:

- Have an interest in a publicly held company, vendor, customer or competitor of SWMBH;
- Work for, consult with or provide services to a competitor; and/or
- Use confidential information obtained for any person's personal gain or benefit.

Accordingly, staff/agents, officers, senior managers, and medical staff must disclose the existence and nature of any actual or potential conflict of interest on their Conflict of Interest Form or to the Chief Compliance Officer at the time of interview, orientation and annually thereafter and/or when a conflicting interest arises. All actual or potential conflicts of interest

disclosed shall be reviewed by the Chief Compliance Officer, according to previously identified criteria, to determine whether there is a conflict of interest.

Substance Abuse

To protect staff/agents and consumers, SWMBH is committed to an alcohol and drug-free environment. All staffs/agents must report for work free of the influence of alcohol and illegal drugs. Reporting to work under the influence of any illegal drugs or alcohol, having an illegal drug in one's system, or using, possessing, or distributing/selling illegal drugs while on SWMBH's work time or property may result in immediate termination.

Harassment

Mutual respect among all staff members in the way we treat each other is expected. Each SWMBH staff/agent has the right to work in an environment free of harassment. Therefore, harassment of staff/agents in the work place by any person or in any form is prohibited by SWMBH. This includes sexual harassment; harassment based on sex, race, color, religion, national origin, citizenship, disability, age, sexual orientation, or any other protected category; or conduct such as ridicule or degrading comments to others which severely and adversely affect their work environment or interferes with their ability to perform their job. Alleged harassment should be reported to a member of the senior management team or to the Human Resources Director.

Confidentiality

SWMBH is committed to protecting the privacy of its consumers and shall strictly govern the disclosure of any consumer information to anyone other than a staff/agent or staff member involved in the care and treatment of that consumer. Any staff/agent who engages in the unauthorized disclosure of any information concerning a consumer may be subject to immediate termination. Staff/agents shall comply with the SWMBH Confidentiality Policy, the Michigan Mental Health Code, HIPAA Privacy requirements, and all other applicable laws and regulations.

To ensure that all consumer information remains confidential, staff/agents are required to comply with the following guidelines:

- Staff/agents shall not discuss any consumer in an external or internal environment where such information could be heard by unauthorized personnel or other consumer/visitors.
- If asked about a consumer by anyone other than staff/agents involved in the care or treatment of the consumer, staff/agents will disclose no information unless first obtaining the written consent of the consumer or the consumer's representative/legal guardian.
- Medical staff members and staff/agents may not have access to the records of any consumer unless they are involved in the care and treatment of the consumer, or if a legal or administrative reason exists requiring them to have access to those documents.

Political Activities and Contributions

SWMBH funds or resources are not to be used to contribute to political campaigns or for gifts or payments to any political party or any of their affiliated organizations. SWMBH resources include financial and non-financial donations of funds, products, or services to any political cause.

Staff/agents may make voluntary contributions provided they do not communicate that their contributions are from SWMBH.

At times, SWMBH may ask staff/agents to make personal contact with government officials or to write letters to present the organization's position on specific issues. In addition, it is part of the role of some SWMBH management to interface on a regular basis with government officials. Such activity is permissible provided that funds and resources are not contributed.

Marketing Practices

There are times when SWMBH directly markets services to potential consumers; however, the federal Anti-Kickback Statute of the Social Security Act makes it a felony, punishable by criminal penalties, to offer, pay, solicit, or receive "remuneration" as an inducement to generate business compensated by the Medicaid or Medicare programs.

Under no circumstances will SWMBH offer free items or services that are not related to medical or health care. Moreover, any free items offered must have no monetary value.

SWMBH staff/agents will not engage in any prohibitive marketing activities. These activities include: the giving of gifts or payments to induce enrollments, discrimination of any kind, unsolicited door-to-door marketing, and contracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with the elderly to solicit enrollment.

Charitable Contributions

All charitable contributions must be made for the benefit of SWMBH and for the purpose of advancing SWMBH's mission. The Executive Officer will oversee all charitable contributions to ensure that they are administered in accordance with the donor's intent. All checks and other documents must be made payable to SWMBH and given to the Finance Department to deposit into the appropriate account.

Contractual/Financial Arrangements with Health Care Professionals

SWMBH is committed to ensuring that all contractual and financial arrangements with health care professionals are structured in accordance with Federal and State laws and other regulations and are in the best interests of the organization and the consumers it serves. In order to ethically and legally meet all standards regarding referrals and enrollments, SWMBH will strictly adhere to the following:

- SWMBH does not pay for referrals. Consumer referrals and enrollments will be accepted based solely on the consumer's clinical needs and our ability to render the needed services. SWMBH does not pay or offer to pay anyone for referrals or consumers. Violation of this policy may have grave consequences for the organization and the individuals involved, including civil and criminal penalties, and possible exclusion from participation in federally funded healthcare programs.

- SWMBH does not accept payments for referrals. No SWMBH staff/agent or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of consumers.
- SWMBH does not use financial incentives to encourage barriers to care and services and/or decisions the result in underutilization. SWMBH does not reward practitioners, or other individuals conducting utilization review, for issuing denials of coverage or service. All utilization management decision-making is based only on the existence of coverage and appropriateness of care and service. Clinical decisions are based on the clinical features of the individual case and the medical necessity criteria.

Receiving Business Courtesies and Gifts

No staff/agent or officer shall accept or solicit any gifts, gratuities, loans (in nature of a gratuity), or favors of any kind from any individual, firm, or corporation doing business with or seeking to do business with SWMBH or any of its affiliates, if the gift is offered or appears to be offered in exchange for any type of favorable treatment or advantage. Specifically, no gifts or favors shall be accepted if valued in excess of $25, with a maximum of $300 per year, or intended to affect the recipient's business decisions with SWMBH. Perishable or consumable gifts, except for items of minimal value such as flowers, cookies or candy from consumers and/or family members given to a department or group are not subject to any specific limitation. Under no circumstances shall a direct care staff receive monetary gifts from consumers and/or family members. Consumers wishing to make a gift must follow the protocol for charitable contributions. If there are concerns regarding any staff's acceptance of gifts, the Chief Compliance Officer, in coordination with the SWMBH Compliance Committee, shall make the final decision.

There are some circumstances where staff are invited to an event at a vendor's expense to receive information about new products or services. Prior to accepting any such invitation, approval must be received from the Executive Officer. Accepting personal gifts and/or entertainment can sometimes be construed as an attempt to influence judgment concerning patient care or performance of other duties at SWMBH. It may also violate the anti-kickback statue or conflict of interest policy. To that end, no staff may accept any cash amount, or any single gift of more than $25 value with the total not to exceed $300 per year.

SWMBH FY 2019 Program Integrity - Compliance Board Report
October 1, 2018 – September 30, 2019

Train & Educate | Audit & Monitor | Report & Evaluate

Date: January 10, 2019 Board Meeting
Chief Compliance Officer: Mila C. Todd

1. **Compliance Allegations/Reports:**

Issue Reported	#	Investigation Opened		Investigation Completed		Complaint Substantiated		Comments
		Yes	No	Yes	No	Yes	No	
Direct Care Wage passthrough practices of a Specialized Residential Provider.	2019-01	X		X		X		Resulted in a recoupment by local CMH for DCW passthrough paid to owners.
MI Health Link provider – incident to billing practices	2019-02	X		X			X	
MI Health Link provider – Coordination of Benefits billing practices	2019-03	X		X		X		Resulted in a recoupment totaling $631.56.
Provider's CLS staff person forging timesheets/progress notes	2019-04	X		X		X		The Provider completed an internal investigation, did not bill the CMH/Medicaid for the inappropriate services, and terminated the employee. Due to the outright allegations of fraud, SWMBH referred the matter to the MI OIG immediately.
Self-D Direct Care Worker billing overlapping billing practices	2019-05	X		X		X		SWMBH took over investigation from CMHSP. Unable to substantiate anything other than poor documentation practices.
MI Health Link provider billing SWMBH AND CMH for same service.	2019-06	X		X		X		Billing SWMBH MHL for contracted services, then billing CMH Medicaid for same services. MHL payments were appropriate. Resulted in a recoupment by the CMH.
CMH direct care worker	2019-07	X		X		X		CMH completed an

SWMBH FY 2019 Program Integrity - Compliance Board Report
October 1, 2018 – September 30, 2019

		Train & Educate		Audit & Monitor		Report & Evaluate		
forging documentation and billing for services not rendered.								internal investigation, reversed all inappropriate encounters, and terminated the employee. Due to the outright allegations of fraud, SWMBH referred the matter to the MI OIG immediately.
CMH Compliance Program Effectiveness Review	2019-09	X		X		X		
Allegation that CMH requiring unqualified staff to perform certain clinical services.	2019-10	X		X			X	
Anonymous all to Compliance Hotline alleging fraud by a Specialized Residential provider.	2019-11	X		X			X	SWMBH coordinated an on-site audit at all provider sites, with local CMH Compliance Officer. Allegations were not substantiated.
Fiscal Intermediary provider rounding service start/stop times inappropriately.	2019-12	X		X		X		
MI Health Link provider – incident to billing practices.	2019-13	X		X			X	
Customer reported using "Skype" for appointments with MI Health Link provider. Inappropriate telehealth delivery.	2019-14	X		X			X	
Anonymous letter regarding multiple issues at CMH.	2019-15	X*		X*			X	*Preliminary review performed to determine if any of the allegations were within SWMBH's purview. Issues ultimately determined to be HR related. Matter referred to the local CMH for further handling.
SWMBH system allowed claims to be paid with no prior Authorization	2019-16	X		X		X		Local billing rules entered incorrectly, CAP required by SWMBH PNM.

SWMBH FY 2019 Program Integrity - Compliance Board Report
October 1, 2018 – September 30, 2019

		Train & Educate		Audit & Monitor		Report & Evaluate		
OIG Referral – services provided and paid for with Medicaid that were Court ordered and not medically necessary.	2019-17	X		X			X	SWMBH does not contract with the identified provider for the services in question, nor were any services paid for with SWMBH funds for the customer identified.
CMH staff violated HIPAA and/or other privacy rules/regulations.	2019-18		X		X			SWMBH monitored and conferred with CMH Compliance Officer to ensure it was being handled. CMH secured a legal opinion from its counsel addressing the issue.
Fiscal Intermediary inappropriately rounding service start/stop times.	2019-19	X		X		X		Rounding start/stop times in accordance with DOL rounding rules instead of Medicaid rounding rules.
SUD Provider failing to follow SWMBH Policy on establishing customer Ability to Pay (ATP) for Block Grant funded services.	2019-20	X		X		X		Resulted in recoupment, Corrective Action Plan, and weekly monitoring of 100% of submitted Block Grant claims.
Duplicate Medicaid IDs in SWMBH Smartcare system	2019-21	X		X		X		SWMBH IT and Operations worked with Streamline to implement a system fix.
Call from previous employee of an SUD Provider alleging there were "unethical things" going on at the provider.	2019-22	X			X		X	Follow-up calls made to reporter with no response.
CMH Report of fraud – Self-D worker billing for services allegedly provided while the customer was in school	2019-23	X		X		X		CMH performed preliminary investigation and reported to SWMBH. SWMBH referred to the MI OIG in accordance with contract requirements.
SUD Provider requested SWMBH "take back" claims paid for a specific practitioner for a specific	2019-24	X		X			X	Additional information gathered – provider had an STR Grant

Train & Educate		Audit & Monitor			Report & Evaluate			
time period.								and billed the claims for payment in error.
Inappropriate/no documentation to support services billed	2019-25	X		X		X		Provider performed internal audit and identified documentation issues, self-reported to Payor CMH and SWMBH.
Overlapping billing – two different providers billed for the same two dates of services (per diem services – Crisis Res and Inpatient)	2019-26	X		X		X		Error in one provider's billing dates, resulted in recoupment of two units of service.
CMH Report regarding staff member with missing documentation	2019-27		X		X			SWMBH worked with CMH Compliance Officer to monitor the course of action being taken.
Total	**27**	**25**	**2**	**24**	**3**	**15**	**9**	

2. **Privacy/Security Allegations/Reports**

All incidences reported to or discovered by SWMBH Compliance that may involve an unauthorized use or disclosure of Protected Health Information are investigated and turned over to SWMBH's Breach Response Team for review and consideration.

FY2019 # Incidents Reported: 43
 # Reportable Breaches: 1
Description: Appropriately addressed letter containing an Authorization Denial was sent to a customer. The letter was delivered to the IRS, which opened the letter, inserted a leaflet stating they had opened the letter, and returned it to SWMBH. The letter was delivered to SLD Read, an organization located in the same building as SWMBH. Staff from SLD Read hand delivered the opened letter to SWMBH.
Reporting: Letter sent to the one (1) affected customer and notification provided to the Office for Civil Rights (OCR).

3. **Planned Audits**

Audit	Date Started	# Services/Claims Reviewed	Result/Progress	Recoupments
Medicaid Verification Review				
FY19 Quarter 1	February 2019	465	99.34% – Completed	12 claims; $2,691.69
FY19 Quarter 2	May 2019	465	99.69% – Completed	13 claims; $6,931.47
FY 19 Quarter 3	August 2019	465	99.43% – Completed	13 claims; $5,475.32
FY19 Quarter 4	October 2019	465	In progress, pending appeals.	In progress, pending appeals.
Medicare Claims Audit				
FY18 Quarter 1		270	93.7% -Completed	17 claims; $832.25

SWMBH FY 2019 Program Integrity - Compliance Board Report
October 1, 2018 – September 30, 2019

	Train & Educate	Audit & Monitor	Report & Evaluate	
FY18 Quarter 2		270	94.1% - Completed	16 claims; $930.40
FY18 Quarter 3		300	97.6% - Completed	7 claims; $339.54
FY18 Quarter 4		300	96.3% - Completed	11 claims; $618.68
FY19 Quarter 1		300	In progress	In progress
FY 19 Quarter 2		300	In progress	In progress
SUD Block Grant – ATP Audit				
FY19 Quarter 1	January 2019	60	71.6% - Completed	17 claims; $374.55
FY19 Quarter 2	May 2019	60	63.3% - Completed	22 claims; $1292.00
FY19 Quarter 3	October 2019	60	In progress – Pending Preliminary	18 claims; $923.50
FY19 Quarter 4	October 2019	60	In progress – Pending Preliminary	11 claims; $403.00
SUD Coordination of Benefits Audit				
FY19 Quarter 1	February 2019	30	96.6% - Completed	1 claim - $102.00
FY19 Quarter 2	May 2019	30	100% - Completed	N/A
FY19 Quarter 3	October 2019	30	In progress – Pending Preliminary	8 claims - $57.05
FY19 Quarter 4	October 2019	30	In progress – Pending Preliminary	4 claims - $94.98

	E	H	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**		*Mos in Period*								
2	For the Fiscal YTD Period Ended 11/30/2019	P02FYTD20	2								
3	*(For Internal Management Purposes Only)*										
4	***INCOME STATEMENT***	TOTAL	Medicaid Contract	Healthy Michigan Contract	Autism Contract	MI Health Link	SA Block Grant Contract	SA PA2 Funds Contract	SWMBH Central	ASO Activities	Indirect Pooled Cost
5											
7	**REVENUE**										
16	Contract Revenue	41,809,967	31,635,194	5,233,373	2,632,378	597,885	1,111,588	399,549	-	-	-
17	DHHS Incentive Payments	164,671	164,671	-	-	-	-	-	-	-	-
18	Grants and Earned Contracts	191,061	-	-	-	-	191,061	-	-	-	-
19	Interest Income - Working Capital	35,645	-	-	-	-	-	-	35,645	-	-
20	Interest Income - ISF Risk Reserve	1,330	-	-	-	-	-	-	1,330	-	-
21	Local Funds Contributions	287,699	-	-	-	-	-	-	287,699	-	-
22	Other Local Income	42,083	-	-	-	-	-	-	42,083	-	-
23											
24	**TOTAL REVENUE**	42,532,457	31,999,865	5,233,373	2,632,378	597,885	1,302,649	399,549	366,758	-	-
25											
26	**EXPENSE**										
27	Healthcare Cost										
28	Provider Claims Cost	3,384,805	642,933	711,282	-	542,439	1,122,813	165,358	-	-	-
29	CMHP Subcontracts, net of 1st & 3rd party	36,416,525	29,992,095	3,358,184	2,696,155	288,878	111,212	-	-	-	-
30	Insurance Provider Assessment Withhold (IPA)	451,925	451,925	-	-	-	-	-	-	-	-
32	MHL Cost in Excess of Medicare FFS Cost	-	256,632	-	-	(256,632)	-	-	-		
33											
34	Total Healthcare Cost	40,253,255	31,533,585	4,069,446	2,696,155	554,685	1,234,025	165,358	-	-	-
35	Medical Loss Ratio (HCC % of Revenue)	96.9%	98.5%	77.8%	102.4%	92.8%	111.0%	41.4%			
36											
37	Administrative Cost										
38	Purchased Professional Services	85,102	-	-	-	-	-	-	85,102	-	-
39	Administrative and Other Cost	1,103,568	-	-	-	-	-	-	1,102,568	-	1,000
41	Depreciation	18,353	-	-	-	-	-	-	18,353	-	-
42	Functional Cost Reclassification	-	-	-	-	-	30,363	-	(30,363)	-	-
43	Allocated Indirect Pooled Cost	0	-	-	-	-	-	-	1,000	-	(1,000)
44	Delegated Managed Care Admin	2,656,037	2,196,851	242,261	197,567	19,358	-	-	-	-	-
45	Apportioned Central Mgd Care Admin	0	905,829	119,585	79,230	23,841	37,155	-	(1,165,640)	-	-
46											
47	Total Administrative Cost	3,863,060	3,102,680	361,847	276,796	43,200	67,518	-	11,020	-	-
48	Admin Cost Ratio (MCA % of Total Cost)	8.8%	9.0%	8.2%	9.9%	7.2%	5.2%	0.0%	2.6%		
49											
50	Local Funds Contribution	287,699	-	-	-	-	-	-	287,699	-	-
51											
52	**TOTAL COST after apportionment**	44,404,014	34,636,266	4,431,293	2,972,951	597,885	1,301,543	165,358	298,718	-	-
53											
54	**NET SURPLUS before settlement**	(1,871,556)	(2,636,400)	802,080	(340,573)	-	1,106	234,191	68,039	-	-
55	Net Surplus (Deficit) % of Revenue	-4.4%	-8.2%	15.3%	-12.9%	0.0%	0.1%	58.6%	18.6%		
56											
57	Prior Year Savings	-	-	-	-	-	-	-	-		
58	Change in PA2 Fund Balance	(234,191)	-	-	-	-	-	(234,191)	-		
59	ISF Risk Reserve Abatement (Funding)	(1,330)	-	-	-	-	-	-	(1,330)		
60	ISF Risk Reserve Deficit (Funding)	2,174,883	2,174,883	-	-	-	-	-	-		
61	Settlement Receivable / (Payable)	(1,106)	461,507	(802,080)	340,573	-	(1,106)	-	-	-	-
62	**NET SURPLUS (DEFICIT)**	66,709	-	-	-	-	-	-	66,709	-	-
63	*HMP & Autism is settled with Medicaid*										
64											
65	SUMMARY OF NET SURPLUS (DEFICIT)										
66	Prior Year Unspent Savings	-	-	-	-	-	-	-	-		
67	Current Year Savings	-	-	-	-	-	-	-	-		
68	Current Year Public Act 2 Fund Balance	-	-	-	-	-	-	-	-		
69	Local and Other Funds Surplus/(Deficit)	66,709	-	-	-	-	-	-	66,709	-	-
70											
71	**NET SURPLUS (DEFICIT)**	66,709	-	-	-	-	-	-	66,709	-	-
72											

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 11/30/2019			2									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
6	**Medicaid Specialty Services**			HCC%	79.0%	73.8%	76.4%	79.1%	77.4%	82.4%	81.2%	85.0%	76.5%
7	Subcontract Revenue		31,835,194	3,610,029	28,225,165	1,169,391	5,614,244	1,582,001	5,326,674	1,642,690	8,025,682	2,111,205	2,753,278
8	Incentive Payment Revenue		164,671	157,258	7,413	7,413	-	-	-	-	-	-	-
9	**Contract Revenue**		31,999,865	3,767,287	28,232,578	1,176,804	5,614,244	1,582,001	5,326,674	1,642,690	8,025,682	2,111,205	2,753,278
10													
11	External Provider Cost		22,965,270	842,933	22,122,338	688,245	4,345,064	1,152,495	3,907,856	1,031,259	6,104,045	1,435,192	1,478,182
12	Internal Program Cost		8,220,905	-	8,220,905	485,547	1,724,845	443,762	1,691,129	407,712	1,447,282	762,143	1,258,485
13	SSI Reimb, 1st/3rd Party Cost Offset		(94,237)	-	(94,237)	(3,102)	32,900	(10,665)	(43,272)	(2,661)	(50,926)	(4,990)	(11,299)
14	Insurance Provider Assessment Withhold (IPA)		451,925	451,925	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		(31,604)	(31,604)	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		31,512,259	1,263,253	30,249,006	1,170,690	6,102,809	1,585,572	5,555,713	1,436,110	9,500,399	2,192,344	2,725,368
17	*Medical Loss Ratio (HCC % of Revenue)*		98.5%	33.5%	107.1%	99.5%	108.7%	99.0%	104.3%	87.4%	118.4%	103.8%	99.0%
18													
19	**Managed Care Administration**		3,122,038	905,629	2,216,209	96,743	405,613	137,581	355,833	106,801	769,628	146,299	197,711
20	*Admin Cost Ratio (MCA % of Total Cost)*		9.0%	2.5%	6.4%	7.6%	6.2%	8.1%	6.0%	6.9%	7.5%	6.2%	6.8%
21													
22	**Contract Cost**		34,634,297	2,169,082	32,465,215	1,267,432	6,508,422	1,703,153	5,911,547	1,542,911	10,270,028	2,338,643	2,923,079
23	**Net before Settlement**		(2,634,431)	1,598,205	(4,232,637)	(90,628)	(894,178)	(121,152)	(584,873)	99,779	(2,244,346)	(227,438)	(169,802)
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		461,507	(3,771,130)	4,232,637	90,628	894,178	121,152	584,873	(99,779)	2,244,346	227,438	169,802
28	**Net after Settlement**		(2,172,924)	(2,172,924)	-	-	-	-	-	-	-	-	-
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		145,480	145,480	145,480	7,379	28,271	7,994	27,435	8,570	38,300	12,074	15,457
32	Revenue PMPM		$ 109.96	$ 12.95	$ 97.03	$ 79.74	$ 99.29	$ 98.96	$ 97.08	$ 95.84	$ 104.77	$ 87.43	$ 89.06
33	Expense PMPM		$ 119.03	$ 7.45	$ 111.58	$ 85.88	$ 115.11	$ 106.53	$ 107.74	$ 80.02	$ 134.07	$ 96.85	$ 94.56
34	Margin PMPM		$ (9.06)	$ 5.49	$ (14.55)	$ (6.14)	$ (15.81)	$ (7.58)	$ (10.66)	$ 5.82	$ (29.30)	$ (9.42)	$ (5.49)
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		145,480	145,480	145,480	7,379	28,271	7,994	27,435	8,570	38,300	12,074	15,457
41	Budget		148,407	148,407	148,407	7,521	28,972	8,437	27,913	8,550	39,123	12,222	15,669
42	Variance - Favorable / (Unfavorable)		(2,927)	(2,927)	(2,927)	(142)	(701)	(443)	(478)	20	(823)	(148)	(212)
43	% Variance - Fav / (Unfav)		-2.0%	-2.0%	-2.0%	-1.9%	-2.4%	-5.3%	-1.7%	0.2%	-2.1%	-1.2%	-1.4%
44													
45	**Contract Revenue before settlement**												
46	Actual		31,999,865	3,767,287	28,232,578	1,176,804	5,614,244	1,582,001	5,326,674	1,642,690	8,025,682	2,111,205	2,753,278
47	Budget		34,011,475	2,873,673	31,137,802	1,232,730	6,199,356	1,664,872	5,713,851	1,625,394	9,627,535	2,090,162	2,983,904
48	Variance - Favorable / (Unfavorable)		(2,011,610)	893,614	(2,905,224)	(55,925)	(585,113)	(82,870)	(387,177)	17,297	(1,601,853)	21,043	(230,626)
49	% Variance - Fav / (Unfav)		-5.9%	31.1%	-9.3%	-4.5%	-9.4%	-5.0%	-6.8%	1.1%	-16.6%	1.0%	-7.7%
50													
51	**Healthcare Cost**												
52	Actual		31,512,259	1,263,253	30,249,006	1,170,690	6,102,809	1,585,572	5,555,713	1,436,110	9,500,399	2,192,344	2,725,368
53	Budget		31,774,872	1,721,674	30,053,199	1,295,029	6,075,510	1,593,202	5,357,459	1,542,796	9,109,251	2,161,960	2,915,990
54	Variance - Favorable / (Unfavorable)		262,613	458,421	(195,807)	125,340	(27,298)	27,630	(198,254)	106,686	(391,148)	(30,384)	191,622
55	% Variance - Fav / (Unfav)		0.8%	26.6%	-0.7%	9.7%	-0.4%	1.7%	-3.7%	6.9%	-4.3%	-1.4%	6.6%
56													
57	**Managed Care Administration**												

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			Mos in Period									
2	For the Fiscal YTD Period Ended 11/30/2019			2									
3	(For Internal Management Purposes Only)			ok									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
58	Actual		3,122,036	905,829	2,216,209	96,743	405,613	137,581	355,833	106,801	769,628	146,289	197,711
59	Budget		3,430,961	1,161,322	2,269,639	96,509	452,881	133,052	386,656	118,214	765,755	134,987	181,585
60	Variance - Favorable / (Unfavorable)		308,923	255,493	53,430	(234)	47,268	(4,529)	30,823	11,413	(3,874)	(11,311)	(16,125)
61	% Variance - Fav / (Unfav)		9.0%	22.0%	2.4%	-0.2%	10.4%	-3.4%	8.0%	9.7%	-0.5%	-8.4%	-8.9%
62													
63	**Total Contract Cost**												
64	Actual		34,634,297	2,169,082	32,465,215	1,267,432	6,506,422	1,703,153	5,911,547	1,542,911	10,270,026	2,338,643	2,923,079
65	Budget		35,206,833	2,882,995	32,322,838	1,392,538	6,526,392	1,726,254	5,744,115	1,661,010	9,875,005	2,296,947	3,098,575
66	Variance - Favorable / (Unfavorable)		571,536	713,914	(142,377)	125,106	19,970	23,101	(167,431)	118,099	(395,022)	(41,696)	175,496
67	% Variance - Fav / (Unfav)		1.6%	24.8%	-0.4%	9.0%	0.3%	1.3%	-2.9%	7.1%	-4.0%	-1.8%	5.7%
68													
69	**Net before Settlement**												
70	Actual		(2,634,431)	1,598,295	(4,232,687)	(90,526)	(894,175)	(121,152)	(884,873)	99,779	(2,244,346)	(227,438)	(169,802)
71	Budget		(1,194,356)	(9,322)	(1,185,036)	(159,809)	(329,035)	(61,362)	(30,265)	(35,517)	(247,471)	(206,785)	(114,671)
72	Variance - Favorable / (Unfavorable)		(1,440,073)	1,607,618	(3,047,651)	69,180	(565,143)	(59,769)	(554,608)	135,396	(1,996,875)	(20,652)	(55,130)
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**		*Mos In Period*										
2	For the Fiscal YTD Period Ended 11/30/2019		2										
3	*(For Internal Management Purposes Only)*		DR										
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
75	***Healthy Michigan Plan***			HCC%	8.6%	14.5%	6.8%	10.8%	12.4%	4.6%	6.3%	9.7%	7.2%
76	**Contract Revenue**		5,233,373	395,235	4,838,138	232,946	991,400	225,621	896,789	258,949	1,374,630	389,831	467,972
77													
78	External Provider Cost		2,526,182	711,262	1,814,919	87,942	396,563	108,712	482,917	21,067	545,760	96,802	95,056
79	Internal Program Cost		1,543,265	-	1,543,265	139,431	306,853	101,632	428,344	58,653	195,339	151,881	161,133
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		4,069,446	711,262	3,358,184	227,373	703,416	210,344	891,261	79,720	741,099	248,783	256,188
82	**Medical Loss Ratio (HCC % of Revenue)**		77.8%	180.0%	69.4%	97.6%	71.0%	93.2%	99.4%	30.8%	53.9%	63.8%	54.7%
83													
84	**Managed Care Administration**		361,847	119,585	242,261	18,790	46,751	18,485	57,084	5,929	60,037	16,802	18,585
85	**Admin Cost Ratio (MCA % of Total Cost)**		8.2%	2.7%	5.5%	7.6%	6.2%	8.1%	6.0%	6.9%	7.5%	6.3%	6.8%
86													
87	**Contract Cost**		4,431,293	830,848	3,600,445	246,162	750,167	228,828	948,345	85,649	801,135	265,585	274,773
88	**Net before Settlement**		802,080	(435,613)	1,237,693	(13,216)	241,233	(3,208)	(51,556)	173,300	573,495	124,447	193,199
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(802,080)	435,613	(1,237,693)	13,216	(241,233)	3,208	51,556	(173,300)	(573,495)	(124,447)	(193,199)
93	**Net after Settlement**		(0)	(0)	-	-	-	-	-	-	-	-	-
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		24,536	24,536	24,536	1,184	5,074	1,145	4,443	1,514	5,634	1,962	2,382
97	Revenue PMPM		$ 106.65	$ 8.05	$ 98.59	$ 98.37	$ 97.70	$ 98.52	$ 100.93	$ 85.52	$ 100.58	$ 99.37	$ 98.23
98	Expense PMPM		90.30	16.93	73.37	103.96	73.93	99.93	106.74	28.29	58.62	67.65	57.68
99	Margin PMPM		$ 16.34	$ (8.88)	$ 25.22	$ (5.58)	$ 23.77	$ (1.40)	$ (5.80)	$ 57.23	$ 41.96	$ 31.72	$ 40.55
100													
101	***Healthy Michigan Plan***												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		24,536	24,536	24,536	1,184	5,074	1,145	4,443	1,514	5,634	1,962	2,382
106	Budget		51,569	51,569	51,569	2,512	10,410	2,431	9,168	2,975	15,052	3,917	5,103
107	Variance - Favorable / (Unfavorable)		(27,033)	(27,033)	(27,033)	(1,328)	(5,337)	(1,286)	(4,726)	(1,461)	(9,419)	(1,956)	(2,721)
108	% Variance - Fav / (Unfav)		-52.4%	-52.4%	-52.4%	-52.9%	-51.3%	-52.9%	-51.5%	-49.1%	-54.6%	-49.9%	-53.3%
109													
110	**Contract Revenue before settlement**												
111	Actual		5,233,373	395,235	4,838,138	232,946	991,400	225,621	896,789	258,949	1,374,630	389,831	467,972
112	Budget		4,837,836	836,033	4,001,803	193,209	807,426	187,538	716,094	228,052	1,174,935	302,810	391,739
113	Variance - Favorable / (Unfavorable)		395,537	(440,798)	836,335	39,737	183,974	38,083	180,695	30,897	199,695	87,021	76,233
114	% Variance - Fav / (Unfav)		8.2%	-52.7%	20.9%	20.6%	22.8%	20.3%	25.2%	13.5%	17.0%	28.7%	19.5%
115													
116	**Healthcare Cost**												
117	Actual		4,069,446	711,262	3,358,184	227,373	703,416	210,344	891,261	79,720	741,099	248,783	256,188
118	Budget		4,187,954	968,838	3,219,116	230,125	481,409	210,972	798,967	163,739	854,713	194,219	289,972
119	Variance - Favorable / (Unfavorable)		118,508	257,575	(139,067)	2,753	(222,007)	628	(97,295)	84,019	113,614	(54,564)	33,784
120	% Variance - Fav / (Unfav)		2.8%	26.6%	-4.3%	1.2%	-46.1%	0.3%	-12.3%	51.3%	13.3%	-28.1%	11.7%
121													
122	**Managed Care Administration**												
123	Actual		361,847	119,585	242,261	18,790	46,751	18,485	57,084	5,929	60,037	16,802	18,585
124	Budget		400,943	156,427	242,516	17,138	35,865	17,619	57,302	12,548	71,850	12,127	18,051
125	Variance - Favorable / (Unfavorable)		39,096	36,842	255	(1,653)	(10,886)	(866)	218	6,618	11,814	(4,675)	(534)
126	% Variance - Fav / (Unfav)		9.8%	24.5%	0.1%	-9.6%	-30.3%	-4.9%	0.4%	52.7%	16.4%	-38.5%	-3.0%

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 11/30/2019			2									
3	*(For Internal Management Purposes Only)*			ok									
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	WoodLands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
127													
126	**Total Contract Cost**												
129	Actual		4,431,293	830,848	3,600,445	246,162	750,167	228,828	943,345	85,649	801,135	255,385	274,773
130	Budget		4,588,897	1,127,265	3,461,632	247,262	617,294	228,590	851,269	176,285	926,563	208,345	308,023
131	Variance - Favorable / (Unfavorable)		157,604	296,417	(138,813)	1,099	(232,873)	(238)	(97,077)	90,637	125,428	(59,039)	33,250
132	% Variance - Fav / (Unfav)		3.4%	26.3%	-4.0%	0.4%	-46.0%	-0.1%	-11.4%	51.4%	13.5%	-28.6%	10.8%
133													
134	**Net before Settlement**												
135	Actual		802,050	(435,618)	1,237,693	(13,216)	241,233	(3,208)	(51,556)	173,300	573,495	124,447	193,199
136	Budget		248,939	(291,232)	540,171	(54,053)	290,132	(41,052)	(135,174)	51,766	248,372	96,465	83,715
137	Variance - Favorable / (Unfavorable)		553,141	(144,381)	697,522	40,836	(48,898)	37,844	83,619	121,534	325,123	27,982	109,483
138													
139		X											

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 11/30/2019			2									
3	*(For Internal Management Purposes Only)*			ok									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
140	**Autism Specialty Services**			HCC%	7.0%	5.1%	10.7%	5.5%	3.5%	5.3%	7.1%	3.5%	11.2%
141	Contract Revenue		2,632,378	119,981	2,512,397	131,643	526,341	146,690	504,675	120,713	809,139	-	273,196
142													
143	External Provider Cost		2,337,176	-	2,337,176	-	855,723	106,294	2,021	110,537	828,182	63,482	370,936
144	Internal Program Cost		358,979	-	358,979	80,315	758	2,491	249,522	-	-	266	25,629
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	Total Healthcare Cost		2,696,155	-	2,696,155	80,315	856,480	108,786	251,543	110,537	828,182	63,748	396,565
147	Medical Loss Ratio (HCC % of Revenue)		102.4%	0.0%	107.3%	61.0%	162.7%	74.2%	49.8%	91.6%	102.4%	0.0%	145.2%
148													
149	Managed Care Administration		276,796	79,230	197,567	6,637	56,924	9,560	16,111	8,220	67,091	4,254	28,769
150	Admin Cost Ratio (MCA % of Total Cost)		9.3%	2.7%	6.6%	7.6%	6.2%	8.1%	6.0%	6.9%	7.5%	6.3%	6.8%
151													
152	Contract Cost		2,972,951	79,230	2,893,721	86,952	913,404	118,346	267,654	118,757	895,273	68,002	425,334
153	Net before Settlement		(340,573)	40,751	(381,324)	44,692	(387,063)	28,344	237,021	1,956	(86,135)	(68,002)	(152,137)
154	Contract Settlement / Redistribution		340,573	(40,751)	381,324	(44,692)	387,063	(28,344)	(237,021)	(1,956)	86,135	68,002	152,137
155	Net after Settlement		0	0	-	-	-	-	-	-	-	-	-
156													
157		x											
158	**SUD Block Grant Treatment**			HCC%	0.3%	0.5%	0.5%	0.5%	0.0%	0.5%	0.0%	0.8%	0.5%
159	Contract Revenue		1,111,588	877,762	233,826	15,241	76,634	5,827	-	36,908	45,194	31,877	19,946
160													
161	External Provider Cost		1,122,813	1,122,813	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		111,212	-	111,212	7,926	36,244	18,300	-	8,080	930	20,505	19,227
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	Total Healthcare Cost		1,234,025	1,122,813	111,212	7,926	36,244	18,300	-	8,080	930	20,505	19,227
165	Medical Loss Ratio (HCC % of Revenue)		111.0%	127.9%	47.6%	52.0%	46.0%	314.1%	0.0%	21.9%	2.1%	64.3%	96.4%
166													
167	Managed Care Administration		(123,543)	(123,543)	-	-	-	-	-	-	-	-	-
168	Admin Cost Ratio (MCA % of Total Cost)		-11.1%	-11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
169													
170	Contract Cost		1,110,482	999,270	111,212	7,926	36,244	18,300	-	8,080	930	20,505	19,227
171	Net before Settlement		1,106	(121,508)	122,614	7,314	42,590	(12,473)	-	28,829	44,264	11,372	719
172	Contract Settlement		(1,106)	121,508	(122,614)	(7,314)	(42,590)	12,473	-	(28,829)	(44,264)	(11,372)	(719)
173	Net after Settlement		0	-	-	-	-	-	-	-	-	-	-
174													
175		x	0										

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 11/30/2019			z									
3	*(For Internal Management Purposes Only)*			ok									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
176	**SWMBH CMHP Subcontracts**												
177	Subcontract Revenue		40,812,583	5,003,006	35,809,527	1,549,221	7,210,819	1,960,139	6,726,138	2,059,260	10,254,644	2,532,913	3,514,392
178	Incentive Payment Revenue		164,671	157,258	7,413	7,413	-	-	-	-	-	-	-
179	**Contract Revenue**		**40,977,204**	**5,160,265**	**35,816,940**	**1,556,634**	**7,210,819**	**1,960,139**	**6,726,138**	**2,059,260**	**10,254,644**	**2,532,913**	**3,514,392**
180													
181	External Provider Cost		28,951,441	2,677,008	26,274,433	776,187	5,597,350	1,347,501	4,372,795	1,162,862	9,477,987	1,585,576	1,944,174
182	Internal Program Cost		10,234,360	-	10,234,360	713,219	2,068,698	566,185	2,368,995	474,445	1,643,551	934,794	1,464,472
183	SSI Reimb. 1st/3rd Party Cost Offset		(94,237)	-	(94,237)	(3,102)	32,900	(10,685)	(43,272)	(2,861)	(50,928)	(4,990)	(11,299)
184	Insurance Provider Assessment Withhold (IPA)		451,925	451,925	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		(31,604)	(31,604)	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**39,511,885**	**3,097,329**	**36,414,556**	**1,486,304**	**7,698,948**	**1,903,002**	**6,698,518**	**1,634,446**	**11,070,610**	**2,525,380**	**3,397,347**
187	Medical Loss Ratio (HCC % of Revenue)		96.4%	60.0%	101.7%	95.5%	106.8%	97.1%	99.6%	79.4%	108.0%	99.7%	96.7%
188													
189	**Managed Care Administration**		**3,637,138**	**981,101**	**2,656,037**	**122,169**	**509,289**	**165,626**	**429,028**	**120,950**	**696,756**	**167,154**	**245,065**
190	Admin Cost Ratio (MCA % of Total Cost)		8.4%	2.3%	6.2%	7.6%	6.2%	8.0%	6.0%	6.9%	7.5%	6.2%	6.7%
191													
192	**Contract Cost**		**43,149,022**	**4,078,429**	**39,070,593**	**1,608,473**	**8,208,237**	**2,068,627**	**7,127,546**	**1,755,397**	**11,967,366**	**2,692,534**	**3,642,413**
193	**Net before Settlement**		**(2,171,818)**	**1,081,836**	**(3,253,654)**	**(51,839)**	**(997,418)**	**(108,489)**	**(399,408)**	**303,864**	**(1,712,722)**	**(159,621)**	**(128,021)**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		(1,106)	(3,254,760)	3,253,654	51,839	997,418	108,489	399,408	(303,864)	1,712,722	159,621	128,021
198	**Net after Settlement**		**(2,172,924)**	**(2,172,924)**	**-**	**(0)**	**-**	**-**	**0**	**-**	**-**	**(0)**	**(0)**
199													
200													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 11/30/2019			2									
3	*(For Internal Management Purposes Only)*			ok									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Berry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
201	**State General Fund Services**			HCC%	4.9%	5.3%	5.6%	3.5%	6.6%	6.2%	5.3%	1.9%	4.5%
202	**Contract Revenue**				1,807,439	60,184	320,788	114,500	328,256	114,709	613,102	99,094	156,806
203													
204	External Provider Cost				695,055	47,430	39,201	9,190	68,318	73,948	407,813	26,337	22,817
205	Internal Program Cost				1,214,468	53,043	249,196	97,434	406,808	34,105	245,106	23,180	135,596
206	SSI Reimb, 1st/3rd Party Cost Offset				(29,357)	-	-	-	-	-	(29,357)	-	-
207	**Total Healthcare Cost**				1,880,167	100,473	288,397	76,624	475,127	108,053	623,562	49,517	158,413
208	Medical Loss Ratio (HCC % of Revenue)				104.0%	166.9%	89.9%	66.9%	144.7%	94.2%	101.7%	50.0%	101.0%
209													
210	**Managed Care Administration**				153,445	9,058	21,260	7,556	33,817	8,604	56,637	3,699	12,814
211	Admin Cost Ratio (MCA % of Total Cost)				7.6%	8.3%	6.9%	9.0%	6.6%	7.4%	8.3%	7.0%	7.6%
212													
213	**Contract Cost**				2,033,612	109,531	309,657	84,180	508,944	116,657	680,199	53,216	171,228
214	**Net before Settlement**				(226,173)	(49,347)	11,131	30,320	(180,688)	(1,948)	(67,097)	45,878	(14,422)
215													
216	Other Redistributions of State GF				(22,184)	(7,853)	-	-	-	-	-	-	(14,331)
217	Contract Settlement				(70,179)	-	-	(29,029)	-	-	-	(41,150)	-
218	**Net after Settlement**				(318,535)	(57,200)	11,131	1,291	(180,688)	(1,948)	(67,097)	4,728	(28,752)
219													

Southwest Michigan
BEHAVIORAL HEALTH

Fiscal Year 2019 Medicaid Services Verification Results

01/10/2020

Medicaid Services Verification Audit

Required by MDHHS-SWMBH Master Contract

- Specifications contained in the Medicaid Services Verification Technical Advisory – Contract Attachment P 6.4.1
- Report due to MDHHS by December 31 following the end of the Fiscal Year
- Any scores below 90% require submission of a Corrective Action Plan

SWMBH FY2019 Methodology

- Review performed Quarterly as follows:
- 30 unique dates of service from each CMHSP (15 CMH, 15 external provider);
- 30 unique dates of service from a universe of all SUD providers;
- 15 unique dates of service from each of the top three hospital providers (by dollar volume);
- 30 unique dates of service from each of the top three external providers (by unit volume);
- 60 unique dates of service from a Region-wide universe stratified to remove the top three hospitals and top three external providers.

Medicaid Services Verification Audit

FY2019 Audit Results

- 1,860 claims/encounters reviewed
- 1,798 claims/encounters verified to be a valid service reimbursable by Medicaid
- 62 claims/encounters identified as invalid
  - Mostly due to missing or insufficient documentation
- Overall Compliance Rate: 96.67%

2019 SWMBH Board Member & Board Alternate Attendance												
Name:	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
Board Members:												
Robert Nelson (Barry)												
Edward Meny (Berrien)												
Tom Schmelzer (Branch)												
Patrick Garrett (Calhoun)												
Michael McShane (Cass)												
Moses Walker (Kalamazoo)												
Angie Price (St. Joe)												
Susan Barnes (Van Buren)												
Alternates:												
Robert Becker (Barry)												
Nancy Johnson (Berrien)												
Jon Houtz (Branch)												
Kathy-Sue Vette (Calhoun)												
Karen Lehman (Cass)												
Patricia Guenther (Kalamazoo)												
Cathi Abbs (St. Joe)												
Angie Dickerson (Van Buren)												

as of 12/13/19

Timothy Carmichael (St. Joe)												
James Blocker (Calhoun)												
Anthony Heiser (St. Joe)												
Mary (Mae) Myers (Cass)												

Green = present

Red = absent

Black = not a member

Gray = meeting cancelled

Southwest Michigan

BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting
5250 Lovers Lane, Portage, MI 49002
Dial In: 1-844-655-0022
Access Code: 738 811 844
March 13, 2020
9:30 am to 11:30 am
Draft: 12/23/19

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d)**
3. **Financial Interest Disclosure – Conflict of Interest Handling (M. Todd)**
4. **Consent Agenda**
   - January 10, 2020 SWMBH Board Meeting Minutes (d)
5. **Operations Committee**
   a. Operations Committee Minutes December 18, 2019 (d)
   b. Operations Committee Minutes January 22, 2020 (d)
6. **Ends Metrics Updates**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?
   a. 2019 Customer Satisfaction Survey Results (d) (J. Gardner)
   b. SWMBH 2019 Health Services Advisory Group (HSAG) External Quality Review Compliance Monitoring Report (d) (J. Gardner)
7. **Board Actions to be Considered**
   a. Fiscal Year 2019 Performance Bonus Incentive Program (d) (B. Casemore)
   b. Southwest Michigan Behavioral Health Operating Agreement (d) (B. Casemore)
   c. Southwest Michigan Behavioral Health Operations Committee Charter (d) (B. Casemore)
   d. SWMBH Board Retreat Planning – May 2020 (d) (B. Casemore)
8. **Board Policy Review**
   Is the Board in Compliance? Does the Policy Need Revision?
   - None scheduled
9. **Executive Limitations Review**
   Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?
   - None scheduled

10. **Board Education**

    a. Final Fiscal Year 2019 Consolidated Financial Statements (d) (T. Dawson)
    b. Fiscal year 2020 Year to Date Financial Statements (d) (T. Dawson)
    c. Fiscal Year 2019 Program Integrity Compliance Program Evaluation (d) (M. Todd)
    d. Fiscal Year 2019 HIPAA Privacy/Security Report (d) (M. Todd)
    e. Fiscal Year 2019 Quality Assurance and Performance Improvement Program Evaluation (d) (J. Gardner)
    f. Integrated Care (M. Kean)
    g. Consider Alternate Board Meeting Locations (B. Casemore)
    h. Auditor Procurement (T. Dawson)

11. **Communication and Counsel to the Board**

    a. Michigan Consortium for Healthcare Excellence (B. Casemore)
    b. 2020 Public Policy Legislative Event (d) (B. Casemore)
    c. Board Member Attendance Roster (d)
    d. April: Board Elections

12. **Public Comment**

13. **Adjournment**

Next SWMBH Board Meeting
April 10, 2020
9:30 am - 11:00 am
5250 Lovers Lane, Portage, MI 49002

Southwest Michigan
BEHAVIORAL HEALTH

2020 Regional Healthcare Policy Forum

Invitees:
- Community Mental Health Service Providers
- Elected and Appointed State, Local, County Officials

Date: April 17, 2020

Location: Kalamazoo Area

Panelists: Invited Panelists

Robert Gordon, Director
Michigan Department of Health and Human Services

Kevin Fisher, Executive Director
Michigan National Alliance on Mental Illness

Michael Shirkey, Senator
Michigan Senate Majority Leader

George Mellos, M.D., Senior Deputy Director
Behavioral Health & Developmental Disabilities Administration

Jay Rosen, President
Health Management Associates

Purpose/Objectives

- To explore the Michigan Department Health and Human Services proposal and plans for specialty integrated health plans
- To deliberate the implications, ramifications, and transition requirements

Facilitator: Scott Dzurka, Vice President
Public Sector Consultants

Agenda

8:30 am – 9:15 am	Registration and Continental Breakfast
9:15 am – 9:25 am	Welcome & Introductions Bradley Casemore, Executive Director Southwest Michigan Behavioral Health
9:35 am – 11:30 am	Discussion Invited Panelists • MDHHS ** Gordon/Mellos • Shirkey • Fischer • Rosen • Questions and Answers
11:30 am – 12:00 pm	Light Hors D'oeuvres and Conversation

** Photographer Available **

vs 1/7/20

December 16, 2019

Mr. Brad Casemore
Southwest Michigan Behavioral Health
5250 Lovers Lane
Portage, MI 49002

Dear Brad,

It is with regret that I inform you of my decision to resign my position as an Alternate member representing Cass County Mental Health dba Woodlands Behavorial Healthcare Network on the SWMBH Board of Directors effective immediately.

It has been a great privilege to have had the opportunity to serve along side such dedicated individuals who represent our region.

Wishing you all the best In the New Year.

Sincerely,

Karen Lehman

Karen Lehman

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

December 19, 2019

Bradley Casemore, Director
Southwest Michigan Behavioral Health
5250 Lovers Lane, Ste 200,
Portage, MI 49002

Dear Bradley Casemore,

On September 19, 2017, the federal Department of Health and Human Services, Office of the Inspector General (OIG), announced their intent to start an audit to determine if Michigan made capitation payments on behalf of deceased beneficiaries after their dates of death. This audit covered capitation payments made for calendar years 2014-2016 and was conducted nationally.

The Michigan Department of Health and Human Services (MDHHS) was recently notified of the results of this audit. The OIG is now requiring that all states, including Michigan, return any inappropriate capitation payments made for deceased beneficiaries to the federal government. Michigan has validated the inappropriate payment data identified by the federal auditor and has one year to return all applicable associated funding.

Your agency, Southwest Michigan Behavioral Health, was identified as receiving $317,331.84 in inappropriate capitation payments, pertaining to 214 unique member identification numbers made after the beneficiaries' month of death. As a result of these inappropriate payments and the federal requirement to return these payments, MDHHS will be recouping these overpayments from your agency over the next twelve months in increments based on the beneficiaries' month of death.

The first recoupment of inappropriate capitation payments will begin in January 2020 and will cover all payments made to a respective beneficiary with an associated death that occurred in January of any year; such as, January 2014, January 2015 or January 2016. All respective payments made on behalf of the deceased beneficiary will be recovered within the month of death during calendar year 2020. For example, if a beneficiary died in January 2014 and capitation payments were made through March 2014, the recoupment for all the beneficiary's inappropriate capitation payments will occur in January 2020. This will allow MDHHS to recoup all payments within the twelve months required for MDHHS to return the applicable funding. All member-level detail for these recoupments will be included in the monthly 820 payment file. Specifically, the capitation month being recouped as well as the recoupment dollar amount will be listed for each member for which MDHHS processed a recoupment that month.

Thank you for your partnership in this challenging endeavor. We want to work with you to make this as seamless as possible. If you have any questions, please contact MDHHS Bureau of Audit Director, Pam Myers at 517-241-4237 or Myersp3@michigan.gov.

Sincerely,

Farah A. Hanley
Senior Deputy Director
Financial Operations Administration

cc: Elizabeth Hertel, Chief Deputy Director
Kate Massey, Senior Deputy Director
Dr. George Mellos, Senior Deputy Director
Jeff Wieferich, Director
Mary Ann Bush, Assistant

Southwest Michigan
BEHAVIORAL HEALTH

Board Meeting /Retreat

Date: May 8, 2020

Sherman Lake YMCA Event & Retreat Center

6225 North 39th St. Augusta, MI 49012

To Be Confirmed

Draft Agenda

1/3/20

Facilitator: Scott Dzurka, Public Sector Consultants

9:00 am-9:30 am	*Full Breakfast*
9:30 am–10:30 am	SWMBH Board Meeting
10:30 am-10:45 am	*Break*
10:45 am-11:00 am	Board Retreat
	Welcome, Introductions, and Session Objectives (Scott Dzurka)
Objectives:	1) Environmental Scan
	2) Implications and Ramifications of Environmental Scan
	3) Identify Course of Action for SWMBH Regional Entity
11:00 am-11:45 am	Environmental Scan
	Alan Bolter, Associate Director
	Community Mental Health Association of Michigan

- Overview of the evolving federal, state, and regional healthcare policy landscape
- Questions and Discussion

11:45 am-12:45	Sarah Esty, Senior Deputy Director (Invited) Michigan Department of Health and Human Services • Overview of the evolving federal, state, and regional healthcare policy landscape • Questions and Discussion
12:45 pm-1:30 pm	Lunch Break
1:30 pm-2:30 pm	Jay Rosen, President (Invited) Health Management Services • Overview of the evolving federal, state, and regional healthcare policy landscape • Questions and Discussion
2:30 pm-3:00 pm	Summary and Next Steps • Follow Up Meeting – June 12, 2020 • Extended Board Meeting -- 11:00 am – 1:00 pm • Lunch Provided
3:00 pm	Adjourn

* * * * * * *

Participants:

* SWMBH Board and Board Alternates

* CMHSP CEOs

* SWMBH Chief Financial Officer, Chief Compliance & Privacy Officer, Chief Information Officer, Chief Administrative Officer, Director of Quality Assurance and Performance Improvement, Director of Clinical Quality, Director of SUD Services

* SWMBH Consumer Advisory Committee Chair/Vice Chair

* SWMBH Substance Use Disorder Oversight Policy Board Chair/Vice Chair

Articles:

SAMHSA Strategic Plan FY2019-FY2023

NIHCM Foundation – Mental Health Trends & Failure Outlook

MDHHS PUBLIC FORUMS:
THE FUTURE OF BEHAVIORAL HEALTH IN MICHIGAN

Please join the Michigan Department of Health and Human Services (MDHHS) for a conversation about the future of behavioral health in Michigan.

In December 2019, MDHHS outlined a vision for a stronger behavioral health system that integrates specialty behavioral health and physical health services. If you are served by Michigan's Medicaid-funded behavioral health system or are the family member of a person served, we want to hear from YOU.

MDHHS is hosting five public forums throughout the state and online in early 2020. Department leadership will be in attendance to further discuss the vision, answer your questions, and listen to your feedback. Please join us!

1. **Detroit**: January 8, 2020 from 5:00-6:30 p.m.
   Cadillac Place, 3044 W Grand Blvd
   Conference Room L-150

2. **Grand Rapids**: January 9, 2020 from 5:00-6:30 p.m.
   Grand Valley State University L.V. Eberhard Center, 301 W Fulton
   Room 201

3. **Marquette**: January 22, 2020 from 5:00-6:30 p.m.
   Marquette Senior High School, 1203 W Fair Ave
   Little Theater

4. **Saginaw**: January 30, 2020 from 5:00-6:30 p.m.
   Saginaw Valley State University Gilbertson Hall, 7400 Bay Road
   Ott Auditorium

5. **Virtual Forum**: February 6, 2020 from 5:00-6:30 p.m.
   The link for this event will be shared on www.michigan.gov/FutureOfBehavioralHealth in late January.

To learn more about the Department's vision, please visit www.michigan.gov/FutureOfBehavioralHealth. If you cannot attend an event, we would still love to hear from you. You can email your feedback to FutureOfBH@michigan.gov.

MDHHS

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

January 6, 2020

Bradley Casemore
Southwest Behavioral Health
5250 Lovers Lane, Suite 200
Portage, MI 49002

Dear Mr. Casemore:

We have completed a review of Southwest Michigan Behavioral Health's (SWMBH) fiscal year (FY) 2020 Risk Management Strategy. The components of SWMBH's Risk Management Strategy are in compliance with Prepaid Inpatient Health Plan contract sections 8.6.3 Risk Management Strategy, 8.6.4 PIHP Assurance of Financial Risk Protection and attachment P8.6.4.1 Internal Service Fund Technical Requirements and the Michigan Department of Health and Human Services policy regarding Risk Management Strategies as established in the Technical Advisory issued October 10, 2008.

If there are any anticipated changes to SWMBH's FY 2020 Risk Management Strategy during the fiscal year, please submit a revised plan to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov.

Sincerely,

Jeffery L. Wieferich, M.A., LLP, Director
Bureau of Community Based Services

cc: George Mellos, MDHHS
Kendra Binkley, MDHHS
Lyndia Deromedi, MDHHS
Tracy Dawson, SWMBH

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- Facilitating Organizational Change: the Transition to Effective Governance
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- The Monitoring Schedule: When and How Often to Monitor
- Board Motions

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Healthcare Affordability State Policy Scorecard

Polling data repeatedly shows that healthcare affordability is the number one issue that state residents, on both sides of the political aisle, want their policymakers to work on. This scorecard identifies areas where Michigan is doing well and areas where it can improve.

STATE: MICHIGAN **RANK: 22** out of 42 states + DC

Michigan has an average level of healthcare spending per person, yet a high percentage of residents report affordability problems, suggesting a need for policymaker attention.

	POLICY SCORE	OUTCOME SCORE	RECOMMENDATIONS
EXTEND COVERAGE TO ALL RESIDENTS	**3 OUT OF 10 POINTS** Medicaid coverage for childless adults extends to 138% of FPL. Certain recent immigrants have state coverage options.	**8 OUT OF 10 POINTS** In 2018, MI was in the top third of states in terms of covering the uninsured, ranking 9 out of 50 states, plus DC, for this measure.	*Consider options that help families that make too much to qualify for Medicaid like Basic Health Plan, reinsurance or supplementary premium subsidies. Additionally, MI should consider adding affordability criteria to its insurance rate review.*
MAKE OUT-OF-POCKET COSTS AFFORDABLE	**1 OUT OF 10 POINTS** MI has some protections against skimpy, confusing STLD health plans.	**5 OUT OF 10 POINTS** Forty-one percent of adult residents report healthcare OOP affordability burdens. As a result, MI ranked 28 out of 49 states, plus DC, for this measure.	*In light of grave affordability problems, MI should consider a suite of measures to ease consumer burdens, including: SMB protections; stronger protections against STLD health plans; and enacting provisions to lower the cost of high-value care.*
REDUCE LOW-VALUE CARE	**1 OUT OF 10 POINTS** MI has not enacted meaningful patient safety reporting. MI performs below average for hospital antibiotic stewardship and has not measured the provision of low-value care.	**4 OUT OF 10 POINTS** MI ranks average in terms of reducing C-sections for low risk mothers (32 out of 50 states, plus DC). MI ranks 32 out of 50 states, plus DC, in terms of per capita antibiotic prescribing.	*Curtailing low- and no-value care is a key part of a comprehensive approach to affordability. MI should use claims & EHR data to identify unnecessary care & enact a multi-stakeholder effort to reduce it. MI should stop paying for 'never events,' use other techniques to reduce medical harm and increase efforts to address antibiotic overprescribing.*
CURB EXCESS PRICES IN THE SYSTEM	**3 OUT OF 10 POINTS** While MI has an APCD, the state is otherwise a middle-ranked state with a few policies to curb the rise of healthcare prices.	**8.3 OUT OF 10 POINTS** MI's private payer price levels are close to the national median, ranking 15 out of 42 states, plus DC, for this measure.	*Year-over-year increases in healthcare prices overwhelmingly drive healthcare spending in a state. MI should consider strong price transparency requirements; establishing a health spending oversight entity; and creating health spending targets.*

APCD = All-Payer Claims Database FPL = Federal Poverty Level EHR = Electronic Health Records OOP = Out-of-Pocket Costs SMB = Surprise Medical Bill STLD = Short-Term, Limited-Duration

See state notes on page 2.

Full report and additional details at **www.HealthcareValueHub.org/Affordability-Scorecard/Michigan**

ALTARUM HEALTHCARE VALUE HUB

Healthcare Affordability State Policy Scorecard

STATE: **MICHIGAN** RANK: **22** out of 42 states + DC

MICHIGAN NOTES

Methodological Notes:

State rank reflects the weighted sum of the policy and outcome scoring components. In this summation, the Extend Coverage to All Residents category received the biggest weight (reflecting its large impact on the uninsured population) and Reduce Low-Value Care received the smallest weight, reflecting its smaller impact on spending. A lower state rank number (i.e. close to 1) reflects a higher overall score and better performance when compared to other states.

For a complete discussion of methodology, please see healthcarevaluehub.org/affordability-scorecard/methodology.

The Problem:

Forty-one percent of Michigan adults report healthcare OOP affordability burdens, giving the state a rank of 28 out of 49 states, plus DC, for this measure. The most common burden reported was 'trouble paying medical bills' (32% of adults), followed by 'made changes to medical drugs because of cost.' According to the BEA, healthcare spending in Michigan totalled $7,031 per person in 2018.* Moreover, between 2013 and 2018, healthcare spending per person grew 15.3%.* Residents are struggling to afford needed healthcare and Michigan has much work to do to ensure wise health spending and affordability for residents.

Extend Coverage to All Residents:

Some level of prenatal care is available, regardless of immigration status, through CHIP's "unborn child" option.

Make Out-of-Pocket Costs Affordable:

High-deductible health plans create barriers to care for many families. Between 2011 and 2016, the average deductible associated with employer coverage rose 8.6% per year in Michigan.*

Reduce Low-Value Care:

Addressing medical harm to increase patient safety can take many forms. One form is declining payment for services related to "never events," serious reportable events identified by the National Quality Forum (NQF) that should never occur in a healthcare setting.

Eighty-three percent of Michigan hospitals have adopted the CDC's 'Core Elements' of antibiotic stewardship — short of the goal of 100% of hospitals.

Curb Excess Prices in the System:

Private payer prices in Michigan are 156% higher than prices paid by Medicare.*

Claims submission to the APCD is voluntary.

NOTE: The very high healthcare prices seen in Alaska (relative to the national median) means that most other states received a relatively good outcome score for this category.

* Informational data, not used in state score or ranking. DOI = Department of Insurance BEA = U.S. Bureau of Economic Analysis • Scorecard Updated: Jan. 7, 2020

Full report and additional details at **www.HealthcareValueHub.org/Affordability-Scorecard/Michigan**

ALTARUM HEALTHCARE VALUE HUB

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

January 7, 2020

Community Mental Health Association of Michigan
426 S. Walnut Street
Lansing, MI 48933

Dear Community Mental Health Association of Michigan:

I am writing to you to follow up on our December 4, 2019 announcement about the Michigan Department and Health and Human Services approach to strengthening Michigan's behavioral health and developmental disabilities system. We have laid out more information about our plans at www.Michigan.gov/FutureOfBehavioralHealth, and encourage your members to review those materials to better understand our approach. However, we realize further information may be helpful, particularly around the central role we are asking Community Mental Health service providers (CMHs) to play in the future system.

I honor the extraordinary work that your members have done to establish a public safety net that serves all Michiganders. So many states would love to create what you have built. At the same time, we must confront the significant shortcomings in Michigan's overall approach to behavioral health: At the frontline level, physical and behavioral health are not sufficiently integrated. With separate financing approaches, there are neither incentives nor simple mechanisms to increase investment into behavioral health care, even when so doing saves physical health dollars. The system provides limited choice for consumers or public accountability for results, and it faces ongoing financial instability. What is more, the conditions that have driven past movement for major system reform—growing needs and limited resources—will only intensify in coming years.

Piecemeal reforms would add complexity without addressing the system's deepest challenges. The question is not whether Michigan's approach to behavioral health service delivery will fundamentally change; the question is *how* it will fundamentally change. That is a question we can answer together, today. The administration in which I serve deeply understands the importance of Michigan's community-based mental health providers. We are committed to addressing systemic challenges in a way that strengthens what is best in our public system, while also bringing needed modernization. While change will be hard in the short term, change now will create a stronger foundation for the future that serves people better and ensures the long-term sustainability of our public system.

Some still believe a carve-in to the Medicaid Health Plans (MHPs) would best serve our state. We believe that a specialty integrated plan model offers a better option for Michigan, building on the strengths of our current system while also addressing its shortcomings. Our proposal includes the following fundamental elements:

- **Preserving the public safety net.** We will preserve and strengthen the safety net and community benefit system, continuing to fund and manage these services through the CMHs. We will move to greater statewide consistency in funding and benefits, while also retaining flexibility and responsiveness to meet local needs. We will ensure a

clearly defined set of core services are available statewide, and appropriate dedicated funding to support those activities.

- **Specialty integrated plan (SIP) model.** There will be one payer and one accountable organization – a specialty integrated plan or a traditional Medicaid plan – for every person. These specialty integrated plans will have clinical expertise and comprehensive provider networks to address complex physical and behavioral health needs for those requiring such support. They will offer the higher-touch model of care of the public specialty behavioral health system, with the administrative infrastructure, management expertise, and full risk-bearing of traditional insurance companies.
- **Focus on the specialty population.** This new system will apply to individuals in Medicaid with significant mental health needs, substance use disorders, and intellectual or developmental disabilities. At a minimum, it will include those with managed physical and behavioral health care today (served by Prepaid Inpatient Health Plans, (PIHPs) and MHPs.)
    - We look forward to public input on whether and how to include unenrolled individuals, such as Medicare-Medicaid duals.
    - We are eager to better meet the needs of individuals with mild-to-moderate behavioral health needs. We will seek significant further discussion about how to manage the transition of individuals in and out of SIPs, expecting there will be some differences between populations served by PIHPs today and those served by SIPs in the future. However, given that the purpose of SIPs is to offer a higher-touch and specialized model of care to the highest need individuals, we do not propose including all individuals with mild-to-moderate needs in SIPs.
- **Multiple SIP options.** People will have choices between SIPs, allowing them to select the one that best meets their needs. Organizations looking to offer SIPs will bid for a MDHHS contract and then to attract members, driving accountability and improved performance. We expect to offer 3-5 SIP options to ensure meaningful choices for people, while at the same time sustaining sufficient membership in each plan for actuarial soundness.
- **SIPs offered by multiple types of organizations.** Organizations seeking to offer SIPs will need to be licensed Managed Care Organizations with the requisite networks, clinical expertise, and insurance administrative functions. We invite the public behavioral health system, health plans, providers, hospitals, and others to step forward and apply to lead SIPs. We encourage all parties to form partnerships that bring in complementary expertise, networks, relationships, and capital.
- **Preference for statewide SIP design.** Our preference is for all SIPs to be statewide for several reasons: to create economies of scale; to ensure sufficient access and choice for all Michiganders (including those in rural areas); to avoid provider networks that cut off at county lines; to reduce provider burden of managing many payers; and to ease oversight and administration. We recognize the strength in many existing regional partnerships and believe these can be incorporated into statewide SIPs or potentially scaled to the state level as such. However, we are open to further conversation and input about whether regional structures are advisable.
- **Call for a statewide public-led SIP.** Because we believe in the virtues of the public system and want to ensure all people have the option to continue receiving behavioral care managed by that system, we support the establishment of a statewide SIP run by the public behavioral health system. We also see significant opportunity for a statewide public behavioral health organization to support greater consistency and efficiency in management and oversight of the public safety net system. We look forward to input and further discussion about what specific components are necessary to establish and

protect the "publicness" of this plan. At a minimum, we propose that the public SIP should be formed by public entities (like CMHs). Public entities should control what partner organizations they bring in; and there should be governance by public-entity representatives.

- **Continuing to serve as providers for the whole system.** In addition to leading your own SIP, we expect that your member CMHs and providers will be included in the provider network for all SIPs in the future system. For some organizations, this will require building new capabilities to manage multiple payers and separating out managed care costs from service costs in your accounting systems. This will be an important transition in which we know CMHs can succeed through effective planning.

We hope that you and your member organizations answer our call and form a statewide organization capable of offering a SIP. We realize applying to be a SIP will require you to build significant new capabilities: a statewide legal and governance structure such as an independent practice association (IPA), physical health networks, centralized and standardized managed care functions, and administrative capabilities and risk reserves sufficient to achieve Michigan Department of Insurance and Financial Services licensure and CMS approval as a fully risk-bearing managed care organization.

Given our plan to launch the first SIPs in October 2022, we ask that you begin taking steps to establish this new organization so that you have sufficient time to form the necessary partnerships and structures to meet these requirements.

The public system has much to offer through a holistic managed care entity. Creating a SIP can secure the strength and vitality of Michigan's public behavioral health system for decades to come, delivering quality care for hundreds of thousands of Michiganders. However, if you do not anticipate being willing or capable of offering a SIP, please inform us as soon as possible.

Throughout January, we will be hosting public forums to hear from individuals served by our behavioral health system, and continuing to have smaller conversations with legislators, advocates, providers, health plans, CMHs, PIHPs, and other stakeholders. We aim to begin moving forward with more detailed planning and legislative changes shortly thereafter. We look forward to an ongoing conversation and collaboration with your members through this process. Please do not hesitate to let me know personally how I may assist in your deliberations.

Thank you for everything you do in service to the people of Michigan.

Sincerely,

Robert Gordon
Director

RG:se